

1 Institutional Burden to Care

What's wrong with our society that so many people are ending up in jail who are really sick?

Health administrator at the San Francisco jail

The correctional system should not be held to account for the weaknesses of the community system.

Kevin, medical administrator at a private correctional health corporation

DESERVINGNESS AND THE CARCERAL BURDEN

In 1975, prisoner J.W. Gamble injured his back while doing labor on a prison farm in Texas.¹ He alleged that the medical care he then received was inadequate and that he was further punished for not working due to back pain. The Supreme Court, which considered his claims in the landmark 1976 case *Estelle v. Gamble*, disagreed, and Gamble lost the case. However, the court used his case to establish health care as a right for prisoners. Justice Thurgood Marshall declared “that deliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ *Gregg v. Georgia, supra*, at 173 (joint opinion), proscribed by the Eighth Amendment.”² This legal mandate for health care that *Estelle* created is foundational for jailcare, for it acknowledges that incarcerated people deserve some degree of care. This recognition opens the possibility that people might seek jail for the promise of care.

Since *Estelle*, administrators, accrediting organizations, private health care corporations, lawyers and judges, advocacy groups, correctional

health workers, and inmates have actively translated the meaning of “serious medical needs” and “deliberate indifference” into facility policies, contracts, lawsuits, activism, and everyday health care relationships.³ The vagueness of these phrases has nurtured a central tension in thinking about care for prisoners, one that is at the core of jailcare. One aspect of this tension appears in questions about the prison or jail’s responsibility to care for those whom it confines, which legal scholar Sharon Dolovich calls “the state’s carceral burden”: its obligation to fulfill prisoners’ basic human needs, since prison deprives them of their ability to sustain themselves and places them in potentially dangerous situations.⁴ This line of questions parallels larger questions about the state’s role in ensuring citizens’ well-being through a safety net for the most vulnerable. Another aspect of this tension appears in questions about for whom the state is obligated to care. Here, notions of “health-related deservingness” are useful. Deservingness, Sarah Willen has argued, is the “flip side of rights.”⁵ Rather than being understood in universal claims of truth or legal assurances, deservingness is negotiated relationally. Certain groups are constructed as worthy of public support. Others are unworthy.⁶

This chapter describes the institutional and historical contours of this tension between the obligation to care and prisoners’ deservingness of care. These contours determine the existence of the San Francisco jail clinic, Evelyn’s desire to use its services, and the flourishing of its daily intimacies of care. The context this chapter provides involves four domains. The first is the twinned rise of mass incarceration and retreat of the public safety net. These interrelated processes have deep economic and racialized roots, and are unified by the argument that the state has, over the last forty years, managed poverty by incarcerating the poor rather than investing in robust and effective services.⁷ The second of these domains is judicial. The courts have played a major role in establishing prisoners’ rights to health care and delineating what it should look like. The third domain is the emergence of “correctional health care” as a professional field and source of profit. Finally, organized social justice advocacy has shaped the terms of prisoners’ rights to health care. Together, these institutional and historically located forces situate the unfolding of care inside the jail.

RETREAT OF THE SAFETY NET AND RISE
OF MASS INCARCERATION

Evelyn was born in 1983, during a radical shift in the state's approach to managing poverty that accompanied rising concerns about crime.⁸ Her parents were poor, black, held no steady employment, and struggled with addiction. Her mom used drugs while she was pregnant with Evelyn. When Evelyn was five years old, her mother was murdered. Evelyn was alternately cared for by her father and a cousin, whom she referred to as Aunt Vera. When Evelyn was nine years old, the state discovered that Evelyn's father and uncle had been molesting her, so she was removed from Aunt Vera's custody, nurturing though it was, and funneled into a series of group homes and foster care families. She never received mental health care for the sexual abuse or her mother's murder. Not surprisingly, this unaddressed trauma manifested in anger and drug use, and eventually led to juvenile detention and an early entry into adult correctional facilities.⁹

Evelyn is one of millions whose involvement in the criminal justice system is a product of the twinned rise of mass incarceration and the waning public safety net. These phenomena emerge from a racially biased historical arc in the management of poverty, one end of which is rooted in social services and the other in the "penal treatment of poverty."¹⁰ This historical convergence is important in contextualizing the experiences of pregnant women like Kima and Evelyn.

In exploring these paired historical trajectories, I understand the safety net to be a complicated and multidimensional phenomenon, one explored by many scholars. In common usage, "safety net" denotes the provision of services for disenfranchised people who need help meeting their basic needs and who would otherwise "slip through the cracks." As a social institution, the safety net represents a contested moral and ethical stance toward society's most vulnerable. From an operational standpoint, the safety net includes a set of government-sponsored programs, medical clinics and publicly funded health insurance, and tens of thousands of nonprofit service organizations. Perennial debates about the nature of the safety net overlap debates about prisoners' right to health care, involving obligation and deservingness: what is the state's

responsibility to care for its citizens, and which subjects are constructed as worthy of that care?

