A GRASSROOTS LEADERSHIP • SOUTH CAROLINA FAIR SHARE

SPECIAL REPORT

PRESCRIPTION FOR RECOVERY: Keeping South Carolina's Prison Health Care Public and Making It Better

Marguerite G. Rosenthal, Ph.D.
Grassroots Leadership

400 Clarice Avenue, Suite 400
P.O. Box 36006
Charlotte, NC 28236
704-332-3090
www.grassrootsleadership.org

South Carolina Fair Share
1338 Main Street, Suite 301
p.o. Box 8888
Columbia, SC 29203
803-252-9813
www.scfairshare.org

Executive Summary

As a follow-up to our earlier Prescription for Disaster: Commercializing Prison Health Services in South Carolina, this report is focused on important issues that the South Carolina Budget and Control Board should consider as it fulfils its legislated mandate to complete a study comparing the current public prison health care system with privatization before the South Carolina Department of Corrections SCDC] awards any contract. We are very concerned that SCDC proposed privatization apparently before conducting any objective study of its own and seemingly proceeded on ideological convictions rather than on objective realities. Prison health care is fundamentally a public responsibility both legally and morally, and we maintain that SCDC should retain it.

There are ongoing reports of deplorable health care provided by the three commercial entities that have submitted bids for SCDC's health care system. For example, the State Auditor in Vermont has just released a report that states that Correctional Medical Services has over-billed the state for non-existent staff and off-formulary psychotropic drugs the state's losses amount to almost $830,000. The Idaho Department of Corrections has launched three different investigations into the activities of its contractor, Prison Health Services. The third company, Wexford Health Sources, cancelled a 5-year contract with Pennsylvania last year, hoping to extract more money from that state.

Two studies that have compared prison health care costs among different states show

clearly that South Carolina‘s costs are already lower than most and that public systems are less costly than privatized ones. A 2003 study by PriceWaterhouseCoopers found that South Carolina‘s expenditures were over $1,000 (or 1/3) less expensive than the average of six southern states. In general the second study, conducted by Jacqueline Moore and Associates, demonstrates the financial advantages of public systems, though the author is associated with private prison health care.

The current SCDC health care system has both strengths and weaknesses. Its principal strength is its cadre of dedicated and loyal medical staff, its state-run laboratory and its own, efficient pharmacy. However, because of ob freezes and cumbersome hiring practices, the Department has left many positions unfilled, and the system is under great stress. Proactive hiring policies, creative approaches to filling positions in underserved prisons and streamlining bureaucratic regulations will ease these difficulties. Some of these will save money by making the system more efficient. Prison health care is a public responsibility and needs sufficient support to ensure the health and safety of prisoners and, ultimately, the public.

Introduction and Update

This report is a follow-up to our earlier one, Prescription for Disaster: Commercializing Prison Health Services in South Carolina. Governor Mark Sanford and his Corrections Department Director, Jon Ozmint, have advocated privatizing prison health services in South Carolina. Prescription for Disaster documented the dangerous and expensive prison health care services provided by for-profit, private corporations in South Carolina from 1986-2000 and elsewhere.

This report is being written as the South Carolina General Assembly has required the Budget and Control Board to complete a study comparing the current public prison health care system with privatization before the South Carolina Department of Corrections awards any contract.

We are writing this report in large part because the South Carolina Department of Corrections hereafter SCDC apparently conducted no thorough study of its own before making the decision to privatize its prison health care system to a private company. Especially in light of the fact that SCDC had a troubled experience with its partially privatized health system in the past, we are convinced that an objective examination of the many complex components of any prison health care system must be conducted before a major decision such as privatization goes forward. Part of this needed examination must include the experiences of the State of South Carolina and other states and localities that have or have not privatized their prison medical services.

Prescription for Disaster reported numerous examples of deplorable health care provided by the three commercial health care companies that have submitted bids for South Carolina‘s prison health care contract award, Correctional Medical Services hereafter, CMS, Prison Health Services hereafter, PHS and the smaller Wexford Health Sources.

