Health Care in New York State Prisons

Linda Sollish Sikka
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INTRODUCTION

The Department of Correctional Services (DOCS) of the State of New York is responsible for the confinement, care, treatment, and rehabilitation of tens of thousands of prisoners each year. The State Departments of Mental Hygiene, Health and Education as well as the Commission of Correction and the Health Planning Commission also have statutory responsibility for the health care of inmates. The number of inmates in state custody as of March 31, 1991 was reported to be 54,746. They are housed in facilities across the state which vary according to capacity and degree of security. Funding for administration of the system comes primarily from the state coffers, with certain costs reimbursed by the Federal government. In fiscal year 1990, total

1. Linda Sollish Sikka is a graduate of the University at Buffalo School of Law. Ms. Sikka, Ph.D., J.D., dedicates this article to Julio, an inmate whose medical problems led her to investigate the issue of health care for prisoners.

2. Reported by the New York State Department of Correctional Services, included in Table H-17 of the 1992 NEW YORK STATE STATISTICAL YEARBOOK, at 254. This table does not include persons held in county jails and penitentiaries or those under custody in New York City correctional facilities.

3. There are fifteen maximum security, thirty-five medium security, and twenty-one minimum security facilities, in addition to ten prisons reserved for female inmates. The maximum security prisons house over 19,400 persons. There are over 25,700 held under medium security, and over 9,500 in minimum security arrangements. Id.

4. For example, New York State is reimbursed for costs related to the incarceration of Cuban prisoners who entered the United States at the time of the Mariel boatlift. STATE OF NEW YORK EXECUTIVE BUDGET 94 (April 1, 1988
DOCS expenditures amounted to almost $1.1 billion, which included approximately $112 million for health care costs.\(^5\)

The cost of providing health care to prisoners is considerable and bound to increase. In part, the figure will climb as a result of the rapidly rising number of inmates afflicted with AIDS, but the problem is not exclusively AIDS-related.\(^6\) Greater numbers of middle-aged and elderly prisoners, who require more and more expensive medical attention, will contribute to the increase in expenditures, as will more expensive medications, medical supplies, testing procedures, transportation, and physicians' services.

It is in the state's best interest to provide quality health care to persons in its custody, despite the cost. Failure to do so shifts the burden to the community at large when inmates are released, and contributes to the cycle of illness, unemployment and crime which leads to recidivism. Therefore, although improving health care for prisoners costs more in the short term, it ultimately represents a long-term savings.

Health care for prisoners is an unpopular theme for reflection or discussion, but it cannot be ignored. International bodies, professional associations, the United States Supreme Court,

\(^{5}\) U.S. DEPARTMENT OF JUSTICE, SOURCEBOOK OF CRIMINAL JUSTICE STATISTICS - 1990 (Kathleen Maguire & Timothy J. Flanagan eds., 1991), at 13 [hereinafter SOURCEBOOK]. This data collected by the National Commission on Correctional Health Care in Spring 1990 is included in Table 1.9. Mental health services as well as medical and dental care are included in the figures. In his budget presentation for 1991-1992, Governor Cuomo briefly mentioned a reconfiguration plan for the prison system. Certain facilities located near each other will be regionalized, clustered into "Hubs" in an effort to eliminate duplicate staffing and achieve improved service and more economical administrative and maintenance operations. The four "Hubs" planned for 1991-1992 are expected to save more than $24 million (see STATE OF NEW YORK EXECUTIVE BUDGET 1991-92).

\(^{6}\) The number of prisoners with AIDS has increased to six times the 1983 rate. EXECUTIVE BUDGET 1988-89, supra note 4, at 95.
federal and state courts, and state legislatures all have addressed the issue. This article will explore some of the debate and the factors peculiar to the correction system which make implementation of court holdings and recommendations difficult. It will also relate some sobering statistics that should assist those in positions of power to make rational, practical decisions.

STANDARDS PUBLISHED OUTSIDE NEW YORK STATE

The incarceration of prisoners on criminal or political grounds is as much a fact of contemporary life as it was in earlier centuries. What distinguishes the practice today is the recognition that it ought to be informed and regulated by certain objective standards. It is widely acknowledged, if not always practiced, that each person is entitled to expect that his rights will be respected, even, and perhaps especially, if he happens to be in prison. The fact that an individual is incarcerated, unable to fend for or defend himself, or to move about freely in an attempt to seek out alternatives to what his caretakers offer, renders him utterly dependent. Equity places a special burden on those who exercise power over the prisoner to do so in accordance with objective, humane standards. This is particularly true in the area of health care, since a sick prisoner is, in a sense, doubly vulnerable.