A brief historical sketch clarifies the connections between the safety net and mass incarceration. The first institutional threads of the public safety net were spun in the 1930s by New Deal programs designed to mitigate the effects of the Great Depression, and grounded in the notion that it was the government's responsibility to help struggling citizens.¹¹ From its inception, this safety net excluded African Americans from accessing federal benefits.¹² Unsurprisingly, racially encoded language like "deserving" and "undeserving" poor followed this exclusion. Several decades later, President Lyndon Johnson's Great Society programs endeavored to equalize access to the safety net for black citizens; his "war on poverty" expanded government services, including food stamps and federally funded medical care for the poor (Medicaid) and elderly (Medicare).¹³

The growing safety net, however, left behind the mentally ill. The 1960s and 1970s saw the closing of state-run mental institutions, considered inhumane and coercive, while the expansion of community-based mental health treatment services never materialized.¹⁴ Without adequate support, many suffering from mental illness found themselves incarcerated for petty and nonpetty crimes, or for being "nuisances" to the public. By default, jails and prisons became the largest provider of mental health services in the country.¹⁵

Johnson's war on poverty coincided with civil rights activism over the effects of racial segregation—including the unequal availability of safety net services for African Americans. By the 1970s, protest in urban centers spilled into civil unrest, which in turn generated unprecedented fear of crime.¹⁶ Incarceration became an anxiolytic for these fears, isolating and removing groups perceived to threaten the dominant moral order.¹⁷ Not coincidentally, the imagined "dangerous underclass" was poor, black, and located in now-abandoned urban ghettos.¹⁸

Simultaneously, shifts in the industrial labor market and the deregulation of the market economy generated a surplus of unemployable laborers. The already disenfranchised, particularly in urban ghettos, were further undermined by neoliberal economic policies that shifted the responsibility for economic insecurity from the state to the free-market individual.¹⁹

These transformations disproportionately affected urban communities of color and deepened racial economic inequality.²⁰

Under the leadership of President Ronald Reagan, the 1980s witnessed the dismantling of publicly funded social welfare programs, through privatization, decentralization, and elimination of many programs. The poor were left to precarious wage opportunities and illicit markets, including the drug economy. As many women at the San Francisco jail told me, selling drugs remained the only reliable way they could make money, and they made more than at a minimum-wage job.²¹

Formalizing the neoliberal restructuring of the public safety net, President Bill Clinton's 1996 welfare reform act shortened the duration in which one could receive public assistance and applied more stringent criteria, emphasizing individual responsibility to join the workforce while refusing to provide a living minimum wage or universal childcare.²² The law allowed states to cap the number of children for whom mothers and families could receive Temporary Assistance for Needy Families (TANF) benefits.²³ Moreover, welfare policy changes focused on poor women, single mothers, and black women, blaming their reproductive patterns for the cycle of poverty and directing their children into child welfare programs.²⁴ These changes accompanied social narratives stereotyping poor black mothers as drug addicts and "welfare queens" who ostensibly produced children to get subsidies from the state.²⁵

The rise of mass incarceration is inseparable from these racially grounded reformulations of public welfare.²⁶ Even as the Reagan administration rolled back government financing of the safety net, it expanded the prison system. In addition to neoliberal reformulations of welfare, Clinton, too, passed harsher sentencing laws and increased funding to prisons and policing,²⁷ investing an astounding amount of money in prisons, jails, and their management, disproportionately punishing African Americans and profiting private corporations.²⁸ This financial trend has continued for decades: in 1982, approximately \$16 billion was spent on state prisons; in 2010, that number was \$40 billion (adjusted for inflation).²⁹ The war on poverty morphed into the "war on drugs" and the "war on crime."³⁰ Tellingly, a senior advisor to former president Richard Nixon has admitted that the Nixon administration invented the war on drugs as

a political tool, criminalizing drugs and associating drug use with antiwar activists and blacks.³¹ Although drug crime was declining, states ramped up incarceration through increased policing and draconian sentencing laws, such as mandatory minimum sentences and California's notorious "Three Strikes" law.³² Changes to drug sentencing laws also reflexively increased sentencing for violent crimes, leading to overall longer imprisonments for all convicted felons.

