BEYOND THE SENTENCE: THE CONSTITUTIONAL CRISIS OF END-OF-LIFE CARE FOR INCARCERATED INDIVIDUALS

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I. Introduction

Currently, the United States has nearly two million people incarcerated, the highest incarceration rate in the world.[1] Among this population, the number of incarcerated elderly adults has increased at an alarming rate, setting the stage for a growing and overlooked crisis within the prison system. Human Rights Watch, a global non-governmental organization dedicated to researching and advocating for the protection of human rights, has determined that the total percentage of state and federal incarcerated individuals 65 and older grew 94 times faster than the total incarcerated population between 2007 and 2010.[2] More recently, data has even shown that the number of incarcerated individuals age 55 or older, in both state and federal prisons, increased by 280% (nearly quadrupling), while the number of all incarcerated individuals only grew by 42%.[3] According to the Bureau of Justice Statistics' most recent report revised 2025, 15.7% of the current 1,185,648 incarcerated individuals are aged 55 or older, putting the number at a total of 186,146 individuals.[4] These statistics are alarming, prompting critical questions about how prison systems will accommodate a rapidly aging population and highlighting the urgent need for correctional institutions to address these challenges.

This striking data is the result of "tough on crime" incarceration policies that date back to the 1970s, which imposed mandatory minimum sentencing laws, the incarceration of individuals at younger ages (resulting in extended periods of imprisonment), and a systemic shift away from rehabilitation in favor of prolonged confinement.[5] One in seven incarcerated people are currently serving life sentences, meaning they will likely die in prison.[6] Moreover, it is widely believed that aging is accelerated in incarcerated individuals due to environmental factors including poor healthcare, limited access to healthcare, and stressors from incarceration.[7] Studies have also shown that incarcerated individuals typically experience a two-year reduction in average life expectancy compared to non-incarcerated individuals.[8] As a result, the "aging" prison population is widely believed to start at 55 years old.[9]

Given that one in seven incarcerated individuals is serving a life sentence and that poor environmental factors are causing chronic health issues, many incarcerated individuals will presumably die alone—either in their

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[1] *United States Profile*, PRISON POL'Y INITIATIVE, https://www.prisonpolicy.org/profiles/US.html (last visited Feb. 22, 2026).

[2] JAMIE FELLNER, HUM. RTS. WATCH, OLD BEHIND BARS: THE AGING PRISON POPULATION IN THE U.S. 6 (2012) (pulling data directly from the U.S. Bureau of Justice Statistics), https://www.hrw.org/report/2012/01/28/old-behind-bars/aging-prison-population-united-states?.

[3] Stacia Ray, *Hospice: The Prison's Forgotten Corner*, PRISON FELLOWSHIP (Oct. 31, 2019), https://www.prisonfellowship.org/2019/10/hospice-the-prisons-forgotten-corner/.

[4] E. ANN CARSON & RICH KLUCKOW, U.S. DEP'T OF JUST., PRISONERS IN 2022 – STATISTICAL TABLES 21 (2025).

[5] Brooke Cooley Webb et al., *Dying in Prison: End-of-Life Care Services in a State Correctional Facility*, 12 J. QUALITATIVE CRIM. JUST. & CRIMINOLOGY 260, 260 (2023).

[6] ASHLEY NELLIS, THE SENTENCING PROJECT, NO END IN SIGHT: AMERICA'S ENDURING RELIANCE ON LIFE IMPRISONMENT 4 (2021).

[7] Farah Acher Kaiksow et al., *Caring for the Rapidly Aging Incarcerated Population: The Role of Policy*, 49 J. GERONTOLOGICAL NURSING 7, 8 (2023).

[8] Evelyn J. Patterson, *The Dose–Response of Time Served in Prison on Mortality: New York State, 1989–2003*, 103 AM. J. PUB. HEALTH 523, 526 (2013).

[9] Stephanie L. Stephens et al., *Palliative Care for Inmates in the Hospital Setting*, 36 AM. J. HOSPICE & PALLIATIVE MED. 321, 321 (2019).

cells or chained to a hospital bed—without receiving adequate end-of-life care.[10] As such, there is a growing need for palliative care in prison. To date, only 75 state prisons—out of the approximate 1,566 state prisons found across the United States—have implemented hospice programs.[11]

The widespread failure of U.S. prisons to provide adequate end-of-life care—including access to hospice services—for an aging prison population constitutes a violation of the Eighth Amendment's prohibition against cruel and unusual punishment. In 1976, the Supreme Court established through the landmark case *Estelle v. Gamble* that deliberate indifference to a prisoner's medical needs constitutes a violation of the Eighth Amendment's cruel and unusual punishment clause.[12] This means that the basic healthcare needs of prisoners, including hospice care, should be met, regardless of age or illness. Because *Estelle v. Gamble* has been applied very narrowly and sets a difficult standard to meet, it—along with other legal barriers—has made it nearly impossible for dying incarcerated individuals to advocate for their end-of-life care.[13]

To combat this problem, programs like the California based Humane Prison Hospice Project have worked to reshape end-of-life care for incarcerated individuals through education, advocacy, and specialized training.[14] The Director of the Humane Prison Hospice Project agreed to share her experiences working within the criminal justice system, implementing these programs, and handling some of the challenges she has experienced as a result.[15] She shared the story of a 92-year-old woman, Jane Doe,[16] serving a life sentence for a non-violent crime she committed decades ago.[17] Jane is suffering from dementia; however, no official diagnosis appears in her medical records.[18] Like many dementia patients,[19] Jane reacts strongly to disruptions in her routine.[20] One day, when a peer-caregiver provided Jane with a wheelchair instead of her usual walker, she became agitated, shouting and causing a commotion.[21] Within minutes, correctional officers swarmed her, escalating her distress.[22] In response to what they perceived as disruptive behavior, the officers followed standard protocol and placed Jane in solitary confinement.[23] But Jane is not an ordinary inmate.[24] Jane is a 92-year-old woman with undiagnosed dementia, trapped in a system ill-equipped to address her medical needs.[25] Because she has not been properly diagnosed, she has not been given the proper care she so desperately needs.[26] Unfortunately, this is a reality many elderly inmates face daily.[27] The Humane Prison Hospice Project is working to address injustices that occur to elderly incarcerated individuals like Jane.[28] They have implemented peer-caregiver programs and training for those peer-caregivers and prison staff, allowing incarcerated individuals to provide care for elderly inmates with the support of prison staff.[29] While this initiative is a step in the right direction, it is only a small piece of the larger fight for systemic change and basic human rights.

