Healthcare Standard for Federal Prisoners: Examining the Eighth Amendment and Principle of Equivalence of Care

Francesca Jereis
Cuny Hunter College

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The discourse on punishment and the evolution of penal institutions, rooted in capital and corporal practices, underwent a significant shift with the introduction of prisons in the late 1700s.[1] Prisons aimed to accomplish deterrence, retribution, and the safeguarding of liberty by threatening to isolate individuals from the external world. In this essay, the historical trajectory, influenced by societal changes and political philosophies, is explored with insights from philosopher Jeremy Bentham's panopticon metaphor. Modern prisons reflect Bentham's focus on constant monitoring through surveillance technology and layouts, emphasizing control and discipline; his ideas shape contemporary prison objectives and practices. Modern prisons emphasize order and authority over incarcerated individuals.[2] The entrenched focus on control within the prison system has yet to prove entirely effective in addressing the multifaceted challenges faced by prisons. This approach potentially exacerbates some issues and gives rise to new complexities, particularly in the realm of healthcare provision for incarcerated individuals. This essay asserts the fundamental right of federal prisoners to healthcare while scrutinizing the distinct standards set by *Estelle v. Gamble* and the principle of equivalence in care.

Prison system structures encompass elements such as institutional policies, organizational hierarchies, and systemic protocols, which are not overtly linked to healthcare but indirectly shape the healthcare dynamics within correctional facilities. All

personnel within the federal prison system, irrespective of their specific roles, receive training as correctional officers.[3] This training includes upholding security measures, effective inmate supervision, and promoting a secure institutional environment. While the primary responsibility of prison physicians is to deliver medical care, their concurrent and foremost obligation, stemming from their employment within the prison, is to uphold the institution's policies and protocols. One concern arising from this dual loyalty centers on preserving prisoner confidentiality. The tension between the duty to provide comprehensive healthcare and the obligation to assist in maintaining a secure environment can create ethical dilemmas for prison physicians. Suppose a prison doctor is conducting a routine physical examination of a prisoner and finds an illicit substance. On one hand, their obligation to provide healthcare demands addressing the inmate's medical needs, which may include addiction treatment and counseling. Addressing an inmate's addiction as a confidential matter becomes crucial when considering the potential consequences of non-confidential handling. If information about an inmate's addiction were to be disclosed, correctional officers might use this information to justify punitive measures, such as placing the inmate in solitary confinement. Such actions could exacerbate the inmate's mental health and lead to a counterproductive cycle of punishment rather than rehabilitation. Correspondingly, the potential for mistrust between inmates and their physicians rises when they perceive that their medical information might be shared with correctional staff. As the physician-patient relationship is compromised, inmates may be less inclined to disclose critical health concerns, interfering with the delivery of effective healthcare interventions. On the other hand, the discovery of drugs could pose a security risk within the prison, and it is reasonable to assume that part of the training for correctional officers involves reporting such findings. Striking the right balance between these conflicting responsibilities is challenging, requiring careful consideration of medical ethics and institutional security. If institutional security takes precedence, it can undermine the physician-inmate relationship.

While this dilemma represents only one among numerous issues regarding prison health, the well-demonstrated and undeniable fact remains: incarceration has a detrimental impact on the health of inmates. Compared to the general population, individuals in prison

exhibit elevated rates of infectious diseases, stress-induced ailments, weight gain, cardiovascular disease, and cancer.[4] These health disparities are not evenly distributed, with the burden falling disproportionately on incarcerated Black communities, further exacerbating the cycle of systemic inequality that these communities face.[5] Establishing causal links between imprisonment and health conditions proves difficult due to other structural factors linked to poor health, including poverty and limited education among incarcerated individuals. The state of prison medical care is subpar, facing significant challenges in ensuring adequate healthcare for incarcerated individuals. According to the *American Journal of Public Health*, 13.9% of federal inmates did not receive a medical examination once during their incarceration. Moreover, 3.9% of federal inmates experiencing an ongoing medical issue requiring regular laboratory monitoring had not undergone a single blood test during their period of incarceration.[6] This is particularly concerning given that many of these conditions are preventable or manageable with appropriate care. For example, there is a correlation between incarceration and elevated rates of hypertension, even when adjusting for factors such as drug use, family income, and previous smoking habits, in comparison to individuals who have never been incarcerated.[7] The elevated rates of various diseases and ailments among inmates suggest a lack of access to adequate medical care and preventive health services.