Since the first report was written, we have found other, recent examples of private prison health care companies‘ failures. In several cases, states and counties have had to bear expensive financial costs as a consequence of both contract non-compliances and medical malpractice. News articles, official reports, and lawsuits against these companies are easily located on the internet. We cite only a few, but egregious, examples below:

Correctional Medical Services

In 2003, the Philadelphia Inquirer published a report that charged that CMS was failing to inform and treat prisoners suffering from hepatitis C in New Jersey‘s prisons. A class action suit against CMS and the NJ Department of Corrections on these same grounds was filed, and the state was forced to pick up the costs for treating the hepatitis epidemic, estimated to cost between $4.5 and $8 million in Vermont‘s State Auditor has ust released a review of that state‘s Department of Corrections‘ contracts, including one with CMS. CMS was criticized for billing for non-existent staff, needless expenses for off-formulary psychotropic drug costs and failure to submit required quarterly and annual financial reports. The state‘s losses amounted to almost $830,000. The Vermont report‘s serious charges concerning CMS‘ practices echo those of South Carolina‘s 2000 Legislative Audit Report. The U.S. Justice Department‘s Civil Rights Division, along with the American Civil Liberties Union of Eastern Missouri, is currently investigating CMS for alleged inadequate medical attention and care that may have led to the premature death of several prisoners at the state‘s Vandalia women‘s prison.

Sister Frances Buschell, prison coordinator for the Jefferson City Roman Catholic Diocese and a regular presence in the Vandalia prison, reports that CMS routinely imposes obstacles to care. She has observed the following problems: women must line up in the early morning just to fill out a request to be seen by medical personnel, and only a fraction of them actually complete the necessary forms because the time allotted for this task is much too short women wait 4-6 months for cancer treatment, at which point their cancers have worsened and may have become terminal; two women have lost sight because their meningitis was misdiagnosed as a psychiatric problem pain medication has been denied when needed; and records have been falsified. Buschell states that there is frequent turnover of medical staff and that the doctors are inept. Prison Health Services

PHS, which has contracts with many county ails as well as a few states, apparently ignored the obvious serious health problems of several Lee County, Florida prisoners. A December 2002 article reported that several prisoners died either in the ail or very shortly after being released. A lawsuit was filed in US District Court on a claim of one former prisoner who was paralyzed from —botched medical care. The same Florida newspaper report also cited the New York City Comptroller who, in expressing grave concerns over the medical care being provided at the infamous prison on Rikers Island, noted nation-wide criticism of PHS and questioned whether PHS should be permitted to provide services in New York State. Nurses at Rikers Island have claimed that PHS had so reduced staff that employees and prisoners were both at risk.

A nurse who once worked for PHS in St. Lucie County, Florida claimed that she was fired for refusing to participate in illegal and unethical practices, including ignoring a request for medication, verbal abuse of prisoners, antagonizing mentally ill prisoners and falsifying medical records.

In 2002, the ACLU filed a class action against Clark County, Nevada and PHS for dreadful conditions in the ail‘s medical unit and inadequate medical care that caused —widespread harm.“ Mental health treatment was called —atrocious and uncivilized“ and the ail was said to have no protocols for treating chronic illnesses.

In April, 2004, Idaho‘s Corrections Director expressed dissatisfaction with PHS, its contractor. The Department has launched three different investigations, and the Director was quoted as saying: —We have employee management issues, communication issues and accountability issues.

Wexford Health Sources In June, 2003, Wexford cancelled a 5-year contract with Pennsylvania after only a little over one year, hoping to renegotiate for more money.

There are recent allegations that seven deaths in Florida‘s ails–including one of a 56-year-old minister and Purple Heart Vietnam veteran who died when he did not receive dialysis on time–are attributed to poor medical treatment by Wexford.

An article in an Illinois paper reported that Wexford obtained a $114 million contract with the Illinois Department of Corrections after the company contributed $10,000 to Governor Rod Blagoevich‘s campaign. Wexford had the lowest bid but also did not have the highest score in the Department‘s evaluation.