While it posed as a response to increasing crime rates, mass imprisonment actually resulted from "a politics of resentment toward categories deemed undeserving and unruly, chief among them the public aid recipients and street criminals [who] came to dominate the . . . debate on the plight of America's urban poor."³³ Increased policing in and of black communities has become a central feature of the urban landscape, with the criminal justice system playing a key role in inner-city governance and re-instantiating processes of racial dispossession.³⁴ Overcrowded "warehouse prisons" and jails are now characterized by harsher and more punishing conditions, in which the imprisoned—a disproportionate number of whom are African American—linger idly, increasingly unprepared for reentry and doomed to both recidivism and marginality.³⁵ These qualities reflect a shift in prisons, which focus less on regulating and transforming individuals for reentry into society and more on maximizing security, and a parallel social shift in emphasis from discipline to risk management.³⁶ Even post-release, prisoners remain under the control of the carceral state via probation and parole and restrictions imposed by criminal records. Exorbitant bails and fines, even for minor offenses, keep the poor in jail.³⁷ In many poor urban neighborhoods, especially those inhabited by African Americans, the threat of impending arrest, increased policing, and the relational impact of imprisonment of family members become part of the fabric of the community, a process Megan Comfort calls "secondary prisonization."³⁸

A significant proportion of incarcerated adults likely receives some form of public assistance when not confined, though that number has not been documented. Being jailed or imprisoned results in the suspension or discontinuance of these benefits.³⁹ To reinstate benefits upon release from prison or jail, individuals must complete stacks of paperwork, provide documentation of eligibility, and submit these forms in person at government offices. Some states preclude convicted felons from receiving food

stamps or subsidized housing; in most states, employers can legally refuse to hire a convicted felon.⁴⁰ Incarceration thus disrupts safety net services people previously received, and furthers their economic marginality upon release. What's more, some law enforcement agencies use food stamp and other public benefit rosters to locate and arrest people with outstanding warrants.⁴¹

The entwined histories of the public safety net and mass incarceration are crucial for understanding the relationships of care between jail workers and inmates.⁴² A safety net catches people when they fall. Certainly for some, jail is part of that fall. But for many, jail is a normalized part of life. Its shelter and other material resources routinely provides them respite from the danger of the streets, in ways public assistance, free clinics, and nonprofit social service agencies have failed to do.

SAN FRANCISCO'S EXPANSIVE SAFETY NET

Most of the women I knew in the San Francisco jail received services from myriad government agencies, publicly funded clinics, and community organizations. San Francisco is known as a progressive city committed to helping marginalized people. As a San Francisco resident working with marginalized groups, I was astounded by the number of community programs serving the poor, homeless, addicted, and transgender communities.⁴³ One public official told me the city provided grants to over eight hundred nonprofit organizations, most of which serve poor and vulnerable residents.

One group visited daily rent hotels to provide health care and harm-reduction interventions; one nonprofit clinic hosted a "Ladies Night" where women could drop in for food, HIV testing, toiletries, entertainment, manicures, Narcan kits to prevent opiate overdoses, and meetings with case managers. I helped at several of these events, and usually saw at least one woman I knew from jail.⁴⁴ The city's county hospital was known for its clear mission, and provided care for anyone who walked through its doors.⁴⁵

Another example of San Francisco's commitment is the "Healthy San Francisco" program implemented in 2007—years before the Affordable Care Act—to provide coordinated health care coverage to approximately

sixty thousand residents who lacked health insurance.⁴⁶ In addition to a network of health department clinics, more than a dozen nonprofit community clinics provided free care.⁴⁷

City government and nonprofit agencies administered safety net services specifically for pregnant women. For instance, one organization has been helping homeless pregnant women and families find housing, employment, and other services for twenty-five years, and has worked inside the jail to establish connections with women before release. Several residential drug treatment centers allowed pregnant and parenting women to live with their children, though many did not.

Alisha, a pregnant woman I met in jail during her third trimester, lived at many such programs, one while she was pregnant, and others after her baby was born. At one program she was permitted to live with her son, Deijan, but she relapsed, and he was placed in foster care. Alisha's circulation among programs specifically designed for women like her raises questions about the "success" and "failure" of the safety net, specifically in terms of programs to help mothers.

Some services delivered to individuals in San Francisco were channeled through the city's criminal justice system; they included basic safety net services as well as "rehabilitation programs," which city agencies hoped would prevent reincarceration.⁴⁸ During my fieldwork, for example, the Adult Probation Department opened a "One Stop" center for San Franciscans on probation, where they could get social work and case management services, mental health care, job training, housing assistance, education, and referrals for medical care. The Sheriff's Department has received national recognition for innovative programs in and out of the jail: the 5 Keys Charter High School where people can study upon release;⁴⁹ art and music therapy workshops; an antiviolence initiative, "Resolve to Stop the Violence"; drug treatment programs; a "Women's Re-Entry Center," offering a variety of social services and support groups; work alternatives to incarceration programs; and an array of classes about computer skills, parenting, harm reduction, trauma support, anger management, and more.⁵⁰ In addition to programs directly administered by the Sheriff's Department, dozens of community organizations sent volunteers into the jail to provide everything from health education to music and art workshops.

