

FAILING HEALTH:

The Crisis of Health Care
for Indigent Offenders
and for the Community



WRITTEN BY: ERIC J. MILLER, LL.M., LL.B.

Community Voices

Community Voices

Community Voices: Healthcare for the Underserved is working to make health care available to all. With eight sites across the country and managed by the National Center for Primary Care at the Morehouse School of Medicine, Community Voices is helping to ensure the survival of safety-net providers and strengthen community support services. Launched in 1998 by the W.K. Kellogg Foundation, the sites are part of a national effort to sort out what works from what does not in meeting the needs of those who receive inadequate or no health care.

FAILING HEALTH: THE CRISIS OF HEALTH CARE FOR INDIGENT OFFENDERS AND FOR THE COMMUNITY

Written by: Eric J. Miller, LLM, LLB

Abstract

In 2004, the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), issued a letter “encouraging states to “suspend” and not “terminate” Medicaid benefits while a person is in a public institution or Institute for Mental Disease (IMD)” citing that “persons released from institutions are at risk of homelessness; thus, access to mainstream services upon release is important in establishing a continuum of care and ongoing support that may reduce the demand for costly and inappropriate services later.”¹ In its recommendation, CMS recognized the necessity of these benefits. This ‘letter’ is an opportunity that does not answer all questions but does give options on what could be a standard. Without some form of health care provision, American jails and prisons incubate and transmit disease while being stripped of Medicaid and other health insurance. Much of this is due to a policy of denigrating prisoners as less deserving than the rest of society. Yet it is the rest of society that bears the burden of the healthy returning from prison sick, without health care funding, which has often been terminated by the state prison system or outlawed under federal statute.

¹Centers for Medicare and Medicaid ServicesCenter for Medicaid and State Operations, Disabled and Elderly Health Programs Group (2004). *Letter: Ending chronic homelessness*. Retrieved June 17, 2007 from <http://aspe.hhs.gov/homeless/smd052504.pdf>

What is most profoundly required, however, is a change of policy in terms of welfare eligibility and standards of prison health care. The range of remedies is, unfortunately, limited. Under current constitutional law, there are some, but few, litigation opportunities. State or federal legislation could resolve many of the current problems quickly and effectively, but requires spending targeted at a population expressly singled out for opprobrium. Other initiatives, promoting planning for the transition from prison to community or providing a means of linking the various services available to prisoners on re-entry, provide additional avenues. Perhaps the primary issue, however, is to recognize the tremendous impact prison and re-entry health policies have upon the urban poor, stunting whole communities’ ability to thrive.

I. INTRODUCTION

Medical treatment in prison and upon release presents profound difficulties for social policy. For the most part, such difficulties arise from problems associated with indigent health care more generally. The structure of health care access and funding results in large numbers of the indigent or poor lacking medical coverage. Adding to coverage issues, however, is the status of prison as an incubator of certain diseases or amplification point for a range of socially disadvantageous behaviors.²

² See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1734 (2005).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

These diseases and behaviors in turn have a severe health impact upon the poor and mostly urban communities to which the jail and prison populations return.³

The two major programs for indigent health care, Medicaid and Medicare, are not and were not originally intended as systems of universal health care.⁴ In particular, Medicaid is a joint federal-state program that requires each state to determine how best to fulfill its coverage obligations under a scheme of partial federal funding for non-institutionalized residents. What results is a health-care funding system that depends primarily on private insurance to pay for access to health care.⁵ For the uninsured, the current funding system treats health care as a welfare issue and restricts access based on outdated conceptions of the workhouse and the undeserving poor. Class and gender stereotypes pervade the issue of access to Medicaid.

In the prison context, the funding problem is complicated by the federal constitution, which mandates health care for those confined in prison but not for those released into the community.⁶ In recognition of this state obligation, federal Medicaid dollars do not supplement state funding for institutionalized persons.⁷

³ See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1725 (2005).

⁴ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 215-17 (Ruth Roemer & George McKray, eds., 1980).

⁵ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 215-17 (Ruth Roemer & George McKray, eds., 1980).

⁶ See *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁷ See Social Security Act §1905(a)(A) and 42 U.S.C.

Accordingly, state determinations of how much to spend on health care, and which populations are eligible for coverage have a massive distributive impact on the poor.

Finally, inmate health care operates under a “deliberate indifference” standard, rather than the ordinary negligence standard applicable to treatment outside prison.⁸ Thus, even though inmates have a right to health care, they do not have a right to the same standard of (non-negligent) health care available for those in the community. Thus, even if federal funding were available for prison health care, it remains an open question whether it would make a difference to the *quality* of prison health care.

Of course, issues of prison health care do not determine what health care should be made available outside the prison. There, Medicaid’s emphasis on certain severe disabilities and coverage of indigent children through designated parents tends to disproportionately exclude indigent men from health care coverage. Furthermore, due to insufficient planning and support, Medicaid and Medicare benefits removed during incarceration may not be restored upon release. Given the massive numbers of individuals returning to urban communities from jail and prison — *seven million* from jail *each year*, which dwarfs

§1396(d)(a)(27)(A).

⁸ “‘Deliberate indifference’ requires that an individual ‘know [] of and disregard [] an excessive risk to inmate health or safety.’” *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). “[D]eliberate indifference describes a state of mind more blameworthy than negligence,” *id.* at 835; it “requires ‘more than ordinary lack of due care for the prisoner’s interests or safety.’” *Id.* (quoting *Whitley v. Albers*, 475 U.S. 312, 319 (1986)).

Community Voices: Healthcare for the Underserved

more than six-hundred thousand returning from prison⁹ — prison can serve as a vast mechanism for stripping primarily the mentally ill and addicted of their health care coverage.

The range of remedies is, unfortunately, limited. Under current constitutional law, there are some, but few, litigation opportunities. State or federal legislation could resolve many of the current problems quickly and effectively, but requires spending targeted at a population expressly singled out for opprobrium. Other initiatives, promoting planning for the transition from prison to community or providing a means of linking the various services available to prisoners on re-entry, provide additional avenues. Perhaps the primary issue, however, is to recognize the tremendous impact prison and re-entry health policies have upon the urban poor, stunting whole communities' ability to thrive.

II. PRISON HEALTH ISSUES

Before considering the major issues related to treatment of prisoners' health problems — standards of care and scope of coverage — it is important to gain a sense of who the policies impact. There are a variety of people under the supervision of the criminal justice system, and the range of health issues they face can be quite diverse. Nonetheless, certain issues predominate: communicable diseases; sexually transmitted diseases; chronic conditions; and serious mental

⁹ See Theodore M. Hammett, Cheryl Roberts & Sofia Kennedy, *Health-Related Issues in Prisoner Reentry*, 47 CRIME & DELINQUENCY 390, 391 (2001); REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY xviii (2005).

illness.¹⁰ Some of the medical conditions from which they suffer directly entitle them to Medicaid coverage; some directly preclude them from coverage. Furthermore, their relation to Medicare is often dependent upon their status within the criminal justice system: on probation, in prison, on parole.

A. The Expanding, Changing Prison Population

Although there were more than 2 million people in state and federal prisons in 2005,¹¹ most people under the supervision of the criminal justice system are not incarcerated; twice as many are outside the prisons on probation or parole.¹² The largest number of people are those passing through local jails: institutions that house offenders for less than one year. "Each year more than 10 million people are admitted to U.S. jails."¹³ Of that number, 747,529 were in local jails on the night of June 30, 2005.¹⁴

It is worth noting that jails are correctional facilities, operated by state or municipal governments, that confine persons before or after adjudication by the criminal justice system.

¹⁰ John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447 (2006).

¹¹ "At midyear 2005 the Nation's prisons and jails incarcerated 2,186,230 persons." PAIGE M. HARRISON & ALLEN J. BECK, PRISON AND JAIL INMATES AT MIDYEAR 2005 (2006).

¹² Harold Pollack, Kaveh Khoshnood & Frederick Altice, *Health Care Delivery Strategies for Criminal Offenders*, 26 J. HEALTH CARE FINANCE 63, 65 (1999).

¹³ See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1725 (2005).

¹⁴ PAIGE M. HARRISON & ALLEN J. BECK, PRISON AND JAIL INMATES AT MIDYEAR 2005 7 (2006).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

Accordingly, many of the people confined in jail need not receive any adjudication of their guilt or innocence — and may not even appear before a court for arraignment. Those inmates that remain in jail after sentencing are usually those sentenced to less than a year of incarceration. Jails also receive individuals pending arraignment and hold them during their stay in the criminal justice system. They also hold probation, parole, and bail-bond violators, and may hold juveniles awaiting transfer to juvenile court, or mentally ill persons awaiting transfer to mental health facilities.¹⁵ More than three-quarters of jail inmates return home within a few months; the remainder are sentenced to prison.¹⁶ They do not all remain in jail, however. The minority goes on to prison. In any given year, there are “more than 7 million returning from jail.”¹⁷

That means that one of the major problems associated with health care in the criminal justice system is not the health care that they receive during more or less lengthy stays in prison, what happens during the process of being cycled in and out of jail. One issue is the disincentive of treating prisoners who stay a relatively short period in jail during any one year; a second is the loss of coverage for otherwise-eligible offenders.

