PRIVATIZATION AND ITS DISCONTENTS: THE TROUBLING RECORD OF PRIVATIZED PRISON HEALTH CARE

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As part of a decades-long national trend towards privatization, local governments have turned to private contractors to provide health care in American prisons and jails. Ostensibly, the driving force behind this phenomenon is a desire to cut costs in an era of expanding prison health care expenditures and contracting governmental revenue streams. Local government officials build the cost-cutting incentive directly into their contracts via fixed-rate payment structures and cost-sharing provisions for off-site emergency treatment. While these contracts encourage cost-reduction, they simultaneously discourage proper oversight; their indemnification clauses render local governments largely immune from financial consequences when contractors deny

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emergency care to inmates in crisis. The predictable and tragic result of this combination of incentives and disincentives is unnecessary injury and death. A § 1983 lawsuit against the contracting local government, however, could force officials to reform their prison health care contracts—to elevate the goal of quality health care provision to the priority it should be.

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INTRODUCTION

When Bret Fields entered Florida's Lee County Jail in July of 2007, charged with several misdemeanor offenses, he was a relatively "healthy" and "athletic" 24-year-old man.[1] At the time, Lee County contracted out its prison medical services to Prison Health Services, Inc. (PHS).[2] Within a few weeks, Mr. Fields began complaining of back pain.[3] On August 8, 2007, Mr. Fields found himself unable to stand because of weakness in his legs.[4] PHS personnel diagnosed Mr. Fields with muscle strain and prescribed Tylenol.[5] Around 1:30 a.m. the next morning, Mr. Fields and other inmates screamed for help from his cell.[6] After trying to use the bathroom, Mr. Fields could not walk and told the PHS nurse supervisor that his "'insides were falling out"; the nurse obtained some K-Y Jelly and pushed the inmate's intestines back into his body.[7] Ignoring Mr. Fields's complaints of complete paralysis below the waist, the nurse diagnosed him with hemorrhoids, put him in an observation cell, and told him he could see the doctor later in the morning.[8] The prison doctor saw Mr. Fields at 10:30 a.m. and sent him to the hospital, where an immediate surgery revealed a Methicillin-resistant Staph abscess on his spine.[9] Mr. Fields is now burdened with permanent paralysis below the waist.[10]

Patricia Pollock, twenty-five years old at the time,[11]

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1. Fields v. Corizon Health, Inc., 490 F. App'x 174, 176 (11th Cir. 2012); Pat Gillespie, *Jury Awards Plaintiff $1.2 Million in Lawsuit Against Prison Health Services*, NEWS–PRESS.COM (Mar. 18, 2011), http://www.news-press.com/article/20110318/CRIME/110318032/Jury-awards-plaintiff-1-2-million-lawsuit-against-Prison-Health-Services, *archived at* http://perma.cc/WW27-THS3.

2. *Fields*, 490 F. App'x at 175. PHS has since become part of Corizon Health Care (Corizon) after a 2011 merger between the respective parent corporations of PHS and Correctional Medical Services. In April 2013, Corizon was the United States' largest prison health care provider. *Corizon Health, Inc.*, IN PUB. INTEREST, http://www.inthepublicinterest.org/organization/corizon-health-inc (last visited Nov. 18, 2014), *archived at* http://perma.cc/BJW7-H68A.

3. Gillespie, *supra* note 1.

4. *Id.*

5. *Id.*

6. *Id.*

7. *Id.*; *Fields*, 490 F. App'x at 178.

8. *Fields*, 490 F. App'x at 178.

9. Gillespie, *supra* note 1.

10. *See id.*

11. Holly Otterbein, *Suit Alleges Wrongdoing by Pa. Prison Company in*

entered Montgomery County Correctional Facility (MCCF) in Eagleville, Pennsylvania, on September 22, 2011,[12] on charges of theft, possession of drug paraphernalia, and driving under the influence of alcohol.[13] Montgomery County contracted its prison health care out to Correctional Medical Care, Inc. (CMC).[14] On the day she entered MCCF, Ms. Pollock complained that she couldn't move her arm, was having trouble breathing, and was suffering from severe chest pain.[15] But because she had been taking the anti-anxiety medication Clonazepam for two years, CMC nurses assumed she was going through withdrawal and ordered treatment for withdrawal from benzodiazepines.[16] Later that day, the prison doctor ordered an echocardiogram, which showed Ms. Pollack had an elevated heart rate.[17] She was also known to be an intravenous drug user,[18] a population especially prone to bacterial endocarditis.[19] However, rather than ordering the standard examinations and treatment for bacterial endocarditis, the prison doctor sent Ms. Pollock to an observation room and again ordered a treatment protocol for benzodiazepine withdrawal.[20] For more than four days, Ms. Pollock's condition deteriorated and her organs began to fail.[21] Throughout this period CMC nurses and doctors ordered no additional exams or tests; instead, they continued the standard treatment for benzodiazepine withdrawal—medication and IV fluids.[22] On the morning of September 27th, the prison doctor ordered that Ms. Pollock be transferred to an off-site emergency room at a

Woman's Death, NEWSWORKS (June 3, 2013), http://www.newsworks.org/index.php/local/philadelphia/55507-suit-alleges-wrongdoing-by-pa-prison-company-in-womans-death, *archived at* http://perma.cc/5CBZ-57FF.

12. Matt Stroud, *Did Private Prison Medics Let a Woman Die to Save Cash?*, IN THESE TIMES (Oct. 7, 2013, 7:42 AM), http://inthesetimes.com/prison-complex/entry/ 15694/did_private_prison_medics_let_a_woman_die_to_save_cash, *archived at* http://perma.cc/ED67-MHGJ.

13. Otterbein, *supra* note 11.

14. Complaint and Demand for Jury Trial, Kenney v. Montgomery Cnty., No. 2:13-cv-02590 (E.D. Pa. May 13, 2013), *available at* http://www.courthousenews.com/2013/10/04/Kenney%20complaint.pdf, *archived at* http://perma.cc/6SAN-EKKY [hereinafter Kenney Complaint].

15. *Id.* at 6.

16. *Id.*

17. *Id.* at 7.

18. *Id.* at 7.

19. *Id.* at 5.

20. *Id.* at 7.

21. *Id.* at 10–11.

22. *Id.* at 9–10.

local hospital, where doctors immediately diagnosed multiple organ failures resulting from bacterial endocarditis.[23] While en route to another Philadelphia hospital for surgery, Ms. Pollock died.[24]

Ken McGill was in his mid-forties when he was incarcerated in Jefferson County Detention Facility (JCDF) in Jefferson County, Colorado, after being convicted of a DUI in 2012.[25] The County contracted out its prison health care duties to Correctional Healthcare Companies, Inc. (CHC).[26] As Mr. McGill worked in the prison kitchen on the morning of September 17, 2012, he became so dizzy he had trouble standing on his own.[27] He went to the prison infirmary after lunch, where nurses told him he was dehydrated.[28] After a nap, Mr. McGill awoke that afternoon with a headache and pain spreading down his neck.[29] Shortly after 7:00 p.m., Mr. McGill could feel his face starting to droop.[30] He began to lose control of the right side of his body.[31] Slurring his speech, Mr. McGill told two of his friends he thought he was having a stroke.[32] They alerted prison deputies, who told Mr. McGill to wait for the nurse to come by on her evening medication rounds.[33] After collapsing to the floor in the middle of a desperate phone call to his wife, Mr. McGill was taken to the infirmary.[34] The nurse diagnosed him with an anxiety attack, and prescribed bed rest and Gatorade.[35] His cellmate, a former EMT, recognized the obvious signs of a severe stroke and again alerted prison

23. *Id.* at 11.

24. Otterbein, *supra* note 11 ("The cause of Pollock's 2011 death, an autopsy report shows, was a heart condition known as 'acute fulminant verrucous endocarditis.'").

25. Joel Warner, *Ken McGill Left Jail Behind, but He Can't Escape the Stroke He Suffered There,* DENV. WESTWORD (Apr. 25, 2013), http://www.westword.com/2013-04-25/news/ken-mcgill-stroke-jefferson-county-jail, *archived at* http://perma.cc/D6XQ-ARMC.

26. *See* Health Services Contract Between Jefferson County, Colorado, and Correctional Healthcare, Inc., (Nov. 1, 2010) [hereinafter Jefferson County-CHC Contract] (on file with author).

27. Warner, *supra* note 25.

28. *Id.*

29. *Id.*

30. *Id.*

31. *Id.*

32. *Id.*

33. *Id.*

34. *See id.*

35. *Id.*

guards to Mr. McGill's desperate state.[36] Yet again Mr. McGill went to the infirmary and asked for more sophisticated treatment.[37] After tiring of Mr. McGill's complaints, the nurses sent him to the Special Housing Unit (SHU), the prison's solitary confinement facility, where he spent the rest of the night.[38] Shortly after 9:00 a.m., the prison doctor arrived, examined Mr. McGill, and ordered him to the hospital.[39] At 12:30 p.m., twenty-eight hours after he first began noticing his stroke symptoms, Mr. McGill's MRI confirmed a massive stroke.[40] He now suffers from the effects of permanent brain damage.[41]

Mr. Fields's, Ms. Pollock's, and Mr. McGill's personal tragedies are about more than the misconduct of a few "bad apples." The three episodes involved different victims, different prison health care contractors, and different local governments, but they tell the same story of contractors who ignored or refused to treat severe and obvious medical emergencies. These kinds of stories are all-too-common in the contemporary American prison system. Collectively, they point to the systemic failure of an increasingly privatized prison health care regime.[42] At best, privatized prison health care is a theoretically flawed concept; at worst, it may be a system that facilitates the illegal treatment of citizens in the custody of the state.

The privatization of prison health care is not an inevitable consequence of some obscure market dynamic; rather, it represents a deliberate decision by local government legislative bodies to subject a particular constituency to market forces.[43] After more than thirty years of experimentation with

36. *Id.*
37. *Id.*
38. *Id.*
39. *Id.*
40. *See id.*
41. *See id.*
42. *See, e.g.*, CAROLINE ISAACS, DEATH YARDS: CONTINUING PROBLEMS WITH ARIZONA'S CORRECTIONAL HEALTH CARE (2013), *available at* http://www.afsc.org/sites/afsc.civicactions.net/files/documents/DeathYardsFINAL.pdf, *archived at* http://perma.cc/LE9Z-5H8R.
43. *See* Alfred C. Aman, Jr., *Privatization, Prisons, Democracy, and Human Rights: The Need to Extend the Province of Administrative Law*, 12 IND. J. GLOBAL LEGAL STUD. 511, 513 (2005), *available at* http://www.repository.law.indiana.edu/cgi/viewcontent.cgi?article=1309&context=ijgls, *archived at* http://perma.cc/9A9B-937X.

privatized prison health care services,[44] legislators have gravitated towards a particular type of contract: one that simultaneously incentivizes contractors to reduce costs by offering as little care as possible, and *dis*incentivizes local governments from exercising robust oversight of the contractor.[45]

The twenty-first century prison health care contract would not represent such a legal and moral emergency if the market were self-correcting, as advertised by advocates of privatization.[46] Regrettably, however, there is little evidence of self-correction in this particular market.[47] Private prison health care corporations can survive lawsuits for constitutionally deficient care with little impact on their ability to win contracts in the future.[48] Even when a local government cancels a contract after an embarrassing incident, the offending corporation seems to have little trouble winning bids from other local governments.[49]

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44. Phillip J. Wood, *The Rise of the Prison Industrial Complex in the United States*, *in* CAPITALIST PUNISHMENT: PRISON PRIVATIZATION & HUMAN RIGHTS 16, 18 (Andrew Coyle et al. eds., 2003).

45. *See generally infra* Part III.

46. *See, e.g.*, LAUREN GALIK & LEONARD GILROY, REASON FOUND., PUBLIC-PRIVATE PARTNERSHIPS IN CORRECTIONAL HEALTH CARE 7 (2014) [hereinafter REASON FOUND. REPORT], *available at* http://reason.org/files/ppp_correctional_health_care.pdf, *archived at* http://perma.cc/W5C7-8RVM ("When states outsource their correctional health care services to private vendors, they do so only for a limited time, and are free to contract with other companies if they're not satisfied with a particular vendor's performance, among other things. This in turn creates a competitive marketplace that incentivizes these private companies to provide better quality care than their competitor in order to obtain a contract renewal, or enter into a new state contract. To a vendor, the threat of a failed contract renewal serves as an incentive to provide the highest quality care at the lowest cost over the duration of the company's contract. If the company doesn't offer the level or quality of services that the state finds acceptable, it may choose to contract services out to another vendor that has offered to provide better quality services.").

47. *See, e.g.*, Dan Christensen, *Florida Prison Healthcare Providers Sued Hundreds of Times*, MIAMI HERALD (Oct. 2, 2013, 10:03 PM), http://www.miamiherald.com/2013/10/02/3666091/florida-prison-healthcare-providers.html, *archived at* http:// perma.cc/D3PC-J22V.

48. *See id.*

49. For instance, in October of 2013 Corizon failed to win renewal of its contract with the Minnesota Department of Corrections after coming under scrutiny for the death of "a 27-year-old inmate who had suffered at least seven seizures while in his prison cell in 2010." Beth Kutscher, *Corizon Loses Minnesota Prison Healthcare Contract*, MODERN HEALTHCARE (Oct. 18, 2013, 3:00 PM), http://www.modernhealthcare.com/article/20131018/NEWS/310189964, *archived at* http://perma.cc/2DJS-AG7D. In the same month Corizon won a multimillion-

Attempts to escape legal sanction notwithstanding, local governments are potentially liable when their prison health care contractors maim or kill inmates.[50] Even as local governments contract away their core functions, they cannot contract away their ultimate legal responsibility for violations of their citizens' constitutional rights. In fact, where local governments sign or re-sign a contract with a prison health care contractor sporting a lengthy litigation history, the contract itself could be the vehicle for attaching liability to the government.

The Civil Rights Act of 1871, codified at 42 U.S.C. § 1983, is an increasingly important statute in an era of privatized government services.[51] Legal action under this statute has the potential to force important policy changes on otherwise reluctant or indifferent local government officials.[52] A § 1983 claim against a local government for constitutionally deficient prison health care, as provided by a private contractor, has been characterized as a "tough but viable claim."[53] This Comment, while in agreement with this apt characterization, argues that a certain type of private prison health care contract—those with fixed reimbursement structures, cost-sharing provisions for off-site care, and indemnification clauses—creates such a perverse incentive structure that it should constitute an actionable Eighth Amendment violation under § 1983.

Part I offers some theoretical and historical context for the

dollar contract to provide prison medical, dental, pharmaceutical, and mental health services for inmates incarcerated by the Kansas Department of Corrections. Kelsey Ryan, *Corizon Wins Contract to Provide Health Care at Kansas Prisons*, WICHITA EAGLE (Aug. 8, 2014, 10:19 AM), http://www.kansas.com/2013/10/31/3088718/corizon-wins-contract-to-provide.html, *archived at* http://perma.cc/ FL3M-4MJ4.

50. See *infra* Part III for further elaboration of this point.

51. 42 U.S.C. § 1983 (2012). See *infra* Part III for further discussion. Professor Richard Frankel argues that § 1983 can serve a public policymaking function, in that it could be used to incentivize private contractors to respect constitutional rights where they are performing governmental functions. *See* Richard Frankel, *Regulating Privatized Government Through § 1983*, 76 U. CHI. L. REV. 1449 (2009). Importantly, however, Professor Frankel's argument is premised on a significant change to current law. *See id.* He argues that claimants should be able to pursue a *respondeat superior* theory of liability against private entities that perform governmental functions. *Id.*

52. See *infra* Part V for further discussion.

53. Richard Siever, Note, *HMOs Behind Bars: Constitutional Implications of Managed Health Care in the Prison System*, 58 VAND. L. REV. 1365, 1401 (2005).

modern trend towards privatization of prison health care services. Part II follows with an investigation of the three contemporary prison health care contracts in place when Mr. Fields, Ms. Pollock, and Mr. McGill entered their respective jails. In particular, Part II offers a criticism of the incentive structure inherent in these agreements. Part III delves into the background legal rules of prison medical care and municipal liability, followed by a discussion of the elements of a § 1983 claim for constitutionally deficient prison health care in Part IV. Part V demonstrates that courts, though reluctant, will occasionally enjoin privatization contracts in the criminal justice context, where the perverse financial incentives inherent in the agreement lead to particularly unjust outcomes. Finally, Part VI addresses an important counterargument to judicial review of legislative or executive branch contracting.

I. PRIVATIZATION AND THE PRISON HEALTH CARE INDUSTRY

In this present crisis, government is not the solution to our problem; government is the problem.
– President Ronald W. Reagan[54]

The era of big Government is over.
– President William J. Clinton[55]

America's recent bipartisan infatuation[56] with the privatization of core government services began in the late 1970s[57] and continues to the present day.[58] This "privatization

54. Ronald Reagan, President of the U.S., Inaugural Address (Jan. 20, 1981).

55. William Clinton, President of the U.S., State of the Union Address (Jan. 23, 1996).

56. This label comes from Paul R. Verkuil, who has come to see its current iteration as a serious threat to modern principles of governing. *See* PAUL R. VERKUIL, OUTSOURCING SOVEREIGNTY: WHY PRIVATIZATION OF GOVERNMENT FUNCTIONS THREATENS DEMOCRACY AND WHAT WE CAN DO ABOUT IT 2 (2007).

57. *See* Wood, *supra* note 44, at 18.