In my observations of the nature of jailcare in the San Francisco jail, I struggled with a core question: how, in a progressive city like San Francisco, which expresses an explicit commitment to help its vulnerable residents, are so many people slipping through the cracks to the extent that jail becomes their safety net? Over time, I have found many possible explanations. One, offered by several jail and public health administrators, was that there were not enough safety net services, particularly supportive housing units, mental health services, and drug treatment programs. In 2016, the city was developing a multisector initiative for police officers to take people using drugs on the streets to a treatment program instead of jail, but it was not clear that there would be enough treatment spots.⁵¹ Furthermore, the city is experiencing a deepening income inequality, in part due to a recent tech boom; many activists claim that the mayor's pro-business policies have further marginalized and displaced people in desperate need of safety net services.

Another explanation is an extension of critiques of welfare reform and the individualizing ethos it propagated, alongside implicit racial bias. Craig Willse offers a related argument, that government and nonprofit agencies dedicated to the poor depend upon and perpetuate the continued marginality of those they serve; rather than ameliorating root causes, the goal has become to manage insecurity.⁵² In this view, the robust safety net in San Francisco depends on people continuing to slip through the cracks.

While the Sheriff's Department provided social services in and out of jail, it also inserted law enforcement activities into safety net sites. I frequently heard from women in the jail that they sometimes avoided seeking medical care at the county hospital, because deputies stationed in the emergency room would run their names for outstanding warrants—and could arrest them there.⁵³

Another answer to my question about San Francisco's extensive social services involves bureaucratic hoops, duplication, and lack of coordination among services. When I accompanied Evelyn to reinstate her general assistance benefits after a release from jail, we were sent on a wild goose chase to offices throughout the Bay Area to obtain an official copy of her birth certificate. I was astounded by the array of rules, acronyms, and numerical details Evelyn and other women could rattle off to me—information I could never keep straight. Receiving safety net support

services required resourcefulness and tremendous time. Moreover, the bureaucratic demands were such that the services did not always arrive—government checks sent to the wrong place, signatures missed here, boxes unchecked there, appointments cancelled because of court appearances. Even after enrolling in programs, utilizing those programs' services requires a challenging degree of surveillance.⁵⁴ This is compounded by the fact that many people receiving benefits are on probation or parole, with a variety of reporting requirements and restrictions.

Knight's ethnography of pregnant, drug-addicted women in San Francisco paints a vivid picture of medical and social programs that failed to improve lives but used their enrollees as subjects for ongoing legal and social interventions. For example, Knight notes that a pregnant woman in a methadone program would be considered too stable for a residential drug-treatment program; as a pregnant woman, though, she would be excluded from the city's supportive housing units and would have to add her name to a long waitlist for low-income housing.⁵⁵

I asked an administrator in the health department who has worked for decades with homeless people why, amid a seemingly robust public safety net in San Francisco, so many people still struggle with basic survival. He pithily replied, "Access does not mean quality." Just because free services for, say, health care exist does not mean people's needs are met. He added, "It's all about relationships, and how interactions make someone feel" while that person is accessing safety net services. The connection between feelings and quality of care surfaces, he posited, through a number of interactions, what he called "touches," with people working at these sites. For example, a patient's first human contact at one of San Francisco's public health clinics is with an armed guard. This introduction to the clinic means patients are more likely to feel judged, unsafe, and alienated from the services they seek. Five more "touches" with staff occur before patients receive their service; each touch can potentially make patients "bristle" and increase their unease. This administrator's diagnosis of public safety net problems suggests that shortcomings are not due simply to lack of funding or material services, or even the neoliberal need to manage marginalized bodies. Rather, the quality of these services hinges on their ability to convincingly demonstrate care. If people using the services feel cared for, they are more invested in the outcome.

There is no single answer to the question about the discrepancy between San Francisco's robust safety net and its failures. Clearly, though, the relationships and structures of the social safety net are entangled in jailcare and the services and care that jailcare provides.⁵⁶

“JUDICIALISATION OF THE RIGHT TO HEALTH” FOR PRISONERS

These features of the safety net and mass incarceration have forced the carceral system to confront the reality that it must tend the basic needs of the bodies it confines—Dolovich's carceral burden. The courts have been deeply involved in delineating the nature and scope of this health care. Juridical claims surrounding prisoner health care grapple with the unresolved tension between obligation to care and an individual's deservingness.

In the 1920s, several state-level court cases recognized the state's carceral burden to provide medical care within jails and prisons.⁵⁷ Fifty years later, in the wake of civil rights activism that resulted in the jailing of many activists, the 1970s saw a surge in prisoners' rights lawsuits.⁵⁸ Lower court cases in the early part of the decade revealed atrocious medical conditions. Instances of prisoners' death by neglect and their conscription to perform procedures on fellow inmates prompted prisons and jails to establish formal health care systems.⁵⁹ This was true in San Francisco, where a 1970s lawsuit against the city for abysmal jail conditions forced the creation of health care services; a 1982 case created a “consent decree,” allowing for expansion of services, and a 1991 class action lawsuit further mandated the jail improve medical conditions.⁶⁰ As one longtime jail health administrator told me, “All of this [health care in the San Francisco Jail] has developed through lawsuits. It wasn't because someone said, ‘Wow, we really need to do right by these people.’” While the response to this surge in litigation across the nation in the 1970s and 1980s established systems of health care in jails and prisons, many facilities improved services just to the point of avoiding more lawsuits.