While the preceding paragraphs illuminate the health disparities experienced by incarcerated individuals, the consequences extend beyond morbidity alone. In December 2021, the most recent release of data, the U.S. Department of Justice's Bureau of Prisons reported a mortality rate of 259 deaths per 100,000 inmates.[8] The Department of Justice has a troubling track record of omitting crucial details in its reports, such as the circumstances surrounding each individual's death. Alarmingly, 70% of the prisons included in the report had one or more missing elements.[9] This lack of transparency raises genuine concerns regarding the accuracy and comprehensiveness of these mortality statistics. It is important to note an alternative rationale for the low mortality rates among individuals in prison is that incarceration provides a protective environment. Spending time in prison may lower risk of death due to violence or accidents, restrict access to illicit drugs and alcohol,

and enhance healthcare accessibility for some communities. Notably, these protective mechanisms are pronounced for Black male prisoners compared to other demographic groups.[10]

Health and mortality effects of imprisonment extend beyond prison stays due to prevalent conditions which may have long-term negative consequences if not promptly diagnosed and treated. As highlighted by Daza et al., prison environments lead to acute and chronic stress, unhealthy behaviors, and mental health issues, contributing to drug abuse, depression, anxiety, and decreased life satisfaction.[11] Potential contributing factors include exposure and threats of violence, as well as adversarial relationships with both guards and fellow inmates. Extreme conditions like solitary confinement increase the risk of fatal self-harm. Unhealthy behaviors and mental health problems during incarceration can have lasting effects on an individual's post-prison life, with outcomes influenced by prison conditions and access to prevention and treatment programs. Binswanger et al. found that former inmates faced a mortality risk 3.5 times higher than non-incarcerated area residents after adjusting for relevant variables, with drug overdose and cardiovascular issues being the leading causes of death.[12] This may arise from post-release psychopathology—the development and worsening of mental health disorders following incarceration—or from barriers that impede access to clinical care.[13] The worrisome state of health in prisons demands attention as it is a cornerstone of personal and societal well-being.

The importance of health becomes most apparent at the societal level in its impact on productivity, economic stability, and community resilience. The unique nature of health as an asset is understandable when viewed through ethical principles that emphasize the inherent worth of well-being and the advancement of justice, emphasizing its essential contribution to human flourishing. This view of health aligns with the notion of a "primary social good," as articulated by John Rawls. Rawls defined primary social goods as the commodities that every rational individual is presumed to prefer, regardless of their life circumstances, when situated behind the veil of ignorance; the veil of ignorance prompts individuals to imagine a scenario where they lack knowledge about specific details concerning themselves, encouraging them to formulate principles for a just society impartially.[14] Rawls identifies two criteria for something to be

considered a primary social good. First, primary social goods are valuable for every rational individual, regardless of any particular life plan, values, or conception of the good. They are assets with broad and general significance, applicable to people with diverse aspirations and goals. Second, primary social goods are deemed necessary to effectively pursue a wide range of life plans. They are the foundational resources and conditions individuals require to lead a satisfying life and exercise their basic liberties. Without these goods, individuals would face significant obstacles in realizing their aspirations.[15]

