THE SOCIAL CONSTRUCTION OF INMATES: WHY SOME STATES FORCE INMATES TO PAY FOR HEALTHCARE AND WHAT THAT MEANS FOR INMATE MORTALITY

by

MICHAEL CONNER NICHOLSON

RICHARD FORDING, COMMITTEE CHAIR
GERARD CAILLIER
GWENETTA CURRY
HYUNJUNG JI
DANA PATTON

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ABSTRACT

Prisoners are one of the most vulnerable populations in a society. Part of this vulnerability stems from the complete lack of their participation in the formation of the public policies that control their lives. As a result, the policies that target inmates are often influenced by negative societal perceptions, and therefore extremely punitive. However, as inmates have been found to possess a constitutional right to healthcare services, punitive policies that prevent barriers to their medical access must be carefully assessed.

One of these policies that may potentially prevent inmate access to care is a copay policy requiring inmates to pay a fee in order to request medical care. While the adoption of these policies is often presented as a financial necessity by states, no evidence is found to support this claim. Instead, the results indicate that the primary factors influencing a state's decision to adopt an inmate copay policy are the ideological make-up of a state's government, and the racial make-up of a state's inmate population. Specifically, states with conservative governments are more likely to adopt a copay policy, and states with a high proportion of Black inmates are more likely to adopt a copay policy.

Furthermore, the results also indicate that when these policies impose debt on indigent inmates, they are resulting in increased inmate mortality rates and decreases in state corrections expenditures. Therefore, while the states are correct in their assertions that these policies save money, these savings come at the cost of inmate lives. This result is alarming, especially in light of the finding that the adoption of these policies is the result of ideological and racial factors.

DEDICATION

I would like to dedicate this dissertation to all of those who have encouraged and supported me. The faculty and staff in the Behavioral and Social Sciences Department at the University of Montevallo encouraged me to pursue my doctorate, and this work would never have been possible without them. I could not ask for kinder or more inspirational parents, and my grandmothers have both played an enormous role in shaping my desire to learn and to share knowledge for the good of all. I would also like to thank my partner, Layla Khan, for her steadfast confidence in me – it is only possible to believe in change when you can believe in yourself, and much of my belief comes from you.

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I would like to acknowledge my own limitations in understanding and in writing about issues of race in America. While I and others consider race to be a social construction, I recognize the power of this construction in our society and in my own perception of the world. Therefore, I have done my best to discuss race as sensitively as possible. However sensitive I may be, as someone who is White, I acknowledge the role that my own race and cultural experiences may play in my ability to speak appropriately and accurately about Blackness.

Throughout this work I use the terms “Black” with a capital B, and “White” with a capital W, in recognition of the powerful role that our cultural experiences and expectations play in our world. This decision was made based on the recommendations of Black academics who encourage the use of Black with a capital B in academia to designate a person or persons, rather than a color. Furthermore, the data used to categorize the race of inmates was collected through surveys where inmates were asked to designate their own racial identity. This self-identification is why I use the term Black in this study, as this is how these respondents identified themselves.

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I. INTRODUCTION

"The degree of civilization in a society can be judged by entering its prisons" (Dostoevsky 1985). Dostoevsky was not the first to identify prison conditions as an indication of a nation's civility, and he will certainly not be the last. In the United States, we have experienced an unprecedented rise in incarceration rates over the last 40 years. And while many scholars have explored the causes of this massive increase in incarceration rates, it is still startling for most to learn that over the last four decades our penal population has risen from around 300,000 to over 2 million. We are indeed living in the age of "mass incarceration" (Alexander 2012).

While many social activists, and eventually the public, have been increasingly concerned with the rate of incarceration, this increase in the prison population is more than just a growing number. In addition to concern over the number of Americans in prison, many have taken up Dostoevsky's mantle in their apprehension of the conditions of those in prison. With many recent high-profile lawsuits over prison conditions in the news-media, states have begun to be held accountable for the conditions of their prisons and jails. These conditions have been found to be unacceptable in a number of states, and over-crowding, lack of sanitation, and lack of access to health services have all been identified as major areas of concern.

Of course, what is to be considered unacceptable is up for debate. For the most part, arguments against poor prison conditions have rested upon the 8th Amendment which prohibits cruel and unusual punishment. Importantly, what is considered cruel is rarely straight-forward. The body with the clearest power to define what is and is not to be considered cruel in the case of prison conditions, the Supreme Court, has often remained vague and unhelpful in resolving this

matter (Dolovich 2009). As a result, prison policy has always been slow to evolve and resistant to most change.

This vagueness has also left states with the freedom to essentially use whatever standard they wish until someone makes enough fuss to bring the problem into the eye of either the public or the law. As a result, prison conditions have been slow to improve. In fact, some scholars have even found that litigation intent upon improving the living conditions within prisons has resulted in politicians feeling forced to build more prisons as a solution. These rulings have inadvertently created newer but often empty prisons that need to be filled in order to justify their cost. As a result, litigation aimed at improving living conditions sometimes unintentionally results in higher incarceration rates (Schoenfeld 2010).

All of this is to say that achieving improved living conditions for prisoners has been neither linear nor simple. And while states have faced the majority of the burdens associated with improvements in care, they have not, for the most part, accepted this increased financial responsibility willingly. These increases in financial responsibility have come from a variety of different areas within their prison systems. These costs have mostly come from required improvements to deal with issues of overcrowding, sanitation, and healthcare access. Of these, by far the most significant has been the rising costs associated with the healthcare of those behind bars.

In general, state budgets have seen dramatic increases in correctional expenditures as incarceration rates continued to climb. Of these correctional expenditures, some estimates put the cost of prison operation at over 75% of the total correctional spending by states. Furthermore, the costs of medical care for inmates is more than the costs of utilities and food service combined (Stephan 1999). This means that while the public, and more importantly the courts, has been

requiring improvement from the states in terms of prison conditions, expenses have also been rising.

These rising costs, coupled with rising expectations, have presented very real and complex financial challenges for states. These financial circumstances have led states to desperately seek policies that allow them to mitigate the growing costs of prisoner care. Many states have experimented with contracting out some or all of their prison services in attempts to reduce costs (Bedard and Frech 2009). This trend of privatization has not been without controversy, but many states have maintained that contracting out has allowed them to offer their inmates a similar level of care with substantially lower costs.

While the debate over privatization in prisons has been quite public, states have also been facing another, less public but more financially significant, battle. While the general cost of care in prisons has risen dramatically, by far the most significant increases in cost have been associated with healthcare services. This is because the cost of medical care is more than the costs of utilities and food combined (Stephan 1999). This is due to the exponential increases in the cost of medical services offered to inmates. These costs have been mostly driven by three factors.

The first of these is a general increase in the cost of medical care that has taken place inside and out of prisons – healthcare in the United States is just expensive (Bodenheimer 2005). Secondly, various groups have successfully fought for increases in the standards of care in prisons, and these higher standards have come with higher costs (Awofeso 2005a). Finally, and perhaps most significantly, the prison population has been steadily aging. As in the general population, the elderly require more medical care and are therefore more expensive patients (Ahalt et al. 2013). This means that as the age of the average prisoner increases, so too does the

cost of medical care for those prisoners. These three factors have all contributed to significant increases in state expenditures of prison healthcare services.

The rising costs of healthcare in the American general population have been well documented and explored (Bodenheimer 2004). While there are a variety of explanations for these increased costs, there is little doubt that these same factors have influenced the costs of care in prisons and jails. In addition to these increases in costs of care, prisons have also experienced increases in standards of care. After a series of prisons riots motivated by, among other factors, prisoners' concerns over a lack of medical care, the federal case *Newman v. Alabama (1972)* resulted in a legal precedent that would later be expanded in the Supreme Court case *Estelle v. Gamble (1976)*.

In *Newman v. Alabama (1972)*, a federal court found that the state of Alabama was violating the 8th Amendment by not providing its inmates with access to adequate medical care. In response to this ruling, a number of organizations initiated campaigns to raise the standards of medical care for prisons and jails throughout the country. The two main groups involved in this endeavor, the American Bar Association (ABA) and the American Medical Association (AMA), worked together to raise the standard of medical treatment offered to inmates. Their efforts helped to establish the National Commission on Correctional Health Care (NCCHC). The NCCHC has since evaluated and set standards of care for state prisons and jails (Awofeso 2008).

The product of the efforts put forth by these groups has resulted in the provision of care for inmates at a standard similar to that set for the general public. In most prisons and jails, inmates now have access to on-site medical services for a variety of issues. While these improvements in access and increases in standards of care have all been undeniably beneficial to inmates, they have been rather costly. Importantly, in addition to the rising cost of care among

the general population, as well as standards of care in prisons, the aging of the prison population has also contributed to the financial strain felt by states.

In what has been referred to as the "graying" of the prison population, the inmate population has been getting older. From 1992 to 2002, prisons and jails experienced a doubling in the number of prison or jail inmates over the age of fifty. This demographic is by far the most expensive in terms of healthcare expenditures, both in and out of prison. As the average age of inmates gets older, and as the number of inmates over 50 increases, the healthcare costs in prisons and jails will continue to constitute a significant strain on states and their ability to finance prisons and jails (Mitka 2004).

In order to deal with these tough financial situations, states have had to find alternative means of finance for their corrections budgets. The federal government has been historically unwilling to help states with the costs of basic operating expenses like healthcare provision, so prisons and jails have been forced to ask their state legislatures for additional finances. However, as more states have faced budgetary crises, this option has been less effective in the procurement of additional funds. The failure of state legislators to allocate more money to compensate for the increasing costs of care in prisons has led prisons and jails to, for the most part, fend for themselves in terms of dealing with the rising costs of care (Anno 2004).

The primary means through which states have attempted to address these costs is through the use of policy innovations they feel will make prison expenditures, especially in the area of healthcare provision, more affordable. States have attempted a number of strategies to deal with the rising costs of healthcare in prisons. As mentioned, many states have contracted out healthcare services, asserting that these private companies can provide care at lower levels of

cost. Contracting out healthcare services in prisons has been controversial because some scholars have found that this strategy leads to higher inmate mortality rates (Bedard and Frech 2009).

Many states have introduced managed care systems in which private organizations are incentivized to keep costs low. While these efforts are often praised for saving states money, there has been ample reason to believe these financial savings are the result of the costs to patients' health (Robbins 1999). A more recent trend by states has been to require inmates to pay a copay in order to access most health services. This copay, similar to copays in the general population, is implemented to discourage patients from abusing healthcare services and forcing individuals to consider the financial burden of a fee before they request to see a doctor or nurse. These managed care systems, and especially copay policies, are worrisome in that there is a real possibility that they are limiting inmates' access to some healthcare services.

The main concern with policies like these copay fees and managed care systems is that the policies are directed towards a very unpopular group with little to no political power. Prisoners are likely the least sympathetic group in society, and there is little incentive for policymakers to ensure that prisoners have access to quality healthcare services. Therefore, there is little reason for politicians, or even the private providers, to make sure that such polices are not negatively influencing either the quality of care or access to healthcare services in prisons and jails.

The Target Populations Theory, popularized by Schneider and Ingram, explores the relationship between the perceptions of a group and the policies that target them. Their theory, applied simply, would predict that a group such as prisoners, a group that is negatively constructed and with little power, is unlikely to benefit from the policies that target them (Schneider and Ingram 1993). Therefore, it seems there may be a real danger that these copay

policies are presenting barriers to prisoners' access to care. Further exploration is needed to determine why states are adopting these policies, as well as the effects they are having on inmates' access to care.

While the Supreme Court has been unclear in its definition of cruel and unusual punishment in terms of incarcerated care, it has been quite clear in its stance on healthcare access. In the 1976 case *Estelle v. Gamble (1976)*, the Supreme Court ruled that prisoners are constitutionally guaranteed access to healthcare services. Although the Court left it to the lower courts to debate what level of access should be guaranteed, their ruling laid the foundation for decades of litigation that would establish and expand the medical services inmates are legally afforded.

While access to healthcare is often understood as important in prisons, access to care as a function of group membership is often underappreciated. Specifically, inmates' access to healthcare services in state prisons is of particular importance as inmates have no political power to address issues of access. Historically, inmate access to care has changed dramatically over time. While inmates were once attended to by underqualified and overwhelmed practitioners, inmates now typically have some access to qualified healthcare practitioners on-site (Anno 2004).

And while the credentials of these practitioners are now rarely called into question, a concern now lies in the access that inmates have to these physicians. In matters of care, health or otherwise, a two-pronged question must be answered. The first, is the quality of care up to standard, has been answered. The physicians that attend to these inmates are qualified in the same way as the physicians that attend to those in the general population. The second question, are inmates provided with adequate access to these medical services, remains to be answered.

To understand inmates' access to healthcare in state prisons, one must first understand the policies that may limit or enhance such access to care. As some scholars have noted, prison policy is remarkably different from that of most policy areas. This is because, instead of granting benefits or costs, the criminal justice system is responsible for administering punishment (Schneider 1999). Specifically, a growing number of states have approved and implemented policies that allow prisons to charge inmates with a fee in order to access healthcare services in their facilities.

These policies are diverse in their severity and effect, but they undoubtedly have serious implications for inmate access to care in state prisons. Understanding the impact of healthcare copayment policies on inmate access to care is important for a number of reasons, but undoubtedly the most important is that prisoners are the only group in America constitutionally guaranteed access to healthcare services. This constitutional guarantee has become increasingly costly as the average inmate's age has become progressively older. Healthcare for these older inmates has become increasingly important, and, therefore, expensive.

In order to curb these expensive healthcare costs, many states have begun to charge inmates copayments in order to access health services. It is vital to determine why some states have adopted these policies while others have explicitly avoided them. Additionally, as these policies become increasingly common, it becomes essential to understand their effects. It must be discovered what factors encourage these policies, if these policies are saving money, and, most importantly, how these policies are affecting inmate access to care and inmate health outcomes.

To understand the causes and impacts of these copay policies, I will conduct two studies. The first study explores the reasons why states are adopting these policies. The second study will

test the impact that a state's financial duress has on their decision to adopt a copay policy, as well as the possibility that the social construction of prisoners is driving state policy adoption. The Target Populations Theory would indicate that states with citizens that have more negative perceptions of prisoners will be more likely to adopt punitive copay policies that restrict inmate access to care. The second study in my analysis examines the impacts of copay policies. I will design two models – one that tests the impact that these policies have on health outcomes, and one that tests the states' assertions that the policies are saving money.

II. OVERVIEW OF PRISONERS' ACCESS TO CARE

In the landmark case *Estelle v Gamble (1976*), the Supreme Court found that prisoners have a constitutional right to healthcare. Indeed, while this right to care for prisoners was established in 1976, the case set a precedent that has only further legally established the right to care. Specifically, *Estelle v Gamble* and its legal progeny has resulted in a variety of protections in prisons. The case led to a series of rulings that established prisoners' right to access care, that this care is to be administered appropriately, and that prisoners possess the right to professional medical judgment (Rold 2008). Furthermore, *Estelle v Gamble* catalyzed the movement to professionalize prison health care provision (Wright 2008). Finally, this right is fundamentally derived from the Constitution's prohibition of cruel and unusual punishment (Greifinger et al. 2007).

And while a vast majority of scholars agree this ruling was noble in its intent, some contend that its application has been too broad. Specifically, they argue that the dual functions of prisons – imprisonment and custodial care – were folded into one area of legal protection under the Eighth Amendment. This legal establishment has resulted in a blurred line between the two functions so that applying the Eighth Amendment standard to all facets of prison life has become increasingly difficult and impossibly convoluted (Genty 1996). Regardless, it is clear that *Estelle* paved the way for improved access to care in American prisons.

Before Estelle

If *Estelle* and the following legal battles established a constitutional right to care in prisons, what did inmate care look like before the landmark case? Before *Estelle*, inmate access the healthcare was far from being a right. Rather than the promise of care, inmates were often rewarded with or motivated by healthcare access. Oftentimes, access to care was a function of a prisoner's behavior – something to be rewarded or denied. Before *Estelle*, the courts repeatedly and broadly dodged responsibility for the well-being of prisoners by leaving quality of care decisions in the hands of those who ran prisons (Anno 2004).

Generally, this meant that prison officials had leave to offer as little access to and quality of care as possible. Many of those who provided care in prisons were unlicensed in any way, many of whom received most of their training in the United States military. Furthermore, these unlicensed physicians were assisted by similarly untrained nurses with little to no experience in medical treatment. As a result, in the unlikely event that an inmate managed to gain access to medical services, those services were likely provided by an individual or individuals with little to no medical training (Anno 2004).

This limited access to such low quality of care encouraged the development of informal networks of inmates, administrators, and physicians. Because opportunities for care were so limited, patients were often forced to bribe administrators for the opportunity to receive care from unlicensed physicians. Moreover, the limited care that these inmates received was provided in less than ideal conditions. Very few prisons had designated medical areas that could meet current medical standards of cleanliness. Overall, access to and quality of care in prisons was much lower than in the general population (Anno 2004).

These conditions - specifically a lack of access to care and a lack of quality of care - were part of the motivation for the Attica Prison Riot on September 9th, 1971. The riot, sparked by the death of an inmate, culminated in the seizure of much of the Attica correctional facility, with prisoners taking a few dozen guards as hostages in the process. Much debate has surrounded the handling of the riot – most accounts claim that only one guard was killed by the inmates, while nine were killed in the ensuing assault by officers retaking the prison. In addition to the death of the guards, nearly thirty inmates were killed, many of whom were attempting to surrender.

Regardless of the outcome, the political nature of the riot was clear. Specifically, the prisoners released a list of demands, many of them political in nature. Some of the demands revolved around the way inmates were treated and taken care of, but the focus of the resulting negotiations centered around the removal of the warden and the political rights of the inmates to protest (Pallas and Barber 1972). However, many of the inmates were rioting to protest a lack of provision for health care and acceptable food (Anno 2004).

The Legal Battle for Care

The Attica riot led to the advent of two particular groups that attempted to address concerns with the way prisoners were being treated and the conditions in which they lived. These two groups were an affiliation of professional associations and the American federal courts. About a year after the Attica riots, a federal district court ruled in *Newman v. Alabama (1972)* that the state of Alabama's entire correctional system was guilty of violating inmates' Eighth Amendment right to be free of cruel and unusual punishment. Specifically, this violation had occurred when the state had repeatedly failed to ensure that their inmates had adequate medical care.

This case opened the door for broader legal protections, and the Supreme Court delivered its ruling in *Estelle v. Gamble* only a few years later. This ruling set a precedent defining inmates' constitutional right to medical care while in prison, mainly due to imprisoned individuals' inability to seek care on their own. Only a few years after *Estelle*, a federal appeals court ruled in *Bowring v. Godwin (1977)* that the previous decision in *Estelle* applies to psychiatric care as well. This series of landmark rulings changed the legal responsibilities of those in prison administration. It became increasingly apparent that the courts would no longer avoid responsibility in protecting the physical and mental well-being of the incarcerated in their care (Awofeso 2008).

Professional Organizational Response

While this string of legal battles played out, professional associations also began their own activism in support of the incarcerated. The two groups most active in their support for prisoners were the American Bar Association (ABA) and the American Medical Association (AMA). This movement began with the American Bar Association's litigious battle for the rights of those in jails and prisons. The ABA worked tirelessly to legally establish clear and defined rights for the incarcerated. When it became apparent that one of the most important but neglected rights was access to health services, the ABA recruited the American Medical Association for their aid in identifying what exactly should qualify as adequate care in prisons and jails. The AMA's first goal was to obtain a government grant with the purpose of improving health conditions in American jails. This move established the National Commission on Correctional Health Care, or the NCCHC, in 1983 (Awofeso 2008).

Once enlisted, the AMA immediately commenced on a project envisioned to more efficiently and accountably deliver health services to those in jails. The key component of this project was a two-pronged method of the standardization of care for the incarcerated. The first prong was the creation of a clearly defined standard of care to measure and compare the services provided in each jail. The second prong was a program through which jails could voluntarily become accredited in terms of their health care services provision. The newly established standards of care and accreditation program were the first of their kind. Jails had never seen anything quite like them in terms of national standards of compliance. The accreditation program and standard of care guidelines were inevitably pushed toward the prison system, as well as in juvenile facilities.

Eventually, the AMA project would develop into the aforementioned NCCHC. The NCCHC is still active in the realm of correctional health care, and the organization continually updates its standards for care and has kept up its offer of voluntary accreditation to any incarceration facility that wishes to observe the organization's standards. Importantly, the NCCHC is not the only organization in the business of the accreditation of correctional health care. The American Correctional Association (ACA) is a formal collaboration of corrections officers and prison administrators that works to maintain and evolve correctional standards of care. Additionally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) continues to be a driving force behind many of the changes in evolving prison healthcare standards. This organization is known primarily for its accreditation of hospitals and other various health providers (Anno 2004).

Modern Prison Health Care Provision

The work of the ABA, the AMA (now NCCHC), and the JCAHO, has all contributed to a reform of prison healthcare. In modern America, the majority of jails and prisons have some form of healthcare access on site. The vast majority of state prisoners are sent from county jails. Upon arrival to a state facility, most inmates pass through a reception and diagnostic facility. Here, the inmates are processed and assessed. They typically relay their medical history and their present medical needs. This has led to progress in the advancement of controlling the spread of Tuberculosis in prisons and jails. While many scholars and physicians noted the rising incidence of tuberculosis in prisons, prisons have steadily made progress in their attempts to test for and control the prevalence of the disease (Jones et al. 1999).

After the initial processing of inmates, prisoners typically undergo a follow-up health screening within a week or two. These screenings involve a more detailed examination, and physicians typically test for a multitude of communicable diseases, as well as conduct tests for substance abuse and mental deficiencies or illness. Once the inmate has been through the second screening, the majority of prisons systems offer general health services within their prison facilities. Additionally, prison systems typically have arrangements with other prisons or local hospitals in case of the need for emergency care (Jones et al. 1999).

Most state prison systems have, at the very least, one prison facility within the state that affords specialty services not available at the local prisons or jail. The local clinics are fairly typical in comparison to facilities for the general populace. These facilities usually have laboratories, exam rooms, dental wards, and even radiological services, most of which are well maintained. Additionally, a growing number of facilities house offices and rooms for meeting and working on the mental health of patients.

While the qualifications of health care workers in prisons may have been suspect before *Estelle*, this is no longer the case. Typically, providers who work in prisons and jails are certified and licensed to work just like practitioners in the general community. Before *Estelle*, it was common practice to employ inmates as health care workers in some capacity – whether it be providing medication or scheduling appointments. However, this arrangement has since been abandoned as these practices have become forbidden (Jones et al. 1999).

In fact, the majority of healthcare practitioners that work in prisons or jails are employed through each state department of corrections. However, some of these medical providers are retained using personal service contracts. In prisons, a growing trend in health care delivery is the contracting out of services to profit driven firms (Anno 2004). As this trend has become more common, some scholars have begun questioning the use of such private firms in a prison setting (Restum 2005).

At least a few studies have found that when prisons contract out health services, the mortality rates of inmates tend to rise (Bedard and Frech 2009; Von Zielbauer 2005). And while some studies also find that contracting out health services tends to save money (Lamb-Mechanick and Nelson undated), Bedard and Frech surmise that "Contracting out may reduce both cost and quality" (Bedard and Frech 2009:18). Furthermore, a survey of 27 prison systems found that nearly one-third of these systems had moved to privatized health care delivery within their states (Anno 2001). Indeed, other research has also documented significant increases in this trend (Bedard and Frech 2009). Finally, as late as 2006 LaFaive's study finds that 32 states either fully or partially contract out the health services offered to the inmates in their prisons (LaFaive 2006).

Prisoners' Access Now

The means through which prisoners access health care is dependent on a number of factors, most importantly, the level of security associated with each prison. In lower level security facilities, many prisons have an on-site clinic with hourly access. To receive care, an inmate simply walks in during operating hours. In higher level security prisons, inmates typically submit request for care forms of some sort. These forms are typically used to request routine care, and the process can vary if more serious care is needed. This process is most often referred to as "sick call," and the form requests basic information from the inmate, such as their medical request and name.

Importantly, NCCHC has more than a few standards regarding inmate rights to access sick call. Firstly, their standards require that some form of confidentiality be observed in the request for care. This confidentiality usually comes in the form of a secure box, usually locked, in which inmates can place their medical requests. Secondly, NCCHC standards dictate that prisoners must be afforded the occasion to submit medical requests at least once a day. Furthermore, these requests should be assessed by medical personnel on a 24-hour basis. These standards are meant to ensure that inmates have regular access to medical requests, that these requests remain confidential, and that their requests are considered within a day's time. Finally, the majority of prison systems employ some form of an automated system that helps to schedule follow-up appointments, information regarding medication, and regular health exams (Anno 2004).

And while access to care and health care quality have improved for some groups, others remain underserved and therefore at risk. In correctional facilities, the mentally ill, mentally deficient, substance abusers, as well as the terminally ill remain under-served. In her 1990 study,

Teplin finds that the rate of those with affective mental disorders, including schizophrenia, is two to three times higher in jails than in the general population (Teplin 1990). Other studies have found similar results, such as the finding that 4-9 percent of offending adults are mentally deficient (Santamour 1989).

Research shows that even if identified as having an intellectual disability, inmates rarely receive specialized care. In fact, one such study finds that a mere ten percent of these identified prisoners receive the specialized services they need (Hall 1985). Similarly, much research has shown disturbingly high rates of the alcoholic and drug dependent inmates. According to a meta-analysis by Fazel et al., in male prisons, it is estimated that between 18 to 30 percent of inmates were considered alcoholics, while a staggering 10 to 48 percent were considered drug abusers or drug dependent (Fazel et al. 2006). While these figures demonstrate the undeniable need for programs that serve these populations, research has shown that these groups are usually underserved in prisons and jails, and failure to treat them is often linked with inmate recidivism (Chandler et al. 2009).

Furthermore, as recently as 2009 researchers have found that this problem has worsened rather than improved. In state prisons, nearly 43% of inmates suffer from at least one chronic mental condition. In jails, this figure is slightly lower but still nearly 39%. Importantly, of those in state prisons with a chronic mental condition, only 69%, or two-thirds, are put on appropriate psychiatric medication after admission. In jails, this number is even worse, with fewer than half of those with a chronic mental condition put on appropriate medication. These findings are indicative of the lack of care the mentally ill are afforded in state prisons and jails (Wilper et al. 2009).

Communicable diseases are another topic of concern in prisons. Tuberculosis, hepatitis B, gonorrhea, and human immunodeficiency virus (HIV) are all more common in prisons than in the general population. Many are concerned with the tendency for these diseases to spread to the general population upon inmates' release. However, some scholars have come to view incarceration as an opportunity for medical treatment. The majority of inmates are unlikely to have had access to healthcare services prior to incarceration, and, as a result, are more likely to contract these communicable diseases. In fact, one study of Baltimore ex-offenders finds that more than half of recently released convicts have two or more chronic health conditions. Additionally, only forty percent of these recently released inmates had any form of health insurance (Hawkins et al. 2010). Unfortunately, this lack of healthcare services means these individuals are unlikely to be identified as infected outside of prison or jail.

If these individuals are identified and treated while incarcerated, they will be less likely to spread diseases into the general population. Therefore, it is of great importance that these inmates are identified as infected and treated accordingly. Alarmingly, in a study of California prisoners, nearly 22% of female inmates with HIV or AIDS have reported that they missed their prescribed medications on at least one occasion (Stoller 2001). Scholars who see correctional health care as an opportunity often focus their recommendations on improved health screenings upon arrival in prisons and jails, as well as improved access to care once incarcerated (Glaser and Greifinger 1993). In fact, some scholars have advocated for a reexamination of our entire inmate health system (Adams and Leath 2002). These evaluations suggest a necessary emphasis on the monitoring of the condition of infected inmates upon their re-entry into the general population.

Some scholars, while seeing correctional health care as an opportunity, also see it as a chance to reduce racial disparities in health outcomes. If involvement with the criminal justice system is likely to result in poor health outcomes, the criminal justice system might have indirect, or even direct, impact upon the health outcomes of prisoners. It is well documented that while many countries see disparities in health outcomes based on race, these disparities are especially pronounced in the United States (Lasser et al. 2006). Therefore, racial and ethnic disparities in health outcomes and care may be reduced, or aggravated, by the criminal justice system.

It is well established that people of color are more likely to experience incarceration than Whites. In fact, some scholars have found that Black men are about seven times more likely to have a prison record than White men (Pettit and Western 2004). This disproportionate contact with the criminal justice system for people of color is the culmination of a number of factors, including the concentration of urban poverty and racial segregation. This concentration of class and racial segregation results in what John Eason refers to as "the hyperghetto," which he defines as circumstances wherein "… high levels of incarceration within urban neighborhoods remove the structural and cultural cleavages blurring the institutional boundaries of modern U.S. prisons and Black urban ghettos" (Eason 2012:275).

If people of color are disproportionately likely to be involved with the criminal justice system, then the quality of care in that system may have a disproportionately strong impact on those communities. If, as many suspect, jails and prisons in America actually put prisoners at risk, then the disproportionate influence on communities of color will result in even greater racial and ethnic disparities in health outcomes. However, if prisons and jails envision correctional healthcare as an opportunity to improve the health of their wards, the disproportionate effect on

communities of color could actually lead to a reduction in the racial disparities of health outcomes. Instead of widening the health gap, prisons and jails have the opportunity to reduce racial disparities in health outcomes (Binswanger et al. 2011).

Health Care Financing in Prisons

As in the non-prison population, health care expenses in prison have become increasingly costly. And, like the outside world, state prisons and jails often face constricted options when considering the finance of healthcare. Realistically, state prisons and jails have four options in financing healthcare services. They can turn to state legislatures, private sources of funding, the federal government, or payments from the prisoners themselves. Traditionally, funding for state prisons has come primarily from state legislatures. Generally speaking, inmates have not typically qualified for Medicare and Medicaid programs. Even rarer are inmates with a private health insurer that is willing to cover incarcerated individuals.

Some national organizations like the Centers for Disease Control and Prevention (CDC), the National Institute of Corrections, and the National institute of Justice, will find money for state prisons and jails if these organizations have a vested interest in a special project. Similarly, private organizations such as drug companies, professional organizations, and foundations, will occasionally offer grants for the purposes of inmate health care. However, like the money infrequently available from federal organizations, this money is usually a small amount and designated for a specific purpose or project, preventing use of the money for basic operating costs. Instead, this money is usually used for educational programs or research and development purposes (Anno 2004).

With federal agencies and private sources offering very little in the way of funding for prison healthcare costs, state prisons and jails are primarily funded by state legislature appropriations. Of the appropriated money for state Departments of Corrections in 1998, healthcare costs amounted to nearly 12% of total costs (Awofeso 2005a). In 2012, Washington D.C.'s medical services for inmates in jail cost nearly $33 million, or almost a quarter of their entire corrections budget. (Schaenman et al. 2013). While there was significant variation in the cost of inmate healthcare (the least expensive state was North Dakota with less than a million dollars in healthcare costs, while the most expensive state was California with a cost of almost half a billion dollars), the average cost of healthcare for inmates was approximately 70 million dollars.

Similar to the variation in total costs of care for each state, the amount of money spent on healthcare for each inmate also varied significantly by state. While North Dakota only spent an average of about a thousand dollars on each inmate per year for health services, Michigan and Massachusetts both spent nearly four thousand dollars on average each year for each inmate. However, the average amount of money spent on inmate healthcare was around $2,500 (Anno 2001). It is well recognized that healthcare costs in prisons are concerning, especially as prison populations age and care becomes more expensive. Many scholars have advocated for focus on health promotion and preventative care as a means of cost-reduction (Awofeso 2005a).

It is well documented that the prison population is aging over time. Over the course of ten years, from 1992 to 2002, the number of inmates in prisons or jails over the age of fifty had more than doubled to 8.6% if the entire inmate population. The over-fifty population is an important demographic in that these inmates constitute a disproportionate portion of the cost of inmate care. As the over fifty population becomes a larger and larger proportion of all inmates, the

costliest inmates will cause an increasingly noticeable strain on the prison healthcare industry (Mitka 2004). This "greying" of the inmate population, as it is sometimes called, is happening at a time when states are having difficulty financing prison healthcare.

Alternative Means of Finance

These factors, in combination with the record high number of inmates, has made inmate healthcare an increasingly costly expense. Because federal money and private sources do not cover basic operating expenses, such as health care, prisons are left pleading with their state legislatures to increase appropriations in order to finance the health care of their aging inmate populations. As states become more and more constrained by budgetary crises, prisons and jails are left with few options in terms of financing. These circumstances have led to a number of attempts to decrease the rising costs of inmate care.

One of these attempts that has now spread its way across the majority of US states is the implementation of a prison health care copay policy. Copay policies were introduced to the general population as a means to reduce the number of unnecessary expenditures by the insured (Awofeso 2005b). Similarly, prisons have been implementing copay policies, typically cited as a means to reduce the number of frivolous or unnecessary visits to the infirmary. Scholars have long explored the way that our prison system forces the families of inmates to pay what little money they have in order to provide for their family members while in prison, including medical fees and copays (Katzensttein and Waller 2015). While increasingly common in prisons and jails, the effects of these copay policies have yet to be conclusively evaluated.

States argue that these copay policies reduce unnecessary expenses while maintaining quality of inmate care. However, it is yet to be determined if these policies actually reduce costs.

Similarly, the impact that these policies have had, and continue to have, on the quality of inmate health care services is undetermined. As these policies become increasingly common, and as inmate healthcare becomes increasingly expensive, such an analysis become vital to our understanding of inmate access to care.

Copay Policies in Health Care Services

Copayment requirements are nothing new in the healthcare industry. Insurance companies introduced these policies in order to discourage the frivolous use of healthcare services. The premise is simple – people with insurance must sometimes pay a flat fee in order to visit the doctor. This fee is usually insubstantial, oftentimes between ten and twenty-five dollars. The logic is straight-forward. If a person really needs to visit their physician, they would be willing to pay the copay. However, if the person is forced to consider the cost of the copay, they are less likely to visit the doctor for services that they may not really need. In other words, the copay is simply a fee to incentivize insurance policy holders to only visit the doctor when they really need to.

In theory, copayment policies, and other similar policies like coinsurance, are a means of controlling costs by disincentivizing policy holders from over-using their insurance and therefore costing everyone more money in the long term. Insurers have argued that these policies will only discourage those who are wasting time and money, and that those who really need to see the doctor or need medicine will continue to receive care as needed. However, physicians and researchers have long been concerned that copay policies will, in fact, discourage all sorts of people from utilizing services that they need.

