THE LAW AND ECONOMICS OF PRISON HEALTH CARE: LEGAL STANDARDS AND FINANCIAL BURDENS

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I. INTRODUCTION

The United States is facing a major health care crisis. Millions of people across the country are unable to afford medical care,¹ many people do not engage in preventive care due to high costs,² those without insurance face long waits to see doctors who will accept state-funded or self-funded patients,³ and as the nation’s economic situation worsens, so does the mental health of the U.S. population.⁴ As a country, we are also facing an incarceration crisis. As of 2008, one in every one hundred adults in the United States is incarcerated.⁵ This number continues to rise each

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³ See, e.g., Allison Sherry, Doctors Say CU Hospital Is Refusing Poor Patients, DENVER POST, October 22, 2003, at A1 (stating that Medicaid and Medicare users may face up to eight-month waiting times for appointments); Elliot Jaspin, Austin Medicaid Patients Enduring Long Waits and Long Drives to Get Care, AUSTIN AMERICAN-STATESMAN, August 6, 2007, at A1 (stating that only 18% of the city’s doctors accepted new Medicaid patients in 2007 and that some patients must wait up to fourteen months for an appointment).


⁵ The Pew Center on the States, One in 31: The Long Reach of American Corrections, 1 (2009).
year, and the U.S. continues to be the world leader in percentage of population incarcerated and in sheer numbers of people incarcerated.\textsuperscript{6}

The combination of the health care crisis and the incarceration crisis can be deadly.\textsuperscript{7} Health care problems do not disappear for those who are behind bars. People incarcerated by the state are facing largely the same health care issues as those in the general population. Women in particular are bearing the brunt of this combination crisis.\textsuperscript{8} Female inmates are unable to pay the co-payments that prison doctors often require for preventive care,\textsuperscript{9} regularly encounter difficulties getting an appointment with a doctor who is willing to see them,\textsuperscript{10} and have extremely restricted access to mental health services.\textsuperscript{11} Many institutions simply cannot afford preventive care.\textsuperscript{12} With the onset of one of the largest economic depressions in United States history, courts are struggling with the new


\textsuperscript{7} See, e.g., Amy Petre Hill, Death Through Administrative Indifference: The Prison Litigation Reform Act Allows Women to Die in California’s Substandard Prison Health Care System, 13 HASTINGS WOMEN’S L.J. 223 (2002) (describing the various ways that women have died due to poor health care in the California prison systems); See also John J. Gibbons & Nicholas de B. Katzenbach, Confronting Confinement: A Report of the Commission on Safety and Abuse in America’s Prisons, 38 (2006) (finding that in California, as late as 2005, one prisoner was dying every week as a result of medical malpractice or neglect).


\textsuperscript{10} Zulficar Gregory Restum, Public Implications of Substandard Correctional Health Care, 95 AM. J. PUB. HEALTH 1689, 1691 (2005) (concluding that the primary barrier to health care in prisons is the inability to see a doctor).

\textsuperscript{11} See, e.g., Elizabeth Alexander, The Caged Canary, 14 WM. & MARY J. WOMEN & L. 257, 267-68 (2008) (describing the lack of mental health services available to female inmates in Wisconsin, including lack of in-patient facilities and full-time psychiatric staff for women. Also states that these problems are typical of those that incarcerated women across the country face).

\textsuperscript{12} Id. at 264.
issue of how to remedy these problems—especially when they rise to the level of constitutional violations.

When the state subjects someone to incarceration, she naturally loses certain privileges. However, she should not lose her constitutional rights or sacrifice her human dignity. The United States Supreme Court, in noting the constitutional right to medical care, explained the legal principles behind this right:

[W]hen the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being.... The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual’s liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs ... it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause.¹³

Due to the current economic climate, states increasingly are cutting the budgets of some of the most needed public services—health care for those in need is among them.¹⁴ Prisons have not escaped the chopping block as states around the country rethink their budgeting priorities.¹⁵ As the country continues to balance ongoing health care issues with necessary budgetary cuts, the issue of constitutional responsibility arises. The first part of this article delineates the evolving constitutional standards of medical care. The second section discusses how the Prison Litigation Reform Act¹⁶ has impacted these standards. Finally, this paper will look at how the current economic situation has affected constitutional standards for prison medical care. It will explore California’s response to the

financial crisis and evaluate whether the response passes constitutional muster.