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[10] *Humane Prison Hospice Project is Transforming the Way Terminally Ill People in Prison Die*, COMPASSION & CHOICES (Nov. 17, 2023), https://compassionandchoices.org/news/humane-prison-hospice-project-is-transforming-the-way-terminally-ill-people-in-prison-die/.
[11] *Id.*
[12] 429 U.S. 97, 106 (1976).
[13] Philip Genty, *Confusing Punishment with Custodial Care: The Troublesome Legacy of* Estelle v. Gamble, 21 VT. L. REV. 379, 381 (1996).
[14] HUMANE PRISON HOSPICE PROJ., https://humaneprisonhospiceproject.org/ (last visited Mar. 2, 2026).
[15] Zoom Interview with Laura Musselman, Dir. of Commc'ns, The Humane Hospice Project (Feb. 27, 2025).
[16] Due to HIPAA restrictions, Jane Doe's identity has been redacted.
[17] *Id.*
[18] *Id.*
[19] TANIS J. FERMAN ET AL., LEWY BODY DEMENTIA ASS'N, UNDERSTANDING BEHAVIORAL CHANGES IN DEMENTIA 8 (2026) (discussing how routine "[c]hanges—even small ones—can cause agitation").
[20] *Supra* note 15.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] Katie Engelhart, *I've Reported on Dementia for Years, and One Image of a Prisoner Keeps Haunting Me*, N.Y. TIMES (Aug. 11, 2023), https://www.nytimes.com/2023/08/11/opinion/dementia-prisons.html.
[28] Zoom Interview with Laura Musselman, *supra* note 15.
[29] *Id.*; HUMANE PRISON HOSPICE PROJECT, *supra* note 14.

This Article addresses the critical issue of end-of-life care in U.S. prisons, highlighting the systemic failures that leave aging and terminally ill inmates without adequate care. It begins by examining the history of the Eighth Amendment's cruel and unusual punishment clause, tracing its evolution from its original intent to its current application. This analysis includes key cases that have shaped the modern interpretation of this clause. The Article then explores the increasing need for end-of-life care in prisons, particularly as the population of individuals over the age of 55 continues to grow, and compares this trend to the aging population in the public. It then delves into the common illnesses faced by older inmates and the legal challenges associated with providing appropriate medical care, with a focus on the Eighth Amendment's requirement for adequate treatment under *Estelle v. Gamble* and the obstacles imposed by the Prison Litigation Reform Act of 1996. This Article also considers the ethical implications of providing such care, examining the moral responsibilities of both state and federal governments. Additionally, it explores key policy barriers, such as funding constraints and the financial burdens on taxpayers, families, and incarcerated individuals who must advocate for their right to proper medical treatment. Next, this Article presents a reform proposal, advocating for systemic changes that would ensure humane treatment for incarcerated individuals in need of palliative care. Finally, the Article concludes by asserting that the failure to provide adequate end-of-life care in prisons constitutes a violation of constitutional and human rights.

II. Legal Background: The History of the Eighth Amendment

The Eighth Amendment of the U.S. Constitution was ratified on December 15, 1791.[30] The original text of the Eighth Amendment reads "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."[31] Over the years, the Eighth Amendment has been criticized for its vagueness and what it means to have a punishment be "cruel and unusual."[32] Even at the time of its inception, the nature of "cruel and unusual" was not wholly defined.[33] During the debates of the First Congress, Representative Livermore complained of the Eighth Amendment's vagueness, stating

> [n]o cruel and unusual punishment is to be inflicted; it is sometimes necessary to hang a man, villains often deserve whipping, and perhaps having their ears cut off; but are we in the future to be prevented from inflicting these punishments because they are cruel? If a more lenient mode of correcting vice and deterring others from the commission of it would be invented, it would be very prudent in the Legislature to adopt it; but until we have some security that this will be done, we ought not to be restrained from making necessary laws by any declaration of this kind.[34]

At the time of its ratification, the term "cruel and unusual" was widely believed to be only in reference to torture devices and other common barbaric punishments of the time-period.[35]

While modern day critics still hold that the Eighth Amendment is vague, they have now added a new layer of argument regarding how exactly one should interpret this famous provision: either as an originalist looking at the plain meaning of the text at the time it was written or through a modern lens as it applies to today's society.[36] Over time, the Supreme Court has interpreted the Eighth Amendment's meaning through case law such as *Trop v. Dulles*, where the Supreme Court expressly stated the view that the definition of "cruel and unusual

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[30] Nicholas J. Dilley, *"Constitutional Amendments" Series – Amendment VIII – "Freedom from Excessive Bail, Fines, and Cruel Punishments."*, THE REGAN LIBR. EDUC. BLOG (Aug. 22, 2022), https://reagan.blogs.archives.gov/2022/08/22/constitutional-amendments-series-amendment-viii-freedom-from-excessive-bail-fines-and-cruel-punishments/.
[31] U.S. CONST. amend. VIII.
[32] Bryan A. Stevenson & John F. Stinneford, *The Eighth Amendment: Common Interpretation*, NAT'L CONST. CENTER, https://constitutioncenter.org/the-constitution/amendments/amendment-viii/clauses/103 (last visited Mar. 2, 2026).
[33] *Id.*
[34] 1 ANNALS OF CONG. 754 (1789).
[35] Stevenson & Stinneford, *supra* note 32.
[36] *Id.*

punishments" will change over time, taking into consideration those punishments which offend society's "evolving standards of decency."[37] The Supreme Court also sought to define "cruel and unusual" in *Weems v. United States* and *Estelle v. Gamble,* applying the "evolving sense of decency" standard.[38]

In *Weems v. United States,* the Court held that excessive punishments disproportionate to the offense could also be "cruel and unusual."[39] In *Weems*, a prisoner convicted for falsifying a public document while serving as a disbursement officer in the Philippines was sentenced to 15 years of imprisonment, a hefty fine, lifelong surveillance, and disqualification of certain rights including holding office, voting, receiving honors, and collecting retirement pay.[40] The prisoner argued that his sentence constituted cruel and unusual punishment under the Philippine Bill of Rights.[41] Given that the prohibition on cruel and unusual punishment in the Philippine Bill of Rights was derived from the Eighth Amendment of the U.S. Constitution, the Court applied the same interpretive framework.[42] Ultimately, the Court determined that the punishment was disproportionate to the offense and therefore violated the Eighth Amendment's prohibition against cruel and unusual punishment.[43] As such, *Weems v. United States* became a landmark case that sets the parameters of allowable punishment under the Eighth Amendment, specifically holding that punishment must be proportionate to the crime committed to not run afoul of the amendment's cruel and unusual punishment clause.[44]