As early as 1977, researchers have been interested in understanding the impact that copay policies have on access to care. A study performed by such researchers examined the impact of a twenty-five percent copayment on the non-elderly. The researchers find that a twenty-five percent copayment policy results in a near reciprocal reduction in the utilization of physicians by twenty-five percent. Additionally, important services like x-ray examinations and lab-tests were reduced about thirteen percent (Scitovsky and McCall 1977). More than few such studies have been conducted, and most, if not all, have found similar reductions in the utilization of medical services in response to copay policies (Manning et al. 1987; Scheffler 1984). And while many studies did find that copay policies lead to reduction in the use of medical services, many experts remain concerned that more than just non-frivolous services are being impacted.

Specifically, some researchers have found that copay policies actually reduce the use of medicines across the board, not just medicines that are seen as non-essential or frivolous. Particularly troubling, scholars found an eleven percent decrease in the adherence to prescribed medications, including the use of what are considered essential medications like those that treat hypertension and other serious conditions. In other words, the policies are not just discouraging people who over-use insurance, they are also discouraging people with serious health risks from using their insurance.

This finding is concerning from a health standpoint in that the policies are preventing people who need medicine to pursue medication through insurance. In an economic sense, this finding is problematic in that it implies that a significant portion of those with insurance are being discouraged from acquiring the medicine they need due to the copayment policies. The acquisition of medicine that would prevent their illnesses from worsening is less likely in the presence of copay policies. The eventual result is that, instead of insurers paying for medicine for

these at-risk policy holders, the insurers are often forced into paying hospital bills. This is obviously costlier in the long term, and an undeniable financial problem for insurance providers (Sinnott et al. 2013).

In other studies examining the effects of copay policies, researchers find both direct and indirect negative outcomes on the use of clinical services when copayment and other cost-saving measures are introduced (Solanki et al. 2000). Others have found that increasing deductibles as a means of cost-sharing actually moves services to inpatient procedure, thereby increasing the actual costs of the services (Harris and Custer 1991). Furthermore, an assessment of Japan's introduction of a copay to their national health insurance program finds a significant, albeit modest, influence on the use of medical services. Many medical services, but especially outpatient care services, were significantly reduced after the introduction of the copay policy (Kupor et al. 1995).

The effects of copayment policies on patients are not limited to private citizens. In 2002, the US Department of Veterans affairs (VA) raised the copayment for veterans from two to seven dollars for a month's supply of prescription medication. Researchers have since attempted to understand the impact that this increased copay has had on veterans' use of medication. Specifically, a study was conducted to examine the impact of this increase in copay cost on veterans' use of lipid-lowering medicines. In other words, they hope to find if the incease in copay costs encourage veterans who would otherwise have taken their lipid lowering medication to forgo the use of that medication. Understanding this impact is vital in the greater understanding of copay policies in general.

The results of the study are illuminating. A significant portion of veterans who would otherwise have taken their prescriptions chose to forgo medication as a result of the increase in

the copay. Importantly, this means that those who needed this drug were likely to go without it. Many of these veterans were at risk for heart disease, and should have been taking this medication. However, as a result of the copay increase, these veterans chose not to purchase their medications. This impact seems to cast doubt upon the insurance industry's assertion that copayment policies only discourage frivolous use of medical services. At least in this study, those who were discouraged from utilizing health care services were veterans in need of medication meant to lower their lipids (Doshi et al. 2009).

The impact of copay policies on access to healthcare services has also been examined in regards to Medicaid recipients. Specifically, researchers have asked whether copayment policies for state Medicaid programs influence the decision of those within the program in the purchasing of medication and their attempts to access healthcare services. Hartung et al. find that, in fact, the copay policies for state Medicaid programs lead to a reduction in the use of clinically important prescription drugs by more than 17%. This means that, if not for the presence of the copay policy, those in state Medicaid programs would be more likely to purchase their necessary medications and to access vital health care services (Hartung et al. 2008).

Copay Policies in Prisons

If copays have been found to influence the healthcare decisions of individuals in the general population, veterans, and participants of state Medicaid programs, it is likely that similar copay policies will influence the health care decisions of those in state prisons. As previously discussed, prisoners are the only group in America that have a constitutional right to access health care services. As a result, any policy that might potentially reduce the likelihood that inmates are receiving access to care must be scrutinized with earnest sincerity.

It is therefore of the utmost importance that two questions be answered. Firstly, why have some states adopted these policies while others have not? Is it a function of how well the states are doing financially, the efficiency of that state's prison system, or something else entirely? Secondly, what effects are the copay policies having in state prisons? If, as the insurance companies have always claimed, the policies are reducing costs and preventing frivolous use of resources, then the adoption of these policies is somewhat reasonable. Importantly, this cost saving is only justifiable in the event that the policy is not also reducing inmates' access to healthcare services.

In 1997, John Clark was asked to analyze the Berks County Prison system's "Inmate Fee for Medical Services Program" in response to a class action suit. This suit was brought by several inmates in the prison asserting that this policy was a violation of their civil rights. Importantly, Clark's assessment offers vital insight into the importance of motivation in the implementation of such policies. He writes of the Berks County prison policy:

> The goal of reducing unnecessary visits to 'Sick Call' is an inappropriate reason to start such an inmate-fee-for-medical-services program, regardless of the reason or number of times a client seeks the services of medical staff. Each visit should be viewed as an opportunity to evaluate a high-risk population for the presence of clinically significant pathologies.
>
> As a consultant and expert witness on many cases involving inmate deaths, I have reviewed a number of cases where patients were not objectively evaluated for a specific complaint because they had acquired the label of a 'malingerer.' These inmates invariably succumb to premature death, which has resulted in avoidable and unnecessary liability for correctional facilities. (Clark 1997:1)

Previous Research of the Impact of Copay Policies in Prisons

During the late 1990's, the Federal Bureau of Prisons felt forced to introduce a copayment policy within the federal prison system. The BOP specifically asserted that the Federal Prisoner Co-Payment Act of 2000 would produce a more efficient system of healthcare delivery in federal prisons. The BOP principally identified illegitimate medical requests as a source of unnecessary and inefficient services. Importantly, the federal government is not the only entity to have instituted a copay policy in its prison system (Hyde and Brumfield 2003).

Like the federal government, state governments have increasingly found themselves combatting the rising costs of inmate care. As a result, the majority of states have instituted some form of a copayment policy within their state prison systems. While the impact of these policies remains to be determined, some researchers have conducted studies that attempt to analyze the implications of copay policies in state prisons. One of these studies examines the impact that a copay has had on roughly 700 inmates detained in Idaho prisons (Hyde and Brumfield 2003).

This particular study examines the impact of copayments, the gender of the inmates, and an interaction of the two, to determine how copay policies influence inmate access to healthcare services. Two prisons are examined in the analysis, one male prison and one female prison. In 1998, Idaho introduced a copayment policy for these two prisons in order to contain the rising costs of inmate care. The Board of Corrections settled upon a fee of three dollars in a case where the inmate self-initiates a sick care visit (Hyde and Brumfield 2003).

Importantly, the policy does not require a payment if the inmate suffers from a chronic or serious illness. Only routine visits require a copayment fee; visits to primary care physicians, dentists and dental hygienists, optometrists, and psychiatrists all resulted in a $3 fee. Additionally, the policy included additional fees of the inmate were to require medical

prescriptions. A copayment fee of two dollars would be charged to the inmates for prescription medication. The money collected from the medical and prescription copayment fees are given to the state board of corrections (Hyde and Brumfield 2003).

Interestingly, the policy did contain exceptions to the copay requirement. Many states would soon adopt similar exceptions, most of them resting upon the financial state of the particular inmate. In this case, Idaho determined that indigent inmates would not be charged the copayment fee for either medical visits or prescription medication (Hyde and Brumfield 2003). Many states have exceptions in their policies regarding copayments and the indigent, but a great deal of variation exists in the states' definitions of who should be considered indigent. While some states are very clear in the language used to determine indigent status, many states are very vague and leave much discretion to the individual prisons in the determination of who is to be considered an indigent inmate, and therefore exempt from the copay fee.

In the study of Idaho prisons, researchers examined the medical requests of hundreds of inmates. The requests were initiated from a period of a year before the implementation of the copay policy and for ten months after the policy began. These data include requests for services from psychiatrists, dentists, physicians, nurse practitioners, physician assistants, medication requests, and sick care visits. As medically necessary requests are omitted from the policy, nearly 80% of these requests fell under the purview of the copay policy once the new policy was put into effect (Hyde and Brumfield 2003).

The analysis shows that in these two Idaho prisons, male and female inmates submitted medical requests at different rates, across all categories of requests. In every single category, women are statistically more likely to request medical services than their male counterparts. Furthermore, the adoption of the copay policy has a statistically significant impact on the request

for certain medical services. Specifically, requests for sick care are significantly less common after the implementation of the copay policy. Interestingly, requests for medication and psychiatric visits actually increased, but the effect does not achieve the same level of statistical significance.

Additionally, the researchers find some indication of an interactive effect between gender and the introduction of the copay policy. Requests for sick call and for dental hygienists were significantly less likely when gender and the introduction of the copay policy are interacted. Similarly, requests for physicians' assistants and physicians are statistically less likely when these two variables are interacted, but at a lower level of statistical significance. These results indicate the impact of the copay policy on medical requests, as well the impact of gender. Additionally, the interaction of the two seems to have some impact on certain types of medical requests, some more statistically significant than others (Hyde and Brumfield 2003).

The statistical impact of gender on the frequency of medical requests is unsurprising. For some time now, researchers have consistently found that female inmates request more medical services than male inmates (Berkman 1995; Ingram-Fogel 1991). The finding that inmates are statistically less likely to request sick care and dental visits is likely the result of a financial calculus. Inmates, when faced with a copay, are likely to skip the services they feel they need the least. The decline in requests for sick care is rather dramatic, with both male and female requests declining by over a third. This immediate decline in requests for sick call is a clear and direct example of the impact of a copay policy in a prison system (Hyde and Brumfield 2003).

Furthermore, after interviewing hundreds of women in California's two largest women's prisons, the Valley State Prison for Women (VSPW) and the Central California Women's Facility (CCWF), Chandler documents the problems associated with what she refers to as the

"Prison Industrial Complex." Her interviews have led her to believe that, rather than addressing violent behavior in the general population, prisons have become an industry that perpetuates and reproduces "…state sanctioned acts of racist, misogynist, and classist violence against some of the most vulnerable members of our society" (Chandler 2003 p. 45).

Similar studies have been conducted that examine the impact of copayment policies on the access that female inmates have to healthcare services. In California prisons, inmates can earn between seven and thirteen cents an hour as compensation for their labor. As a result, the five-dollar copay required in the state prisons costs inmates approximately nine days of labor. It takes inmates nine days of work to afford a single visit to see a healthcare provider, and, during that visit, they can only address one health issue. In the general population, if this same calculation is used, it would cost a person making sixty thousand dollars a year a staggering two-thousand-dollar copayment in order to see their physician (Chandler 2003).

Similarly, Stoller's examination of female inmates in California finds that the state's five-dollar copay for medical services "… discourages utilization of services, creates a bureaucratic burden to the health service and an economic burden to the very poor prisoner, while providing no documented economic gain to the department" (Stoller, p. 10, 2001). She therefore concludes that the copay system should be eliminated as soon as possible. Until this elimination takes place, she argues that the money collected from the copay policy should be used in a manner that will improve the systems health services, especially programs of health education, as well as health services that are preventative in nature (Stoller 2001).

These policies have been found to impose a disproportionate obstacle to the underprivileged in prisons. To better understand the impact of a copay policy in women's prisons, Fisher and Hatton conducted focus group interviews with thirty-one females recently

released from incarceration in either a jail or prison. These women reported that they had been required to pay copay fees for a variety of services, including dental, mental, and physical health care requests. Their requests covered issues such as asthma, hypertension, diabetes, seizures, pregnancy, mental health, and dental pain (Fisher and Hatton 2010).

The authors find that the "vast majority" of women feel that the copayments presented very real obstacles in their pursuit of health care access. Specifically, the researchers found that a number of the former inmates felt as though the copays were administered inequitably. Therefore, they almost all reported situations in which they felt forced to choose other options when faced with health concerns, rather than pay the copay every time. Additionally, many reported that the copay process affected the quality and timeliness of healthcare delivery in their respective facilities.

Some women have reported that after requesting to see medical professionals, months or even years would pass before they would see a physician. This is especially problematic in that the copayment is deducted from the inmate's account immediately, meaning that, if their symptoms disappear in the time it takes to see a physician, they will have paid a copay unnecessarily. The authors conclude that from the experiences of these women, there is concern that copayments result in unnecessary charges to inmates, and that the quality and timeliness of health care delivery both suffer. This is unnerving, especially in light of the prevalence of communicable diseases in prisons, and the importance of timely and effective treatment in response to these diseases in order to prevent outbreaks (Fisher and Hatton 2010).

While other studies have also examined that impact of copay policies in prisons, not all of these studies focused specifically on traditional health care access. One such study assessed the impact of a three-dollar copayment policy for requested dental services implemented by the

Michigan Department of Corrections in 1997. As with most prison copay policies of this nature, this fee is not required in cases of emergency, or if the visit has been recommended as a follow-up visit by a dentist on a previous visit. This analysis of prison copay policies on access to dental care in prisons spans five years and ten institutions. The study thoroughly examines the one-and-a-half-year period preceding the implementation policy, the year and a half following the implementation policy, and an additional year and half after that to account for any rebounding impacts of the policy. This allows the authors to confidently ascribe the changes in access to the implementation of the copay policy (Ormes 2004).

The authors find that while the populations of these institutions did not significantly change, there was a significant shift in the number of requests for dental care over this five-year period. After the implementation of the copayment policy, the number of requests for dental care declined during both the initial year-and-a-half following the implementation, as well as during the year-and-a-half period after that. Essentially, while the population remained relatively stable, inmates are significantly less likely to request health care visits after the implementation of the copay policy (Ormes 2004).

Importantly, most of these studies have examined the impact of copay policies on inmates' access to care. Insurance companies have been claiming for years, and states have been claiming in response to rising healthcare costs, that copay polices will deter unnecessary expenses while containing costs. Currently, there are no studies of which this author is aware that have shown that prison health copay policies reduce costs in prison healthcare delivery. In opposition to this claim, an assessment of California's department of corrections by the state auditor found that the state's copayment policy only collected a third of departments' annual costs (Birdlebough S. Analysis of SB 396: health care for prisoners 2001).

Furthermore, the auditor found that the administration of the copay policy could cost up to as much as five times the amount of the entire annual cost. In other words, the auditor in this study found that, at least in the case of California prisons, the collection of copayments actually cost more to administer than the state managed to collect (Birdlebough S. Analysis of SB 396: health care for prisoners 2001). Additionally, these figures do not include the costs of future lawsuits that are likely to arise as a result of the copay policies. As the policies become more common, these suits are likely to increase in number as well as in magnitude.

Prison Copay Policies – An Overview

Supreme Court justice Louis Brandeis is often quoted for his assertion that the states of America are "laboratories of democracy" (Brandeis, New State Ice Co. v. Liebmann). While the exact meaning of this comment remains debated, the most common understanding of this phrase is the idea that states are microcosms of a larger political entity. As such, we can learn from the successes and failures of the states in terms of their policy outcomes. A recent example of this concept is the success of "Romneycare" in the state of Massachusetts. Romneycare was the nickname given to the Massachusetts healthcare reform of 2006.

This initiative was known for progressively attempting to expand the coverage of health insurance available to the residents of Massachusetts. It included provisions that required employers with over ten full-time workers to provide health insurance for their employees, and the law provided health insurance credit for those under 150% of the federal poverty line, as well as a number of other provisions (Mulligan 2013). This law was, at least at the time, considered a policy success across the political spectrum by policy analysts and citizens alike.

In fact, the law was so popular the Obama administration and the Democrats in Congress modeled the Patient Protection and Affordable Care Act, a national health insurance reform program, after many aspects of Romneycare in 2010. While Mulligan documents some important differences between the two policies, the fact remains that the federal government, specifically executive and Congressional policy-makers, took note of the success of a state-level policy, and used its provisions as guidance when writing the Patient Protection and Affordable Care Act. In this case, as well as others, one can appreciate Brandeis' observation that the states are laboratories of democracy.

Importantly, the adoption of inmate copayment polices by the states and the federal government can be understood in a similar light as the example above. The federal government passed the Federal Prisoner Health Care Copayment Act of 2000 in October of that year. This act was written and implemented after multiple states had passed and implemented state prisoner copayment policies since the mid-1990's. While the federal Bureau of Corrections and national lawmakers who wrote the bill may not have modeled it directly after a particular state policy, as was the case with Romneycare and the Affordable Care Act, it is clear that the state level policies regarding inmate copayments for health-services were an indication to federal policy-makers that, at the state level, such policies were operating and possibly saving money.

After the national government adopted a form of inmate copayment policy, a number of states followed suit. It between the 2000's and mid-2010's that we see the most state adoptions of inmate copayment policies. Specifically, 34 of the 42 states who adopted such policies did so during this period. This explosion of policy adoption was undoubtedly, at least in some way, influenced by a recognition of these states that the federal government had followed the lead of state policy adoption. While other factors are unquestionably important and remain unexplored,

there is reason to suspect that the federal government emulated, at least to some extent, the inmate copay policies of state governments.

The state level policies regarding inmate healthcare copays vary greatly in the date of their adoption. The earliest, California's, was passed in September of 1995, while the most recent policy was passed in Arizona in October of 2016. As California's prison population is one of the largest in the nation, it is no surprise that it was one of the first states to experiment with policies that could potentially reduce the cost of healthcare in their prisons – healthcare being one of the largest portions of the correctional budget in most states. California is also very large in comparison to most states, and perhaps this is one of the reasons the Federal Bureau of Corrections took notice of their copayment policy and felt comfortable implementing something similar at the federal level.

These policies, as well as varying in the date of their adoption, vary in their severity. Specifically, states vary in the extent to which they legally hold their inmates financially accountable for the healthcare copayment. Many states are very specific in the wording of their policies to make exceptions for those unable to pay the copay. However, while some states legally require these indigent inmates to pay off their borrowed copay (State of Alabama Department of Corrections 2013), others explicitly excuse such indigent inmates from future payment (State of California Code of Regulations 2018).

For example, Alabama passed an inmate copay policy in June of 2013 in which indigent inmates are still allowed to request medical attention. However, their unpaid balance is placed on their account until that inmate has the necessary funds to pay the state back (State of Alabama Department of Corrections 2013). This policy, not unlike many other state inmate copay policies, is severe in that it specifies a mechanism through which the indigent inmates are still legally

responsible for their copayment fees, no matter how long it takes to pay off the fees. Contrastingly, California's copayment policy forgives the indigent inmate if they are unable to pay the fee within 30 days (State of California Code of Regulations 2018).

These two states are vastly different in the way they treat their inmates in terms of their respective copayment policies. While California is willing to forgive any debt incurred by the copayment charge after 30 days, Alabama is clear that it will collect the fee from the indigent inmate no matter how long it takes. This is interesting because one would suspect that it would be California, a state with nearly 130,000 prisoners, that would be keen on collecting delinquent copayment fees, no matter how long it takes. After all, California spends more on inmate healthcare than nearly any other state (Anno 2004).

However, it is Alabama, a state with fewer than 30,000 prisoners that explicitly ensures it will make all inmates pay, regardless of the time-frame involved. Importantly, there are a number of states that make no mention of repayment in their copay policies. Additionally, a small minority of states do not have an official state law or policy that requires prisons and jails to collect copayments in order to see medical staff at all. Seven states make no mention of an inmate copay policy in their state statutory codes or the official state policies within the state department of corrections.

Finally, the largest contrast of a policy like that found in Alabama is the policy of New Mexico. Rather than simply not having a copay policy, New Mexico has a state department of corrections policy that explicitly states, "The New Mexico Corrections Department currently does not impose medical copayments on inmates" (New Mexico Corrections Department, Policy CD-010100). Clearly, different states have different expectations of how prisoners should be held responsible for their own healthcare needs. Most states, 42 of 50, require inmates to pay a

fee in order to see a healthcare professional. Of these 42, a majority (27) make some mention of how indigent inmates will be required to pay back the fee. Seven states have no official copayment policy, and one, New Mexico, explicitly states that no copayment is required for inmates to see medical staff.

While the copay policies for inmates have varied, the majority of states have adopted some form of copay policy to reduce costs sometime between 1994 and 2016. This means that the adoption of this policy has been spreading for over twenty years. Additionally, these policies are in no way uniform. Perhaps most importantly, the severity of the policy varies greatly from state to state. Of the states who have an official copay policy for inmates, a broad spectrum exists in the extent to which prisoners are held financially responsible for their medical attention.

On one end of the spectrum, states essentially forgive the inmate's debt if he or she is unable to pay. Within the states that do have copay policies, this type of clemency is undoubtedly significant. These states are actively choosing to make access to healthcare easier on poorer inmates. Conversely, the other end of the spectrum consists of state policies that legally require the prisons to collect the copay fee, no matter how long it takes. These types of policies are clearly more concerned with the principle of the copay, or the message the copay sends, than they are about the well-being of the inmates or the financial gains made from the collection of the copay.

Recall that at least one study finds that the administration costs of implementing a copay generally meet or exceed the amount of money actually collected (Birdlebough S. Analysis of SB 396: health care for prisoners). Why then do these states choose to implement policies that typically fail to recoup the costs of the policy's implementation? There are likely a number of reasons, but some suspect that, to these lawmakers, sending a message about what inmates

deserve is more important than the financial success of the policy. Put another way, some states may be more concerned with the message they send by passing legislation that treats inmates a certain way – either leniently or punitively.

This type of argument has also generally been made in the support of drug-testing welfare recipients. While the constitutionality of such testing remains a topic of debate, numerous reports have indicated that the drug testing almost always costs more money than it saves. Many countries have received pushback for similar programs, but the United States stood firmly on the side of the right to drug-test welfare recipients when Congress passed and Bill Clinton signed The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Part of this act enabled states to test those receiving benefits, and, more importantly, enabled the denial of those benefits if the recipient tests positive for illicit substances (Amundson et al. 2015).

Many scholars have expressed concern over these state policies. Specifically, they recognize that the way a policy targets or treats a group can influence and reflect the way that that group is viewed by others. Essentially, these scholars are worried that the government's sanctioning of drug testing welfare recipients is an acknowledgment that those on welfare are more likely to do drugs. This acknowledgment has branded those on welfare as a group that must prove they are deserving of help. The government stepped in and targeted welfare recipients with a policy that essentially questions that group's deservingness. By introducing this policy, states introduce worth as a factor when considering an application for assistance (Amundson et al. 2015).

Since the policy passed in 1996, at least one study examines the discourse that ensued in state legislatures. Specifically, the scholar is attempting to understand the way that states were socially constructing those on welfare after the passage of the PRWORA. This study finds that

legislators were nearly five times as likely to support than oppose drug testing welfare recipients. Furthermore, of these supportive opinions, more than half (56%) were arguments based on questioning the worthiness of welfare recipients (Amundson et al. 2015). Clearly, by passing PRWORA, the federal government allowed the states to introduce worth as a calculus in their decision to assist those applying for welfare benefits.

If states considered worthiness as a factor when deciding their laws regarding welfare reform, it would not be all that surprising if states used a similar calculus when considering their laws pertaining to the treatment of inmates. While states have been required by law to provide access to healthcare to inmates since *Estelle*, the law is less clear as to how this access can be restricted. As a result, different states have different outlooks when it comes to inmate healthcare. Some, like California, are more lenient in their policies and allow debts to be forgiven after a certain period of time. Others, like Alabama, are more punitive and require the inmates to repay their debt - even if it takes years.

Importantly, one must ask why the states differ so dramatically in their treatment of inmates. If the reason were purely financial, as many states have claimed, then it would make sense for a state like California to have a very severe copay policy. After all, California houses more inmates than almost any other state. Contrastingly, a state with a relatively small prison population like Alabama could more likely afford to forgive debt, as they have fewer prisoners than California. However, we find the exact opposite to be the case. It is California, a state with so much to lose by forgiving debt that has the more forgiving policy. Contrastingly, it is Alabama, a state that makes very little off of its inmate copay policy that has such a severe and unforgiving system of repayment.

In fiscal year 2018-2019, California's department of corrections allocated nearly $3.3 billion for its prison healthcare services, which is close to a third of the state's corrections budget. Alabama, on the other hand, allocated close to $125 million for prison healthcare services for the fiscal year 2017-2018, which was also nearly a third of overall corrections costs. So while healthcare costs were a similar percentage of each states' corrections budget, California spent more than twenty-five times as much on healthcare costs as Alabama. Clearly, California has a lot more to lose in terms of unpaid copay costs than does Alabama. It is reasonable to believe the argument that states pass policies requiring inmates to pay copays for healthcare visits because they are a financial burden on the corrections systems. However, it is also reasonable to doubt the authenticity of the claim that these policies are solely fiscally motivated when a state like California forgives its prisoners' debts while a state like Alabama does not.

Research to be Done

While research has shown the significant impact that copay policies can have on access to healthcare services in the private sector, this effect has similarly been found to influence healthcare decisions in prisons. Importantly, the prison healthcare setting is unique in that its population is the only group found to have a constitutional guarantee to healthcare services. Therefore, it is especially important that we understand the impact that these prison copay policies are having at the state level. If these policies are saving states money while simultaneously maintaining similar levels of access, then the policies are undoubtedly in accordance with the legal precedent set in *Estelle v Gamble (1976*).

However, if these policies are saving money by inhibiting access to care, then they are saving money at the cost of the constitutional rights of millions of Americans. Furthermore, if

inmate access to care is inhibited and the policies fail to save the states money, then the policy is legally problematic as well as inefficient. It is therefore of the utmost importance that we understand, to the fullest extent possible, the effects that these policies are having on the health outcomes of prisoners. Furthermore, for these outcomes to be judged in terms of acceptability, we must also understand the fiscal impact that the policies are having. In other words, how do the policies affect the health outcomes of prisoners, and to what extent do the copay policies save states money?

Previous research has indicated that state copay policies have, at least at the individual prison level, unnecessarily limited the access that inmates have to care. If these policies are influencing health outcomes and simultaneously being justified in terms of their financial impact, an obligation exists to show if the policies are, at the very least, actually saving money. If the policies are in fact saving money, it must be determined what the savings cause in terms of health outcomes. The justifiability of the policies may be judged as a result.

In addition to understanding the impact of these policies, both in terms of health and financial outcomes, it is equally important that we understand the motivations behind these policies. The extreme diversity in the adoption of these copay policies at the state level, as well as their range in severity, is an indication of differing motivations by the states. It is therefore vital that we understand the way in which these policies have spread and become increasingly common. The diffusion in the adoption of these copay policies is indicative of the motivations behind their inception. These motivations are essential to our understanding of the policies as social constructions, and, therefore, our understanding of the way we as states feel about prisoners as a group.

Why is it that some states have adopted copay policies while other have not? It is indisputable that sates are eager to pass policies that will save money. If these policies are intended as cost-saving measures, why have nearly a fifth of the states refrained from their adoption? Importantly, other research in prison health care has shown that, at least in the case of some communicable diseases, practicality and financial consideration are not the driving force behind prison policy, but rather, the perception of inmates seems paramount in predicting policy decisions (Nicholson-Crotty and Nicholson-Crotty 2004).

Could a similar relationship exist with the adoption of copay policies? Might it be possible that inmates' access to care is being restricted in some states more than others not because they are confined in a state that needs to save money, but rather, they live in a state that judges criminals more harshly? If this is a case, it would seem that prisoners unfortunate enough to have committed crimes in these more punitive states might be deprived of their constitutional right to healthcare not because their state is financially obligated to do so, but because the people in their state view prisoners more critically than in other states.

This possibility is grounded in what is often referred to as neo-liberal paternalism. In short, this is the idea that we as a society are generally willing to assist those in need of help. However, this help is often conditioned by the cultural expectations we as a society have of those in need of assistance. More than possibly any other country in the world, the United States has historically infused ideas of worth and deservingness into our notions of assistance. This can best be seen in the welfare reform of the 1990's, during which many paternalistic changes were made to our welfare system (Soss et al. 2011).

Chief among these changes was the inclusion of requirements that pressure states to move recipients off of their welfare programs, as well as requirements that those enrolled in the

program who are able to work must be working or looking for work. While the previous program, Aid to Families with Dependent Children (AFDC), did encourage enrollees to work, it did not do so to the extent or with the same vigor as the reformed program, Temporary Assistance to Needy Families (TANF). The evolution of our public assistance program was not simply a change in guidelines or qualifications, it embodied a shift in the underlying philosophy of our nation's evaluation of those in need (Ozawa and Yoon 2005).

Indeed, research has shown that this shift has been detrimental to American families who are in need. Those who left AFDC typically experienced significant increases in terms of financial success – especially income. Conversely, an examination of TANF recipients shows that enrollees that leave the program typically have significantly worse financial outcomes – especially in terms of income. Scholars have explained these outcomes by comparing the flexibility of the two programs.

Specifically, AFDC allowed families more latitude in their decisions about when and where to work, as well as when to move on from the program. TANF, on the other hand, is very rigid in its work requirements and the limitations of the program. As a result, families do not necessarily leave the program when the time is right, rather, they leave when the state feels they have benefitted from the program for a long enough period of time. As a result, families in TANF are often forced to move forward before they are financially ready to leave the program, resulting in worse financial outcomes (Ozawa and Yoon 2005).

This neo-liberal approach is also evident in the way some states are now passing laws that allow for the drug-testing of welfare recipients. As previously mentioned, these states continue to pass drug testing measures despite the mounting evidence that the tests typically cost more to implement than is saved by the programs (Amundson et al. 2015). It is increasingly clear

that these states are at least as interested in sending a message about the deservingness of those on welfare as they are concerned with saving money. The message – you do not deserve help if you are on drugs.

The idea that policies can influence the perceptions of a group is not new. Many scholars have explored the way that policies target certain groups. This research tends to focus on the relationship between the social construction of groups and how that construction can positively or negatively impact the types of policies directed at that group (Schneider and Ingram 1983). For instance, the elderly are generally recognized as a sympathetic group. As a result of this perception, policies directed at the elderly are typically very positive. Criminals, on the other hand, are largely viewed as deviants who cannot be trusted.

As a result of this construction, policies directed towards criminals tend to be harsher in their treatment, even towards those who have finished serving their sentences. Importantly, this perception is not uniform. In some states, criminals are judged much more severely than in others. The result of this lack of uniformity is 50 different states with 50 different approaches to making policy for the incarcerated and for those who have served time in prison. This is why we have many states that have passed laws that prevent convicted felons from voting, some states that force felons to appeal for their right to vote, a few states that automatically restore felons' right to vote, and even a few states that allow felons to vote while in prison (Allard and Mauer 1999).

The outcome of these felony disenfranchisement laws is that a substantial proportion of the population can no longer vote. A 1998 report found that nearly four million Americans were either permanently, or at least temporarily, being deprived of the right to vote due to felony disenfranchisement laws (Fellner and Mauer 1998). The treatment of convicts in terms of voting

rights is one of many policy areas in which criminals are treated harshly based on the social perception as being deviant. The target population literature might therefore suggest that the policies targeting criminals, and the manner in which they receive healthcare, may also be influenced by the public's perception of them.

The result of previous research into healthcare copay policies in prisons paints an unclear picture of their impact on prisoners, as well as an uncertain understanding of their origin. A comprehensive exploration of both the cause and the impacts of these copay policies is therefore appropriate. Firstly, we must understand why states are passing these polices as well as why the policies have such range in severity. Is it a purely financial decision, or are states passing policies that mirror citizens' feelings towards prisoners? Secondly, it must be determined what outcomes these policies are having on inmate health outcomes. Are these policies maintaining a similar level of care, or are they presenting a significant obstacle in the path of inmate health? Furthermore, as these policies are justified in terms of their financial impact, this financial impact must also be explored.

III. STUDY 1: STATE ADOPTION OF INMATE COPAY POLICIES

The first analysis contained in this study will examine the process through which different states have or have not adopted a prison copay policy. Specifically, this analysis will examine the claim made by many states, as well as the federal government, that these policies were adopted in order to save money and to combat financial strain. To ascertain the validity of this claim, I will attempt to establish the driving force behind the diffusion of these copay policies across the states. Recall that the vast majority of these policies were all passed within about a twenty-year period between 1994 and 2016. My first analysis will then attempt to determine the catalyst for the adoption of these policies.

I will therefore test the claim that the motivation behind these policies is financial in nature. Specifically, states and the federal government have claimed that these policies will reduce the number of unnecessary requests for medical attention within prisons, thereby saving money. While this claim is believable on its face, a review of the research pertaining to copayment policies in the private sector may lead to skepticism of this assertion. Previous research has shown that, across multiple groups, copay policies tend to discourage a variety of health care service initiations, not just unnecessary services. This means that copay policies are also discouraging individuals from pursuing preventative services that will undoubtedly save both the insurers and the patients money in the long-run (Doshi et al. 2009; Hartung et al. 2008; Scitovsky and McCall 1977; Solanki et al. 2000; Sinnott et al. 2013).

Furthermore, there is plenty of reason to believe that the states have motivations for passing such policies other than financial duress. From the language of the debates during the

1990's welfare reform movement, it is clear that state legislators were very concerned with the deservingness of welfare recipients. Similarly, as drug testing welfare recipients has rarely been found to save states money, questions of deservingness are clearly relevant in the decision by some states to drug-test welfare recipients (Amundson et al. 2015). And while those in prison are certainly not the same population as those receiving welfare assistance, the two groups are similar in their tendency to be stigmatized by many Americans.

Therefore, it is not outside the realm of possibility to think that the policies directed towards those in prison is, at least in part, influenced by the public's perception of their deservingness. This idea is consistent with the concept of target populations popularized by Schneider and Ingram in their seminal study, "Social construction of target populations: Implications for politics and policy." After all, previous research has found that the social construction of inmates has influenced the types of policies, at least in terms of funding, directed towards those in prison (Nicholson-Crotty and Nicholson-Crotty 2004). It is reasonable then to imagine the possibility that the social construction of inmates in different states has influenced the adoption of specific types of copay policies in those states, as well as the decision to adopt a policy at all.

This idea that the social construction of groups can influence the policies directed towards them was formalized by the researchers Anne Schneider and Helen Ingram, among others. These scholars posit that the way groups are socially constructed has major implications for a number of policy related outcomes. Specifically, the policy agenda directed towards a group, as well as the policy tools used to accomplish this agenda, is influenced by the way society has come to conceptualize that group (Schneider and Ingram 1993). This theory has been

used repeatedly to understand the way that some groups are seemingly more benefitted than others through public policy.