58. The state of Florida is the latest governmental entity to outsource its prison health care function. *See* Steve Bousquet, *Massive Privatization of Prison Health Care Looms in Florida*, TAMPA BAY TIMES (June 29, 2013, 5:30 AM), http://www.tampabay.com/news/publicsafety/crime/stage-set-for-massive-privatization-of-prison-health-care-in-florida/2129248, *archived at* http://perma.cc/2HKS-SDX5. Governor Rick Scott campaigned on reducing prison health care spending via privatization in 2010. *Id*. The contracting process was held up, however, by a public-employee union lawsuit that "accused the Legislature of illegally seeking to privatize health care in most prisons by steering the decision

revolution" has "rema[de] the American regulatory landscape."[59] However, like many other winning economic, legal, or political theories, privatization is an idea with serious downstream consequences for citizens who were likely shut out of the high-level debates over its adoption. This Section first offers a brief glimpse at the contours of the debate over privatization, followed by some historical context regarding the modern wave of American privatization. The Section concludes with a discussion of how and why the privatization revolution came to the prison health care industry.

A. *Privatization Theory*

Proponents of privatization advance a number of arguments, both pragmatic and ideological.[60] The leading pragmatic argument is that privatization will save money.[61] Advocates argue that private entities are inherently more efficient at providing goods and services as compared to their governmental counterparts.[62] Further, proponents assert, the

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to a 14-member Legislative Budget Commission." *Id*. While the unions won at the district court level, a state appeals court reversed, allowing the agreement to be implemented. *Id*. Under the terms of its $230-million contract, Corizon is required to "offer comprehensive care to Florida's inmate population for 7 percent less than it cost the state in 2010." *Id*.

59. Jon D. Michaels, *Privatization's Pretensions*, 77 U. CHI. L. REV. 717, 725 (2010).

60. *See, e.g.*, MAC TAYLOR, CAL. LEGISLATIVE ANALYST'S OFFICE, PROVIDING CONSTITUTIONAL AND COST-EFFECTIVE INMATE MEDICAL CARE 24 (2012), *available at* http://www.lao.ca.gov/reports/2012/crim/inmate-medical-care/inmate-medical-care-041912.pdf ("Contracting out would introduce competition into the inmate medical care system, which would incentivize the adoption of cost-containment measures.").

61. For an example of one such argument, see Ira Robbins, *Managed Health Care in Prisons as Cruel and Unusual Punishment*, 90 J. CRIM. L. & CRIMINOLOGY 195, 219 (1999) (citing *Matters Relating to the Federal Bureau of Prisons: Hearing Before the Subcomm. on Crime of the House Comm. on the Judiciary*, 104th Cong. 121–32 (1995)). *See also* Aman, *supra* note 43, at 518.

62. *See, e.g.*, REASON FOUND. REPORT, *supra* note 46, at 5 ("Indeed, private vendors have fewer bureaucratic barriers and a greater incentive to employ cost-efficient measures than a state-run system has, and states that have used public-private partnerships in correctional health care have seen enormous savings."). *See generally* Robert Kuttner, *When Public Is Better*, DEMOS (Nov. 1, 2013), http://www.demos.org/publication/when-public-better, *archived at* http://perma.cc/8S32-CUD5 ("Government is said to be cumbersome, bureaucratic, subject to pressure group influence and political corruption, averse to innovation, and so on. [Private entities,] by contrast, are lean, subject to competitive pressures, and have other natural mechanisms that maximize efficiencies.") (alteration in original).

competitive discipline of the marketplace will induce production of a higher quality good or service than could be provided by a government monopoly; firms that provide high-quality services at low cost will be rewarded with more contracts while firms that fail to do so will go out of business.[63] Ideological proponents of privatization argue that the American governmental system has taken on too much responsibility and has become overweening and intrusive.[64] Such an unwieldy set of institutions, they argue, is prone to capture by special interest groups who manipulate government officials to the detriment of taxpayers—in the form of unnecessary and wasteful programs.[65] Thus, for each function a government delegates to private firms, individuals benefit from lower taxes and greater autonomy.[66]

63. *See, e.g.*, REASON FOUND. REPORT, *supra* note 46, at 6–8.

64. *See, e.g.,* PRESIDENT'S COMM'N ON PRIVATIZATION, PRIVATIZATION: TOWARD MORE EFFECTIVE GOVERNMENT xi (1988) [hereinafter REAGAN'S COMM'N ON PRIVATIZATION REPORT], *available at* http://pdf.usaid.gov/pdf_docs/PNABB472.pdf, *archived at* http://perma.cc/8N3H-WTET .

65. Alexander Tabarrok of the Independent Institute offers a version of this argument, setting forth, among other assertions, a rationale for prison privatization as a way to undermine the undeserved and antidemocratic power of correctional officers' unions. *See* Alexander T. Tabarrok, *Private Prisons Have Public Benefits*, INDEP. INST. (Oct. 24, 2004), http://www.independent.org/newsroom/article.asp?id=1411, *archived at* http://perma.cc/VZ3N-7ZJ3 ("[P]rison privatization will lay the foundation for a more open political system one in which a single special-interest group cannot dominate what should be matters of public policy."). Recent action by the Arizona state legislature offers another good illustration of the ideological rationale for prison health care privatization, in this case unaccompanied by any cost-saving rationale. *See* Bob Ortega, *Arizona Prisons' Health Care To Be Run by a Pa. Company*, AZCENTRAL.COM (Apr. 3, 2012, 11:10 PM), http://www.azcentral.com/news/articles/20120403arizona-prisons-health-care-run-by-penn-company.html, *archived at* http://perma.cc/ NU5D-ANHF. In fact, Arizona legislators persisted with prison health care privatization despite learning that privately provided care would cost more, not less, than state-provided care. *Id*. In 2012 Arizona's Department of Corrections awarded a $349 million contract to Wexford Health Sources, Inc. for prison health care in ten state prisons, knowing that the state would have to pay Wexford $5 million more than the state spent on these services in 2011. *Id*. The Legislature's original bill mandating the privatization of prison health care in Arizona contained a provision requiring bidders to "meet or better the Corrections Department's costs." *Id*. However, Republican chairman of the House Appropriations Committee John Kavanagh stripped this provision from the bill. *Id*.

66. President George W. Bush sounded this theme in his 2005 State of the Union Address when he pitched his proposal to partially privatize Social Security for younger workers. *See* George W. Bush, President of the U.S., State of the Union Address (Feb. 2, 2005) ("As we fix Social Security, we also have the responsibility to make the system a better deal for younger workers. And the best way to reach that goal is through voluntary personal retirement accounts. Here is

Critics of privatization question both the pragmatic and ideological rationales for privatization.[67] They point out that private contractors sometimes provide low-quality services,[68] high-cost services,[69] or services that are both of lower quality and higher cost than those offered by a government provider.[70] Critics further offer an ideological critique of privatization, arguing that some governmental functions simply cannot be outsourced in a manner consistent with modern democratic norms.[71] This objection has been labeled variously as the

how the idea works. Right now, a set portion of the money you earn is taken out of your paycheck to pay for the Social Security benefits of today's retirees. If you're a younger worker, I believe you should be able to set aside part of that money in your own retirement account, so you can build a nest egg for your own future. . . . And best of all, the money in the account is yours, and the government can never take it away . . . . It's time to extend . . . security and choice and ownership to young Americans.").

67. *See, e.g.*, Kuttner, *supra* note 62; VERKUIL, *supra* note 56.

68. The most visible recent example of this is the calamitous rollout of "Healthcare.gov," the online portal to the federal health insurance exchange. The Obama Administration farmed out design and development of the critical Healthcare.gov website to a number of contractors. *See* Tom Cohen, *Obamacare Website Developers: It's Not Our Fault*, CNN (Oct. 23, 2013, 10:00 PM), http://www.cnn.com/2013/10/23/politics/congress-obamacare-website/, *archived at* http://perma.cc/HL5R-4T8K ("In the first detailed account of what happened, the prepared testimony describes a convoluted system of multiple companies designing parts of the website under oversight of the federal Centers for Medicaid and Medicare Services, a part of the Department of Health and Human Services."). While it was unclear in the immediate aftermath of the disastrous rollout whether to blame contractor ineptitude or a lack of government oversight, for the purposes of this Comment, it hardly matters. *See also* Carrie Budoff Brown, *The Making of an Obamacare Management Failure*, POLITICO (Nov. 12, 2013), http://www.politico.com/story/2013/11/obamacare-affordable-care-act-health-care-law-99777.html, *archived at* http://perma.cc/RH4M-HXYV.

69. Private security contractors in Iraq are a notable example of this phenomenon. *See* Steve Fainaru, *U.S. Pays Millions in Cost Overruns for Security in Iraq*, WASH. POST (Aug. 12, 2007), http://www.washingtonpost.com/wp-dyn/content/article/2007/08/11/AR2007081101378.html, *archived at* http://perma.cc/6UC3-SGA5.

70. *See, e.g.*, Kuttner, *supra* note 62; *see also* VERKUIL, *supra* note 56, at 2 (citing a House Committee on Government Oversight and Reform report that blamed, in part, the Army's decision to privatize support services at Walter Reed Medical Center for unconscionable conditions at the hospital); David S. Cloud, *Army Secretary Is Ousted in Furor over Hospital Care*, N.Y. TIMES (Mar. 3, 2007), http://www.nytimes.com/2007/03/03/washington/03veterans.html, *archived at* http://perma.cc/S6T8-9CLX ("The [House Committee on Government Oversight and Reform] made public an internal hospital memorandum written last September that warned that [the] Army decision to privatize support services at Walter Reed was causing an exodus of experienced career personnel and putting patient care 'at risk of mission failure.'").

71. *See, e.g.*, Kuttner, *supra* note 62.

"democracy problem,"[72] or the "democracy deficit,"[73] and posits that some instances of privatization are a *per se* undermining of democratic governance: because the public can neither see nor respond to much of what the contractors do, contractors are close-to-unaccountable for their mistakes or intentional violations of the law.[74]

B. A Brief History of Privatization in the United States

Privatized government has been around since the early days of the American republic.[75] Even for activities that today would be considered the very core of governmental responsibility, the young United States relied on private providers to perform the task in exchange for a "bounty," or fee.[76] For example, well into the nineteenth century, state and local governments contracted with "tax ferrets" to collect taxes—then largely synonymous with assessments on personal property.[77] Private tax collectors were necessary because of two conflicting forces: (a) the increasing responsibilities of state and

72. Aman, *supra* note 43, at 517–20.

73. VERKUIL, *supra* note 56, at 2; *see also* Alfred C. Aman, Jr., *Globalization, Democracy, and the Need for a New Administrative Law*, 49 UCLA L. REV. 1687, 1700–01 (2002) ("[H]owever, in some contexts (for example, the privatization of prisons), such privatizations can intensify the democracy problem—because when regulation is given over to the market, the public may no longer be as directly involved in decision making, nor is the information that would make public participation meaningful available.").

74. *See* Aman, *supra* note 73, at 1701.

75. In fact, the American corporation likely originated as a tool for state governments to facilitate their efforts at building modern states. William J. Novak, *Public-Private Governance: A Historical Introduction*, *in* GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY 30 (Jody Freeman & Martha Minow eds., 2009).

> [T]here is now a fairly strong consensus that the business corporation was devised in the early American republic as a peculiar instrument of statecraft—a quasi-public or public service corporation—to aid funds-strapped state governments in accomplishing public objectives like the construction of a national infrastructure in a capital-scarce economy.

Id.

76. NICHOLAS R. PARRILLO, AGAINST THE PROFIT MOTIVE: THE SALARY REVOLUTION IN AMERICAN GOVERNMENT, 1780–1940 183 (2013) ("The bounty—a reward that an official received for doing something the affected person did not want—held great promise . . . for it gave officers an extrinsic motivation to enforce sovereign directives faithfully and aggressively even when faced with the scorn and resistance of the communities and individuals whose expectations were being violated.").

77. *Id.* at 184–85.

local governments for road-building, sanitation, and schooling in a rapidly industrializing and urbanizing society; and (b) the long-settled expectation of many Americans that property taxes would not be assessed on the increasingly widespread intangible forms of property—like bank accounts and securities.[78] Locally elected tax assessors were too enmeshed in the community by personal relationships to conduct the thorough investigations of their neighbors' properties necessary for rigorous enforcement of the property tax.[79] Thus Gilded Age officials turned to "tax ferrets": private investigators from outside the local community who ferreted out intangible property, and thus tax liability, in exchange for a bounty—a percentage of what they found.[80]

Even in the American penal system, the privatization wave of the late twentieth century was not wholly unprecedented. Nineteenth-century penitentiaries routinely contracted out their prisoners' labor to private businesses.[81] As with property tax assessments, this form of privatization arose when local governments decided to perform a new function.[82] Before the 1800s, the main penal institution was the jail, which, in contrast to today's jails, was a non-punitive institution designed to hold inmates for trial, for future punishment, or until they paid their debts.[83] On the inside, inmates paid their jailors for various services as one would an innkeeper.[84] Around the turn of the nineteenth century, however, the penitentiary displaced the jail.[85] A penitentiary was a highly punitive institution designed to reform the inmates' character, in part by subjecting them to forced labor.[86] Penitentiary wardens turned to private contractors to implement their inmate labor programs, offering these businesses a rigidly disciplined atmosphere and a compliant labor force in exchange for a fee.[87] By 1850, this model had spread from its origins in

78. *See id*.
79. *Id*.
80. *Id*.
81. *Id*. at 298–300.
82. *Id*. at 297–300.
83. *Id*. at 297.
84. *Id*.
85. *Id*. at 298–300.
86. *Id*.
87. *Id*. at 299 ("The wardens . . . used the increasingly disciplined atmosphere of the prison to induce manufacturers (contractors) to set up shop inside the prison walls and pay the state for the use of the inmates' labor . . . . Effectively,

New York to nearly every northern state in the Union.[88]

The concept of privatization fell on hard times, however, beginning in the late 1800s and early 1900s, when the American governmental system began to modernize at the state and local level.[89] Progressive-era local governments grew concerned that the private parties on whom they relied to perform core government functions were either (a) not up to the job, or (b) undermining the legitimacy of the state—no small problem in a democracy with a rhetorical commitment to citizen participation and governmental accountability.[90] Over the course of the next few decades, local governments insourced tax collection and prison labor supervision, among other previously privatized functions.[91]

This profound change in governing philosophy came about as state and local officials began to see the connection between effectiveness and legitimacy: where a privatized government function lacked legitimacy, popular evasion or resistance

salaried government personnel kept the inmates disciplined while the manufacturers kept them occupied.").

88. *Id.* at 300. The infamous "convict lease system" of the American South was that region's privatized forced labor system. It flourished in particular after the Civil War, and is thoroughly and movingly described in DOUGLAS A. BLACKMON'S SLAVERY BY ANOTHER NAME: THE RE-ENSLAVEMENT OF BLACK AMERICANS FROM THE CIVIL WAR TO WORLD WAR II (2009).

89. Nicholas Parrillo discusses a central aspect of this modernization: the shift from a fee-based model of governmental service provision to a salary-based model.

> [The public] perception [was] widespread by the late 1800s, that fee-based compensation of officers, even when formally regulated by a statute, led unavoidably to fee-taking that evaded the statute, which was now defined as 'corruption.' Reformers argued that, to stop officers from taking unlawful fees, one must prohibit them from taking any fees, placing them on salary instead.

PARRILLO, *supra* note 76, at 17. The shift away from fee-based governmental service provision is temporally related, not coincidentally in the view of this Comment, to a similar suspicion of the role of for-profit entities in public governance. William Novak writes of the latter development:

> [I]n the reform movements of the early twentieth century . . . [t]he idea that the private sphere was corrupting the public sphere (rather than the other way around) marked a lasting redirection of American political thought and action. In a host of public legal, legislative, and administrative reforms that only climaxed with [the] New Deal, reformers created an expanded public sphere—a new liberal state—to regulate, police, and rein in private excess.

Novak, *supra* note 75, at 34.

90. *See, e.g.*, PARRILLO, *supra* note 76, at 200–02.

91. *Id.* at 200, 296–97.

ensued, dramatically decreasing the effectiveness of the private provider.[92] Near the turn of the twentieth century, empirical studies demonstrated that tax ferrets had only been marginally effective at increasing the collection of property taxes.[93] Yet these private tax assessors seemed to be extracting a significant cost from the governments they served in the form of an increasingly poisoned relationship between the public and the state.[94] Thus, in one state after another, officials repudiated tax ferrets and lowered tax rates on the personal assets that Americans were hiding from tax assessors; a dramatic rise in collections ensued, as property taxs were now collected by salaried government assessors who in turn relied largely on voluntary cooperation from a public that saw the new regime as relatively fair.[95]

Privatized prison labor systems in American penitentiaries similarly fell out of favor as state and local officials confronted a number of inmate mutinies and riots during the 1870s and 1880s.[96] These disturbances "helped reopen public debate over both the efficacy and the ethical value of the prevailing system of penal servitude."[97] Disorder in the prisons with the largest contractors and most tyrannical work regimes strongly refuted one of the central rationales of these contractors: that they could impose and maintain order.[98] Moreover, the ineffectiveness of these contractors seemed to be closely tied to their lack of legitimacy as profit-seeking enterprises.[99] Beginning with New York, states began insourcing the prison labor function in an effort to regain order by enhancing the legitimacy of their labor supervisors.[100]

The insourcing of tax collection and prison labor supervision during the Populist and Progressive Eras foreshadowed an even more aggressive repudiation of private governmental power, and concomitant embrace of public governmental power, that characterized the American response

92. *See id*. at 4.
93. *Id*. at 200–02.
94. *Id*. at 203–06.
95. *Id*. at 206–20.
96. *Id*. at 303.
97. *Id*. (internal quotation marks omitted).
98. *Id*.
99. *See id*. at 302–06.
100. *Id*.

to the Great Depression.[101] This commitment to a robust and active public sector continued during the middle decades of the twentieth century, through the "Great Society" of the 1960s.[102]

The pendulum swung back, however, during the late 1970s and early 1980s.[103] Proponents of privatization found a champion in the Reagan Administration, which was fiercely committed to the twin goals of devolution and privatization.[104] In an effort to publicize and institutionalize these commitments, President Reagan convened a Commission on Privatization, which issued a report in March 1988 recommending greater reliance on private institutions across a wide swath of the public sector, including low-income housing, air traffic control, education, and prison administration, to name just a few of the cited examples.[105] The Commission claimed a mandate from no less an authority than "the American people" for this sweeping change:

101. *See* Novak, *supra* note 75, at 24 ("[During the early 1930s,] [t]he private sector and market mechanisms were in a state of disrepute even among the most traditional of economists. Private economic actors could not be counted on to produce and distribute even the most basic of human commodities—for example, milk and coal. In that critical period, it was the public sector—the government, the state—that was called on to provide distinctly public remedies to pervasive private sector ills through increased public regulation (e.g., the SEC), public welfare (e.g., Social Security), public works programs (e.g., the PWA, WPA, and the CCC), public ownership and management (e.g., TVA), and public planning (e.g., NRPB).").