¹⁵ PAIGE M. HARRISON & ALLEN J. BECK, PRISON AND JAIL INMATES AT MIDYEAR 2005 7 (2006).

¹⁶ See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1725 (2005).

¹⁷ See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1725 (2005).

Third, is the failure to bring the sorts of “transient offenders” that disproportionately populate our city and county jails,¹⁸ and who may be eligible for health care, into the system; a fourth is the impact of reentry on already-strained local communities. In particular, our nation’s jails are disproportionately concentrated in urban areas. They are populated mostly by people from urban areas, and recycle those individuals back into the poor, urban communities from which they are drawn.¹⁹

Importantly, from a public health perspective, the prison population is changing. The criminal justice system is traditionally a predominantly male-oriented institution. Nonetheless, the fastest-growing prison population is women. While women do not make up a relatively large proportion of the prison population, as compared to men, “[s]ince 1980, the number of women in prison has increased at nearly double the rate for men.”²⁰ Women suffer from medical problems at higher rates than men. “More than half (53 percent) of female jail inmates reported having a current medical problem, compared to about a third (35 percent) of male jail inmates.”²¹

¹⁸ Harold Pollack, Kaveh Khoshnood & Frederick Altice, *Health Care Delivery Strategies for Criminal Offenders*, 26 J. HEALTH CARE FINANCE 63, 65 (1999).

¹⁹ “Jail populations are concentrated in cities: 50 of the nation’s 940 jails, all in urban areas, held 31.2% of all inmates in 2003.” See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1725 (2005).

²⁰ See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1726 (2005).

²¹ LAURA M. MARUSCHAK, MEDICAL PROBLEMS OF JAIL INMATES 2 (2006).

Community Voices: Healthcare for the Underserved

Furthermore, the male prison population's average is dropping. "[B]etween 1985 and 1997, the number of adolescents sentenced to adult prison more than doubled."²²

These young men are particularly *un*-healthy. They "typically have poor physical and mental health status, with higher-than-average rates of substance abuse and psychiatric disorders as well as acute and chronic medical conditions."²³

B. Incarcerating the Ill

The prison population is significantly less healthy than people of comparable age in the general population. Not only are more people ill, but the illnesses are often more serious, including chronic illnesses, infectious diseases and severe mental disorders.²⁴ "In 2002 an estimated 229,000 jail inmates reported having a current medical problem other than a cold or virus."²⁵ Many will have been sicker before they entered prison, suffering from mental illnesses or drug addiction;²⁶ others will have become sick while in prison. Prison serves to accelerate transmission or provoke

the sorts of crises — either during incarceration or upon release — that exacerbate mental issues or drug or alcohol dependency issues.

Prison provides a prime opportunity to treat the health needs of the least well off in our society. As a group, American prisoners are less healthy, "than virtually any other group of Americans, in large part because of poverty and drug abuse. Not only are rates of diabetes, asthma, hypertension, and heart disease disproportionate to age-adjusted cohorts in the free world, but the rates of alcohol and drug use, communicable disease, and mental illness are even higher in comparison."²⁷

In 1996, "[m]ore than 1 out of 3 jail inmates reported some physical or mental disability. The rate of mental illness in state prisons and local jails in the United States is at least three times greater than the rate in the general population."²⁸ According to the Federal Bureau of Justice Statistics, 16 percent of adult prisoners report having either a mental disorder or an overnight stay in a psychiatric facility.²⁹ That means that nationally, "one out of every seven inmates has a major mental illness such as schizophrenia, bipolar disorder, major depression, or post-traumatic stress disorder,"³⁰ amounting to a raw figure of "nearly 300,000 people in active need of mental

²² See, e.g., Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1726 (2005).

²³ Alison Evans Cueliar, Kelly J. Kelleher, Jennifer A. Rolls & Kathleen Pajer, *Medicaid Insurance Policy for Youths Involved in the Criminal Justice System*, 95 AM. J. PUB. HEALTH 1707, 1707 (2005)

²⁴ See REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 64 n.31 (2005) (citing NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE, THE HEALTH STATUS OF SOON-TO-BE-RELEASED PRISONERS: A REPORT TO CONGRESS (2002)). "According to this report, significant illnesses afflicting correctional populations include coronary artery disease, hypertension, diabetes, asthma, chronic lung disease, HIV infection, hepatitis B and C, other sexually transmitted diseases, tuberculosis, chronic renal failure, physical disabilities, and many types of cancer." *Id.*

²⁵ LAURA M. MARUSCHAK, MEDICAL PROBLEMS OF JAIL INMATES 1 (2006).

²⁶ See LAURA M. MARUSCHAK, MEDICAL PROBLEMS OF JAIL INMATES 1 (2006) ("More than a third of jail inmates reported having a current medical problem [existing before admission]").

²⁷ Robert B. Greifinger, *Inmates as Public Health Sentinels*, 22 WASH. U. J.L. & POL'Y 253, 256 (2006).

²⁸ REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 64 (2005).

²⁹ PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS (1999).

³⁰ Robert B. Greifinger, *Inmates as Public Health Sentinels*, 22 WASH. U. J.L. & POL'Y 253, 257 (2006).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

health treatment while detained and after release.³¹ The stress of jail or prison life can have a devastating effect on these individuals, often causing them to regress while incarcerated.³²

The number of mentally ill inmates in prison or jail — 283,800³³ — is just over half the number — 547,800 — of mentally ill persons on probation in the community.³⁴ In terms of age, the rates of mental illness are highest among the middle-aged (ages 45 to 54) and much lower among people ages 24 or younger;³⁵ in terms of race and gender, “the highest rates of mental illness were among white females in State prison.”³⁶

Prisons have, in effect, become dumping grounds for individuals afflicted with mental health problems. Institutionalization in mental institutions is an ineffective and demeaning way to treat the afflicted; the appropriate goal is some form of care that seeks to effectively integrate individuals with mental disorders into the larger

community. Unfortunately, this lofty goal is not matched by either practice or funding. Many mentally ill individuals are simply released from hospital into the community with no provision made for their care. These people often cycle from homeless shelter to prison to hospital, without any effective means of therapeutic support.³⁷

Perhaps most worrisome of all, significant percentages of the jail and prison population suffer from dangerous communicable diseases. “In 1996, 17 percent of HIV-infected Americans passed through a correctional facility; 12-15 percent of those with hepatitis B and 30 percent with a hepatitis C infection were released; and an estimated 35 percent of Americans with active tuberculosis were released.”³⁸ These individuals remain untreated, even though there are “clear, cost-effective methods” that could be used to help them while in prison or jail.³⁹ In part, the problem is that the short length of many inmates’ stay in jail is simply too short to provide an incentive to engage in diagnosis and treatment. The type of treatment plan likely to prove effective may have to be continued outside the prison, requiring linkages between different health care providers and, as we shall see, different sources of funding. Specifically, there is a distinctive lack of coverage for jail and prison inmates upon re-entering the community that is

³¹ Wendy Pogorzelski, Nancy Wolff, Ko-Yu Pan & Cynthia L. Blitz, *Behavioral Health Problems, Ex-Offender Reentry Policies, and the “Second Chance Act,”* 95 AM. J. PUB. HEALTH 1718, 1719 (2005).

³² Robert B. Greifinger, *Inmates as Public Health Sentinels*, 22 WASH. U. J.L. & POL’Y 253, 257 (2006).

³³ As of mid-year 1998. See PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 3 (1999).

³⁴ As of mid-year 1998. See PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 3 (1999).

³⁵ “About 20% of State prisoners, 10% of Federal prisoners, 23% of jail inmates, and 21% of probationers between ages 45 and 54 had a mental illness, compared to 14% of State inmates, 7% of Federal inmates, 13% of jail inmates, and 14% of probationers age 24 or younger.” PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 3 (1999).

³⁶ “An estimated 29% of white females, 20% of black females, and 22% of Hispanic females in State prison were identified as mentally ill. Nearly 4 in 10 white female inmates age 24 or younger were mentally ill.” PAULA M. DITTON, MENTAL HEALTH AND TREATMENT OF INMATES AND PROBATIONERS 3 (1999).