Rawls classified health as a primary natural good rather than a primary social good, contending that its uneven distribution in society results from it being beyond direct control. In "Enhancing John Rawls's Theory of Justice to Cover Health and Social Determinants of Health," Ekmekci and Arda highlight health as fulfilling the first criteria of a primary social good. A rational individual behind Rawls's veil of ignorance would deem health a fundamental social good due to the absence of guaranteed baseline health, and even if such assurance existed, it remains susceptible to loss or reduction at any stage of life.[16] Norman Daniels presents an argument upholding the second requirement. Daniels contends that health plays a crucial role in upholding the principle of "fair equality of opportunity."[17] This principle asserts that every individual should have an equal opportunity to achieve their potential and pursue life goals. Given that health significantly influences one's capacity to lead a fulfilling life, Daniels argues that ensuring equitable access to healthcare becomes indispensable for realizing the principle of fair equality of opportunity. Thus, safeguarding health emerges as an integral component in advancing justice and promoting the equitable distribution of opportunities within society.

In Rawls's *Theory of Justice*, the first principle of justice ensures individuals equal access to fundamental liberties.[18] Consequently, adopting Ekmekci and Arda's as well as Daniels' perspective and recognizing health as a primary social good solidifies health as an inherent and fundamental right. Recognizing health as such underscores that individuals possess a legitimate entitlement to access the conditions necessary for well-being; it is more than a desirable outcome—it is a right within a just and fair society. Rawls's theory emphasizes the fairness of distributing primary goods. This

perspective aligns seamlessly with the broader discourse on the right to health, highlighting that essential healthcare services should not be denied based on arbitrary factors. Rawls's theory underscores the need to recognize and protect health as a right, ensuring individuals, regardless of socio-economic status, race, gender, or incarcerated status, have the means to pursue their conception of the good life in a just and equitable society.

Having affirmed the right to healthcare, I will now articulate the duty associated with this right. According to the correlativity thesis, there is a corresponding duty for every right and a corresponding right for every duty, asserting that the existence of a right implies the existence of a duty.[19] Take, for example, the positive right to legal counsel. If an individual has a legal right to counsel, it implies a corresponding duty on the part of the legal system or the government to provide access to legal representation. In this scenario, the right to counsel is not merely an abstract claim; it implies that others, such as those in the legal system, have a duty to facilitate and ensure the availability of legal assistance. Conversely, consider the negative right not to be killed. In that case, it imposes a duty on others, including fellow individuals and societal institutions, not to kill. This negative right establishes a boundary on the actions of others, outlining a duty to refrain from engaging in lethal conduct. While these examples are rights entailing duties, the existence of a duty also entails a right. Lyons illustrates this concept by highlighting the scenario where Bernard owes Alvin money. In this case, Bernard has a duty to repay the debt, and simultaneously, Alvin possesses the corresponding right to receive the owed sum. The correlativity thesis, therefore, emphasizes that Bernard's duty to repay entails Alvin's right to be repaid.[20] Whether dealing with a positive or negative right, the correlativity thesis underscores the interpersonal nature of these ethical relationships. The assertion of a right, such as the right to counsel or the right not to be killed, implies that others—be they legal systems, fellow citizens, or institutions—have corresponding duties to respect and fulfill these rights. Where there are duties, there are responsible agents.

With the recognition of health as a fundamental right and understanding of the correlativity thesis, I will discuss a federal prison's duty to provide healthcare by first examining *Estelle v. Gamble* and what it established. *Estelle v. Gamble* is a U.S. Supreme Court case

that took place in 1976. The case originated when J.W. Gamble, a Texas state prisoner, filed a lawsuit against prison officials, including the prison's medical director, Estelle, for failing to provide him with adequate medical care while incarcerated, specifically regarding a back injury sustained during a prison work assignment. Gamble contended that the prison officials' handling, or rather lack thereof, of his injuries amounted to cruel and unusual punishment, a violation of the Eighth Amendment to the U.S. Constitution. The central question in this case was whether the prison officials' handling of Gamble's injuries amounted to deliberate indifference to serious medical needs. The Supreme Court, in an 8-1 decision, ruled in favor of Gamble.[21] The ruling affirmed that deliberate indifference to an inmate's medical needs is a violation of the Eighth Amendment's prohibition against cruel and unusual punishment. As a result, *Estelle v. Gamble* established two crucial principles through judicial precedent: first, it recognized that prison systems, due to their confinement of inmates, are obligated to offer healthcare to those incarcerated, and second, this healthcare must meet a standard that does not fall below "deliberate indifference" to address the "serious needs" of prisoners. Healthcare has been interpreted not only in the strict sense of providing medical assistance but also in the sense of providing humane living conditions and protection from violence, meaning the word carries certain expectations with it.[22]