102. *See generally* Karen Tumulty, *The Great Society at 50*, WASH. POST (May 17, 2014), http://www.washingtonpost.com/sf/national/2014/05/17/the-great-society-at-50/, *archived at* http://perma.cc/CD45-8LDH.

103. In its (re)-embrace of privatization, the United States was joined by a number of other post-industrial democracies in a "global privatization movement." Jody Freeman, *The Contracting State*, 28 FLA. ST. U. L. REV. 155, 160 (2000). Professor Jody Freeman writes:

> The rise of contract as an administrative and regulatory instrument in the United States has occurred in the context of a global privatization movement in which governments around the world have privatized state industries and undergone significant public sector reform. Over the last twenty years, following the Thatcher government's lead in Great Britain, numerous liberal democracies such as New Zealand, Australia, and Canada have adopted aggressive reforms aimed at developing markets for the provision of most social services, including education, health care, job training, housing, municipal services, and the like.

Id.

104. *Id.* at 161–62.

105. REAGAN'S COMM'N ON PRIVATIZATION REPORT, Executive Summary, *supra* note 64, at xv–xxi.

> The American people have often complained of the intrusiveness of federal programs, of inadequate performance, and of excessive expenditures. In light of these public concerns, government should consider turning to the creative talents and ingenuity in the private sector to provide, wherever possible and appropriate, better answers to present and future challenges.[106]

The "privatization revolution" that "rema[de] the American regulatory landscape" continued long after President Reagan left office.[107] In 1996 a Democratic President Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act, known colloquially as the Welfare Reform Act.[108] The Act devolved the welfare system to state governments—under the auspices of the new Temporary Aid to Needy Families (TANF)—and in doing so "gave states great flexibility in the design of programs and services."[109] In particular, the work-oriented mandate of the new welfare system—states were required to move a substantial portion of their welfare caseloads to work or work-related activities—incentivized states to turn to private contractors.[110] The Republican-led House and a Democratic president, demonstrably behind the larger movement towards privatization,[111] were happy to use the Welfare Reform Act to enable and encourage this turn.[112] The result has been a significant shift away from government provision of welfare services, in favor of service-provision by the for-profit and non-profit segments of the private sector.[113]

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106. *Id.* at xi.

107. Michaels, *supra* note 59 ("From humdrum clerical and sanitation services to military, policing, and even regulation-writing and enforcement responsibilities, private contractors are assuming ever larger and ever more sensitive roles in carrying out public functions, all ostensibly in the name of efficiency and good governance.").

108. *See* MARY BRYNA SANGER, THE WELFARE MARKETPLACE: PRIVATIZATION AND WELFARE REFORM 2 (2003).

109. *Id.* at 28.

110. *Id.* at 28–29.

111. *See, e.g.*, Richard W. Stevenson, *Clinton Proceeds with Plan to Privatize Security Checks*, N.Y. TIMES (July 2, 1996), http://www.nytimes.com/1996/07/02/us/clinton-proceeds-with-plan-to-privatize-security-checks.html, *archived at* http://perma.cc/LG9K-EYX7.

112. *See* SANGER, *supra* note 108, at 28–31.

113. *See id.* at 29–30 ("The result has favored contracting . . . . Milwaukee has contracted eligibility determination and assessment, job readiness services, and

Further examples abound: private firms have recently been invited by local governments to collect government debts, fight fires, and oversee foster care programs.[114] During the second Bush administration, even the tax ferret made a comeback, as the IRS initiated a program that licensed private tax collectors to go after delinquent taxpayers in exchange for a modern-day bounty—a percentage of the revenue collected.[115]

C. *Diagnosis: Exploding Prison Health Care Costs; Prescription: Privatization*

Privatization mania reached American prisons in the mid-1980s as prison costs expanded rapidly.[116] Rising prison costs in turn were at least partially the result of earlier policymaking trends that caused an unprecedented expansion and graying of the American prison population.[117] Beginning in

placement. San Diego and Houston have contracted for case management. New York has separate contractors for assessment and placement and engages still others to provide employment services and placement for clients with more significant needs. Recently the city has entered into an additional set of contracts with private vendors to serve clients with special needs."); *see also* Wendy A. Bach, *Welfare Reform, Privatization, and Power: Reconfiguring Administrative Law Structures from the Ground Up*, 74 BROOK. L. REV. 275, 278–79 (2009) ("The privatization of the United States public assistance provision system through contracting has accelerated dramatically in the last ten years . . . . Importantly, the [Welfare Reform Act] joined a rising tide of initiatives to 'reinvent government' by using private sector tools and entities to free government from the constraints of what was seen as excessive bureaucracy and constrictive civil service rules. Throughout the country, state and local jurisdictions have turned to the private sector to respond to the challenges posed by the [the Act].") (footnotes omitted).

114. Frankel, *supra* note 51, at 1451–52.

115. *See* Rob Wells, *IRS to Begin Outsourcing Debt Collection*, WALL ST. J. (Nov. 24, 2004, 12:01 AM), http://online.wsj.com/articles/SB110125350589182413, *archived at* http://perma.cc/7BLG-RGGG. This "bounty" is functionally equivalent to the one described by Nicholas Parrillo earlier in this Part. *See supra* notes 76–80 and surrounding text. Noting that this return to privatized government is characteristic of earlier periods in American and world history, Nobel-laureate economist Paul Krugman decried this development as a "retreat from modern principles of government." Paul Krugman, *Tax Farmers, Mercenaries and Viceroys*, N.Y. TIMES (Aug. 21, 2006), http://select.nytimes.com/2006/08/21/opinion/21krugman.html?hp&pagewanted=print, *archived at* http://perma.cc/F5TJ-QZMG.

116. *See* Wood, *supra* note 44, at 18; NAT'L RES. COUNCIL OF THE NAT'L ACADS., THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES 315 (Jeremy Travis, Bruce Western & Steve Redburn eds., 2014) [hereinafter NAT'L RES. COUNCIL REP.] ("Adjusted for inflation, states' combined corrections spending from 1980 to 2009 increased by just over 400 percent . . . .").

117. *See* Carrie Abner, *Graying Prisons: States Face Challenges of an Aging*

the early 1970s, policymakers at both the state and federal levels substantially revamped sentencing policy, and set in motion a phenomenon now commonly labeled "mass incarceration."[118] In place of the old "indeterminate sentencing" regime, which allowed a substantial degree of discretion for judges, policymakers substituted a much more punitive and far less discretionary sentencing regime, which included mandatory minimum sentences, three-strikes laws, and life-without-parole laws, among other innovations.[119] Predictably, an unprecedented number of Americans ended up behind bars.[120] The swelling of the prison population and the lengthening of sentences combined to cause a rapid aging of the American prison population.[121] From 1986 to 1989, the percentage of prisoners over the age of fifty more than doubled, rising from 11.3 percent to 26 percent.[122] This graying phenomenon had important budgetary consequences: while the prison population was already unhealthy relative to its general population counterpart,[123] this disparity worsened as the

Inmate Population, ST. NEWS, Nov.–Dec. 2006, *available at* http://www.csg.org/knowledgecenter/docs/sn0611GrayingPrisons.pdf, *archived at* http://perma.cc/4H7N-595Z.

118. *E.g.*, Editorial Bd., *End Mass Incarceration Now*, N.Y. TIMES (May 24, 2014), http://www.nytimes.com/2014/05/25/opinion/sunday/end-mass-incarceration-now.html, *archived at* http://perma.cc/GBH2-24L7.

119. *See* NATIONAL RES. COUNCIL REP., *supra* note 116, at 71–73.

120. *See id*. at 33 ("In 1973, after 50 years of stability, the rate of incarceration in the United States began a sustained period of growth. In 1972, 161 U.S. residents were incarcerated in prisons and jails per 100,000 population; by 2007, that rate had more than quintupled to a peak of 767 per 100,000."). The growth of the incarcerated population appears to have leveled off in the past five years, but remains at a historically high level. E. ANN CARSON, BUREAU OF JUSTICE STATISTICS, PRISONERS IN 2013 1 (2014), *available at* http://www.bjs.gov/content/pub/pdf/p13.pdf, *archived at* http://perma.cc/U8XP-WSKM.

121. *See* NAT'L RES. COUNCIL REP., *supra* note 116, at 314–17.

("Between 1972 and 2010, public expenditures for building and operating the country's prisons and jails increased sharply, keeping pace with the increase in the number of people held in those facilities. From fiscal year 1985 to 2012, corrections spending increased from 1.9 percent to 3.3 percent of state budgets, or from $6.7 to $53.2 billion. State corrections spending accounted for 7 percent or more of combined states' general fund expenditures from fiscal year 2008 through fiscal year 2012. Over 20 years beginning with fiscal year 1980, only Medicaid grew more rapidly as a proportion of state budgets.") (citations omitted).

122. Abner, *supra* note 117, at 9.

123. *See* THE PEW CHARITABLE TRUSTS & MACARTHUR FOUND., MANAGING PRISON HEALTH CARE SPENDING 8 (last updated May 15, 2014) [hereinafter 2013 PEW REPORT], *available at* http://www.pewtrusts.org/en/research-and-analysis/reports/2014/05/15/managing-prison-health-care-spending, *archived at* http://perma.cc/HNF8-FGBZ ("Inmates have a higher incidence of mental illness

prison population grew older.[124] Thus prison health care costs rose faster than the already rapid increase of general prison budgets.[125]

Budgetary pressure on state finances due to prison health care costs intensified dramatically during the first decade of the twenty-first century.[126] Though the incarceration rate leveled off late in the decade, there was no appreciable decrease in the average length of sentences, and thus the incarceration rate remained at historically high levels.[127]

and chronic and infectious diseases, such as AIDS and hepatitis C, than the general population.").

124. *See id.* at 10–11. ("Like senior citizens outside prison walls, elderly inmates are more susceptible to chronic medical and mental conditions . . . . In prisons, these ailments necessitate increased staffing levels, more officer training, and special housing—all creating additional expense. Medical experts say inmates typically experience the effects of age sooner than people outside prison because of issues such as substance abuse, inadequate preventive and primary care prior to incarceration, and stress linked to the isolation and sometimes-violent environment of prison life."). In addition to caring for older inmates, prison officials were forced to contend with AIDS and hepatitis epidemics that further drove costs upwards. Paul von Zielbauer, *As Health Care in Jails Goes Private, 10 Days Can Be a Death Sentence*, N.Y. TIMES 3 (Feb. 27, 2005), http://www.nytimes.com/2005/02/27/nyregion/27jail.html, *archived at* http://perma.cc/J95N-QMRR ("AIDS and hepatitis have torn through cellblocks, and mental illness is a mushrooming problem. In the last decade, state and local government spending for inmate health care has tripled nationwide, to roughly $5 billion a year.").

125. *See* David Levine, *Aging Inmates Squeeze Health-Care Budgets*, GOVERNING (Mar. 2011), http://www.governing.com/topics/public-justice-safety/courts-corrections/gov-aging-inmates-squeeze-corrections-health-care-budgets.html, *archived at* http://perma.cc/3TGQ-GRVZ ("'When I started in this field in 1978, health care was on average about 10 percent of the correctional budget,'" says Jacqueline Moore, a Colorado-based correctional health-care consultant. 'Now, it's about 20 percent.'"); *see also* CHAD KINSELLA, COUNCIL OF STATE GOV'TS, CORRECTIONS HEALTH CARE COSTS 2, 6 (2004), *available at* http://www.prisonpolicy.org/scans/csg/Corrections+Health+Care+Costs+1-21-04.pdf, *archived at* http://perma.cc/6PSV-LW3D (noting that state correctional health care costs grew faster than both incarceration rates and general corrections costs).

126. For example, during fiscal year 2011–12, the Florida Department of Corrections spent an estimated 19 percent of its budget on inmate health care, one of the largest line items in its budget. Beth Kutscher & Harris Meyer, *Rumble Over Jailhouse Healthcare*, MODERN HEALTHCARE (Aug. 31, 2013, 12:01 AM), *available at* http://www.modernhealthcare.com/article/20130831/MAGAZINE/308319891, *archived at* http://perma.cc/ZD9M-PHT2.

127. *See* LAUREN E. GLAZE & ERIKA PARKS, BUREAU OF JUSTICE STATISTICS, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 2011 1 (2012); PEW CENTER ON THE STATES, PUBLIC SAFETY PERFORMANCE PROJECT, TIME SERVED: THE HIGH COST, LOW RETURN OF LONGER PRISON TERMS 8, 13 (2012) ("Pew estimates that the average [length of stay] for offenders released from prison in reporting states rose by 36 percent between 1990 and 2009."); 2013 PEW REPORT, *supra* note 123, at 9 ("The graying of American prisons stems largely from the use of longer

Further, the graying of American prison inmates showed no sign of slowing down.[128] In fact, the elderly were, and remain, the fastest growing segment of the incarcerated population.[129] Accordingly, prison health care spending exploded from 2001 to 2008: forty-two states saw increases in their total spending on prison health care, with a median growth of 49 percent.[130] Per-inmate spending also rose significantly during this period in thirty-five states, with a median growth of 28 percent.[131]

Importantly, local government legislators faced the aforementioned explosion of their prison health care budgets in the political context of a burgeoning tax revolt and endemic skepticism of governmental power, ushered in by the rise of the Reagan-led G.O.P. and associated policy preferences.[132] The

sentences as a public safety strategy over the past two decades. From 1984 to 2008, the number of state and federal prisoners serving life sentences more than quadrupled to 140,610, or 1 in 11 prisoners. Nearly a third of these inmates were ineligible for parole. The proportion of prisoners with life sentences has continued to rise, reaching 1 in 9 by 2012.").

128. *See* Abner, *supra* note 117, at 9 ("[S]ome estimates suggest that the elder prison population has grown by as much as 750 percent in the last two decades."); *see also* 2013 PEW REPORT, *supra* note 123, at 9.

129. Abner, *supra* note 117, at 9.

130. 2013 PEW REPORT, *supra* note 123, at 3. The authors of this study note a number of drivers of the increase in overall and per-inmate costs of correctional health care, including: a decades-long spike in the incarcerated population which has only recently slowed; a general aging of inmate populations; the prevalence of infectious diseases, substance abuse, and mental health problems among the incarcerated population; and the inherent challenges of delivering medical care to a population that is by definition disconnected from the community health care system. *Id*. at 2–4.

131. *Id*. at 5. The very latest prison health care spending data suggest, however, that the aforementioned increase may have plateaued and perhaps begun to decline. THE PEW CHARITABLE TRUSTS & MACARTHUR FOUND., STATE PRISON HEALTH CARE SPENDING 3–5 (2014), *available at* http://www.pewtrusts.org/en/research-and-analysis/reports/2014/07/08/state-prison-health-care-spending, *archived at* http://perma.cc/A2P4-64AK. While caution is warranted due to the relative paucity of similar studies or findings, a summer 2014 study by The Pew Charitable Trusts and MacArthur Foundation found a significant slowing of prison health care spending across the country. *Id*. While most states still saw significant increases in their prison medical expenditures from 2007 to 2011—a 13 percent median growth rate in total spending and a 10 percent median growth rate in per-inmate spending—in thirty-four states total spending peaked prior to 2011, while per-inmate spending peaked in thirty-seven states prior to 2011. *Id*. at 3. The 2014 Pew study attributed this pattern, in part, to "a reduction in state prison populations." *Id*. at 8.

132. California's Proposition 13, a ballot measure passed overwhelmingly by voters in 1978, is often cited as the beginning of the aggressively anti-tax and anti-government attitude that captured the imagination of the country in the 1970s, 1980s, and beyond. *E.g.*, JOHN MICKLETHWAIT & ADRIAN WOOLDRIDGE, THE RIGHT NATION: CONSERVATIVE POWER IN AMERICA 88 (2004) [hereinafter

success of Reaganism in its effort to recast government taxation as something akin to theft meant that some solutions—higher taxes, for example—were presumptively taken off the table.[133] In this context privatization looked especially favorable: it promised to relieve the pressure of exploding prison health care costs while hewing to the ascendant anti-tax and anti-government ideology. Additionally, state and local officials had recent experience with privatization: the Reagan Commission on Privatization Report noted that as of 1988 "[c]ontracting for services and nonsecure facilities is a common practice in the field of corrections. Virtually all the individual components of corrections (such as food services, medical services and counseling, educational and vocational training, recreation, maintenance, transportation, security, and industrial programs) have been provided by private contractors."[134]

Thus, with confidence borne of a politically permissive environment and previous experience with privatization in the prison context, local legislators moved en masse to outsource the seemingly core governmental function of prison medical care. The rush to privatize was particularly intense during the late 1990s and early 2000s. According to one study, by 1997,

RIGHT NATION]. Proposition 13 capped state property taxes at a flat one percent rate, and required voter approval for new tax measures. *Id*. However, the stirrings of this revolt of "angry suburbanites," *id*., can be traced to the campaign of then governor Reagan to sell California voters on Proposition 1, a similar tax-limitation initiative that the governor himself got on the November 1973 ballot. RICK PERLSTEIN, THE INVISIBLE BRIDGE 160–63, 168–69, 195–96 (2014).