³⁷ See, e.g., Sidney Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 363-67 (2000).

³⁸ Robert B. Greifinger, *Inmates as Public Health Sentinels*, 22 WASH. U. J.L. & POL’Y 253, 257 (2006). See also John V. Jacobi, *Prison Health, Public Health: Obligations and Opportunities*, 31 AM. J.L. & MED. 447 (2005); RE-ENTRY POLICY COUNCIL, REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY 157 (2005).

³⁹ Robert B. Greifinger, *Inmates as Public Health Sentinels*, 22 WASH. U. J.L. & POL’Y 253, 260 (2006).

Community Voices: Healthcare for the Underserved

traceable, in part, to the history of Medicaid and Medicare, and more generally, to the story of health care provision in America.

III. MEDICAID AND PRISONER HEALTH

A. History of Medicaid

Congress enacted Medicaid in 1965 as Title XIX of the Social Security Act.⁴⁰ Medicaid was “hastily appended to the Medicare bill”: prior to its enactment, the main legislative focus had been Medicare. As a result, Congress passed Medicaid after little, if any, debate.⁴¹ Medicaid was, from the outset, a compromise provision intended to appeal to the various institutions providing health care for the indigent, rather than the indigent themselves. Thus, although promoted as “bring[ing] the poor into the ‘mainstream’ of medicine,”⁴² the primary beneficiaries were to be “state and local governments, the medical establishment, and the hospital industry, all of which felt they had borne too great a burden of providing charity care.”⁴³ Rather than providing health care directly to the covered groups, Congress instead chose a model of health care provision that simply reimbursed traditional health

care providers through state and federal payment for services.⁴⁴

Instead of providing comprehensive indigent health care, the Medicaid statute provided patchy coverage at best. In part, this reflected the underlying model for Medicaid: the 1960 Kerr-Mills Program of Medical Assistance for the Aged. Kerr-Mills was primarily a welfare program of health insurance for the indigent aged rather than a system of universal health coverage. Medicaid followed the Kerr-Mills model by identifying three primary categories of indigent welfare recipients as eligible for federally funded health insurance: “the blind, the permanently and totally disabled, and families with dependent children deprived of parental support.”⁴⁵ Subsequent to its enactment, Congress promised to provide comprehensive coverage to all poor persons by the mid-1970s: that promise was never acted upon, and was abandoned in 1972.⁴⁶

The resulting Medicaid system limits funding primarily to the “categorically needy”:⁴⁷ recipients of Temporary Assistance for Needy Families (TANF)⁴⁸ or Supplemental

⁴⁰ 42 U.S.C. §1396 et seq.

⁴¹ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 215 (Ruth Roemer & George McKay, eds., 1980). “It is generally conceded that, despite Medicaid’s fairly specific language, the Congress that enacted it did not understand the program very well. It had never even been considered in hearings or debated on the floor.” *Id.* at 217.

⁴² Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 215 (Ruth Roemer & George McKay, eds., 1980) (quoting Hearings Before subcommittee on Medicaid and Medicare of Senate Finance Committee, 91st Cong., 2d Sess., Pt. 1 at 57).

⁴³ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 217 (Ruth Roemer & George McKay, eds., 1980).

⁴⁴ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 217 (Ruth Roemer & George McKay, eds., 1980).

⁴⁵ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 217 (Ruth Roemer & George McKay, eds., 1980). “This welfare orientation arbitrarily limited the recipients of the program.” *Id.* at 215.

⁴⁶ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 218 (Ruth Roemer & George McKay, eds., 1980).

⁴⁷ 42 U.S.C. §1396a(a)(10)(A). It can be extended, at state discretion, to the “categorically related medial needy.” 42 U.S.C. §1396a(a)(10)(C).

⁴⁸ See Personal Responsibility and Work Opportunity Reconciliation Act § 101-116 (codified as amended at 42 U.S.C. §§601-617, 619).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

Security Income (SSI). “These categories omit a large number of childless couples and single individuals who are not blind or disabled as required for welfare eligibility.”⁴⁹ Furthermore, Medicaid permits substantial state discretion in setting eligibility requirements: outside certain mandatory services,⁵⁰ the program permits states to choose the various options for benefits. Accordingly, the services provided under Medicaid are not uniform across the nation, but vary from state to state.

B. Medicaid and Incarceration

Two features of healthcare coverage stand out when considering public health issues related to incarcerated individuals: prisoners have a Constitutional right to health care that others do not; and prisoners are excluded from receiving federal Medicaid coverage.

Prisoners incarcerated in jail or prison are the only U. S. citizens who have a constitutional right to health care.⁵¹ This odd situation arises from the nature of imprisonment: because the prisoner is in effect under the total care and control of the state, “[a]n inmate must rely on prison authorities to treat his medical needs; if the authorities

fail to do so, those needs will not be met.”⁵² Accordingly, in *Estelle v. Gamble*,⁵³ the Supreme Court held that “the government’s obligation to provide medical care for those whom it is punishing by incarceration,”⁵⁴ and prisoners have a legal claim to state-based funding for their treatment needs that people outside prison do not.

Where, as with incarcerated offenders, the state has a Constitutional duty to provide health care, the federal government declines to do so through Medicaid⁵⁵ and so does not provide states with matching Medicaid or Medicare funds.⁵⁶ This Medicaid exclusion for individuals in public institutions was originally intended to preclude states from using federal Medicaid funds to support a variety of institutional services that the states were constitutionally bound to provide.⁵⁷ The exclusion thus also applies to state mental hospitals.⁵⁸ On a similar theory, prisoners are also ineligible for SSI payments while incarcerated: federal funding is welfare to help the individual, not to subsidize the state’s incarceration efforts.⁵⁹

⁵²*Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁵³*Estelle v. Gamble*, 429 U.S. 97 (1976).

⁵⁴ *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

⁵⁵ 42 CFR § 435.3, which references § 1905(a) of the Social Security Act.

⁵⁶ Social Security Act § 1905(a)(A) 42 USC § 1396(d)(a)(27)(A).

⁵⁷ Social Security Act §1905(a)(A); 42 U.S.C. §1396(d)(a)(27)(A).

⁵⁸ Social Security Act § 1905(a)(A) 42 USC § 1396(d)(a)(27)(A).

⁵⁹ 42 U.S.C.A. §1382(e)(1)(A); Social Security Disability Income (SSDI) benefits are suspended if someone has been convicted and confined in jail longer than 30 days, whether or not it is a full calendar month. See 42 U.S.C. §402(x)(1)(A)(i). SSDI payments to an eligible spouse or child are not suspended or terminated when the worker is in jail. 20 C.F.R. §404.468(a).

⁴⁹ Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 219 (Ruth Roemer & George McKay, eds., 1980).

⁵⁰ “The benefit structure in the Medicaid law is outwardly simple: all states must pay for certain mandatory services. For the categorically needy, these are inpatient hospital services; outpatient hospital services; physician services; rural clinic services; x-ray and laboratory services; skilled nursing facility services for persons over twenty-one years of age, and home health care services for persons eligible to be in nursing homes; and family planning services and screening for children’s health care defects.” Patricia A. Butler, *Legal Problems in Medicaid*, LEGAL ASPECTS OF HEALTH POLICY: ISSUES AND TRENDS 221 (Ruth Roemer & George McKay, eds., 1980).

⁵¹ *Estelle v. Gamble*, 429 U.S. 97 (1976).

Community Voices: Healthcare for the Underserved

If a person is incarcerated for a calendar month the government suspends SSI payments;⁶⁰ if a person is imprisoned for more than twelve months, the federal government terminates SSI eligibility.⁶¹ Federal law requires state correctional facilities to inform the Social Security Administration that a person is confined and provides a financial incentive to do so.⁶² If correctional facility information leads to suspension or termination of benefits, it receives a federal payment of \$400 for information sent within 30 days of the inmate's arrival and \$200 for information sent within 90 days.⁶³ "This information should — but does not always — include an estimated release date."⁶⁴ Furthermore, state correctional facilities do not receive a payment for notifying the SSA of an inmate's release so that benefits can be restored.⁶⁵

A prisoner's Medicaid coverage need not end, but may be suspended while in prison or jail. The ability of the state to suspend or terminate Medicaid coverage depends upon whether the prisoner receives Medicaid through SSI or some other program; Medicaid terminates when SSI terminates, normally 12 months after incarceration. Thus, if the prisoner is in jail for less than 12 months, or if Medicaid is dependent upon TANF rather than SSI, then the state can choose to suspend, rather than terminate,

Medicaid coverage.⁶⁶ Suspension enables the prisoner to "remain on the Medicaid rolls even though services received while in jail are not covered."⁶⁷ Accordingly, someone who had a Medicaid card when jailed may be able to use it again immediately after release to obtain needed services and medication."⁶⁸

With regard to Medicaid coverage, there are a variety of different categories of prisoners cycling through prison or jail: (1) those who are eligible for and receive Medicaid before and after imprisonment; (2) those who receive Medicaid before imprisonment and should receive it after, but are disqualified in prison and not re-qualified upon leaving; (3) those who do not receive Medicaid before imprisonment and should receive it upon leaving; (4) those who are ineligible for Medicaid. State prison systems tend to favor termination of Medicaid coverage over suspension. That, combined with the educational and mental health problems prevalent in a large number of the prison population, serves to remove from the rolls a large number of individuals who should receive Medicaid during their stay in prison. Accordingly, state prison policy shrinks the number of people who could be in category (1) and increases those in category (2). Furthermore, the state could adopt a process to ensure that those in category (3) do in fact receive coverage upon release; the policy favoring termination militates against this goal.