What Should the Budget and Control Board Study?

We applaud the General Assembly‘s requirement that privatization should not be entered into headlong and without an obective evaluation of its true costs. At the same time, we have concerns that the focus of the Legislature‘s mandate to the Budget and Control Board is on costs alone. South Carolina‘s prison health care system is already among the least expensive in the country, and it is hard to imagine that any more financial reductions can be extracted from the system without harm.

Indeed, because of frozen positions within the SCDC health care system, the current costs are below what they should be. Further, what commercial companies promise is often not what they deliver, as our earlier report documented. Private companies have a record of promising to reduce costs and then wangling for increases once they have gotten their contracts. They have avoided or refused to provide needed health care services such as diagnosing and treating hepatitis C, and they have reloaded onto the public systems health services that they consider too costly. Comprehensiveness and quality of services should, in other words, be important foci of any comparison, difficult as such a detailed study might prove to be.

We are concerned that SCDC's decision to privatize its prison health care system is based upon the ideological assumption that privatization must be more efficient and cheaper rather than upon an evidence-based analysis. In this regard, we are very concerned that SCDC did not carefully study the needs of its prison health care system as well as the serious problems and financial losses associated with its previous CMS contract before launching into another privatization initiative.

There are fundamental services that are the duty of the public sector to provide. Purchasing automobiles and copying machines from commercial dealers is one thing states do not manufacture and supply themselves with these sorts of items. Running prisons, on the other hand, is an age-old function of the state. Caring for those in prison is a public obligation stemming from the consequences of prisoners' losing their liberty. Selling this obligation raises the specter of incompetent care, profits to corporate executives and shareholders–most of whom live and spend out of state–paid for by South Carolina taxpayers, and exploitation of prisoner-patients.

SCDC is fortunate to have many dedicated health care professionals. Some of them have thought carefully about needed changes to improve the delivery and efficiency of the prison health care system. These improvements would result in reducing bureaucratic functions so that more time can be spent in direct care. At the same time, these professionals recognize the difficulty the Department has had in attracting and employing personnel in some of the more remote parts of the state and they have suggestions to remedy these difficulties.

This report will briefly review of what is known about several prison health systems. It will then relate some of the suggestions that have come from current SCDC personnel.

The SCDC Prison Health Care System in Comparative Perspective

South Carolina's Prison Health Care Costs are Comparatively Low Already

In January, 2003, the accounting consultant firm, Price Waterhouse Coopers, issued a report, Interstate Survey of Health Care Costs for Inmates, commissioned by the Georgia Department of Corrections. This report, which compared prison health costs for Alabama, California, Florida, Georgia, Mississippi, South Carolina, Texas and Virginia, found that the average cost per prisoner in these states in FY02 was $3,523South Carolina, the cost was nearly one-third less: $2,280 Only Alabama and Mississippi spent less than South Carolina that year. Alabama's system was a troubled privatized one that has since switched providers, but Mississippi's was public at that time.

Another study was conducted by the firm, Jacqueline Moore and Associates, in 2003. Moore was a co-founder of Prison Health Services (PHS) but currently has ties to Corrections Medical Services [CMS]. PHS and CMS are the two biggest for-profit prison medical companies, and both have submitted bids to the SC Budget and Control Board. Moore's study compared FY 2002 per prisoner health costs for 8 states. A comparison of

average costs as published in this report is reproduced on the following page.

Note that Vermont, Maine and Wyoming contracted with CMS and paid between $4,318 (without pharmacy charges) and $6,420 (capped) per prisoner per year. The chart above also shows that Utah, a publicly provided system, had lower per prisoner costs than the privatized systems, $2,998 (after funds allocated for clinical services but used for other purposes were returned to the Department of Corrections). Although Moore's report made some recommendations for further efficiencies, it concluded that Utah had a cost-effective and comprehensive system that should not be privatized. This report, available online at http://www.le.state.ut.us/interim/2003/pdf/00001128.pdf, could well be useful to those reviewing South Carolina's prison health care system.