133. Governor Reagan vigorously campaigned for the passage of Proposition 1, and in doing so, road-tested many of the moralistic and apocalyptic themes he and others would use to transform popular understanding of the nature and purpose of government and taxation. *See* PERLSTEIN, *supra* note 132, at 163, 169, 195. Rick Perlstein offers some of the most colorful examples of Governor Reagan's campaign-trail rhetoric: "When the advocates of bigger and bigger government manage to get their hands on an extra tax dollar or two they hang on like a gila monster until they find some way to spend it . . . . What they mean by 'flexibility' is the unlimited ability to get in your pockets . . . . Have we really forgotten what the Constitution is for? It is not designed to protect the government from the people; it is to protect the people against government . . . . When a government becomes powerful, it is destructive, extravagant, and *violent*." *Id*. In 1973, this rhetoric was not persuasive enough; Proposition 1 lost handily. *Id*. at 196. However, the defeat of Proposition 1 proved to be a Pyrrhic victory for supporters of well-funded government; Proposition 13 won 65 percent of the vote in 1978, and ushered in "a peasants' revolt that swept across the country . . . ." RIGHT NATION, *supra* note 132, at 88. Within the next four years, eighteen states would follow California's lead and pass referenda to cut or limit taxes. *Id*.

134. REAGAN'S COMM'N ON PRIVATIZATION REPORT, *supra* note 64, at 147.

twelve states had fully privatized their prison health care function, while an additional twenty states operated partially privatized systems; by 2000, thirty-four states had at least partially privatized their prison health care function, including twenty-four states that oversaw fully privatized systems.[135] Another investigation revealed that in 2005 "half of all state and local prisons and jails [had] outsourced healthcare services . . . ."[136]

As has been demonstrated in this Part, the privatization of American prison health care has a powerful historical momentum behind it. In the first decades of the twenty-first century, the historical forces seemed to push entirely in one direction: cost-cutting. The contracts reviewed in the next Part illustrate how the cost-cutting imperative structures the relationship between local governments and prison health care providers.

II. THE INCENTIVE STRUCTURE OF CONTEMPORARY PRIVATIZED PRISON HEALTH CARE

Many contemporary private prison health care contracts incentivize providers to offer inmates only limited medical treatment while *dis*incentivizing governments from providing sufficient oversight.[137] To make matters worse, local government officials routinely sign these contracts with providers that have known histories of unconstitutional denials of medical care to prisoners in their charge.[138] The predictable result is personal tragedy for inmates and their families who are unlucky enough to be caught up in this system.[139] This Part discusses three important provisions that are common to many

135. KINSELLA, *supra* note 125, at 18.

136. Zielbauer, *supra* note 124, at 4 ("[As of 2005,] [a]bout 40 percent of all inmate medical care in America is now contracted to for-profit companies, led by Prison Health, its closest rival, Correctional Medical Services, and four or five others. Though the remaining 60 percent of inmate care is still supplied by governments, most often by their Health Departments, that number has been shrinking as medical expenses soar.").

137. *See infra* Part II.B.

138. *See, e.g.*, Dan Christensen, *Florida Prison Officials Didn't Ask, Companies Didn't Tell About Hundreds of Malpractice Cases*, BROWARD BULLDOG (Oct. 2, 2013, 6:09 AM), http://www.browardbulldog.org/2013/10/florida-prison-officials-didnt-ask-companies-didnt-tell-about-hundreds-of-malpractice-cases/, *archived at* http://perma.cc/V76U-HE5F.

139. *See supra* Introduction.

modern prison health care contracts. Section A describes the overall fixed-rate payment structure of these agreements, as well as the cost-sharing provisions for off-site medical care; together these provisions create an incentive for private providers to ignore inmate medical problems and delay treatment whenever possible. Section B then describes the similarly common indemnification clauses that effectively immunize local governments from financial liability in most cases, thus diminishing their incentive to maintain a proper oversight regime. Section C follows with a discussion of how the financial incentives of these contracts can translate into provider policies that put inmate lives at risk in the name of securing a higher profit margin. Finally, section D demonstrates how this risk is exacerbated by the all-too-common practice of local governments signing and re-signing contracts with known constitutional violators.

A. *Fixed Reimbursement Rates and Cost-Sharing Provisions*

Many prison health care contracts are fixed-rate contracts, agreements whereby the local government offers the contractor a flat rate of compensation regardless of the degree of medical need of prisoners in the contractor's care.[140] Another common feature of contemporary private prison health care contracts is a clause that requires the private contractor to pay the first several tens of thousands of dollars of off-site medical care for each prisoner.[141]

The contracts in place between Lee County and PHS, Montgomery County and CMC, and Jefferson County and CHC all contain similar fixed reimbursement rates.[142] In 2007, the year of Mr. Fields' ordeal, the Lee County-PHS contract offered

140. *See* Introduction; *see also, e.g.,* Jessica Vander Velde, *Jail Health Care Always a Challenge—and Pricey*, TAMPA BAY TIMES (July 7, 2013), http://www.tampabay .com/news/publicsafety/jail-health-care-always-a-challenge-8212-and-pricey/2130 356, *archived at* http://perma.cc/8B2B-26G2 (reporting that Hillsborough County, Florida, pays Armor Correctional Health Services a fixed compensation rate of $20.36 per inmate per day for inmate health care).

141. *See, e.g.*, Vander Velde, *supra* note 140 (describing the fixed reimbursement structure of the prison health care contract between Hillsborough County, Florida, and Armor Correctional Health Services, stipulating that Armor will pay for the first $40,000 of any inmate's per-event medical care).

142. *See infra* notes 143–51.

the contractor a flat fee of $5,122,086 for the year.[143] The agreement assumed an average daily population (ADP) of inmates for each contract year; if the actual inmate population varied above or below this number, the contractor could earn a small additional amount or have to credit back to the county a small portion of its fee.[144] When Ms. Pollack died in 2011, Montgomery County Jail paid CMC a flat yearly fee of $4,245,828.24 for prison health care services.[145] The only additional compensation to CMC came from separate charges for two staff positions, and for any variable costs that might result from the jail population exceeding 1400 inmates, as an average daily figure, during any given month of the contract.[146] Apart from these minor allowances for extra charges to the

143. This was the second year of a three-year deal between the two parties that paid the contractor a flat fee of $4,893,656 for the first year, $5,122,086 for the second year, and then $5,374,615 for the final year of the contract. Inmate Health Services Agreement Between Lee County Sheriff's Office and Prison Health Services, Inc. 14–15 (Sept. 26, 2005) [hereinafter Lee County-PHS Contract] (on file with author).

144. For the first year of the contract, the ADP was assumed to be 1740, for the second year 1890, and for the third year 2040. *Id.* at 15. For the first year of the contract PHS earned an additional $0.81 per diem, applied to its monthly base payments, for each inmate in excess of the average monthly base population of 1740. *Id.* For an inmate population lower than 1740, PHS would credit back the same amount to the County. *Id.* PHS would only be responsible for these credits up to a maximum of 100 inmates below the 1740 assumed average. *Id.* For the second and third years of the contract, the same system applied, only the per diem per inmate rate went up to $0.96 for the second year, and to $1.11 for the third year. *Id.*

145. The original contract between the Montgomery County and CMC, covering the period from August 8, 2006, to January 7, 2010, offered CMC increasing yearly base compensation rates of $3,809,493.47 for 2007, $3,962,745.80 for 2008, and $4,122,163.32 for 2009. Health Services Agreement By and Between Montgomery County Correctional Facility and Correctional Medical Care, Inc. 11–12 (July 13, 2006) [hereinafter Montgomery County-CMC Contract] (on file with author). The contract was extended by amendment for two more years, and offered CMC a 3 percent increase (from the 2009 rate) in base compensation for 2010, and a 5 percent increase (from the 2010 rate) for 2011. Contract Extension, 1–2 (Jan. 14, 2010) [hereinafter Montgomery County-CMC Contract Extension] (on file with author).

146. Montgomery County-CMC Contract, *supra* note 145, at 18–21; Montgomery County-CMC Contract Extension, *supra* note 145, at 2. The limited variable cost provision in this contract can be found in section 14(C), and states: "For each day that the average daily population exceeds 1,400, CMC shall be entitled to a Per Diem of $3.06 times the difference between the maximum average daily population and the actual daily population." Montgomery County-CMC Contract, *supra* note 145, at 12. Section 14(F) further explains that the purpose of the per diem increase in payments to CMC is only to compensate the contractor for costs incurred as a result of minor, short-term increases in the jail's population. *Id.* at 12–14.

County, the contract goes out of its way to expressly state that CMC's compensation is to be fixed for each contract year.[147] The 2011 Jefferson County-CHC contract in place when Mr. McGill suffered his stroke was also a fixed-rate agreement, with minor allowances for short-term increases in inmate population above a set threshold.[148] Under this agreement CHC earned $4,140,000 for the year.[149] So long as Jefferson County kept the facility's population below 1300, this rate would not vary.[150] Like the Lee County-PHS and Montgomery County-CMC agreements, the Jefferson County-CHC contract mandated a staffing plan, though it allowed the contractor to submit its own plan as part of its response to the County's request for proposal.[151]

The three contracts under investigation here also contain similar off-site cost-sharing provisions.[152] The Lee County-PHS agreement first mandates that PHS pay for an all-inclusive basket of specialty medical services, hospitalization, and off-site specialty care, but then sets an annual aggregate cap for "hospital and off-site medical specialty care costs" of $950,000.[153] While the County will assume the costs for non-emergency off-site transportation, PHS must pay for emergency off-site transportation to local hospitals or other

147. "16. Additional Compensation. With the exception of normal increases in inmate population (covered under Article 14, 'MONTHLY ADJUSTMENTS IN PAYMENTS') or written amendments agreed to by the parties, CMC shall not be entitled to receive or seek additional compensation from the County for services under this Agreement." Montgomery County-CMC Contract, *supra* note 145, at 14.

148. Jefferson County-CHC Contract, *supra* note 26, at 4 ("The County agrees to pay the Contractor a firm, fixed amount of four million one hundred forty thousand dollars ($4,140,000.00) for the full term of the Contract.").

149. *Id.* at 4, 7.

150. The only element of variable compensation in the 2011 contract between CHC and Jefferson County is a provision that entitles CHC to an extra $0.96 per inmate per day, during months where the average monthly population of the Detention Center rises above 1,300 inmates, but only for days where the actual number of inmates is above 1,300. *Id.* at 5.

151. Section 5(F) requires CHC to develop and submit a staffing plan as part of its response to the County's RFP. *Id.* at 5–7. This staffing plan must be updated and reported on a daily basis to the County. *Id.* at 6. The County sets two minimum staffing requirements: first, that "at least one registered nurse is working each shift," and second, that "[l]icensed practical nurses may not work without the supervision of a registered nurse." *Id.*

152. *See* Lee County-PHS Contract, *supra* note 143, at 2–4; Montgomery County-CMC Contract, *supra* note 145, at 14–15; Jefferson County-CHC Contract, *supra* note 26, at 5.

153. Lee County-PHS Contract, *supra* note 143, at 2–4.

outside medical specialists.[154] Similarly, the Montgomery County-CMC contract requires the contractor to fund a significant portion of hospital and off-site specialty care, subject to a cap.[155] Specifically, the agreement limits CMC's liability for off-site medical care on a per-inmate, per-year basis, to the first $40,000 or the first $50,000, depending on the circumstances in which the medical necessity arose.[156] Like its counterpart agreement between Lee County and PHS, Montgomery County and CMC share the costs of off-site transportation for inmate medical care.[157] Jefferson County's 2011 contract with CHC also caps the contractor's liability for off-site medical care on a per-inmate, per-year basis.[158] The 2011 contract between Jefferson County and CHC obligates CHC to pay the first $50,000 of off-site medical care for any one inmate within a contract term.[159] The Jefferson County-CHC contract does not make any specific mention of how transportation costs will be allocated,[160] though presumably such costs would be included within the $50,000 aggregate cap for each inmate.

The resulting financial incentive of these agreements is clear: the fewer off-site appointments that the prison health care contractor authorizes, the less it will have to dip into its fixed compensation to cover the associated costs. The contractor is thus tempted to ignore inmate medical problems, or to try and treat everything in the prison infirmary. But prison infirmaries are not equivalent to emergency rooms.[161] Thus, for

154. *Id.* at 2.

155. Montgomery County-CMC Contract, *supra* note 145, at 14–15. The only notable exception to the above cost-sharing provisions is for AIDS-related medication or treatment, during the first year of the contract. *Id.* at 15.

156. *Id.*

157. *Id.* at 17.

158. Jefferson County-CHC Contract, *supra* note 26, at 5.

159. *Id.* ("The Contractor's maximum liability for costs associated with off-site provision of medical or other health care services for any one Inmate during any Contract term from date of first service under this Contract will be Fifty Thousand Dollars ($50,000). Any expenses incurred or to be incurred for medical and other health care services provided off-site (e.g., hospital, specialist) in excess of that amount will be the responsibility of the County.").

160. *See id*.

161. Based on an email exchange with Alex Friedmann, Managing Editor of Prison Legal News, a well-respected and now decades-old publication of civil rights law as it applies to the American penal system, it appears that there is no such thing as a "typical" prison infirmary. Rather, prison infirmaries vary greatly from facility to facility in terms of their staffing, equipment, and the medical care they are capable of providing. Mr. Friedmann writes:

a true medical emergency, a prison health care provider will often need to send the inmate patient to an emergency room. Even in non-emergency situations, an infirmary may lack the specialized personnel or equipment necessary to treat a chronic condition that could become life threatening without specialist care.

For-profit corporations are ultimately responsible to their shareholders, bound by their fiduciary duty to operate in as profitable a manner as possible.[162] In the prison health care context one way to do that is to delay or refuse necessary off-site medical care. While problematic, this reality of for-profit provision of public services would not be so dangerous if the governmental body responsible for oversight were not so disengaged.

B. Indemnification Clauses

While the three contracts under investigation here all contain very similar compensation and cost-sharing provisions,[163] they also have in common a similarly consequential indemnification or hold-harmless clause.[164]

> In regard to prison infirmaries, it really depends on the prison. Some prisons are designated as medical facilities and have robust resources. Most others have infirmaries that are more like clinics, though some have X-ray machines, etc. Keep in mind that many prisoners have a hard time getting anything other than Tylenol and Pepto-Bismol, even for ailments like heart attacks and cancer, regardless of the resources that prison infirmaries have on hand. I'm unaware of any studies that discuss this issue, though.

E-mail from Alex Friedman, Managing Editor, Prison Legal News, to author (July 3, 2014) (on file with author) (Prison Legal News is a monthly publication that reports on criminal justice issues, and is a project of the Human Rights Defense Center). As Mr. Friedman notes, this appears to be an under-examined area of the American penal system. *Id.*

162. *See, e.g.*, Dodge v. Ford Motor Co., 170 N.W. 668, 684 (Mich. 1919).

163. *See supra* Part III.A.

164. Jefferson County-CHC Contract, *supra* note 26, at 11–12; Lee County-PHS Contract, *supra* note 143, at 17; Montgomery County-CMC Contract, *supra* note 145, at 6–8. The indemnification clause in the Jefferson County-CHC contract is the most succinctly stated, and reads as follows:

> 10. Indemnification/Joinder of Parties.
>
> A. The Contractor agrees to and does hereby indemnify and hold the County, its agents and employees harmless from and against any and all claims, damages, losses, injuries and expenses, including attorney's fees related to or arising out of the Contractor's performance or failure to perform the services, or an omission or error caused by Contractor's

While not containing the exact same language, these clauses are substantively similar in that they include (i) a joinder provision allowing the County to join the contractor and its personnel to any lawsuit against the County arising from prison health care issues;[165] (ii) an indemnification provision that requires the contractor to reimburse or pay outright the County's legal-defense costs for lawsuits arising out of any action of the contractor or its employees; and (iii) a complete disclaimer by the County of any responsibility for providing the contractor legal counsel or paying for legal costs associated with the contractor's provision of medical care to inmates.[166] These provisions effectively render the local government only *symbolically liable* for the injuries or deaths that result from constitutionally deficient medical care in its prisons and jails. As discussed further in Part III, a government cannot escape legal liability for contractor violations of citizens' constitutional rights. However, indemnification provisions ensure that a local government likely will face only small or non-existent financial

> performance hereunder. Contractor, its agents, employees or independent contractors, shall not in any event be required to indemnify, defend, or hold harmless, the County with respect to any claims, actions, lawsuits, damages, judgments or liabilities of any kind whatsoever caused by, based upon or arising out of any act, conduct, misconduct or omission of the County, its officials, agents and employees.
>
> B. In the event that any lawsuit is filed against the County, its elected officials, employees or agents based on or containing allegations concerning medical care of Inmates or on the performance of Contractor's employees, agents, subcontractors or assignees, the parties agree that the Contractor's employees, agents, subcontractors, assignees or independent contractors, as the case may be, may be joined as defendants in any such lawsuit and shall be responsible for their own defense and any judgments rendered against them.

Jefferson County-CHC Contract, *supra* note 26, at 11–12.

165. Jefferson County-CHC Contract, *supra* note 26, at 12; Lee County-PHS Contract, *supra* note 143, at 17; Montgomery County-CMC Contract, *supra* note 145, at 6–7.