Importantly, Schneider and Ingram do not stop at the assertion that the social construction of groups is influential in the types of policies directed towards that group. An equally important component of the target populations theory is the idea that the policies directed towards a group are social constructions themselves. As a result, the policies are, in effect, messages that signal to citizens how they should feel about the targeted group. These messages then become a factor in each citizen's calculation of policy orientation, as well as the likelihood of a group's political participation (Schneider and Ingram 1993).

Put another way, the social construction of a group is influential in the types of policies that are directed towards them. Borrowing from Huxley then, one example group, the "Alphas", is generally thought of more positively than another group known as the "Epsilons." As a result of these images, the Alphas are generally the beneficiaries of generous policies, whereas the Epsilons are generally left with policies that treat them quite poorly. While the Alphas are awarded things such as subsidized housing and free education, the Epsilons are only offered such benefits under the condition that they submit themselves once a week to be evaluated by a panel of Alphas. If the behavior of the Epsilon in question is found to be inconsistent with the requirements set forth by the policy, they are judged to be unworthy and are denied access to all benefits.

To continue with this analogy, the types of the policies directed toward Epsilons in turn informs the way that the rest of society views them. If one of the requirements set forth for the Epsilons is that they must pass a spelling exam, the message sent by the policy, and subsequently inferred by the rest of society, is that Epsilons must have difficulty with spelling. Furthermore,

after years of being told that they must pass a spelling test in order to receive any benefits, the Epsilons themselves begin to question their own spelling ability. This in turn leaves them quite disillusioned with their ability to qualify for help, and, as a result, they eventually quit trying to participate in any process that could potentially change the requirements that leave them without help in the first place.

While this example may appear a bit detached from the matter at, it effectively encapsulates many aspects of the policy process in the real world. The above example is easily demonstrative of the way that those on welfare may feel in the United States' political system, especially when states pass legislation requiring them to submit to drug tests in order to qualify for welfare benefits. The policy targeting those on welfare implicitly assumes that those who need welfare benefits are more likely to use illicit substances than those who do not. As a result, those on welfare in the United States are more likely to be stigmatized by the rest of society. Furthermore, these individuals are more likely to consider themselves removed from the political process, and, as a result, are less likely to participate in the process that stigmatized them in the first place.

Review of the Target Populations Literature

While Schneider and Ingram are often discussed in terms of their impact on the target populations literature (for good reason), many other scholars have also attempted to explain and understand the impact of social construction on policy outcomes, as well as other aspects of the policy process. These scholars have all acknowledged the role that the social construction of groups can play in the discussion, formulation, and implementation of public policy. While

important work in the area remains, the soil from which the target populations literature has grown is rich and fruitful.

The target populations literature is full of intersections between diverse academic traditions. As a result, the types of research that have employed a perspective accommodating the importance of social construction come from all over the academic spectrum. Social construction has been used to examine attitudes of environmental policy (Fischer 2000), all the way to understanding the way people think and discuss the problem of obesity (Lawrence 2004). This is to say that the value of the social construction perspective is enormous, especially in its ability to speak to a variety of disciplines.

Understanding the social construction of groups is essential to understanding the policies that target them. Furthermore, acknowledging the role of social construction in public policy is integral in our understanding of the policy process in general. More specifically, the roles of social construction and target populations theory are essential in our understanding of the policies that target and impact a variety of groups, perhaps most importantly, those groups that have the least control over the types of policies that impact them.

And while not all earlier studies used the language of social construction and target populations, many studies have asked remarkably similar questions. Many scholars have celebrated this movement, insofar as these studies continue to improve upon various aspects of their analyses (Campbell 2002), and continue to improve upon exploratory techniques (Gstrein 2017). The root of these analyses is usually some form of question aimed at understanding the impact that a social construction has had, or will have, on different groups. In the tradition of Laswell's now legendary definition of politics, social construction attempts to understand all four components of the adage – the who, the what, the when, and the how (Laswell 1936).

Additionally, it seems as though little disagreement exists as to who is doing the getting as far as politics goes. Our political system is fairly transparent in its disproportionate allocation of political resources, and few would, for example, question the assertion that the imprisoned get less than the unimprisoned. The larger and more pertinent questions most important to the social construction literature deal with the what and the how. What do different groups get, and how do they get it? Importantly, this research begins from a framework of acceptance that daily life is such that we are inherently encouraged to rely upon our generalizations of groups. This typification is part of being human, and understanding this is the first step in any real understanding of social construction and target populations (Loseke 2011).

Growth of Target Populations Theory

While some scholars have been utilizing and engaging with the target populations framework for decades, not all policy researchers have been enthusiastic to embrace studies using target population theory as a basis for understanding. Most notably, Paul Sabatier, one of the leading policy process experts in the field, published his *Theories of the Policy Process* in 1999. This work has been highly influential not only in how theories of the policy process have developed, but also in which theories are to be considered legitimate within policy process research. Importantly, the 1999 publication of Sabatier's book failed to include theories that he identified as constructivist.

While constructivist approaches to the policy process were relatively sparse at the time, the published work using this general approach tended to focus on the impact of social factors in policy-making, as well as the importance of understanding perceptions in the policy-process. Sabatier initially critiqued this approach for being nonfalsifiable, as well as suffering from a

serious lack of consideration for the role of institutions and socio-economic factors (Sabatier 1999). In response, many scholars who found value in a constructivist approach implored Sabatier to reconsider his neglect of their approach in his work, and he subsequently invited Schneider and Ingram, as well as Peter deLeon, to submit a chapter detailing social construction theory in policy design to be included in the 2007 edition of his book.

Importantly, Sabatier goes on to praise their constructivist framework in the introduction of this edition (Sabatier 2007), thereby adopting the social constructionist and target populations frameworks into the fold of legitimate and valuable approaches in public policy research. This acceptance has led to a rapid growth in target populations research, and scholars from around the world and across a multitude of disciplines have used the framework to explore the impact of social construction on the policy process. This growth in popularity has led to an abundance of target populations research, and some scholars have therefore attempted to identify the extent to which the framework has been employed by academics (Pierce et al. 2014).

As many of the early critiques of the target populations theory have focused on arguments of nonfalsifiability, these authors thoroughly explore the academic state of the target populations literature by documenting all of the published studies employing the framework. Specifically, Pierce at al. narrow their search to research designs that have used the framework to design quantitative research models that produce statistically significant results. They then use this knowledge to assess the current state of target populations theory within policy process research, and to explore how the theory has impacted, and will continue to impact, the larger body of public policy research.

The authors' analysis finds that 123 target populations studies have been published in over eighty academic journals. These publications have appeared in major journals in a variety of

disciplines, including public policy, public administration, political science, and interdisciplinary journals. In addition to peer-reviewed journals, target populations theory has appeared in twenty-five different book or book chapters. Furthermore, these publications were submitted by researchers from around the world, with twelve different countries represented among the authors. Significantly, the publication of target populations studies has more than doubled since 2008, most likely due to the inclusion of Schneider, Ingram, and deLeon's chapter in Sabatier's 2007 edition of *Theories of the Policy Process* (Sabatier 2007).

Of these 123 publications, 111 are applications of the target populations theory while 12 are focused on its theoretical development. The authors identify nine distinct policy areas in which target populations theory has been applied. With almost a third of the publications, social welfare is the most commonly examined policy area by target populations researchers. In descending order of application frequency, the other policy areas are health, criminal justice, immigration, education, the environment, fiscal policy, housing, and other topics (Pierce et al. 2014).

Interestingly, nearly two-thirds of these studies examine policies at the federal level, while the rest explore policies are the state, local, or regional levels. In rare cases, a few authors even examine policies at multiple levels of government. Furthermore, the methodology used in these analyses has been diverse. However, nearly two-thirds of the studies are empirical in that they analyze data through a clearly designed research process. Similarly, the majority of these publications, nearly two-thirds, focus singularly on an application of the target populations theory. Only one-third of the studies use target populations theory in combination with other theories of the policy process (Pierce et al. 2014).

Finally, the authors examine the category of target populations examined in these studies. Specifically, Schneider and Ingram identify four categories of target populations determined by a group's level of power and positive or negative social construction. These groups are the deviants, the dependents, the advantaged, and the contenders (Schneider and Ingram 1993). Over a third of the studies using target populations theory examined policies targeting deviants. Nearly a third of the studies explore policies targeting dependent groups. Nearly a fifth of the studies focus on advantaged groups, and the least studied group has been the contenders (Pierce et al. 2014).

Pierce et al.'s (2004) analysis is important in that it helps us understand the current state of the target populations literature. Their analysis identifies 123 studies that have employed the target populations theory, and these studies have been published in over eighty journals by authors all over the world. These studies have mostly been empirical in nature, and most have examined policies at the federal level. The policies and groups examined have varied, with the studies ranging across nine distinct categories. These studies demonstrate the extent to which target populations scholars have responded to criticisms of nonfalsifiability, and reveal the ways in which future target populations scholars might further strengthen the framework – most notably, in explanations of group categorization change (Pierce et al. 2014).

Ideas of Deservingness

Schneider and Ingram are clear in how they feel their work, and the target populations literature in general, can help one to understand what groups get and how they get it. They write, "The theory [of the social construction of target populations] contends that social constructions influence the policy agenda and the selection of tools, as well as the rationales that legitimate

policy choices" (Schneider and Ingram 1993:334). One can see that, among other things, the target populations literature has identified the crucial role that social constructions play in the allocation of power in our political system. Furthermore, the literature has identified the way in which the construction of groups not only influences the policy agenda, but how it also affects the tools that policy makers use to implement those policies. Finally, the construction of groups is influential in the rationales, or the justifications, of the policies and policy tools used.

The policy agenda, or what policies and problems are important, is, in a large part, decided upon by those with power. In Bartel's 2002 analysis, he finds that United States senators are much more responsive to the opinions of the wealthy than they are to poor and middle-class Americans – up the three times as responsive, in fact (Bartel 2002). This is a single example of a complicated relationship in which some groups are able to influence the political process while others are not. Importantly. It is not only the agenda that is influenced by the social construction of groups, but the policies themselves - as well as the policy tools - that are informed by social constructions.

Perhaps no aspect of policy making has been more influenced by social construction than that of the concept of deservingness. American politics has a somewhat unique and well discussed history of the concept of deservingness and public assistance. Recall that during the states' discussions of welfare reform during the 1990's, one of the most important and thoroughly discussed aspects of reform under consideration was the idea of deservingness (Amundson et al. 2015). Clearly, our nation, and especially our policy-makers, has considered deservingness to be a legitimate and appropriate qualification for public help.

As a result, deciding who is deserving is a complex yet decidedly important aspect of policymaking. This process of deciding is deeply ingrained in the American policy process.

Importantly, the target populations literature is essential in that it helps us to understand how these decisions are influencing the policy process, and, equally important, how the policies then reinforce or create new constructions of deservingness (Schneider and Ingram 1993). This is why the target populations literature is so important in any pursuit of knowledge that focuses on groups and the way that policy making does or does not benefit them.

In Ingram and Schneider's book *Deserving and Entitled: Social Constructions and Public Policy* (2005), they take a broad look at the impacts of social construction in policy making. Specifically, this work focuses on the concept of deservingness and how it informs policy decisions from agenda-setting all the through the implementation of polices. Their analysis takes a holistic approach in that it asks the reader to begin from a familiar perspective of the "us versus them" mentality (Schneider and Ingram 2005). Many scholars from a multitude of disciplines have found, and variously addressed, the desire that all humans seem to possess to be seen as part of a group that is in some way superior in a social setting.

Whether this drive is explained through psychological, biological, or sociological terms, the idea that humans tend to sort themselves into groups is a well-documented and researched phenomenon (Monroe et al. 2000). Furthermore, these tendencies to sort become sociological constructs that then perpetuate themselves and become embedded in institutions and practices. Some of these constructions are particularly static in their construction, and they tend to persist for generations - eventually establishing themselves as part of a natural order (Schneider and Ingram 1993).

Welfare Policy

Many welfare policy scholars have examined social construction, particularly in terms of the construction of deservingness. The policies examined by these scholars have varied significantly, but their focus is undoubtedly on policies that target groups particularly sensitive to the construction of their group. And while not all of these studies have singularly employed social construction as a framework of analysis, understanding the construction of groups is integral to understanding the policies that target them. For example, Joe Soss (2002) has extensively examined the politics of welfare policy, those who construct welfare policy, and those who are influenced by its construction (Soss 2002).

A significant part of his analysis focuses on the way that those on welfare are influenced by their interaction with welfare policies. For many of these Americans, their interactions with the welfare system are the primary, if not the only, interaction that they have with their political system. As a result, their views of government are largely informed by their experiences with welfare policy. By extension, and informed by our understanding of the target populations literature, these experiences go on to influence the way these individuals in turn view themselves in the context of welfare policy, and therefore within the larger context of our political system. In other words, their interactions with the welfare system end up shaping the way they view themselves within the context of a larger political system, and this perception ultimately affects their desire to participate, or to not participate, in that political system (Soss 2002).

Other scholars have also used social construction theory as a framework for understanding aspects of welfare policy. C. A. Larsen's 2008 analysis of welfare attitudes is undeniably influential in our understanding of welfare policy. Specifically, his analysis attempts to strengthen our understanding of the mechanisms through which a state's welfare regime can

influence the welfare perceptions of that state's citizens. His study takes a particularly sophisticated approach in its view of the role that bureaucratic organization can play in the formation of the citizenry's welfare policy perceptions. These perceptions are undoubtedly influential in the way that the citizens view those on welfare, as well as the way those on welfare view themselves (Larson 2008).

Welfare policy is an area rife with analyses employing social construction as a framework. This is undoubtedly due to the complicated process through which our nation has socially constructed those on welfare. Many scholars have even argued that those in marginalized groups tend to have less control over their own identities than the larger public. Importantly, this lack of control leads to further marginalization of these groups, and makes their political participation less likely (Larson 2008).

Furthermore, this public perception can, and most likely will, be manipulated by those in positions of policy making authority. This manipulation is especially likely to be influential for those groups with little to no political power in the first place. These groups are often the same groups identified within the target populations literature as being either deviant or negatively constructed, as well as lacking in any real political power. The members of these groups, more often than not, have very little control over the perceptions placed upon their group or the policies directed towards them (Hancock, 2004).

As a result, politicians often find it advantageous to manipulate the image of these groups in order to illicit certain feelings from the public. In the case of welfare, Angie-Marie Hancock argues that the feelings most often manipulated are feelings of disgust. These feelings result in what she identifies as the "Politics of Disgust." The politics of disgust are often associated with

marginalized groups, as these politics allow those in power to disrespect and devalue the voices and opinions of those groups being manipulated and targeted (Hancock, 2004).

Importantly, these politics are continually reinforced and justified by official policy and government decision-making. This assertion is well grounded in the work of other theorists, especially the work of Schneider and Ingram. Hancock's work is important in that it introduces, or emphasizes, the importance of elite manipulation in the formation and perpetuation of these socially constructed group images. In her work, these elitist cues and manipulations are one of the more important contributions in the creation and maintenance of negative social constructions, and therefore in the politics of disgust.

Her research examines the persistently negatively constructed public identity of welfare recipients. This identity is based upon the incorrect assumption that those on welfare are mostly poor and single Black mothers. Hancock asserts that this constructed identity "… interacts with a context I term the politics of disgust to produce legislative outcomes that are undemocratic both procedurally and substantively" (Hancock 2004:6). She then goes on to build a very convincing case supporting this claim using data collected during the open and public discourse of welfare reform during the mid-1990's (Hancock 2004).

Clearly, the work done by Hancock is essential in our understanding of the way that social constructions can influence and reproduce the public image of marginalized groups, especially those on welfare. Sanford Schram has also written extensively on welfare policy, and he has even critiqued the way in which welfare policy research has in turn gone on to shape and even reproduce the very stereotypes that welfare policies are based upon. His concern lies mainly in the lack of attention researchers have given to the symbolic consequences of welfare policy for those on welfare (Schram 1995).

Specifically, Schram writes of the two different influences that welfare policy has had on those within the welfare system. The primary focus of researchers has been on the material outcomes of the changes in welfare policy – how the policies have shaped and influenced the material needs and therefore physical structures of families. However, Schram is fearful that an equally influential aspect of welfare policy has gone unexamined for some time. He argues that the "symbolic" effects of welfare policy have had just much a role in shaping the image of welfare recipients as the material benefits. He writes that welfare policy has had "…symbolic consequences in reinforcing prevailing understandings of 'the poor,' 'welfare dependency,' 'dysfunctional families,' and so on" (Schram 1995 p. xxiv).

In other words, Schram has identified an entirely separate influence that welfare policy has on welfare recipients. He is acknowledging that the policies are influencing the images of those on welfare, as well as what it means to be poor. He recognizes that these policies are influencing the image of how those on welfare appear to the public, as well as how they appear to themselves. Essentially, Schram is linking an absence in welfare policy research with the work of scholars who emphasize the role that policies can play in the shaping of public perceptions of groups. He is opening the door for scholars who recognize the importance of social construction into welfare policy research, and, more broadly, into social science (Schram 1995).

Other studies have also examined the influence of social construction on welfare policy (Keiser et al. 2004; Schram et al. 2009). These scholars have explored the role that social construction plays in the decision of social workers to sanction, or punish, the participants of Temporary Assistance for Needy Families (TANF). These sanctions are used as motivations for those who fail to complete the requirements set forth by the policy guidelines. Schram et al. find strong evidence that implicit racial bias plays a significant role in the decision to punish those on

welfare. Specifically, Black participants are significantly more likely to be sanctioned than Whites for the same behaviors and violations (Schram et al. 2009).

Researchers have also used social construction frameworks to understand support for welfare policies in nations other than the United States. In a study that examines the public perception of deservingness, the authors focus on four distinctly constructed groups. These groups are similarly constructed into distinct populations in the United States as well. The groups examined in the study are immigrants, the elderly, the sick and disabled, and the unemployed (Van Oorschot 2006).

Interestingly, the degree to which each group is seen as deserving is consistent across different European countries and across social categories. According to the views of those surveyed, researchers find that the elderly are unwaveringly considered to be the most deserving group. Similarly, sick and disabled people are consistently seen as the second most deserving group – less deserving than the elderly, but more so than the other two groups. Furthermore, the unemployed are reliably found to be considered the second least deserving group, while immigrants are steadfastly considered the least deserving group of all.

Importantly, these findings indicate a consistent and measurable hierarchy of deservingness that contributes to a cultural understanding that spans multiple countries. This finding persists across nations with various levels of public assistance, welfare policies, and public spending. Therefore, the conclusion drawn is that these groups are socially constructed similarly across different countries in Europe. Clearly then, the construction of different groups has effectively and persistently reproduced itself across physical borders and through time. This is a testament to the lasting and powerful nature of the social construction of groups (Van Oorschot 2006).

Health Policy

While research examining the impact of social construction and target populations within welfare policy is rich, it is by no means the only policy area where these frameworks can help us understand policy making. Social construction and target population perspectives have been helpful in a variety of settings across a number of disciplines. Some researchers are even beginning to use these frameworks to understand the decision-making processes employed by policymakers during their discussions of public health issues.

Public health policy researchers have not always considered the target population of the intended policy to be influential in the formation of that policy. Within the last two decades or so, however, this tendency has been reconsidered. In an important study nearly a decade ago, Oliver explores the importance of considering the political context within which a given health policy is crafted and employed. Specifically, he argues that three main factors influence governmental priorities in terms of health policy. These main factors are the cause of the health concern, the severity of the health concern, and, most relevant to this author, the perceptions of the population targeted by the health policy (Oliver 2006).

In his work, Oliver identifies the relevance of the social construction of the group being targeted, and, as a result, the social construction of the health problem. He writes, "When public health problems are stratified by income, age, race, gender, geographic location, or other markers, one group's problems may not be treated the same as another's" (Oliver 2006:200). Here, Oliver is looking at the construction of public health problems through the target populations theory framework. He is acknowledging the importance of understanding the impact that a group's perception can have on the priority given to their health problem. Whether it is a factor mentioned above – income, age, race, gender, or geographic location – or something else

entirely, the perception of a group is, in one way or another, influential in the health policies they experience (Oliver 2006).

Oliver explicates a particularly knowledgeable application of the target populations theory, and he references Schneider and Ingram's work to demonstrate the applicability of the theory to a study of health policy. To demonstrate, he relays the influence that the public perception of AIDS (Acquired Immunodeficiency Syndrome) has had on the types of policies that have addressed those with the disease. As Oliver documents, the severity of AIDS has meant that the responding health policies quite literally have direct life and death implications for those with the condition. Regardless of this fact, the policies designed to address the HIV/AIDS epidemic was, to a great extent, influenced by the social construction of those diagnosed with the illness (Oliver 2006).

This influence is readily observed in the governmental response to the changes in those groups associated with the disease. During the beginning of the HIV/AIDS epidemic, the group most publicly associated with the disease was gay men. For the most part, the federal government considered gay men to be social deviants at that time. Recall that in the target populations framework, deviants are those who have little power and are also constructed with a negative image (Schneider and Ingram 1993). As a result of this construction, the federal government was slow, if not opposed, in providing assistance to those with the disease.

Furthermore, this perception - and therefore neglect - was reinforced by the eventual recognition that injection drug users were also likely to contract the disease due to the sharing of infected needles. As drug users were also constructed as deviants, the image of HIV/AIDS victims remained negative, and the resulting federal response was tepid. It was not until the disease became associated with more sympathetic individuals like Ryan White that the federal

government began to mount a legitimate response. As these positively constructed victims became publicly recognized, the federal government became increasingly motivated to address the epidemic (Oliver 2006).

Ryan White, and others like him, were constructed as dependents in the eye of the public. As previously discussed, dependents are those who have little power, but are also constructed with a positive social image (Schneider and Ingram 1993). These individuals were seen as innocent victims, rather than drug addicts or other risk takers. As a result, their social construction was much more positive, and Congress eventually recognized the importance of addressing the HIV/AIDS crisis. They subsequently acted with the passage of the 1990 *Ryan White Act*, one of the very few national responses to the epidemic. Importantly, this act was explicitly unsympathetic to drug users with the disease (Oliver 2006).

Furthermore, Oliver explains how the act was fiscally undermined by Congress. He writes, "The failure of Congress to appropriate all the funding authorized under the legislation demonstrated the weak political power associated with virtually all HIV/AIDS victims at the national level…" (Oliver 2006 p. 202). This failure is a stark recognition that the social construction of negative groups can severely undermine the successful implementation of policies directed towards them. In fact, a lack of financial assurance is one of the two most significant ways policymakers can undermine the success of policies targeting negatively constructed groups (Mazmanian and Sabatier 1983). A 1998 study similarly examined the social construction and subsequent policy design of those with AIDS, especially in the types of benefits and burdens of those policies (Schroedel and Jordan 1998).

One of the more fascinating examples of research employing target populations theory to understand health policy is a 2004 study by Lawrence. This study examines the struggle that has

been occurring over the framing of obesity as a public health epidemic. Specifically, this study examines the two competing frames being used to discuss and address the growing obesity problem in America, which was really gaining attention at the time of his analysis. The study is important because, although the subject is far removed from the topic of prisoner access to care, it shares a common approach in its analysis. The discussion of the two competing frames is remarkably similar to a discussion using a target populations perspective. The two frames in question are: 1) to approach the obesity problem as an individualistic responsibility, or 2) to approach obesity as a systemic problem and therefore a societal responsibility (Lawrence 2004).

These frames closely reflect the struggles that different groups have in the framing of policy problems. The author points out that a similar faming battle occurred over the framing of other issues, including both crime policy (Scheingold 2011), and the classification of cigarette use a public health issue (Nathanson 1999). These framing debates all center around the ultimate question of who is to blame. As Stone notes in her 1997 work, the decision of who to blame is a political one. More importantly, this decision "… locate[s] the responsibility and burden of reform differently" (Stone 1997 p. 205). In other words, deciding that cigarettes are harming everyone moved the issue from the realm of individual responsibility to that of a public health issue.

Lawrence's study examines the similar struggle that is occurring between similar frames of the obesity epidemic. The nation, at the time of Lawrence's analysis, was split over deciding if obesity was a personal responsibility or a societal one. This is certainly an issue of framing, but it is also clearly within the realm of a target populations framework. Deciding if obesity is a personal problem says one thing about the target population, the obese, while deciding it is a systemic problem says something entirely different (Lawrence 2004).

Specifically, a policy that views obesity as a personal problem and responsibility will undoubtedly encourage society, as well as the obese, to feel that their health is largely the result of their own actions. Contrastingly, a policy that views obesity as a systemic problem will encourage society to view obesity as everyone's problem. This would mean that less stigma would be placed on the obese, and the responsibility of addressing the problem would be society's as a whole, rather than just the obese. This is very much in line with the framework used in the target populations literature (Lawrence 2004).

Lawrence is not the only scholar interested in understanding the construction of obesity and how it relates to policy. Husman (2015) recently published a study that tests the target populations framework in its applicability to health policies concerning obesity. Her experiment offers participants with four competing frames, each socially constructed in a different manner. She then explores the effects that these frames have on the participants' support for health policies that benefitted or penalized the obese. She finds evidence in support of the target populations framework. Specifically, her study shows how the different frames are influential in the participants' support for negative or positive policies, depending upon the specific frame's construction (Husman 2015).

Other Policy Areas

As mentioned, the target populations theory is useful in a variety of circumstances. The social construction of groups has been found to impact a number of policy areas, including immigration policy. Using a target populations and social construction framework, Newton explores the relationship between the social construction of immigrants and the types of immigration policies passed in the United States. She contends that different narratives of

immigration are employed to appeal to certain supporters. Furthermore, these constructions "… are essential to understanding how lawmakers divide and subdivide the immigrant population to achieve policy goals" (Newton 2008:4).

As with many other scholars exploring public policy, Newton recognizes the necessity of understanding the impact that the social construction of the target population has on the policy process. In this case, one must understand the competing constructions of immigrants in the United States in order to appreciate resulting policy outcomes. Specifically, Newton claims that these different constructions can be categorized as either "illegal," "Alien," or "immigrant," narratives. These different narratives grant policymakers the ability to designate which groups are deserving of acceptance and which groups are not. The result of these designations is a capacity for policymakers to shepherd immigration policy into outcomes pleasing to supporters of restricting immigration, while simultaneously choosing which industries benefit from immigrant labor (Newton 2008).

Criminal Justice Policy

Oher scholars studying within criminal justice have also found the framework of social construction and target populations to be useful. In Provine's 2008 analysis of the war on drugs, she discusses the social construction of crack-cocaine as a national crisis, especially in terms of its impact on Black men. In the case of the War on Drugs, these policies were extremely punitive in their punishment, and those associated with the drug, mostly Black men, were harmed as a result. The policies that targeted those who were caught with crack-cocaine were, and are, very severe. As a result, the war on drugs has severely impacted Black families, and the way that Americans view those who use and sell drugs (Provine 2008).

In the United States, Black citizens have been the victims of a persistently negative construction. This construction has been perpetuated in the enduring perception that Black people are disproportionately likely to commit crime, as well as the stereotype Whites hold that they are generally lazy. Furthermore, studies have shown the way in which criminal justice policy, especially drug-related policy, has been influenced by the social construction of those who use drugs. Importantly, much of this construction has been based upon racial stereotypes (Campbell 2000).

These constructions have impacted all sorts of policies targeting Black Americans, including crime policies, housing policies, welfare policies, and other types of policies (Schneider and Ingram 2005). This negative construction of Black Americans is unique, persistent, and, above all, negatively influential in the policy processes that determine what types of policies target Black Americans, as well as the tools used to implement these policies.

Another topic often discussed in terms of social construction is the media's role in the formation of public attitudes and opinions. Lawrence has also researched the role that the media has played in the construction of police brutality. Many scholars have long noted the importance that the media plays in deciding what is important. These decisions are often translated into the problems that then become addressed through the policymaking process (Lawrence 2000).

This means that "News organizations thus play a vital role in the social construction of public problems" (Lawrence 2000 p. 4). Lawrence's research into this area focuses on the importance that this social construction plays in defining and identifying problems that can later be addressed through policy – in this case, the problem of police brutality. Her work demonstrates that social construction influences the very definition of what is and what is not a problem in the eye of the public, in this case, the importance of police brutality (Lawrence 2000).

As previously mentioned, a number of researchers have explored the social construction of those with AIDS, and the policies that target them. Most notably, Donovan has published several studies examining the ways that policies addressing the AIDS epidemic have been influenced by the perceptions of people with AIDS (Donovan 1993; 1997; 2001). While all of these studies examine the construction of those with AIDS, his 2001 study does so within the context of criminal justice policy. In this study, Donovan explores the ways in which policies during the War on Drugs were influenced by the perceptions of drug users with AIDS (Donovan 2001). Similarly, Miller has written of the importance that symbolic politics and cultural meaning have played in the formation of perceptions of drug users and therefore drug policy in the United States (Miller 2012).

In another study exploring the construction of AIDS within the criminal justice system, Hogan employs a case study of a single prison. Her descriptive analysis examines the progress of AIDS policies in this prison as perceptions of those with AIDS change. She finds that the prison initially employs restrictive policies aimed at prisoners with AIDS. These policies reflect the initially negative stereotypes associated with AIDS victims. However, as the stigma of AIDS became less negative over time, the prison's policies become less restrictive and therefore less negative (Hogan 1997).

In another study by Patterson and Keefe, prisoners with AIDS are examined within the context of drug and alcohol addiction in prisons (Patterson and Keefe 2008). Additionally, it has been documented that the social construction of drug addicts has influenced the policies that target them. Specifically, the constructed deservingness of drug addicts in prisons can influence the types of programs that may help them address their addictions (Brucker 2007). Furthermore,

some scholars have examined the factors that can influence the behavior of those most likely to be sent to prison.

One such study examines Sandtown-Winchester, a predominately Black neighborhood in Baltimore. The focus of this study is the way that neighborhoods socially construct what is considered acceptable behavior. This way, they can target the members of their community who fail to meet such a standard, and are therefore deemed to be at-risk. The result of this environment is the ability of neighborhoods to target populations and address behaviors that may lead individuals to incarceration (Camou 2005).

Other studies have also examined ways that communities try and deter criminal behavior that may lead to prison time. Drunk-driving has long been a problem in the United States. The reasons for its prevalence in the United States are complex but well investigated (see Ross 1994), but the public's reaction to drunk-driving has not been static. As public opinion towards drunk-drivers has shifted, states have increasingly sought to minimize drunk-driving through the use of sanctions (Houston and Richardson 2004).

The social construction of the drunk-driver has shifted from that of poor decision-maker to that of a criminal. As a result, state laws have become increasingly harsh. And while the effectiveness of these laws has been questioned, the relationship between the perception of drunk-driving and criminal sanctions is clear. As drinking and driving has become increasingly constructed as deviant and criminal, states have made it increasingly legally perilous to do so (Houston and Richardson 2004).

In addition to the construction of those who drink (and break the law), other scholars have examined the changing perception of users of amphetamine versus that of methamphetamine users within the context of popular fiction. An inspection of television shows,

movies, and novels, shows that popular fiction tends to represent amphetamine users as upper-middle-class people who use these drugs to deal with lives full of stress and difficulty. Methamphetamine users, however, are most often presented as low-income individuals who have strayed from a moral lifestyle (McKenna 2011).

These contrasting constructions have had significant impact on the way Americans view those who use both drugs, and some worry that the more positive portrayal of amphetamine use may actually contribute to the use of such drugs. Furthermore, these representations "… reflect and reproduce existing class- and gender-related inequalities and prejudices, perhaps hindering more compassionate, data-driven approaches" (McKenna 2011:95). Furthermore, the role that the office of the presidency has played in the construction of drug users, especially during the War on Drugs, has been thoroughly explored by academics (Whitford and Yates 2009).

Many researchers have examined the impact that punitive policies have on criminals - especially felons. However, some scholars have also explored the ways in which these policies affect the social rights of felons. In other words, some academics wish to understand the impact that the public's perception of criminals may have on the punitiveness with which those criminals are treated. An examination of state policies regarding the banning of felons from receiving cash and food assistance has been important in this understanding. The authors of this study find that perceived threat of felons is significant in the adoption of severe policies. The perception of criminals is therefore influential in the severity of the policies that target them (Owens and Smith 2012).

More recently, other scholars have also examined the impact of social construction on policies affecting those with HIV in the criminal justice system. Kay and Smith's 2017 study investigates the influence of social construction on the passage of HIV criminalization laws in

states. Specifically, they ask "… whether HIV criminalization laws are more likely to be present in states with higher percentages of socially marginalized populations" (Kay and Smith 2017:2). Using a target populations framework, these authors find that there is a strong relationship between large Black populations and the presence of HIV criminalization laws (Kay and Smith 2017).

Target Populations within Prisons

The relationship between social construction and public policy is the core of Schneider and Ingram's theory. Importantly, this relationship is not only discussed in terms of theoretical possibility, rather, in that researchers have found concrete evidence of the influence that social construction can have on policy. The study most relevant to my research examines the relationship between the social construction of deviant groups and policy choices that later become problematic in the implementation of those policies. In turn, these problems inhibit the viability of the policy by undermining the policy's necessary objectives ((Nicholson-Crotty and Nicholson-Crotty 2004)).

In the late 1990's and early 2000's, prisons and jails experienced a crisis over the risk of both tuberculosis and HIV/AIDS. Inmates were increasingly likely to contract either HIV or tuberculosis, and the contraction of either was becoming increasingly severe. As mentioned before, the prison system has improved dramatically in terms of both access to care and quality of care, however, this new crisis demonstrated the medical vulnerability of those in prison. Furthermore, scholars have repeatedly identified the access that inmates have to healthcare as the only likely healthcare access that many inmates will have throughout their lives. Therefore, research that has focused on the improvement of health screenings in prisons demonstrates that

addressing health concerns in prisons is a viable and important way to limit the spread of infectious diseases to the general population (Glaser and Greifinger 1993).

This all means that the resurgence of HIV/AIDS and tuberculosis was quite frightening for prisons, and equally as frightening for a general population who was at risk for potential exposure. This scare was therefore the impetus that many states needed to reexamine their policies regarding the screening of, and treatment for, inmates with tuberculosis and HIV/AIDS. However, some scholars are interested in the way that the social construction of the prison population may have influenced the amount of funding that each state allocated to combat this increasingly frightening health epidemic (Nicholson-Crotty and Nicholson-Crotty 2004).