II. EIGHTH AMENDMENT STANDARDS FOR PRISON HEALTH CARE

A legal history of prisoners’ medical rights standards necessarily begins and ends with the Eighth Amendment. The Eighth Amendment was originally drafted to ban torture and other “barbarous” forms of punishment, but courts have interpreted it broadly to include the denial of medical care or wholly inadequate medical care. Despite recognizing this constitutional right, the Supreme Court has placed a high bar on proving a constitutional violation. In order to bring a successful claim, a plaintiff must prove that prison staff showed “deliberate indifference” to a prisoner’s “serious medical condition.” The first prong requires intent, and the second requires a medical condition that has caused or has the potential to cause serious harm to the inmate.

Deliberate indifference exists when an “official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of the facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference.” In addition to the standard definition of criminal recklessness, a prison official can also be liable if “the risk [of harm] was obvious and a reasonable prison official would have noticed it.”

A serious medical condition is one that “has been diagnosed by a physician as mandating treatment or … is so obvious that even a lay

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18 Id. at 104 (citing Gregg, 482 U.S. 153 at 173).
19 See generally Helling v. McKinney, 509 U.S. 25 (1993) (stating that in order to bring an Eighth Amendment claim of deliberate indifference to a serious medical condition it is not necessary to prove that the harm has already occurred, plaintiff can instead show that there is an unreasonable risk of serious damage to their future health).
21 Id. at 842.
person would easily recognize the necessity for a doctor’s attention.” 22 In many situations, courts rely on context to determine whether the condition was in fact a serious one. 25

Courts have increasingly been amenable to new legal interpretations that reflect current societal standards of health care. In fact, as early as 1910 the Supreme Court noted that the Eighth Amendment “is not fastened to the obsolete but may acquire meaning as public opinion becomes enlightened by a humane justice.” 24 Case law truly is evolving traditional standards. For example, in 2003 a Wisconsin court held that pregnancy was a serious medical condition under the Eighth Amendment. 25 Moreover, in *Helling v. McKinney*, the Supreme Court held that exposing inmates to environmental tobacco smoke against their will “pose[d] an unreasonable risk of serious damage to [the inmate’s] future health,” and therefore satisfied pleading standards under the traditional Eighth Amendment tests. 26 These cases reflect the courts’ willingness to take societal norms into consideration when determining the health care standards we impose on prison health care facilities.

Despite recognition of prisoners’ constitutional right to medical care, the Court’s standards of medical care are still difficult to delineate. The Court famously noted in *Estelle v. Gamble* that “[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner.” 27 Inmates may be forced to prove that the standard of care they received was so minimal that it suggests criminal culpability. 28 Yet such an interpretation still does not provide guidance as to what the Supreme Court would consider a satisfactory level of care. Case law states

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26 *Helling*, 509 U.S. at 35.
27 *Estelle*, 429 U.S. at 106.
28 *Farmer*, 511 U.S. at 837; see also Vaughn v. Gray, 557 F.3d 904, 908 (2009).
that prisons must provide inmates with care that is above the “minimal civilized measure of life’s necessities,” meaning that only a failure to provide the bare minimum of care will trigger constitutional concerns. Medical care that is “repugnant to the conscience of mankind” or which can “be said to constitute an unnecessary and wanton infliction of pain,” is also unconstitutional. Together these statements are vague and they force medical staff to render their own personal interpretation of the Constitution.