The most influential case was undoubtedly *Estelle v. Gamble*, notable for invoking the Eighth Amendment's proscription of cruel and unusual punishment.⁶¹ The majority opinion of the Supreme Court came to this

conclusion by appealing to “standards of decency.” It is worth citing at length:

These elementary principles establish the government’s obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met. In the worst cases, such a failure may actually produce physical “torture or a lingering death,” (*In re Kemmler, supra*), the evils of most immediate concern to the drafters of the Amendment. In less serious cases, denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose. (Cf. *Gregg v. Georgia, supra*, at 182–183 [joint opinion]). The infliction of such unnecessary suffering is inconsistent with contemporary standards of decency as manifested in modern legislation codifying the common law view that “it is but just that the public be required to care for the prisoner, who cannot, by reason of the deprivation of his liberty, care for himself.” We therefore conclude that deliberate indifference to serious medical needs of prisoners constitutes the “unnecessary and wanton infliction of pain,” *Gregg v. Georgia, supra*, at 173 (joint opinion), proscribed by the Eighth Amendment.

The Court’s use of pathos appeals to the reader’s sympathy and sense of justice, as its diction—“torture or a lingering death,” “evils,” “decency,” “suffering”—imbues prisoners’ right to health care with moral weight.

Likewise, Justice Marshall’s phrase “deliberate indifference” suggests that lack of sentiment in prisoner health care is a problem.⁶² This lack of sentiment, or indifference, is the classic attitude of modern bureaucracy, and the “moral alibi for inaction.”⁶³ But indifference can also be seen as an active “rejection of common humanity.”⁶⁴ It takes effort not to care. The courts have, subsequent to *Estelle*, codified deliberate indifference as “action or inaction taken in conscious disregard of a substantial risk of serious harm.”⁶⁵ That is, if a prison guard were not aware that his actions (or inactions) would lead to injury, his (in)actions would not qualify as deliberate indifference. Ignorance cannot be prosecuted.⁶⁶ In order to be in violation of the Constitution, concern must be consciously withheld. Furthermore, deliberate indifference can be prosecuted only if it is directed toward a “serious medical need.”

Because the phrases are difficult to pin down, there have been tens of thousands of lawsuits⁶⁷ since *Estelle* to challenge and define the meaning

of both “serious medical needs” and “deliberate indifference.”⁶⁸ Such extensive litigation of prisoner health care has contributed to the “judicialisation of the right to health,”⁶⁹ as well as the medicalization of the prisoner, whose body becomes terrain for demonstrating the presence or absence of the state’s deliberate indifference.⁷⁰

Identifying “serious medical needs” has largely been retroactive, defined through lawsuits that then designate certain neglected health issues as “serious.”⁷¹ Examples include: untimely or absent distribution of critical medications; incompetent health care providers who neglected symptoms; suicides that could have been prevented; the shackling of pregnant women in labor; the prevention of women from getting abortions; and the ignoring of a pregnant woman’s labor pains, resulting in the jail-cell birth of a baby who died.⁷² As individual cases, each seeks to specify serious medical need and deliberate indifference. Each, too, grapples with moral questions about the state’s carceral burden to care, the kind of care incarcerated people deserve, and the way sentiments of concern or indifference figure into care.

The judicialization of prisoners’ right to health care has set the stage for a spectacular intersection of juridical power, human rights, health, and imprisonment. In the 2011 case *Brown v. Plata*, the Supreme Court ordered California to depopulate its prisons by forty-six thousand people in three years, because health conditions in its overcrowded prisons were abysmal and previous court-mandated attempts to overhaul the prison’s medical system were inadequate. In *Brown*, the Supreme Court reaffirmed the moral stakes of prisoner health care, arguing that suffering due to inadequate medical and mental health care in California prisons was “incompatible with the concept of human dignity and has no place in a civilized society.”⁷³

Nurses at the San Francisco jail did not speak the judicial language of “serious medical needs” and “deliberate indifference.” In fact, many of the medical staff were not aware of the *Estelle* mandate that made their work a matter of constitutional rights. Once, I heard a patient in the waiting area of the jail clinic threaten to sue the jail because she had to wait two weeks for a gynecologic exam. The medical staff hardly gave her notice, and those who did mocked her. Perhaps they, like I, assumed that the patient was unlikely to pursue legal action, and that even if she did, she was unlikely to win. What

is clear in these caregivers' derisive responses is that health care rights for prisoners are not only adjudicated in courtrooms, but through everyday human relationships and practices of care. After all, rights are not pre-political entitlements but are configurations of social, political, and institutional arrangements, made meaningful through human interaction.⁷⁴