7. "The constitutional protections afforded prisoners are not as extensive as those enjoyed by non-prisoners. Prisoners' rights are necessarily tempered both by the fact of their confinement and by the legitimate needs of penal administration. Yet it is well established that "[t]here is no iron curtain drawn between the Constitution and the prisons of this country." Douglas W. Dunham, Inmates' Rights and the Privatization of Prisons, 86 COLUM. L. REV. 1475, 1481 (1986).

8. "The Court's decision [in Estelle v. Gamble] also rested on a concept of 'fairness' that requires the state to take upon itself a special duty of protection when it imprisons a person and thereby deprives her of her ability to seek help from other sources." Lisa E. Heinzerling, Actionable Inaction: Section 1983 Liability for Failure to Act, 53 U. CHI. L. REV. 1048, 1053-1054 (1986).
There are many standards of health care for prisoners on the international and national level. The United Nations' Standard Minimum Rules for the Treatment of Prisoners, approved in 1957, include five rules devoted to medical services. There are recommendations on staffing, scope of services, and specialized treatment outside the prison. The rules also deal with accommodations in women's institutions for pre-natal and post-natal care and treatment of inmates and their children. In addition, the U.N. standards spell out proper screening and monitoring procedures for both men's and women's facilities. Finally, the rules outline the effect of incarceration on prisoners' health, and affirm the need to inspect regularly the quantity, quality, preparation and service of food, sanitary conditions, and the suitability and cleanliness of prisoners' clothing. There are even rules concerning physical education and sports.

The directors of departments of corrections of the federal and state, dominion and provincial governments of North America have published the Association of State Correctional Administrators, Policy Guidelines: Health Services. This document consists of detailed observations and suggestions for health maintenance and rehabilitation as it is affected by health. The directors discuss diagnosis and treatment, administrative procedures for effectively delivering health care in circumstances ranging from emergency to elective situations, record-keeping, preventive measures, environmental health and medical experimentation.

The second edition of Standards for Health Services in Correctional Institutions was published by the American Public


11. See id. at 217-222.
Health Association in 1986. It is a meticulously detailed, book-length treatment of the subject, encompassing services for special populations like children, adolescents, and the elderly as well as adult men and women. In addition to discussions of physical, mental, and dental health care services, it contains recommendations concerning environmental health, pharmacy services, record-keeping, staffing, and legal and ethical issues. Similarly thorough, though concentrating exclusively on the adult prison population, is the second edition of the American Correctional Association's Standards for Adult Correctional Institutions, published in 1981.\(^\text{12}\)

These are but a few of the published standards available.\(^\text{13}\) All these sources agree on the principles that ought to inform the delivery of medical services to prison inmates. Moreover, the recommendations spelled out in each of the standards are indistinguishable from general standards of good medical practice outside prison walls.

\(^{12}\) The American Correctional Association began to concern itself with improving the practices in correctional institutions in 1870, when it published its Declaration of Principles. AMERICAN CORRECTIONAL ASSOCIATION, STANDARDS FOR ADULT CORRECTIONAL INSTITUTIONS vii (1981).

IN THE PUBLIC INTEREST

CASE LAW

There are abundant decisions on both the federal and state
level which discuss the issue of prisoners' rights to medical care.
Suits brought in the first third of this century were generally for
the infliction of bodily injury resulting from the failure of prison
authorities to provide medical care. These early suits were treated
as simple negligence cases. 14 The duty to provide medical care
to the incarcerated was recognized in 1926 in Spicer v.
Williamson,15 when the court held "[i]t is but just that the public
be required to care for the prisoner, who cannot, by reason of the
depilation of his liberty, care for himself."16 In 1930, Hunt v.
Rowton17 held that the jailer breached his statutory duty to
provide adequate medical care when his failure to isolate a
prisoner diagnosed with smallpox resulted in the death of the
plaintiff's husband.18

In the 1960s, although cases alleging negligence of prison
authorities in discharging their statutory duties continued to be
brought,19 the majority of the challenges to medical care and
treatment of prisoners involved questions raised under the federal
Constitution. Cases usually alleged either denial or inadequacy of
medical treatment constituting cruel and unusual punishment under
the Eighth Amendment, or a denial of due process and equal
protection under the Fourteenth Amendment. The due process
right has been expressed "in terms of the inmate's right to be free

14. SOUTH CAROLINA DEPARTMENT OF CORRECTION, THE EMERGING RIGHTS
OF THE CONFINED 146 (1972) [hereinafter EMERGING RIGHTS].

15. 191 N.C. 487 (1926).

16. See EMERGING RIGHTS, supra note 14, at 490.

17. 143 Okla. 181 (1930).