Individual institutional standards are no help. For example, the Pennsylvania Department of Corrections states in their Management and Administration of Health Care Policy that their health care providers must comply with “policy and procedures [American Correctional Association] standards and applicable laws.” There is no firm definition of the actual standards enforced by the institution itself or of standards required by law, and as shown above, the law itself is not clear on these standards.

As mentioned, health care professionals in the prison setting must often define constitutional standards themselves. They are also expected to know and follow both accepted medical procedures as well as the administrative and safety procedures of the institution. Restrictions put in place by institutions themselves are an added consideration. Adequately trained medical staff surely will know accepted professional standards of care, but the nature of their workplace has “a tendency to subjugate professional standards to administrative consideration in the decision-making process, fostering in professions a lack of autonomy which is vital for successful performance.” This suggests that even if a professional wanted to follow legal standards, administrative procedures and regulations limit their ability to do so. An example of such a limitation is the very common co-pay requirement. In some states, inmates who request non-emergency sick-calls must pay a “co-pay” fee, usually around five

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29 Farmer, 511 U.S. at 834.
30 Estelle, 429 U.S. at 105-06 (internal citations omitted).
dollars.\textsuperscript{33} Though a nurse may recognize that an inmate needs preventive medical attention, she might advise an inmate to wait until she has the money in her account.\textsuperscript{34} The nurse might otherwise explain to the inmate that the money will be deducted from her account when the balance reaches five dollars, no matter what other items from commissary she desperately need (such as sanitary pads, etc.)\textsuperscript{35} perhaps thereby deterring the inmate from seeking the medical attention she requires. This is a clear example of where a medical professional could be forced to choose between following institutional regulations or constitutional standards of care. These procedural limitations coupled with vague constitutional standards leave the state of constitutional health care standards in disarray.

III. THE IMPACT OF PRISON LITIGATION REFORM ACT ON CONSTITUTIONAL STANDARDS

The Prison Litigation Reform Act (hereinafter PLRA) was passed by Congress as a rider to the Balanced Budget Downpayment Act of 1996.\textsuperscript{36} It was swiftly pushed through Congress as a political reaction to the ‘tough on crime’ mentality that was enveloping the nation in the 1990s.\textsuperscript{37} The original impetus behind the law was to curtail litigation brought by prisoners against their incarcerating institutions.\textsuperscript{38} During the debate surrounding the PLRA, legislators tended to characterize all

\textsuperscript{33} Commonwealth of Pa., Dep’t of Corrections, Policy Statement: Co-Payment for Medical Services (2008), available at http://www.cor.state.pa.us/standards/cwp/view. asp?a=463&x=131813&portalNav.

\textsuperscript{34} The Pennsylvania Department of Corrections policy states that no inmate shall be denied health care due to the inability to pay; however, situations in other states suggest that inmates are forced to forego health care until they are able to pay. See Heskamp, supra note 9.

\textsuperscript{35} Hill, supra note 7, at 229.

\textsuperscript{36} Id. at 236.

\textsuperscript{37} Id.

prisoner lawsuits similarly, characterizing them as frivolous and clogging the already backed up court dockets.\(^\text{39}\)

The administrative exhaustion requirement is the PLRA’s primary defense of warding off so-called frivolous lawsuits.\(^\text{40}\) This section of the law states that in order to bring a claim using U.S. Code Section 1983, a prisoner must exhaust all administrative remedies provided by their institution before filing a federal action in court.\(^\text{41}\) If a prisoner has not exhausted all available institutional remedies, her case will be dismissed.\(^\text{42}\)

Compliance with administrative remedial procedures is often difficult for female prisoners for several reasons. Female inmates typically have higher rates of mental illness than their male counterparts\(^\text{43}\) and they are unlikely to have a high school diploma.\(^\text{44}\) Low education levels and high rates of mental illness often make it difficult to follow reporting guidelines such as filling out reports correctly and filing before deadlines.