PROFESSIONALIZING AND PRIVATIZING CORRECTIONAL HEALTH CARE

While the courts have retroactively attempted to create a taxonomy for serious medical needs and criteria for identifying the absence of appropriate concern, a burgeoning professional health care community has attempted to prospectively delineate such medical conditions and obligations. A field of practice catalyzed by the *Estelle* mandate and known as "correctional health care" has emerged around the problem of the carceral burden to care.⁷⁵

The professional organization of carceral health care is relatively recent—since the 1970s—though doctors and nurses have long served prisons and jails in varyingly limited capacities.⁷⁶ The National Prison Association (now the American Correctional Association) formed in the reformist era of 1870, and asserted in its foundational document, "Declaration of Principles," that the prison has a role in caring for its inmates: "The hospital accommodations, medical stores and surgical instruments should be all that humanity requires and science can supply; and all needed means for personal cleanliness should be without stint."⁷⁷

Literature on medical care in prisons in the days before it was legally mandated is sparse, but there are accounts of inmates being made to act as nurses to other inmates and doctors participating in the overall management of prisons and presiding over electric chair executions.⁷⁸ One exposé of Arkansas prison farms suggested that sections of the on-site prison hospital served as a torture chamber, with assistance from prison doctors.⁷⁹ Alongside medical atrocities, the post-World War II era of penology aspired to rehabilitate prisoners using a curative, medical model of criminality and confinement.⁸⁰ Yet many jails and prisons had no official on-site medical staff until *Estelle* came along. According to several

former San Francisco health administrators I interviewed, this was the case in the San Francisco jail until lawsuits in the 1970s and 1980s. If someone got sick, deputies called paramedics. The jail stocked a few medications distributed by custody staff or other nonmedical professionals. In 1983, “Forensic Services” (the name was later changed) was established as a division of the San Francisco health department to provide health care services inside the jail, although there was minimal interest from the health department. As one jail health administrator who had worked in the jail since the 1970s told me:

It was seen as a necessity, but leaders in the health department did not have much concern for health care services inside the jail. [People at the health department] absolutely did not see that . . . the people we were treating [in jail] were also [getting care] in the rest of the health department when they weren’t in custody. And so we had to do a lot of work to persuade people to fund and integrate our system of care with the rest of the department. . . . We were really sort of trying to push the idea that the person next to you on the bus, your next-door neighbor, your nephew, were all people who had been in and out of jail, and they were going to be back out on the streets and therefore we needed to do better.

This attitude was corroborated by another early Forensic Services administrator, who reminisced that the agency’s offices were located in the jail’s plumbing chase, and operated on a shoestring budget. The only way the administrator could get anything done, like hiring nurses and doctors, was by using “the heavy hammer or hand of the court.” Forensic Services leaders built their division from scratch, hiring health care staff, developing protocols, building relationships with custody staff, creating innovative programs for HIV patients in the early days of the epidemic, and cultivating a mission to help the inmate who was also “the person next to you on the bus.”

The first national-scale effort of the medical community to address health care for incarcerated people was a 1973 American Medical Association (AMA) report. The AMA surveyed 1,159 sheriff’s jurisdictions and found a systematic and egregious absence of adequate medical care.⁸¹ This prompted the AMA, in 1975, to undertake a pilot program at thirty jails to systematize health care provision.

In 1983, this pilot program formalized into the nonprofit organization the National Commission on Correctional Healthcare (NCCHC).⁸²

According to NCCHC's website, its "early mission was to evaluate, formulate policy, and develop programs for a floundering area clearly in need of assistance."⁸³ The NCCHC now accredits hundreds of jails, prisons, and juvenile facilities across the United States that have chosen to meet its nationally accepted standards of health care.⁸⁴ The American Correctional Association also offers an accreditation program. Interestingly, the San Francisco jail clinic was not accredited by the NCCHC. A health department official explained to me that accreditation was an expensive logistical hassle; since the services provided at San Francisco exceeded the standards, the leadership did not see a need for accreditation.

Although the NCCHC is not a legal organization, the juridical framework established by *Estelle* nonetheless gets played out through the organization's regulatory guidance for prison and jail clinics. Standardizing clinical care provides jails and prisons with a road map for what the NCCHC deems a "constitutionally acceptable level of care,"⁸⁵ or avoiding deliberate indifference to serious medical needs. The NCCHC's two-hundred-page book of standards translates these phrases into specific logistics and services, from personnel and administration to medical diets and health care services.⁸⁶ Most standards are "required" for an accredited facility, but a few are optional. Such a dichotomy parallels the central tension between the minimum care to which prisoners are entitled—rights and constitutional requirements—and the moral vernacular of their deservingness.