Another cost comparison is contained in the following: In FY 2004, CMS was charging Missouri $7.84 per day per prisoner or $2,861.50 annually. This amount exceeds South Carolina's costs and is more than double the charges of $3.70 per prisoner per day originally contracted for in 1992.

These cost analyses demonstrate that, on its face, public prison health care is less expensive than privatized prison health care. There may, of course, be some unique situations in each state's system. Nonetheless, these studies certainly suggest that South Carolina will not save money by contracting with for-profit prison health companies.

We suggest that privatizing will not save money because a commercialized system necessarily adds costs since it must reward its investors with profits and its executives with salaries much higher than public sector compensation. To make up for these added costs and charge the state less, commercial companies must reduce the quantity and quality of services, as the many stories of inadequate care cited above attest, and/or they must substantially reduce the compensation of those actually providing the services. In the latter case, dollars are removed from South Carolina's economy.

If costs can be saved by better management, as private companies often claim, there is no reason that the SCDC cannot itself become more efficient see below for some suggestions We suspect, however, that having already suffered several severe budget cuts, there is very little else that can be cut out of the SCDC prison health system. Except as an initial loss leader as has happened elsewhere), how can a commercial company possibly save dollars reward its investors and executives except by improperly rationing services?

South Carolina's Prison Health Care Costs Have Been Dropping

Not only is South Carolina's prison health system relatively inexpensive, it has also been reducing its average costs per prisoner. While most of the states in the Southeast region saw increases of between 3% and 16% between FY01 and 02, South Carolina's costs dropped by 14.7%, nearly 3 times more than the only other state to see reductions, Tennessee. We note that CMS pulled out of its contract with SCDC during FY 2001. In

other words, when South Carolina took its prison health care system back from a private company, its costs went down significantly. We urge future investigators to look carefully into these reductions to determine their causes and evaluate their promises for the future.

We observe that South Carolina‘s total payments to outside medical providers such as general hospitals (presumably for emergency services and complex health services was nearly 13 of its prison health care budget in both FY01 and FY02.20 Perhaps this significant expenditure is related to the fact that SCDC continues to contract with Columbia Care, run by Just Care, Inc. of Alabama, a private health care corporation, for some of its prisoner patients. According to SCDC‘s chief accountant, private care was estimated to cost the state $20,000 more per prisoner per year than care in the prison system‘s infirmary. Continued use of this facility and its associated costs is certainly an area that should be examined further.

Can SCDC‘s Prison Health Care System Improve?

As noted above, personnel in the current, public SCDC prison health system have hands-on knowledge of their system and have offered this writer some suggestions for greater efficiency and cost savings. Some of these suggestions are presented below, but–again–we urge that future investigators consult with a variety of medical and mental health care givers, pharmacists and laboratory technicians, particularly those currently working within the SCDC system, to gain a more detailed description of their work while also gaining important information and recommendations for improving the system.

To begin with strengths, SCDC medical personnel point to several important factors:
- Dedicated and loyal employees
- A system of medical directives that has functioned well in the past but may be slipping currently
- A state-run pharmacy that runs efficiently and in a cost-cutting manner
- A state-run laboratory which, similarly, is cost-efficient since testing is done in-house; and
- Strong specialty clinics.

There are a number of weaknesses, however, that are frequently mentioned. These include and will be further elaborated on, below
- Insufficient direct medical personnel, including doctors, nurses, nurse practitioners and psychiatrists
- Cumbersome hiring practices that dissuade applicants from seeking positions at SCDC;
- Hiring freezes that have left clinics understaffed, creating tremendous burdens on the loyal staff remaining and costing SCDC substantial financial outlays for per diem hiring; Few medical protocols in place, resulting in wasted effort and time in getting approvals for prisoner care;
- Quality of care that is not always up to standard
- An inadequate administrative structure with poor linkage and communication between

the Central Office and individual clinics and
• An overly bureaucratic system that wastes time and effort that could better be spent on patient care.