The first tenet articulated by *Estelle v. Gamble* underscores that prisons have a recognized duty of delivering a certain level of healthcare to individuals in their custody. The acknowledgment and content of this duty are further emphasized by the Federal Bureau of Prison's Health Services division, which "is responsible for medical, dental, and mental health (psychiatric) services provided to adults in custody in Federal Bureau of Prisons (BOP) facilities, including healthcare delivery, infectious disease management, and medical designations."[23] It is important to note this obligation is not explicitly outlined in the Eighth Amendment; instead, it is established through the judicial interpretation and precedents set by the Supreme Court. When the Supreme Court makes a decision, it becomes a binding law of the country, one that every person must comply with. Thus, the judicial interpretation has solidified a legal obligation incumbent upon prisons. The correlativity thesis, then, signifies the concurrent

existence of prisoners' right to receive essential healthcare services as an entitlement during their period of confinement.

Estelle v. Gamble's second principle introduces a concept known as the "harm threshold," a critical point to underscore. It is crucial to explicitly specify that, in this context, "harm" is specifically health-related. In contrast, the Eighth Amendment allows for the deprivation of liberty through incarceration and, in some cases, the deprivation of life through capital punishment, provided that specific legal procedures are followed. However, the Eighth Amendment restricts certain harm to wellness, reflecting a legal and ethical recognition that health, as an intrinsic good, warrants protection to prevent unnecessary suffering. It underscores the idea that denying healthcare access to inmates who are suffering, allowing significant harm to one's health, runs counter to the principles of justice and fairness. Therefore, the harm threshold can be defined as the juncture at which a specific degree of healthcare inadequacy is deemed unacceptable or intolerable.

The Eighth Amendment's relevance to penal healthcare serves as a standard that delineates what prison healthcare should avoid rather than prescribing an exact model for its provision. If a prison's healthcare system consistently provided inadequate medical care, such as delays in addressing serious medical conditions or neglecting essential treatments, it would be considered a violation of the Eighth Amendment. The amendment does not spell out every detail of how prison healthcare should operate but rather specifies that it should not fall below the constitutional standard of preventing cruel and unusual punishment by neglecting the medical needs of inmates. The Eighth Amendment, as interpreted in *Estelle v. Gamble*, confirms the existence of a right to a certain level of healthcare, ensuring it does not descend to a standard that would be deemed cruel and unusual punishment. Building on this foundation, I will scrutinize the principle of equivalence as a separate standard from the Eighth Amendment and critically assess its interpretation.

In December 1990, the United Nations Organization articulated a resolution stating: "Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation."[24] This fundamental concept gave rise to what is known as the principle of equivalence of care, meaning that prisoners should receive healthcare services that are of a quality

and standard equivalent to what is available to the general population outside of the prison system.[25] This reflects a commitment to uphold the dignity and well-being of individuals in custody by ensuring that their healthcare needs are met with the same standards of adequacy as those of the broader community.

Extensive literature delves into the relevance, limitations, and shortcomings of the principle of equivalence as a framework for prison medicine. Nonetheless, two common errors frequently arise. Firstly, there is a tendency to confuse and conflate the relationship between the principle of equivalence and *Estelle v. Gamble*'s interpretation of the Eighth Amendment. Secondly, the principle of equivalence has been poorly defined, leading to unwarranted challenges. In "Relevance and Limits of the Principle of 'Equivalence of Care' in Prison Medicine," Gérard Niveau states:

> In the USA, the principle of equivalence is present in the jurisprudence relating to the care of prisoners. Following the case of *Estelle v Gamble* (1976), it is recognised that the right of prisoners to receive healthcare is enshrined in the eighth amendment to the US Constitution. Although the principle of equivalence is not named among these rights, it is indirectly included among them and appears in the standards of accreditation of health services in the USA.[26]

The Eighth Amendment does not, as Niveau has framed it, confer upon prisoners the right to receive healthcare at the level that the principle of equivalence would suggest. While acknowledging the pivotal role of *Estelle v. Gamble* in establishing the fundamental right of prisoners to receive medical care, it is crucial to recognize the limitations associated with relying solely on this legal precedent as the guiding principle for healthcare in correctional facilities. *Estelle v. Gamble* primarily addresses the issue of deliberate indifference to serious medical needs, focusing on the constitutional prohibition of cruel and unusual punishment under the Eighth Amendment. Attending to significant, immediate needs is a crucial aspect of prisoner healthcare, but it does not comprehensively cover the broader scope of healthcare quality and standards. For instance, suppose a prison healthcare system fails to perform yearly physical examinations for their inmates. Prisoner A has high blood pressure, and the absence of these examinations means that potential health issues related to high blood pressure may go undetected or untreated.

If Prisoner A has a stroke, that could be a direct consequence of their high blood pressure, as hypertension increases the risk of damage to blood vessels in the brain. This situation is not considered cruel and unusual punishment because it was not a case of deliberate indifference by the prison authorities. Deliberate indifference typically involves the conscious disregard of or failure to take reasonable measures to address an inmate's serious medical needs or a failure to provide necessary care when there is clear knowledge of the risks involved. In this scenario, the absence of regular physical examinations might have been due to resource limitations, oversight, or systemic issues rather than a deliberate indifference towards Prisoner A. Although this situation may not be deemed cruel and unusual, it highlights the limitations of the Eighth Amendment in specifying the necessary healthcare standards and ensuring comprehensive medical care for inmates.

The difference between the Eighth Amendment and the principle of equivalence is that they underscore two distinct viewpoints. The Eighth Amendment, by design, primarily acknowledges a negative perspective, setting a constitutional baseline that prohibits prison conditions or healthcare from falling below a certain threshold. It serves as a safeguard against cruel and unusual punishment, setting the minimum standard that correctional facilities must meet to avoid violating the Constitution. In contrast, the principle of equivalence aligns with a positive perspective, emphasizing an aspirational goal for correctional institutions. It encourages prisons not only to meet the legal requirements outlined by the Eighth Amendment but also to aim for a higher standard. The principle of equivalence emphasizes the importance of providing equitable and comprehensive healthcare, not merely to avoid constitutional violations but to genuinely address inmates' medical and humane needs. It embodies the idea that inmates should receive healthcare that is not just the bare minimum but reflective of a higher moral and ethical standard. The principle of equivalence is not explicitly or implicitly encoded within the Eighth Amendment; the standard's specific definition and parameters remain ambiguous. However, it is crucial to recognize that guidelines remain distinct from a codified mandate in the amendment, no matter how diligently adhered to. Even with strict adherence to these standards, the

absence of codification poses challenges in ensuring a consistently constitutional level of healthcare within prison systems.