18. See EMERGING RIGHTS, supra note 14, at 181.

from an abuse of discretion by prison administrators, protection from unconstitutional administrative action, [and] protection of an inmate's life and health from administrative action. 20 The Eighth Amendment right is invoked when necessary medical care is intentionally denied, or when a prison official demonstrates "deliberate indifference to [the] medical needs of inmates." 21

Courts were unsympathetic to the new focus, holding the Eighth Amendment inapplicable to the states. Often courts applied the "hands off" doctrine, holding that care and treatment of inmates was a matter of internal prison administration, and therefore one in which the courts would not interfere absent exceptional circumstances. 22 Although denial of medical treatment was acknowledged to be an exceptional circumstance, it generally was insufficient to outweigh the burden imposed by the "hands off" doctrine. Even in 1962, when Robinson v. California 23 held that the Eighth Amendment was applicable to the states, the effect was to increase reliance on the "hands off" doctrine. Moreover, the doctrine as applied to medical treatment was refined by three separate theories to limit the concept that the denial of medical care was tantamount to cruel and unusual punishment. 24

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21. Id.

22. EMERGING RIGHTS, supra note 14, at 147.


24. One theory was that an action for deprivation of civil rights could not be a substitute for a malpractice action under state remedies; it was used principally to defeat suits for damages under the Civil Rights Act. The second theory was that the refusal or failure to provide medical care had to be shocking or barbaric in order to qualify as cruel and unusual punishment. Finally, the courts maintained that they would not inquire into the adequacy of medical treatment for inmates, that adequacy of care was a matter for the physician to decide or, alternatively, that it was an institutional administrative matter with which the courts would not interfere. For a thorough discussion of these theories, see
The year 1970 saw some progress for prisoners' rights. *Tolbert v. Eyman*\(^\text{25}\) distinguished between professional medical personnel and lay prison officials, ruling that the court could inquire into the manner in which the latter carried out the treatment ordered by physicians. The same approach was used in *Sawyer v. Sigler*,\(^\text{26}\) in which the court recognized the physician's authority regarding adequacy of treatment and the prisoner's absolute right to the medical treatment prescribed by the physician. Any restrictions placed by prison authorities on the right to receive prescribed medical treatment were to be justified by a compelling interest, and accomplished by the minimum restriction possible.\(^\text{27}\)

Generally, an inmate is entitled to "reasonable medical care," or the level of care available to the general public.\(^\text{28}\) However, if there is a choice to be made between inexpensive palliative care and a moderately expensive curative treatment, the curative course must be followed.\(^\text{29}\) If a particular treatment is prescribed to relieve a diagnosed medical condition, the inmate's

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**EMERGING RIGHTS, supra note 14, at 147-149.**

25. 434 F.2d 625 (9th Cir. 1970).


27. See id. at 697-699.

28. In Priest v. Cupp, 545 P.2d 917 (Or. App. 1976), the court explained that inmates have no federal or state guarantees that they will be cured of medical disabilities while they are in custody. They can expect such medical care as is reasonably available under the circumstances of their confinement and medical condition.

29. In Ricketts v. Ciccone, 371 F.Supp. 1249 (W.D.Mo. 1974), the court held that a federal inmate was entitled to "the most suitable medical treatment reasonably available." *Id.* at 1256. The standard to be applied in adjudicating a claim for lack of medical treatment "is whether needed or essential, as opposed to desirable, treatment is being denied." *Id.* at 1255.
interest in receiving treatment outweighs that of the state in preserving its financial resources.\(^3\)

Events in the early 1970s, specifically a number of prison uprisings and a rapidly increasing prison population nationwide, focused attention on the inhumane conditions prevailing in U.S. prisons. The "hands off" doctrine gave way to an expectation that prison administrators should be able to justify their policies and practices. In *Procunier v. Martinez*,\(^3\) the Court held that administrators must show that the "regulation or practice in question furthers an important or substantial government interest," thus paving the way for a degree of accountability not previously required.\(^3\)

In deciding a class action suit that heavily emphasized medical issues and exposed scandalous conditions in an entire prison system, the court in *Newman v. Alabama*\(^3\) held that the Eighth Amendment had been violated by "rampant and not isolated deficiencies,"\(^3\) and that prisoners as a class had a constitutional right to appropriate medical care.

After *Newman*, there was a brief interval in which federal courts attempted to define a constitutional standard of care. Some courts required "reasonable care" and others held merely that if "some" care had been provided, the standard had been met.\(^3\)

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30. EMERGING RIGHTS, supra note 14, at 153. Also, Gates v. Collier, 501 F.2d 1291 (5th Cir. 1974), ruled in part that a lack of funds is not recognized as a defense or excuse in cases in which inadequate care has been provided.


32. AMERICAN PUBLIC HEALTH ASSOCIATION, STANDARDS FOR HEALTH SERVICES IN CORRECTIONAL INSTITUTIONS v (1986) [hereinafter STANDARDS].