⁶⁰ 20 C.F.R. §416.1321(b).

⁶¹ 20 C.F.R. §416.1335.

⁶² 42 U.S.C. §1382(e)(1)(I)

⁶³ 42 U.S.C. §1382(e)(1)(I).

⁶⁴ THE BAZELON CENTER FOR MENTAL HEALTH LAW, FINDING THE KEY 8 (2003).

⁶⁵ THE BAZELON CENTER FOR MENTAL HEALTH LAW, FINDING THE KEY 8 (2003).

⁶⁶ THE BAZELON CENTER FOR MENTAL HEALTH LAW, FINDING THE KEY 11-12 (2003).

⁶⁷ Social Security Act §1905(a)(A).

⁶⁸ THE BAZELON CENTER FOR MENTAL HEALTH LAW, FINDING THE KEY 11 (2003).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

C. Social Impact of Health Care Coverage

Health care issues outstrip the impact on individual offenders, and burden the predominantly poor, urban communities to which they return.⁶⁹ Lacking insurance, many offenders cannot or do not find health care providers willing or able to treat the illness they bring back into the community. “Lack of timely care, in turn, could lead to flare-ups in medical or mental health conditions, which could translate into higher health care costs and possibly higher rates of rearrest and diminished public safety.”⁷⁰ For women, access to health care can have a significant impact upon recidivism in general, and drug use in particular.⁷¹

The welfare reforms of the mid-1990s have had an impact upon health care eligibility. Particularly important for probationers or prisoners reentering the community, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (the Welfare Reform Law of 1996) “eliminated substance abuse as a preliminary qualifying diagnosis for Supplemental Security Income

⁶⁹ “Our findings show the central role that health plays in the lives of people leaving jail. These individual experiences have a significant impact on community health. In the 1980s and 1990s, jails became an amplification point for a variety of ills, serving either as a place of infection in the case of tuberculosis or as a school for behaviors that put communities at risk.” Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1734 (2005).

⁷⁰ Alison Evans Cueliar, Kelly J. Kelleher, Jennifer A. Rolls & Kathleen Pajer, *Medicaid Insurance Policy for Youths Involved in the Criminal Justice System*, 95 AM. J. PUB. HEALTH 1707, 1707 (2005).

⁷¹ Nicholas Freudenberg, Jessie Daniels, Martha Crum, Tiffany Perkins & Beth E. Richie, *Coming Home From Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents, and Their Families and Communities*, 95 AM. J. PUB. HEALTH 1725, 1731 (2005).

(SSI) aid. ... Less well known, SSI disqualification often deprives drug-dependent offenders and ex-offenders of health care coverage and access to other social services.”⁷² The Welfare Reform Law of 1996 introduced TANF to replace Aid to Families with Dependent Children.⁷³ The movement from ADFC to TANF transformed welfare from an open-ended program for qualifying parents to an avowedly transitional one designed to remove parents from the welfare rolls. TANF also permits the disqualification of parents with felony drug convictions.⁷⁴ Accordingly, health care coverage for prisoners reentering the community is decreasing, not increasing, and this in turn is likely to have an impact on community health and safety.

Imprisonment for drug offenses can have serious health care repercussions for criminal offenders: because the Welfare Reform Law of 1996 denies federal benefits to individuals convicted of a drug offense,⁷⁵ the impact on drug offenders who had been receiving Medicare is profound. Drug offenses are particularly prominent among

⁷² Harold Pollack, Kaveh Khoshnood & Frederick Altice, *Health Care Delivery Strategies for Criminal Offenders*, 26 J. HEALTH CARE FINANCE 63 (1999). See Public Law 104-193 §115, as amended by § 5516 of the Balanced Budget Act of 1997 (P.L. 105-33). See also 21 U.S.C. §862.

⁷³ PL 104-193 transformed Aid to Families with Dependent Children from an open-ended cash entitlement into an avowedly transitional system with time limits and work requirements. Parents with prior drug felony convictions can be penalized or removed from the assistance rolls.” Harold Pollack, Kaveh Khoshnood & Frederick Altice, *Health Care Delivery Strategies for Criminal Offenders*, 26 J. HEALTH CARE FINANCE 63, 68 (1999).

⁷⁴ Harold Pollack, Kaveh Khoshnood & Frederick Altice, *Health Care Delivery Strategies for Criminal Offenders*, 26 J. HEALTH CARE FINANCE 63 (1999). Furthermore, “[d]uring the 1980s and 1990s, many states eliminated General Assistance (GA) to able-bodied adults without dependents ... GA has often included health insurance and other social services whose financial value often exceeded the small monthly grant.” As a result, “parolees and probationers who lack qualifying disabilities and who have no dependent children are often uninsured.” *Id.*

⁷⁵ See 21 U.S.C.A. §862.

Community Voices: Healthcare for the Underserved

female prisoners; over 35 percent of women in state prison and 73 percent of women in federal prison have been convicted of a drug offense.⁷⁶ Prior to their incarceration, over 41 percent of women in state prison and 33 percent of women in federal prison had been receiving some form of transfer payment, “including welfare, Social Security, Supplemental Social Security income, and compensation payments such as unemployment insurance, workman’s compensation and Veteran’s Compensation.”⁷⁷ Women are over three times more likely to receive such payments than male prisoners. Accordingly, increasing numbers of women are losing Medicaid coverage as a result of incarceration.

Adding to this picture, the rate of incarceration is increasing at a greater pace for women than for men. Since 1995 the annual rate of growth in the number of female inmates has averaged 4.7 percent, higher than the 3.0 percent average increase of male inmates. Women accounted for 7.0 percent of all inmates at midyear 2005, up from 6.1 percent at yearend 1995. ... During the 12-month period ending June 30, 2005, the number of adult female inmates rose 8.0 percent, while the number of adult male inmates increased 4.3 percent. On average the adult female jail population has grown 6.2 percent annually in the past 10 years, while the adult male population has grown 3.7 percent.⁷⁸

Female prisoners are much more likely than male prisoners to have lived with their children prior to incarceration. “About 64 percent of mothers in state prison and 84 percent of those in federal prison reported living with their minor children prior to admission, compared to 44 percent and 55 percent of fathers, respectively.”⁷⁹ These gender differences may well have a trickle-down effect: women exit prison less healthy, without federal benefits, and the majority of them return to taking care of their children.

IV. LEGAL ISSUES IN PRISON HEALTH AND MEDICAID

Prisoner health funding proceeds along two distinct paths. For those in jail or prison, federal funding is unavailable, although state funding is mandatory; for those who are not incarcerated, federal and state health care funding depends upon a variety of welfare categories that may render an indigent person without any public health care funding at all. The effect of state or federal categorization of the indigent can have a profound impact on their access to health care, impacting not only the individual but the community in which he or she happens to reside. Since these communities tend to lack resources more generally, they experience a heightened burden of coping with the chronically ill.

There are a range of potential legal routes to conceptualize the classification schemes adopted by the state and federal government. Primary among them is the Equal Protection Clause of the Fourteenth Amendment, which applies to

⁷⁶ CHRISTOPHER J. MUMOLA, INCARCERATED PARENTS AND THEIR CHILDREN 8 (2000).

⁷⁷ CHRISTOPHER J. MUMOLA, INCARCERATED PARENTS AND THEIR CHILDREN 10 (2000).

⁷⁸ PAIGE M. HARRISON & ALLEN J. BECK, PRISON AND JAIL INMATES AT MIDYEAR 2005 5, 8 (2006).