Suggested Solutions

Staffing problems appear to be at the core of the various challenges facing SCDC's medical services and, indeed, have provided at least one of the rationales for seeking to commercialize the system. These problems fall into two categories: staffing qualifications and appropriate levels of responsibility; and hiring protocols to attract new personnel. Specifically, the following recommendations have been suggested by current SCDC health staff:

Staffing the clinics: Currently, there appears to be an over-emphasis on having physicians in each clinic. Since nurse practitioners are licensed to prescribe medication, having a nurse practitioner in each clinic would be cost effective and is more likely to result in eliminating the large number of physician vacancies.

Hiring medical and mental health specialists: Staffing all the prisons, particularly those in rural areas, is admittedly a difficult challenge. However, scholarship or loan pay back arrangements for students attending South Carolina's public institutions of higher education who are training for relevant specialties, such as psychiatrists, psychologists, psychiatric nurses and social workers, could assist in filling some positions. Under this arrangement, students receiving scholarships would be obligated to work for the SCDC for a fixed amount of time after they receive their advanced training. Some may, of course, choose to remain in the prison health system after they have fulfilled their mandatory obligations. A related suggestion is that SCDC partner with the University of South Carolina's Medical School and its public universities to arrange for internships. Under appropriate supervision, interns can greatly augment SCDC's medical and mental health staff.

Recruitment methods More aggressive outreach, particularly through active use of the internet, is needed. Commercial prison health care companies use the internet for recruitment; SCDC should use the same techniques. We note that North Carolina's Department of Corrections, which contracted with CMS to staff its prisons in remote, rural areas, found that the private company was no more successful than it had been and therefore terminated the contract.

Hiring incentives: SCDC should consider instituting sign-on bonuses to recruit medical and mental health personnel who agree to work in hard-to-staff prisons.

Streamlining the hiring process: The current hiring process takes too long and is overly bureaucratic. Especially since there is a nursing shortage in South Carolina, the red tape involved in hiring must be cut so that appropriate applicants receive ob offers quickly and are rapidly moved into their SCDC positions. Allowing medical personnel in each facility

to hire staff would greatly shorten the lag time and administrative costs currently involved in employing new personnel.

Unfreezing medical records personnel positions: Nurses currently have responsibility for medical records, taking time away from nursing. Shifting responsibility for medical records duties to other personnel might make sense since they are often not fully occupied with their primary responsibilities.

Developing a pool of nurses: Instead of hiring per diem nurses from a private and expensive nursing agency, SCDC could develop its own pool of nurses to fill in as needed in several institutions.

Allowing positions to be filled before a resigning employee leaves: Being proactive about replacing personnel would assure that positions are filled in a timely fashion.

Filling vacant pharmacist positions with technicians: Licensing requirements allow for 3 technicians for each pharmacist hiring technicians this way would be cost-effective. Streamlining the bureaucracy to make medical care more efficient would allow medical personnel to attend to patient care instead of filling out request forms and waiting for approvals from central office. A key to achieving more efficiency involves having nurses use existing Medicare protocols, thus eliminating the need for a physician‘s having to review and approve consultations and treatment regimens.

A specific recommendation offered by a current nursing supervisor is to purchase the computerized version of McMillan, Robertson Utilization Review and to make it available to all SCDC clinic physicians and nurse practitioners to save time on routine cases. Another suggestion is to revamp the nursing hierarchy, eliminating a supervising nurse at each location and allowing the head nurse to serve in that capacity with, perhaps, 3 or 4 nursing supervisors for the whole system to whom the head nurses would report. In general, there needs to be an evaluation of the true staffing needs to determine how many supervising staff are actually needed in order to reduce costs associated with higher ranking medical personnel.