In *Estelle v. Gamble*, the Supreme Court established that the Eighth Amendment's prohibition against cruel and unusual punishment extends to the medical treatment of incarcerated individuals. Specifically, the Court held in *Estelle* that deliberate indifference to serious medical needs constitutes the unnecessary and wanton infliction of pain.[45] On November 9, 1973, the respondent inmate was injured when a bale of cotton fell on him while unloading a truck.[46] Over the following months, he reported severe pain and was diagnosed with lower back strain by a prison doctor.[47] In January of 1974, after refusing to work due to his pain, he was threatened with being sent to the "farm" and later was placed in solitary confinement by the prison disciplinary committee.[48] On February 4, after experiencing chest pain and "blank outs," he requested medical attention but was not examined until later that evening, when a medical assistant ordered his hospitalization.[49] A week later, on February 11, the inmate filed his § 1983 complaint.[50] In making its decision, the Court analyzed the history of the Eighth Amendment's prohibition against cruel and unusual punishment and recognized that, while it was originally intended to prevent barbaric practices, its scope has expanded over time.[51] Applying the principle that punishments must align with society's evolving standards of decency, the Court concluded that deliberate indifference to an inmate's serious medical needs constitutes the unnecessary and wanton infliction of pain prohibited by the Eighth Amendment.[52]

Estelle built upon the evolving standards of decency outlined in *Trop v. Dulles*[53] and the principle against wanton infliction of pain from *Gregg v. Georgia,*[54] reinforcing the government's constitutional obligation to

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[37] Trop v. Dulles, 356 U.S. 86, 101 (1958); *see* Doug Linder, *Cruel and Unusual Punishments*, EXPLORING CONST. LAW, http://law2.umkc.edu/faculty/projects/ftrials/conlaw/cruelunusual.html (last updated 2025).
[38] Stevenson & Stinneford*, supra* note 32.
[39] 217 U.S. 349, 368 (1910).
[40] *Id.* at 358.
[41] *Id.*
[42] *Id.* at 352, 367.
[43] *Id.* at 382.
[44] *Id.* at 388.
[45] Estelle v. Gamble, 429 U.S. 97, 106 (1976).
[46] *Id.* at 99.
[47] *Id.*
[48] *Id.* at 100–01.
[49] *Id.* at 101.
[50] *Id.* A claim brought under 42 U.S.C. § 1983 provides a civil cause of action against any individual acting under color of state law who deprives another of rights, privileges, or immunities secured by the Constitution or federal law.
[51] *Id.* at 103–04.
[52] *Id.*
[53] 356 U.S. 86 (1958) (holding that stripping someone of U.S. citizenship as a punishment for desertion was "cruel and unusual punishment" because the punishment was out of proportion to the crime).
[54] 428 U.S. 153 (1976) (holding that a punishment of death did not violate the Eighth and Fourteenth Amendments under all circumstances).

provide adequate medical care to prisoners.[55] The Court's ruling in *Estelle* broadened the scope of the Eighth Amendment, but in doing so found that only inadequate medical treatment resulting from deliberate indifference, rather than mere negligence, violates a prisoner's constitutional rights.[56] Thus, *Estelle* has become the legal framework for incarcerated individuals to rely on when the prison system fails to provide adequate healthcare.

III. The Growing Need for End-of-Life Care in Prison, Legal Barriers, and Ethical Considerations

The aging population in prisons has increased significantly over the past decade due to punitive criminal justice policies and the accelerated aging phenomena of inmates.[57] It is widely believed that the term "elderly," as applied in the prison context to incarcerated individuals, begins with individuals ages 50 to 55, due to accelerated aging.[58] This aging population suffers from multiple chronic conditions and generally has high rates of associated symptoms of distress.[59] Several factors contribute to worse health outcomes among incarcerated individuals such as delayed diagnosis of advanced diseases, limited health literacy, restricted access to online resources, exclusion from clinical trials, inadequate hospice care, and minimal opportunities for compassionate release.[60] Terminally-ill individuals face heavy restrictions to pain and symptom control medications and a lack of communication between healthcare providers.[61] Furthermore, incarcerated individuals often suffer from serious health conditions such as cancer, Alzheimer's disease, and dementia, as well as a high prevalence of infectious diseases including hepatitis and HIV/AIDS.[62] Notably, COVID-19 has continued to pose a significant health risk to the aging incarcerated population, as its effects have disproportionately impacted them even beyond the peak of the pandemic.[63]

A. Common Terminal Illnesses in Prisons

Cancer has been identified as the leading cause of death in the U.S. prison population.[64] For example, incarcerated individuals experience higher rates of lung and liver cancer and have shorter survival times when compared with similar groups of non-incarcerated individuals.[65] Cancer-related pain is a significant issue, with many inmates reporting inadequate pain management in prison settings.[66]

Mortality data from state prisons indicate that cancer is responsible for 30% of illness-related deaths, making it the leading cause of death among incarcerated individuals.[67] Among male state prisoners, the mortality rate from cancer was twice as high.[68] Similarly, federal prison statistics show that cancer and other illnesses are the primary causes of death.[69] Lawsuits and accounts from patients show that delays and inadequate cancer treatment for incarcerated individuals are common due to the significant disparities in healthcare access available

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[55] *See Estelle*, 429 U.S. at 106.
[56] *Id.*
[57] Stephens et al.*, supra* note 9.
[58] *Id.*
[59] *Id.*
[60] Chris McParland et al., *Caring for People in Prison with Palliative and End-of-Life Care Needs*, 17 CURRENT OP. SUPPORTIVE & PALLIATIVE CARE 224, 225 (2023).
[61] *Id.*
[62] *See* Stephens et al.*, supra* note 9.
[63] McParland et al., *supra* note 60, at 227.
[64] *Id.* at 225. Comparatively, in the general population, the top categories of diagnosis for hospice care beneficiaries under Medicaid are Alzheimer's and Cancer. NAT'L ALL. FOR CARE AT HOME, NHPCO FACTS AND FIGURES 11 (2024), https://allianceforcareathome.org/wp-content/uploads/2024/09/Facts-Figures-2024_FINAL.pdf.
[65] Stephens et al.*, supra* note 9.
[66] *Id.*
[67] Oluwadamilola T. Oladeru, *The Impact of Incarceration on Cancer Outcomes,* UNIV. FLA. COLL. MED., https://radonc.med.ufl.edu/researchlabs/current-radiation-oncology-research-at-uf/the-impact-of-incarceration-on-cancer-outcomes/ (last visited Mar. 2, 2026).
[68] *Id.*
[69] *Id.*

in U.S. prisons.[70] Without meaningful judicial reform, incarceration will continue to be a key social determinant contributing to cancer disparities.