In their 2004 study, Jill and Sean Nicholson-Crotty examine the influence that the social construction of prisoners has had on the amount of funding the prisoners in each state receive for health services. Specifically, these scholars are examining the impact that the negative social construction of prisoners has had on the amount of money budgeted by each state to combat the increasingly dangerous prevalence of tuberculosis and HIV/AIDS. They hypothesize that the shortage of funds for treating these epidemics in many states was the result of negative constructions of prisoners in some states. This is problematic in that it would mean that attempts to treat growing incidents of HIV/AIDS and tuberculosis were being undermined by the negative constructions of prisoners (Nicholson-Crotty and Nicholson-Crotty 2004).

This study is vital in that it does not simply theorize about the impact of social construction on policy, rather, it attempts to trace the measurable impacts of that construction. In this case, the measurable impacts are a lack of adequate funding in dealing with the HIV/AIDS and tuberculosis outbreaks. The target populations theory would expect states with harsher views of prisoners to treat those prisoners more punitively (Schneider and Ingram 1993). In this

instance, more punitive measures would be realized through less funding to treat these outbreaks. As a result, the prisoners' social construction is undermining the policy objective clearly identified by state governments.

This is, in the eyes of Jill and Sean Nicholson-Crotty, a self-defeating policy. They argue that in this specific instance of HIV/AIDS and tuberculosis treatment, as well as in other policy areas, the implementation of the policy is inherently doomed to fail because of the introduction of a fatal problem within that process. The attempt to address these outbreaks was unlikely to be successful because the policy process involved a negatively constructed group as the targeted beneficiary. The negative construction of the group, in this case prisoners, introduces a problem that subsequently inhibits the successful implementation of that policy (Nicholson-Crotty and Nicholson-Crotty 2004).

According to these scholars, it is the problem introduced by targeting negatively constructed groups that remains to be identified. In their seminal 1983 analysis, Sabatier and Mazmanian share a now well-known theory of policy implementation that is relevant to understanding the possible problems introduced by policies that target negatively constructed groups. These authors suggest that there are three distinct dimensions of policy implementation necessary to understanding its ultimate success. These three categories are nonstatutory influences, tractability, and the structural characteristics of the policy in question (Mazmanian and Sabatier 1983).

The first two dimensions examined by Sabatier and Mazmanian, nonstatutory influences and tractability, are generally considered to be outside the influence of policy-makers. However, it is the third dimension, the structural characteristics of the policy, that allow political actors to influence the ultimate success or failure of a policy's eventual implementation. Sabatier and

Mazmanian identify two specific structural characteristics that allow policy-makers the most leverage in the successful implementation of the policy. The first of these characteristics, the clarity and precision of the policy, is very overt in nature.

If the policy is unclear in its goals or intent, that policy is very likely to fail. Policies with clear and direct goals and objectives are those most likely to undergo successful implementation. After all, it is difficult to implement a policy when one is unsure of that policy's intent. Similarly, the second characteristic that allows political actors leeway in a policy's success or failure is monetary assurance. This characteristic, while more overt, is no less influential. Few aspects of a policy are more influential in its success than that policy's assurance of funds (Mazmanian and Sabatier 1983).

This work by Sabatier and Mazmanian lead Jill Nicholson-Crotty and Sean Nicholson-Crotty to focus on funding as a starting point in understanding the implementation of policies attempting to address the growing epidemic of HIV/AIDS and tuberculosis. Specifically, what is the driving force behind the variation in health funding for prisoners across states? The target populations literature, in conjunction with the work by Sabatier and Mazmanian, lead these authors to predict that political actors will structure or finance policies directed towards negatively constructed groups in ways that will undermine the successful implementation of those policies. In other words, because prisoners are viewed so negatively, policy-makers will design policies and fund them in ways that make them difficult to implement.

Jill Nicholson-Crotty and Sean Nicholson-Crotty therefore hypothesize that the variation in states' financial willingness to address the growing concern of communicable diseases in prisons is the result of the variation in the way states view those in prison. Put another way, states that view criminals more negatively are less willing to spend money on their health, and

therefore, on combatting the spread of communicable diseases. Importantly, the objective of each state is the same – to put a halt to the spreading of HIV/AIDS and tuberculosis. However, the work of Sabatier and Mazmanian indicates that this objective will be, to varying extents, undermined by the negative construction of inmates (Mazmanian and Sabatier 1983). In this instance, the states that view prisoners more negatively will have policies that are more financially undermined than those states that view criminals more positively. As a result, the states will be financially committed to these policies in measurably different ways, and this variation is caused by different ways that states construct those who are incarcerated (Nicholson-Crotty and Nicholson-Crotty 2004).

The authors find that the number of inmates with tuberculosis or AIDS failed to influence the spending on prison healthcare. In other words, states with higher incidences of HIV/AIDS and tuberculosis were not spending more money on their inmates' health than states with fewer incidences. However, the most significant finding of the study is the impact of societal perceptions on prison healthcare spending. As predicted by the target populations literature, the social construction of groups does indeed impact the policies that target them. In the case of prisoners, the authors find that:

> … the measure of societal perceptions regarding incarcerated and potentially incarcerated persons was a powerful predictor of inmate health-care expenditures across states. The factored indicator of social construction was significant and in the expected direction. A positive one standard-deviation shift in the social construction measure, indicating a more positive perception of prison inmates, resulted in an additional $332 of annual spending per inmate for healthcare. This would represent more than a 50 percent increase in some states. (Nicholson-Crotty and Nicholson-Crotty 2004:250)

This finding means that the way people view prisoners in a state influences the amount of money spent by each state on prisoners' healthcare. In states where prisoners are viewed as more deviant, inmates may receive nearly half of the healthcare expenditures that they would receive if their state viewed them more positively. Shockingly, the actual prevalence of HIV/AIDS and tuberculosis had no significant impact on the amount of money states spend on their inmates' healthcare. Contrastingly, a significant influence on the health expenditures is the social construction of the criminals in each state. This finding is highly significant in that it demonstrates both the impact of a social construction on a policy, but also the ability to measure that social construction and impact (Nicholson-Crotty and Nicholson-Crotty 2004).

Jill Nicholson-Crotty and Sean Nicholson-Crotty's research indicates that negatively constructed groups, specifically inmates, are targeted with policies that are influenced not by that group's needs, but rather, by societal perceptions of the group. Furthermore, these findings are vital to the study of target populations due to the authors' methodological innovation – the creation of a measure for the social construction of criminals. This author hopes to build upon this innovation in order to further understand the impact of social construction on inmates' access to care in prisons. By using a more precise measure of social construction, it will be possible to further our understanding of the impact that the social construction of criminals has on state policies that limit their access to healthcare – specifically, through the implementation of inmate copay policies (Nicholson-Crotty and Nicholson-Crotty 2004).

My Contributions to the Literature

It is well established that the healthcare of prisoners is becoming an increasing significant financial burden on the states. As states are faced with these financial burdens, it is also clear that they will attempt to find ways to lower these costs, especially in the face of growing and aging prison populations. While the impact of many of these cost-saving measures has been systematically explored (Bedard and Frech 2009), no research has yet to thoroughly examine the impacts of the increasingly common state inmate copay policies. Furthermore, while these policies have been justified in terms of their financial impacts, these financial impacts have yet to be documented. Finally, while some studies have found that the policies targeting prisoners are greatly influenced by the social construction of those prisoners (Nicholson-Crotty and Nicholson-Crotty 2004), it is yet to be determined if social construction plays a part in the adoption of these copay policies.

As prisoners are guaranteed access to healthcare services as a constitutional right, and as they have very little agency within the policy process, it is essential that we understand both the impetus for, and causes of, these copay policies. With my research, I hope to make theoretical gains in our understanding of the social construction of inmates and the policies that target them. Methodologically, I hope to demonstrate the value of using a more direct measure of the social construction of inmates. Finally, as previous research has indicated that cost-saving measures taken by states can end up costing inmates' lives (Bedard and Frech 2009), we are morally obligated to determine if these copay policies are causing similar harm.

Theoretical Contributions

While a great deal of the Target Populations literature has examined the impact of social construction on criminal justice policies, the majority of this examination has focused on the social construction of prisoners with HIV/AIDS. While this is irrefutably important, strides must be made in the more general understanding of the social construction of inmates and the policies that target them. With my research, I hope to study the social construction of criminals more broadly and in a way that sheds light onto the way the different perceptions of inmates can influence the way that prisoners are treated and, more specifically, granted access to healthcare services. This approach will also allow for a better understanding of the variation in the perception of prisoners across different states.

Furthermore, few studies have considered the competing constructions of those in prison. In most studies, the prisoners have been assumed to be statically categorized as deviants – for good reason. However, my research will explore the conditions under which other social conditions may play a role in the relationship between the construction of prisoners and access to care. Specifically, I hope to explore the role that the race of the prisoner plays in the categorization of that prisoner. It is possible that, in instances where prisoners are mostly White, attitudes towards universal care are paramount in considering the needs of those prisoners. In these cases, it may be that the desire for universal healthcare takes precedence over feelings of negativity toward criminals, and therefore moves prisoners in need of care from the category of deviant (those negatively constructed and with little power) and into the category of dependent (those positively constructed but with little power).

Contrastingly, in situations where criminals are mostly non-White, attitudes towards universal care and the needs of the prisoner may become less important than attitudes towards

the incarcerated in general. In these instances, the race of the criminal activates racial bias in Whites and the social construction of prisoners becomes a clearly deviant categorization. In this way, the construction of the target population, prisoners, is dependent on the perceived race of the prisoners. If the prisoners are White, the target population is not just prisoners, it is a group in need of healthcare – making them dependents. However, if the prisoner is non-White, the target population is a group of criminals, and whether or not they receive care is less important than their punishment – making them deviants.

Much research has been done on the activation of different frames when race is introduced as a factor - especially within criminal justice and welfare literature. Gilliam and Iyengar find that the introduction of race in news stories about crime activate racial biases about Blacks in White viewers, thereby increasing support for punitive polices when thinking about crime policy (Gilliam and Iyengar 2000). Similarly, Gilens finds that when a welfare recipient is identified as being Black, racial bias towards Blacks becomes influential in Whites' perceptions of deservingness towards those on welfare (Gilens 1996b; Gilens 2009).

Additionally, Schram et al.'s research on welfare sanctions shows that racial biases play an important role in the decision to discipline welfare recipients. Specifically, their Racial Classification Model (RCM) explores how confirmations of expectations or stereotypes of Black and Latino clients lead case-workers to penalize them for behavior when they would not penalize White clients for the same behavior (Schram et al. 2009). These and other studies indicate that race can alter the frame with which Whites use to analyze ideas of deservingness and punitiveness, both of which are undoubtedly part of the decision calculus used to grant healthcare access to criminals – or dependents, conditional on which frame is used.

Methodological Contributions

While many empirical studies have employed the Target Populations framework, not many have done so by looking at state level policies. According to Pierce et al., sixty-one percent of studies within the literature examine the impacts of federal policies, while only twelve percent of studies within the literature examine state policies. While federal policies are undoubtedly important, they constitute only a small fraction of the overall policies passed within the United States. It is fairly obvious, then, that state policies are under-studied within the literature when compared to federal policy - making the examination of state policies a valuable contribution to the literature (Pierce et al. 2014).

Furthermore, most of the studies that have looked at the social construction of prisoners have measured the social construction of the incarcerated indirectly. For example, Nicholson-Crotty and Nicholson-Crotty examine the construction of prisoners, but their measure of social construction is capturing the policy outcomes that a social construction produces, rather than the actual constructions themselves (Nicholson-Crotty and Nicholson Crotty 2004). To improve upon this measure, I will be using a current and direct measure of feelings about prisoners.

Normative Contributions

As access to healthcare has been deemed a constitutional right for the incarcerated, we are obligated to understand the impacts of any policy that could potentially create barriers to that access. Additionally, as previous research has shown that cost-saving mechanisms can reduce quality of care (Bedard and Frech 2009), understanding the impact of these copay policies is of vital importance. Whether the policies are the result of financial duress or the result of differing

social constructions, it is clear that some prisoners are facing more restrictions to healthcare access than others.

If a prisoner is denied access because his or her state has passed a policy out of financial necessity, this is an ethical and legal violation. If the state has done so because people within that state think worse of criminals (especially because of their race), then this is a crime most profound. However, if the policies are simply preventing the abuse of services as the states have claimed, this will be reflected in the results. This is important as no state has shown that their copay policy is in fact saving money while offering similar levels of care. The only such report of which this author is aware was published in California. This report found that inmates were unnecessarily being deprived of healthcare, and that the copay policy was costing more money to implement than it was saving (Birdlebough S. Analysis of SB 396: health care for prisoners 2001).

Study 1: Hypotheses

All of this calls the question, do the attitudes and feelings towards the incarcerated in each state influence the types of policies that in turn target prisoners in those states? Specifically, do states that feel more punitively towards prisoners go on to employ more punitive policies, in this case, more punitive barriers in their access to healthcare services? In this first study, the attitudes and feelings of those in each state will be examined, as well as their impact on each state's decision to pass, or to not pass, prison copay policies of varying punitiveness. This question can be empirically answered by examining the attitudes towards those in prison in each state and assessing their impact on the type of prison copay policy that is adopted in each state.

Hypothesis 1: The Influence of Social Construction on Prisoners' Access to Care

The first hypothesis, that the punitiveness of a state's prison copay policy is the result of the social construction of its criminals, is grounded in the target populations literature. This literature argues that in public policy, groups that are negatively constructed and that have relatively little political power are likely to be targeted with policies that are mostly out of their control. Specifically, policies that target these groups tend to undersubscribe the benefits and oversubscribe the burdens of such policies (Schneider and Ingram 1993).

One would be hard-pressed to envision a group that is more aptly characterized as "deviant" than those who are currently incarcerated. Schneider and Ingram's example group for those who have been socially constructed as "deviant" is, in fact, criminals (Schneider and Ingram 1993). Furthermore, few could argue against the idea that the burdens of a punitive copay policy in a prison are burdens that are oversubscribed. Recall that in California prisons, a $5 copay in terms of prison wages is similar to a $2,000 copay for someone who makes $60,000 a year (Fisher and Hatton 2010).

Clearly then, one can see how prisoners are considered deviants by many within society. As the incarcerated are constructed as deviants, it remains to be seen how this construction influences their access to healthcare. It is the extent to which the people in different states consider prisoners to be deviant that may produce variation in the punitiveness with which each state treats the incarcerated. Specifically, this variation may be manifested in terms of the policies that affect prisoners' access to healthcare services.

Hypothesis 2: The Influence of Financial Strain on Prisoners' Access to Care

In competition to hypothesis one, the influence of social construction on policy adoption and design, is hypothesis 2. This hypothesis represents the claim of states and the federal government – that they have all been forced to adopt copay policies in response to an increasingly expensive, and therefore burdensome, prison system. While this claim is rational enough, there are reasons to question its veracity. Recall that California, a state with one of the largest prison populations, has a more forgiving copay policy than Alabama, a state with a comparatively small prison population.

Rationally then, it makes much more sense for California to have a restrictive copay policy, as it has more to gain financially. Furthermore, from a review of copay policies in general, and in prisons specifically, it is clear that a large portion of work has identified a number of situations in which copay policies do not simply discourage unnecessary medical visits, but rather, they discourage a wide variety of medical treatment seeking, some of which is considered quite vital (Doshi et al. 2009; Hartung et al., 2008; Manning et al. 1987; Scheffler 1984; Scitovsky and McCall 1977).

The results of this research have often indicated that copays discourage cost-effective treatment that can prevent very costly conditions. It stands to reason then, that if the goal is to save money, policymakers would want to know if the copay policies are costing or saving money. As more and more states pass these copay policies, it becomes more important that their effects become known. As previous research has indicated, in many instances, policymakers are less concerned with saving money, and more concerned with the messages that their policies send.

Arguably, this is best encapsulated in the debate surrounding the drug-testing of welfare recipients, despite ample evidence that these policies rarely save money, and sometimes even end up costing states precious financial resources (Amundsen et a. 2015). As a result, the policy process surrounding the passage of prison copay policies can best be understood in terms of policymakers' motivations. Are these policies adopted and implemented in a punitive manner because it is politically beneficial to treat a negatively constructed group in such a way? This is essentially what hypothesis 1 tests. Or, are copay policies passed and implemented punitively because states are financially constrained, as hypothesis 2 suggest?

Hypothesis 3: The Influence of Race on the Construction of Prisoners

The target populations literature is clear in its findings of the impact of social construction on policy construction. What is not so clear within this literature are the conditions under which the categorizations of groups can dynamically change. Some studies have examined the ways in which the construction of groups has changed over time, such as the construction of HIV/AIDS patients over time. Clearly, as the construction of HIV/AIDS patients shifted over the course of a decade, the policies that targeted them shifted as well (Donovan 1993; 1997; 2001). However, few studies have examined the fluidity with which context can impact the construction of groups and the resulting policy outcomes.

In a variety of settings, researchers have found that different frames, or situations, have impacted the way that individuals evaluate policies (Gilliam and Iyengar 2000). However, it is also possible that different frames can impact the way that individuals construct groups. Specifically, it remains to be established what impact that race can have on the construction of a social group within a given context. In the case of the current study, the motivations of the

adoptions of copay policies is paramount in understanding the impact of the policies themselves. Therefore, if the race of the prisoners is impacting the type of policies that states use to target prisoners, especially in terms of access to healthcare services, serious questions must be posed to these states.

The target populations literature has found that the construction of a group impacts the policies aimed at that group. In the case of prisoners, this study aims to explore the relationship that the construction of prisoners has on the policies that influence their access to care – specifically, polices that require them to pay a copay. This relationship is explored in hypothesis 1, wherein the impact of the construction of prisoners in each state is tested on a state's likelihood in passing a restrictive copay policy. However, the mechanism through which this variation in construction acts has yet to be established. One possible mechanism, variations in the impact of race, will be tested in hypothesis 3. This hypothesis posits that the race of the prisoners in each state will influence the way that the incarcerated in each state are constructed.

Gilens has extensively explored the relationship between racial attitudes and opinions of welfare policy. He has argued that crime and welfare are both race-coded issues. This means that the opinions of White Americans on issues of crime and poverty are closely tied to Whites' attitudes towards Blacks. In fact, he finds that White attitudes towards Blacks is the most influential factor on the welfare policy views of Whites (Gilens 1996b).

In a similar study, Gilens examines the influence of racial attitudes on opinions of welfare, even against the competing presence of economic self-interest, individualism, and egalitarianism. Gilens does find that these feelings are influential in White attitudes towards welfare policy, but, overwhelmingly, racial attitudes are still the most significant contributor to formation of Whites' attitudes on welfare policy (Gilens 1995).

His findings also indicate that this influence largely stems from the stereotype that Black Americans are lazy. This stereotype is pervasive among Whites, and highly influential in the formation of White attitudes on race-coded issues (Gilens 2009). These findings are similar to those of Schram et al. in their previously discussed article on welfare sanctioning. Their findings indicate that racial biases play a significant role in the decision of White welfare workers to sanction, or punish, Black welfare recipients in instances when they would not penalize Whites for the same behavior (Schram et al. 2009). They use their Racial Classification Model (RCM), which was developed in an earlier study (see Soss et al. 2008), to explore the impact that incidents confirming racial stereotypes can have on Whites' attitudes and therefore, behavior (Schram et al. 2009).

Furthermore, Gilens has also examined the way that the poor are represented in news media and how that representation is influential in the views of White Americans. He finds that news media vastly overrepresents the proportion of Black people in poverty, especially overrepresenting unsympathetic groups like unemployed adults. This overrepresentation has had major impacts on the way White Americans perceive those in poverty, and especially the perception of Black Americans in poverty (Gilens 1996a).

The impact of the racial perceptions of Whites on White Americans' policy preferences is extensive, and scholars have even explored how White racial bias impacts modern day segregation. These scholars explore the role that social constructs play in the reinforcement and premeditation of Detroit's segregated neighborhoods (Farley et al., 1994). Furthermore, Keith Reeves has elegantly explored how racial bias has impacted the way White Americans view and oppose Black voters and office-seekers. This bias continues to impact White voting behavior and

White views of voting practices in modern America, not just during the Jim Crow South (Reeves 1997).

These findings by Gilliam and Iyengar, Soss et al., Schram et al., Gilens, Farley et al., and Reeves all indicate the extent to which White attitudes are shaped by racial opinions of Black Americans. These studies all produce findings that Whites tend to form attitudes and policy preferences in response to their opinions of Blacks. Therefore, it is within reason to consider it a possibility that the race of the prisoners in a state can influence the policy preferences of Whites in those states. Therefore, hypothesis 3 posits that when a state has mostly White prisoners, the construction of the prisoners will not be influenced by perceptions of race. Conversely, in states where a significant proportion of those in prison are non-White, feelings of racial animosity drive the categorization of prisoners, resulting in a deviant classification. In these states, feelings of punitiveness derived from racial animosity will drive opinions of prisoners' access to care.

Study 1: Data and Research Design

Study 1 will examine the adoption and design of state prison copay policies. Therefore, the best model for such an examination is a policy diffusion model. As was previously mentioned, the majority of states that passed a copay policy did so between 2000 and the mid-2010's. Specifically, 34 of the 42 states who adopted such policies did so during this period. Importantly, this period directly follows the federal government's decision to implement a health copay policy in federal prisons. The Federal Bureau of Prisons introduced the Federal Prisoner Co-Payment Act of 2000 around this time.

Research Model – Policy Diffusion

Walker's 1969 study of state innovation catalyzed efforts to empirically examine the process through which states innovate policy (Walker 1969). Walker's analysis influenced the examination of education, welfare, and civil rights (Gray 1973), as well as the role of elite perception in the diffusion of a number of other policy areas (Grupp and Richards 1975). This focus on diffusion continued into the late 70's and 80's. However, while studies of policy innovation continued to cover new policy areas, the trend to study this diffusion continued along two distinct explanatory paths.

One type of research focused on the internal factors that could lead states to adopt new policies, while a separate vein of research concentrated on the external regional influences that can impact policy diffusion. For some time, these explanatory factors were seen as distinct and incompatible. Even when both internal and external factors were analyzed in the same study, they were done so in complete isolation of each other and in two separate models (Gray, 1973; Walker 1969).

In many early studies, the adoption of state policies is often understood in terms of their spread from one state to another. These models have examined the influence that the surrounding states can have on the decision of another state to adopt, or to not adopt, a policy. However, these models often ignore the significant influences within a state. These political and cultural events, while undoubtedly instrumental in our understanding of policy adoption, are markedly absent in many early studies within the field (see Grupp and Richards 1975; Light 1978). Similarly, studies that have focused on the internal characteristics of a state have often failed to account for the regional influences undoubtedly salient in a state's policy adoption decision (see Downs 1976; Regens 1980).

As early as 1969, scholars have recognized the need for a method to understand both the internal and external factors that influence state policy innovation. Famously, Mohr writes of the circumstances that can lead to or inhibit state policy innovation. He asserts that likelihood of state innovation is essentially the difference between the obstacles of innovation and a given state's motivation to innovate, as well as its access to the resources required to overcome those obstacles (Mohr 1969).

With this calculus in mind, other scholars have diligently explored the factors that influence states' motivations and present obstacles for innovation, as well as those factors that can be seen as resources in overcoming these obstacles. Elazar's 1972 study is influential in its identification of both a major obstacle in policy innovation, as well as a resource in overcoming that obstacle. Two of the most significant risks of policy adoption are uncertainty and public opinion; essentially, is the policy safe to adopt, and do the people support its adoption? One of the more vital ways states can overcome the obstacles of uncertainty and unpopularity is to learn from and justify by the innovation of other states.

In this way, the risks – uncertainty and unpopularity - can be overcome through access to resources - information obtained from the innovation of other states (Elazar 1972). The identification of using the innovative behavior of other states as resources opened the door to explorations of the impact that regional influences have on state policy adoption. With an understanding of the importance that both internal factors and regional influences can have on a state's decision to innovate, Berry and Berry's use of the event history analysis model on state lottery adoption is unquestionably vital. Their study demonstrates both the ability and success of unifying the external and internal characteristics of policy innovation (Berry and Berry 1990).

Other important works have also examined the factors that contribute to the impact of regional influences on policy diffusion. Andrew Karch (2007b) has written extensively on policy diffusion and the influence that states have on each other in policy adoption. Specifically, he has identified three questions which policy diffusion scholarship must address. He argues that the literature needs to explore the causes of diffusion, and he contends that to answer this question, scholars must study emulation, competition, and imitation (Karch 2007b).

Furthermore, scholars must gain stronger insights into the political forces that either encourage or prevent policy diffusion. This insight can be achieved through an examination of the causal mechanisms involved in state adoption of similar policies. Finally, Karch argues that the very subject of diffusion needs elaboration. In other words, what is being diffused is as important to the literature as understanding why the diffusion occurs in the first place. He contends that this understanding can be achieved if scholars are willing to consider the content of public policy as both an outcome and a cause within the process of diffusion (Karch 2007b).

His research also examines the different stages of the policy cycle, and the constraints policy-makers face at each stage. His work has explored the constraints on lawmakers that make regional policy innovation a significant influence on state policy adoption. He contends that during the early stages of the policy-making process, insufficient time is perhaps the most influential factor in policy-makers' decisions to adopt similar innovations to their neighbors (Karch 2007a).

He writes, "Time-pressed officials are likely to be drawn to highly visible and politically salient policy innovations and to utilize resources that provide a maximum amount of information about them for a minimal amount of effort" (Karch 2007a:4). This assertion expands upon Elazar's earlier work in which he identifies the adoption of policies in other states to be

resources in overcoming obstacles to policy adoption. In this case, Karch is identifying the obstacle to be time, and the resource needed is the adoption of polices that have already been successful.

Mechanisms of Policy Diffusion

Importantly, a large component of the policy diffusion literature is the identification of the mechanisms through which policies are diffused. As previously mentioned, Karch's 2007 article examined the important steps to be taken within the policy diffusion literature to grow as a field. In Sabatier and Weible's prominent *Theories of the Policy Process*, Berry and Berry contribute an informative chapter on theories of innovation and diffusion of public policy (Sabatier and Weible 2014). This chapter is informative in a number of ways, but two specific components that are of interest to this analysis are the sections on advancements in the event history analysis technique, and the section on the mechanisms through which policy diffusion can be achieved (Berry and Berry 2014).

The authors discuss five different mechanisms through which the diffusion of a policy can occur: learning, imitation, normative pressure, competition, and coercion. While not all instances of diffusion can be understood as operating through one of these five mechanisms, much of policy diffusion research has found these explanations to be sufficient. Policy learning is the idea that policy-makers from one group observe the success of a policy in another group. In its most basic sense, policy learning is understood as a group witnessing the success of a policy and using that success as resource in their own policy-making (Berry and Berry 2014).

Imitation, while similar to learning, is somewhat distinct. Pursuing a policy that a neighbor successfully passed due to similar goals or agendas is considered policy learning.

Policy imitation is when a group copies another group in order to appear similar to their neighbor. The key difference is what is being imitated or learned. In policy learning, the group that innovates in response to their neighbor is drawing from the success of the policy. In policy imitation, the group that innovates in response to a neighbor is attempting to look like, or imitate, their neighbor. The focus of the emulation is on the actor, rather than the action (Berry and Berry 2014).

Normative pressure, on the other hand, is an instance when a government or group of policy-makers observes a policy being adopted by other groups, and therefore feels the need to conform. This action is usually the result of shared values or norms. If a multitude of groups is passing a similar type of policy, and another group without that policy feels that these groups share common values and norms, the group without the policy will feel pressure to adopt a similar policy in order to maintain a status of similarity or uniformity. This can often be observed in regions, where one state passes policies similar to neighbors in order to remain regionally linked, such as attempts to stay "Southern" (Berry and Berry 2014).

Furthermore, another mechanism through which policy-diffusion occurs is policy competition. In cases of competition, a group of policy-makers is motivated to adopt a policy based on the desire to establish or maintain some economic advantage over its neighbors. This can be readily observed in a state's decision to adopt a lottery. If state A has a lottery while state B does not, it is very likely that people from state B will travel to state A in order to take advantage of state A's lottery. The purchasing of tickets, as well as the travel involved, will undoubtedly end up gifting state A with taxable purchases that would otherwise have been spent in state B. As a result, state B may see it as in their best interest to pass a similar lottery policy in

order to compete with state A's policy and take advantage of tax revenue from tickets and traveling (Berry and Berry 2014).

Finally, policy coercion is a situation in which a more powerful government either forces or incentivizes a weaker government to adopt or to not adopt a policy. Policy coercion is most often observed in vertical scenarios in which a national government coerces a state government into adopting a policy (Berry and Berry 2014). Similarly, policy coercion is readily observed internationally when a powerful country, or group of countries, coerces a smaller country into adopting a policy. This can be seen in instances where developing countries have passed gender quotas for government positions in order to appeal to more powerful nations in terms of foreign aid (Bush 2011).

While diverse, these five mechanisms are the standard discussed in the policy diffusion literature. Policy learning, imitation, normative pressure, competition, and coercion, are all different in terms of the motivations of those emulating the policy decisions of others. This emulation has occurred vertically, from federal governments to states, and horizontally, from state to state. While further exploration of these mechanisms is undoubtedly needed (Karch 2007b), the advancement in our understanding of these mechanisms has increased over time (Berry and Berry 2014).

Event History Analysis (EHA)

Recognizing the growing policy diffusion literature's inability to account for both internal and external explanations of policy diffusion, Berry and Berry, in their seminal 1990 study, introduce the use of an event history analysis to address these shortcomings. Event history analyses, while often used in biological and other social sciences, had largely been under-utilized

by political science, as well as other social sciences. Berry and Berry examine the diffusion of state lottery policies in order to demonstrate the ability of the technique to examine internal characteristics of a state, as well as the impact of regional characteristics on policy adoption (Berry and Berry 1990).

In their event history analysis, each year is a discrete window of opportunity, during which the "risk set," in this case each state without a lottery, has the opportunity to experience the event – in this case, lottery adoption. The variable to be explained expresses a hazard rate, which is each individual state's probability of experiencing the event (adopting a lottery) in any given year. The dependent variable is essentially a dummy variable for each state during each year that they have not experienced the event. As the event can only happen once, states that experience the event by adopting a lottery are dropped from the remaining years in the analysis. In essence, the dependent variable is the observation of whether or not a state without the policy adopts that policy in any year during the observed timeframe. As a result, Berry and Berry's model is "… a form of pooled cross-sectional time series analysis" (Berry and Berry 1990:395).

As mentioned, the event history model is ideal for understanding state policy adoption because it allows a model to account for both individual state characteristics, as well as the regional influence of surrounding states. Berry and Berry's examination of state lottery adoption is an attempt to unify two previously isolated explanations for policy diffusion, an important component of the policy diffusion literature (Berry and Berry 1990).

Study 1: Research Model

A growing number of scholars have employed event history analysis, especially in the exploration of policy diffusion across states. As this method has become more common, it has also become increasingly sophisticated (Berry and Berry, 2014). However, it is clear that the most appropriate technique to explore the internal and external factors influencing policy adoption in the states is a policy diffusion model employing even history analysis. As a result, the model in my study that tests the validity of hypotheses 1-3 will be an event history analysis. Specifically, this analysis will employ the Cox Proportional Hazards model. This model, an increasingly popular model in the social sciences, allows flexibility within the analysis in terms of assumptions about time, leaving the duration dependency unspecified (Box-Steffensmeier and Jones 2004).

Independent Variables of Interest

Like the work done by Jill and Sean Nicholson-Crotty (2004), this model will have social construction as the primary independent variable of interest. One of the most important aspects of their work is their operationalization of the social construction of prisoners. Their variable for social construction, while an important step forward, is problematic in a few ways. Their variables are:

1) A dummy variable indicating the permanent disenfranchisement of felons
2) A measure of Black representation in each state legislature, relative to that state's Black population

3) A punitiveness measure made up of the residuals from an equation that regresses incarceration rates in each state on both the crime rate and the law enforcement expenditure rate
4) The minimum guaranteed AFDC benefit set by each state legislature for a family of three

Measuring the Social Construction of the Incarcerated (Hypothesis 1)

While these components are all important in the understanding of the social construction of criminals, they fail to offer a direct measure of that construction (Nicholson-Crotty and Nicholson-Crotty 2004). Specifically, instead of capturing the way individuals feel about prisoners, these measures all capture the political outcomes of the underlying ideology that contributes to a social construction. By measuring the construction indirectly through policy outcomes, as Nicholson-Crotty and Nicholson Crotty do, our picture of the way individuals feel about prisoners is incomplete. To really capture the social construction of prisoners, we must go to the source – the feelings of those who are socially constructing.

In an attempt to strengthen Jill and Sean Nicholson-Crotty's measure of the social construction criminals, this study will attempt to capture the construction of prisoners more directly. Stephen Ansolabehere and his colleagues have collected a variety of data in their Cooperative Congressional Election Survey (CCES) from 2005 to 2016. These surveys have been conducted ten times since the original study in 2005, and include a variety of measures that indicate respondents' attitudes towards criminals. As the years of the survey overlap heavily with the years during which states were primarily adopting policies regarding prison copayments, the CCES is ideal for measuring individual attitudes over time. (https://cces.gov.harvard.edu/)

Jill and Sean Nicholson-Crotty are visionaries in their work in that they found a way to measure an abstract idea – the social construction of a group (Nicholson-Crotty and Nicholson-Crotty 2004). This measure suffers from the need for a more direct approach, and the use of the CCES is important in that it allows for a measure of individual attitudes. Furthermore, the CCES data contribute a more direct indication of the way people feel about those who are incarcerated, and of those who have been convicted of a felony.

Specifically, the 2016 CCES asks four questions within the criminal justice section that can be used to create a scale that measures individual attitudes towards criminals. The first of the four questions asks respondents if they would support or oppose a policy to "Eliminate mandatory minimum sentences for non-violent drug offenders." The second of the four questions asks respondents if they would support or oppose a policy to "Require police officers to wear body cameras that record all of their activities while on duty." The third question asks respondents if they would support or oppose a policy to "Increase the number of police on the street by 10 percent, even if it means fewer funds for other public services." The final question of asks whether respondents would support a policy that would "Increase prison sentences for felons who have already committed two or more serious or violent crimes.