166. Jefferson County-CHC Contract, *supra* note 26, at 11–12 ("The Contractor agrees to and does hereby indemnify and hold the County . . . harmless from and against any and all claims . . . and expenses, including attorney's fees related to or arising out of the Contractor's performance or failure to perform . . . ."); Lee County-PHS Contract, *supra* note 143, at 17 ("PHS agrees to indemnify and hold harmless, pay the cost of defense, including attorney's fees, and save the SHERIFF . . . from any claim . . . or expense of any kind whatsoever arising out of any act . . . omission or failure to act by PHS . . . ."); Montgomery County-CMC Contract, *supra* note 145, at 7 ("CMC will indemnify and hold the County . . . harmless for defense costs, damages and/or liability arising from [CMC's] administration of health care services.").

losses even if a § 1983 prison health care claim against the contractor succeeds. Thus the local government has no real financial skin in the game.

This *dis*incentive structure allows local governments to escape an important component of § 1983 liability, and thus to get away with cursory oversight of the private contractors to which they have outsourced their prison medical care function. Legal scholars have warned of the potential for private contractors to evade oversight and thus abuse their discretion.[167] This is recognized as one of the fundamental drawbacks of the privatization model.[168] Once a government service is contracted out, many local government agencies become satisfied, according to Professor Alfred Aman, Jr., "with monitoring compliance with the terms of the contracts."[169] Local governments tend to trust the market to discipline contractors who provide low-quality services.[170] However, the prison health care market is not likely to be competitive enough to discipline contractors who impose the costs of low-quality, or even illegal-quality, service provision on their captive consumers.[171] Where the privatization contract does not

167. *See, e.g.*, Wendy Netter Epstein, *Contract Theory and the Failures of Public-Private Contracting*, 34 CARDOZO L. REV. 2211 (2013) (examining issues concerning public-private contracts). *See generally* Michaels, *supra* note 59 (discussing the implications of government "workarounds").

168. *See* Michaels, *supra* note 59, at 718 ("The case against [privatization] has . . . rested largely on accountability concerns—the excessive delegation of sovereign authority paving the way for private contractors to abuse their discretion, evade oversight, and generate unanticipated cost overruns.").

169. Aman, *supra* note 43, at 529 (quoting DOUGLAS C. MCDONALD ET AL., PRIVATE PRISONS IN THE UNITED STATES: AN ASSESSMENT OF CURRENT PRACTICE (1998)).

170. *See, e.g.*, Epstein, *supra* note 167, at 2218 ("Governments function loosely as a monopoly and lack the incentive to innovate to reduce cost. By introducing competition, so the argument goes, private firms are motivated to deliver services efficiently and effectively. In addition, whereas the government must negotiate a considerable bureaucracy, private entities have more flexibility to adjust staffing and wage levels and to utilize private capital as necessary. Privatization proponents conceive of public-private contracting similarly to commercial contracting and expect that governments can take advantage of market mechanisms at play in commercial transactions.") (footnote omitted).

171. *See id*. Professor Epstein asserts:

> Although advocates of privatization herald the move from state-run monopoly to a competitive market, the reality is that in certain types of public-private contracting, the seller-side market is shallow. For instance, very few entities are positioned to provide such complex and sophisticated services as administering Medicaid for a state or running a prison, which has no commercial analogue. Therefore contracts do not

contain any "human rights provisions,"[172] local government oversight moves away from a substantive guarantee of constitutionally adequate medical care for a subset of the citizenry to a formalistic contract review, largely devoid of concern for the health of prisoners or the community into which most will reenter.

C. *Contractors React by Implementing Care-Denying Policies*

Into the void described above steps a private corporation, which, while hired to care for prisoners to be sure, is concerned above all else with satisfying shareholders with a reasonable return on their investment. This requires squeezing as much profit out of each contract as possible.[173] Given the fixed overall payment structure and the fact that the contractor must pay for the first $40,000 or $50,000 of off-site medical care for each prisoner, it is not surprising that these incentives would translate into specific contractor policies and practices that deny outright, or otherwise interfere with, necessary medical care to prisoners in crisis.[174]

Corizon's work in the Idaho State Correctional Institution (ISCI) in Boise offers an illustration of the sorts of care-denying policies that a for-profit contractor will institute to save money. The court-appointed Special Master in *Walter Balla, et al. v. Idaho State Board of Correction, et al.* investigated the state of

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benefit from the competitive effects of an efficient market.

Id. Professor Epstein goes on to argue that public-private contracts, as distinct from traditional commercial contracts, contain two "systematic biases." *Id*. "First, the government lacks the proper incentives to ensure high-quality service provision. . . . [and] [s]econd, even if the government were incentivized to provide high-quality service, it faces systematic difficulties in doing so." *Id*. These biases allow the private contractors "to impose a cost on service recipients in the form of low-quality service." *Id*.

172. Aman, *supra* note 43, at 529.

173. Joel H. Thompson, *Today's Deliberate Indifference: Providing Attention Without Providing Treatment to Prisoners With Serious Medical Needs*, 45 HARV. C.R.-C.L. L. REV. 635, 640–41 (2010).("Through privatization, a jail or prison seeks to obtain cost savings and predictability for its health care spending. The winning bidder must fulfill its contractual obligation—the provision of health services to prisoners—while trying to ensure that costs do not exceed the amount of the winning bid. The pressure to bid as low as possible, in order to win the contract in the first place, is followed by the pressure to keep costs in line with the winning bid. This reality influences all decisions about prison medical care.") (footnotes omitted).

174. *See infra* Part III.B.

medical care in ISCI in 2012, and subsequently issued a scathing report on a number of Corizon policies that in his view constituted "deliberate[] indifferen[ce]."[175] For example, Corizon medical personnel routinely delayed their responses or failed to respond altogether to prisoner "kites," or requests for medical care.[176] Additionally, the Report found that Corizon staffed its infirmary primarily with Licensed Practice Nurses (LPN), and that these LPN's often "operate[d] independently, i.e. taking the patient's history, conducting examinations, making conclusions about the patient's condition, and providing treatment, all without input from a Licensed Professional Nurse (RN) or practitioner."[177] The *Balla* Special Master found such conditions to be "dangerous, . . . depriv[ing] patients of their constitutional right to access to care and the opinion of a qualified health care professional."[178]

Further examples of contractors' care-denying and money-saving policies abound,[179] but alarmingly, and contrary to the

175. Marc. F Stern, MD, MPH, Report of the Special Master at 3, Balla v. Idaho St. Bd. of Corr., No. 1:81-cv-1165-BLW, 2011 WL 108727 (D. Idaho Mar. 19, 2012) ("I found serious problems with the delivery of medical and mental health care. Many of these problems either have resulted or risk resulting in serious harm to inmates at ISCI. In multiple ways, these conditions violate the right of inmates in 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.").

176. *Id.* at 8 ("I found delays as long as five weeks between the time a patient submitted an HSR [or "kite"] and when he was seen for the problem.").

177. *Id.* at 9 (footnote omitted). The *Balla* Special Master further noted:

> Most states' nurse practice acts, including that of Idaho, draw a clear distinction between the scopes of practice of LPNs and RNs. Generally LPNs collect data which they provide to RNs or practitioners and execute care plans as developed by RNs and practitioners. Making independent assessments (the nursing equivalent of a diagnosis) and prescribing nursing interventions is the sole domain of the RN and is beyond the scope of an LPN.

Id.

178. *Id.* at 14.

179. A common contractor policy is to delay treatment for serious injuries as long as possible, instead prescribing mild pain medication more commonly used for minor injuries. *See, e.g.*, Christopher Zoukis, *Prison Health Care Provider Under Fire in Illinois*, PRISON LEGAL NEWS (May 15, 2013), https://www.prisonlegalnews.org/news/2013/may/15/prison-health-care-provider-under-fire-in-illinois/, *archived at* http://perma.cc/V6VH-N3S9. Mr. Zoukis recounts the experiences of an inmate and a local lawyer with Wexford, Inc. in the Illinois Department of Corrections:

> Another Illinois state prisoner, Jeff Elders, who has a hard growth on his hand that is causing his fingers to curl up, said, "They tell you flat out,

promises of privatization advocates, these policies and the tragic results they predictably produce do not result in much discipline from the market.

D. Counties Sign and Re-Sign Contracts with Care-Denying Contractors

Contractors who repeatedly pay out settlements, defend themselves at trial, or become the target of a scathing court-ordered report like the one discussed above generally have little difficulty staying in business. This Teflon-like ability to withstand reputational damage was the subject of a long investigative series by the New York Times in 2005, which characterized the prison medical care meted out by PHS in upstate New York prisons and jails as "flawed and sometimes lethal."[180] Paul von Zielbauer spent a year investigating PHS's record of service and found that "[t]he company's performance around the nation has provoked criticism from judges and sheriffs, lawsuits from inmates' families and whistle-blowers, and condemnations by federal, state and local authorities."[181] He found that PHS had "paid millions of dollars in fines and settlements."[182] State investigators who looked into several deaths in PHS-served facilities "kept discovering the same failings: medical staffs trimmed to the bone, doctors underqualified or out of reach, nurses doing tasks beyond their training, prescription drugs withheld, patient records unread and employee misconduct unpunished."[183] While PHS was

> they can't do nothing for you. Unless it's an immediate issue, they're not doing nothing for you. [The doctor] said, well, I'll give you some aspirins and I suggest you take care of it as soon as you can when you get out or you're going to end up like this, all crippled up, but there's nothing we're going to do for you here." Situations like this aren't surprising to Alan S. Mills, legal director of the Uptown People's Law Center on Chicago's North Side. "It's absolutely representative of the level of care. That sort of delaying of treatment until things get worse is typical," he said. "[T]hat unfortunately is what we see all the time in the Department of Corrections: putting off care that would be very simple at the beginning and putting it off and putting it off and putting it off until it becomes a serious problem which nobody can ignore any more."

Id. (alterations in original).

180. Zielbauer, *supra* note 124.

181. *Id*.

182. *Id*.

183. *Id*.

finally kicked out of most of its upstate New York jails, as Zielbauer aptly put it, PHS was "hardly out of work."[184] On the contrary, by 2005 PHS had become the biggest for-profit prison health care contractor in America.[185]

As has been demonstrated by this Part, the fixed-rate prison health care contract gives contractors ample incentive to reduce costs as much as possible. Further, these contracts give local government officials little incentive to exercise proper oversight over contractor personnel. If officials expect the market to step in and discipline wayward contractors, as the PHS story illustrates, this expectation is based on a theoretical premise that doesn't survive the transition to real-world implementation. For all intents and purposes, there is no oversight. For-profit contractors operating under a fixed-rate contract are largely free to pad their profit margins by denying or refusing necessary care. This is the context that makes an otherwise very difficult § 1983 claim seem like a plausible agent of change.

III. LOCAL GOVERNMENTS' CONSTITUTIONAL RESPONSIBILITY FOR PRISON HEALTH CARE

In stark contrast to the "health care" provided to Mr. Fields, Ms. Pollock, and Mr. McGill, stands the legal regime erected by the Supreme Court to set a minimum standard for prison health care—whether provided by local governments or their private contractors. This Part provides a basic outline of the current legal backdrop against which a § 1983 lawsuit would proceed for constitutionally deficient prison health care. The discussion begins with the constitutional minimum for the quality of prison medical care, set by the Court in *Estelle v. Gamble*.[186] Following that, the Part covers a similarly consequential development in Supreme Court municipal liability jurisprudence—the establishment of potential *Monell* liability for local governments that violate their citizens' constitutional rights pursuant to governmental or contractor policy. [187]

184. *Id.*
185. *Id.*
186. Estelle v. Gamble, 429 U.S. 97, 105–06 (1976).
187. Monell v. Dep't of Soc. Servs., 436 U.S. 658, 690 (1978).

A. *Prison Health Care and the Eighth Amendment*

Prisoners are entitled to a minimum level of medical care.[188] In *Estelle v. Gamble*, the Supreme Court first announced that the Eighth Amendment's prohibition against "cruel and unusual punishment"[189] extends to situations where prison officials or prison medical personnel exhibit "deliberate indifference to [the] serious medical needs" of the citizens in their custody.[190] Some denials of medical care, the Court reasoned, could be so egregious that they could cause the same sort of "unnecessary and wanton infliction of pain" or "lingering death" that proscribe certain forms of execution.[191] Moreover, the resulting "pain and suffering" could not "serve any penological purpose."[192] Thus, the Court concluded, some denials of prison medical care are "inconsistent with contemporary standards of decency . . . ."[193]

The *Estelle* Court was careful, however, to insist that only especially egregious denials of medical care to prisoners could constitute an Eighth Amendment violation.[194] Accident, negligence, or even medical malpractice would not rise to the level of "deliberate indifference" necessary to find an actionable § 1983 claim.[195] In later cases the Court further refined the "deliberate indifference" standard to include both an objective and subjective component.[196] To satisfy the objective component, the prisoner-claimant must prove that the alleged deprivation was, in objective terms, sufficiently serious.[197] To satisfy the subjective component, the prisoner-claimant must show that the prison official alleged to have unconstitutionally denied medical care was aware both that a substantial risk to the prisoner's health existed and that the official disregarded that risk.[198]

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188. *Estelle*, 429 U.S. at 105–06.
189. U.S. Const. amend. VIII.
190. *Estelle*, 429 U.S. at 105–06.
191. *Id.* at 103–05 (citing Gregg v. Georgia, 428 U.S. 153, 173) (further citations omitted).
192. *Id.* at 103.
193. *Id.*
194. *Id.* at 105–06.
195. *Id.*
196. *See, e.g.*, Wilson v. Seiter, 501 U.S. 294 (1991); Farmer v. Brennan, 511 U.S. 825 (1994).
197. *Wilson*, 501 U.S. at 298.
198. Thompson, *supra* note 173, at 638.

In practice, this refined standard is very difficult to meet.[199] It places both a heavy burden of proof on the prisoner-claimant, as described above, and a relatively light burden on the prison health care provider to show that *some* care was provided.[200] The prison health care provider will often cite their records to show a series of checks by guards or inmate visits to the prison infirmary, and argue that officials have neither interfered with nor denied all medical treatment.[201]

B. Municipal Liability

Local governments and officials can be liable for unconstitutional denials of health care to prisoners with known and serious medical needs.[202] As stated in 42 U.S.C. § 1983, the codification of the Civil Rights Act of 1871:

> Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.[203]

After a debate over the meaning of "person" in this statute, the Court in *Monell v. Department of Social Services of City of New York* held that local governing bodies could be sued directly under § 1983 for monetary, declaratory, or injunctive relief where a local government violates a citizen's constitutional rights pursuant to the implementation of an official policy, ordinance, or regulation (*Monell* policy).[204] Importantly, local governments may also be held liable for deliberately indifferent failures to act in the face of known violations of their citizens' constitutional rights.[205] However,

199. *Id*. at 650.
200. *Id.*
201. *Id.*
202. Monell v. Dep't of Soc. Servs., 436 U.S. 658, 690 (1978).
203. 42 U.S.C. § 1983 (1996).
204. *Monell*, 436 U.S. at 690.
205. This can be done indirectly with what amounts to an acquiescence theory. *See* City of Canton v. Harris, 489 U.S. 378, 388 (1989). In *City of Canton v. Harris*,

whether it is a governmental act or a governmental omission at the heart of the § 1983 claim, a showing of negligence will not suffice for liability to attach; rather, a claimant must again prove "deliberate indifference."[206]

C. *Contractor Liability Does Not Preclude Local Government Liability*

Where local governments have contracted out their prison health care responsibilities, liability for constitutionally deficient prison health care can attach to both the governmental entity and the private contractor.[207] In *West v. Atkins*, the Court held that a part-time private doctor, under contract with a local government to provide prison medical care, acted "under color of state law" because his conduct was "fairly attributable to the state."[208] Thus, private prison health care providers are liable for unconstitutional denials of care under § 1983.[209] The *West* court, however, was careful to note that § 1983 liability for the doctor did not relieve the governmental entity of the same.[210] Rather, the Court reasoned that the state, by incarcerating a citizen and authorizing him to receive medical care only from a particular private provider, was as much a cause of the constitutionally deficient care as the private provider; after all, prisoners do not have the ability to walk away from deliberately indifferent medical care.[211]

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the Court confronted a § 1983 claim against city police officers for an alleged denial of necessary medical care while in police custody. *Id.* The plaintiff alleged that pursuant to a municipal regulation, shift commanders were given sole discretion to determine whether a detainee needed medical care. *Id.* at 381. The court held that a local government could be liable under § 1983 for constitutional violations that result from inadequate training of city employees. *Id.* at 388. The Court described the "failure to train" theory of municipal liability as such: "the jury could find from the evidence that the vesting of such *carte blanche* authority with the police supervisor without adequate training to recognize when medical treatment is needed was grossly negligent or so reckless that future police misconduct was almost inevitable or substantially certain to result." *Id.*

206. *Id.*
207. *See* West v. Atkins, 487 U.S. 42 (1988).
208. *Id.* at 54.
209. *Id.* at 57.
210. *Id.* at 56.
211. *Id.* at 54–55. The *West* Court explained:

> The Court recognized in *Estelle:* 'An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.' . . . If Doctor Atkins misused his power by demonstrating deliberate indifference to West's serious medical needs,

Accordingly, when a government contracts out the provision of prison health care, it does not, in the *West* Court's words, "relieve [itself] of its constitutional duty to provide adequate medical treatment to those in its custody."[212]

Thus, while contracting certainly confuses the legal analysis of the municipal liability issue, it does not immunize local governments from legal responsibility for how they treat incarcerated citizens. Given that the wave of American privatization decisions occurred amidst a zeitgeist favoring the reduction of the size, scope, and responsibility of government,[213] it should not come as a surprise that local government officials may assume that, by outsourcing prison health care, they have unburdened themselves of a set of duties. This is an important but mistaken assumption; privatization arguably changes the responsibilities of the local government official, but it does not decrease those responsibilities and may even increase them.[214] This mistaken assumption is evident in the way local governments structure their prison health care contracts, effectively disincentivizing themselves from providing proper oversight. This has to change.