In 2018, the American Society of Clinical Oncology ("ASCO") published an article emphasizing the rising cancer rates among incarcerated populations and the widening healthcare gap in correctional facilities.[71] According to ASCO, the disparities are further exacerbated by the lack of comprehensive data on cancer-related factors such as screening rates, treatment compliance, and overall health outcomes.[72] While advancements in oncology, including precision medicine and machine learning, are transforming cancer care, incarcerated individuals remain largely overlooked and face heightened cancer risks in remote locations with limited access to specialized treatment centers.[73]

Many aging prisoners are also heavily at risk of developing dementia.[74] Approximately 6.2 million Americans aged 65 or older have been diagnosed with some form of dementia, although this number is expected to increase to 13.8 million by 2060.[75] As the number of dementia diagnoses increases nationwide, it can be presumed that the prison population affected by dementia is also increasing. Although comprehensive data on the prevalence of Alzheimer's disease and related dementias among incarcerated individuals is limited, one report estimates that between 70,341 and 211,020 older adults in prison will be affected by some form of Alzheimer's disease or related dementias by 2030.[76] Additionally, approximately 20% of incarcerated individuals over the age of 50 are believed to be experiencing some form of cognitive decline related to their incarceration.[77]

The dementia crisis in prisons is a vastly underreported issue with no ongoing national study being done to estimate the current rate of dementia among the U.S. prison population.[78] However, one study arising from the United Kingdom found that roughly 8% of the English and Welsh aging prison population suffered from some cognitive impairment, including different forms of dementia.[79] While no comparable studies have been conducted in the United States, numerous stories which highlight incarcerated individuals' experiences with cognitive decline in the U.S. prison system exist.[80] One example of a striking story reported by the *New York Times* recounts the tale of an inmate at the Federal Medical Center Devens—a federal prison in Massachusetts—who believed he was the warden of the institution.[81] A senior officer at that same institution estimates that 90% of the men he currently oversees at the center do not know why they are there or what crime they committed to put them there.[82]

Due to the many reported experiences and other incidents focusing on incarcerated individuals living with dementia, the American Bar Association adopted a resolution specifically calling for government agencies to address these issues.[83] The American Bar Association urges all levels of government to implement laws, policies, and practices that address the complex needs of individuals in the criminal justice system who are living with dementia; to provide training for legal and law enforcement professionals on recognizing and understanding the effects of dementia; to establish partnerships between the criminal justice system and healthcare providers to create appropriate care settings for individuals with dementia who have a history of violence; and to prioritize diversion to community resources over commitment for restoration of capacity when a defendant with dementia

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[70] *Id.*
[71] Ronald Piana, *Cancer Care in the U.S. Prison System*, THE ASCO POST (Nov. 10, 2018), https://www.ascopost.com/issues/november-10-2018/cancer-care-in-the-us-prison-system.
[72] *Id.*
[73] *Id.*
[74] Rima Nathan, *Why Am I Here: Redefining Compassionate Release to Address the Dementia Crisis in Prisons*, 16 J. AGING L. & POL'Y 4, 4 (2025).
[75] ALZHEIMER'S ASS'N, 2024 ALZHEIMER'S DISEASE FACTS AND FIGURES 32–33 (2024).
[76] Erin Kitt-Lewis & Susan J. Loeb, *Emerging Need for Dementia Care in Prisons: Opportunities for Gerontological Nurses*, 48 J. GERONTOLOGICAL NURSING 3, 3 (2022).
[77] *Id.*
[78] Tina Maschi et al., *Forget Me Not: Dementia in Prison*, 52 THE GERONTOLOGIST 441, 442 (2011).
[79] Katrina Forsyth et al., *Dementia and Mild Cognitive Impairment in Prisoners Aged Over 50 Years in England and Wales: A Mixed-Methods Study*, 8 HEALTH SERV. & DELIVERY RSCH., June 2020, at 1, 14.
[80] Engelhart*, supra* note 27.
[81] *Id.*
[82] *Id.*
[83] *ABA House Adopts Host of New Policies, Including Support for Ethics Code for U.S. Supreme Court*, A.B.A. (Feb. 6, 2023), https://www.americanbar.org/news/abanews/aba-news-archives/2023/02/midyear-house-actions-recap/.

is deemed permanently incompetent to stand trial.[84] Under the current administration, no laws have been implemented to facilitate this training.

Another major health impact on the U.S. prison system's aging population was prevalent during the COVID-19 pandemic. Even though vaccinations and different treatments now exist for COVID-19, the pandemic's impact is still very noticeable in the prison system.[85] At the height of the pandemic, incarcerated individuals experienced what felt like an additional layer of imprisonment.[86] Confined to shared cells for most of the day with little access to activities or social connections, prisoners' well-being declined and a distrust of the prison system deepened.[87] Even now there is limited research on the extent of COVID-19's impact on end-of-life care in prisons, despite incarcerated individuals being at an elevated risk of mortality.[88] Although what occurred during the height of the COVID-19 pandemic may not seem as relevant to the current need for end-of-life care, the policies and procedures—or lack thereof—brought to light how ill-equipped U.S. prisons are to care for elderly inmates.[89] It also highlighted the necessity of proactive care planning, goal setting, and facilitating a certain level of care for elderly inmates, especially those in the final stages of life.[90]

B. Legal Barriers

The lack of research on how cancer, Alzheimer's, dementia, and even COVID-19 have impacted the prison population is alarming. Equally concerning is the absence of case law addressing end-of-life issues for incarcerated individuals, particularly under *Estelle v. Gamble*. The reason for this gap is straightforward: prisoners facing terminal illness often lack the time, resources, or legal advocates necessary to bring their claims forward. Even if they could, *Estelle v. Gamble* sets a high bar for proving inadequate medical care, and its application remains narrowly limited.[91] Further compounding these challenges is the Prison Litigation Reform Act of 1995, which imposes additional legal hurdles for incarcerated individuals seeking relief.[92]

Unfortunately*, Estelle v. Gamble* establishes an unreasonably high bar for incarcerated individuals seeking relief under the Eighth Amendment.[93] Nonetheless, courts applying *Estelle* have generally recognized a prisoner's constitutional right to healthcare in three key areas.[94] Courts following *Estelle* typically hold that deliberate indifference can be demonstrated through (1) the denial of or an undue delay in access to medical care; (2) an inadequate opportunity to receive a professional medical evaluation; or (3) the failure to provide prescribed treatments.[95]

The Court in *Estelle* explicitly stated that the Eighth Amendment requires incarcerated individuals' medical treatment, living conditions, and overall standards of care to be assessed against "idealistic concepts of dignity, civilized standards, humanity, and decency."[96] However, "[t]he *Estelle* opinion suffers from a fundamental inconsistency in its reasoning."[97] To bring the denial of medical care within the Eighth Amendment's prohibition against cruel and unusual punishment, the Court relied on an impact-based standard that likened the

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[84] HOUSE OF DELEGATES, AM. BAR ASS'N, RESOLUTION NO. 600 (2023).
[85] McParland et al., *supra* note 60, at 226.
[86] *Id.*
[87] *Id.*
[88] *Id.*
[89] Joyce Frieden, *Overcrowding, Lack of Healthcare Access Help Increase COVID Mortality in Prisons*, MEDPAGE TODAY (Nov. 23, 2022) https://www.medpagetoday.com/infectiousdisease/covid19/101920.
[90] McParland et al., *supra* note 60, at 227.
[91] Genty, *supra* note 13, at 371.
[92] Prison Litigation Reform Act of 1995, Pub. L. No. 104–134, 110 Stat. 1321; *see* Andrea Fenster & Margo Schlanger*, Slamming the Courthouse Door: 25 Years of Evidence for Repealing the Prison Litigation Reform Act*, PRISON POL'Y INITIATIVE (Apr. 26, 2025), https://www.prisonpolicy.org/reports/PLRA_25.html.
[93] Genty, *supra* note 13, at 371.
[94] *See* Estelle v. Gamble, 429 U.S. 97, 97 (1976).
[95] *Id.* at 104–05.
[96] *Id.* (quoting Jackson v. Bishop, 404 F.2d 571, 579 (8th Cir. 1968)).
[97] Genty, *supra* note 13, at 397–98.