35. STANDARDS, supra note 32, at v.
Constitutional adequacy of care is now defined by *Estelle v. Gamble*:^36^ 

Deliberate indifference to the serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain . . . proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with treatment once prescribed.

The Court cautiously added, however, that an inadvertent failure to provide adequate medical care does not constitute an "unnecessary and wanton infliction of pain," nor does an accident, simple negligence, or a disagreement concerning treatment options.^37^

Soon after the decision in *Estelle v. Gamble*, the prison health care delivery system in New York State's Bedford Hills Correctional Facility was held unconstitutional in *Todaro v. Ward*.^38^ In this case, the court ruled that proof of deliberate indifference did not require a showing of intent to harm an individual inmate. Systematic deficiencies may constitute deliberate indifference, and such deficiencies may be proved either by "a series of [individual] incidents closely related in time" or medical facilities and service delivery plans which are so wholly inadequate that suffering will be inevitable.^39^ A few years later, the Second Circuit ruled that economic reasons cannot excuse the

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37. *Id.* at 105-106.


imposition on jailed inmates of "genuine privation and hardship over an extended period of time." 40

NEW YORK STATE STATUTORY AUTHORITY

Statutory authority for providing health care to inmates in New York State prisons is set forth in the New York Correction Law. 41 For example, Section 45 of the law outlines the functions, duties and powers of the State Commission of Correction, which include the power to oversee and regulate the safety and health of those in state custody. Section 601 discusses the forwarding of medical records of prisoners entering a state correctional facility to the prison medical director. Section 137 mandates that the state evaluate each prisoner’s physical, mental and emotional condition, as well as the prisoner’s other needs and propensities. To prevent the spread of disease among the inmate population, new detainees are screened for health problems as soon as possible after arrival at the correctional facility.

Facilities and staff in New York State correctional institutions are not always adequate to diagnose and treat prisoners’ ailments. Section 70 of the Correction Law allows the Commissioner of Correction to enter into contracts for qualified persons to render professional services to a correctional facility. Section 23 permits inmates to be transported to outside hospitals where they can receive medical services unavailable in the prison facility. Leaves of absence for surgery or medical or dental treatment outside the prisons are granted only if the treatments are absolutely necessary to the inmates’ health and well-being. 42

40. Lareau v. Manson, 651 F.2d 96 (2d Cir. 1981).

41. The statutory law that follows is an overview of N. Y. CORRECT. LAW (McKinney 1987).

Provisions for pregnant inmates and their children born during incarceration are set forth in Section 611. New York Correction Law section 47(e) entrusts the correction medical review board with the duty to "investigate and report to the commission on the condition of systems for the delivery of medical care to inmates of correctional facilities and where appropriate [to] recommend such changes as it shall deem necessary and proper to improve the quality and availability of such medical care."

The New York Correction Law does not limit the provision of care to acute situations, nor does it preclude treatment of pre-existing conditions or even corrective or elective procedures. As long as the care can be shown to be absolutely necessary for the prisoner's health and well-being, it is considered justified. All inmates are covered by the health-related provisions of the New York Correction Law, irrespective of the length of their sentence.

43. Pregnant women are removed from prison before the anticipated birth of their children and are provided with comfortable accommodations and medical care in supervised, secure surroundings. They are returned to the prison as soon after the delivery as their health permits. The women or their relatives are expected to pay for the delivery; if they are unable to pay, it is paid for out of public resources. N.Y. CORRECT. LAW §611(1) (McKinney 1987).

Provided the mother is physically fit to care for the child, and provided the child's father or other relatives are unable to properly care for and maintain the child, the child may return to the correctional institution with the mother. It may remain there for a maximum of one year; if the mother is to be paroled from a state reformatory shortly after the child's first birthday, it may remain there with her for an additional six months. N.Y. CORRECT. LAW §611(2) (McKinney 1987). Section 611 also outlines the circumstances in which the medical officer of the correctional institution may remove the child to foster care. N.Y. CORRECT. LAW §611(2) (McKinney 1987).

44. The Facility Health Service Director is responsible for identifying inmates who should be admitted to outside hospitals for planned medical or surgical procedures. Legislative Commission on Expenditure Review, State Prison Inmate Health Services 27 (1981).
CARRYING OUT THE MANDATE

If providing health care to prisoners were merely a matter of allocating sufficient resources so that the system could adhere to standards of professional associations and conform to statutory and judicial mandates, the task would be considerably simpler than it is. Unfortunately, practical considerations involve more than finding the needed funds.