IV. A § 1983 CLAIM FOR CONSTITUTIONALLY DEFICIENT PRIVATE PRISON HEALTH CARE

Significant improvement in the provision of privatized prison health care requires a reordering of the incentives under which contractors and their governmental supervisors operate. Contractors should be incentivized to provide quality medical care over taking profits. Local governments should be incentivized to contract more carefully, and to monitor the performance of their contractors much more aggressively. As argued previously, the fundamental problem with

> the resultant deprivation was caused, in the sense relevant for state-action inquiry, by the State's exercise of its right to punish West by incarceration and to deny him a venue independent of the State to obtain needed medical care.

Id. (quoting Estelle v. Gamble, 429 U.S. 97, 103 (1976)).

212. *Id.* at 56.

213. Jody Freeman & Martha Minow, *Reframing the Outsourcing Debates*, *Introduction* to GOVERNMENT BY CONTRACT: OUTSOURCING AND AMERICAN DEMOCRACY 7–8 (Jody Freeman & Martha Minow eds., 2009).

214. *Id.* at 7.

contemporary privatized prison health care is the elevation of the cost-cutting incentive above all else, including the governmental incentive—more aptly characterized as a legal duty—to care for citizens in its custody. The fixed-rate contracts highlighted in this Comment are stark illustrations of this sublimation of public values to private interests. One way to force public values back to the forefront is to invoke the scrutiny of the judicial system via a § 1983 lawsuit against the governmental body ultimately responsible for outsourced prison health care. A fixed-rate agreement with a contractor that has a history of providing constitutionally deficient care could serve as the *Monell* policy necessary to attach liability where it belongs—to the local government that negotiated the agreement that makes inmate injury or death "almost bound to happen, sooner or later."[215] This Part will discuss the basic elements of such a claim.

To establish local government liability for constitutionally deficient prison medical care, as provided by a private entity, a claimant must establish four elements: (a) that an official policymaker (b) promulgated a policy, custom, or practice that (c) caused an unconstitutional denial of medical care, and (d) that the local government actor was "deliberately indifferent" in doing so.[216] This last element is essentially a culpability requirement, and it may be proven directly: by arguing that an

215. *See* Jones v. Wellham, 104 F.3d 620, 627 (4th Cir. 1997) (characterizing the moving-force causation necessary for liability to attach to a governmental entity under § 1983 as one where the violation was "almost bound to happen, sooner or later" (quoting Spell v. McDaniel, 824 F.2d 1380, 1391 (4th Cir. 1987))). Importantly, the indemnification clause would not be a barrier to this argument, as the clause shields the local government only from liability for the *provider's* own policies, customs, or practices that give rise to constitutionally deficient prison medical care. The clause does not shield the local government from claims that are based on the government's own action. For example, the Jefferson County-CHC agreement states:

> Contractor, its agents, employees or independent contractors, shall not in any event be required to indemnify, defend, or hold harmless, the County with respect to any claims, actions, lawsuits, damages, judgments or liabilities of any kind whatsoever caused by, based upon or arising out of any act, conduct, misconduct or omission of the County, its officials, agents and employees.

Jefferson County-CHC Contract, *supra* note 26, at 12.

216. *See generally* SWORD AND SHIELD: A PRACTICAL APPROACH TO SECTION 1983 LITIGATION 224–47 (Mary Massaron Ross & Edwin P. Voss, Jr. eds., 3d ed. 2006) [hereinafter SWORD AND SHIELD] (discussing the requirements for municipal liability under § 1983 with respect to government policies, customs, and practices).

affirmative policy of the local government caused the constitutional deprivation, or indirectly: by arguing that the responsible government officials acquiesced as the private contractor implemented a policy that caused the constitutional deprivation.[217]

The first step in any such § 1983 claim is to identify the policymaker.[218] Where the suggested *Monell* policy is a county contract with a private prison health care provider, the policymaker requirement is unquestionably satisfied because an officer of the governing body must sign the contract, thereby adopting it in the county's name.[219]

The next step is to identify a policy—written or unwritten—that caused the constitutionally deficient medical care.[220] While the Court has recognized three ways for a plaintiff to establish a *Monell* policy,[221] one is particularly relevant here. If a "policymaker promulgates a generally applicable statement of policy, and the implementation of that policy results in a constitutional deprivation,"[222] the local

217. Prisoner-claimants pursuing the indirect approach must also show that the local government had notice of constitutionally deficient care being provided in its prisons, and that it was deliberately indifferent in failing to remedy the situation. *See* City of Canton v. Harris, 489 U.S. 378, 388–91 (1989).

218. Monell v. Dep't of Soc. Servs., 436 U.S. 658, 690–91 (1978) ("Local governing bodies . . . can be sued directly under § 1983 for monetary, declaratory, or injunctive relief where, as here, the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers."); SWORD AND SHIELD, *supra* note 216, at 226.

219. *E.g.*, Bowman v. Corr. Corp. of Am., 188 F. Supp. 2d 870, 880–81 (D. Tenn. 2000) ("The Court concludes that the contract between CCA and Coble constitutes a policy for § 1983 analysis as this CCA contract reflects a written understanding for a fixed plan to provide medical care for inmates at SCCF."), *aff'd in part, rev'd in part*, 350 F.3d 537 (6th Cir. 2003). The Sixth Circuit reversed the *Bowman* District Court's ruling that the instant prison health care contract should be enjoined on mootness and standing grounds, but did not disturb the rest of the district court's analysis. *Bowman*, 350 F.3d at 549 ("CCA contends that the district court's holding that its medical policy is unconstitutional should be reversed for three reasons. CCA argues that the district court: 1) did not have jurisdiction to issue injunctive relief since it confronted no live "case or controversy"; 2) was precluded from awarding injunctive relief by the Prison Litigation Reform Act of 1996, 18 U.S.C. § 3626 (PLRA); and 3) erred in finding that CCA violated its Eighth Amendment duty to Anthony. We need only look at the first argument, for this issue is clearly moot as a result of Anthony's death, and Bowman has no standing to request injunctive relief.").

220. SWORD AND SHIELD, *supra* note 216, at 226.

221. *Id.*

222. *Id.*

government may be held directly liable for the injuries sustained by the plaintiff. A county contract with a private corporation to provide prison medical care fits nicely into this framework, as the promulgation, by county lawmaking officers, of a generally applicable statement of policy.

Having established that the policymaker county government has promulgated a policy in the form of a prison health care contract, the prisoner-claimant must next establish that the policy at issue *caused* the constitutionally deficient medical care.[223] Admittedly, this element is more difficult to prove than the relatively straightforward policymaker and policy elements. However, at this stage of a § 1983 claim, *Monell* asks not for a perfect causal link, but only that the policy at issue be the moving force behind the injuries.[224] As more recently formulated, "moving-force" causation has been described a "policy decision . . . that made the ultimate violation 'almost bound to happen, sooner or later,' rather than merely 'likely to happen in the long run.'"[225]

Finally, having demonstrated that an official policymaker promulgated a policy that caused an unconstitutional denial of medical care, a § 1983 claimant must establish the culpability of the local government entity.[226] Where a plaintiff alleges that a government-enacted policy itself caused the constitutional deprivation, culpability is automatic if causation can be demonstrated.[227] Where a plaintiff alleges that a facially constitutional government policy causes the constitutional deprivation, the culpability standard requires a showing that the government's "action was taken with 'deliberate indifference,' quite apart from the underlying constitutional claim."[228] The deliberate indifference of a local government can be demonstrated by showing that the government has "actual or constructive notice that its action or failure to act is substantially certain to result in a constitutional violation, and

223. SWORD AND SHIELD, *supra* note 216, at 224–27.
224. Monell v. Dep't of Soc. Servs., 436 U.S. 658, 694–95 (1978).
225. Jones v. Wellham, 104 F.3d 620, 627 (4th Cir. 1997) (quoting Spell v. McDaniel, 824 F.2d 1380, 1391 (4th Cir. 1987)). See *infra* Part V for further discussion.
226. SWORD AND SHIELD, *supra* note 216, at 243.
227. *Id.*
228. *Id.*; *see also* City of Canton v. Harris, 489 U.S. 378, 388 (1989) (holding that liability could attach to a municipality where the failure to train its personnel amounted to "deliberate indifference to the rights of persons with whom the police come into contact").

it consciously or deliberately chooses to disregard the risk of harm."[229] This is where the contractor's litigation history becomes critical to the analysis. As discussed previously, companies like PHS or Corizon, among others, come with lengthy public histories of providing deliberately indifferent care to prisoners in their charge. Local governments either are, or should be, aware of this fact, and as such are put on notice. By signing a prison health care contract with these companies, in the face of clear evidence of systemic contractor malfeasance, government officials consciously choose to disregard a substantial risk of harm to inmates in their custody.

When a local government signs or resigns a fixed-rate prison health care contract with a contractor that brings to the table a lengthy litigation history, all of the above elements are arguably present. The policy and policymaker elements are relatively easy to satisfy via the contract itself. The notice element—and thus demonstration of deliberate indifference—is satisfied by the contractor's litigation history. The causation element is certainly more difficult to prove, and is thus the crux of the analysis. But this Comment argues that the financial incentive inherent in the fixed-rate contracts used by Lee County, Florida; Montgomery County, Pennsylvania; Jefferson County, Colorado; and countless others around the country, provides the necessary causal link between government policy and inmate injury or death. The next Part offers a couple of illustrations of courts recognizing this power of contract-based financial incentives to distort the medical treatment of inmates, to the point where the profit motive itself can get a § 1983 claim over the causation hurdle.

V. COURTS' CONCERN WITH FINANCIAL INCENTIVES IN THE CRIMINAL JUSTICE SYSTEM

American courts have demonstrated a willingness to consider the impact of financial incentives imbedded in local governments' privatization contracts, particularly when this outsourcing occurs in the criminal justice system. This Part discusses two examples of American courts scrutinizing prison health care contracts in the manner suggested above, followed

229. Barney v. Pulsipher, 143 F.3d 1299, 1307 (10th Cir. 1998) (citing Bd. of Cnty. Comm'rs v. Brown, 520 U.S. 397, 407–10 (1997)).

by another example where the contractual incentives were so inimical to inmate health and safety that a court felt it necessary to enjoin the contract. The Part concludes with a more recent example of a court's use of an injunction to stop an abusive private probation services contract.

A. Judicial Notice of the Danger of the Profit Motive

Courts have demonstrated concern with the perverse financial incentives of privatized prison health care for some time.[230] In a 1985 decision by the Eleventh Circuit, *Ancata v. Prison Health Services, Inc.*, the court took aim at the prison health care policies of Broward County, Florida.[231] In *Ancata*, the personal representative of the deceased Anthony Ancata sued, among others, Broward County, Florida, and its sheriff, after Mr. Ancata died in custody from untreated leukemia.[232] On Defendants' Motion to Dismiss, the Eleventh Circuit held that two Broward County policies—its underfunding of its prison health care contract and its requirement that prisoners obtain a court order before getting necessary medical care—plausibly subjected the County to liability for the private contractor's constitutionally deficient medical care.[233] The *Ancata* court worried that "the defendants put the financial interest of Prison Health Services ahead of [the Plaintiff-inmate's] serious medical needs."[234] The court then concluded that such a delay of necessary medical treatment for "non-medical reasons" was sufficient to meet the "deliberate indifference" culpability standard of a § 1983 claim.[235]

In a more recent example of the same phenomenon, *Revilla v. Glanz*, Ms. Revilla and the estates of three other deceased

230. *See, e.g.*, Ancata v. Prison Health Servs., Inc., 769 F.2d 700, 704–06 (11th Cir. 1985).

231. *Id.*

232. *Id.* at 701–02.

233. *See id.* at 705–06.

234. *Id.* at 704–06. The *Ancata* court reversed the lower court's dismissal, for failure to state a claim, of the cases against both PHS and Broward County. *Id.* at 704–05. The court held that the Plaintiff had plausibly alleged "deliberate indifference" by PHS, *id.* at 705, and that a genuine issue of material fact remained as to whether or not Broward County "established or utilized a policy or custom requiring that inmates needing medical assistance obtain court orders and the result of that policy or custom played a role in the delay in treatment and deliberate indifference shown towards Anthony Ancata," *id.* at 705–06.

235. *Id.* at 704 (citing Archer v. Dutcher, 733 F.2d 14, 17 (2d Cir. 1984)).

inmates brought a § 1983 action against Tulsa County Sheriff Glanz, as well as CHC medical personnel and CHC itself, for constitutionally deficient health care at the Tulsa County Jail.[236] Ms. Revilla entered the Jail with a number of serious medical conditions, including diabetes, epilepsy, and schizophrenia.[237] Over the course of the next few weeks, jail personnel both gave Ms. Revilla the wrong dosage of some of her medications and denied outright her access to others, resulting in three trips to the hospital and two suicide attempts.[238] The *Revilla* Plaintiffs' claims survived motions to dismiss for failure to state a claim, filed separately by the Sheriff and the CHC Defendants.[239] In two orders outlining its reasoning for allowing all claims to proceed, the *Revilla* court noted two alleged "*Monell* policies" that could attach liability to the Sheriff and CHC: "a longstanding policy . . . at the Jail of . . . refusing to send inmates with emergent needs to the hospital for purely financial reasons," and "a policy . . . of understaffing the Jail's medical unit . . . ."[240] In discussing the plausibility of these allegations, the court further described the vulnerability of inmates in the context of privatized prison medical care, by way of an extended quotation from a recent Seventh Circuit opinion:

> Private prison employees and prison medical providers have frequent opportunities, through their positions, to violate inmates' constitutional rights. It is also generally cheaper to provide substandard care than it is to provide adequate care. Private prisons and prison medical providers are subject to market pressures. Their employees have financial incentives to save money at the expense of inmates' well-being and constitutional rights.[241]

236. Order, Revilla v. Glanz, No. 13-CV-315-JED-TLW, 2014 WL 1017903, at *1 (N.D. Okla. Mar. 17, 2014) [hereinafter Revilla Order I]; Order, Revilla v. Glanz, No. 13–CV–315–JED–TLW2014 WL 1234701, at *1 (N.D. Okla. Mar. 25, 2014) [hereinafter Revilla Order II].

237. Amended Complaint, Revilla v. Glanz, No. 13-CV-315-JED-TLW, 2013 WL 8705098, at ¶ 2 (N.D. Okla. May 31, 2013).

238. *Id.* at ¶¶ 17–28.

239. Revilla Order I at *9; Revilla Order II at *9.

240. Revilla Order I at *6 (quoting ¶¶ 52–53 of Amended Complaint).

241. Revilla Order II at *4 (quoting Shields v. Ill. Dep't of Corr., 746 F.3d 782, 794 (7th Cir. 2014)).

The *Glanz* court also discussed the Plaintiffs' allegations of specific notice to both Sheriff Glanz and CHC, as described in numerous audit reports by, among others, the Oklahoma Department of Health and the United States Department of Homeland Security's Office of Civil Rights and Civil Liberties, "which 'found a prevailing attitude among clinic staff [at the Jail] of indifference.'"[242]

Revilla thus demonstrates the basic recipe for a contract-based § 1983 claim against a prison health care contractor with a particularly egregious history of providing constitutionally deficient care. Given how many times inmates under Sheriff Glanz's and CHC's care had been maimed or killed by constitutionally deficient health care, an injunction would seem to be a plausible remedy, perhaps the only plausible remedy, for this situation. As of this writing, the case is still being adjudicated, so it remains to be seen what the *Revilla* court is willing to do about its obvious concern.

B. Injunctive Relief

A court will sometimes, albeit rarely, find the financial incentives of a privatization contract so conducive to maltreatment of citizens caught in the criminal justice system that it will enjoin further implementation of the agreement.

The best example in the prison health care context is *Bowman v. Correction Corporation of America* (CCA). In *Bowman*, an inmate's mother brought a § 1983 suit against CCA, CCA's subcontracting doctor, and the prison warden, when the inmate died from sickle cell anemia after the doctor and warden refused to transfer him to an off-site hospital for specialty care.[243] Specifically, the inmate's mother alleged that "CCA's contract with [Dr.] Coble, particularly Coble's incentive provisions under the contract motivated Coble's decision to delay Anthony Bowman's transfer."[244] CCA had hired the subcontracting doctor after three years of failing to hold costs down on its prison health care contract with Tennessee's South Central Correctional Facility (SCCF).[245] The doctor's contract

242. Revilla Order I at *6; Revilla Order II at *5.

243. Bowman v. Corr. Corp. of Am., 188 F. Supp. 2d 870, 873–74 (D. Tenn. 2000), *aff'd in part, rev'd in part*, 350 F.3d 537 (6th Cir. 2003).

244. *Id.* at 874.