Aside from concerns of knowing how to report and to whom, exhaustion has other implications for female inmates; it can mean that they must report medical abuses and neglect to the very people who committed the crime or to someone who is in collaboration with the perpetrator. This harassment follows women even when they seek medical attention.\(^\text{45}\) Reports have turned up stories of women seeking help for headaches, but instead getting pelvic exams from a male doctor, and of verbal abuse from

\(^{39}\) Id; see also Jones v. Bock, 549 U.S. 199, 203 (2007) (“In 2005, nearly 10 percent of all civil cases filed in federal courts nationwide were prisoner complaints…. Most of these cases have no merit; many are frivolous.”)

\(^{40}\) See Porter v. Nussle, 534 U.S. 516, 524-25 (2002) (“Beyond doubt, Congress enacted § 1997e(a) to reduce the quantity and improve the quality of prisoner suits …”).


\(^{42}\) Id.


medical technician assistants. Even those women who are brave enough to fight back face harassment. One woman describes how guards often mock those who threaten to file administrative grievances:

[Corrections officers] will tear it up and throw it in the garbage.... Or [they] will say, “go ahead and 602 me because I know it won’t go nowhere.” Most 602s will get thrown in the garbage before you go away. It’s a joke to them.

Because more than 60% of women in prison have histories of abuse, the culture of fear created by these stories and others, can hinder women from seeking medical attention and from seeking remedies when their constitutional rights are violated.

Not only can it be difficult to figure out the administrative process, but once a complaint gets into court it must state legal claims upon which there is legal relief available. If a prisoner fails to state a claim upon which relief can be granted, the PLRA does not allow prisoners to amend complaints as most civil litigants are able to do; instead, the court must dismiss the entire claim. If an inmate tries unsuccessfully to litigate a claim three times, the PLRA’s “Three Strikes Provision” bars her from filing a prison conditions suit again. This means that women who are being deprived of care cannot recover no matter the merits of their claim. When seen in conjunction with the educational and emotional barriers already faced by incarcerated women, the Three Strikes Policy functions as an added punishment to those who are already over-penalized with substandard health care.

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46 Hill, supra note 7, at 232-33.
47 In California “602” is the name of the administrative grievance form.
51 28 U.S.C § 1915(g) (2008).
52 This section makes an exception if the prisoner is in “imminent danger of serious physical injury.” Id.
The PLRA also states that women who have suffered mental or emotional injury while incarcerated may not recover without first showing physical injury. While this only applies to women seeking damages, when women are deprived of adequate health care it can lead to bona fide mental injury. As mentioned above, the female prison population has a high rate of mental illness and without proper treatment their problems can be exacerbated to the point of trauma. This trauma is precisely the sort of added punishment that the Constitution prohibits institutions from imposing on inmates. This PLRA restriction essentially modifies the constitutional standard of care initially determined by courts. Inmates can no longer receive damages if guards are deliberately indifferent to their serious mental health needs. In order for federal courts to recognize the right to damages under Section 1983, mental illness must rise to the level of self-inflicted violence or violence against others. Oddly enough, this idea of “waiting for an illness” is just what the Helling court sought to abate by holding that the Eighth Amendment protects against future harm. With the PLRA restriction on damages, inmates are unable to obtain relief for the pure failure to treat mental illness, no matter what caused the mental suffering and no matter how severe the suffering might be. In this way, the PLRA altered the Helling standard of future harm and changed the nature of potential constitutional violations.

54 See Thompson v. Carter, 284 F.3d 411, 418 (2d Cir. 2002) (stating that the physical injury provision does not prevent a prisoner from obtaining injunctive or declaratory relief).
56 See Wilson v. Seiter, 501 U.S. 294, 297 (1991) (holding that the Eighth Amendment can “be applied to some deprivations that were not specifically part of the sentence but were suffered during imprisonment”). See also Estelle v. Gamble, 429 U.S. 97, 103 (1976) (stating that Eighth Amendment prohibits punishments “which involve the unnecessary and wanton infliction of pain” (internal citations omitted)).
57 Helling v. McKinney, 509 U.S. 25, 33 (1993) (noting that “It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them. The Courts of Appeals have plainly recognized that a remedy for unsafe conditions need not await a tragic event.”).
58 Belbot, supra note 38, at 296.
When the PLRA was passed in 1996, it also drastically changed the cost structures of filing a lawsuit for impoverished inmates. Criminal defendants who are not incarcerated are entitled to a waiver of filing fees if they are determined to qualify for *in forma pauperis* status.59 Prisoners who file civil suits, however, must still pay full filing fees, albeit in installments.60 Payments of 20% of the inmate’s preceding monthly balance are automatically transferred to the clerk of the court each month until the entire fee has been paid.61