The second error when discussing the principle of equivalency is its interpretation to mean the direct application of healthcare delivery methods used in the general population to the prison setting. Scholars such as Lines, Charles and Draper, and others argue that prison populations have their own healthcare needs and issues distinct from the general population and thus require healthcare that exceeds the principle of equivalence of care.[27] Lines illustrates his point with Dublin's methadone public health issue. In Ireland, those on community methadone treatment can maintain it if arrested, but prisoners cannot initiate a new methadone regime while in jail. Lines argued that even if inmates were allowed to join the waiting list while in prison, it would not sufficiently mitigate the risk of HIV and hepatitis C transmission through syringe sharing in prisons, as prisoners lacking access to needle/syringe programs would continue injecting drugs, sharing and reusing equipment while awaiting methadone treatment.[28] Lines contends that the principle of equivalence of care falls short in addressing the needs of prisoners. Although the case presented by Lines does not adequately meet the health needs of prisoners, it is inaccurate to attribute this deficiency to adhering strictly to the principle of equivalence. The principle does not mandate identical healthcare delivery for prisoners compared to the general population. Recognizing this, for example, would suggest that prisoners should have the right to choose their healthcare providers and seek a second opinion from an alternative physician, paralleling the healthcare delivery granted to the general population. For prisoners to have access to the same health services as those afforded to the general public they would have to receive medical care and treatment that is similar in quality and standard to what is available to individuals outside the prison system. This includes physical and mental health services, preventive care, and treatment for medical conditions. Exploring the nuanced aspects of this concept and potential forms it could take requires a more in-depth examination. Delving into various possibilities and envisioning practical application demands thoughtful consideration of multiple factors. I will proceed to address potential objections.

Objection 1: *Regarding the Eighth Amendment and the example of Prisoner A, there is reason to think the case also fails on Eighth Amendment grounds.*

The scenario described might not necessarily constitute deliberate indifference, as the absence of yearly physical examinations may be due to factors other than deliberate neglect or indifference on the part of the prison authorities. In the given scenario, if the failure to perform yearly physical examinations is due to resource limitations, oversight, or systemic issues rather than a conscious disregard for the health of the inmates, it may not meet the criteria for deliberate indifference. However, if there is evidence that prison authorities were aware of the potential risks, had the means to address them, and chose not to act, then the term would apply. To determine deliberate indifference, the state of mind and intent of the authorities regarding the risks faced by the inmates is the focus and, specifically, whether they knowingly and recklessly ignored those risks. This idea is stated in *Estelle v. Gamble*:

> Similarly, in the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute "an unnecessary and wanton infliction of pain" or to be "repugnant to the conscience of mankind." … In order to state a cognizable claim, a prisoner must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs. It is only such indifference that can offend "evolving standards of decency" in violation of the Eighth Amendment.[29]

The distinction is between a descriptive and normative claim about what constitutes deliberate indifference. The descriptive claim observes and describes a standard wherein deliberate indifference entails a conscious disregard or failure to address an individual's serious medical needs, often involving a lack of responsiveness or neglect in providing necessary care. The normative claim calls for a broader interpretation to encompass situations where there is a lack of care—that is, a failure to provide adequate medical attention, services, or treatment, even if it falls short of intentional harm. The descriptive claim represents the judicial precedent of the Eighth Amendment, and the normative claim precisely represents why the Eighth Amendment is inadequate as a healthcare standard for prisoners: it does not include the many scenarios where it can fail.

Objection 2: *Regarding the principle of equivalence, prisoners should receive whatever the general population receives. However, the general population has massive disparities in access to healthcare. Some prisoners may receive better care than some non-prisoners. So, what does this standard amount to, given the inequalities in the general population?*

Before proceeding, I want to emphasize the importance of acknowledging healthcare disparities prevalent in the general population and do not wish to minimize them. The principle of equivalence stipulates that prisoners should have access to the healthcare available, not accessible, to the general population. Accessibility pertains to the ability to access or utilize something, indicating its ease of reach or approachability. On the other hand, availability concerns the presence of something and its obtainability. In essence, accessibility focuses on ease of use, while availability centers on the existence of something. It is crucial to recognize that these terms are distinct. Something may be easily available yet not accessible to everyone due to factors like financial barriers. Imagine a specialized educational program that is available at a certain institution. The program's availability indicates that it exists and can be pursued by interested individuals. However, if the tuition fees for the program are high, it may not be financially accessible to some potential students. In this scenario, the program's existence does not ensure its accessibility for everyone due to the financial barriers that limit certain individuals from participating.