⁷⁹ CHRISTOPHER J. MUMOLA, INCARCERATED PARENTS AND THEIR CHILDREN 4 (2000).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

the states, or the Fifth Amendment, which applies to the federal government. These clauses could be used to argue that the manner in which the state and federal government provides Medicaid coverage (1) engages in gender discrimination through TANF, which employs a range of gender stereotypes to determine coverage; or (2) arbitrarily selects among classes of indigents to determine coverage. In essence, the claim would be that the various programs determining Medicaid eligibility classify individuals on the basis of their gender, class, or both in determining who receives benefits under the federal-state scheme.

A different claim could be directed at state or federal prisons: that a failure to ensure an effective transition from prison to the community by ensuring continuity of health coverage violates the Constitution's mandate to provide adequate health care for prisoners. Prison policies that fail to ensure a reentering prisoner receives Medicaid coverage, where available, may thus be illegal. This latter strategy, while piecemeal, dependant upon the patchy coverage provided by existing Medicaid categories, and dependant upon a somewhat unsympathetic set of constitutional standards, may provide the best hope for developing a litigation strategy.

A last option is to promote legislative initiatives directed at increasing access to healthcare for probationers, prisoners, and parolees. This option appears to be particularly difficult given the tough-on-crime attitude taken by Congress and many state legislatures: health care is generally included in that approach. Further complicating any broad political

initiative is the shrinking range of services covered by state Medicaid as a result of budget cuts at the national and local level.

A. Medicaid

A central question is whether Medicaid's coverage system engages in the sort of arbitrary discrimination that would violate the Equal Protection Clause of the United States Constitution.⁸⁰ The Equal Protection Clause precludes the state and federal governments from applying invidious classifications to discriminate against identifiable groups of people. Not every classification, however, is invidious; different types of discrimination receive different treatment under the complicated case law that developed in the last half of the twentieth century.

The Supreme Court essentially applies a three-tiered approach to determining whether a government classification violates the Equal Protection Clause. The Court uses a particular standard of review — strict, intermediate, or rational-basis — to evaluate governmental classifications relative to the purpose they serve. Where the use of a classification is likely to be stigmatic in and of itself, the Court generally strikes down the statute unless the government can point to some extremely compelling reason for using the classification.⁸¹ Where the classification has little social stigma associated with it, the Court generally permits the government to use the classification, unless the plaintiff can show that the classification is so arbitrary as to be irrational.

⁸⁰ *Bolling v. Sharpe*, 347 U.S. 497 (1954).

⁸¹ *See, e.g., Shaw v. Reno*, 509 U.S. 630 (1993).

Community Voices: Healthcare for the Underserved

Accordingly, under the Court's three-tiered approach, the most stringent level of review is strict scrutiny. It applies when a state or federal statute or program seeks to regulate some classification based on race or national origin, or which impacts some right deemed "fundamental." Governmental use of such classifications must be "narrowly tailored" to advance a "compelling governmental interest."⁸² Traditionally, whenever the Court applies strict scrutiny, the program is generally found to be unconstitutional.

A middle level of intermediate scrutiny applies to a variety of classifications, including gender-based ones. It demands that the proposed classification is "substantially related to an important governmental objective."⁸³ In the realm of gender classifications, the Court has more recently adopted a slightly more heightened standard of "skeptical scrutiny" that necessitates an "exceedingly persuasive justification" rather than simply some important state goal.⁸⁴

Finally, for all other governmental classifications, the Court applies a "rational basis" standard, one so deferential that it essentially ensures that the government program will pass constitutional muster. All that is required is some "rational relation to a legitimate governmental purpose."⁸⁵

Where a statute is silent on a particular classification, a plaintiff could argue that the statute disparately impacts some class of individuals.⁸⁶ A showing of disparate impact is not enough, however: a plaintiff seeking to assert a violation of the Equal Protection Clause would also have to argue that the statute manifests some intention to discriminate that can be inferred from circumstantial evidence if not the text of the document.⁸⁷ Accordingly, to mount a disparate impact claim, the plaintiff must establish that a facially neutral statute has a particular negative effect upon an identifiable class of people, and that differential treatment is a result of some discriminatory animus underlying the statute. The plaintiff would then argue that, under the appropriate standard of scrutiny applicable to the class, the statute insufficiently narrowly tailored, or so irrational as to violate the Constitution.

B. Standard of Scrutiny Applicable to Medicaid

Under the Equal Protection analysis, the standard of scrutiny applied is essentially determinative of the constitutional question. Since Medicaid does not apply to race, one option is to claim that TANF or Medicaid classifies individuals — primarily indigent men — or disproportionately excludes them from benefits based on gender stereotypes; another is to claim discrimination more generally on the basis of indigence. For various reasons, neither of these options is likely to succeed.

⁸² *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995) ("we hold today that all racial classifications, imposed by whatever federal, state, or local governmental actor, must be analyzed by a reviewing court under strict scrutiny. In other words, such classifications are constitutional only if they are narrowly tailored measures that further compelling governmental interests.").

⁸³ *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 724 (1982).

⁸⁴ *United States v. Virginia (VMI)*, 518 U.S. 515 (1996)

⁸⁵ *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 446 (1985); *see also, e.g., Plyler v. Doe*, 457 U.S. 202, 216 (1982).

⁸⁶ *See, e.g., Washington v. Davis*, 426 U.S. 229 (1976).

⁸⁷ *See Washington v. Davis*, 426 U.S. 229 (1976).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

It is plain that, historically, Congress and the states designed and administered welfare laws in a manner that discriminated upon the basis of both race and gender. A forerunner to TANF, Aid to Dependent Children (ADC), “though technically available to all children in single-parent households, was in practice an income support program exclusively for white widows.”⁸⁸ Under its replacement, Aid to Families with Dependent Children (AFDC), states employed “absent father’ rules, which denied benefits to AFDC recipients who cohabit with a nonparental male.”⁸⁹ These rules were enforced in a manner that targeted minority families in an effort to restrict AFDC as a benefit payable only to whites.⁹⁰ TANF replicates many of the gender assumptions surrounding the roles of men and women and the advantages of marriage and two-parent families.⁹¹ “TANF incorporates a system of financial punishments designed to deter disapproved behavior (e.g., out of wedlock childbearing, dependence of needy parents on government benefits) and to encourage approved behavior (e.g., marriage and economic independence).”⁹² In particular, TANF permits states to “prevent and reduce the incidence of out-of-wedlock pregnancies and establish

annual numerical goals for preventing and reducing the incidence of these pregnancies; and encourage the formation and maintenance of two-parent families,”⁹³ or “activities promoting responsible fatherhood.”⁹⁴

As early as 1970, however, in *Dandridge v. Williams*,⁹⁵ the Supreme Court endorsed state interference with family planning. Discussing the manner in which Maryland chose to implement AFDC,⁹⁶ the Court pointed out that Congress created AFDC to promote a certain vision of the family, and the child’s place within it.⁹⁷ In addition, Maryland argued, and the Court affirmed, that it had “legitimate state interests in encouraging gainful employment, in maintaining an equitable balance in economic status as between welfare families and those supported by a wage-earner, in providing incentives for family planning, and in allocating available public funds in such a way as fully to meet the needs of the largest possible number of families.”⁹⁸ The Court then permitted the State of Maryland to cap its payments per family, thus providing less money per child to larger families. The intent was to encourage family planning; the effect may have been to require parents in large families to farm out their children to be raised by designated relatives.⁹⁹ This sort of social engineering through the family is precisely the type of regime contemplated by TANF.¹⁰⁰

⁸⁸ Morgan B. Ward Doran & Dorothy E. Roberts, *Welfare Reform and Families in the Child Welfare System*, 61 MD. L. REV. 386, 393 (2002).

⁸⁹ Morgan B. Ward Doran & Dorothy E. Roberts, *Welfare Reform and Families in the Child Welfare System*, 61 MD. L. REV. 386, 393 n.39 (2002) (citing *King v. Smith*, 392 U.S. 309, 334 (1968); *Van Lare v. Hurley*, 421 U.S. 338, 346 (1975); *Lewis v. Martin*, 397 U.S. 552, 559-60 (1970)).

⁹⁰ See, e.g. Morgan B. Ward Doran & Dorothy E. Roberts, *Welfare Reform and Families in the Child Welfare System*, 61 MD. L. REV. 386, 393(2002); *King v. Smith*, 392 U.S. 309, 334 (1968).

⁹¹ See 42 U.S.C. §§601-603.

⁹² Morgan B. Ward Doran & Dorothy E. Roberts, *Welfare Reform and Families in the Child Welfare System*, 61 MD. L. REV. 386, 388-89 (2002). See also 42 U.S.C. §§602(a)(1)(A); 603(a)(4), (5)(E); 607(c)-(e); 608(b).

⁹³ 42 U.S.C. §601(a)(3)-(4).

⁹⁴ 42 U.S.C. §603(a)(2)(C).