Mental health screening and appropriate placement are crucially important to the functioning of the prisons. Mental health professionals such as social workers and psychiatric nurses can conduct mental health screenings, considered very important in light of the large numbers of mentally ill and substance-dependent prisoners. These professionals can be hired at less cost than psychiatrists and clinical psychologists who are currently required to perform these functions.

Re-instituting the accreditation process would assure that medical services conform to standards. Assuring obectivity in evaluations is crucial. With oversight to insure that they remain obective, using available SCDC medical staff for audits is cost-effective, particularly because they can establish appropriate policies and procedures as part of this function. There needs to be more accountability in the system currently too many decisions pertaining to health care are left to each warden.

Establishing an independent medical services review body that can receive, investigate and respond to questions and complaints related to prison health care services raised by prisoners, their families, employees and advocates is vitally important to improve the prison health care system and assure that health care is properly delivered and crises are avoided

Hidden Costs of Inadequate Prison Health Care Systems

States are obligated by a U.S. Supreme Court decision to provide prisoners with adequate health care. Even when prison health care systems are privatized, the states continue to bear this legal responsibility. Prison health care is not just a matter of personnel, physical facilities and medications. There are the costs of attorney and legal fees, insurance and settlement payouts associated with malpractice claims and lawsuits. If the prison health care system is under-funded and under-staffed, lawsuits will abound, and the state will have costly damage awards. While the current costs to the State of South Carolina are not known to us, it should be cautionary that officials in one New York County suggested doubling their insurance protection when it privatized its jail‘s health program.

And then there is the matter of public health. Nearly every prisoner will be returning to his or her community someday. Thus, prison health care is truly a public health concern. Because of the crowded conditions of their confinement and their poor health status, prisoners are particularly susceptible to communicable diseases such as tuberculosis, hepatitis C and HIV/AIDS. It is therefore critical that they get appropriate treatment. If they do not, these illnesses will spread to the general population. To save lives and to protect public health, health care should be efficiently but also adequately provided. These are all important factors to consider when evaluating who should be delivering prison health services.

Conclusion

The current SCDC prison health care system is not expensive when compared to other state systems. Privatizing does not save money. Indeed, giving state money away to out-of-state executives and shareholders results in further squeezing the health care system.

SCDC has a cadre of dedicated and thoughtful personnel, many of whom have devoted much of their professional lives to caring for the state‘s incarcerated population. The system appears to be functioning fairly well, but, as should be clear from the briefly outlined suggestions above, there are many areas that can be greatly improved. These suggestions, if explored in greater detail and implemented appropriately, may result in financial savings to the state. At the same time, we caution that the system appears to be seriously understaffed, particularly in the area of primary caregivers. Reducing bureaucratic functions will make more current personnel available to perform caring functions, but more personnel are clearly needed.

The changes outlined above have been suggested by current SCDC medical staff. These professionals are in the best position to provide details about their current ideas as well as to provide additional suggestions for improvements in the system in which they work. Establishing a task force composed of current staff representing different specialties and geographical areas of the state and outside medical experts familiar with institutional health care is, we feel, the best way to evaluate how to improve the SCDC health care system both to make it more cost-efficient and to enhance the quality of care it provides.

ABOUT THE AUTHOR: Marguerite G. Rosenthal is a Professor of Social Work at Salem State College in Salem, Massachusetts. She holds a Ph.D. in Social Work and Social Welfare from Rutgers University. She has received awards and grants from the National Institute of Mental Health, the National Association of Social Workers and the U.S. Department of Health and Human Services. Early in her career, she served as a juvenile probation officer with the Onondaga County Probation Department in Syracuse, New York and as supervisor of field staff at the State of New Jersey‘s Department of the Public Advocate. She has published and presented widely on issues of social policy, privatization, managed care, welfare reform, residential care, juvenile corrections and faith-based initiatives. She is currently serving as Senior Research Fellow for Grassroots Leadership while on sabbatical from Salem State College.

References

Rosenthal, M.G. (2004). Prescription for Disaster: Commercializing prison health care in South Carolina Grassroots LeadershipSouth Carolina Fair Share.