absence of medical care to torture or lingering death—a concept firmly established in precedent.[98] The Court recognized that for a prisoner, being denied medical care feels like torture or a slow, painful demise.[99] However, rather than maintaining this impact-based approach, the Court ultimately resolved the case using an intent-based standard: requiring proof of deliberate indifference to serious medical needs.[100] This shift weakened the ability of incarcerated individuals to successfully challenge inadequate healthcare, as it placed the burden on them to prove not just harm but also the intent behind it.[101]

Thirty years ago, President Bill Clinton enacted the Prison Litigation Reform Act ("PLRA"), a law that significantly restricts the ability of incarcerated individuals to file and succeed in federal civil rights lawsuits.[102] For over two decades, this legislation has imposed barriers at every stage of the legal process, creating an unequal standard for those behind bars.[103] It mandates the dismissal of civil rights cases over minor procedural issues before the courts even consider their merits; requires incarcerated individuals to pay filing fees that low-income individuals outside of prison are not subject to; limits access to legal representation by severely capping attorney fees; makes settlements more difficult to reach; and reduces the authority of courts to mandate reforms in prison and jail policies.[104] Under the PLRA, incarcerated individuals must exhaust all administrative remedies first, meaning they have to go through the correctional facility's internal grievance policies which can be convoluted and take many years.[105] The PLRA's cap on attorney's fees and increased filing fees deters many private attorneys from taking cases unless they are taking it pro-bono.[106] In addition to the process being more difficult to navigate for aging individuals, the combination of their normal age limitations and their length of incarceration, education level, support system, and health status can account for additional layers of difficulty when bringing PLRA claims.

C. Ethical Considerations

The lack of adequate caregiving and the exhaustive administrative appeals process in prisons adds an extra layer of punishment to already harsh sentences. Many individuals serving life sentences are there due to nonviolent offenses, largely driven by the War on Drugs and "tough on crime" policies.[107] It is estimated that close to 4,000 people in federal prisons are serving life sentences for non-violent drug offenses.[108] Despite legal protections that theoretically guarantee adequate healthcare set forth in cases like *Estelle v. Gamble*,[109] aging incarcerated individuals or individuals in need of end-of-life care often lack a fair opportunity to advocate for their medical needs because of restrictive laws such as the PLRA.[110] The rigid structure of government bureaucracy, combined with the physical and cognitive toll of terminal illnesses and age, makes it nearly impossible for these individuals to access proper care or advocate for their rights.

One of the most pressing ethical concerns is the growing population of incarcerated individuals with dementia. Prisons are rapidly becoming—if they are not already—home to elderly inmates who no longer understand why they are there.[111] Dementia introduces unique challenges in a prison setting, where confinement and rigid routines exacerbate behavioral issues and any disruption to a person's routine can cause a visceral reaction.[112] A real-life example of this dilemma is the incarcerated woman discussed at the beginning of this

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[98] *Id.*
[99] *Id.* at 397.
[100] *Id.*
[101] *Id*. at 393–94.
[102] Prison Litigation Reform Act of 1995, Pub. L. No. 104–134, 110 Stat. 1321 (1996); Fenster & Schlanger, *supra* note 92.
[103] Fenster & Schlanger, *supra* note 92.
[104] *Id.*
[105] *Know Your Rights: The Prison Litigation Reform Act*, AM. C.L. UNION, https://www.aclu.org/sites/default/files/images/asset_upload_file79_25805.pdf (last visited Feb. 22, 2026).
[106] Fenster & Schlanger, *supra* note 92.
[107] NELLIS, *supra* note 6, at 20.
[108] *Id.* at 24.
[109] 429 U.S. 97, 106 (1976).
[110] Fenster & Schlanger, *supra* note 92.
[111] Zoom Interview with Laura Musselman, *supra* note 15; Engelhart, *supra* note 27.
[112] Lay Kodama et al., *Prioritizing Diversion and Decarceration of People with Dementia*, 25 AMA J. ETHICS 783, 784 (2023).

Article.[113] The disruption of her routine led her to exhibit behaviors commonly seen in individuals with dementia, causing her to be perceived as a threat to other inmates and resulting in her being unfairly punished.[114] The prison system is fundamentally unprepared to provide the level of care that is necessary for individuals experiencing severe cognitive decline.[115]

This crisis demands a serious examination of the Eighth Amendment's implications of imprisoning individuals who can no longer comprehend their punishment.[116] When someone is incapable of understanding why they are incarcerated, their continued confinement serves neither rehabilitative nor deterrent purposes.[117] Instead, it becomes an exercise in cruelty, stripping away any justification for their continued imprisonment beyond mere retribution.[118] As the prison elderly population continues to grow, this issue will only become more urgent, giving rise to the need for legal and policy reforms to address the ethical and constitutional concerns at stake.[119]

IV. Funding Policies and Barriers

Now, examining the fiscal constraints that correctional institutions face, another substantial problem emerges: the structural inaccessibility of necessary healthcare, especially long-term care. Correctional systems face significant financial barriers to providing adequate healthcare, particularly end-of-life care, due to structural limitations such as the Medicaid "inmate exclusion," which shifts the full cost of care to states and, in some cases, to incarcerated individuals through copayments despite their extremely low wages.[120] These constraints are compounded by the high cost of hospice and long-term care,[121] making such services difficult to implement in already underfunded prison systems. At the same time, the aging prison population has dramatically increased overall correctional healthcare spending, with elderly individuals costing two to three times more to incarcerate due to complex medical needs.[122] Despite these rising costs care often remains inadequate, while more cost-effective alternatives like compassionate release and prison hospice programs remain underutilized, highlighting both the economic inefficiency and ethical concerns of current practices.