⁹⁵ 397 U.S.C. §471 (1970).

⁹⁶ 42 U.S.C. §601 et seq. (1964 ed. and Supp. IV).

⁹⁷ *Dandridge v. Williams*, 397 U.S.C. 471, 479 (1970) (“Congress wished to help children through the family structure.”).

⁹⁸ *Dandridge v. Williams*, 397 U.S.C. 471, 484 (1970).

⁹⁹ *Dandridge v. Williams*, 397 U.S.C. 471, 479-84 (1970).

¹⁰⁰ State-sponsored social engineering cannot, however, conflict with the Congressional purposes of welfare. See *King v. Smith*, 392 U.S. 309, 334 (1968).

Community Voices: Healthcare for the Underserved

Similarly, in *Harris v. McRae*,¹⁰¹ decided a decade later, the Court held that Congress could deny Medicaid coverage for abortions, thereby “making a value judgment favoring childbirth over abortion, and . . . implement[ing] that judgment by the allocation of public funds.”¹⁰² The Court essentially employed the familiar distinction between positive and negative liberty: the result is that, in the welfare context, the constitution only protects negative liberty from government interference with various rights. Individuals certainly have freedom from invidious state discrimination that places barriers in their way. But “although government may not place obstacles in the path of a woman’s exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category.”¹⁰³

In *Dandridge vs. Williams*, the Court noted that, “Although a State may adopt a maximum grant system in allocating its funds available for AFDC payments without violating the Act, it may not, of course, impose a regime of invidious discrimination in violation of the Equal Protection Clause of the Fourteenth Amendment.”¹⁰⁴ Thus, a law refusing to apply federal welfare law on the basis of race or gender would violate the Equal Protection Clause.

Part of the problem in both *Dandridge* and *McRae* is that in neither case does the state discriminate against a suspect classification. In neither *Dandridge* nor *McRae* is the suspect class “women,” nor even “women-seeking-a-large-family” or “women-seeking-an-abortion.” Rather, the class in *Dandridge* is “indigent-parents-seeking-funding-for-large-families,” and in *McRae* “indigent-women-seeking-state-funded-abortion.” The *McRae* Court noted that “the principal impact of the [Congressional prohibition on providing abortions through Medicaid] falls on the indigent. But that fact does not itself render the funding restriction constitutionally invalid, for this Court has held repeatedly that poverty, standing alone is not a suspect classification.”¹⁰⁵ Accordingly, the Supreme Court applied a rational basis test to state and federal Medicaid statutes despite the use of gender stereotypes or the promotion of certain types of family organization.¹⁰⁶

TANF is generally a welfare provision. Rather than providing an unlimited amount of matching funds for family welfare programs, TANF delegates the development of child care policies to the states, and funds them through a mandatory block grant for child care to low-income families. It is intended to apply to children and their guardians, irrespective of gender. The Welfare Reform Law of 1996 does not expressly classify those people who can receive TANF by gender: rather, it requires the states administering TANF to engage in a range of educational programs to promote good parenting.¹⁰⁷

¹⁰¹ 448 U.S. 297 (1980).

¹⁰² *Harris v. McRae*, 448 U.S. 297, 314 (1980) (citation and internal quotation omitted).

¹⁰³ *Harris v. McRae*, 448 U.S. 297, 316 (1980).

¹⁰⁴ *Dandridge v. Williams*, 397 U.S.C. 471, 483 (1970).

¹⁰⁵ *Harris v. McRae*, 448 U.S. 297, 323 (1980).

¹⁰⁶ *Dandridge v. Williams*, 397 U.S.C. 471, 485, 487 (1970).

¹⁰⁷ See 42 U.S.C. §§601-603; 607-08.

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

TANF, though strongly regulating the indigent family, does not, however, condition receipt of funding upon the performance of certain gender roles; nor does it limit funding to a particular gender. On the face of the statute, it does not engage in the sort of discrimination necessary to draw intermediate scrutiny.

TANF may, however, engage in surreptitious discrimination that has a disparate impact on men and women. Certainly, TANF engaged in a range of goals that have a direct impact upon families, and potentially gender roles within those families. For example, TANF's redefinition of welfare's goals includes reducing non-marital pregnancies and promoting two-parent families. As a result of its definition of family, in 2005, there were 112,986 male adult recipients of TANF and 979,032 female adult recipients of TANF.¹⁰⁸

There thus appears to be a significant disparate impact: almost nine times as many women receive federal funding as men. The disparate impact analysis does not end there, however: courts have to look beyond the statute to determine whether there was a sufficient intent or animus to exclude men from receiving aid through the TANF program. Sources of the required circumstantial evidence include the congressional debates surrounding TANF and the Republican *Contract with America*.¹⁰⁹

¹⁰⁸ See OFFICE OF FAMILY ASSISTANCE, TABLE 30 — CONTINUED” TEMPORARY ASSISTANCE FOR NEEDY FAMILIES — ACTIVE CASES: PERCENT DISTRIBUTION OF TANF MALE/FEMALE ADULT RECIPIENTS BY EMPLOYMENT STATUS, OCTOBER 2004 SEPTEMBER 2005 at <http://www.acf.hhs.gov/programs/ofa/character/FY2005/tab30b.htm>.

¹⁰⁹ CONTRACT WITH AMERICA: THE BOLD PLAN BY REP. NEWT GINGRICH, REP. DICK ARMEY AND THE HOUSE REPUBLICANS TO CHANGE THE NATION (Ed Gillespie & Bob Schellhas eds., 1994). Pointing to the link between the *Contract with America* and TANF is the approach taken by Jill Elaine Hasday. See Jill Elaine Hasday, *Parenthood Divided: A Legal History of*

Most critiques of TANF focus on its negative redefinition of the value of child rearing, and so the *woman's* role in the family. TANF's demand that parents find work within twenty-four months and receive federal payments for a lifetime maximum of five years¹¹⁰ appears to denigrate the child-rearing activities of indigent women, much in the manner sponsored by the *Contract with America*.¹¹¹ Accordingly, TANF promotes a picture of motherhood, marriage, and family life that strongly endorses a conservative version of both the father's and mother's role and “family values.”¹¹²

The purpose of TANF may be “to regulate families in which there was no father able to support his dependents, and the mother had called on the state for economic assistance. [Like ADC and AFDC, TANF] functioned on the guiding principle that where either parent in these families was concerned, the law needed to be suspicious of parental judgment, eager to scrutinize parental conduct, and anxious to limit parental autonomy and reshape parental relations.”¹¹³

That focus on the family is, however, the problem for making a disparate impact claim. Regulating indigent families, even when such regulation impacts men more *the Bifurcated Law of Parental Relations*, 90 GEO. L.J. 299 (2002).

¹¹⁰ 42 U.S.C. §§602(a)(1)(A)(ii); 608(a)(7).

¹¹¹ Jill Elaine Hasday, *Parenthood Divided: A Legal History of the Bifurcated Law of Parental Relations*, 90 GEO. L.J. 299, 364 (2002); CONTRACT WITH AMERICA: THE BOLD PLAN BY REP. NEWT GINGRICH, REP. DICK ARMEY AND THE HOUSE REPUBLICANS TO CHANGE THE NATION 65-71 (Ed Gillespie & Bob Schellhas eds., 1994).

¹¹² See 42 U.S.C. §§601-03.

¹¹³ Jill Elaine Hasday, *Parenthood Divided: A Legal History of the Bifurcated Law of Parental Relations*, 90 GEO. L.J. 299, 359 (2002).

Community Voices: Healthcare for the Underserved

harshly than women, is a permissible goal of welfare. Under the *Dandridge* and *McRae* analyses, however, the focus is on family structure; men are as able to participate in family life as women, and to choose to marry or not, as they (and their partner) please. TANF does not preclude that choice; it simply incentivizes it by favoring marriage.

C. Prison Health Provision

Although prison health care is a right established by the Eighth Amendment to the United States Constitution, the standard for health care inside prison is significantly lower than that outside the prison. Mere “negligence,” “inadverten[ce]” or “inadequately attending to [a prisoner’s] medical needs” is insufficient, to establish a violation of the right to health care.¹¹⁴ Instead, a prisoner must demonstrate the state or a doctor acted with “*deliberate indifference*.”¹¹⁵ Furthermore, “[b]ecause society does not expect that prisoners will have unqualified access to health care, deliberate indifference to medical needs amounts to an Eighth Amendment violation only if those needs are ‘serious.’”¹¹⁶

States thus operate under a constitutional permission to provide something less than the type of health care considered appropriate outside prison, particularly for non-serious medical needs.