245. Siever, *supra* note 53, at 1381–82.

included a base salary and financial incentives that were potentially worth an additional $95,000 per year.[246] The case went to trial, and the jury returned a verdict in favor of the Defendants.[247]

While the *Bowman* court felt bound by the jury's determination of a lack of causal connection between the CCA-Coble contract and Mr. Bowman's inadequate treatment, the court went on to assess the constitutionality of the contract based on the Plaintiff's motion for an injunction against the agreement.[248] The court began by noting that "prisoners are completely dependent upon prison officials for their medical care."[249] Accordingly, the court felt it "ha[d] a separate obligation for injunctive relief to determine if the medical policy at issue would likely expose inmates to harm and if so, whether the policy violates contemporary standards of decency."[250] Dr. Coble, the court noted, was a "general surgeon with some limited prior experience in psychiatry," and yet he was in charge of "decid[ing] all medical issues of inmates at SCCF."[251] Moreover, Dr. Coble was subject to "little meaningful supervision" of his substantive medical decisions by his nominal supervisor, CCA medical director Dr. Fletcher, whose "concerns were primarily financial costs."[252] The court then specifically took notice of Dr. Coble's "substantial financial incentives to limit medical care."[253] The *Bowman* court ultimately found that "CCA's medical policy with its exclusive contract for Dr. Coble's services and its extreme financial incentives for Coble poses a significant risk for the denial of necessary medical treatment for inmates at SCCF in violation

246. *Id.* at 1382.
247. *Bowman*, 188 F. Supp. 2d at 874.
248. *Id.* at 880–83 ("The Court concludes that the contract between CCA and Coble constitutes a policy for § 1983 analysis as this CCA contract reflects a written understanding for a fixed plan to provide medical care for inmates at SCCF . . . . Given that CCA sets the medical policy for inmates at SCCF and because as discussed *infra,* CCA's liability for its medical policy is measured by a different legal standard than plaintiff's damages claim against Myers and Coble in their individual capacities, the Court concludes that the jury's verdict on Myers and Coble's treatment of Anthony Bowman does not foreclose the Court's consideration of the constitutionality of CCA's medical policy on plaintiff's claim for injunctive relief.").
249. *Id.* at 887.
250. *Id.*
251. *Id.*
252. *Id.*
253. *Id.*

of the Eighth Amendment."[254] Further, the court found that Dr. Coble's ability to literally double his income by holding down SCCF's medical costs violated contemporary standards of decency as defined by the American Medical Association and federal regulations.[255] Because of the seemingly clear possibility that the Coble-CCA contract would result in the delay of necessary medical care for non-medical reasons, the *Bowman* court enjoined the agreement.[256]

A similar concern about the financial incentives of a private corporation operating in the criminal justice system has motivated judges in Georgia and Alabama to put a temporary halt to the operations of private probation companies.[257] One such dispute pitted Plaintiff Gina Kay Ray—and others similarly situated—against Judicial Corrections Services (JCS) and the Town of Childersburg, Alabama, in *Ray v. Judicial Corrections Services*.[258] The Town of Childersburg contracted its Municipal Court probation-supervision and fee-collection services to JCS.[259] The *Ray* Plaintiffs sought declaratory and injunctive relief from Childersburg's contract with JCS,

254. *Id.* at 874. The Sixth Circuit subsequently reversed the *Bowman* District Court, but on mootness and standing grounds. Bowman v. Corr. Corp. of Am., 350 F.3d 537, 541 (6th Cir. 2003) ("We reverse the district court's holding with respect to the unconstitutionality of CCA's medical policy and the injunction awarded on that basis, because this issue is moot as to Bowman and she had no standing upon which to bring such a claim for prospective relief.").

255. *Bowman*, 188 F. Supp. 2d at 890 ("With these collective medical, legal and correctional standards applicable to non-personnel medical services, this Court concludes that CCA's medical policy at SCCF, as represented by its contract with Dr. Coble, violates contemporary standards of decency, by giving a physician who provides exclusive medical services to inmates, substantial financial incentives to double his income by reducing inmates' necessary medical services . . . . Inmates at SCCF do not have any another [sic] choice for a health care provider, just Dr. Coble. And, under his contract with CCA, Dr. Coble has significant financial incentives to limit inmate medical care.").

256. *See id.* ("Thus, the Court concludes that plaintiff's motion for judgment as a matter of law as to CCA should be granted in part so as to enjoin the current contract between CCA and Dr. Coble at SCCF.").

257. *See* Order, Cash et al. v. Kellie McIntyre, Richard Roundtree, & Sentinel Offender Servs., LLC, No. 2013-RCHM-001 *12 (Superior Court of Richmond County, Ga. Sept. 16, 2013) [hereinafter Cash Order], *available at* http://www.nbc26.tv/story/23469875/judges-order-requires-sentinel-probation-to-pay-back-unlawfully-collected-fees, *archived at* http://perma.cc/AMS7-9J5C ; Ray v. Judicial Corr. Servs., No. 2:12-CV-02819-RDP, 2013 WL 5428360 (N.D. Ala. Sept. 26, 2013); *see also* Sarah Stillman, *Get Out of Jail, Inc.*, NEW YORKER (June 23, 2014), http://www.newyorker.com/magazine/2014/06/23/get-out-of-jail-inc, *archived at* http://perma.cc/L34G-HJB9.

258. *Ray*, 2013 WL 5428360, at *1.

259. *Id.* at *2.

alleging that JCS routinely violated Plaintiffs' Fourteenth Amendment due process rights, as well as their Fourth, Sixth, and Eighth Amendment rights.[260] Under the Childersburg-JCS contract, when a person appearing before the Municipal court could not pay costs or fines associated with their charges, they were automatically placed on probation with JCS regardless of whether or not the court imposed a jail sentence.[261] JCS subsequently determined how much each probationer should pay each month, collected payments directly from probationers, and made recommendations to the court regarding punishment for probationers who missed payments—usually revocation (and re-incarceration), additional fines, or both.[262] The Childersburg Municipal Court then followed the JCS recommendation without conducting the necessary determination-of-indigency hearings.[263] Under this system, probationers were routinely re-incarcerated on the word of JCS personnel and punished with fines well in excess of the statutory maximum.[264]

The lead plaintiff in this case, Ms. Ray, originally appeared before the Childersburg Municipal Court on charges of "no insurance" and "driving while license suspended."[265] She was fined $1,146 but did not receive a jail sentence; because she could not pay this fine she was placed on probation with JCS and billed monthly amounts of $145.[266] Subsequent charges of "expired tag" and "driving while license suspended" added an additional $846 total and $45 per month fines to her previous responsibilities.[267] Despite Ms. Ray's claims of indigence, neither Childersburg nor JCS inquired into her ability to pay.[268] Rather, at the discretion of JCS, Ms. Ray was jailed for more than twenty-five days for "failure to obey a court order," with no probation-revocation hearing and no assistance from counsel.[269]

260. *Id.*
261. *Id.*
262. *Id.*
263. *Id.*
264. *Id.* at *3.
265. *Id.* (quoting Second Amended and Restated Complaint, Ray v. Judicial Corr. Servs. No. 2:12-CV-02819-RDP, 2013 WL 1852463 (N.D. Ala. 2013) ¶ 34 [hereinafter Ray Complaint]).
266. *Id.*
267. *Id.* (quoting Ray Complaint ¶ 35).
268. *Id.*
269. *Id.* (quoting Ray Complaint ¶ 37).

The Defendant Town of Childersburg filed a Motion to Dismiss, arguing that it lacked authority over its own Municipal Court and, in the alternative, should this seemingly farcical argument fail, that the Town's contract with JCS could not plausibly be the moving force behind the Plaintiffs' alleged constitutional violations, such that § 1983 liability could attach to it as a municipality.[270] The *Ray* court did not find either argument persuasive, countering that the contract could indeed be the necessary moving force.[271] Having found a plausible causal relationship between the contract and the alleged constitutional violations, the *Ray* court refused to dismiss the Plaintiffs' claims and request for injunction until at least the summary judgment stage, "after discovery [could] . . . shed light on the contents and nature of the contract."[272]

The Bowman and Ray examples discussed above notwithstanding, asking a court to become involved in what appears to be a contract dispute between a local government and a private contractor could seem like an invitation to judicial overreach. But this sort of interventionist attitude may be necessary in an era where the contract is the "government's most important means of control over the provision of public services."[273]

VI. THE DEMOCRACY DEFICIT

Courts are understandably reluctant to intervene in the contracting processes of local governments. Enjoining a contract that has been lawfully negotiated between a legislative body or executive branch agency and a private contractor smacks of the sort of judicial overreach that could offend important principles of democratic theory. The following Part will address this counterargument by arguing that judicial reluctance to police local government contracting is

270. *Id.* at *1, *6–7.

271. *Id.* at *8 ("Plaintiffs contend that, in carrying out its duty to assist and support the Childersburg Municipal Court, Childersburg entered into a contract that handcuffed the autonomy of the municipal court and imbued JCS with a power unchecked by procedural safeguards. Indeed, Plaintiffs plausibly allege that the policy (contracting out probation services) of a state actor (Childersburg) was the "moving force" behind their constitutional deprivations. The court concludes that these allegations are sufficient to satisfy the pleading requirements for claims under § 1983.") (citation omitted).

272. *Id.* at *15.

273. Freeman & Minow, *supra* note 213, at 7.

premised upon the perceived efficacy of political solutions to problematic contracts. In the context of prison health care, however, the beneficiaries of the contract—incarcerated inmates—are, at best, largely unrepresented by local government legislative bodies, and at worst, targets of active legislative hostility.

A. *The Roots of Judicial Deference*

A good part of the theoretical case against judicial scrutiny of local government contracts rests upon the notion that unelected judges should not interfere with the lawful actions of the political branches of government, which are subject to electoral discipline. Professor Alexander Bickel considered this infirmity of judicial review under the rubric of "the countermajoritarian difficulty" in his seminal work *The Least Dangerous Branch*, published in 1962, just as the Warren Court was about to embark on its especially activist phase.[274] To Professor Bickel, judicial review was fundamentally undemocratic: when a court "invalidates the work of an actor who is subject to the electoral process, the [c]ourt 'exercises control, not in behalf of the prevailing majority, but against it.'"[275]

While Professor Bickel's notion "ultimately came to grip the attention of a generation of constitutional theorists" responding to Warren Court activism,[276] it has since come under criticism for overstating the "deviance" of judicial review.[277] The deviance of a judiciary with the power to strike

274. *See, e.g.*, Barry Friedman, *The Birth of an Academic Obsession: The History of the Countermajoritarian Difficulty, Part Five*, 112 YALE L.J. 153, 201 (2002) ("Yet, it was the framing device he employed for his argument that caught the attention of the ages. In the opening chapter of *The Least Dangerous Branch*, Bickel employed the phrase 'the counter-majoritarian difficulty,' by which he meant the problem of reconciling judicial review with the workings of democratic government.") (quoting ALEXANDER BICKEL, THE LEAST DANGEROUS BRANCH 16 (1962)).

275. Friedman, *supra* note 274, at 201–02 ("Nothing in the 'complexities' that Bickel saw in the American system of government could 'alter the essential reality that judicial review is a deviant institution in the American democracy.' 'It is this reason the charge can be made that judicial review is undemocratic.'") (quoting BICKEL, *supra* note 274 at 1, 16).

276. Friedman, *supra* note 274, at 202.

277. *See, e.g.*, Daniel J.H. Greenwood, *Beyond the Counter-Majoritarian Difficulty: Judicial Decision-Making in A Polynomic World*, 53 RUTGERS L. REV. 781, 784–85 (2001); Romer v. Evans, 517 U.S. 620, 636 (1996) (Scalia, J.,

down actions of legislators, executives, or administrators at the federal, state, or local level, rests on two important assumptions about judges and judging that may not hold: (a) that as appointed decision makers not subject to reelection, federal judges' "majoritarian credentials" are in all cases inferior to those of popularly elected officials,[278] and (b) that losers in give-and-take of legislative or executive branch policymaking can always turn to the political branches for redress of their grievances.[279]

The first assumption likely understates the majoritarian credentials of judges and overstates those of elected officials.[280] In fact, in some circumstances the "majoritarian deficit associated with judicial review is smaller than the majoritarian deficit associated with other decisional processes."[281] Drawing from Charles Black's structuralist defense of judicial review, Professor Mark Tushnet offers an instructive hypothetical: Imagine a court confronted by a legislative body's decision to authorize searches of automobile junkyards on less-than-probable cause, and then the decision of a police officer to execute such a search in the absence of probable cause, acting solely on her general authority to investigate a possible criminal act.[282] Professor Tushnet first suggests that a court's "relative majoritarian deficit is surely larger in the first than in the second situation . . . ."[283] This is an important insight, suggesting that the legitimacy of a judicial review depends on the context of the decision-making process being reviewed. Professor Tushnet then goes on to suggest that in the latter situation "an individual police officer may have less majoritarian legitimacy than a court."[284] This is also an

dissenting).

278. *See* Greenwood, *supra* note 277 at 784–85.

279. *See Romer*, 517 U.S. at 636 (Scalia, J., dissenting) (inferring that the "politically powerful" gay and lesbian minority targeted by Amendment 2 should seek redress via "normal democratic means").

280. Greenwood, *supra* note 277, at 784–85.

281. Mark Tushnet, *Policy Distortion and Democratic Debilitation: Comparative Illumination of the Countermajoritarian Difficulty*, 94 MICH. L. REV. 245, 246 (1995) (noting the defense of judicial review—or at least the critique of the countermajoritarian-difficulty critique of judicial review—offered in CHARLES L. BLACK STRUCTURE AND RELATIONSHIP IN CONSTITUTIONAL LAW 61–98 (1969)).

282. Tushnet, *supra* note 281, at 246 n.7 (citing BLACK, *supra* note 281, at 77–93).

283. *Id.*

284. *Id.*

important counterpoint to the too-often-assumed majoritarian deficit of a court. While there is indeed a strong argument that a court reviewing Congressional legislation for constitutionality acts in a fundamentally countermajoritarian manner, the same cannot be automatically assumed where a court reviews the decision of local government officials to delegate the power of life and death to a private contractor.[285] In the case of a privatization contract, this Comment takes the position that the legislators or executive branch officials who sign the contract have only as much legitimacy—if that much—as the police officer in Professor Tushnet's hypothetical.

The second assumption behind the "countermajoritarian difficulty" is difficult to square with the historical experience of certain disfavored groups, among them African-Americans, immigrants, and prisoners. There are permanent losers in American policymaking: those groups for whom the political branches offer not redress but only continued pain.[286] The existence of a political underclass in a democracy—a seeming contradiction in terms—is possible because, in any democratic system, procedures and institutions cannot be separated from underlying social hierarchies.[287] Professor Jack Balkin argues that the American social hierarchy is shaped like a vase—with a small number of high-status citizens, a large number of middle-status citizens, and a small number of low-status

285. *See* BLACK, *supra* note 281, at 73–74 ("[T]he modes of legitimation [of judicial review of acts of Congress versus judicial review of acts of the states] are entirely different . . . . There simply is no problem about the fundamental legitimacy of judicial review of the actions of the states for federal constitutionality. Article VI says as much, literally and directly . . . . On the whole, there is nothing in our entire governmental structure which has a more leak-proof claim to legitimacy then (sic) the function of the courts in reviewing state acts for federal constitutionality.").

286. J. M. Balkin, *The Footnote*, 83 NW. U. L. REV. 275, 283 (1989) ("*Carolene Products*, especially in its famous footnote, is concerned with impurities in the democratic process caused by adulteration of the means of political deliberation (the subject of the footnote's second paragraph) or by the exclusion of discrete and insular minorities from full political participation (the footnote's third paragraph). According to the logic of the footnote, certain groups are shut out of the democratic process, relegated to the periphery. They are . . . persons subject to the power of the political community yet excluded from participation within it.").

287. J.M. Balkin, *The Constitution of Status*, 106 YALE L.J. 2313, 2313 (1997) ("Democracies are societies. Behind the formal features of democratic self-governance—whether regular elections or majority rule—lie social organization and social structure. Like other societies, democracies have varying degrees of social stratification and social hierarchy, group competition and group subordination.").

citizens.[288] In a vase-shaped democracy, even perfectly democratic procedures and institutions can still result in a majority that targets low-status citizens with policies that the majority would never tolerate if it had to suffer the result.[289] American history is replete with examples of this phenomenon: African-Americans targeted by vagrancy laws in the Jim Crow South;[290] immigrant kids denied public school education;[291] and prisoners disenfranchised, sometimes for life.[292]

Privatized prison health care fits nicely into this tradition; non-incarcerated middle-class Americans would never stand for a health care regime where they could only get care from a single corporate entity, which preselected a handful of individual nurses and a single doctor who typically could not be seen right away. The inability to shop around alone is a deal breaker for most Americans. In fact, during the 1990s American policymakers experimented with a health care regime that took a very small step in this direction—the Health Maintenance Organization, or HMO—and soon faced an enormous political backlash from patients and doctors alike.[293]

288. *Id.* at 2369 ("However, in many societies—including our own—social stratification is shaped more like a vase than a pyramid. As before, there are comparatively few people with very high status; but members of very low status groups may also tend to be comparatively few in number. The largest group of people in the middle will have the most votes. It will tend to be fairly well-protected, but low status groups will not be. Here ordinary democratic processes work against the eventual dismantling of status hierarchy.").

289. *Id.* ("The middle ranks of the status 'vase' may well be tempted to keep some groups on the bottom because this reinforces their own comparatively high status. For example, white middle-class and working-class Americans might hope to retain the comparatively higher status of being white. In short, even in an otherwise well-functioning democracy, majorities may have an interest in perpetuating status hierarchies over low status minorities to preserve their status capital. This result is due less to failures of coalition building than to the fact that status is a relative good.").

290. Blackmon, *supra* note 88, at 53–54.

291. Plyler v. Doe, 457 U.S. 202, 205–08 (1982) (discussing the provisions, purported state rationale, and potential negative effects on immigrant children, of a Texas statute that authorized local school districts to deny enrollment in public schools to "children not 'legally admitted' to the country").

292. *Criminal Disenfranchisement Laws Across the United States*, BRENNAN CENTER FOR JUSTICE (Mar. 27, 2014) [hereinafter BRENNAN CENTER FOR JUSTICE], http://www.brennancenter.org/analysis/restoring-right-vote-state, *archived at* http://perma.cc/AU7W-WZSE .