A. Funding

Under federal law, Medicaid does not cover healthcare costs for incarcerated individuals due to the "inmate exclusion" provision of the Social Security Act, which bars states from receiving federal reimbursement for medical care provided to individuals during incarceration, with only limited exceptions such as inpatient care outside the prison lasting more than 24 hours.[123]

As a result, incarcerated individuals are often required to bear the cost of medical care through copayments or similar fees. In Florida, for example, state law mandates a $5.00 copayment for visits to a physician.[124] While this may appear minimal, such costs present a significant burden to individuals in custody, the majority of whom enter the system from impoverished backgrounds and are either unable to work while incarcerated or receive

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[113] Zoom Interview with Laura Musselman, *supra* note 15.
[114] *Id.*
[115] Kodama et al., *supra* note 112, at 786; Meg Anderson, *The U.S. Prison Population is Rapidly Graying. Prisons Aren't Built for What's Coming*, NPR (Mar. 11, 2024, 5:12 AM EDT), https://www.npr.org/2024/03/11/1234655082/prison-elderly-aging-geriatric-population-care.
[116] Kodama et al., *supra* note 112.
[117] FELLNER, *supra* note 2, at 92–94.
[118] *Id.* at 91.
[119] Kodama et al., *supra* note 112.
[120] 42 U.S.C. § 1396d(a)(30)(A).
[121] NAT'L ALL. FOR CARE AT HOME, *supra* note 64, at 1.
[122] *Understanding the Cost of Hospice Care,* BREEZE HOSPICE OF MO. (Feb. 25, 2025), https://www.breezehospiceservices.com/resources/understanding-the-costs-of-hospice-care.
[123] 42 U.S.C. § 1396d(a)(30)(A).
[124] FLA. STAT. § 945.6037 (2026).

severely inadequate wages.[125] Those employed in correctional facilities often earn between $0.14 and $0.63 per hour, while Florida does not offer any wages to its inmates working regular prison jobs.[126] For individuals with such limited financial resources, the cumulative effect of medical copays can lead to delays in care or outright denial of medical services.[127]

These economic barriers are only magnified when considering more resource-intensive care, such as hospice care. Hospice care—which includes pain management, emotional support, spiritual guidance, and palliative interventions—is substantially more expensive than routine care.[128] The National Hospice and Palliative Care Organization estimates the cost of hospice services in the United States to average between $150 and $200 per day, or $10,000 to $20,000 per month.[129] These costs, when viewed against the backdrop of prison healthcare systems that are already underfunded and often operate under crisis conditions, emphasize the structural difficulty of implementing consistent and adequate end-of-life care within prisons.

While institutional hospice care in prisons remains rare, several reform efforts have emerged. Notably, as previously discussed in this Article, The Humane Prison Hospice Project advocates for peer-led, prison-based hospice programs and provides training to incarcerated individuals to care for fellow prisoners nearing the end of life.[130] Such programs offer a more humane and cost-effective solution to the care gap and demonstrate a growing recognition of the ethical imperative to ensure dignity in death, even for those behind bars.[131]

B. Financial Burden of End-of-Life Care in Prisons

The financial costs of incarcerating elderly and terminally ill individuals have placed a mounting burden on correctional systems across the United States.[132] Older incarcerated people require more intensive and frequent medical care, including treatment for chronic and life-limiting illnesses such as cancer, heart disease, and mobility impairments.[133] These healthcare needs significantly increase the cost of incarceration compared to younger populations.[134]

State corrections departments are responsible for the entirety of incarcerated individuals' healthcare costs, as incarcerated people are excluded from federal programs like Medicaid and Medicare.[135] This leads to steep expenditures, especially in states with aging prison populations.[136] Some estimates show that annual costs for incarcerating elderly individuals are two to three times higher than for younger prisoners.[137] As a result, the nationwide total cost of prison healthcare has grown substantially, amounting to approximately $8 billion annually.[138]

Despite these growing expenses, incarcerated individuals often receive inadequate care, leading to suffering and worsening health outcomes.[139] As previously mentioned, even basic medical services in prison can

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[125] Bernadette Rabuy & Daniel Kopf, *Prisons of Poverty: Uncovering the Pre-incarceration Incomes of the Imprisoned*, PRISON POL'Y INITIATIVE (July 9, 2015), https://www.prisonpolicy.org/reports/income.html.
[126] Wendy Sawyer, *How Much Do Incarcerated People Earn in Each State?*, PRISON POL'Y INITIATIVE (Apr. 10, 2017), https://www.prisonpolicy.org/blog/2017/04/10/wages/.
[127] Emily Widra, *New Research Links Medical Copays to Reduced Healthcare Access in Prisons*, PRISON POL'Y INITIATIVE (Aug. 9, 2024), https://www.prisonpolicy.org/blog/2024/08/29/fees-limit-healthcare-access/.
[128] NAT'L ALL. FOR CARE AT HOME, *supra* note 64, at 1.
[129] *Understanding the Cost of Hospice Care*, *supra* note 122.
[130] Zoom Interview with Laura Musselman, *supra* note 15; HUMANE PRISON HOSPICE PROJ., *supra* note 14.
[131] Zoom Interview with Laura Musselman, *supra* note 15.
[132] Matt Mckillop, *Prison Health Care Spending Varies Dramatically by State*, PEW (Dec. 15, 2017), https://www.pewtrusts.org/en/research-and-analysis/articles/2017/12/15/prison-health-care-spending-varies-dramatically-by-state.
[133] *Id.*
[134] AM. C.L. UNION, AT AMERICA'S EXPENSE: THE MASS INCARCERATION OF THE ELDERLY 27–28 (2012).
[135] CHAD KINSELLA, THE COUNCIL OF STATE GOV'TS, CORRECTIONS HEALTH CARE COSTS 6 (2004).
[136] *Id.* at 14.
[137] AM. C.L. UNION, *supra* note 134, at 28.
[138] *Prison Health Care: Costs and Quality*, PEW (Oct. 18, 2017), https://www.pew.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.
[139] Cecille Joan Avila, *Prison Health Care is Only Available if You Can Afford It*, PRISM REPS. (Oct. 31, 2022), https://prismreports.org/2022/10/31/prison-health-care-hidden-costs/.

come with a financial burden for incarcerated people themselves due to their wages. This practice can discourage prisoners from seeking timely medical attention and contributes to the accumulation of medical debt.[140] Some families are forced to take on the burden of paying for outside care, medications, or other support, adding to the economic strain incarceration places on low-income communities.[141]

Further, since the 1980s, corrections expenditures as a percentage of overall state budgets have surged, often at the expense of other essential services like public education and infrastructure. Over the past 25 years, 14 states have doubled their corrections spending, while 30 states have increased their budgets by at least 50%.[142] From 1988 to 2008, total state spending on corrections rose dramatically from $11 billion to $52 billion, and when factoring in federal expenditures the total climbed to $68 billion.[143] However, a recent report by the Vera Institute of Justice reveals that the real cost of incarceration extends beyond these allocated corrections budgets.[144] In states such as New York, significant portions of the costs—such as prison employees' health insurance, pensions, and hospital care for prisoners—are drawn from other areas of the state budget. According to the Vera Institute, the total taxpayer cost of incarceration is 14% higher than what is reflected in corrections budgets alone, bringing the true cost to approximately $77 billion annually.[145] Furthermore, a Pew Center study estimates that 90% of correctional spending is dedicated to incarceration, as opposed to alternatives like probation or parole.[146] This adds up to an average annual cost of $34,135 per prisoner.[147]