In part, this is due to the “penal harm movement”¹¹⁷ that seeks to undermine the dignity of the prisoner, and treat him or her as worthy of less consideration than people (including the indigent) living outside the prison. Under this “principle of less eligibility”¹¹⁸ prisoners *should* be treated worse than the worst off in society. The point is to “mak[e] imprisonment more painful by reducing amenities and services and in resurrecting sanctions such as chain gangs. Supporters of such measures typically characterize medical care as a luxury that government cannot afford to provide free of charge to inmates and should not provide to inmates without a strict assessment of needs.”¹¹⁹

The deliberate indifference standard enables states implicitly to endorse penal harm as a goal and less eligibility as a value so long as the health care provided is not directed at inflicting pain or punishment. Thus, the central problem with encouraging Congress to change direction and provide Medicaid funding for prisoners is that such funding would not automatically resolve the issue of deliberate indifference. The deliberate indifference standard implicates the state’s willingness to care for inmates, irrespective of funding. What is most relevant is the state’s attitude to prisoners, particularly in the selection of programs and delivery of services. If a state adopts the principle of less eligibility, then under the deliberate indifference standard it may prioritize other categories

¹¹⁴ *Estelle v. Gamble*, 429 U.S. 97 104(1976); *Wilson v. Seiter*, 501 U.S. 294, 297 (1991).

¹¹⁵ *Wilson v. Seiter*, 501 U.S. 294, 297 (1991) (internal quotations omitted) (emphasis added).

¹¹⁶ *Hudson v. McMillian*, 503 U.S. 1, 9 (1992); *Estelle v. Gamble*, 429 U.S., at 103-104 (1976).

¹¹⁷ Michael S. Vaughn & Leo Carroll, *Separate and Unequal: Prison Versus Free-World Medical Care*, 15 JUST. Q. 3, 5 (1998).

¹¹⁸ Michael S. Vaughn & Leo Carroll, *Separate and Unequal: Prison Versus Free-World Medical Care*, 15 JUST. Q. 3, 4 (1998).

¹¹⁹ Michael S. Vaughn & Leo Carroll, *Separate and Unequal: Prison Versus Free-World Medical Care*, 15 JUST. Q. 3, 5-6 (1998).

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

of individuals as more deserving of health care, even to the neglect of its prison population. If this is the express or implicit policy of the state, then its federal funding is unlikely to provide the solution to what is, at bottom, an attitudinal issue.

Requiring federal co-payment for prison health care would not remedy a problem that depends upon a philosophical policy of state under-funding. Worse, it may aggravate the re-institutionalization of ill indigents. The problem is, after all, one of the allocation of scarce federal and state resources among the indigent population, whether in or out of prison. One fear behind the provision of federal subsidies to state prisons is not that people will commit crimes to get into prison, but that more people who are ill and commit crimes, even minor ones, will be channeled into prison as a form of institutionalized health care. Federal funding thus provides a perverse incentive to incarcerate the indigent. In particular, target populations include drug addicts, who lose or have lost their federal coverage upon conviction, and the mentally ill, two groups of people who do not receive sufficient care on the “outside.”

Even without federal co-payments or increased access to Medicaid for indigent men, a major problem remains the state’s failure to adequately prepare inmates for the transition from jail or prison back to society. Worst affected are those who have permanently lost coverage as a result of incarceration; but there will be others who never had coverage, or who are eligible for Medicaid coverage on reentry. Essential parts of transition planning are to use

transition planning teams and community collaborations to ensure continuity of care, to determine which prisoners are eligible for benefits, and to assist them in completing applications for benefits.

It is instructive to compare the treatment of inmates by the jail and prison systems to the treatment of the homeless by state or private hospitals. Both these institutions have traditionally failed to engage in adequate discharge planning for the indigent and homeless.¹²⁰ In the context of hospitals, the federal government, however, has devoted funding to help improve this type of transition and developed a series of recommendations for hospitals to follow.

The recommendations stress that discharge planning for homeless people is about “community re-entry,” connecting the about-to-be discharged patient with community resources, and that making these linkages requires institutions to enter into active collaborations with community providers. Discharge planning needs to be conceived as a team effort that includes the patient, the institution, someone knowledgeable about community resources and a community case manager or other person responsible for following up with the consumer to ensure the implementation of the discharge plan.¹²¹

¹²⁰ See Sidney Watson. *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357 (2000).

¹²¹ See Sidney Watson. *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 373 (2000).

Community Voices: Healthcare for the Underserved

Failure to engage in adequate discharge planning violates Medicaid.¹²² Furthermore, if repeated re-institutionalization is a result of poor discharge planning, such that mentally ill individuals are cycled repeatedly through jail simply as a result of their illness, then it may fall foul of the Americans with Disabilities Act “because it unnecessarily institutionalizes and segregates people who can be housed and treated in the community.”¹²³ In the hospital context, some states require discharge planning, creating a legally enforceable right to transition preparation and aftercare.¹²⁴

While the analogy to hospital discharge of the homeless does not point to an absolute right to discharge planning, it does indicate a possible means of arguing that a failure to engage in such treatment constitutes a failure of health care. If it does not rise to the level of deliberate indifference, then it provides some direction for future legislation on behalf of indigent prisoners.

CALL TO ACTION

In light of limited policy and legal remedies to address the legislative restrictions and barriers to health coverage for the poor and stigmatized in our society, it is necessary to stir the collective consciousness and find the political will to institute meaningful and necessary changes.

¹²² 42 U.S.C. 1395x (ee); 42 C.F.R. §482.43; *see also* Sidney Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 377 (2000).

¹²³ *See* Sidney Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 377 (2000) (citing *Olmstead v. L. C.*, 119 S. Ct. 2176 (1999)).

¹²⁴ *See* Sidney Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS U. PUB. L. REV. 357, 379-380 (2000) (citing *Heard v. Cuomo*, 610 N.E. 2d 348 (1993) and *Koskinas v. Carrilo*, 625 N.Y.S.2d 546 (1 Dept. 1995)).

It is also imperative that we consider that the urban poor are creating economic opportunity in rural areas for a variety of reasons including poverty and the inappropriate use of racial profiling and racism. What is the rural area commitment to those urban poor that are improving the economic profile of rural communities that are often quite different racially and ethnically from those behind the fence? Even if what they give is extra oral health providers and mental health counselors to provide quantity, quality, and culturally competent, this would be a promising premise. We must ask ourselves if we should build these edifices in the race to incarcerated in places that do not have the infrastructure to serve the population, based on their provider numbers and composition. Moreover, we must ask ourselves what is the risk to providers to providing care in a system in which infectious diseases such as tuberculosis, hepatitis B and C, and HIV/AIDS are not identified and treated? This not only impacts urban communities but also place rural communities at risk.

As a call to action, we propose the following recommendations:

- In order to ensure that inmates receive needed health services upon release, legal strategies must be researched and litigated that address inadequate discharge planning.
- Medicaid should provide ‘incentives’ to states to provide the full complement of oral health and mental health services.

Failing Health: The Crisis of Health Care for Indigent Offenders and for the Community

- Medicaid coverage must be re-initiated or initiated for those becoming eligible on the day of release to all those returning to community and states and federal governments should be required to pay for such coverage.
- State policy must ensure that inmates who remain eligible for Medicaid have their benefits reinstated upon release so they can access needed medical services immediately. Incentives and penalties should ensue when Medicaid benefits are not immediately initiated.
- Co-payment for primary health care services, including oral health services received in prison, must be outlawed and entities guilty of violating this law must risk the loss of all local, state, and federal income support.
- All federally-funded and state-supported community-based clinics must have an approved and auditable plan for how they will work collaboratively with jails and prisons to ensure health care to include local district attorneys and departments of corrections in their area of service or risk loss of their status and funding.
- A system of data collection must be initiated that integrates the health data of prisoners (including Medicaid eligibility and reinstatement data) with the data of communities to provide an accurate assessment of the health status and health disparities in communities and, in particular, inmates and former inmates. Analysis of such data will foster systems changes that will lead to a more comprehensive system of health care to those communities and individuals in greatest need of care.
- An organization such as the Institute of Medicine should review and recommend standards for quality health care that include mental health, substance abuse, oral health, and restorative care, promote their use, and enforce laws and regulations to ensure quality care.
- Because inmate health does not exist in a vacuum, policymakers must address the other barriers and hidden sanctions that impact the health of inmates and of the communities to which they return. Recommendations include addressing barriers to housing, employment, welfare and food stamp eligibility, and restrictions on educational benefits.
- A national accrediting body should be empowered to ensure that all prisons are accredited by the appropriate regulatory body. A system of accreditation is available but is not mandatory. No standards of care may compromise the care that individuals receive or the care that health providers in prison can deliver.