Objection 3: *Why should we prioritize improving care/access to prisoners when so many non-prisoners have inadequate access/care?*

Disparities in healthcare access across the general population exist, but prisoners have unique circumstances due to their limited autonomy and custodial status. Non-prisoners may have the agency to seek and navigate healthcare choices. J. E. Paris illustrates this idea in "Why Prisoners Deserve Health Care" when he writes:

> Free persons may or may not have health insurance based, at least in part, on their decisions about how to prioritize the use of their money. Some who decide against buying insurance have the option to pay cash for the health services they seek. The very poor, the aged, and the disabled are generally provided with assistance in the form of federal and state Medicare and Medicaid programs. Even the so-called "working poor," loosely

> defined as those who earn too much to qualify for assistance and too little to afford to pay for health care, have the option to use or borrow cash when they need medical treatment. Moreover, federal law requires that hospitals provide medically necessary emergency health services regardless of a patient's health insurance status or ability to pay.[30]

Prisoners being under the care of the state do not have the choices outlined above. It is not about exclusive prioritization but rather acknowledging the distinct duty to provide a certain standard of care to individuals whose autonomy is restricted due to their incarcerated status. Moreover, a significant portion of prisoners will eventually reintegrate into society as non-prisoners. It would be beneficial if they were equipped with the knowledge and skills to manage their health conditions, if any, instead of perpetuating existing healthcare disparities.

Objection 4: *Can one extend Rawls's Theory of Justice to the incarcerated status? Given that we deprive criminals of other social goods, why can we not deprive them of healthcare?*

Rawls envisioned the purpose of punishment as safeguarding liberty, emphasizing the accountability of wrongdoers to establish and uphold a just society. Within this framework, Rawls ascribes the term "bad character" to individuals who engage in wrongdoing and are excluded from Rawls's ideal, just society. On the other hand, Rawls contends there are those with "superior character [possibly due to] fortunate family and social circumstances." [31] These individuals are obligated to contribute to the collective well-being of all members of society per the Difference Principle. The Difference Principle asserts that social and economic inequalities are justifiable only if they lead to the improvement of the least advantaged members of society. In other words, any disparities in the distribution of goods and resources should be structured to benefit those in the most disadvantaged positions socially and economically.

As Stuart Greenstreet highlights in "Prison Doesn't Work," if some individuals owe their "superior character" to fortunate family and social circumstances, it follows that others might attribute their "bad character" to unfortunate conditions. Greenstreet extends the point to say that should individuals in this imagined situation decide to jointly experience the outcomes related to the allocation of income

and wealth, it is rational to broaden this arrangement to include aspects of criminal accountability. Fundamentally, this suggests a logical agreement to view the dispersion of natural and social disadvantages as a shared responsibility, consistent with their handling of benefits.[32] Therefore, one could extend Rawls's view of primary social goods to be afforded to prisoners.

The second part of the question remains: given that we deprive criminals of other primary social goods, why can they not also be deprived of healthcare? The purpose of prisons needs to be established to answer this question properly. While Rawls established the purpose as a device to preserve liberty, Chad Flanders, reconstructs Rawls's argument in "Criminals Behind the Veil: Political Philosophy and Punishment" to pose punishment as a means of reducing crime and improving society.[33] However, the goals of punishment, whether aimed at preserving liberty or serving as a rehabilitative measure for society's wrongdoers, are not entirely incompatible and partially explain why we deprive prisoners of social goods but not healthcare. The deprivation of liberty for wrongdoers serves to both preserve individual freedoms and protect society. For example, incarcerating individuals who threaten public safety ensures that the broader community is shielded from potential harm while simultaneously upholding the laws necessary to maintain a free and just society.