In a situation where security plays a central role and the majority of the patients are housed in remote locations, delivery of health care becomes complicated. Society’s fear of and scorn for its prisoners constitute another obstacle to compliance with legislative and judicial decrees. Finally, the increasing number of HIV-positive inmates and the special needs presented by elderly detainees have placed a significant strain on the system in recent years.

a) Economic obstacles

The $112 million spent by New York State in fiscal 1990 for correctional health services represented 10.2% of total corrections expenditures. Based on average daily population, the total inmate population for the same period was approximately 50,000. Since 1983, the number of individuals in custody has increased at an average annual rate of 8%. This growth is attributable in large part to higher arrest and conviction rates and strengthened State sentencing laws which require incarceration and longer terms of imprisonment.

As a result of the steady increase in the number of individuals in protective custody, New York State has had to construct new prison space and expand correctional services. In an effort to keep costs down and reduce overcrowding, the Earned Eligibility Program (EEP) was implemented. EEP improves the

45. SOURCEBOOK, supra note 5, at 13.

46. EXECUTIVE BUDGET 1988-89, supra note 4, at 93.
chances for parole for inmates who complete their assigned work and treatment programs by the end of their minimum sentence. The Shock Incarceration Program for non-violent, first-time felons allows inmates to become eligible for parole after successful completion of a program of structured physical activity and therapeutic counseling. When Governor Cuomo presented the Executive Budget for 1991-1992, he announced that the State's prison system would be regionalized by clustering facilities located near each other into "Hubs." The "Hubs" plan is designed to eliminate duplication in staffing, improve service and streamline administrative and maintenance operations within the New York State correctional system. The introduction of four "Hubs" in 1991-1992 was projected to reduce Department of Correctional Services (DOCS) operating costs by over $24 million.

Innovative programs for reducing the time prisoners spend in state custody and eliminating wasteful administrative procedures leave more funds available for health care. However, major problems must still be addressed.

Since not all correctional facilities are equipped to provide a full range of medical care, inmates must be transported elsewhere in secure vehicles to appointments or for hospitalization or emergency care. There must be sufficient numbers of corrections officers available to accompany them. The additional expense associated with transportation and security escorts is considerable, because most prisons are located in remote areas, while hospitals and physicians' offices are generally in or near population centers. However, savings are realized at the secure wards maintained by the DOCS at four locations within New York State. In-patient inmates are grouped together in these wards, thus decreasing security costs.

47. Id.
49. Id. at 15.
50. LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW, supra note 44, at 32.
Following the cost-effective principle of grouping inmates with similar needs together, the Legislative Commission on Expenditure Review recommended careful evaluation of each newly admitted inmate's health, allowing those with similar problems and requirements to be placed in the same specially-equipped facilities. Since a small number of chronically or acutely ill inmates use disproportionately more of the available health services, those inmates were to be placed together in specifically designated correctional facilities equipped and staffed to provide more intensive or specialty services.

It would be cost-effective for outside medical specialists to treat inmates on-site at the correctional facilities, but physicians have little incentive to do this, because they are compensated according to outdated fee schedules. In a 1981 analysis of the problem, the New York State Legislative Commission on Expenditure Review noted that "it is extremely difficult to find physicians who will work a 35 hour week at many upstate correctional facilities for the available compensation." The audit revealed severe anachronisms in the fee schedule. The discrepancies between the amounts allowed for reimbursing physicians in seven specialties and the then-current median fee in the eastern region of the United States ranged from 20-73 percent, with an average discrepancy of 55 percent.

Other problems are physicians' concerns about coping with unpleasant situations while treating inmates, delayed payment by the state, and time spent commuting and clearing security at the facility. Moreover, the fee schedule allowed for higher rates of reimbursement for physicians who examined inmates in their own

51. Id. at 90-91.

52. Id.

53. Id. at 49.

54. See id. at 26.
offices. Thus, physicians preferred to schedule patient visits at their own offices for their own convenience and efficiency.\footnote{55}{Id. at 25.}

b) Additional hurdles

Recruiting and retaining physicians to work in prisons on a full-time basis is difficult. In addition to low salaries and a rigid schedule, obstacles to locating doctors willing to practice in prisons include "lack of physician peer support; [the r]emote geographic location of most facilities; . . . low status and esteem in the community at large; [i]nsufficient resources within the health unit;" and abusive inmates and threats of lawsuits.\footnote{56}{Id. at 49.} The Health Manpower Advisory Committee of the State Health Planning Commission suggested another, less obvious factor: the sharp drop in the supply of foreign medical graduates has reduced the pool of available personnel.\footnote{57}{Id. at 50.}

Some of the Legislative Commission on Expenditure Review's recommendations to reduce the cost of inmate health care have been implemented.\footnote{58}{Id. at 50.} Prisons may now qualify under the New York State Physician Shortage Program as shortage areas. Under this program, physicians can have their medical school tuition waived in exchange for working in a designated shortage area for an equal number of years upon completion of their studies. Other programs also attempt to reduce the cost of inmate health care. Since 1991, New York State has had a cooperative

\footnote{55}{Id. at 25.}
\footnote{56}{Id. at 49.}
\footnote{57}{Id. at 50.} When the observation was made in 1980, inflation contributed to diminishing the State's ability to compete for physicians. \textit{Id.} In the present recessionary period, the amount of remuneration in the form of loan forgiveness is still pathetically low.