Data Tables

- All prisoners must be released with state-issued personal identification that does not identify the individual as coming from prison but that does allow the individual to seek housing and other benefits so that health care providers can locate and track the individuals to deliver services.
- For those former inmates involved in reentry programs and who are Medicaid eligible, they must receive one year of Medicaid coverage with visits mandated by parole and probation, in coordination with public/community/primary health care entities to protect the public from infectious disease.
- A continuum of care must become mandatory just as discharge planning from hospitals is mandatory to those exiting hospitals and not engaged with the criminal justice system. This bifurcated standard implies a dismissal of the need for follow-up and treatment, no commitment to track and treat, in collaboration with public health or primary health care systems infectious diseases and efficacy of treatment, and lack of a system of care that will take the initiative in service provision to those who have paid their debt to society.
- Judges should be more vigilant on mental health screening and other health care needs as a part of sentencing so as to give the state systems guidance on the care to be provided.

CONCLUSION

Without some form of health care provision, America's jails and prison incubate and transmit disease while stripping the indigent of health care coverage. Much of this is due to a policy of denigrating prisoners as less deserving than the rest of society. Yet it is the rest of society that bears the burden of the healthy returning from prison sick without health care funding, which has often been terminated by the state prison system or outlawed under federal statute. What is most profoundly required, however, is a change of policy in terms of welfare eligibility and standards of prison health care. Both these programs have increasingly restricted quality health care for the indigent. The impact of these restrictions is felt by everyone, but most particularly by the poor and mostly urban communities that must try to absorb ill and indigent prisoners as they reenter the community.

Number of Prisoners Under State or Federal Jurisdiction

Prisoners under the jurisdiction of State or Federal correctional authorities

Period	U.S. total	Federal	State
6/30/2006	1,556,518	191,080	1,365,438
12/31/2005	1,526,470	187,618	1,338,852
6/30/2005	1,513,966	184,484	1,329,482

Sabol, W.J., Minton, T.D. and Harrison, P.M. (2007). *Prison and jail inmates at midyear 2006*. (Bureau of Justice Statistics Bulletin, NCJ 217675). Retrieved September 10, 2007, from <http://www.ojp.usdoj.gov/bjs/abstract/pjim06.htm>

Number of State and Federal prisoners in the seven largest jurisdictions, June 30, 2006

Jurisdiction	Number of prisoners	Percent of total	Cumulative Percentage
U.S. total	1,556,518	100.0%	
Federal	191,080	12.3	12.3%
California	175,115	11.3	23.5
Texas	172,889	11.1	34.6
Florida	91,001	5.8	40.5
New York	63,295	4.1	44.5
Georgia	51,549	3.3	47.9
Michigan	50,701	3.3	51.1

Sabol, W.J., Minton, T.D. and Harrison, P.M. (2007). *Prison and jail inmates at midyear 2006*. (Bureau of Justice Statistics Bulletin, NCJ 217675). Retrieved September 10, 2007, from <http://www.ojp.usdoj.gov/bjs/abstract/pjim06.htm>

Number of inmates in local jails on June 30, 2000, 2005, and 2006

	2000	2005	2006
Average daily population ^a	618,319	733,442	755,896
Number of inmates, June 30	621,149	747,529	766,010
Adults	613,534	740,770	759,906
Male	543,120	646,807	661,329
Female	70,414	93,963	98,577
Juveniles ^b	7,615	6,759	6,104
Held as adults ^c	6,129	5,750	4,836
Held as juveniles	1,489	1,009	1,268

Sabol, W.J., Minton, T.D. and Harrison, P.M. (2007). *Prison and jail inmates at midyear 2006*. (Bureau of Justice Statistics Bulletin, NCJ 217675). Retrieved September 10, 2007, from <http://www.ojp.usdoj.gov/bjs/abstract/pjim06.htm>

The Number of Prisoners Held in Private Facilities, June 30, 2000-2006

Year	Total	Federal	State	Percentage of All Prisoners
2000	90,542	15,524	75,018	6.5%
2001	91,953	19,251	72,702	6.5
2002	93,912	20,274	73,638	6.5
2003	95,522	21,865	73,657	6.5
2004	98,901	24,768	74,133	6.6
2005	101,720	26,544	75,176	6.9
2006	111,975	27,108	84,867	7.2

Sabol, W.J., Minton, T.D. and Harrison, P.M. (2007). *Prison and jail inmates at midyear 2006*. (Bureau of Justice Statistics Bulletin, NCJ 217675). Retrieved September 10, 2007, from <http://www.ojp.usdoj.gov/bjs/abstract/pjim06.htm>

Inmates in Custody of State or Federal Prison Authorities Known to be HIV Positive, Year-end 2002-04

Jurisdiction ^a	Total HIV cases ^b			HIV cases as a percent of total custody population ^c		
	2004	2003	2002	2004	2003	2002
U.S. total						
Reported ^d	23,046	23,663	23,866	1.8%	1.9%	1.9%
Comparable reporting ^e	22,961	23,653	23,808			
Federal	1,680	1,631	1,547	1.1%	1.1%	1.1%
State	21,366	22,032	22,319	1.9	2.0	2.0

^aAt year-end 2001 responsibility for housing District of Columbia sentenced felons was transferred to the Federal Bureau of Prisons.

^bCounts published in previous reports have been revised.

^cPercentages are based on custody counts, except for New Mexico for which percentages are based on its jurisdiction count.

^dExcludes inmates in jurisdictions that did not report data.

^eExcludes data from Maine, Kentucky, Alaska, and Oregon for all three years due to incomplete reporting.

^fThe number of HIV-positive inmates in California was estimated by applying the percentage of inmates known to be HIV positive in 2002 to the 2004 custody population.

Maruschak, L.M. (2007). *HIV in prisons, 2004*. (Bureau of Justice Statistics Bulletin, NCJ 213897). Retrieved September 10, 2007, from <http://www.ojp.usdoj.gov/bjs/abstract/hivp04.htm>

Percent of Jail Inmates Reporting Specific Current Medical Problems, by Gender and Age, 2002

Current medical problem	All inmates	Gender		Age			
		Male	Female	24 or younger	25-34	35-44	45 or older
Arthritis	12.9%	12.0%	19.4%	5.3%	9.4%	16.6%	32.5%
Asthma	9.9	8.7	19.4	10.9	10.8	8.9	7.3
Cancer	0.7	0.5	2.5	0.2	0.7	0.6	2.2
Diabetes	2.7	2.5	4.1	0.6	2.3	2.9	8.4
Heart problem	5.9	5.5	9.2	4.4	4.6	6.4	11.7
Hypertension	11.2	10.8	14.1	5.3	8.5	14.3	26.1
Kidney problems	3.7	3.0	8.9	2.3	4.0	4.4	4.8
Liver problems	0.9	0.8	1.6	0.1	0.4	1.3	3.4
Paralysis	1.3	1.3	1.3	0.3	1.3	1.7	3.1
Stroke	3.2	3.2	3.3	1.3	2.9	4.9	4.8
Hepatitis	2.6	2.3	5.0	0.4	1.4	4.6	7.2
HIV	1.3	1.2	2.3	0.2	1.1	2.1	2.7
STDs	0.9	0.8	2.0	0.7	0.7	1.0	1.7
Tuberculosis*	4.3	4.3	4.0	2.2	3.8	5.3	8.6

*Includes all inmates who reported ever having TB.

Maruschak, L.M. (2006). *Medical Problems of Jail Inmates* (Bureau of Justice Statistics Special Report, NCJ 210696). Retrieved September 10, 2007, from <http://www.ojp.usdoj.gov/bjs/abstract/hivp04.htm>

NOTE: Jails are correctional facilities, operated by state or municipal governments that confine persons before or after adjudication by the criminal justice system. Those inmates that remain in jail after sentencing are usually those sentenced to less than a year of incarceration. Jails also receive individuals pending arraignment and hold them during their stay in the criminal justice system. They also hold probation, parole, and bail-bond violators, and may hold juveniles awaiting transfer to juvenile court, or mentally ill persons awaiting transfer to mental health facilities.¹ Individuals in prison are generally those sentenced to one year or more of incarceration.

OUR P OUR N

The National Center for Primary Care (NCPC) has the unique distinction of being the only congressionally sanctioned center in the country dedicated to promoting optimal health care for all, with a special focus on serving underserved communities. Headquartered at the Morehouse School of Medicine, the NCPC is committed to the pursuit of a healthier nation.

Editor In Chief

Henrie M. Treadwell, Ph.D.

Director, Community Voices

Associate Director, Development

National Center for Primary Care

Morehouse School of Medicine

720 Westview Drive, SW

Atlanta, GA 30310

Office: 404-756-8914

Fax: 404-752-1198