The likely result of the PLRA change in fee structures is the exclusion of many women from court. From 2007 to 2008, the number of *pro se* appeals that prisoner petitioners brought increased by 8.9%.62 In fact, from September 2007 to September 2008, almost 93% of all prisoner petitions were brought *pro se*.63 Although there are statistics showing how many cases challenging prison conditions are filed in federal court, these statistics do not differentiate according to gender.64 One may assume, however, that many *pro se* appellants are women because many of them do not have the requisite credentials that would allow them to command more than forty cents per hour.65 Low pay rates make it unlikely that women will be able to afford court filing and other litigation costs on top of the already high prices they must pay for other items in prison, such as basic hygiene products.66 Even though the PLRA states, “in no event shall a prisoner be prohibited from bringing a civil action... for the reason that

63 Id. at 78 (reporting prisoner petitions in table S-23).
64 Id.
the prisoner has no assets and no means by which to the initial partial filing fee.\textsuperscript{67} The reality is that ability to pay makes a difference in some cases.\textsuperscript{68} The inability to pay is yet another obstacle for women who have suffered violations of the Eighth Amendment.

The aforementioned problems with the PLRA have reduced the health care standards that prisons must meet in order to comply with the U.S. Constitution. The combination of exhaustion, the Three Strikes Provision, the physical injury requirement, and the change in fee structures create a situation wherein the PLRA deprives women of remedies for violations of their constitutional rights. Arguably, each provision bars some number of genuine lawsuits, even if small. The combined components suggest to prison officials that they need not pay much attention to the legally accepted standards of prison health care.

Research shows that the PLRA has significantly decreased the number of prisoner-initiated lawsuits, as Congress intended.\textsuperscript{69} However, the same research also raises important questions about the PLRA's effect on both frivolous and legitimate lawsuits. One author notes that:

Preventing inmates from raising legitimate claims is precisely what the PLRA has done in many instances. If the PLRA were successfully reducing the quantity and improving the quality of prisoner suits, as its supporters intended, one would expect the dramatic decline in filings to be accompanied by a concomitant increase in plaintiffs’ success rates in the cases that remain. The evidence is quite the contrary. The shrunken inmate docket is less successful than before the PLRA’s enactment; more cases are dismissed, and fewer settle. An important explanation is

\textsuperscript{68} See Lawrence S. Wrightsman, The Psychology of the Supreme Court, 60 (finding that only 0.05% of the in forma pauperis cases seeking certiorari from the Supreme Court are granted as compared to 3.5% of paying cases).
that constitutionally meritorious cases are now faced with new and often insurmountable obstacles.\textsuperscript{70}

The PLRA has lowered the bar for prison health care standards. A prisoner’s claim alleging deliberate indifference to a serious medical condition must now satisfy at least two other conditions—exhaustion and, if seeking money damages, physical injury—before he or she is allowed to proceed in court.