\footnote{58}{Information regarding implementation was received through telephone inquiries made to the Office of Admissions and the Residency Director in the Department of Family Practice at the State University of New York Medical School in Buffalo.}
agreement with the U.S. Public Health Service to manage the National Health Service Corps in New York State. The Corps pays for a student's medical education in exchange for service in rural areas or prisons. Similar State and Federal Loan Repayment Programs pay up to $15,000 and $25,000, respectively. In addition there is a State Loan Forgiveness Program that reimburses medical students up to a maximum of $10,000.59

The public perception of prison medicine discourages physicians from treating inmates in prisons, despite state and federal inducements to do so. A physician who participated in one of these programs suggested the real reason for the shortage is that doctors simply do not want to work in prisons.60

c) Special problems

In the last decade, the increasingly large numbers of HIV-positive and elderly inmates in correctional facilities have constituted an additional burden on the prison health care system. While both conditions place exceptional demands on resources, HIV-positive inmates are more troublesome due to the risk of contagion they represent.

1. HIV-positive inmates

According to figures published recently by the National Institute of Justice (NIJ) in its AIDS Bulletin,61 cumulative total inmate AIDS cases in the United States increased by 600% since


60. Interview with Dr. Yvette Walker, physician, Rikers Island Prison, City of New York (Nov. 25, 1992).

the first NIJ study in 1985 and by 72% since the fourth survey in 1988.

Between 1988 and 1989, the 72% increase in AIDS cases in prisons exceeded the 50% increase in cases in the general population.\textsuperscript{62} The higher incidence of AIDS among inmates is a result of the high concentration of individuals with histories of high-risk behavior, particularly intravenous (IV) drug use. Comparison of the incidence rate of AIDS with the rate in state and federal correctional systems, 202 cases per 100,000, in the entire U.S. population, about fifteen cases per 100,000 in 1989, dramatically underscores the difference.\textsuperscript{63} Although the disparity can be explained in part by a reduced rate of increase in the population at large and improved reporting and record-keeping in several correctional systems, the inescapable conclusion is that the number of AIDS victims in prisons is increasing at an alarming rate.

Currently, AIDS is the leading cause of death among inmates in New York State.\textsuperscript{64} This is principally due to the large numbers of inmates who are HIV positive and to the practice of sharing HIV-contaminated needles and syringes.\textsuperscript{65} In 1990, the New York State and New York City correctional systems appeared to have HIV seroprevalence rates in excess of 15%. At that time,

\begin{itemize}
  \item \textsuperscript{62} Id. at 4.
  \item \textsuperscript{63} Id.
  \item \textsuperscript{64} Louis A. Pagliaro & Ann M. Pagliaro, Sentenced to death? HIV infection and AIDS in prisons--Current and future concerns, 34 CAN. J. CRIMINOLOGY 201, 203 (1992).
  \item \textsuperscript{65} Id. at 205. Needle sharing has been reported to be a greater risk factor in prison than homosexual activity.
\end{itemize}
New York State corrections officials estimated that there were 8,000 HIV-infected prisoners in the prison system.\textsuperscript{66}

Treating New York State's large and rapidly increasing numbers of HIV-infected and AIDS-afflicted inmates has placed a great strain on the prison health care system. Dr. Robert Cohen, the former medical director of Rikers Island Prison and an expert on prison medical care, warns that the "extraordinary medical demands of the AIDS epidemic" threaten to overwhelm the "dangerously inadequate prison health care system."\textsuperscript{67} In treating AIDS patients, the New York State correctional system spent $6 million in 1990 for two medications alone.\textsuperscript{68}

Faced with criticism and legal challenges to the quality of health care provided to HIV-infected inmates,\textsuperscript{69} New York State has improved to a certain extent the medical services it provides to prisoners. The administration and fiscal management of the Division of Health Services has been centralized. Regular visits to all facilities have been instituted, leading to a thorough monitoring of health services. New and more qualified medical staff have been hired in many institutions. Several of the Special Needs Units, where some prisoners with AIDS are housed, have been renovated and upgraded. At the same time, more beds for prisoners with HIV at a new hospital facility have been added. A

\textsuperscript{66} THEODORE M. HAMMETT & ANDREA L. DAUGHERTY, 1990 UPDATE: AIDS IN CORRECTIONAL FACILITIES, ISSUES AND PRACTICES IN CRIMINAL JUSTICE 20 (1991). A study carried out in New York City in 1989 revealed that the seroprevalence rates among women inmates were considerably higher than those for men (25.6% v. 16.1%). The difference may reflect the fact that higher percentages of female inmates tend to be intravenous drug users.

