



## Santa Clara Law Santa Clara Law Digital Commons

Faculty Publications

Faculty Scholarship

4-14-2016

# Pay-for-Performance in Prison: Using Healthcare Economics to Improve Criminal Justice

W. David Ball

*Santa Clara University School of Law*, [wdball@gmail.com](mailto:wdball@gmail.com)

Follow this and additional works at: <http://digitalcommons.law.scu.edu/facpubs>

 Part of the [Law Commons](#)

### Automated Citation

W. David Ball, *Pay-for-Performance in Prison: Using Healthcare Economics to Improve Criminal Justice* (2016),  
Available at: <http://digitalcommons.law.scu.edu/facpubs/931>

This Article is brought to you for free and open access by the Faculty Scholarship at Santa Clara Law Digital Commons. It has been accepted for inclusion in Faculty Publications by an authorized administrator of Santa Clara Law Digital Commons. For more information, please contact [sculawlibrarian@gmail.com](mailto:sculawlibrarian@gmail.com).

# PAY-FOR-PERFORMANCE IN PRISON: USING HEALTHCARE ECONOMICS TO IMPROVE CRIMINAL JUSTICE

*W. David Ball*<sup>\*</sup>

## *Abstract*

*For much of the last seventy-plus years, healthcare providers in the United States have been paid under the fee-for-service system, where providers are reimbursed for procedures performed, not outcomes obtained. Providers, insurers, and consumers are motivated by different individual and organizational incentives; costs and burdens of patient care are shifted from one part of the system to another. The result has been a system that combines exploding costs without concomitant increases in quality. Healthcare economists and policymakers have reacted by proposing a number of policies designed to reign in costs without sacrificing quality. One approach is to focus on the ultimate goal—improving health outcomes—by measuring those outcomes and reconfiguring incentives and structures to deliver healthcare in ways that are both efficacious and efficient. One particular strategy is pay for performance, under which providers are paid to improve health by whatever medically-appropriate method they choose. This means providers are no longer paid for simply doing a given “something” but, rather, are paid for doing “something effective.”*

*In this Article, I argue that the criminal justice system is similarly fragmented, expensive, and inefficient, marked by many of the same distorted individual and organizational incentives that have plagued health care. Most significantly, in all but a handful of jurisdictions, states wholly subsidize commitments to prison—the fee-for-service model of doing “something”—without tying any of these subsidies to outcomes obtained in prison. This means prison is paid for even if it is neither effective nor efficient. These similarities with the healthcare system suggest that an outcome-oriented, pay-for-performance framework borrowed from healthcare economics might, if applied to criminal justice, improve its efficacy and efficiency. I envision this Article as the first of several applying healthcare economics to criminal justice. It will focus on the*

---

<sup>\*</sup> Author’s Note. Other possible titles: Healing Criminal Justice, A Return to the Treatment Approach in Criminal Justice, Creating Value in Prisons, A Public Health Model of Criminal Justice.

*similarities of the two systems, the ways in which an outcome orientation might provide a useful framework for controlling costs without making quality subservient, and the suggestion that we begin considering sentencing choices within that framework.*

## Contents

<b>INTRODUCTION.....</b>	<b>2</b>
<b>I. A TALE OF TWO SYSTEMS .....</b>	<b>6</b>
<b>II. THE VALUE CREATION MODEL .....</b>	<b>11</b>
<b>III. CURRENT APPROACHES IN CRIMINAL JUSTICE ECONOMICS.....</b>	<b>17</b>
<b>IV. CREATING VALUE IN CRIMINAL JUSTICE .....</b>	<b>24</b>
A. MEASUREMENT ISSUES, THEORETICAL AND PRACTICAL.....	25
B. VALUE CREATING POLICIES.....	29
C. POTENTIAL ADVANTAGES OF A VALUE ORIENTATION .....	38
<b>V. CRITICISMS OF THE APPROACH .....</b>	<b>40</b>
<b>CONCLUSION .....</b>	<b>43</b>

## INTRODUCTION

Healthcare economists have written extensively about the perverse incentives of fee-for-service reimbursement, where healthcare providers are reimbursed for each medical service rendered. Fee-for-service rewards quantity, not quality—providers get paid for doing something, not for doing something *well*. In fact, under fee-for-service, a hospital’s ineffective heart surgery--or ineffective surgical aftercare--resulting in a patient rehospitalization could be a financial gain to the hospital despite being a bad outcome for the patient. The hospital could be paid for the additional treatments its own ineffectiveness made necessary.

One proposed alternative to fee-for-service is performance-based reimbursement, where providers are reimbursed based on patient outcomes. This Article focuses on Professor Michael Porter’s particular framework, value creation, where value is measured in terms of health care outcomes per dollar spent.<sup>1</sup> Porter’s formulation has the advantage of combining efficacy and efficiency in a single measure. It measures both whether something improves health and whether it does so using the fewest

---

<sup>1</sup> Michael E. Porter and Elizabeth Olmsted Teisberg, Redefining Competition in Health Care, Harv. Bus. Rev. 1, 4 (June 2004).

resources. Health is promoted without making it subservient to cost control; value cannot be created simply by saving money if those savings result in worse health outcomes. Under a value-based system, a hospital is paid to improve or cure a particular condition, not for any procedure in particular. In the previous example, if a heart surgery were performed and the hospital subsequently had to readmit the patient, it would pay the resulting expenses itself. If the hospital's doctor performed the surgery adequately, it would break even or make a little money. But if it treated the condition effectively through other, lower-cost means besides surgery, it would keep the surplus itself.