Meanwhile, evidence shows that elderly people in prison pose minimal risk to public safety, yet they cost dramatically more to incarcerate.[148] The financial burden is greater for aging prisoners, whose costs can be more than double that of younger inmates.[149] According to a 2004 study by the National Institute of Corrections ("NIC"), taxpayers pay twice as much to incarcerate aging prisoners as they do for younger ones.[150] The total annual cost for an aging prisoner can vary, with estimates ranging from $34,135 to three times that amount depending on their medical and staff needs, highlighting the growing strain on state budgets due to aging inmates.[151] The American Civil Liberties Union has projected that releasing low-risk elderly individuals could save states billions of dollars, with little to no impact on public safety.[152]

Despite this group representing a relatively low-risk portion of the prison population, aging prisoners aged 50 and older cost taxpayers a staggering $16 billion annually.[153] This figure exceeds the federal Department of Energy's budget and surpasses federal funding for state elementary and secondary school improvements.[154] The primary driver of these high costs is the increased need for staffing and healthcare.[155] Aging prisoners require more assistance with daily activities, often have limited mobility, and are at a greater risk of mental or physical abuse from younger inmates.[156] As mentioned, healthcare for elderly prisoners is significantly more expensive, with many states estimating that it costs two to three times more than that for younger prisoners.[157] In some states,

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[140] *Id.*
[141] *Id.*
[142] MICHAEL LACHMAN ET AL., CTR. BUDGET & POL'Y PRIORITIES, IMPROVING BUDGET ANALYSIS OF STATE CRIMINAL JUSTICE REFORMS: A STRATEGY FOR BETTER OUTCOMES AND SAVING MONEY 4 (2012).
[143] JENIFER WARREN, PEW CTR. STATES, ONE IN 31: THE LONG REACH OF AMERICAN CORRECTIONS 11 (2009).
[144] CHRISTIAN HENRICHSON & RUTH DELANEY, CTR. SENT'G & CORRS., THE PRICE OF PRISONS: WHAT INCARCERATION COSTS TAXPAYERS 4 (2012).
[145] *Id.* at 6.
[146] WARREN, *supra* note 143, at 1.
[147] AM. C.L. UNION, *supra* note 134, at 27.
[148] *Elderly People in Prison Present Little Risk, but Staggering Costs*, VERA INST. OF JUST. (Jul. 6, 2015), https://www.vera.org/news/elderly-people-in-prison-present-little-risk-but-staggering-costs.
[149] *Id.*
[150] AM. C.L. UNION, *supra* note 134, at 27.
[151] *Id.*
[152] *Releasing Low-Risk Elderly Prisoners Would Save Billions of Dollars While Protecting Public Safety, ACLU Report Finds*, AM. C.L. UNION (June 13, 2012, 10:02 AM EDT), https://www.aclu.org/press-releases/releasing-low-risk-elderly-prisoners-would-save-billions-dollars-while-protecting.
[153] AM. C.L. UNION, *supra* note 134, at 28.
[154] *Id.*
[155] *Id.*
[156] *Id.*
[157] *Id.*

like North Carolina, the cost can be as much as four times higher.[158] While aging prisoners make up only a small percentage of the prison population, they account for a disproportionate share of medical expenses, with some states allocating nearly a third of their correctional healthcare budgets to meet their needs.[159] The high costs are not due to aging prisoners receiving superior healthcare but rather stem from the inadequate prison environment for the elderly.[160] Prisons were designed for younger inmates and lack the facilities and trained staff necessary to address age-related health issues such as cancer, arthritis, hypertension, or dementia.[161] Moreover, due to the lack of appropriate care on-site, prisons often need to send aging prisoners off-site for medical treatment, incurring additional costs for transportation, specialized care, and the officers required to accompany them.[162] The expense of caring for elderly prisoners is further exacerbated by the need for specialized accommodations such as providing medical diets, adapted prison cells, and additional staff to assist with daily care.[163] Overall, the cost of incarcerating aging prisoners highlights the immense financial burden on the corrections system, with healthcare and staffing being the largest contributors to state correctional budgets.[164]

States that continue to rely on incarceration for aging populations bear the dual costs of correctional security and complex medical care, while missing opportunities for fiscally and ethically sound alternatives.[165] Compassionate release programs and medical parole, where available, remain underutilized.[166] The failure to implement these alternatives at scale results in unnecessary expenditures on prisoners who could receive better and more cost-effective care in community settings.[167]

V. Reform Proposal

Meaningful reform is necessary to address the constitutional, ethical, and fiscal failings of the current end-of-life care system in American prisons. This proposal features a multifaceted solution: (1) the establishment of a national framework for improved compassionate release or medical parole programs to eliminate the cost burden of inadequate healthcare followed by structured community reintegration supported by Medicaid, (2) mandatory integration of proper hospice and geriatric care into all correctional healthcare systems, and (3) lower legal barriers to healthcare justice for incarcerated individuals, including legislative incentives for states to comply with constitutional standards as affirmed in *Estelle v. Gamble*.

First, Congress should enact legislation that standardizes compassionate release procedures across federal and state levels. Although a provision of the Sentencing Reform Act of 1984 permits sentence reductions for "extraordinary and compelling" circumstances such as terminal illness,[168] the current system is impeded by arbitrary judicial discretion and fragmented application.

According to Families Against Mandatory Minimums ("FAMM"), nearly 60% of compassionate release applications are denied for procedural reasons, highlighting the need for a national standard.[169] FAMM proposes that the standard should require medical expert testimony, contain defined criteria (such as having a life expectancy of six months or less), and establish firm deadlines for judicial rulings.[170] Furthermore, California's recent halt of its medical parole program—caused by cost concerns, limited contractor capacity, and a shift toward

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[158] *Id.*
[159] *Id.*
[160] *Id.*
[161] *Id.*
[162] *Id.* at 29.
[163] *Id.*
[164] *Id.*
[165] Mckillop, *supra* note 132.
[166] MARY PRICE, FAMS. AGAINST MANDATORY MINIMUMS, EVERYWHERE AND NOWHERE: COMPASSIONATE RELEASE IN THE STATES 13 (2018).
[167] AM. C.L. UNION, *supra* note 134, at 37.
[168] 18 U.S.C. § 3582(c)(1)(A).
[169] PRICE, *supra* note 166, at 19.
[170] *Id.* at 21.

caring for critically ill prisoners inside prisons—also proves the urgent need for a humane, unified approach.[171] Without federal Medicaid reimbursement, states face financial disincentives to release dying prisoners, compounding the systemic neglect of aging and terminally-ill incarcerated individuals.[172] Finally, ensuring a seamless transition from incarceration to community-based care is crucial.[173] Inmates released under compassionate release often encounter significant challenges in accessing healthcare due to delays in Medicaid reinstatement or housing shortages.[174]

To mitigate these issues, the Centers for Medicare & Medicaid Services have introduced the 1115 Reentry Demonstration Opportunity, which allows states to provide Medicaid coverage up to 30 days before release, ensuring that these individuals experience no gap in their care.[175] Congress should promote widespread state adoption of such initiatives through increased funding and by mandating robust transitional care coordination between correctional facilities and community health providers.