\textsuperscript{67} Id. at 57.

\textsuperscript{68} AZT and aerosolized pentamidine. Id. at 57.

computerized system to increase efficiency in scheduling and transporting inmates to off-site medical appointments is planned.\(^\text{70}\)

If there is to be effective change, however, it will come as a result of modifying the behavior of those who have AIDS or risk contracting it. Alterations in administrative procedures and construction of improved treatment facilities contribute to dealing with the disease once it is contracted. However, the more desirable and, in the long run, more productive course of action is to attempt to control the spread of the disease by teaching inmates how to avoid high-risk behavior. According to Hammett, education and training programs "represent the cornerstone of efforts to prevent transmission of HIV infection in prisons and jails," and "most correctional administrators feel strongly that AIDS education and training are not options but absolute requirements."\(^\text{71}\)

Hammett emphasizes that educational programs are most effective if they include peer-led sessions, support groups, and individual counseling.\(^\text{72}\) Sixteen New York State facilities have active support group, counseling, and peer education programs with strong inmate involvement and administrative support. Perhaps the best-known program was initiated by female inmates at the Bedford Hills Correctional Facility. Called ACE (AIDS Counseling and Education), the program has the full support of DOCS. Offered in English and Spanish, it includes orientation sessions for incoming inmates and a pre-release program for those about to finish their sentences. Male inmates have organized similar programs. These include the Health Action Crisis Committee (HACC) in Green Haven Correctional Facility and the

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70. **HAMMETT & DAUGHERTY**, *supra* note 66, at 59-60.


Prisoners' Education Project on AIDS at Auburn Correctional Facility.\textsuperscript{73}

Mandatory or voluntary testing, often recommended to control the AIDS crisis, does not solve the problem of AIDS in correctional facilities. Inmates who test positive and are quarantined may raise Fourteenth Amendment issues of due process and equal protection, as well as Eighth Amendment issues of cruel and unusual punishment.\textsuperscript{74} Furthermore, testing and quarantine may contain the disease during incarceration, but they have no effect once the inmate is released. If the nature of the infection and the precautions necessary to lower the risk of exposing others are not explained to the HIV-infected prisoner, testing and quarantine represent stopgap measures at best.

Even if the inmate tests negative for HIV in prison, the inmate's lifestyle may put him or her at risk for contracting the disease. In such a case, being released from prison without having been taught how to avoid exposure reduces the significance of the negative test result to that of a mere statistic. It is of no practical value for the inmate to know that he or she is HIV negative at a given point in time, unless he or she has learned how to remain healthy after being released.\textsuperscript{75}

Several studies have shown that voluntary HIV testing in conjunction with counseling can change behavior. Moreover, it has been observed that at-risk individuals who test negative for HIV and undergo counseling will take measures to reduce the risk of infection. If most persons at risk are not yet infected, voluntary

\textsuperscript{73} Id. at 34-36. Due to resistance from prison officials who transferred most of the men involved in the project to other facilities, the program at Auburn has been inoperative since December 1989.


HIV prevention programs emphasizing counseling may be more effective than mandatory programs that stress testing.\textsuperscript{76} These conclusions support the approach taken by the Bedford Hills, Auburn, and Green Haven inmates.

2. Elderly inmates

According to figures released by the New York State Department of Correctional Services, there were 2,062 inmates aged fifty and over in state correctional facilities as of March 31, 1991.\textsuperscript{77} This number represented 3.8\% of the total inmate population,\textsuperscript{78} corresponding precisely to nationwide figures.\textsuperscript{79} Although there are relatively few elderly inmates at present, their numbers are increasing,\textsuperscript{80} and they will place ever greater demands on the state correctional system.

There are two types of older inmates. One group are individuals who have been involved in criminal activity throughout their lives, i.e., recidivists or multirecidivists who may spend many years of their lives in prison for various offenses. The second category consists of older people who have committed a crime after a lifetime of being law-abiding citizens.\textsuperscript{81} The first group typically occupies state prison cells, while the second is

\textsuperscript{76} Id. at 842.

\textsuperscript{77} Table H-20, 1992 NEW YORK STATE STATISTICAL YEARBOOK, supra note 2, at 256.

\textsuperscript{78} Id.