The first two questions, if answered positively, indicate a respondents' feelings of leniency and a preference for the civil protections of those convicted (and accused) of nonviolent crimes. Conversely, positive answers on the latter two questions indicate a harsher more punitive construction of criminality that favors punishment over other services, and increasing sentences for offenders. Therefore, I recoded the answers to the latter two responses so that individual responses would indicate punitiveness in the same way as the first two questions. The resulting scale therefore ranges from 4, a lenient response to all four questions, and an eight, a punitive

response to all four questions. These scales were then averaged by state, to give each state an average response on scale of 4-8, indicating that state's level of punitiveness.[1]

Measuring the Financial Duress of States (Hypothesis 2)

In order to test for the impact of the financial situation of states on policy adoption, two separate measures were used. The first indicator is the amount of corrections spending per inmate. This data is available for the states in all years of the study through the Tax Policy Center. The second indicator, state revenue per capita, represents a state's ability to spend on programs based on their revenue raised in any given year. These data are available through the Urban Institute, and are available for every state in every year of the study. I converted these and all other monetary values in both studies to 2017 dollars.

Measuring the Context of Social Construction (Hypothesis 3)

As mentioned, it is possible that, as in other policy areas, social construction of certain groups is tied to views of race. Recall that Whites' attitudes towards welfare are more dependent on their opinions of Black Americans than they or on actual welfare recipients (Gilens 1996a; Gilens 1996b; Gilens 2009; Gilliam and Iyengar 2000). These findings indicate that racial bias can often manifest indirectly through another mechanism during the formation of policy preferences. As a result, racial bias may drive a more negative social construction of criminals in a state where a larger percentage of the incarcerated are Black Americans.

[1] Importantly, the Alpha of the CCES questions is on the low end of the reliability scale. Therefore, these questions, while the most direct questions available on the attitudes of individuals towards inmates, do not have as high of a reliability as would be preferred.

Therefore, in the study I have included the percent of Black prisoners in each state's prison system, which will indicate the impact that the presence of Black American prisoners can have on the adoption of inmate copay policies. Additionally, I include a measure of support for 'universal care," the idea that everyone should be able to access healthcare services. This measure is constructed from three question in the 2016 CCES, and is intended to control for opposition or support of copays in general, so that this opposition or support is not conflated with support for inmate healthcare access. [2]

Other Independent Variables: Control Measures

There are also a number of other variables that act as controls in the analysis. I control for citizen ideology, as well as the ideology of the state government in each state. This is to account for the possibility that partisan or ideological leanings could be driving the adoption of copay policies for inmates, rather than the construction of criminals in a given state. I also control for the cost of physician care outside of prisons in each state. This data is available through the census bureau and is available for all years in the study. As with revenue per capita, I converted these values into 2017 dollars.

Dependent Variable

The dependent variable in the first model of this analysis is the adoption of a copay policy by a state previously without a copay policy, for every year that adoption is available. The data is coded as a 1 if a copay policy is adopted, and 0 if a policy is not adopted in that state

[2] The alpha of these questions also demonstrates a lower than preferred reliability of the scale, demonstrating the need for an improved method of understanding individuals' direct attitudes towards health care policy.

in each given year. However, the analysis will also explore the relationship between the independent variables and the punitiveness of a state's copay policy. For the second analysis exploring copay severity, each copay policy has been coded according to its level of punitiveness. This variable is a state's score on an ordinal scale of punitiveness (1-3), 1 being less punitive and 3 being more punitive.

The least punitive copay policies**,** those scored as 1, make no mention of an inmate having to pay the copay at a future date if they are unable to pay at the time of request. The policies that are moderately punitive are coded as 2 if the policy specifically mentions a system through which inmates must repay the copay at a future date if they are unable to pay at the time of request, but does not allow an inmate's balance to fall below a certain amount. The most punitive policies, coded as 3, specifically mention a system through which inmates must pay the copay at a future date if they are unable to pay at the time of request, and if the policy does not forgive the debt after a period of time.

On the next page, table 3.1 demonstrates the various dimensions of state copay policies, including the adoption dates, the cost of the copay, and the punitiveness of the policies.

Table 3.1 – State Prison Copay Policies

State	Abb.	Cost of Copayment	Date of Introduction	Punitiveness (0-3)
Alabama	AL	$4	June 1, 2013	3
Alaska	AK	$5	January 16th, 2014	3
Arizona	AZ	$5	October 22, 2016	3
Arkansas	AK	Up to $5	January 15th 2005	3
California	CA	$5	September 21st, 1994	2
Colorado	CO	$3	November 1st, 2005	1
Connecticut	CT	$3	2017	3
Delaware	DE	$4	November 14, 2007	1
Florida	FL	$5	November 15th, 2000	3
Georgia	GA	$5	August 1, 2012	3
Hawaii	HI	$3	March 30th, 2010	3
Idaho	ID	$5	March 4th, 2008	1

Illinois	IL	$2	July 1st, 2007	3
Indiana	IN	$5	April 30th, 1997	2
Iowa	IA	$3	September 2005	3
Kansas	KS	$2	January 8th, 2014	1
Kentucky	KY	$3	August 5th, 2016	1
Louisiana	LA	Up to each parish	Not Sure	1
Maine	ME	$5	2015	3
Maryland	MD	$2	May 29th, 2015	1
Massachusetts	MA	$3	September 11th, 2009	1
Michigan	MI	$5	February 9th, 2009	3
Minnesota	MN	$5	July 1st, 2014	3
Mississippi	MS	$	2013	3
Missouri	MO	None	N/A	0
Montana	MT	None	N/A	0
Nebraska	NE	None	N/A	0
Nevada	NV	Cost of Examination	June 17th, 2012	3

New Hampshire	NH	$3	April 1st, 2008	3
New Jersey	NJ	$5	2013	3
New Mexico	NM	None	August 3rd, 2005	0
New York	NY	None	N/A	0
North Carolina	NC	$5	September, 2014	2
North Dakota	ND	$3	February 20th, 2015	1
Ohio	OH	$2	May 16th, 1998	1
Oklahoma	OK	$4	October 20th, 2015	1
Oregon	OR	None	N/A	0
Pennsylvania	PA	$5	April 29th 2008	3
Rhode Island	RI	$3	December 17th, 2007	3
South Carolina	SC	$5	March 1st, 2004	3
South Dakota	SD	$2	October 14th, 2016	3
Tennessee	TN	$3	June 1st, 2011	3

Texas	TX	$100 annual fee	September 28th, 2011	3
Utah	UT	$5	2009	3
Vermont	VT	None	N/A	0
Virginia	VA	$5	September 1st, 2011	3
Washington	WA	$4	July 24th, 2015	3
West Virginia	WV	$5	2012	1
Wisconsin	WI	$7.50 copay	May 1st, 2003	3
Wyoming	WY	None	N/A	0

Shown another way, figure 3.1 below demonstrates the prevalence of prison copay policies among the states. This figure is a map showing states that have adopted inmate healthcare copay policies, with darker shades representing more sever copay policies, and lighter shades representing less punitive copay policies. Figure 3.2 demonstrates the rate of copay policy adoptions over time, and figure 3.3 demonstrates the rate of copay policy adoptions by type of copay.

Figure 3.1 – A Map of Prison Copay Policies in 2017

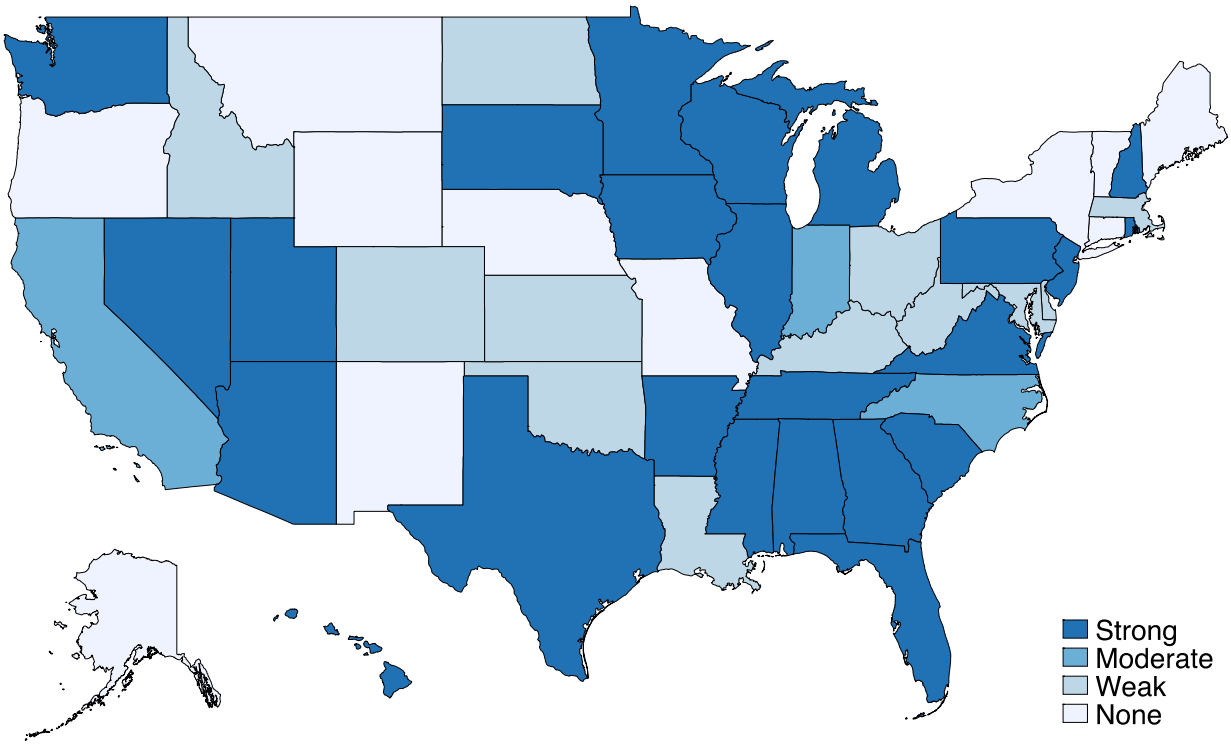


Figure 3.2 – Graph of Copay Adoptions

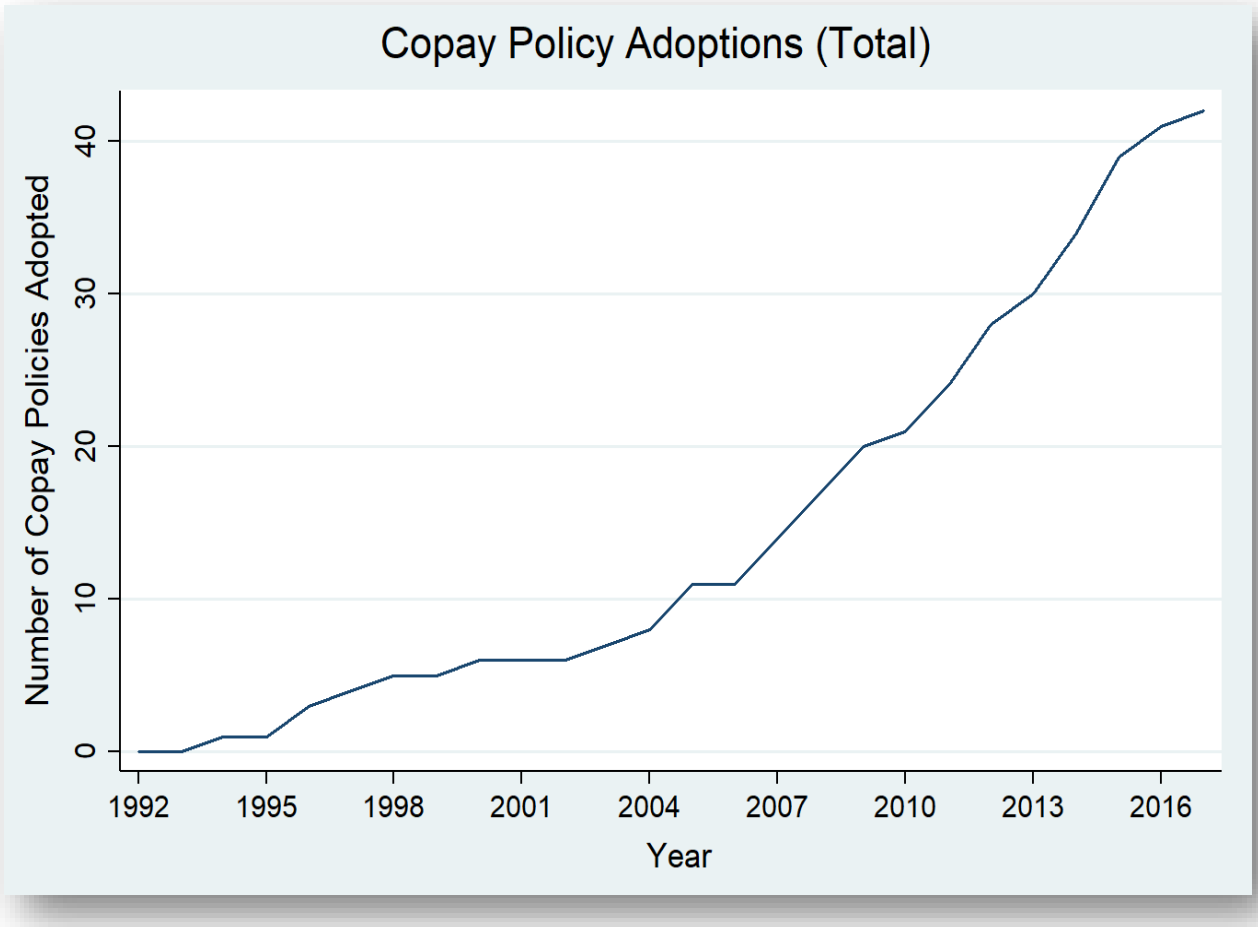
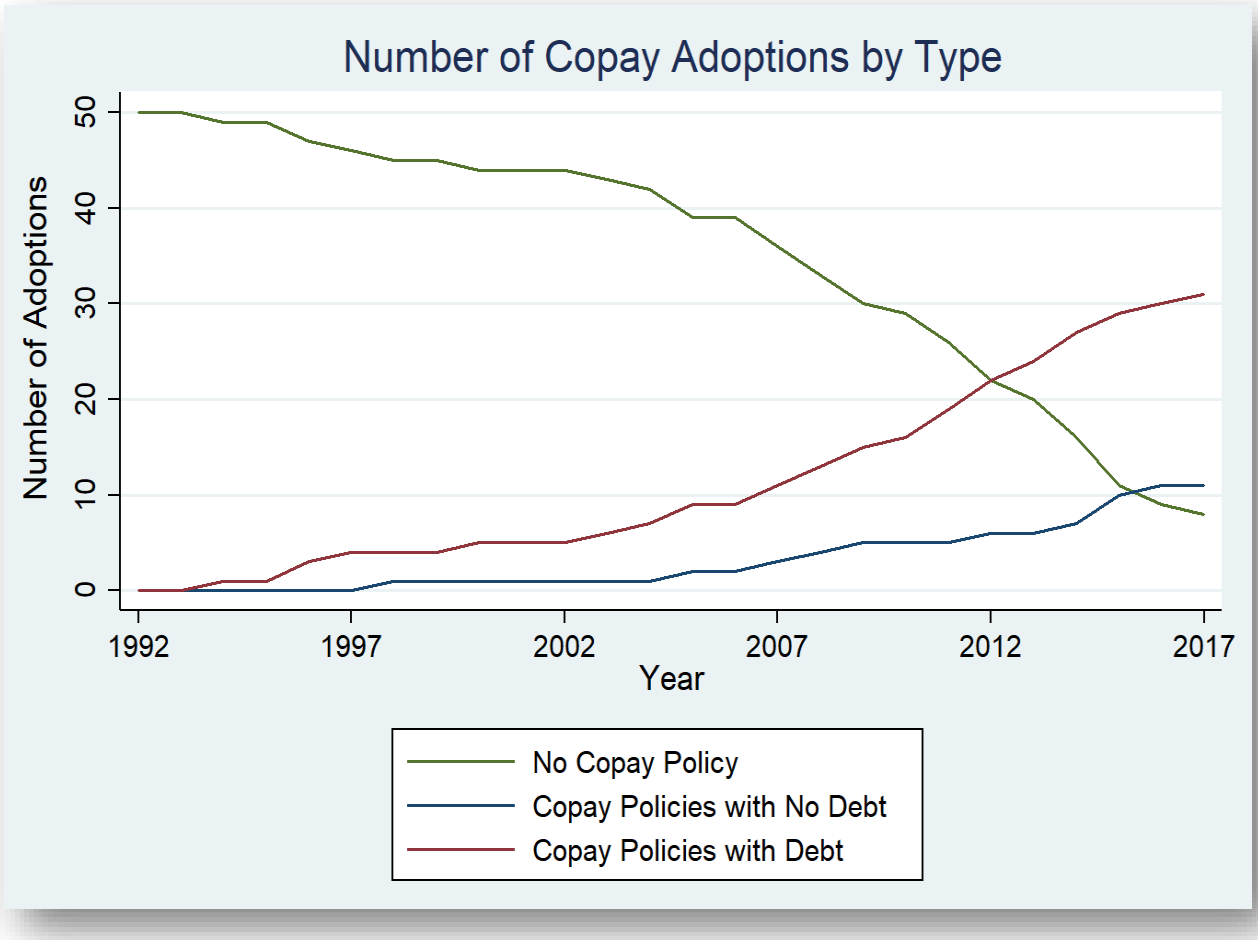


Figure 3.3 – A Graph of Copay Policy Adoptions by Type



Study 1: Findings

Study 1 is an attempt to explore the factors that contribute to the decision of states to adopt a copay policy for inmates. The first hypothesis, that the social construction of inmates impacts the likelihood of a state adopting an inmate copay policy, is not supported by the results of the model. As seen in table 3.2 on the next page, the measure of social construction in the form of the responses to the CCES questions is not statistically significant. There are a few likely reasons why this measure failed to achieve statistical significance, and these will be discussed in depth further on in the study.

Model 1: The Impact of Social Construction on the Likelihood of Copay Adoption

Importantly, the competing theory in hypothesis 2 is also not validated by the findings of the first model. Hypothesis 2 asserts that it is the financial duress of states, rather than the social construction of criminals in each state, that most significantly impacts the likelihood of copay policy adoption. However, as is also seen in table 3.2 below, the variable measuring the financial duress of states, corrections spending per inmate, is not statistically related to the likelihood of a state adopting a copay policy. These results indicate that neither the CCES measure of social construction, nor the states' need to control spending on inmate healthcare are the primary forces driving a state's decision to adopt inmate copay policies. Importantly, the model does suggest that two variables in the analysis are influencing states' decisions to adopt copay polices.

Table 3.2 - The Likelihood of Adopting an Inmate Copay Policy

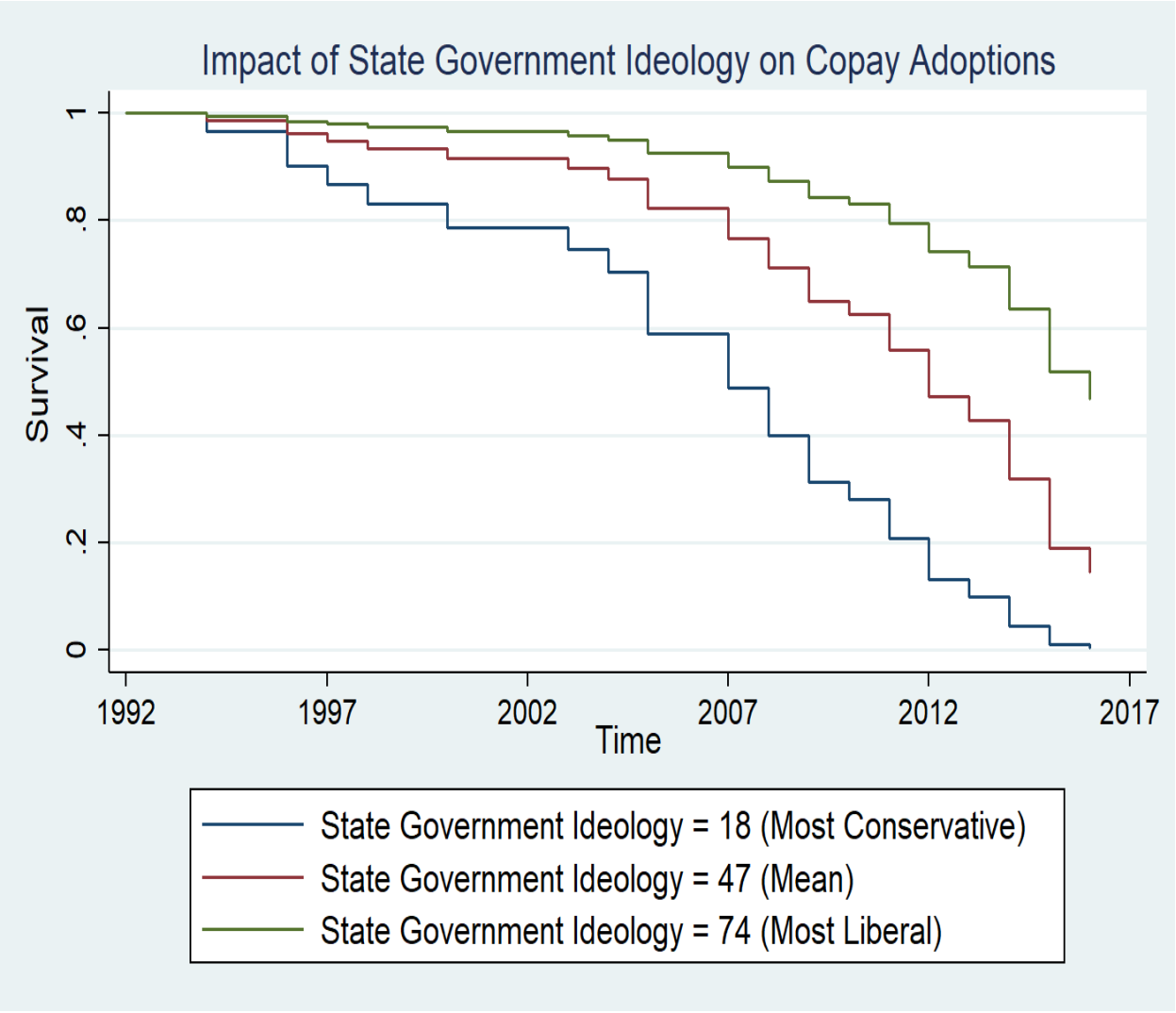
Independent Variables	DV = Copay Adoptions
Inmate Social Construction	0.223
	(0.422)
State Corrections Spending Per Prisoner	0.979
	(0.0167)
State Revenue	1.000
	(0.0000732)
Citizen Ideology	1.018
	(0.0163)
State Government Ideology	0.970*
	(0.0135)
General Population Healthcare Spending	1.000
	(0.000296)
Percentage of Black Inmates	1.028**
	(0.00951)
Support for Universal Care	24.58
	(45.52)
N	949
Hazard Ratios; Standard errors in parentheses	
* p<0.05 ** p<0.01 *** p<0.001	

As shown in table 3.2, while the measures of social construction and corrections spending fail to significantly impact the likelihood of copay policy adoptions, the state government's ideology, as well as the racial makeup of that state's prisoner population, both significantly influence the likelihood of copay policy adoption. Table 3.2 indicates that both having a conservative state government and the percent of a state's inmate population that is Black are statistically significant. The variable measuring the Black inmate population in each state is simply the percentage of each state's Black inmate populations from 0%, meaning no Black inmates, to 100%, meaning all Black inmates. The state government ideology score is a scale of 0 to 100, with lower scores indicating conservative state governments and higher scores indicating liberal state governments.

These findings indicate that a higher government ideology score, meaning a more liberal state government ideology, leads to a lower hazard ratio. This means that a state with a liberal government is less likely to adopt a copay policy, all else constant in any given year. Similarly, the results also show that the higher the percentage of a state's Black prison population, the more likely a state is to adopt an inmate copay policy, all else constant in any given year. Figure 3.4 demonstrates the survival rate for any given state, all else constant, with varying state government ideology.

As shown in the figure, a state with a conservative state government has a remarkably low survival rate. In other words, a state with a conservative government is extremely likely to adopt a copay policy, while a state with a liberal government is significantly less likely to adopt such a policy in a given year. By the end of the analysis, having a conservative state government means that, all else equal, that state has about half the survival rate, and is therefore more than twice as likely to adopt a copay policy by the end of the analysis.

Figure 3.4 - Impact of State Government Ideology on the Cumulative Hazard Rate



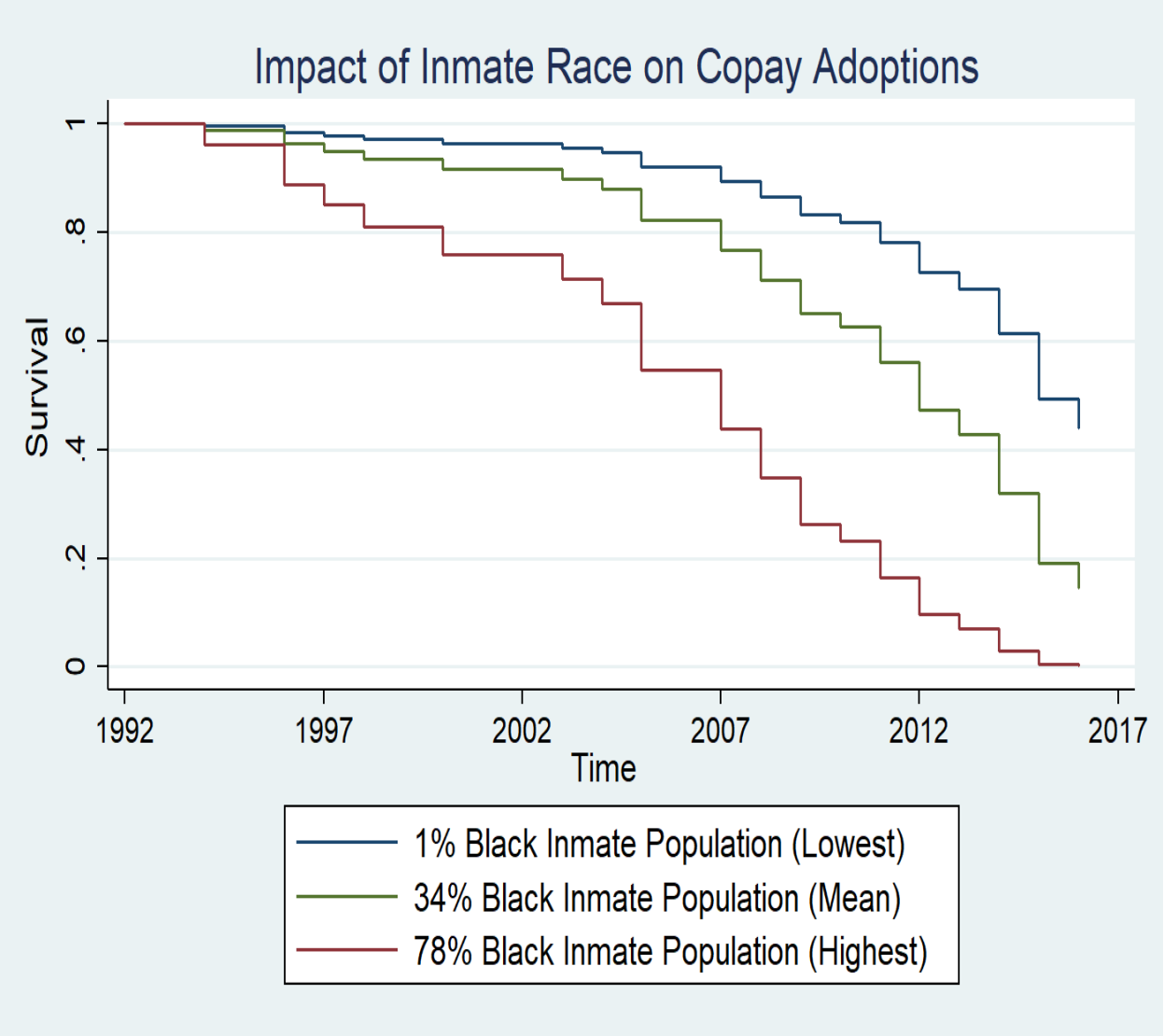
Similarly, the model demonstrates the significant impact of inmate race on a state's decision to adopt a copay policy. The percentage of a state's Black inmate population is strongly related to its decision to adopt a copay policy. This relationship is positive, meaning a state with a higher percentage of incarcerated Black Americans, all else constant, is more likely to adopt a copay policy in any given year. The hazard ratio produced by the model is substantively and statistically significant. The ratio for a state's percentage of Black inmates is 1.028.

In a Cox Proportional Hazards model, a ratio over 1 has a positive impact on the likelihood of the event, while a ratio of less than 1 indicates that the variable has a negative impact on the likelihood of the event. This means that the percentage of Black inmates in a state prison system causes a positive impact on the likelihood of failure, which, in this case, is the adoption of an inmate copay policy. Specifically, this impact is about a 2.8% increase in the likelihood of experiencing the event. Therefore, an increase of 1% in a state's Black inmate population leads to a 2.8% increase of risk for that state to adopt a copay policy. While this increase may not seem excessively significant, this effect translates into a 28% increase in risk of adoption if a state's Black inmate population increases by just 10% - an entirely realistic scenario.

Figure 3.5 on page 114 demonstrates this relationship, showing the impact that race has on copay adoptions with 1% of Black inmates (the lowest of any state), 34% Black inmates (the mean), and 78% Black inmates (the highest of any state). This visually represents the decreasing survival rate, and therefore the increasing likelihood of state copay adoption, as the percentage of a state's Black inmate population increases. By the end of the analysis, a state with the highest proportion of Black inmates is exponentially more likely to adopt a copay policy than a state with the lowest proportion of Black inmates. In fact, the difference in the survival rates of these

two extremes is nearly 0.5, meaning a state with the highest proportion of Black inmates is nearly twice as likely to adopt a copay policy as a state with the lowest proportion of Black inmates.

Figure 3.5 - Impact of Inmate Race on The Cumulative Hazard Rate for Copay Adoption



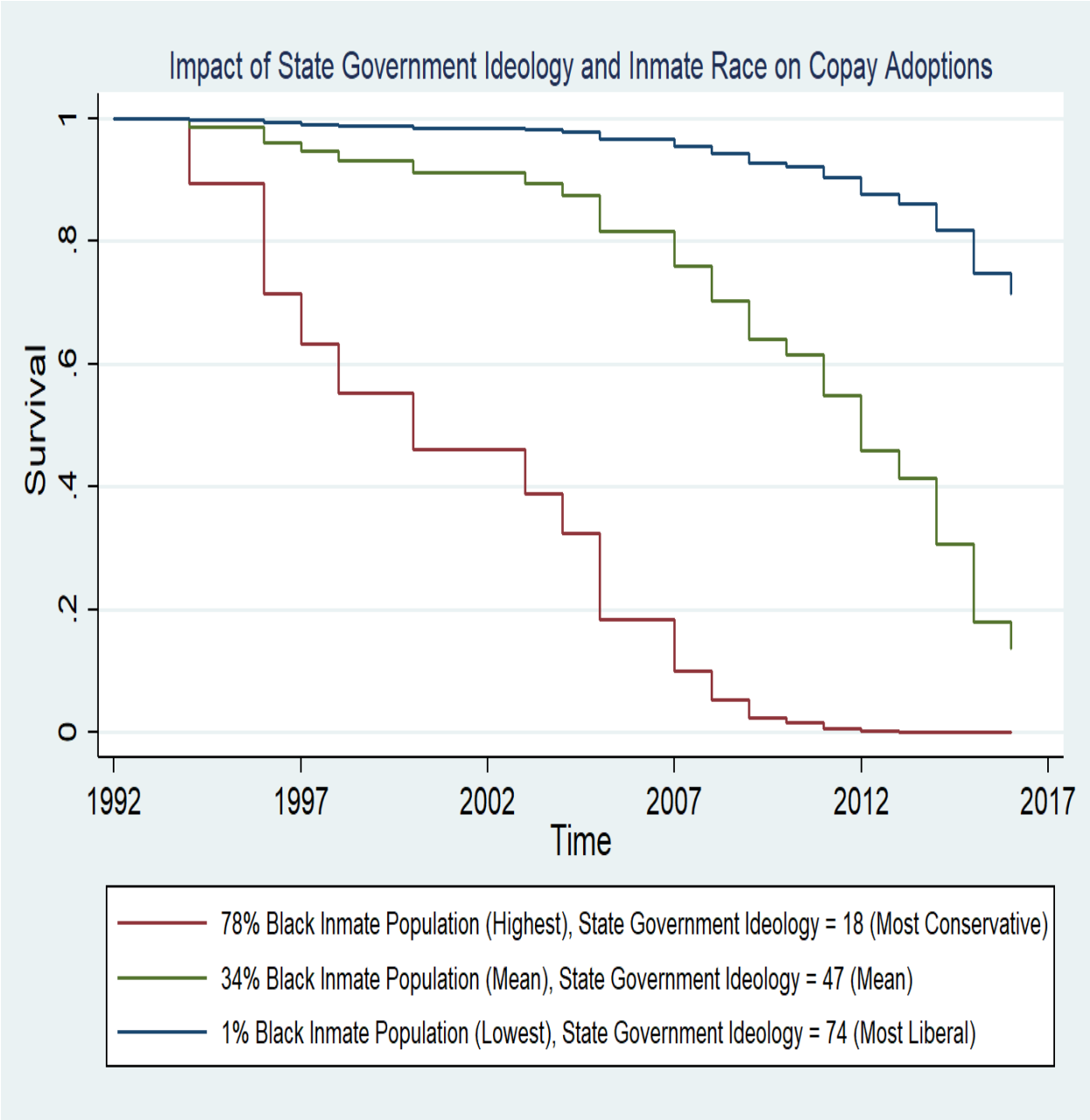
Finally, it is clear from the results that together, the impact of having a conservative state government and a high percentage of Black inmates is overwhelming. In a state with a high percentage of incarcerated Black Americans and a conservative state government, there is very little chance that a state will not adopt a copay policy in the analysis. Conversely, a state with a low percentage of incarcerated Black Americans and a liberal state government has little chance of adopting a copay policy in the model. For example, in the year Georgia adopted a copay policy, 2012, its percentage of Black inmates was 62% (28% above the mean), and the state government ideology score was 19 (28 points more conservative than the mean).

Compare Georgia with a state like Vermont. Vermont has yet to adopt a prison copay policy. Its average percentage of Black inmates during the years of the analysis is 7% (27% below the mean), and the state government ideology averaged a score of 64 throughout the analysis, or 17 points more liberal than the mean. In figure 3.6 on page 117, the stark contrast between a state with a liberal state government and low percentage of Black inmates can be compared to that of a state with a conservative state government and a high percentage of Black inmates. The survival rate is determined by varying both state government ideology and the percentage of Black inmates in a state's prison system.