Furthermore, despite being deprived of their liberty, prisoners retain several civil freedoms while incarcerated. Among these is access to legal counsel, ensuring their ability to navigate legal proceedings and safeguard their rights. Additionally, they maintain the right to free expression, whether through religious or political beliefs. Moreover, prisoners are entitled to be free from discrimination in all its forms, whether based on disability, race, gender, or other protected characteristics. Furthermore, prisoners have the right to be protected from excessive force and abuse by correctional staff. Maintaining order and security within correctional facilities is essential, it must be done in a manner that upholds the inherent dignity of every individual and respects their rights under the law. Given the recognition of these rights and the acknowledgment of healthcare as a fundamental human right, it is reasonable to conclude that prisoners also retain the right to healthcare. Just as access to legal counsel, freedom from

discrimination, and protection from excessive force are essential components of humane treatment in prison, ensuring access to healthcare services is critical for preserving the well-being and dignity of incarcerated individuals. Therefore, while prisoners may forfeit certain liberties due to their actions, they do not forfeit their entitlement to healthcare, which is indispensable for maintaining their health and ensuring their basic human rights are upheld, even within the confines of incarceration.

Our justice system would lack the essence of a fair society if we were to strip prisoners of both their liberty and health, and subsequently release them back into society in a condition likely worse than when they entered. Such an approach would not enhance society but would exacerbate its challenges. Depriving prisoners of healthcare not only conflicts with fundamental principles of human dignity and well-being but also runs counter to the broader Rawlsian goal of benefiting those in the most disadvantaged positions in society.

In summary, Rawls's *Theory of Justice* extends to the incarcerated status by reinterpreting the Difference Principle. This reinterpretation includes not only the expectation that the highly fortunate contribute to the benefit of all but also recognizes that the misfortune of the less fortunate should be collectively borne by society. Upon achieving this, Rawls's primary social goods can be extended to encompass prisoners. In doing so, Norman Daniels' extension of primary social goods, including health, becomes applicable to prisoners as well. Lastly, while the deprivation of certain primary social goods is a facet of the penal system, the question of denying healthcare to prisoners hinges on the overarching purpose of prisons. Rawls's focus on preserving liberty and Flanders' emphasis on reducing crime converge, explaining the deprivation of social goods but not healthcare for prisoners. The deprivation of liberty aligns with dual objectives—preserving individual freedoms and protecting society—essential for a free and just society. However, stripping prisoners of both liberty and health contradicts the pursuit of a fair society, as it compromises human rights and undermines Rawls's broader goal of aiding the most disadvantaged members of society.

Notes

[1] Miller, "The Invention of Incarceration."
[2] Gutting and Oksala, "Michel Foucault."
[3] "Federal Bureau of Prisons," BOP.
[4] Massoglia and Remster, "Linkages Between Incarceration and Health."
[5] Ibid.
[6] Wilper et al., "The Health and Health Care of US Prisoners."
[7] Wang et al., "Incarceration, Incident Hypertension, and Access to Health Care."
[8] Carson, "Mortality in State and Federal Prisons."
[9] Goodwin, PDF.
[10] Daza, Palloni, and Jones, "The Consequences of Incarceration for Mortality in the United States."
[11] Ibid.
[12] Binswanger et al., "Release from Prison"
[13] Joudrey et al., "A Conceptual Model for Understanding Post-Release Opioid-Related Overdose Risk."
[14] Rawls, *A Theory of Justice*.
[15] Ibid.
[16] Ekmekci and Arda, "Enhancing John Rawls's Theory of Justice."
[17] Daniels, *Just Health Care*.
[18] Rawls.
[19] Lyons, "The Correlativity of Rights and Duties."
[20] Ibid.
[21] *Estelle v. Gamble*, Justia.
[22] "Federal Bureau of Prisons," BOP.
[23] Ibid.
[24] "Basic Principles for the Treatment of Prisoners."
[25] Till, Forrester, and Exworthy, "The Development of Equivalence."
[26] Niveau, "Relevance and Limits of the Principle of 'Equivalence of Care.'"
[27] Lines, "From Equivalence of Standards to Equivalence of Objectives;" and Charles and Draper, "'Equivalence of Care' in Prison Medicine.
[28] Lines, "From Equivalence of Standards to Equivalence of Objectives."
[29] *Estelle v. Gamble*, Justia.
[30] Paris, "Why Prisoners Deserve Health Care."
[31] Rawls.
[32] Greenstreet, "Prison Doesn't Work."
[33] Flanders. "Criminals Behind the Veil."

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