293. *See, e.g.*, Jeff Levine, *The HMO Backlash*, CNN (Nov. 5, 1997, 5:04 PM), http://www.cnn.com/HEALTH/9711/05/managed.care/, *archived at* http://perma.cc/YZK6-4LXA; MAXIM L. PINKOVSKIY, FED. RESERVE BANK OF N.Y., THE IMPACT OF THE MANAGED CARE BACKLASH ON HEALTH CARE COSTS: EVIDENCE FROM STATE REGULATION OF MANAGED CARE COST CONTAINMENT PRACTICES 2 (2013),

While even mild restrictions on patient choice of doctors are enough to cause a political firestorm among the upper tiers of the American version of the Balkinian vase, a much harsher restriction of patient choice in the prison health care context has not resulted in anything even close to the political backlash against the HMO. On the contrary, the political branches of our local governments have faced relatively little criticism from their constituents for subjecting the incarcerated population to "the HMO from Hell."[294]

B. The Consequences of Judicial Deference: Privatization as Punishment

Thus the deferential judicial review recommended by the "countermajoritiarian difficulty," while important in other contexts, is built on a tenuous foundation when applied to judicial review of legislative or executive branch policymaking in the criminal justice context. Even absent privatization, when the aggrieved population consists of inmates and their families, the assumption that this minority can turn to the political branches for relief is questionable. These citizens face significant obstacles to political participation.[295] The most obvious impediment to proper representation is of course the felon-disenfranchisement laws that are in force in all but two states.[296] The political impact of this obstacle is significant given how many Americans are incarcerated in the era of mass incarceration.[297] Beyond felon-disenfranchisement laws, recent studies have shown that "those who have contact with the criminal justice system are more likely than others to withdraw from political and civic life"; voter registration,

available at http://economics.mit.edu/files/8448, *archived at* http://perma.cc/5PX8-22AY.

294. Elizabeth Alexander, *Private Prisons and Health Care: The HMO from Hell*, *in* CAPITALIST PUNISHMENT: PRISON PRIVATIZATION & HUMAN RIGHTS 67 (Andrew Coyle, Allison Campbell & Rodney Neufeld eds., 2003).

295. NAT'L RES. COUNCIL REP., *supra* note 116, at 307–09*; see* BRENNAN CENTER FOR JUSTICE, *supra* note 292; Epstein, *supra* note 167, at 2240–41.

296. Only Maine and Vermont do not disenfranchise any of their citizens who have criminal convictions. BRENNAN CENTER FOR JUSTICE, *supra* note 292. The majority of American states not only disenfranchise inmates while they are in prison or jail, but also extend the period of disenfranchisement to include probation or parole. *Id*. Eleven states go further, permanently disenfranchising some of their criminally convicted citizens. *Id*.

297. NAT'L RES. COUNCIL REP., *supra* note 116, at 308.

turnout, involvement in civic groups, and trust in government all suffer in the aftermath of a prison or near-prison experience.[298] To top off the structural disadvantage that inmates and their families face in the United States electoral system, incarceration is highly concentrated among the least-educated segments of the population,[299] segments that are disproportionately disaffected and unrepresented even before contact with the criminal justice system.[300]

Privatization only intensifies the disconnect between inmates, their families, and prison health care policymakers by delegating a governmental function to private corporations responsible primarily to their shareholders and competing in national or international markets. Professor Aman, Jr. writes of a "democracy deficit" associated with privatization in a globalizing world, defining the deficit as a tendency to shrink the public sphere in favor of less transparent and less accountable arrangements.[301] Moreover, there is an inherent disjunction between global economic processes and local democratic political processes.[302] Professor Aman, Jr. defines this "disjunction" as "the exclusion of key stakeholders (or stakeholder communities) from the institutional processes whose outcomes affect them directly."[303] This theoretical construct almost certainly applies in the context of privatized prison health care; the same inherent disjunction exists between the norms of a national prison health care marketplace and those of a county- or state-level democratic government. Just as one would expect, key stakeholders like Mr. Fields, Ms. Pollock, and Mr. McGill were indeed largely excluded from the debate over whether or not to privatize this governmental function. They are likewise excluded from the discussion of how prison health care policy would be implemented by the private provider. Even their families are likely excluded, given that the policymaking functions of a private, for-profit corporation are necessarily much more

298. *Id*. at 309.
299. *Id*. at 64–68.
300. *See* Epstein, *supra* note 167, at 2238–41.
301. Aman, *supra* note 43, at 524. Professor Aman uses the terms "democracy deficit" and "democracy problem" interchangeably throughout his article. *See generally id.*
302. *Id.* at 517.
303. *Id.*

opaque than those of a local government.[304]

Privatization theory answers this challenge with the assertion that even after a governmental function has been delegated to a private corporation, public officials retain an important oversight role. The contracts at issue in this Comment are all replete with various reporting requirements presumably designed to facilitate this role.[305] However, even assuming that government officials exercise their oversight role in good faith, the purpose of this oversight is debatable. As Professor Wendy Epstein notes, local governments serve two masters in the context of privatized prison health care, and the interests of these two masters may be fundamentally at odds.[306] One master is the public at large, whose interest is in cost-savings. The other master is the much smaller incarcerated population, whose interest is in minimally competent medical care while in prison. It is not hard to imagine which political master will take precedence in the eyes of a local legislator.[307]

From the perspective of an incarcerated citizen and his or

304. *Id.* at 524.

305. Lee County-PHS Contract, *supra* note 143, at 9–10; Montgomery County-CMC Contract, *supra* note 145, at 11; Jefferson County-CHC Contract, *supra* note 26, at 9–11.

306. Epstein, *supra* note 167, at 2240 ("Politically, governments are accountable, at least in theory, to the public at whose behest they serve. But the public-private contracting scenario begs the question of which 'public' the government serves. Essentially, the government must serve two masters whose interests are at odds.").

307. *Id.* at 2240–41 ("Because the larger public wields more political power than the service beneficiaries, the government will feel added pressure to prioritize cost savings over quality service provision. Indeed, groups like criminals and poor people decidedly lack political power. Felons cannot vote and are generally powerless to effect change using political means. And for a variety of reasons, low-income people are less likely to vote than their wealthier counterparts, and even less likely to mobilize politically as a group. This problem is unique to soft government services. If a private service provider failed to pick up a city's garbage, everyone would notice and everyone would care. Not so with soft government services affecting a small subset of the populace."). Professor Epstein's assertion that government officials are only responsive to certain affluent or highly engaged subsections of the electorate is well supported by a large body of relatively recent empirical research. The most high profile example is Larry Bartels's study of the responsiveness of American government officials in *Unequal Democracy: The Political Economy of the New Gilded Age*. Professor Bartels argues, to simplify his work dramatically, that only the wealthy segment of the American electorate has any significant influence on public policy. LARRY M. BARTELS, UNEQUAL DEMOCRACY: THE POLITICAL ECONOMY OF THE NEW GILDED AGE 253–54 (2008).

her family, the picture may very well be worse than the above discussion suggests. While local legislators may see no political upside to prioritizing inmates' medical needs above the cost-saving interests of the general taxpayer, they may see political upside in the reverse, in deliberately and publicly sacrificing prisoner health care in the name of budgetary savings. Professor Aman, Jr. suggests that legislators may derive political benefit from subjecting a disfavored population to the discipline of the market: "[T]he idea of bringing market processes to bear not only in the management of prisons . . . but, by implication, on prisoners . . . as well, may resonate with a political goal of ensuring that certain individuals in society do not benefit unduly at the public's expense."[308] For those legislators who are a bit squeamish about publicly expressing their desire to discipline a disfavored population, privatization allows them to disclaim any particular animus towards the targeted groups. If the market for prison health care dictates that prisoners will receive little or no treatment during medical emergencies, then so be it. Such a consequence is akin to an apple falling to the ground when it becomes detached from the tree. As Professor Aman, Jr. puts it: "Markets can imply a degree of harshness that appears to be neutral and simply the logical consequences of processes over which we have no individual control."[309]

Given that local legislators and executive branch officials are part of the problem, and given how little political pressure they face to do the right thing, one cannot reasonably expect local officials to remedy the inherent injustice of privatized prison health care on their own. There is too much historical momentum behind privatization in general, and prison health care privatization in particular. Legislators thus seem to be comfortable remaining willfully blind to its predictable and disastrous consequences. Perhaps this is because privatization allows politicians to adopt the fiction that it is the market, with its inexorable and rational logic, that dictates spending cuts. Alternatively, local policymakers may see electoral benefit in subjecting a disfavored population to the discipline of the market; reducing inmates' medical care can help a local politician look "tough on crime" as they cast an eye on higher

308. Aman, *supra* note 43, at 518.
309. *Id.*

office.

A successful § 1983 claim for constitutionally deficient prison medical care that results in an enjoined prison health care contract could change this calculus significantly. Government officials would then have a significant incentive to either revisit the terms of their contracts with prison health care providers or to cancel them outright. Thus the local government could be forced to internalize the cost of the illegal behavior of its contractors, costs that under fixed-rate contracts get externalized onto inmates and their families.

CONCLUSION

In a recent and particularly striking example of judicial frustration at the state of contemporary privatized prison health care, Texas State District Court Judge Carter Tarrance ordered the Henderson County Sheriff's office to transport inmate David Conis Jr. to a local clinic, with instructions to follow the doctor's orders, after the judge watched Mr. Conis vomit up bile in his courtroom.[310] Mr. Conis was before Judge Tarrance for a bond hearing stemming from charges for "unauthorized use of a motor vehicle" and failing to register as a sex offender.[311] He was a diabetic and had a friend bring his insulin to the jail.[312] Jail employees, however, refused to pass the medication along because it was improperly labeled.[313] The jail's private doctors then prescribed a different kind of insulin and a special diet, ignoring the diabetes protocol Mr. Conis had used for two decades.[314] This was actually the second time Judge Tarrance had intervened to get Mr. Conis medical care—two weeks previously the judge ordered jail personnel to take Mr. Conis to the emergency room for treatment, and had since learned that officials ignored his order.[315] Notably, the county has since lawyered up in response to what it feels is judicial overreaching; it insists that Mr. Conis and other inmates receive "better medical care than most inmates would receive

310. Brandi Grissom, *Sheriff and Judge Battle over Medical Care in Jail*, N.Y. TIMES (Jan. 16, 2014), http://www.nytimes.com/2014/01/17/us/sheriff-and-judge-battle-over-medical-care-in-jail.html, *archived at* http://perma.cc/6EHE-FDBK.

311. *Id.*

312. *Id.*

313. *Id.*

314. *Id.*

315. *Id.*

on the outside."[316]

And so what began in this instance as a prison health care issue is now metastasizing into a separation of powers fight.[317] The county might do better to pause for a moment to wonder why Judge Tarrance, who surely understands separation of powers, would go to such great lengths to get a diabetic man his insulin. What is the source of judicial frustration which drives a judge to consider such an unusual judicial remedy? This Comment argues that it is a clash of values between a fairness-oriented state trial court and a cost-cutting-oriented executive branch agency. While the court worries about constitutional rights, the sheriff worries about defending the profit-oriented and potentially illegal behavior of its prison health care contractor.

Judges are by no means the only ones to take notice of the issue at the heart of this and other controversies arising from the privatization of an increasing portion of the American criminal justice system. Thomas Edsall, a noteworthy observer of American politics for decades, has a name for what is happening in our prisons, jails, and courts. Mr. Edsall calls it "Poverty Capitalism"[318] in a recent discussion of the baleful influence of Sentinel Offender Services:[319] "Sentinel is a part of the expanding universe of poverty capitalism. In this unique sector of the economy, costs of essential government services are shifted to the poor."[320] As privatization reaches beyond peripheral government functions to conscript the core functions at the heart of governmental sovereignty, "traditional public services [have been turned] into profit-making enterprises . . . ."[321] In many ways, we are returning to the regime of privatized government and "bounties" so fashionable during the Gilded

316. *Id.*

317. *Id.* ("'A district court judge has absolutely no power and no authority to order a county to do any kind of specific medical treatment,' Robert Davis, the county's outside lawyer, said.").

318. Thomas B. Edsall, *The Expanding World of Poverty Capitalism*, N.Y. TIMES (Aug. 26, 2014), http://www.nytimes.com/2014/08/27/opinion/thomas-edsall-the-expanding-world-of-poverty-capitalism.html, *archived at* http://perma.cc/2379-ZLRF.

319. *Id.* Sentinel is the chief rival of JCS, of *Ray v. JCS* fame, discussed in notes 269–85 and the accompanying text. The two probation-supervision corporations compete for municipal court contracts in the American southeast, for now. Stillman, *supra* note 257.

320. Edsall, *supra* note 318.

321. *Id.*

Age.[322] Sentinel and JCS perform the governmental function of monitoring and collecting the debts of probationers; similarly, PHS, CMC, and CHC perform the public function of providing inmates with medical care. These firms then take a bounty in the form of whatever difference they can create between their contractually mandated compensation and their operating costs. The less of a service they provide, the greater the bounty they take home to their shareholders.

The ongoing moral and legal emergency that is contemporary private prison health care ought to call into question local officials' reliance on private contracting as "the primary mechanism of government."[323] The crisis should further call into question local governments' widespread adoption of "private measures of performance and efficiency even when pursuing public ends."[324] A § 1983 claim that results in a court order to revise a dangerous prison health care contract could be the wakeup call that elected policymakers need in order to rediscover their public purpose. Local legislators or executive-branch administrators faced with such a judicial directive have a number of plausible alternatives to fixed-rate privatized prison health care. For example, officials could choose to supplement their prison health care contracts—now largely devoid of substantive health care policy terms—with some of Professor Aman's human-rights provisions.[325] Some already do just that by including provisions that take the form of substantive health policy mandates.[326] In the alternative, a local government could insource its prison health

322. *See supra* Part I.B.

323. Freeman & Minow, *supra* note 213, at 7.

324. *Id.*

325. Aman, *supra* note 43, at 529. ("The fact that most government oversight of private prisons concerns the monitoring of contract terms necessitates the inclusion of human rights provisions in privatization contracts.").

326. The Maine Department of Corrections's prison health care contract with Correctional Medical Services (CMS) includes several such provisions, including requirements for routine medical care, provision of medications as prescribed, and emergency medical services, among other specific mandates. OFFICE OF PROGRAM EVALUATION & GOV'T ACCOUNTABILITY OF THE ME. STATE LEG., HEALTH CARE SERVICES IN STATE CORRECTIONAL FACILITIES – WEAKNESSES EXIST IN MDOC'S MONITORING OF CONTRACTOR COMPLIANCE AND PERFORMANCE; NEW ADMINISTRATION IS UNDERTAKING SYSTEMIC CHANGES, Report No. SR-MEDSERV-09 8 (2011), *available at* http://www.maine.gov/legis/opega/GOC/GOC_meetings/Current_handouts/11-15-11/MEDSERV%20Final%20Report%2011-10-11.pdf, *archived at* http://perma.cc/RJ9W-U66Y.

care.[327] In response to a 2003 lawsuit for unconstitutional denials of medical care in its state prison system, the Ohio state government did just that.[328] As a result, Ohio increased the quality of care provided to inmates and realized significant cost savings in the process.[329]

There is no shortage of policy alternatives to fixed-rate prison health care contracting, but the viability of human-rights provisions, insourcing, or other possible fixes ultimately depends on a fundamental change in how local government officials view their incarcerated citizens. Despite mistakes that inmates have made in the past, they are still entitled to, and deserving of, medical care while incarcerated. It is certainly appropriate for officials to be concerned with the cost of prison medical care; taxpayers deserve to have their investments protected by fiscally prudent legislators. However, concerns over the cost of service provision cannot displace the constitutionally mandated concern over the quality of care provided.[330] Regrettably, this subordination of public values to market values is precisely what has happened. This is the

327. Aviva Shen, *Ohio Saves $7.2 Million in Prison Prescriptions After In-Sourcing Health Care*, THINKPROGRESS (Oct. 15, 2012, 11:43 AM), http://thinkprogress.org/health/2012/10/15/1011731/ohio-saves-72-million-in-prison-prescriptions-after-in-sourcing-health-care/, *archived at* http://perma.cc/ G6BV-QDWX; *see also* IN THE PUBLIC INTEREST, BACKGROUNDER BRIEF: INSOURCING (2013) [hereinafter BACKGROUNDER BRIEF: INSOURCING], *available at* http://www.inthepublicinterest.org/sites/default/files/Insourcing%20Backgrounder%20Brief_Template.pdf, *archived at* http://perma.cc/4MBQ-BSSV (presenting evidence that insourcing can improve quality of services while still reducing costs). Insourcing may be a more viable alternative than commonly understood by critics of privatization. BACKGROUNDER BRIEF: INSOURCING at 2. The common assumption of these critics is that privatization decisions will be "sticky": the decision to turn to private service providers cannot be undone because the government's ability to provide the service will atrophy to the point where it simply loses the capacity to perform in the privatized area. VERKUIL, *supra* note 56, at 4 ("[T]he outsourcing of management functions that are best performed in house undermines government performance in two ways: By utilizing second-best performers and by weakening or atrophying government's power to perform these functions in the future."). However, as demonstrated by the aforementioned example, this view may overstate the loss of governmental capacity.

328. BACKGROUNDER BRIEF: INSOURCING, *supra* note 327, at 3.

329. *Id.*

330. Freeman & Minow, *supra* note 213, at 15 ("[W]henever we can reduce costs without losing quality performance, which some say is the primary aim of outsourcing, we should. At the same time . . . the effectiveness or quality of services and programs paid for by the government should be measured in light of democratic as well as economic values. Considerations beyond those that apply in the private sector matter when the government is the customer and when the functions implicate collective needs.").

legacy of a generation of bipartisan infatuation with privatization: a mindset that has permanently damaged or ended the lives of citizens like Bret Fields, Patricia Pollock, and Ken McGill, among countless others. But it is not too late to shift course, to elevate the human rights of prisoners to the same level of concern that efficiency now occupies, and in the process protect future inmates from similar harm.