Fazloliah, M. and Lin, J.2003). Hepatitis C treatment may cost N.J. millions. Philadelphia InquirerJan. 12) Selan, E. HepC class action suit filed in U.S. NJ District Court, retrieved at http://www.hcvinprison.org/doscs/classaction100103.html on 5/31/04.

Ready, E.M., (2004). Keys to Success: Improving accountability, contract management and fiscal oversight at the Department of Corrections. (May 26)

South Carolina General Assembly, Legislative Audit Council (2000). A review of the medical services at the SC Department of Corrections (LAC/SCDC-98-7), retrieved at http://wwww.state.sc.ussclac/Reports20000/SCDS.htm on 4/1/2004.

Dreiling, G. L.2003). Some inmates tell horror stories about healthcare at the women‘s prison in Vandalia. Some didn‘t live to tell their tales. Riverfront Times (Oct. 15 Denise Lieberman, Legal Director, ACLU of Eastern Missouripersonal communication, (May 24, 2004).

Sr. Frances Buschellpersonal communication, (June 1, 2004).

Hoyem, M.2002). Dying in Lee County Jail. News Press (Dec. 22) http:www.news-press.comnewsloca_state/0212222jailmedicine.html.

Ibid.

Service Employees Union Local 1199 (2001). Bad to worse at Rikers (June).

Pollio, M. (2002). Ex-ail nurse sues healthcare company. Retrieved at http://allnurses.comforums/showthread.php?postied=168051 on 5/28/04

Geer Thevenot, C. (2002). Class-action lawsuit: Jail‘s care deficient, ACLU says. Vegas Review-Journal (May 26).

n.a. (2004). The Idaho StatesmanApril 6). Retrieved at http://www.flpba.org/private/ rap_phs.html on 6/1/04. .

Ransom, L. (2003). Wexford ends inmates‘ health care contract. Pittsburgh Tribune-Review. (June 7) Retrieved at http://www.pittsburghlive.comtribune-review/yesterdayprint_138547.html on 3/9/2004.

Barg, J. 2002). Scandals r us: Seems the city can‘t find a prison health care provider without a troubling past. Philadelphia Weekly (Sept. 4 Retrieved at http:wwww.philadelphiaweekly.com/article/asp?ArtID=4195 on 5/28/04.

O‘Connor, J. State awards prison contracts to Blagoevich contributor. Journal RegisterMarch 9).

PriceWaterhouseCoopers (2003). Georgia Department of Corrections: Interstate Survey of Health Care Costs for Inmates (January 21), p. 4.

Broughton, A. Privatization study advisor under scrutiny. The Salt Lake Tribune July 16). Retrieved at http://www.strib.com on May 28, 2004.

Moore, J. and Associates (2003). Analysis of cost and service within the Utah Department of Corrections Bureau of Clinical Services. —Discussion Draft“ prepared at the request of the Office of Legislative Fiscal Analyst (November 18). Table 10. p. 37.

Dreiling, G. L.2003). Some inmates tell horror stories about healthcare at the women‘s prison in Vandalia. Some didn‘t live to tell their tales. Riverfront Times (Oct. 15).

PriceWaterhouseCoopers (2003). Georgia Department of Corrections: Interestate Survey of Health Care Costs for InmatesJanuary 21), p. 7.

PriceWaterhouseCoopers (2003). Georgia Department of Corrections: Interestate Survey of Health Care Costs for InmatesJanuary 21), p. 8.

The Post and Courier (Jan. 27, 2003). Corrections closes 5 prison infirmaries. Retrieved at http://www.charleston.net/cgi-bin/printme.pl on March 31, 2004.

Keith Acree, Public Information Officer, North Carolina Department of Correctionspersonal communication, (April 5, 2004).

Estelle v. Gamble, 429 U.S. 97, 1031976

Martineu, K. (1999). Privatization of ail infirmary advances. The Times Union (November 24) www.grassrootsleadership.org www.scfairshare.org