\textsuperscript{80} "The number of older inmates in state and federal correctional facilities has been increasing as a result of the aging of the general population and changes in arrest and sentencing patterns." Id. at 881.

Health Care

mostly incarcerated in local jails. The state health care delivery system is more concerned with the former group.

State inmates over the age of fifty are affected by the same kinds of health problems common to persons of their age group in the general population. However, as a consequence of the inmates' frequently poor health, smoking, and use of alcohol and drugs, the chances that older prisoners will develop cardiovascular and respiratory problems, cancer, neuropathy, and liver disease are greater than they are for the general public. In order to assess the demands older prisoners place on the health care systems of correctional facilities, one must consider their needs and the degree of care they require in comparison to younger inmates.

Rubenstein's profile of an elderly prisoner describes a man who functions at a lower level of intelligence than the younger inmates. He has a lower I.Q. and educational achievement level, and is twice as likely as the younger prisoners to suffer some mental defect. His general health tends to be poor, he is more likely to be divorced or widowed, and he often has no gainful employment and a less stable work record. There is a high incidence of alcohol abuse among elderly inmates, and their physical and mental condition has been found to deteriorate rapidly during their prison terms. A health survey conducted in the Iowa prison system found that 69.8% of elderly inmates were smokers, and 18.5% were former smokers. Moreover, 29.4% reported using illegal drugs.

If the profile is accurate and the number of elderly inmates continues to increase, there is reason to believe that in the near future, they will require proportionately more—and more costly—

\[\text{82. Delores Golden, Elderly Offenders in Jail, in id. at 143, 145.}\]

\[\text{83. Rubenstein says very few, if any, studies are conducted on the elderly female inmate. He reports that although women were included in some samples, the numbers were statistically insignificant. Supra note 81, at 156.}\]

\[\text{84. See id. at 157.}\]

\[\text{85. Colsher, supra note 79, at 882.}\]
medical care than younger prisoners. Since older inmates are naturally at greater risk of developing health problems which are expensive to treat, and are more likely to suffer ill health as a result of their personal habits, the cost of maintaining and treating older inmates is significantly higher than it is for similar numbers of younger prisoners. Therefore, health care for elderly prisoners in New York State and throughout the nation will require ever-greater expenditures as the prison population continues to age.

WHO CARES?

Why should New York State concern itself with the health of its prisoners? First, because federal and state courts have held that it must. Second, because the New York State Legislature has mandated it. Finally, because statistics demonstrate persuasively that it is both practical and economical to do so.

Over twenty-eight thousand persons were admitted to New York State correctional facilities in fiscal year 1990-91; 26,700 were released. The majority was not sentenced to life terms and minimum sentences generally did not exceed ten years. These statistics suggest that most prisoners spend a greater portion of their adult lives out of prison than in it. If an inmate's health needs are not met while he or she is incarcerated, they persist when the inmate is released and re-enters society.

Unless former inmates are able to pay for their own health care with either insurance or personal funds, the financial burden of their physical and psychological problems will be borne by the state. Elderly ex-prisoners are especially apt to become dependent on state funds. Both their advanced age and their prison records reduce their chances of securing employment and health benefits after release. It is unlikely that the cost of their health care will

86. Table H-13, 1992 NEW YORK STATE STATISTICAL YEARBOOK, supra note 2, at 251.

87. Table H-22, id. at 257.
be met by insurance or private sources, especially in the case of an HIV-positive or AIDS-afflicted ex-inmate. Moreover, if these individuals receive no instruction in how to avoid transmitting the virus, a distinct possibility exists that they will infect others. As one investigator has observed, the prison system may be one of the few public institutions in which there is an opportunity to break chains of infection among high-risk populations. 88

In addition to the public health benefits that will accrue if inmates’ health problems are treated prior to release, society will gain in the long run. A greater commitment to providing health care to prisoners results in long-term savings, even though in the short term, it may appear to be expensive.

Those who emerge from prison burdened by health problems are more likely to need public assistance and may be inclined to resume criminal behavior to provide a means of support. Consequently, they will require further incarceration. The resulting drain on economic resources is not easily quantified, but leads to a decrease in the quality of life of the community. Monies spent on social welfare, crime detection, the judicial system and the prison system are unavailable for more positive services such as education, recreation, maintenance, and improvements to the infrastructure. On the other hand, an individual released from prison in good health has a chance to rejoin society as a productive, participating member.

Even if the United States Supreme Court had not ruled on the issue of health care for prisoners and the statutory mandate did not exist, the practical wisdom of devoting sufficient resources to meeting prisoners’ health care needs would be evident. New York State has demonstrated in a variety of ways that it appreciates the urgency of the situation, but a large gap still exists between recognition and resolution of the problem.

88. Cohen, supra note 13, at 555.