\section{Can Prisons Meet Constitutional Standards in Tough Economic Times?}

At present, prisoners face yet another challenge when demanding that prisons meet constitutional health care standards: state financial constraints. It is clear that states across the country are in financial crisis, but does this mean that they can skirt their Constitutional obligations by saying that they cannot afford them? Each year courts in different parts of the country impede the standard of care in prisons by adding to the list of complaints that the Eighth Amendment fails to reach.\textsuperscript{71}

Most recently, a three judge panel for the Eastern and Northern Districts of California issued a tentative ruling in two consolidated cases holding that the California Department of Corrections (CDC) had violated the plaintiff’s constitutional right to adequate medical care.\textsuperscript{72} The judges decided that the appropriate remedy was a reduction in the size of the prison population, rather than a mandated higher standard of care.\textsuperscript{73} Although parties in both cases conceded that California had a prison

\textsuperscript{70} Id. at 142 (citations omitted).
\textsuperscript{71} See James E. Robertson, \textit{Correctional Case Law 2007}, 33 CRIM. JUSTICE REV. 266, 268 (reviewing the progression of case law in the area of prisoners’ medical rights and finding that courts are consistently lowering previous standards).
\textsuperscript{72} Coleman v. Schwarzenegger, No. 90-0520, 21 (E.D. Cal. filed Feb. 9, 2009).
\textsuperscript{73} Id. at 20 (stating that the primary cause of the Constitutional violation is the extreme overcrowding in California prisons and that the only way to address the problem is to alleviate the underlying problem).
overcrowding problem, the plaintiffs’ specific complaint was the state’s failure to provide adequate health care to inmates. The proposed prisoner release solution does little to help California prisons improve the quality of the health care for inmates. Arguably, these efforts will improve staffing ratios, but staffing ratios are unlikely the only cause of inadequate health care in California prisons.

In the tentative opinion, the court asserts that “the evidence is compelling that there is no relief other than a prisoner release order that will remedy the unconstitutional prison conditions.” The court goes on to state that:

We would be remiss, however, if we did not take note at the outset of this section that California, like most other states, is in the throes of an unprecedented economic crisis and that the budgetary implications are of the most serious order. There are simply no additional funds that are currently being made available by the State.

This added caveat is a cause for concern about the approach being taken by this court and the precedent that it might be setting subsequent litigation in the current fiscal situation of the United States. In determining constitutional remedies, the court should not be analyzing a state’s ability to pay for specific orders in injunctions as a limitation. Limitations on damages and remedies are typically levied when the victim had a duty to do something but failed. In the case of constitutional violations, there is no duty imposed on the victim. The above court decision to explicitly take the State’s ability to pay into consideration is a violation of foundational principles of remedies. Prisoners should not be penalized for the State’s inability to pay for remedying constitutional violations.

The Coleman tentative ruling neither does anything to help those who remain in prison, nor does it help prisoners who are going to be

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74 Id. at 20 (quoting defendant Governor Schwarzenegger’s 2006 declaration of emergency in regard to the severe overcrowding in California prisons).
75 Id. at 25.
76 Id.
77 See generally 22 AM. JUR. 2D DAMAGES § 351 (2008).
78 Id.
released in compliance with the release order. Prisoners who will be released pursuant to the Coleman decision will leave without employment and with significant difficulty in finding future employment. Unemployment, in turn, creates challenges in securing health insurance. Releasing prisoners who have been the victims of constitutionally inadequate medical care also limits their employability after release because many of them have medical conditions that prevent them from working. Without a job, and thus oftentimes without insurance, women are forced to use emergency care instead of primary care, thereby reducing the amount of preventive care they undertake. In addition, research shows that women who do not have access to health insurance after being incarcerated are more likely to recidivate than those who do. This logic leads to the conclusion that releasing prisoners with no “safety net” actually works against the goal of decreasing prison overcrowding.

Notwithstanding California’s ability to pay, perhaps the first thing that Arnold Schwarzenegger should have recognized before he became involved in the prison health care debacle is that “bad health care is more expensive [to provide] than good health care.” Substandard health care has potential litigation costs and exposure costs for prison staff, other healthy prisoners, and the public at large. California is in the midst of litigation over the state of their prison health care and is facing expenditures of millions of dollars trying to improve the system. The Governor

81 Id. at 37.
83 Nicholas Freudenberg et al., Coming Home from Jail: The Social and Health Consequences of Community Re-entry for Women, Male Adolescents, and Their Families and Communities, 95 AM. J. PUB. HEALTH 1732 (2005).
85 Id.
continues to try to resist improvements and might well be held in contempt for refusing to allocate money requested by the state receiver. In addition, the judge in the case planned to “assess financial penalties against the state until it complied with [the] order.” Presumably, these financial penalties, costs of litigation, and costs of appoints for receivers could have all been avoided if the State had complied with constitutional standards before they were court ordered.