One jail nursing administrator whom I met at a conference told me that her facility's NCCHC accreditation saved them from several lawsuits. "It's an assurance," she told me, "that you're not showing 'deliberate indifference.'" She rolled her eyes disdainfully. The legal mandate of *Estelle* was imbricated into her sense of professional obligation, which was to avoid being perceived as indifferent. Her reliance on accreditation for its legal protections suggests a risk-management approach to health care for prisoners.

Over the past three decades, NCCHC has grown into a vibrant professional society for nurses, doctors, administrators, and mental health workers in prisons and jails. The NCCHC holds educational conferences, publishes an academic journal and textbooks, and confirms individuals with the title "Certified Correctional Health Professional."⁸⁷ The majority of the correctional health care workforce is composed of nurses, followed by mental health workers. These forces of professionalism try to normal-

ize the work of health care providers in an area that continues to be marginalized by mainstream professional circles. In some cases, correctional health care gives rise to what some bioethicists have called a “dual loyalty problem,” where doctors and nurses experience tension between their obligations to care and the regimented, punishing space of prison.⁸⁸ This tension sets these providers apart from doctors and nurses who work in hospitals or community clinics.

Correctional health care has also become a revenue-generating business. Total health care spending in correctional institutions in 2010 was nearly \$8 billion.⁸⁹ Privatized prison health care emerged in the years immediately following *Estelle*, with classic neoliberal reasoning that the private sector could more efficiently and cheaply manage prison medical services in prisons than the government. Private prison health contracts now account for 40% of all inmate care in the United States.⁹⁰ Corizon, the largest private prison health company, earns an estimated \$1.5 billion in profits annually.⁹¹ A 2012 article in the trade journal *Corrections Forum* asserts that the predominant concern for a facility choosing to privatize health care is cost savings: “With corrections agencies facing deficits and projected deficits in their budgets they are looking for privatization to close gaps in coverage. . . . [L]awmakers [in Florida] are hoping to achieve \$30 million in annual savings through privatization.”⁹² Nowhere does the article mention quality of health care for patients or inmates.

I visited several of these corporate headquarters, all located in pleasant, generic suburban office parks, which made privatized prison services seem a normal, unobtrusive part of the economy. The sleek office architecture and granite outdoor fountains were a stark contrast to the prisons and jails these corporations managed across the country. People at headquarters spoke of “vendors” and “clients,” referring to jails and prisons that contracted for their services. Their relationship was with paying customers, not inmates or patients.

Sleek corporate headquarters and high profit margins contribute to a stark reality at many privatized correctional health care sites, where media and courtroom accounts have documented neglectful care and avoidable deaths.⁹³ Understaffing, unqualified doctors, missed diagnoses, and withheld drugs are evidence cited by journalists and attorneys to link “cost-effectiveness” strategies to harmful, unconstitutional care. Corizon alone

was sued 660 times for unconstitutional care from 2008–2013.⁹⁴ After Arizona privately contracted its health care services, medical spending in prisons dropped while the number of inmate deaths increased.⁹⁵

Pressure to keep health care costs below what the prison pays the company can influence decisions health care providers make about what constitutes serious need, and how to actively avoid indifference in decision making. When I asked Kevin, a physician-administrator at a private company, the ways in which the profit needs of the company influence medical decisions, he replied: “We’re interested in cost-effectiveness everywhere.”

The calculus of care for Kevin had an implied moral argument. He claimed that the state’s carceral burden should not unburden the constitutive outside of its responsibility to provide care. He used hepatitis C, prevalent in incarcerated populations and expensive to treat, as the example: “I mean, we’re not going to screen them [for hepatitis C] at short-stay facilities. That’s the community’s responsibility. If the community doesn’t do it, then . . . why should you expect the county jail to?” For Kevin, the solutions to problems affecting both the jail and the community were not part of the carceral burden. Kevin added, “The correctional system should not be held to account for the weaknesses of the community system. That’s my belief.” Yet Kevin’s beliefs are in contrast to the everyday realities of jailcare, in which the jail occupies the default position of redressing the deficiencies of the safety net.

This is not to say that care at all private sites is putatively worse, or that correctional medical care delivered by public entities is immune to cost concerns or incompetent care; the San Francisco jail’s medical services were administered through the city’s health department, and budgetary constraints and clinical incompetencies were perennial issues. Nor is it to disregard the nuanced compassion in the everyday experiences of nurses, doctors, and patients at private sites. Rather, this attention to privatized prison health care illuminates the prominent role of market forces in adjudicating the state’s carceral burden.

PUBLIC HEALTH JUSTICE AND PRISONER HEALTH CARE

The overlapping dimensions of public health and social justice represent another domain central to prisoner health care in the United States.

Academic researchers, administrators, jail providers, public health workers, and prisoner activist groups alike have emphasized the broader implications of care (and its absence) inside jails and prisons, for incarcerated individuals and the larger community. For one, prisons house large numbers of people in common space, creating a reservoir for the transmission of infectious diseases. Public health advocates argue that health care infrastructure within prisons should work to prevent disease.