The graph displays two survival rates based on variation in these variables. The blue line on bottom represents a state with the lowest percentage of Black inmates in the analysis (1%), as well as the most liberal state ideological score in the analysis (74). Conversely, the topmost red line represents a state with the highest percentage of Black inmates (78%) and the most conservative state government ideological score in the analysis (18). Finally, the middle green line represents a state with the mean proportion of Black inmates (34%), and the mean state

government ideological score (47). The contrasting plots demonstrate the extent to which both state government ideology and racial composition impact a state's survival rate, and, therefore, the likelihood it will "survive" in the analysis and not adopt an inmate copay policy.

Figure 3.6 - The Impact of Inmate Race and State Government Ideology on Survival Rates



The Influence of Race on Copay Adoption: Neoliberal Paternalism and the RCM

Importantly, while these results clearly demonstrate the impact that inmate race and government ideology have on the likelihood of a state adopting a copay policy, the measure of social construction built using the CCES questions is statistically insignificant. These results could be the result of either two factors. Either the social construction of inmates has no significant impact on the likelihood of a state adopting an inmate copay policy, or the measure used in the analysis fails to adequately capture the social construction of inmates. As discussed, previous research has repeatedly demonstrated the impact that social constructions can have on policy. Recall the finding that the social construction of criminals is more influential in the allocation of HIV and AIDS health funds than the actual prevalence of HIV and AIDS (Nicholson-Crotty and Nicholson-Crotty 2004).

Similarly, welfare research has repeatedly shown that, in terms of Whites' policy preferences, race is so salient that opinions of Black Americans rather than opinions of welfare recipients are the main driving force behind Whites' policy preferences (Gilens 1996b; Gilens 2009). Additionally, the inclusion of race in news stories pertaining to crime tend to activate racial bias in White viewers, leading to an increase in their support of harsh policies when formulating criminal justice policy preferences (Gilliam and Iyengar, 2000). Finally, research into welfare punishment has shown how influential racial bias in welfare workers can be in their decision to sanction welfare recipients (Schram et al. 2009).

This research overwhelmingly indicates the importance of race and racial bias in the policy preferences of Whites. Importantly, this is a finding that is corroborated with the results of this study. States with a higher percentage of Black inmates are more at risk for adopting a policy restricting health access than states with lower percentages of Black inmates. It is possible that

the measure used to capture social construction in this study is ineffective. However, it is also possible that, like in the area of welfare policy, criminal justice policy is so heavily interconnected with race and racial bias, that it is attitudes towards Black Americans, rather than attitudes towards criminals, that significantly impacts White opinions on criminal justice policy – in this case, whether to restrict inmates' access to healthcare services.

The idea that, as an institution, the criminal justice system is heavily impacted by race and White racial bias is well documented. Joe Feagin, an enormously influential sociologist, has prolifically explored the establishment of American economic and political systems based on racial bias and White superiority. From the beginning of our nation's history, the differentiation of treatment for Black Americans has been legally and institutionally enshrined and protected (Feagin 2010a).

These established economic and political systems have led to the use of a "White racial frame" that has for centuries influenced the way White Americans view and treat Black Americans. These views have then reinforced and perpetuated systems of racial oppression in a variety of settings, legitimizing and encouraging bigotry and systemic racism (Feagin, 2010b). This encouragement has, in turn, influenced the living experiences of Black Americans for centuries, and continues to impact the way they live and cope with racial institutions and public discrimination, even to this day (Feagin 1991).

The impact of White racial attitudes on economic and political institutions and public policy has been explored by a number of scholars, but few empirical examinations of this impact are as informative as the Racial Classification Model (RCM), developed by Joe Soss, Richard Fording, and Sanford Schram (Soss et al. 2008). This model was further applied in a study examining the decision to punish welfare recipients when those recipients conformed to racial

stereotypes, thereby punishing Black welfare clients more often than White clients for the same behaviors (Schram et al., 2009). This model was further developed in their book, *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race* (Soss et al. 2011).

In their book, Soss, Fording, and Schram explore the concept of neo-liberal paternalism and the role that race plays in the formulation and application of public policy. When explaining the convergence of neoliberalism and paternalism they write, "Thus, paternalists embrace public authority, not simply to impose choices on the poor, but to cure the deeper pathologies that prevent them from regulating their own conduct in competent ways" (Soss et al. 2011, p 27). Here we can clearly identify the two streams of ideology, and further comprehend the extent to which a marriage of these two philosophies has created a very recognizable brand of help for the poor in America.

Neoliberalism is, in a sense, an ideology wherein traditional forms of political freedom exonerated in liberal thought are somewhat transformed into ideas that center around market freedoms. In other words, neoliberalism is the idea that we should all be free to be a part of and succeed in a marketplace setting. This idea has, to a certain extent collided with the notion of paternalism in U.S. policymaking. Paternalism usually means beginning from an understanding where those who are unsuccessful in a free market, the poor, are no longer seen as fit to ensure their own success. By combining these perspectives, we see an ideology that seeks to create policies that will enable the poor (and in this case the incarcerated) to succeed, however, these policies begin from the assumption that those targeted by the policy have not succeeded on their own because they are unable to improve their own lives (Soss et al. 2011).

This mentality has thoroughly invaded many aspects of U.S. social policy, especially in the areas of welfare and poverty - as Soss, Fording, and Schram explore in their book. When

these policies are designed so that individual racial biases can be expressed, we often see policy implemented in a racially biased manner. Specifically, their Racial Classification Model explores conditions where an individual's biases are confirmed. When a welfare client's behavior confirms the racial bias of a welfare worker, that worker then has the discretion to punish clients in a racially biased manner. As a result, the authors find that Black welfare clients in Florida are more likely than Whites to be punished for the same behaviors, because the workers' biases are being confirmed (Soss et al. 2011).

The RCM is enormously useful not only in our understanding of welfare policy, but in our understanding of criminal justice policy as well (Soss et al. 2011). In this case, the RCM can be used to explain White policy preferences for inmate access to care. As the results of the model show in table 3.2, states with higher percentages of Black inmates are more likely to adopt a copay policy. As in the case of racially biased welfare workers, Whites are likely to see a high percentage of Black prisoners as a confirmation of their racial bias. By ignoring the racial history of the United States, especially as it pertains to the criminal justice system, Whites' opinions of criminal justice policy are being influenced not by their opinion of criminals, but by their opinion of Black Americans.

Model 2: The Impact of Social Construction on Copay Severity

Similar to the finding that the study's measure of social construction does not seem to influence the likelihood of a state adopting a copay policy, the analysis also demonstrates the lack of influence that the measure of social construction has on the punitiveness of the copay policies states adopt. In fact, there is no statistically significant relationship between the severity of a copay policy and the social construction of criminals in any given state. This finding is

consistent with an explanation that finds the measure of social construction in this model inadequate. In table 3.3 on the next page, this lack of significance is clearly demonstrated.

Model 2 is similar to model 1, however, rather than examining the impact of social construction on the likelihood of copay adoption, the second model explores the impact of social construction on the severity of the copay policies adopted. The second model is, in fact, exactly the same as the first model with the exception of the dependent variable. This means that model 2 is also an event history analysis, specifically, a Cox Proportional Hazards model, only with a different dependent variable. In the second model, the dependent variable is capturing the copay policies' severity, using a different dependent variable but the same control variables.

To capture copay policy severity, I sorted the copay policies into one of two categories. Copay policies that either make no mention of repayment or forgive the copay after a certain amount of time are designated as a 0, meaning non-punitive. Copay policies that designate a system of repayment for indigent inmates with no automatic forgiveness of debt are coded as 1, indicating a punitive copay policy. In this way, the dependent variable is expressed as either a state having a severely punitive copay policy that imposes debt on the inmate, coded as 1, or a state that has either a lenient copay policy that does not impose debt or no copay policy at all, which is coded as 0.

For instance, while California has system of collection in place for inmates who are unable to pay, the policy specifies a certain period of time after which the inmate's copay debt is automatically forgiven. This is, comparatively, a non-punitive policy. Alabama, on the other hand, specifies a system wherein indigent inmates unable to pay the copay is then entered into a collections system. This system is designed to track the inmate's commissary funds and automatically withdraw from the inmate's balance until the debt has been repaid. Furthermore,

this debt is even tracked after the inmate is released from prison, following the inmate into their post-conviction life. This is, without a doubt, a comparatively punitive copay policy. Table 3.3 on the next page demonstrates a lack of significance of the social construction of inmates on the severity of the copay policy states adopt.

Table 3.3 - The Likelihood of Adopting a Punitive Inmate Copay Policy

Independent Variables	DV = Copay Severity
Inmate Social Construction	0.790
	(-0.09)
State Corrections Spending Per capita	0.000181
	(-1.42)
State Revenue	1.000
	(0.03)
Citizen Ideology	1.026
	(1.27)
State Government Ideology	0.976
	(-1.55)
General Population Healthcare Spending	1.000
	(-0.54)
Percentage of Black Inmates	1.024
	(1.92)
Support for Universal Care	5.722
	(0.90)
State Violent Crime Rate	1.002
	(1.92)
N	1011
Hazard Ratios; Standard errors in parentheses	
* p<0.05 ** p<0.01 *** p<0.001	

The table above clearly demonstrates the lack of statistical significance of any explanatory variables in the model. Furthermore, no statistical significance is achieved after interacting the percentage of Black inmates in a state with the social construction of inmates in that state, further substantiating the finding that inmate race is not impacting states' decisions to adopt severely punitive copay polices. As table 3.4 on the next page shows, the impact of race is not significant, even when interacted with the measure of social construction. Table 3.4 was produced by running the same model as before with the addition of an interaction between the social construction of inmates and the proportion of Black inmates in a state. The third model with the inclusion of the interaction demonstrates that, unlike the decision to adopt a copay policy, the decision to adopt a more punitive copay policy is unrelated to a state's proportion of Black inmates.

To demonstrate this lack of relationship, I interacted social construction with a state's proportion of Black inmates, showing that the level of punitiveness of a state's copay policy is not related to that racial makeup of that state's inmate population or social construction of inmates. The coding for this variable is therefore a 1 for lenient copay policies that impose no debt, a 2 for policies that impose any debt on inmates, and 0 for states with no copay policies. If the race of the inmates in a state prison system is impacting the severity of the copay policies being adopted, interacting the percentage of Black inmates and the social construction of inmates would produce statistical significance. However, table 3.4 on the next page shows that this is clearly not the case.

Table 3.4 - The Likelihood of Adopting a Severe Inmate Copay Policy

(With Inmate Race and Social Construction Interacted)

Independent Variables	**DV = Copay Punitiveness**
Social Construction of Inmates	0.0267
	(0.0955)
State Corrections Spending Per Prisoner	0.979
	(0.0185)
State Revenue	1.000
	(0.000175)
Citizen Ideology	0.978
	(0.0153)
Government Ideology	1.004
	(0.0134)
General Population Healthcare Spending	1.000
	(0.000307)
Percentage of Black Inmates	0.632
	(0.392)
Support for Universal Care	3.936
	(7.931)
Violent Crime Rate	1.001
	(0.00128)
Social Construction*Inmate Race	1.085
	(0.115)
N	1031
Hazard Ratios; Standard errors in parentheses	
* p<0.05 ** p<0.01 *** p<0.001	

Both the lack of significance in the second model, as well as the insignificance of the same model including an interaction involving race, yield no evidence that the social construction of inmates in a state influences the likelihood that a state will adopt a more punitive copay policy. This conclusion is similar to the findings of the first model that show social construction, at least as it is measured in this analysis, is not significantly impacting states' decisions to adopt inmate copay policies. Additionally, while there is evidence that inmate race is impacting the decision of states to adopt a copay policy, there is no such evidence that inmate race is impacting the type of policies being adopted in the second and third models. Indeed, there is no evidence that inmate race has any impact on the severity of the copay policies that states adopt.

For clarity, table 3.5 on the next page compares the results of model 1 and model 2 in the first study. Model 1 examines the impact of social construction on the likelihood of copay adoption, while model 2 examines the impact of social construction on the likelihood of adopting a more punitive copay policy. [3]

[3] I also ran the first model in this study using different measures of the social construction of inmates. Appendix A demonstrates the results of these models, using measures of social construction produced with the inclusion of weights to the CCES responses, only the responses of White respondents, and only the responses of registered voters. None of these models was found to be significantly different in their outcomes.

Table 3.5 – Comparing Models 1 and 2

Independent Variables	DV = Copay Adoptions	DV = Copay Severity
Inmate Social Construction	0.231	0.790
	(0.425)	(-0.09)
State Corrections Spending Per Prisoner	0.00473	0.000181
	(0.0202)	(-1.42)
State Revenue	1.000	1.000
	(0.000100)	(0.03)
Citizen Ideology	1.019	1.026
	(0.0160)	(1.27)
State Government Ideology	0.966**	0.976
	(0.0129)	(-1.55)
General Population Healthcare Spending	1.000	1.000
	(0.000301)	(-0.54)
Percentage of Black Inmates	1.026*	1.024
	(0.0104)	(1.92)
Support for Universal Care	18.50	5.722
	(33.85)	(0.90)
State Violent Crime Rate	1.002	1.002
	(0.00108)	(1.92)
N	949	1011
Hazard Ratios; Standard errors in parentheses		
* p<0.05 ** p<0.01 *** p<0.001		

Study 1: Discussion

Hypothesis 1: The Influence of Social Construction on Prisoners' Access to Care

The first model in the analysis shows some support for the first hypothesis. Recall that the first hypothesis predicted that the way individuals in a state socially construct criminals would impact that state's decision to adopt a copay policy that restricted inmates' access to care. Importantly, this analysis found no direct evidence that the social construction of criminals, at least as it is measured here, has any measurable impact on states' decisions to adopt copay policies and therefore restrict prisoners' access to healthcare services.

As previously discussed, there is a strong possibility that using the measure constructed from the CCES questions on criminal justice was limited in its ability to gauge individual feelings of criminals. The CCES measure is an attempt to refine and improve the ability to measure social construction, as many scholars throughout the target populations literature have lamented the lack of such a measure in the area of criminal justice. Further work must be done to improve and solidify a technique for measuring the social construction of criminals.

While this effort has been underway at the national level for a number of years (see Enns, 2014), there remains a lack of ability to produce such measures at the state level. It is possible, yet unlikely, that social construction of inmates has no influence on the adoption of copay policies at the state level. This is due to previous research that has indicated that it is much more likely to be the case that, as race and criminality are so closely conceptualized in the minds of White Americans, opinions of race rather than of criminals are the main driving force behind Whites' policy preferences. This has been firmly supported in terms of welfare policy (see

Gilens 1995; Gillens 1996a; Gilens 1996b), and it would not be surprising if this were the case in criminal justice policy.

Hypothesis 2: The Influence of Financial Strain on Prisoners' Access to Care

Unlike hypothesis 1, the model shows no support for the competing second hypothesis. Hypothesis 2 posits that the primary influence in a state's decision to adopt a prison copay policy is the increasingly burdensome costs associated with inmate health. Following the logic of the federal government, many states have asserted that because corrections spending has become so burdensome to the government, especially in terms of healthcare costs, the copay policies are introduced simply a cost saving mechanism. However, as is clear from table 3.2, there is no relationship between corrections spending and copay policy adoptions.

Importantly, the variable used to measure the costs of inmate healthcare is imperfect. Ideally, this analysis would use corrections healthcare spending to more directly measure the impact of increasing healthcare costs on policy adoption. However, this data is, as of now, unavailable for all fifty states in the analysis, especially for a consistent period of time. As a result, overall corrections spending has been used to capture, as much as possible, the growing costs of inmate healthcare expenditures. While this method is imperfect, it poses little risk of misrepresenting the impact of rising healthcare costs. This is because healthcare costs in prisons account for such a significant proportion of overall corrections spending (Bureau of Justice Statistics 2001), and because healthcare has, for some time, been the fastest growing category of prison expenditure (McDonald 1995).

This finding is important because it fails to support the argument made by state governments when they choose to implement inmate copay policies. While study 2 examines the

impact that these policies have on inmate mortality, it is clear from table 1 that the cost of inmate care is not contributing to the decision to adopt a copay policy. To be clear, there is no statistically significant impact of state corrections spending and inmate copay adoption. With corrections spending failing to achieve statistical significance in model 1 the claim made by so many states remains unsupported.

The results of the first study in this analysis indicate that it is not the rising cost of inmate care that leads to states adopting copay policies that could potentially restrict inmate access to health services, it is the ideological composition of a state's government and the racial composition of its prison population. This is, as previously argued, significantly problematic due to the constitutional requirement that all incarcerated individuals in the United States have reasonable access to healthcare services, via the Supreme Court's ruling in *Estelle v. Gamble, 1976*.

If the impetus for these policies is anything other than a financial necessity in order to maintain reasonable healthcare access for a state's inmate population, then these policies deserve, at the very least, strict scrutiny. Evidence that the racial composition of a state's inmate population is leading to the adoption of these policies, rather than financial necessity, is alarming even if these polices are not influencing inmate mortality. If, in fact, these policies are negatively impacting inmate mortality and they are racially motivated, then state inmate copay policies are likely unconstitutional.

Hypothesis 3: The Influence of Race on the Social Construction of Prisoners

Importantly, the results of the first analysis support the third hypothesis in the first study. The third hypothesis seeks to inquire as to the conditions during which the social construction of

prisoners can change when the racial composition of inmates varies. In other words, does the racial make-up of a state's prison population impact the way that that population is socially constructed? More specifically, does the social construction of prisoners change as the racial makeup of a state's prison population changes? This hypothesis is tested on two fronts. The first is the impact that racial composition has on a state's decision to adopt an inmate copay policy, while the second is the impact of race on the severity of the policies once adopted.

It is possible that the social construction of a state's prison population may be a condition of the prison population's racial makeup in that state. If a state's prison population is composed of a significant percentage of Black inmates, the residents of that state may form their policy preferences based more on their perception of Black Americans than on their opinions of prisoners. This influence may manifest in the decision of that state to initially adopt a copay policy, because the citizens of that state wish to impose a paternalistic mechanism on its prison population. If this decision is influenced by the racial composition of the inmates in that state, then it is clear that, at least to some extent, the race of inmates is a condition of inmate the social construction.

Copay policies are inherently paternalistic, as they assume that the population being targeted cannot efficiently make decisions about when to access healthcare services. The underlying assumption of such a policy is that by forcing the targeted population to consider the cost of a copay, they will only request services that are essential. The implication of this logic is that, without a copay policy, the targeted population will make frivolous use of healthcare access and request services that are unnecessary and wasteful. This is often argued by insurance companies, despite multiple studies indicating otherwise.

Moreover, the implementation of such paternalistic policy is very much in line with Schram et al.'s definition of neoliberal paternalism (Schram et al. 2009) in that the policies seek to offer a population help (access to healthcare), while simultaneously making the assumption that the population targeted is unable to make individually advantageous decisions. Furthermore, their Racial Classification Model predicts that as the targeted population conforms to racial stereotypes, they will be punished to a greater extent than Whites who exhibit the same behavior, as policy is then implemented in a racially biased manner (Schram et al. 2009).

In the case of prison copay policies, a state having a disproportionate number of incarcerated Black Americans confirms the expectation that many Whites hold that Black Americans are more likely to be involved in criminal activity. Recall that Gilens finds widespread support among Whites for the idea that Black Americans are lazy and therefore more likely to resort to crime. Furthermore, this stereotype among Whites is highly influential in White attitudes on racially-coded policy issues (Gilens 2009). As a result, states with a higher percentage of Black American inmates are significantly more likely to adopt a paternalistic copay policy, as the opinions of Whites in that state are being influenced by the presence of Black inmates.

These results are in line with the findings of many studies within welfare policy. In addition to the previously mentioned application of the Racial Classification Model, the results of study 1 show remarkable similarities to findings in the welfare policy literature that demonstrate the influence of race on welfare policy preferences. Most significantly, Gilens has, on several occasions, explored the impact of race on welfare policy. He has argued that both crime and welfare are race-coded issues, meaning that these issues activate White perceptions of

Black Americans that in turn influence their opinions on policy. As a result, race plays an important role in welfare and crime policies in the United States (Gilens 1996b).

Specifically, his research finds that the single most influential factor in forming Whites' views on welfare policy is their perception of Black Americans, rather than their opinions of welfare recipients (Gilens 1996b). In fact, even when Whites are prompted to also consider economic self-interest, individualism, and egalitarianism, they still tend to rely on their perceptions of Blacks more than anything else when formulating welfare policy preferences (Gilens 1995). Furthermore, his research strongly suggests that there is a widespread belief among Whites that Black Americans are lazy, and this belief has enormous impact on White opinions of race-coded issues, such as welfare policies and criminal justice policies (Gilens 2009).

Finally, Gilliam and Iyengar find strong evidence that introducing race into media news stories pertaining to crime impacts White opinions about crime policy. Specifically, the introduction of race into news stories triggers Whites to analyze criminal justice policies with racial bias, resulting in an increase in support for punitive criminal justice policies, even at the expense of more communal solutions (Gilliam and Iyengar 2000). The findings of Schram et al., Gilens, and Gilliam and Iyengar, all indicate the extent to which race plays a role in the formation of policies that address race-coded issues; undoubtedly, prison policy, including access to care, is a race-coded issue.

The results of the analysis lend evidence to the idea that the social construction of inmates in a state is conditioned by the racial composition of the inmate population. The impact of this conditionality is seen in a state's decision to adopt a copay policy, but the analysis did not indicate that the same effect of racial composition is present in a state's decision to adopt a strict

copay policy. So, while it is clear that the racial makeup of a prison population influences a state's decision to adopt an inmate copay policy, there is no evidence from the analysis to indicate that racial makeup impacts the decision to adopt a more punitive policy.

This finding could be the result of numerous factors. It is possible that once a state's inmate population reaches a critical tipping point, the White population in the state may become aware enough to push for candidates and policies that are more punitive in their criminal justice policies. However, once elected and appointed, policymakers and policy implementers may recognize the usefulness of a policy that appears punitive, or "tough on crime," but is more symbolic in nature. As a result, they may institute a copay policy to appear punitive, but construct that policy so that it is not as harsh as it could appear.

This symbolic policymaking would result in copay policies that either do not require an indigent inmate to take on debt, or they forgive the debt after a certain period of time. It is also possible that these policymakers feel that the initial barrier of a copay, even one without the possibility of debt, is enough to force inmates to think seriously about whether or not a service is necessary. If so, the policy need only represent the intention of harshness rather than impose a harsh reality. Finally, although rather unlikely, policymakers may have insight into inmate care access that an outsider may not. If the severe forms of the copay either result in higher rates of inmate mortality or fail to collect the necessary funds to justify the debt mechanisms, they may decide that the punitive policies that impose inmate debt are ineffective. Recall that, at least in the case of the California state prisons system, the state auditor estimated that the administration of the state's copay policy could cost up to as much as five times as the amount of money actually collected (Birdlebough S. Analysis of SB 396: health care for prisoners 2001). If this is the case, tracking inmate debt as a result of the inability to pay a copay would be wasteful.

Study 1: Conclusions

Study 1 in the analysis has revealed a number of findings of relative importance to our understanding of criminal justice policy, particularly inmate access to healthcare services. The most significant finding is that a state is more likely to adopt an inmate copay policy, a policy restricting access to healthcare services, if that state has a high percentage of Black inmates. Specifically, in an increase of 10% in a state's Black prison population leads to an increase of about 28% in likelihood that that state will adopt an inmate copay policy in a given year.

The influence of racial composition, coupled with the finding that conservative state governments are also much more likely to adopt inmate copay policies, demonstrates the near certainty that a state with a sizeable Black inmate population and a conservative state government has of adopting a copay policy. Conversely, these findings indicate that a state with a liberal government is significantly less likely to adopt a copay policy in any given year. This means that states with liberal governments and low proportions of Black inmates are significantly less likely to adopt an inmate copay policy in any given year. Importantly, these indicators were not found to have influence over the punitiveness of the copay policy adopted, as was predicted.

The finding that a state's racial composition influences the likelihood of adopting a policy that restricts inmates' access to healthcare services is alarming. While states have contended that it is financial hardship that necessitates the implementation of a copay policy, this analysis has found no evidence backing this claim. Instead, it is the race of a state's inmate population that seems to play the most significant role. As the Supreme Court has ruled repeatedly that prisoners are constitutionally guaranteed access to healthcare services, any

restrictions to that access should be carefully scrutinized. The outcomes of such policies are important, but so too are the motivations.

The next chapter examines the impact that these policies have on inmate mortality, but the findings of study 1 indicate that, even if these policies are not having an adverse effect on inmate health, the policies themselves are the result of racial factors. The message being sent from the adoption of these policies is clear. Copay policies are an extreme form of neoliberal paternalism and they imply that inmates are either too wasteful or too unintelligent to ask for medical attention in an efficient manner. The target populations literature has explored the impacts that these embedded messages can have on a target population. Undoubtedly, aside from the possible physical impacts of the policies explored in the next chapter, there are likely to be mental and emotional impacts on inmates when they are faced with a copay (Schneider and Ingram 1993).

Importantly, much works remains to be done in the creation of a more directly related measure of the social construction of prisoners. As one of the most deviantly constructed groups in society, prisoners are both unsympathetic and powerless in the process that has such dire consequences for their lives. It is no surprise then, that the policies that target them are frequently harsh, often so that those who do have power in the policy process can send a message to the rest of society. These messages are important because they influence the way prisoners are seen by society, and even the way prisoners see themselves (Schneider and Ingram 1993). The goal of our prison system is to help inmates learn from their mistakes in order to find a way to view themselves as invested members of society. Unfortunately, it seems as though they are more often told, through policy decisions, that they are deviant and that they will remain so.

IV. STUDY 2: OUTCOMES OF PRISON COPAY POLICIES

It is clear from a review of the literature that copay policies have, across a variety of settings, had real and measurable impacts on the way that individuals choose to access and utilize health care services. Whether it be the within the general population (Scitovsky and McCall 1977), in other countries (Kupor et al. 1995), among American veterans (Doshi et al. 2009), or Medicaid participants (Hartung et al. 2008), a variety of studies have explored the ways that copay policies can present real and significant barriers when accessing healthcare services across a number of different groups. These studies have demonstrated the tendency of copay policies to discourage individuals from seeking a variety of preventative services other than just the frivolous services most often cited by health insurance companies (Manning et al. 1987; Scheffler 1984).

Additionally, much of the prison health care literature has demonstrated the influence that copay policies in a variety of prisons have had on prisoners' healthcare decisions. Recall that the first state prison copay policy, implemented in California, and the culture surrounding it was found to have discouraged inmates from accessing a number of important health services. This discouragement has been linked to a number of premature deaths within California prisons (Clark 1997). Furthermore, the financial success of the California copay policy was found to be dubious, as little to no evidence has been unearthed that the policy has saved the state money (Stoller 2001). In fact, at least one analysis has indicated that the collection of fees for the copayment policy has cost more than the amount brought in by fees themselves (Birdlebough S. Analysis of SB 396: health care for prisoners 2001).

Interviews with women recently released from prisons and jails in California hinted at the disproportionate influence that these copay policies can have on the underprivileged. At the time of the interviews, the copay in California prisons was five dollars. On inmate wages, this is the equivalent of a $2,000 copay for person making $60,000 a year. As a result, these women almost unanimously chose to forego important medical services (Fisher and Hatton 2010). In Idaho, a similar state prison copay policy was found to disproportionately influence the healthcare decisions of female inmates over their male counterparts (Hyde and Brumfield 2003).

Furthermore, the states and the federal government have almost universally made the claim that these policies are instituted as cost-saving mechanisms. However, previous research into prison healthcare has demonstrated that prison policy, especially policies concerning funding for healthcare services, are often the result of other factors besides purely monetary motivations (Nicholson-Crotty and Nicholson-Crotty 2004). As the Supreme Court has ruled that prisoners are constitutionally guaranteed access to healthcare services, any hindrance to healthcare access for inmates must be scrutinized carefully.

Therefore, it is important that the outcomes of these copay policies are determined, in addition to the motivations. If prisons are forced to save money because they are financially overwhelmed, the obstacles presented by a copay policy may be understandable if the effect of the policy is negligible on inmate health outcomes. However, if the policies are failing to save money, then they are unjustifiable. It is consequently important that we know the extent to which these policies are actually saving the states money.

Prison Health Outcomes

As the United States' prison population has grown, the financial strain on that system has also grown. One of the largest components of this growth in inmate spending has been in the realm of inmate healthcare. The rising cost of prison healthcare has been attributed to a number of things. It is believed that the rate of infectious diseases within American prisoners is somewhere between four and ten times as great as the same rate in the general population (Golembeski and Fullilove 2005).

Furthermore, the average age of the American prisoner is increasing. And, as in the general population, older individuals require costlier care (Kerbs and Jolley 2013). Importantly, the precise cost of care for elderly prisoners is difficult to ascertain. Many scholars have lamented the lack of data collected on the needs and costs of care for the elderly in prisons. They argue that as more data becomes available, researchers will be better able to understand the effects that cost-saving policies will have on the health of prisoners, especially the health of older prisoners (Ahalt et al. 2013).

Finally, as the cost of care in the general population has risen, so too has the cost of care in prisons. In fact, it is generally accepted within the literature that the cost of healthcare in prisons has risen at a higher rate than the same costs in the general population. This growth in medical costs has led a number of scholars to emphasize the need for research that explores the impacts of cost-saving policies on the health of the incarcerated. Privatization of services and prisoner copay policies are especially likely to have significant impacts in terms of costs and health outcomes (Marquart et al. 1997). Some scholars in the United Kingdom have even explored the cost-saving implications of a telemedicine system (Watson et al. 2003). These authors all recognize the importance of understanding the outcomes of cost-saving policies.

Of all the cost-saving measures employed by prisons, the most studied has been the contracting out of services. In some states, entire prisons are contracted out to private companies; in others, individual services – such as healthcare – are contracted out in order to reduce costs. In fact, by 2004, 32 states had either contracted out all or some of their healthcare services in their prisons (Bedard and Frech 2008). Importantly, scholars have diligently examined the effects of contracting out health services. Their findings are informative in our understanding of prisoners' access to, and quality of, care.

Initially, findings on the impact of contracting out health services on inmate care were worrisome. In his 1999 study, Robbins finds that contracting out can result in sub-standard treatment and likely leads to a shortage in healthcare staff (Robbins 1999). However, not all within the legal system are convinced that contracting out health services is problematic. As a result, court orders requiring states to improve quality of care have occasionally resulted in states contracting out their prison health services (McDonald 1999). This is generally the consequence of private entities' ability to pay their workers more than state-mandated pay schedules, resulting in the assumption that their workers will outperform public employees (Gater 2005).

However, the assumption that private entities could provide healthcare services to inmates at a lower cost was not accepted by all – or even most. Scholars who questioned the growing trend to contract out prison healthcare services noted that while previous studies have shown the cost-saving benefits of contracting out to the marketplace, prisons are an exception to that general rule. This is due to the tendency for these contracted services to provide services of a significantly reduced quality – a reduction which could have serious implications for inmate health (Hart et al. 1997).

Due to these disagreements about the appropriateness of contracting out healthcare services in prisons, Bedard and Frech set out to measure the impacts of this growing trend. As previously discussed, their findings are quite worrisome for those who have advocated for contracting out services. Specifically, their analysis shows that increases in the outsourcing of healthcare services in prisons leads to significant increases in inmate mortality. In other words, the more a prison contracts out in health services, the more likely inmates in that prison are to die (Bedard and Frech 2008). These startling findings are indicative of the concerns expressed by Paul von Zielbauer, who has written of his fear for those inmates who are under the care of contract services (Zielbauer 2005).

To measure the impact of contracting out health services on prisoner health outcomes, Bedard and Frech use panel data from the Census of State Adult Correction Facilities. These data are available through 2005, and contains a wealth of information about prisons in the United States. Using these data, the authors essentially ask what impacts contracting out health services have on the health of inmates. In the context of prison copay policies, I believe a similar question needs to be asked. Specifically, I wish to explore the impact that state prison copay policies have on the health outcomes of inmates in those states. To explore this impact, I will also examine inmate mortality rates.

Study 2: Hypotheses

The hypotheses for this section of the analysis are quite straight-forward, and they are intended to reveal the influence that prison copay policies have on inmate mortality rates and state corrections expenditures. Therefore, my model will seek to explore a similar question to that of Bedard and Frech (2009) – does adopting a copay policy in a particular state have a

measurable impact on the health outcomes of inmates in that state, specifically, on inmate mortality rates. Furthermore, as state governments frequently cite the cost-saving aspect of the policies as justification, I also wish to determine the influence that prison copay policies are having on states financially. In other words, are these policies actually saving the states any money in terms of corrections expenditures?

Hypothesis 1: Increased Inmate Mortality

My model will measure the influence of copay policies in state prisons on inmate mortality. Based on previous research, my hypothesis predicts that the adoption of state copay policies will have a positive impact on the rate of inmate mortality. This hypothesis is in line with the research of Bedard and Frech in that it predicts changes in policy to make prisons more like the private sector will worsen prisoner health outcomes (Bedard and Frech 2009), as well as numerous other studies that have found a variety of negative health outcomes as the result of policies that restrict access to health services.

Recall that an earlier 1977 study found that a modest copay reduced the use of x-ray services and lab-tests by thirteen percent (Scitovsky and McCall 1977). This finding was supported by several other studies (Manning et al. 1987; Scheffler 1984). This reduction of services has been documented in a clinical setting (Solanki et al. 2000), in other countries (Kupor et al. 1995), among U.S. veterans (Doshi et al. 2009), and even Medicaid services (Hartung et al. 2008). These studies all demonstrate the propensity of individuals to reduce the use of services and medicines, regardless of their importance, when copays and other similar mechanisms are introduced. These findings stand in direct contrast with the arguments made by insurance

providers in the private sector, and state-run prisons in the public sector, that claim these copays only reduce the use of frivolous or unnecessary services.

In prisons, research has shown that these types of policies negatively affect inmates in terms of health outcomes and psychological health (Clark 1997). A study of Idaho prisons found that copays reduced the use of medical services across the board, including important services as well as less serious "sick call" requests. Furthermore, as female inmates are more likely to request healthcare services, polices presenting barriers to access are likely to disproportionately impact female inmates (Hyde and Brumfield 2003). These quantitative findings are corroborated by in depth interviews with inmates who were forced to consider the costs of copays when requesting medical services (Chandler 2003:45).