Inadequate prison health care has a well-documented effect on the communities in which prisoners are released. Every year “more than 1.5 million people are released from jail and prison carrying a life-threatening infectious disease.” Sending ex-offenders back into underserved neighborhoods with infectious diseases costs more in the aggregate than providing offenders with adequate care while they are institutionalized.

The raw numbers and the California example should be a warning sign to other states and institutions about the ineffectiveness of the “we can’t afford it” strategy to constitutional standards of healthcare. Not only will it end up costing more to fix the inevitable health and community consequences that follow, but it will usually have the consequence of embroiling the state in costly litigation. Either way, states who claim that they cannot afford to live up to constitutional standards because of the high costs now will end up spending more in the long run. Instead of focusing on temporary budget reductions, states should put constitutional rights at the forefront of budgetary considerations, even if it is unpopular to do so. It is the legal and fiscally responsible thing to do.

2008/08/14/MN9U12ACV8.DTL; see also Coleman, supra note 72, at 4 (stating that Plata v. Schwarzenegger has been in litigation since 1995 and Coleman v. Schwarzenegger since 2002).
88 Id.
89 Gibbons, supra note 43, at 38.
90 See Williams, supra note 82, at 81 (listing the various implications of inadequate prison health care on the community).
91 Wilper, supra note 6, at 671.
V. CONCLUSION

Constitutional standards for prison health care are lower than those of the general population, yet institutions still consistently fail to meet them. The World Health Organization deemed healthcare “one of the fundamental rights of every human being without distinction of economic or social condition.” But in the United States, the dual crises of health care and mass imprisonment have created a large problem that cannot be fixed overnight. In addition to system-wide fixes and policy changes, the general attitude about providing health care to prisoners must change. As we have seen in California, even if health care is constitutionally mandated, states have been reluctant to make politically unpopular budgetary decisions in times of economic need.

The Eighth Amendment and the Prison Litigation Reform Act have shaped the acceptable standards of health care for prisoners over the years. The standards continue to evolve, but do so without a unified or cohesive direction. Unfortunately, these standards are currently voluntary, and will not accomplish the goal of excellence in health care until prisons are obligated to write these standards into their regulations. The cost of poor health care is greater to taxpayers than the fiction of adequate prison health care. The first remedial step that society must take, either through the courts or other mechanisms, is to define clear and acceptable stan-

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92 Helling, 509 U.S. at 32 (stating that “accidental or inadvertent failure to provide adequate medical care to a prisoner” does not violate the Eighth Amendment).
93 See Robertson, supra note 71, at 268 (quoting California Department of Corrections health care receiver who complained “There are just far too many horror stories that continue to occur”).
95 See Yi, supra note 86 (quoting California politician who said, “it’s a sad day for California taxpayers when we’re talking about health care improvements for convicted prisoners when hard-working, law-abiding folks are having trouble finding affordable health care for themselves and their families”).
96 See Williams, supra note 82, at 81.
98 Other mechanisms may include the legislature or prominent professional medical associations (such as the American Medical Association).
ards for prison health care. But without a clear idea of what these health
care standards are, prisons can neither adapt their practices to them nor
can they meet them. Once standards are defined, preferably by a neutral
health care organization like the National Commission on Correctional
Health Care, it will be easier for courts to define constitutional violations.
Though health care is considered a human right, our country has failed to
grant this right without bias. Economics is not an excuse for failing to
recognize human rights, nor is it an acceptable excuse for failing to meet
constitutional standards.