Second, correctional institutions should establish national programs like the Humane Prison Hospice Project has implemented in California. This program not only provides compassionate end-of-life care but also offers inmates the opportunity to engage in meaningful work that fosters empathy, responsibility, and personal growth.[176] By allowing incarcerated individuals to care for their terminally-ill peers, the project helps to humanize the prison experience and demonstrates the potential for rehabilitation.[177] Additionally, it has been shown to improve the quality of care for terminally-ill prisoners, ensuring they receive the dignity and respect they deserve during their final days.[178]

Other initiatives, such as medical parole programs implemented across several states, offer partial solutions to the constitutional crisis posed by inadequate end-of-life care in prisons.[179] However, according to the National Conference of State Legislatures, these programs are rarely utilized.[180] In response to the aging prison population, some states have invested in rebuilding their facilities to better accommodate elderly individuals with serious medical conditions.[181] For instance, California established two memory care units specifically for incarcerated men and developed a separate facility for women that provides up to 24-hour skilled nursing care for those with life-limiting illnesses, including dementia.[182]

Despite these efforts, many advocates continue to push for broader compassionate release programs, arguing that they better honor the principle of allowing elderly individuals to "die with dignity."[183] Mark Leno, the former democratic state senator who authored California's medical parole law, sharply criticized prison officials for discontinuing the use of the statute without legislative approval.[184] He further denounced the return of critically ill individuals to prison facilities, calling the practice "perfectly inhumane."[185] Leno questioned the underlying motivations behind the policy change, asking if it was merely an act of "cruel punishment and retribution or [a] thoughtful execution of the law put in place by the legislature?"[186] Importantly, the COVID-19

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[171] Don Thompson, *California Halts Medical Parole, Sends Several Critically Ill Patients Back to Prison,* KFF HEALTH NEWS (Apr. 21, 2025), https://kffhealthnews.org/news/article/california-medical-parole-critically-ill-prisoners/.
[172] *Id.*
[173] *Id.*
[174] *Connecting Recently Released Prisoners to Health Care—How to Leverage Medicaid*, NAT'L CONF. OF STATE LEGIS. (Jan. 16, 2023), https://www.ncsl.org/civil-and-criminal-justice/connecting-recently-released-prisoners-to-health-carehow-to-leverage-medicaid.
[175] *Reentry Section 1115 Demonstration Opportunity*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.medicaid.gov/medicaid/section-1115-demonstrations/reentry-section-1115-demonstration-opportunity (last visited Feb. 22, 2026).
[176] *Humane Prison Hospice Project is Transforming the Way Terminally Ill People in Prison Die*, *supra* note 10.
[177] *Id.*
[178] *Id.*
[179] Thompson, *supra* note 171.
[180] *Id.*
[181] *Id.*
[182] *Id.*
[183] *Id.*
[184] *Id.*
[185] *Id.*
[186] *Id.*

pandemic highlighted the vulnerability of incarcerated populations to public health crises, particularly among elderly and medically fragile individuals.[187]

With public health experts agreeing that the next pandemic is a matter of "when," not "if," correctional systems must proactively develop humane and legally sound responses, including the expansion of medical parole and compassionate release programs.[188] Ultimately, while no singular solution exists to address the complex healthcare needs of elderly inmates, national expansion of these programs could not only improve prison conditions but also serve as a model for integrating restorative justice principles into correctional practices, ensuring that the physical, emotional, and dignified care needs of aging incarcerated individuals are met in times of crisis and beyond.

Lastly, legislative reform must align with constitutional mandates and provide practical incentives for implementation. In *Estelle v. Gamble*, the Supreme Court made clear that deliberate indifference to serious medical needs constitutes cruel and unusual punishment in violation of the Eighth Amendment.[189] However, given its narrowly applied standard and the additional constraints imposed by the Prison Litigation Reform Act, it presents a significant barrier to relief for an already vulnerable population.[190] To address these shortcomings, Congress and federal agencies should enforce legislative frameworks and create regulations that encourage states to develop and maintain constitutionally adequate healthcare systems within their correctional facilities. Federal models like the Justice Reinvestment Initiative have effectively used incentives to encourage criminal justice reforms, suggesting that targeted grants and conditional funding could similarly promote the adoption of humane, cost-effective end-of-life care programs.[191] States that implement robust hospice care initiatives and standardized compassionate release procedures should be rewarded, while states that fail to meet constitutionally required standards of care should be subject to heightened federal oversight, public reporting requirements, and potential penalties on the violating prison. Legislative reform must therefore not only articulate clear constitutional obligations but also embed practical, enforceable incentives that promote sustainable improvements.

VI. Conclusion

The failure of U.S. prisons to provide adequate end-of-life care reveals a systemic crisis that not only violates the Eighth Amendment but also raises profound ethical concerns about human dignity. As the incarcerated population continues to age—driven largely by harsh sentencing policies and limited rehabilitation opportunities—the urgent need for compassionate and accessible healthcare within prisons grows ever more pressing. Yet legal and financial barriers make it extraordinarily difficult for incarcerated individuals to advocate for their medical needs, amplifying the crisis. Legally, the stringent standards established by *Estelle v. Gamble*, coupled with the procedural hurdles imposed by the Prison Litigation Reform Act, create an almost insurmountable challenge for those seeking relief. Financially, states expend substantial taxpayer resources while still delivering grossly inadequate care to the most vulnerable individuals in their custody.

Although initiatives like the Humane Prison Hospice Project offer promising models, their reach remains limited without widespread legal and systemic reform. Compounding the problem, states' chronic underutilization of compassionate release and medical parole programs underscores a broader indifference to the well-being of elderly incarcerated individuals. Addressing these issues demands a fundamental transformation in both policy and public perception—one that acknowledges the inherent humanity of incarcerated individuals and affirms their right to dignified care, regardless of their status. As current practices stand, the systemic neglect of older individuals' medical needs constitutes deliberate indifference and, therefore, a violation of the Eighth Amendment's prohibition against cruel and unusual punishment. Without meaningful and sustained reform, the

[187] McParland et al., *supra* note 60, at 226; Frieden, *supra* note 89.
[188] McParland et al., *supra* note 60, at 227; Frieden, *supra* note 89.
[189] 429 U.S. 97, 104 (1976).
[190] *Id.*; Fenster & Schlanger, *supra* note 92.
[191] *The Justice Reinvestment Initiative*, BUREAU OF JUST. ASSISTANCE, https://bja.ojp.gov/program/justice-reinvestment-initiative/overview (last visited Feb. 22, 2026).

United States will continue to fail its constitutional and moral obligations by allowing incarcerated individuals to age into a system unequipped to meet their needs—condemning many to prolonged suffering and turning them into statistics of neglect as their sentences effectively extend beyond their original terms.