A similar policy in California negatively impacted female inmates' access to healthcare services, especially those who were more financially vulnerable (Stoller 2001). It has also been well documented that the copay systems in prisons are nowhere near as efficient as their counterparts in the private sector. Many inmates would pay the copay fee only to recover before ever having the chance to see a medical professional. Many inmates reported waiting over a year to see a physician after paying a copay (Fisher and Hatton 2010).

All of this research indicates that barriers to healthcare access not only reduce the use of non-necessary services, but that they also force individuals to make decisions to forgo necessary medical services. This is not only costly to individuals' health but can end up costing the insurance companies and medical providers more as preventative services are universally recognized as being less costly and more effective than the services required for untreated problems. As a result, it stands to reason that a copay policy in prisons, especially policies that attach debt to inmates who are unable to pay, would dissuade inmates from accessing vital

healthcare services. By deterring the use of such medical services, these copay policies are likely leading to untreated conditions. This will negatively impact the health of individual inmates, as well as encourage the spread of illness as more inmates are likely to remain ill and therefore contagious. This will likely result in an increase in inmate mortality rates.

Hypothesis 2: Cost-saving Outcomes

Additionally, the financial impact of the copay policies will also be assessed. Specifically, the argument often made by states that the policies are saving states money will be tested. If these arguments have merit, the adoption of a prison copay policy will result in lower prison costs. If the policies save the states money, as they claim, then the state's adoption of a copay policy (as a cost-saving measure) will reduce prison expenditures.

While no official study has assessed the financial impact of these polices, the investigations into individual prison and state systems have, if anything, revealed that it is unlikely that these policies are saving money. In the case of California prisons, the state auditor concluded that the collection of the copays would not even cover the costs of implementing the copay program (Birdlebough S. Analysis of SB 396: health care for prisoners 2001). Therefore, it is unlikely that these policies are saving states money unless they invest heavily in the copay programs so they can consistently attach debt to inmates who are unable to pay, and actually collect the copayments systematically.

Hypothesis 1: Copay Policies Negative Impact on Inmate Health

The first hypothesis, that the adoption of a state copay policy will result in a higher rate of inmate mortality, is grounded in previous research that has found that policies attempting to

emulate conditions of the private sector will have negative impacts on inmate care. Robbins finds that contracting out health services can result in worse health outcomes and a dearth of healthcare staff in prisons (Robbins 1999). Furthermore, recall that Chandler's interviews with recently released female inmates revealed the negative influence that copay policies had on their decision to seek medical care. Nearly every woman interviewed claimed to have either put-off, or forgone, important medical requests due to their difficulty in paying the copay (Chandler 2003).

Similarly, Stoller's examination of California's inmate copay policy revealed not only the policy's tendency to deter necessary requests for care, but also the policy's failure to produce successful financial outcomes (Stoller 2001). Furthermore, research has indicated a trend of the copays to delay the delivery of health services in a variety of circumstances. Some women reported waiting over a year for necessary services, and many ended up paying the copay without ever seeing a healthcare professional (Fisher and Hatton 2010). These studies have all indicated the extent to which one could expect the presence of a copay policy to worsen the health outcomes in a prison, thereby increasing the mortality rates of prisoners within a given state.

Hypothesis 2: Copay Policies as a Cost-saving Mechanism

The second hypothesis, that the adoption of a prison copay policy will result in lower prison costs, is essentially the argument used by states, as well as the federal government, in order to justify their adoption of an inmate copay policy. As was previously discussed, the logic for this argument is quite straightforward. The purpose of copays in the private sector has always been to act as a disincentive to over utilize services by policy holders. In the absence of a copay,

it is assumed, people are likely to request medical visits and procedures without considering the cost of medicines and procedures.

By introducing a copay, individuals will be less likely to request a visit or medicine if they do not consider the need for such services to be greater than the cost of a copayment. As a result, frivolous and unnecessary procedures and requests are avoided because people do not want to pay a copay unless their need outweighs the cost associated with addressing that need. Insurance companies began introducing copays and other similar cost-saving mechanisms in order to reduce what they considered to be wasteful spending by policy-holders. Likewise, states have argued that adopting copay policies in prisons forces prisoners to consider the costs of requesting medical service, thereby avoiding the frivolous costs of such unnecessary care.

While studies have shown that copays, in a variety of settings, have deterred individuals from pursuing medical services, these studies tend to indicate that the copays discourage individuals from pursuing all sorts of treatment - some of it quite significant. In other words, research has shown that copays do not only discourage unnecessary services, but they discourage the use of services vital to positive health outcomes as well. Importantly, it may be possible that the copay policies are saving money by discouraging frivolous requests in prisons. It may be possible that the policies are discouraging the access of vital services as well. By discouraging these services, the copays will worsen health outcomes and possibly increase the cost of care, as preventative services are much less costly than the serious care needed if preventative services are not performed.

However, as the states have argued that the goal of the policies is to save money, one need only test whether the states with these policies are in fact saving money through the adoption of the copay. If the analysis reveals that the policies are having a negative impact on

health outcomes, then the financial impact of the policies becomes, in a way, moot. However, if the analysis reveals that the policies are not having an impact on health outcomes, then the financial impact of the policies becomes much more significant.

Study 2: Data and Research Design

Models 1, 2 and 3 will examine the impacts of the adoption of state inmate copay policies on the mortality rates of state inmates, inmate spending per capita, and spending per inmate, respectively. Specifically, these models will determine the influence that adopting a copay policy has on the mortality rates of a state prisons, the amount of money states spend on corrections per citizen, and the amount of money states spend on corrections per inmate. The analysis will consist of three separate state panel regressions that tests the validity of both hypothesis 1 and 2. After controlling for key variables, I will be able to examine the impact of copay polices on inmate mortality rates in model 1, and the impact of inmate copay policies on state corrections spending in models 2 and 3.

Research Model – State Panel Regression

A panel design is ideal in exploring this relationship, as I'm able to observe the changes in mortality rates and state budgets in each state during each year. This, along with the adoption dates of the state copay policies, will allow my regression analysis to reveal the extent to which the copay policies are influencing inmate mortality rates and budgets. This is very similar to the analysis conducted by Bedard and Frech. Importantly, instead of examining the impact of contracting out health services on inmate health, I'll be examining the impact of copay policies

on both inmate health outcomes and state budgets. Specifically, I'll be using linear regression with panel-corrected standard errors for all three models in the analysis.

Study 2: Research Model

Panel regression models have been prominent in the social sciences for a variety of applications. This type of analysis allows the researcher to examine the impact of a variety of variables on a single variable that changes over time. In this case, my regression will explore the impact of the adoption of a state copay policy on inmate mortality rates in model 1, the impact of state copay policy adoption on the rate of spending per capita in model 2, and the impact of state copay policy adoption on the rate of spending per inmate in model 3. Specifically, my models will use a panel-corrected standard errors regression (PCSE). This type of regression is useful for analyzing data over a number of years. Essentially, PCSE allows for the pooling of time-series observations so that their coefficients can then be estimated by Ordinary Least Squares regression (OLS).

While this method is useful, it is important to recognize the assumptions made by OLS regression, and the necessary steps taken to control for violations of these assumptions in my models. PCSE accounts for panel heteroskedasticity, or the potential for correlated and variable standard errors. However, PCSE does not account for serial correlation, which is the correlation of standard errors over time. To control for serial correlation, I will include a lagged version of the dependent variable in each model. This technique has been endorsed by a number of scholars, perhaps most notably by Beck and Katz (Beck and Katz 1996). This approach will be further examined when controls of the study are discussed.

Independent Variables of Interest

In all three models, my independent variable of interest is the presence of a state copay policy, as well as the punitiveness of that copay policy. This data has been collected by me, and includes the approximate date on which a state adopted an inmate copay policy. The majority of states have adopted a copay policy for their prison systems. The range in copay amounts is small enough to consider them as equal in the analysis. The punitiveness of a state's copay policy is consequently capturing the extent to which a state policy is punitive in terms of assigning debt to inmates who cannot pay the copay at the time of medical service. The least punitive policies make no mention of repayment for indigent inmates. The most punitive policies, on the other hand, keep track of an inmate's debt and require repayment of the debt no matter what. Clearly, there is a significant difference between a policy that requires taking on debt to receive medical services and one that does not.

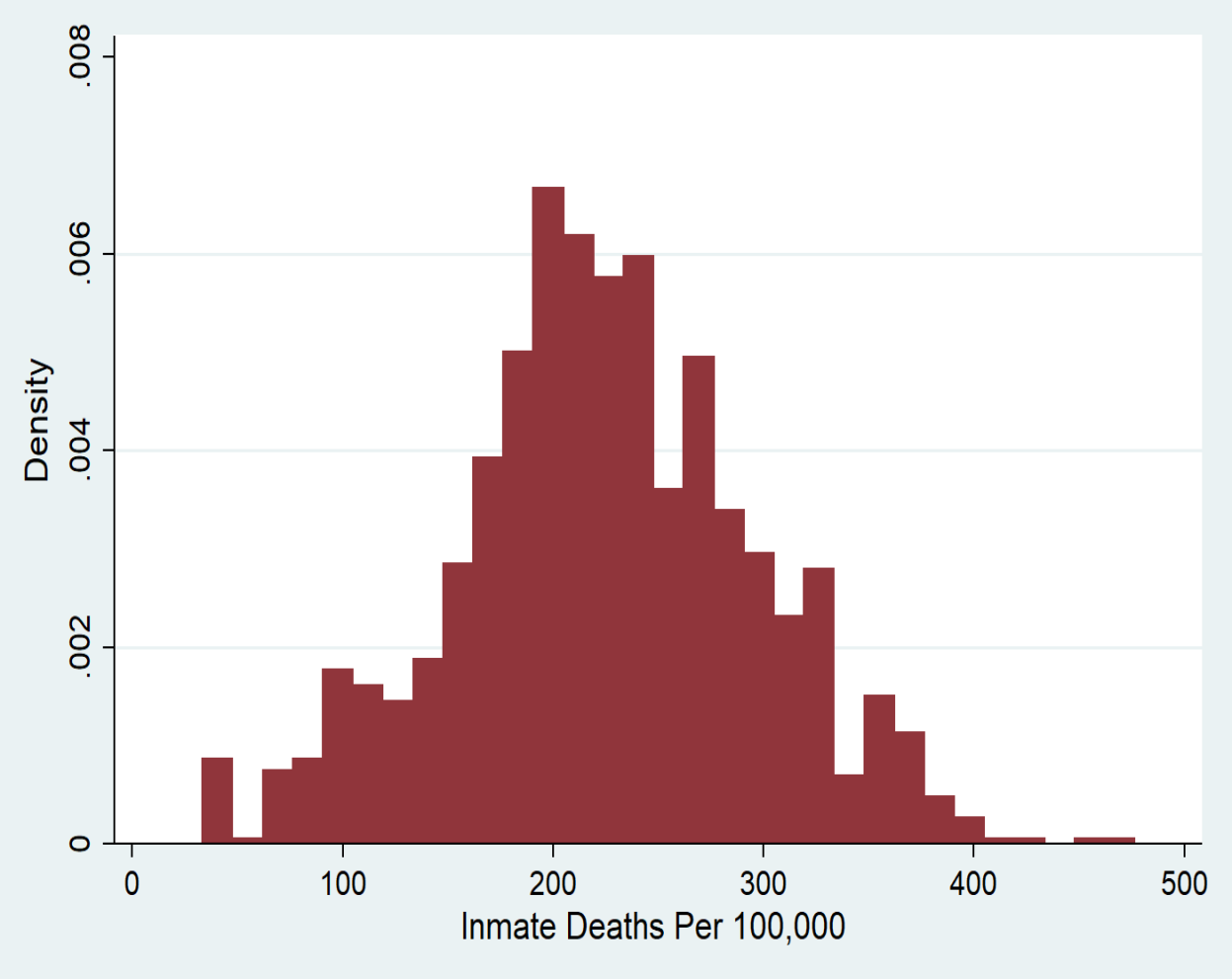
While I originally ran the models in study 2 using the original coding of the punitiveness variable (1 being lenient copay policies, 2 being moderately punitive policies, and 3 being severely punitive policies), the results indicated that the models were treating moderately punitive copays and severely punitive copays as indistinguishable from one another. Specifically, the coefficients for moderately punitive copays and severely punitive copays (the level 2 and level 3 policies) were the same in all three models. However, whereas severely punitive policies were statistically significant in all three models, moderately punitive policies were statistically insignificant in all three. As a result, I collapsed moderately punitive and severely punitive policies into one category (coded as 2), lenient copay policies into another (coded as 1), and a lack of any copay policy into the final category (coded as 0). This allowed me to explore the

differing impacts of copay policies that impose debt on inmates (now coded as 2) and copay policies that do not impose inmate debt (coded as 1).

Measuring Health Outcomes (Hypotheses 1)

The dependent variable in the model that explores the impact of copay policies on health outcomes is the mortality rate of prisoners in each state. These data are publicly available through the Bureau of Justice's National Prisoner Statistics dataset, which has been collected from 1978-2014. This range of dates covers every year in which a state has adopted a copay, and each iteration of the survey includes information about inmate mortality in each state. Furthermore, as demonstrated by figure 4.1 on the next page, the dependent variable in model 1 is normally distributed and well suited for the analysis.

Figure 4.1 - Distribution of Inmate Mortality



Estimating the Financial Impact of Copay Policies (Hypothesis 2)

The dependent variable in model 2 explores the impact of copay policies on state finances by measuring corrections spending in each state. In other words, what impact does adopting a copay policy have on the corrections spending of any given state? While this variable is not as indicative as a state's corrections healthcare spending would be, this measure is still a very good indicator of how much a state is spending on the healthcare of inmates. This is because, as previously noted, one of the largest and most expensive portions of the corrections budget is healthcare expenditures. These data are publicly available through the United States Census Bureau. They perform an annual survey of state finances going as far back as 1996, around of the time of the first state adoption of a copay policy (California, 1994).

For hypothesis 2, I will run two separate models with two distinct dependent variables. In the first of these models, the dependent variable will be a state's corrections spending per capita. This is a measure that captures the amount of corrections spending per 100,000 citizens in a state. In the second of these models, corrections spending will be measured as spending per prisoner. This second measure will explore the impact of the variables in the analysis on corrections spending per prisoner in each state. Figures demonstrating the distribution of both corrections spending per capita and corrections spending per prisoner are found on the next two pages as figures 4.2 and 4.3, respectively.

Figure 4.2 - The Distribution of State Corrections Spending Per Capita

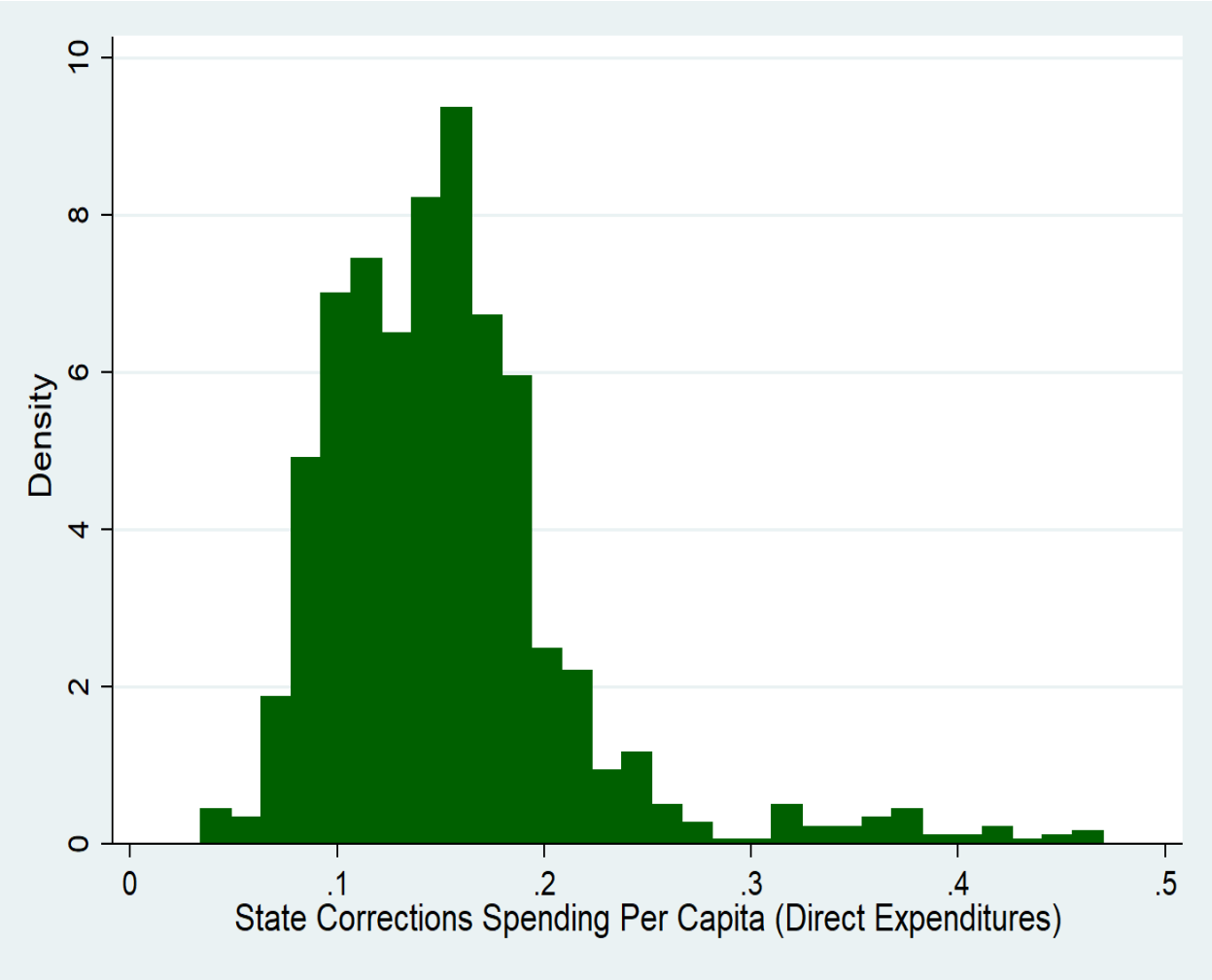
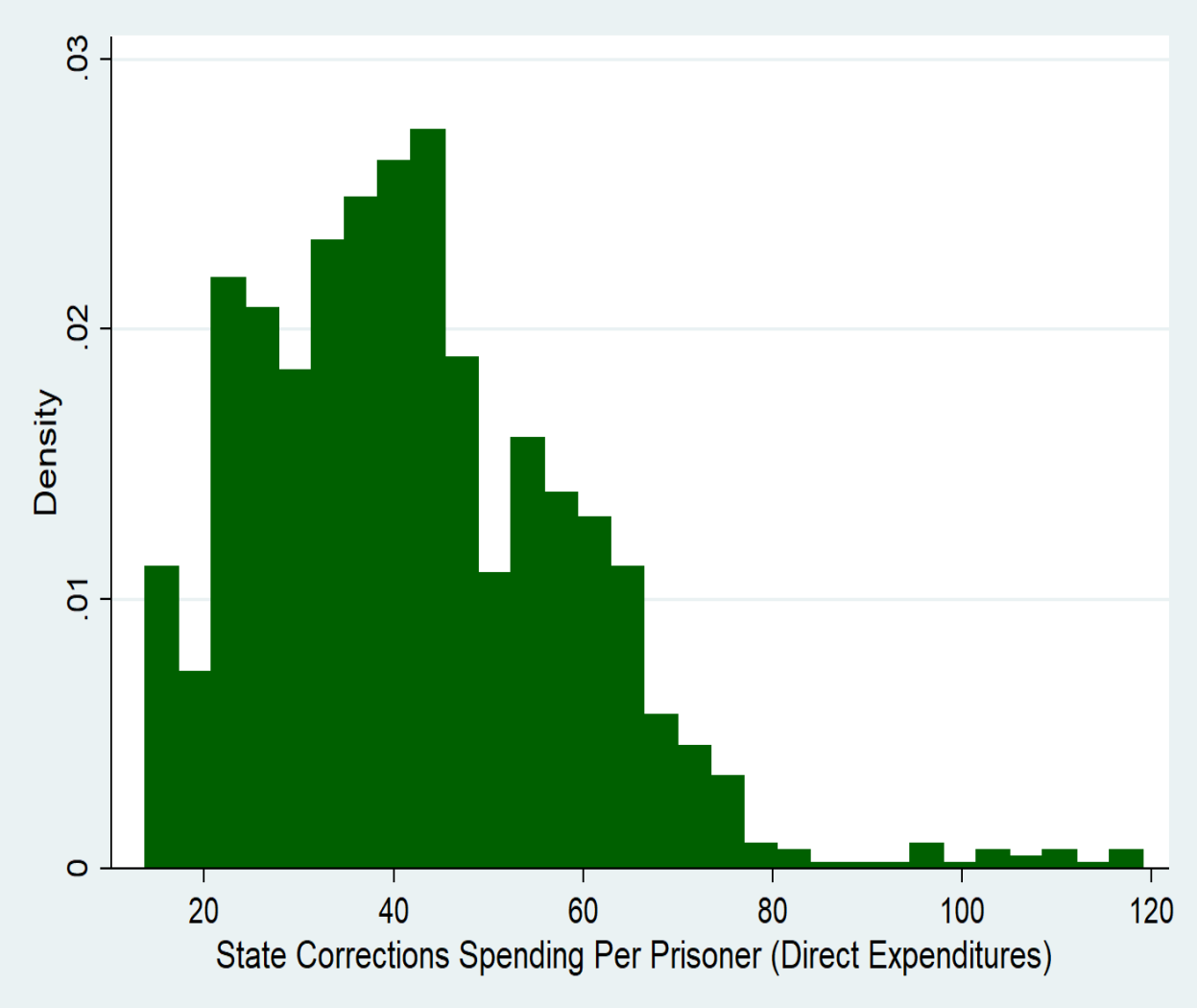


Figure 4.3 - The Distribution of State Corrections Spending Per Prisoner



Other Independent Variables: Control Measures

In order to isolate the impact of inmate copay policies on inmate mortality rates in model 1, and state finances in models 2 and 3, a number of other influences must be accounted for. These controls will allow my model to more accurately attribute changes in health outcomes and state finances to prison copay policies. These controls are a state's government ideology (0-100, conservative – liberal), citizen ideology (0-100, conservative – liberal), the state violent crime rate, the state revenue per capita, the state unemployment rate, the state uninsured rate, each state prison system's design capacity, the percentage of Black inmates in each state, the percentage of inmates over fifty-five years of age in each state, and the extent to which each state has privatized its prison system.

Other Control Measures: Serial Correlation and Fixed Effects

In addition to the above control variables, my models will account for the possibility of serial correlation, the impact of national trends during the analysis, and the impact of states on one another. As previously discussed, panel-corrected standard errors regression (PCSE) accounts for the potential of panel heteroskedasticity, or the correlation of standard errors. However, the potential for serial correlation is present when this type of analysis is used to analyze panel data over time. To correct for the possibility of standard errors correlating over time, I include a lagged version of each dependent variable, specific to each analysis, in the models. This lag is for a period of one year, and it controls for the possibility that the standard errors are correlated over time.

Specifically, some scholars have noted that analyzing time-series cross sectional data such as comparing states over time, while useful, is vulnerable to the impact of "…temporally

and spatially correlated errors as well as panel heteroskedasticity" (Beck and Katz, 1996, p.1). While many alternative methods have been proposed, Beck and Katz have argued that movements away from OLS and PCSE tend to offer misleading results. They evaluate a number of solutions to the problems presented by using PCSE, and after thorough examination, they conclude that using PCSE to calculate panel corrected standard errors and including a lagged dependent variable offers the most accurate estimates. This combination of PCSE with a lagged variable allows for the use of panel data over time, with much less concern over the possibility of misleading results as a consequence of panel heteroskedasticity or serial correlation (Beck and Katz 1996).

In addition to controlling for the possibility of serial correlation, my models must account for the possibility of national and state trends impacting the coefficients. In order to account for this possibility, each of my models will include state and year fixed effects. These fixed effects are essentially dummy variables for every year and every state in the analysis. These variables allow the models to control for state-specific influences, as well as control for national trends over time. If a state has particular characteristics that impact either inmate mortality or state corrections spending (per capita and per prisoner) that are not included in the model, the state fixed effects will control for this impact so that the coefficients are representative of the relationships between the variables in the model rather than unaccounted characteristics.

Similarly, including dummy variables for each year in the analysis allows the models to control for the possibility of national trends impacting either inmate mortality rates or corrections spending. If anything influences all of the states at once, the impact such influence will be controlled for so that the coefficients are unaffected by national trends. For instance, if some new medical technology is introduced to all states in the same year that decreases inmate mortality

rates and impacts healthcare spending costs, the year fixed effects will prevent this national trend from impacting the coefficients of individual states. By controlling for state and year effects, as well as serial correlation, the results of my models will more accurately reflect the relationships I hope to explore.

Study 2: Findings

The findings of the analysis offer some support for both the first hypothesis and second hypothesis. Specifically, the first model shows that, under certain circumstances, copay policies are significantly and positively related to inmate mortality. Similarly, under the same circumstances, copay policies are significantly and negatively related to state corrections spending. The specifics of these relationships are discussed further where each hypothesis is each addressed individually. [4]

Model 1: The Impact of Prison Copay Policies on Inmate Mortality Rates

Model 1 demonstrates very clear support for the first hypothesis in terms of the most severe form of the copay policy. For the model, I collapsed the independent variable into two categories: the first category is all copay policies that specify that a debt will be placed on inmates who cannot pay the copay at the time of services. While most of the policies specified a method by which this debt would be collected, a few clearly indicated that a debt or lien would be placed on the indigent inmate but did not indicate how this debt would be collected. However,

[4] The full table versions of tables 4.1, 4.2, and 4.3 can be found in the appendix. These tables include the impacts of all variables in the analysis, including the state and year fixed effects, which are too lengthy to include in the body of this paper. These full tables can be found in Appendix B.

these two types of policies are similar enough that the analysis indicated that they were having the same impact on the dependent variable.

As a result, the two harshest policies, those outlined above, were collapsed into one category, while the policies that did not impose debt were coded separately. According to model 1, the more severe policies, those that impose debt on indigent inmates, are statistically and positively correlated with inmate mortality rates. As indicated by table 4.1 on page 160, the less severe version of the copay policy has no significant relationship with the dependent variable, inmate mortality rates. However, the more severe policies which create inmate debt are substantively and statistically significant. These results somewhat support the first hypothesis. While some copay policies are impacting inmate mortality rates, the less severe version of the copay policies are not found to be statistically significant. However, it is clear that, all else equal, the severe version of the copay policies are resulting in increases in inmate mortality rates.

My analysis indicates that two of the independent variables are found to be statistically significant. The state uninsured rate is positively correlated with inmate mortality rates, while a state prison system's design capacity is negatively correlated with inmate mortality rates. Neither of these two outcomes are surprising. As states uninsured rates rise, their general populations and inmate populations will become less healthy, and mortality rates in and out of prisons will likely rise. Similarly, as states improve their prisons and design them to accommodate more inmates rather than simply crowd them into existing facilities with limited space, inmate mortality rates are likely to decline.

Table 4.1 - The Impact of Copay Policies on Inmate Mortality

Independent Variables	DV = Inmate Mortality
Lagged DV	0.437***
	(0.0698)
Copay Policy (No Debt)	10.20
	(17.67)
Punitive Copay Policy (Debt)	15.25*
	(6.546)
State Government Ideology	-0.237
	(0.183)
Citizen Ideology	-0.534
	(0.368)
State Violent Crime Rate	-0.00459
	(0.0410)
State Revenue per Capita	0.000394
	(0.00224)
State Unemployment Rate	-0.551
	(1.912)
State Uninsured Rate	2.624*
	(1.112)
State Prison System Design Capacity	-0.000810*
	(0.000367)
Inmate Population Percent Black	-0.526
	(0.830)
Inmate Population over 55	-1.923
	(1.578)
Prison Privatization	-0.247
	(0.425)
Constant	176.6**
	(61.90)
N	797

Note: Cell entries are OLS slope coefficients and panel corrected standard errors in parentheses.
* p<0.05 ** p<0.01 *** p<0.001

Models 2 & 3: The Impact of Inmate Copay Policies on State Prison Expenditures

The second model in the study was ran in the exact same manner as the model 1, the only difference being the dependent variable. In the first model, the dependent variable is the rate of inmate mortality. In model 2, the dependent variable is the states' per capita corrections

spending. Shown in table 4.2 on page 163, there is significant and negative relationship between the more severe version of the copay policy and state corrections spending. Similar to the findings of the first model, the severe version of the copay policy is significant while the less severe policy is not. This finding supports hypothesis two which posits the copay policy as a cost-saving mechanism. At least in the case of the severe copay policies that impose debt on inmates, states are seeing a reduction in corrections spending as a result.

In the second model, two of the control variables are found to be significant as well. There is a significant and very small positive relationship between a state's violent crime rate and per capita corrections spending. This finding makes sense, as states are more likely to see the need for prisons and prison spending when crime rates are higher. Additionally, the state unemployment rate is statistically significant and negative in the second model. This indicates that, all else equal, as the unemployment rate rises in a state, that state becomes increasingly likely to spend less on corrections.

This finding is likely due to the unemployment rate's relationship with a state's economy. When things are financially more difficult, spending decisions must be made. Unsurprisingly, states are likely to spend less on corrections as a result. Budget cuts often come at the expense of corrections spending. As spending on other areas is seen as more important and politically popular, the budget must shift to accommodate such spending. Corrections spending, as previously discussed, is often one of the first state expenses to be scrutinized under such circumstances, as prison spending is not a particularly popular campaign issue.

Table 4.2 - The Impact of Copay Policies on State Corrections Expenditures per Capita

Independent Variables	DV = Corrections Expenditures (Per Capita)
Lagged DV	0.556***
	(0.0753)
Copay Policy (No Debt)	-0.00291
	(0.00423)
Punitive Copay Policy (Debt)	-0.00471*
	(0.00187)
State Government Ideology	0.0000386
	(0.0000558)
Citizen Ideology	-0.0000556
	(0.000107)
State Violent Crime Rate	0.0000240*
	(0.0000112)
State Revenue per Capita	0.00000173
	(0.00000114)
State Unemployment Rate	-0.00217**
	(0.000704)
State Uninsured Rate	-0.0000600
	(0.000299)
State Prison System Design Capacity	-3.79e-08
	(0.000000150)
Inmate Population over 55	-0.000842
	(0.000499)
Prison Privatization	0.000158
	(0.000235)
Constant	0.0523***
	(0.0129)
N	797

Note: Cell entries are OLS slope coefficients and panel corrected standard errors in parentheses.
* p<0.05 ** p<0.01 *** p<0.001

The third model in the analysis is exactly the same as the previous model, only the dependent variable used is the third model is corrections spending per prisoner, rather than corrections spending per capita. Importantly, despite the change in dependent variables, this measure of corrections spending is still found to be negatively impacted by the severe form of the copay policy. This finding indicates that corrections spending measured as both per capita spending and per inmate spending are significantly and negatively related to the presence of a punitive copay policy. This means that forms of the copay policy that impose debts on indigent inmates are saving states money. This finding is demonstrated in table 4.3 on the next page. Table 4.4 presents all three models together. [5]

[5] I also ran the first model of study without the inclusion of the state fixed effects. This model demonstrated the importance of the fixed effects, as the model's results were significantly less clear than when the fixed effects were included. The results of this model can be viewed in Appendix B.

Table 4.3 - Corrections Spending Per Prisoner

Independent Variables	DV = Corrections Expenditures (Per Prisoner)
Lagged DV	0.598***
	(0.0653)
Copay Policy (No Debt)	-0.239
	(1.099)
Punitive Copay Policy (Debt)	-1.118*
	(0.507)
State Government Ideology	0.0197
	(0.0157)
Citizen Ideology	-0.0380
	(0.0292)
State Violent Crime Rate	-0.00431
	(0.00268)
State Revenue per Capita	0.000462
	(0.000286)
State Unemployment Rate	-0.236
	(0.184)
State Uninsured Rate	-0.0697
	(0.100)
State Prison System Design Capacity	-0.0000371
	(0.0000371)
Inmate Population over 55	-0.290
	(0.151)
Prison Privatization	0.0330
	(0.0618)
Constant	14.13***
	(3.387)
N	797

Note: Cell entries are OLS slope coefficients and panel corrected standard errors in parentheses.

* p<0.05 ** p<0.01 *** p<0.001

Table 4.4 – A Comparison of All Three Models

Independent Variables	DV = Inmate Mortality	DV = Corrections Expenditures Per Capita	DV = Corrections Expenditures Per Prisoner
Lagged DV	0.437***	0.556***	0.598***
	(0.0698)	(0.0753)	(0.0653)
Copay Policy (No Debt)	10.20	-0.00291	-0.239
	(17.67)	(0.00423)	(1.099)
Punitive Copay Policy (Debt)	15.25*	-0.00471*	-1.118*
	(6.546)	(0.00187)	(0.507)
State Government ID	-0.237	0.0000386	0.0197
	(0.183)	(0.0000558)	(0.0157)
Citizen Ideology	-0.534	-0.0000556	-0.0380
	(0.368)	(0.000107)	(0.0292)
State Violent Crime Rate	-0.00459	0.0000240*	-0.00431
	(0.0410)	(0.0000112)	(0.00268)
State Revenue per Capita	0.000394	0.00000173	0.000462
	(0.00224)	(0.00000114)	(0.000286)
State Unemployment Rate	-0.551	-0.00217**	-0.236
	(1.912)	(0.000704)	(0.184)
State Uninsured Rate	2.624*	-0.0000600	-0.0697
	(1.112)	(0.000299)	(0.100)
Prison Design Capacity	-0.000810*	-3.79e-08	-0.0000371
	(0.000367)	(0.000000150)	(0.0000371)
Inmate Population Percent Black	-0.526	.	.
	(0.830)	.	.
Inmate Population over 55	-1.923	-0.000842	-0.290
	(1.578)	(0.000499)	(0.151)
Prison Privatization	-0.247	0.000158	0.0330
	(0.425)	(0.000235)	(0.0618)
Constant	176.6**	0.0523***	14.13***
	(61.90)	(0.0129)	(3.387)
N	797	797	797

Note: Cell entries are OLS slope coefficients and panel corrected standard errors in parentheses.
* p<0.05 ** p<0.01 *** p<0.001

Study 2: Discussion

Hypothesis 1: The Influence of Prison Copay Policies on Inmate Mortality

The first hypothesis of the second study is at least partially supported. While not all copay policies lead to higher rates of inmate mortality, it is clear that at least some do. Specifically, the policies that impose a debt on indigent inmates are significantly related to inmate mortality rates. This means that these severe forms of the copay policy are leading to increases in inmate deaths. There are a number of reasons why the less severe policies may not be impacting inmate mortality.