A second public health perspective is opportunistic, premised on an understanding that most incarcerated people have poor indices of health and limited pre-incarceration access to health care. Incarceration becomes an opportunity, albeit an unfortunate one, to work with populations with an already-high prevalence of mental illness, addiction, chronic disease, sexually transmitted infections, hepatitis, HIV, and other conditions. Incarceration may exacerbate those conditions or, when care and reentry services are provided, ameliorate them. It is no surprise, then, that jail has become a primary health care provider to women like Evelyn and Kima. The opportunistic approach, however well intentioned, is nonetheless problematic, for it reflects the deficiencies of health care outside of jail or prison. Moreover, correctional facilities are not designed to treat illness but to punish and confine.

A third public health perspective on prisoner health care builds on the reality that, ultimately, most incarcerated people are released back into mainstream society. This was the message that San Francisco jail health administrators used in the 1980s to procure funding from the health department.⁹⁶ Stephanie, a nurse in San Francisco's intake jail, told me on many occasions that she loved her job because she felt like she was "on the frontlines of public health." In this view, tending inmates' health benefits the health of the communities to which people return; it envisions a body of productive citizens whose health has been improved by incarceration.⁹⁷ Through this lens, mass incarceration is understood as both a problem and a disturbing solution to absent health care.

These public health approaches coexist with a social justice imperative present among certain circles of activists and medical academic researchers.⁹⁸ That is, many researchers and people who provide care to prisoners—myself included—are motivated by a humanistic desire to help individuals they see as marginalized by broader structures of poverty, racism, and

inequality. Many of these activists liken mass incarceration to a public health epidemic, a scourge as destructive as any infectious disease.⁹⁹ Human Rights Watch, Justice Now, Legal Services for Prisoners with Children, and California Coalition for Women Prisoners are but some of the hundred or so nonprofit groups in the United States who advocate for health care improvements in prisons.¹⁰⁰ Indeed, there is much to improve.

Both the social justice and public health perspective were part of the ethos of San Francisco's Jail Medical Care (JMC). Although these views did not resonate with all staff, they were explicit driving forces for some clinical staff and JMC leaders who set the tone and policies of the agency. Many of these leaders had been involved in grassroots social activism in the 1960s and 1970s, and were on the front lines of AIDS activism in the 1980s. One leader who held the position for over twenty-five years worked to expand JMC services beyond the minimum required by law, beyond the "deliberate indifference" standard. He fought for budget increases so that preventive health care services could be provided, and patients could access the same quality and standard of care in jail that existed in the community. When the city government threatened to privatize medical services in the jail, he spoke passionately of society's responsibility to the city's most vulnerable citizens:

What is wrong with our society that so many people are ending up in jail who are really sick? You know, of course there's always going to be people who commit crimes and need to go to jail for whatever reason or, you know, but an overwhelming majority of people are not there because they're bad people; they're just in bad situations. . . . There isn't housing, there isn't food, there, you know, there isn't substance abuse treatment except for very small numbers of people.

He and other JMC leaders had a mission, one infused with justice, to care for people in jail whom they saw as marginalized by broader forces in society.

CARE AND CUSTODY, DESERVINGNESS AND OBLIGATION

Once a month, a joint meeting was held among San Francisco Sheriff's Department leadership—usually the chief custody officer at each jail—and

JMC and jail psychiatric services administrators. These meetings addressed the tricky intersection between overall management of a jail and health care services. One example of an agenda item: what to do with an inmate who needed a cane or walker for mobility, given that these devices could be used as weapons. For the most part, these meetings were collegial; medical and custody staff exchanged pleasantries over coffee and doughnuts before the meetings started. But amid the snacks, formal agendas, and polite exchanges, people discussed fundamental issues at the interface of confinement and medical care: what kind of care did inmates deserve and what was the jail's responsibility to ensure that care? JMC's public health and social justice orientation, the position of the jail in the city's safety net, legal requirements to care, and the health care providers' professional integrity provided the critical backdrop to these meetings.

As I delve into the everyday realities of care within an institution of confinement in San Francisco, these four macro level forces—the safety net intertwined with mass incarceration; legal; professional; and public health—must be kept in mind. These forces take form in the unique circumstances of carcerality: punishment, normalizing regimes, restricted liberty, inequality, violence, and, ultimately, human relations. If the analysis were left to an exploration of these four intersecting spheres of prisoner health care, we would have an interesting narrative of the convergence of policies, ideologies, and calls for change in defining who and under what circumstances people deserve health care. Instead, we must look to the ways that health and care are made meaningful on the ground as individuals contemplate in action the complex moral terrain of obligation and deservingness of health care, and the sentiments that get worked through those assessments. The remaining chapters of *Jailcare* pursue the everyday instantiations of these structural forces in the routine unfolding of care in the jail, and how the inequalities surrounding the jail make it possible for intimate care to flourish inside.