As previously discussed, it is likely that, at least to some extent, some of these copay polices are adopted as a result of symbolic politics. It is possible that, in some cases, governors or other policy makers wish to appear tough on criminals while simultaneously recognizing the unnecessary nature of a severe policy. In these instances, it may be that these policymakers feel as though passing a policy that does not impose debt will appear tough on crime in a manner that imposes no responsibility on themselves for debt collection. In other words, they can appear tough on crime without implementing any policies that actually give them more work to do.

While this reasoning may explain why some states adopt less severe policies, it may also explain why these less severe policies are not resulting in increases of inmate mortality. Primarily, it is most likely due to the ineffectiveness of the policies. It is unlikely inmates are going to forgo services due to a copay fee they know they will never have to pay. This is the same calculus that many would make outside of prison. It is unlikely anyone would pay copay fees if they know they can be treated without ever taking on the unpaid fee as a debt.

Hypothesis 2: The Influence of Prison Copay Policies on State Prison Expenditures

Just as the first model showed some support for the first hypothesis, so too do the second and third models show some support for the second hypothesis. While the first analysis shows that only the severe forms of the copay policy policies impact inmate mortality, the second and third analyses demonstrate that only the same severe policies impact state corrections spending per capita and per prisoner as well. This indicates that the less severe forms of the policy are not saving states money, while the severe forms that impose debt and facilitate debt collection are causing reductions in corrections spending.

It is not all that surprising that the most punitive copay policies are causing decreases in per inmate corrections spending. Just as a person in the private healthcare industry may forgo services in order to avoid paying a copay, it follows that an inmate would make the same calculation, especially considering that inmate copays are the equivalent of around $2,000 for a person making $60,000 a year (Fisher and Hatton, 2010). While the results of the first model clearly indicate these calculations are costing inmates in terms of health outcomes, their decision to forgo medical care is saving money. This is similar to the studies that found similar calculations made by veterans, the Japanese, and even Medicaid recipients.

The second study strongly indicates is that the severe forms of the copay policies, those that impose debt on indigent inmates, are both increasing inmate mortality rates and simultaneously causing a reduction in corrections spending. This finding is entirely logical. When anyone is faced with an upfront fee like a copay, they are likely to avoid the service. This avoidance will likely have negative impacts if they need care, but will also decrease costs as fewer individuals are accessing services. The impact of the control variables on corrections spending are all in the predicted direction.

Study 2: Conclusions

In combination with the findings of the first study, the results of the second study become especially worrisome. It is clear that, to some extent, a state's decision to adopt a copay policy is motivated by the racial makeup of that state's prison population, as well as the state's government ideology. If policymakers in that state then choose to adopt a severe form of the policy that imposes debt on indigent inmates, the inmates of that state are likely to suffer. Specifically, these policies are causing higher rates of inmate mortality. While the states are correct in their assertions that the copay policies save money on corrections spending, they are wrong in their assertion that these policies do not impact the quality of care in their prisons. Clearly, the financial savings come at a cost to inmates – that cost is their health, and even their lives.

These findings are in line with the research of Bedard and Frech. These scholars have examined the impact that contracting out health services can have on inmate health. They find that contracting out health services in prisons leads to increases in inmate mortality rates (Bedard and Frech 2009). Clearly, there is a trend when states attempt to implement market mechanisms in public arenas. This trend results in questionable financial savings at the cost of quality; in this case, quality means the lives of those who are at the mercy, and the responsibility, of the state. While the legal arguments against such an outcome have yet to play out, the moral arguments are quite clear. When an individual is the responsibility of the state, implementing private sector cost-saving mechanisms to reduce the costs of health services is unjustifiable if it costs inmates their lives.

This idea of using private sector market mechanisms to reduce costs and shrink the size of government is nothing new as this trend has been around in the US for some time. The use of

these mechanisms with the underlying assumption that the individuals being targeted are unable to make intelligent decisions for their own well-being is well documented in the welfare literature (Soss et al. 2011), and this neoliberal-paternalism has clearly impacted the way inmates in state prison systems are being treated. Passing policies that imply that inmates are incapable of making intelligent decisions about their health are not only insulting, but they are also clearly harmful. These policies are sending clear messages to the general population, and even clearer messages to those in prisons. Inmates are untrustworthy with their own health, and it is worth saving money - even if these savings come at the cost of their lives.

V. CONCLUSION

If our nation's civility is to be judged by our prison system, we have much to stand in judgement for. As our country is experiencing unprecedented levels of imprisonment, the conditions of our prisons matter now more than ever. Michelle Alexander has rightly dubbed this the age of "mass incarceration" (Alexander, 2012). While work remains to further our understanding of the causes and solutions to this problem, nearly 1.5 million Americans are at the mercy of the correctional departments across fifty states. The policies used to operate these state facilities have dire consequences for those imprisoned in them, and the incarcerated have no input whatsoever into how these policies are designed or implemented.

The results of this one-sided relationship have been, as expected, strained. For some time, there was no recourse for inmates who were victimized by a system that was riddled with indifference and outright hostility. While change has been slow, much has been done to improve the conditions of those living in our prison system. A turning point in this battle was the landmark Supreme Court decision *Estelle v Gamble (1976)* in which the Court ruled that the incarcerated have a constitutional right to healthcare access. A series of later decisions firmly grounded this principle in law, and this has enabled inmates, as well as those concerned on their behalf, to use litigation as a means of holding state departments of corrections accountable for the conditions of their prisons, and to hold them accountable in their duty of providing medical care.

In this way, the American Bar and American Medical Associations have been able to push for improved standards of care. These associations helped to establish the National

Commission on Correctional Health Care in 1983, and the NCCHC has done much to establish standards of healthcare in prisons (Awofeso 2008). This movement towards improving standards even spawned an official organization of concerned correctional officers and prison administrators, the American Correctional Association, who works to update and standardize conditions of care for American prisons (Anno 2004). Thanks to the work of these organizations, among others, we now have a loose network of concerned entities that work for the betterment of our prison systems to ensure that inmates have access to healthcare services.

However, it is not always clear how far the ruling in *Estelle* applies. Corrections spending has become increasingly expensive as our rates of imprisonment have risen, and of this growth in spending, healthcare services is the fastest growing component (McDonald 1995). As a result, states have turned to a number of solutions in an attempt to curb the growing costs of incarceration, especially healthcare costs. These solutions are often based on private sector, free market strategies that are intended to save money.

While states contend that these solutions maintain the same level of care and quality, much research has shown that this is simply not the case. Particularly worrying, research has shown that the contracting out of inmate healthcare services, a very common practice by states, leads to significantly higher rates of inmate mortality (Bedard and Frech 2009). Similarly, introducing managed care systems in state prison systems has been found to negatively impact patients' health (Robbins 1999). A newer policy innovation employed by states in order to reduce the cost of inmate health services is the implementation of a prison copay system.

These copay policies are now common across the fifty states, with 42 states having adopted some form of the policy. As more states have adopted these policies, there has been an increasing amount of variation in the specific characteristics of the copay policies. Specifically,

different state policies have varying levels of punitiveness in regards to the treatment of indigent inmates who are unable to pay the fee at the time of the requested service. In a number of states, indigent inmates who are unable to pay are assigned a debt for future repayment of the copay fee. In the strictest states, such as Alabama, that debt is meticulously tracked, and inmates are accountable for repayment even after their release from prison. In other states, such as California, the policy is less punitive, and the debt is forgiven after a certain period of time. Finally, some state policies make no mention of repayment at all.

Importantly, as prisoners are the only group in America that have been found to possess a constitutional right to healthcare access, it is of vital importance that we understand both the motivations for these policy innovations, as well as the impacts that these policies are having on inmate health. While some research has been done in the area of the privatization of medical services, no previous studies have been conducted that explore this newest policy innovation – a prison copay policy. As the research into the privatization of prison medical services has found strong evidence that these privatized solutions are likely causing harm (Bedard and Frech 2009), it is of the utmost importance that impact of these copay policies is investigated.

Important Findings

Due to the increasing number of states that have adopted these copay policies, as well as a range in the severity of these copay policies, understanding why these policies differ to such an extent is important in our assessment of their legal and moral justifiability. While states have repeatedly claimed that these policies are adopted in order to reduce the growing costs associated with inmate healthcare services, the first study in this analysis finds no evidence to support this claim. Instead, a fifty-state analysis of policy adoption indicates that it is the racial makeup of a

state's inmate population, as well as the ideological makeup of a state's government, that has the greatest impact on a state's decision to adopt a copay policy. Furthermore, there is no evidence that corrections costs play any role in the decision to adopt a copay policy.

If a state has a high percentage of Black inmates, it is significantly more likely to adopt a copay policy. Similarly, if a state has conservative state government, the likelihood of adopting a copay policy increases dramatically. When these two factors are combined, a state with a conservative government and a high percentage of Black inmates is almost guaranteed to adopt a copay policy. Conversely, if a state has a liberal state government and a small percentage of Black inmates, there is very little chance that that state will adopt such a policy.

Importantly, as the motivation for these polices is racial and ideological in nature, it is incredibly difficult for states to justify their adoption. Claims that these policies are introduced as a means of financial necessity are simply untrue. Inmates in states with a high percentage of Black inmates, or states with conservative governments (or both), are being targeted by a policy that is racially motivated and possibly harmful to their health outcomes. While the impact of these policies is also explored in this analysis, the racial and ideological impetus for these copay policies is essential to consider within the context of how prisoners are treated and perceived in American politics.

The way groups are targeted by policies is a function of how they are perceived within society. Policies that target deviant groups send messages to society about those groups. Prisoners are, by definition, the clearest example of a deviant group within a society. The way we socially construct criminals impacts the policies we use to target them. Furthermore, the policies we use to target groups creates and reinforces the perceptions we have about them, as well as the way those within the group view themselves. Within the policymaking world, deviant

groups are both the least sympathetic and the least politically powerful. This means that they are often targeted with punitive policies that are reflective of the negative views of others (Schneider and Ingram 1993).

Furthermore, deviant groups have no political power to change the way they are perceived or the policies that target them. This creates a cycle wherein deviants are targeted by punitive polices that communicate to society that they are deserving of punishment, and this in turn reinforces the negative image that others hold and that they hold of themselves. This reinforced negative image then encourages more punitive policies that further weaken that group's own self-perception and political power (Schneider and Ingram 1993). This cycle is best exemplified by felony disenfranchisement.

Felony disenfranchisement laws are the result of negative perceptions about criminals. Disenfranchisement then signals that, despite having completed their sentences, they are still deviant and therefore deserving of punishment. Furthermore, disenfranchisement institutionalizes felons' lack of political power. They are, in turn, more likely to view political participation as hollow and less likely to enter the parts of the political process they are still legally permitted to access, thereby further weakening their political efficacy.

This cycle of negative construction and punitive policymaking is particularly common and impactful to criminals. Therefore, the motivations for policies that aim to restrict their constitutionally designated right to healthcare access should be carefully scrutinized. While the measure of social construction in this analysis was not found to be significant, the finding that these policies are racially and ideologically motivated is evidence that inmates' constitutional rights are under attack, not due to financial necessity, but due to racial and ideological factors.

These motivations make the outcomes of such a policy even more significant, as the policy could possibly stand in the way of inmates accessing their constitutional right to healthcare services.

Alarmingly, the second study in this analysis finds just that – the severe form of the copay policies is increasing inmate mortality rates. Not only are these policies motivated by racial and ideological factors, there is strong evidence that copay policies, when they impose debt on indigent inmates, are having negative impacts on inmate health. It is very likely that, similar to citizens in the private sector, inmates are forgoing necessary medical services and medicines due to the financial barrier presented by a copay policy. As a result, inmates in the states with the severe copay policies are more likely to die. While it is true that these severe policies also save the states money, these savings are no justification for policies that result in increased inmate mortality.

The finding that prison copays increase inmate mortality rates, especially in view of the racial and ideological motivations of the policies, is morally and legally inexcusable. The Supreme Court has found, through a series of clear and legally binding precedents, that inmates are constitutionally entitled to healthcare services. This analysis finds that state prison copay policies are posing a significant barrier to inmates' healthcare access, and that this barrier is resulting in unnecessary inmate deaths. Despite the financial savings caused by these severe copays, these policies unjustifiably limit access to care and increase inmate mortality rates by imposing a significant financial burden on a group that is paid well less than a dollar for an hour of work.

Limitations

Importantly, this analysis has several limitations. The creation of a variable that can accurately measure the construction of criminals is still incomplete. The measure created using the responses from the CCES is a step towards a more direct measure of people's attitudes towards criminals. However, even these questions may not be direct enough to truly measure real and direct attitudes towards inmates. While the scale using CCES criminal justice questions may be the most indicative measure available, new and improved techniques must be pursued in order to gain the clearest understanding of how the way individuals feel about criminals impacts the policies directed towards them.

Furthermore, as data is unavailable for corrections spending on health services, and the analysis instead uses overall corrections expenditures. While this is less than ideal, using total corrections expenditures as a proxy for corrections healthcare expenditures is justifiable due to health services being such a large proportion of overall corrections expenditures, as well as the fastest growing component of corrections spending.

Similarly, this study is limited in that it uses inmate mortality as a measure of health outcomes. While the ideal scenario would be to examine a multitude of factors such as the prevalence of disease, life expectancy, and a number of other more nuanced measures of health outcomes, these data are not yet available for all fifty states, or for the years of the analysis. It is quite possible that these policies are having negative impacts on health outcomes less severe than death, but the limited availability of mortality data does not enable a more nuanced examination of these impacts.

Furthermore, it is important to recognize the limitations of this study in terms of the prison populations being examined. This analysis only considers the impacts of copay policies on

state inmates in general. Another limitation imposed by the data is the inability to examine the impacts of the copay policies on different groups within the state inmate population. As previously discussed, female inmates are significantly more likely to request healthcare services than male inmates (Berkman 1995; Ingram-Fogel 1991). It is therefore likely that any state-wide policy restricting healthcare access will impact female inmates to a greater extent than male inmates.

Recall that Hyde and Brumfield's 2003 analysis finds that the Idaho prison system's implementation of a copay policy had significantly different impacts for female and male inmates. Specifically, the policy resulted in a greater reduction in sick-call requests for women than for men (Hyde and Brumfield 2003). Additionally, interviews with female inmates in California's prison system revealed that the state's inmate copay policy disproportionately impacted female indigent inmates (Chandler 2003; Stoller 2001), and that these copays are often wasted as a result of the inefficient copay policy system (Fisher and Hatton 2010). These studies all indicate the important differences between the impacts of healthcare barriers on men and women, but this study is unable to explore these differences as the data only reflect state prison populations as a whole and not by gender.

Similarly, the data does not permit for an exploration of the differences the copay policies have on the health outcomes of inmates based on racial and ethnic differences. As there are numerous significant differences in the health outcomes of people of color and Whites outside of prisons, as well as a disproportionate number of people of color in the state prison systems, there is reason to suspect that healthcare policies in prison systems may potentially impact people of color in prison differently than they do White prisoners. It is therefore important to recognize the

inability of this analysis to explore these potentially differing impacts as a result of race or ethnicity.

Conclusions

However, the finding that these policies are not motivated by financial necessity, as states claim, is significant. Policies that target groups are important in that they send messages about how people within society feel about certain groups. The adoption of these policies is related to the racial make-up of states' prison populations, and the severe policies increase the likelihood that inmates will die in state prisons. The message being signaled from such policies is quite clear, and unmistakably uncivil in nature – the lives of inmates are unimportant, and the lives of Black inmates even less so. If our society is to be judged by the state of our prisons, America should be judged harshly – as harshly as these copay policies should be judged in the eyes of the law.

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VII. APPENDICES

Appendix A: Study 1, Additional Tables

The table on the following page demonstrates the results of the first model with different versions of the independent variable of interest, the social construction of inmates. In the first results column, the model was reran using the weights provided for the CCES responses. In the second results column, the model was reran using only responses from White participants. Finally, the third results column represents the results of the model reran using only responses from participants from registered voters. None of the different versions of the measure of the social construction of inmates significantly impacted the results of the analysis. The main findings, the statistically significant and negative impact of liberal state governments, as well as the statistically significant and positive impact the proportion of Black inmates, remain unchanged by the use of these other measures of social construction.

Additional Tables for Study 1

	Model 1 with Weighted SC	**Model 1 with Whites' SC**	**Model 1 with Voters' SC**
Independent Variables	DV = Copay Adoptions	DV = Copay Adoptions	DV = Copay Adoptions
Social Construction of Inmates	0.540	1.021	0.430
	(1.450)	(3.236)	(1.343)
State Corrections Spending Per Prisoner	0.982	0.982	0.982
	(0.0147)	(0.0149)	(0.0147)
State Revenue	1.000	1.000	1.000
	(0.0000800)	(0.0000914)	(0.0000836)
Citizen Ideology	1.023	1.023	1.023
	(0.0150)	(0.0149)	(0.0149)
Government Ideology	0.970*	0.970*	0.970*
	(0.0137)	(0.0136)	(0.0135)
General Population Healthcare Spending	1.000	1.000	1.000
	(0.000310)	(0.000306)	(0.000290)
Percentage of Black Inmates	1.023*	1.024*	1.023*
	(0.0110)	(0.0108)	(0.0102)
Support for Universal Care	13.89	14.68	13.14
	(26.09)	(27.58)	(24.65)
Violent Crime Rate	1.001	1.001	1.001
	(0.00105)	(0.00103)	(0.00110)
Inmate Race*Social Construction	.	.	.
	.	.	.
N	958	958	958
Hazard Ratios; Standard errors in parentheses			
* p<0.05 ** p<0.01 *** p<0.001			

Appendix B: Study 2, Additional Tables

The table on the following page indicates the results of the first model in the second study, reran without the inclusion of state fixed effects. The results indicate that the inclusion of the state fixed effects is important in the analysis. The absence of these effects results in drastically different outcomes for the first model in study 2. The table below also includes the full results of the three models, including the impact of the state and year fixed effects on the models examining inmate mortality, corrections spending per citizen, and corrections spending per prisoner.

Additional Tables for Study 2

	Model 1 Without State Fixed Effects	Model 1 (Full)	Model 2 (Full)	Model 3 (Full)
Independent Variables	**DV = Inmate Mortality**	**DV = Inmate Mortality**	**DV = Spending Per Citizen**	**DV = Spending Per Prisoner**
Lagged DV	0.639***	0.437***	0.556***	0.598***
	(0.0526)	(-0.0698)	(0.0753)	(0.0653)
Copay Policy (No Debt)	6.742	10.2	-0.00291	-0.239
	(9.511)	(-17.67)	(0.00423)	(1.099)
Punitive Copay Policy (Debt)	9.624*	15.25*	-0.00471*	-1.118*
	(4.247)	(-6.546)	(0.00187)	(0.507)
State Government Ideology	0.214	-0.237	0.0000386	0.0197
	(0.140)	(-0.183)	(0.0000558)	(0.0157)
Citizen Ideology	-0.176	-0.534	-0.0000556	-0.0380
	(0.152)	(-0.368)	(0.000107)	(0.0292)
State Violent Crime Rate	0.0422*	-0.00459	0.0000240*	-0.00431
	(0.0177)	(-0.041)	(0.0000112)	(0.00268)
State Revenue per Capita	-0.00148	0.000394	0.00000173	0.000462
	(0.000943)	(-0.00224)	(0.00000114)	(0.000286)
State Unemployment Rate	1.938	-0.551	-0.00217**	-0.236
	(1.232)	(-1.912)	(0.000704)	(0.184)
State Uninsured Rate	0.517	2.624*	-0.0000600	-0.0697

	(0.661)	(-1.112)	(0.000299)	(0.100)
State Prison System Design Capacity	0.0000501	-0.000810*	-3.79e-08	-0.0000371
	(0.0000537)	(-0.000367)	(0.000000150)	(0.0000371)
Inmate Population Percent Black	-0.0893	-0.526	.	.
	(0.105)	(-0.83)	(.)	(.)
Inmate Population over 55	0.193	-1.923	-0.000842	-0.290*
	(0.314)	(-1.578)	(0.000499)	(0.148)
Prison Privatization	-0.371	-0.247	0.000158	0.0330
	(0.221)	(-0.425)	(0.000235)	(0.0618)
Alabama	0	-34.24	0	0
	(.)	(-41.53)	(.)	(.)
Alaska	0	3.239	0.0966***	8.247
	(.)	(-17.87)	(0.0253)	(4.463)
Arizona	0	85.12*	0.0171*	3.934*
	(.)	(-40.02)	(0.00679)	(1.667)
Arkansas	0	-47.5	0.00546	2.391*
	(.)	(-36.97)	(0.00456)	(1.153)
California	0	-37.8	0.0478***	16.25***
	(.)	(-23.42)	(0.0141)	(3.756)
Colorado	0	-6.08	0.0230**	6.893**
	(.)	(-25.78)	(0.00720)	(2.171)
Connecticut	0	10.78	0.0382***	5.944**
	(.)	(-25.71)	(0.00938)	(1.919)
Delaware	0	6.004	0.0857***	7.350***

	(.)	(-22.17)	(0.0180)	(1.984)
Florida	0	-31.65	0.0137	8.094**
	(.)	(-54.46)	(0.00933)	(2.564)
Georgia	0	-92.96	0.0197*	5.080*
	(.)	(-53.12)	(0.00841)	(2.003)
Hawaii	0	4.195	0.00978	3.206
	(.)	(-24.3)	(0.0108)	(2.991)
Idaho	0	-17.91	0.0157*	2.517
	(.)	(-22.11)	(0.00781)	(2.200)
Illinois	0	-59.18	0.0112	9.911***
	(.)	(-33.35)	(0.00574)	(2.205)
Indiana	0	-16.22	0.00209	3.849**
	(.)	(-25.36)	(0.00422)	(1.424)
Iowa	0	6.653	-0.00858	4.592**
	(.)	(-33.27)	(0.00440)	(1.545)
Kansas	0	-14.98	-0.00475	4.914***
	(.)	(-18.85)	(0.00442)	(1.477)
Kentucky	0	-26.38	0.0128*	4.248*
	(.)	(-48.71)	(0.00644)	(1.913)
Louisiana	0	66.36*	0.000585	-1.000
	(.)	(-33.21)	(0.00498)	(1.286)
Maine	0	49.01	-0.00437	16.58***
	(.)	(-36.19)	(0.00667)	(3.470)
Maryland	0	25.93	0.0595***	21.65***
	(.)	(-20.32)	(0.0126)	(3.645)
Massachusetts	0	-40.63	0.0169*	32.46***
	(.)	(-24.37)	(0.00717)	(5.497)

Michigan	0	2.188	0.0395***	10.84***
	(.)	(-21.07)	(0.00770)	(1.870)
Minnesota	0	9.622	-0.0181***	9.621***
	(.)	(-23.11)	(0.00531)	(2.488)
Mississippi	0	-73.29	-0.00300	-3.456*
	(.)	(-54.1)	(0.00591)	(1.680)
Missouri	0	-21.36	0.00127	2.168
	(.)	(-33.53)	(0.00489)	(1.140)
Montana	0	-23.16	0.0173	8.569**
	(.)	(-34.18)	(0.0105)	(3.243)
Nebraska	0	-17.15	0.0100	14.09***
	(.)	(-49.96)	(0.00606)	(2.815)
Nevada	0	32.39	-0.00209	3.527*
	(.)	(-25.81)	(0.00556)	(1.515)
New Hampshire	0	-31.61	-0.00745	8.949***
	(.)	(-54.14)	(0.00553)	(2.255)
New Jersey	0	60.65*	0.0309***	18.21***
	(.)	(-27.53)	(0.00855)	(3.300)
New Mexico	0	0.627	0.0129	13.98***
	(.)	(-19.37)	(0.0124)	(4.234)
New York	0	-121.4*	0.0211*	16.05***
	(.)	(-47.89)	(0.0102)	(3.443)
North Carolina	0	1.607	0.0105	6.689***
	(.)	(-25.51)	(0.00540)	(1.630)
North Dakota	0	6.561	-0.0149*	7.868**
	(.)	(-33.34)	(0.00741)	(2.830)

Ohio	0	-25.87	0.0124	4.776*
	(.)	(-42.99)	(0.00730)	(2.094)
Oklahoma	0	67.78***	0.0109	0.307
	(.)	(-18.9)	(0.00829)	(1.904)
Oregon	0	-11.44	0.0240**	9.043***
	(.)	(-33.12)	(0.00750)	(2.496)
Pennsylvania	0	9.533	0.0160**	9.516***
	(.)	(-21.96)	(0.00620)	(2.176)
Rhode Island	0	-50.17	0.0333***	13.74***
	(.)	(-48.16)	(0.00845)	(2.904)
South Carolina	0	26.02	-0.00391	3.201*
	(.)	(-25.56)	(0.00566)	(1.290)
South Dakota	0	79.08	0.00356	2.615
	(.)	(-61.32)	(0.00479)	(1.425)
Tennessee	0	-88.44	0.00372	8.971**
	(.)	(-45.78)	(0.00950)	(3.090)
Texas	0	-70.26	0.0192	6.993
	(.)	(-47.25)	(0.0231)	(5.496)
Utah	0	18.71	0.00554	11.49***
	(.)	(-19.24)	(0.00515)	(2.570)
Vermont	0	-17.4	0.0282*	12.56***
	(.)	(-37.95)	(0.0112)	(3.454)
Virginia	0	11.98	0.0219***	6.138***
	(.)	(-40.82)	(0.00611)	(1.578)
Washington	0	-30.74	0.0249***	17.53***
	(.)	(-19.13)	(0.00669)	(3.267)
West Virginia	0	-110.6*	0.00876	8.042***

	(.)	(-51.65)	(0.00625)	(2.409)
Wisconsin	0	0	0.0362***	10.42***
	(.)	(.)	(0.00741)	(2.094)
Wyoming	0	-7.513*	0.0508*	14.30**
	(.)	(-3.242)	(0.0199)	(5.092)
Year 1999	0	0	0	0
	(.)	(.)	(.)	(.)
Year 2000	-4.668**	-65.25	-0.000659	-0.677*
	(1.445)	(-57.97)	(0.00125)	(0.282)
Year 2001	6.115***	8.563***	0.00320*	0.0226
	(0.961)	(-1.593)	(0.00142)	(0.248)
Year 2002	-0.429	4.79	0.00260	-0.788
	(2.060)	(-3.344)	(0.00222)	(0.421)
Year 2003	15.37***	20.18***	0.000758	-1.394***
	(2.053)	(-3.869)	(0.00213)	(0.364)
Year 2004	-6.553**	0.207	-0.00492*	-2.850***
	(2.250)	(-5.651)	(0.00233)	(0.432)
Year 2005	3.680	7.191	0.00214	-1.225**
	(2.080)	(-5.882)	(0.00209)	(0.375)
Year 2006	-9.360***	-4.48	-0.00143	-2.309***
	(2.115)	(-6.34)	(0.00225)	(0.410)
Year 2007	20.22***	26.94**	0.00286	-0.811
	(2.590)	(-8.484)	(0.00305)	(0.616)
Year 2008	5.856	22.83*	0.0121***	1.576**
	(3.228)	(-9.008)	(0.00310)	(0.559)
Year 2009	-11.05	12.59	0.0196***	2.362*
	(6.452)	(-11.22)	(0.00476)	(1.033)

Year 2010	-9.462	4.392	0.00702	-1.144
	(6.175)	(-14.58)	(0.00566)	(1.266)
Year 2011	2.795	18.36	0.00614	-1.055
	(5.861)	(-14.85)	(0.00517)	(1.254)
Year 2012	-3.966	13.27	0.00664	-0.286
	(5.493)	(-14.42)	(0.00445)	(1.104)
Year 2013	16.60**	32.23*	0.00543	-0.920
	(5.264)	(-15.74)	(0.00471)	(1.173)
Year 2014	8.500	30.57	0.00443	-0.896
	(5.999)	(-18.02)	(0.00505)	(1.341)
Constant	55.58***	176.6**	0.0523***	14.13***
	(14.06)	(-61.9)	(0.0129)	(3.387)
N	797	797	797	797

Note: Cell entries are OLS slope coefficients and panel corrected standard errors in parentheses.

p<0.05* ** p<0.01 *** p<0.001

Appendix C: Data and Variables Guide

Data and Variable Guide Table

Variable	Measurement	Source	Total	Mean	Standard Deviation	Min	Max
Study 1							
Copay Policy Adoption	A 0 for every year without the policy, a 1 for every year with the policy.	State departments of corrections, as well as state statutes and laws.	1,300	0.2953846	0.456391	0	1
The Social Construction of Inmates	Created using a scale from 4-8, 4 being least punitive and 8 the most, using individual responses to the criminal justice questions on the 2016 CCES averaged by state.	2016 CCES: https://dataverse.harvard.edu/dataset.xhtml?persistentId=doi%3A10.7910/DVN/GDF6Z0	1,300	5.833474	0.0807793	5.568182	5.976048
State Corrections Spending Per Prisoner	A state's total corrections expenditures, divided by the total number of state prisoners. Adjusted to 2017 dollars.	The Tax Policy Center: https://slfdqs.taxpolicycenter.org/pages.cfm	1,300	42.17554	16.91966	13.78508	119.0538
State Revenue Per Capita	A state's total revenue, divided by the total number of citizens in a state. Adjusted to 2017 dollars.	The Urban Institute: https://slfdqs.taxpolicycenter.org/pages.cfm	1,300	6750.284	2457.745	1717.258	27018.61
Citizen Ideology	0-100, conservative to liberal. Measures the ideological make-up of a state's citizen population.	Berry, William D., Evan J. Ringquist, Richard C. Fording, and Russell L. Hanson. "Measuring citizen and government ideology in the American states, 1960–93." (1998).	1,300	50.23611	15.38719	8.449893	97.00153

State Government Ideology	0-100, conservative to liberal. Measures the ideological make-up of a state's government constructed using NOMINATE scores.	Berry, William D., Evan J. Ringquist, Richard C. Fording, and Russell L. Hanson. "Measuring citizen and government ideology in the American states, 1960–93." (1998).	1,300	46.53622	14.9392	17.51221	73.61864
General Population Healthcare Spending	The cost of physician care outside of prisons in each state. Adjusted to 2017 dollars.	Found in U.S. Statistical Abstract, Census Bureau: https://www.census.gov/library/publications/time-series/statistical_abstracts.html	1,300	6907.286	1656.822	3609.536	12077.6
Percentage of Black Inmates	The percentage of a state's prison population that reported as identifying as Black.	Bureau of Justice Statistics: https://www.bjs.gov/	1,300	34.43634	22.36318	1.172791	77.97604
Support for Universal Care	Created using a scale from 4-8, 4 being the least supportive and 8 the most supportive using individual responses to the health policy questions on the 2016 CCES, then averaged by state.	2016 CCES: https://dataverse.harvard.edu/dataset.xhtml?persistentId=doi%3A10.7910/DVN/GDF6Z0	1,300	4.87772	0.1340599	4.599306	5.252174
State Violent Crime Rate	The rate of violent crime in a state in each given year.	https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/34540	1,300	427.497	206.3058	66.91222	1205.699
Study 2							
Inmate Mortality Rate per 100,000	The number of inmate deaths in a state divided by 100,000	Bureau of Justice's National Prisoner Statistics dataset (1978-2014): o https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/36281?q=36281	1,300	223.8182	71.74871	33.30003	476.4741

Copay Policy Adoption	2 for a year a state has a copay policy that imposes debt on inmates, 1 when a state has a copay policy that doesn't impose debt, and 0 if the state has no policy.	State departments of corrections, as well as state statutes and laws.	1,300	0.5261538	0.8434463	0	2
Citizen Ideology	0-100, conservative to liberal. Measures the ideological make-up of a state's citizen population.	Berry, William D., Evan J. Ringquist, Richard C. Fording, and Russell L. Hanson. "Measuring citizen and government ideology in the American states, 1960–93." (1998).	1,300	50.23611	15.38719	8.449893	97.00153
State Government Ideology	0-100, conservative to liberal. Measures the ideological make-up of a state's government constructed using NOMINATE scores.	Berry, William D., Evan J. Ringquist, Richard C. Fording, and Russell L. Hanson. "Measuring citizen and government ideology in the American states, 1960–93." (1998).	1,300	46.53622	14.9392	17.51221	73.61864
State Revenue Per Capita	A state's total revenue, divided by the total number of citizens in a state. Adjusted to 2017 dollars.	The Urban Institute: https://slfdqs.taxpolicycenter.org/pages.cfm	1,300	6750.284	2457.745	1717.258	27018.61
State Violent Crime Rate	The rate of violent crime in a state in each given year.	https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/34540	1,300	427.497	206.3058	66.91222	1205.699
State Unemployment Rate	The rate of unemployment in each state each year.	Bureau of Labor Statistics: https://www.bls.gov/cps/tables.htm	1,300	5.553462	1.856394	2.3	13.7
State Uninsured Rate	The percentage of a state's population that is uninsured each year.	State Health Policy Research Dataset (SHEPRD): https://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/34789?searchSource=revise&q=Prisoner+health&paging.startRow=51,	1,300	14.63792	4.985264	2.5	28.4

		and the US Census Data: vi.https://www.census.gov/library/publications/2017/demo/p60-260.html					
State Prison System Design Capacity	The architecturally designed capacity for the prison system in each state.	Bureau of Justice Statistic's National Prisoner Statistics (1978-2011): i. https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/34540	1,300	18670.18	25188.5	576	166631
Percentage of Black Inmates	The percentage of a state's prison population that reported as identifying as Black.	Bureau of Justice Statistics: https://www.bjs.gov/	1,300	34.43634	22.36318	1.172791	77.97604
Percentage of Inmates over 55	The percentage of inmates in a state's prison system that is over the age of 55.	Bureau of Justice Statistic's National Prisoner Statistics (1978-2011): https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/34540	1,300	8.324347	5.944214	2.2	34.7
Rate of Prison Privatization	The proportion of a state's prison system that is privatized in any given year.	Bureau of Justice Statistic's National Prisoner Statistics (1978-2011): https://www.icpsr.umich.edu/icpsrweb/NACJD/studies/34540	797	7.786041	11.13324	0	46.42518