Much of the existing economic analysis of criminal justice has focused on the economic incentives of criminals, not on the "providers" in the criminal justice system: law enforcement, prosecutors, correctional facilities, and probation and parole. Looking at the incentives of providers in the system might help to explain why the cost and scope of criminal justice have exploded, the way healthcare costs have exploded under fee-for-service reimbursement regimes. As in fee-for-service, criminal justice providers face few cost constraints on their menu of interventions. The government subsidizes particular responses, such as prison, in the name of public safety without demanding evidence that these responses work. Just as a readmitted patient under fee-for-service imposes no financial hardship on providers who failed to cure her, so, too, does a recidivist impose no financial losses on the institutions that fail to reform him. On the contrary, prison budgets tend to get bigger as prison populations increase, even when those increases are the result of ineffective (or non-existent) rehabilitation programs. Given these similarities, perhaps it is time to consider replacing our existing subsidy-for-service criminal justice approach with funding based on performance.

I intend for this Article to be both a thought experiment about how criminal justice might be funded and a potentially useful source of lessons for those interested in reforming the system. Defining health outcomes is an ongoing process that has encountered political, organizational, and theoretical obstacles. Getting constituencies to agree on measures, getting organizations to implement them, and even deciding what health means and which data are best associated with it has been long and difficult—and yet progress has been made. I do not, in any way, mean to suggest that building an outcome-based system of criminal justice centered around improving public safety will be any easier or quicker. But I also know that health outcomes were once seen as impossibly and hopelessly vague, while now they are utilized in funding health care. In this Article, I will not—and

could not—come up with precise, operational definitions of public safety that will apply to all or even most situations. At the very least, imposing a standard by fiat would fail to get the practitioner buy-in necessary to make an outcome orientation work. Nevertheless, there are lessons to be learned from the health care experience, and the framework has clear benefits.

This Article builds on work—including some of my own—about the decentralized nature of criminal justice and the concomitant cost-passing and externalities among criminal justice agencies. It suggests new ways to harmonize social welfare with the welfare of individual organizations.<sup>2</sup> The main thrust of the argument is to actually give weight to the invocation of public safety by making sure that what criminal justice agencies are doing is improving public safety in the most resource-efficient way. This means that the least-expensive alternative that gets the same public safety result should be adopted, or else those who decide to pursue other options will have to foot the bill. One can readily imagine situations that would result in policy changes—for example, elderly prisoners who have already “aged out” of crime would be more likely to be released, because keeping them in prison is both expensive and unnecessary to protect the public. What is different about the approach presented in this Article is that sensible policies would be more than just hortatory—I propose changing funding and financial incentives so that organizations must adopt programs that are both efficacious and efficient.

The approach taken here differs from my prior work in the way it treats incarceration. At the time of sentencing, prison is almost always treated as an undifferentiated mass. I propose instead that prison and other dispositions in a given system be decommodified, and that individual institutions begin to specialize in various subpopulations in order to treat people with various risks and needs. This means that a system would no longer consider that “prison” and “jail” are fungible, where all prison time is essentially the same and where sentencing is just an assignment to be “treated” generally. Instead, sentences would be tailored to individual needs, with individual treatment programs in individual institutions. This would move beyond the current conception of “tailoring” sentences, which, at most, considers only how much time in a generic prison an offender should get.

In short, and perhaps unsurprisingly, a trip through the healthcare economics literature has convinced me that it is time for a full return to the

---

<sup>2</sup> See Part III, *infra*.

medical model of sentencing, but with better science, better data, and economic incentives and budgetary feedback loops to aid in the uptake. The science is much more advanced than it was during the prior heydays of the medical treatment model in the mid-19<sup>th</sup> and -20<sup>th</sup> centuries,<sup>3</sup> and even though it is perhaps not as clearly established as, say, the science supporting the existence of global warming, the evidence about effective programs is certainly better established than claims that an X-plus-two year determinate sentence will deter someone from impersonating a police officer more than an X-year sentence will.

At the outset, there are some obvious limitations to the subsequent analysis. First, this Article takes a utilitarian point of view. I make no initial claims about whether this model helps or hinders the goals of retribution, nor am I (or even could I) attempt to make retribution subject to any kind of scientific or evidence-based analysis. The analysis simply focuses on how we would design a system around treatment as a means to improve public safety. Second, I do not assume that “nothing works” in rehabilitating criminals, a phrase often attributed to Robert Martinson, albeit one he did not write.<sup>4</sup> Having said that, I am not a criminologist and will not do any independent analysis of any of the research cited. Instead, the Article is concerned with how to improve the uptake of the most robust and promising approaches to offender treatment, whatever they may be. Just as medical techniques continue to improve, so, too, will the treatment of offenders. A system that encourages the development and dissemination of the most effective programs need not be locked into a particular theory or method. Third, this Article assumes that data is better than intuition about “what is right” or “what works”, and since people often make claims about what criminal justice is or does or how the justice-involved anticipate or react to it, I want to test these claims with the best techniques we have, even if they are not infallible. Finally, I recognize that much of this approach might be inconsistent with the idea that American criminal justice is adversarial. However, given that at least 95 percent of cases are resolved by plea bargain,<sup>5</sup> I see adversarialism as operating mostly in the breach. Criminal law as it is actually practiced is mostly about negotiation and

---

<sup>3</sup> See Part III, *infra*.

<sup>4</sup> Robert Martinson, *What works? Questions and answers about prison reform*. 35 *the Public Interest* 22 (1974). For a discussion of Martinson’s legacy and a rejoinder to the idea that “nothing works” is still the criminological state of the art, see Francis T. Cullen et. al, *Nothing Works Revisited: Deconstructing Farabee’s Rethinking Rehabilitation*, 4 *Victims and Offenders* 101, 103 (2009).

<sup>5</sup> See, e.g., Jed S. Rakoff, *Why Innocent People Plead Guilty*, N.Y. *Rev. Books* (Nov. 20, 2014) (estimating that 95 percent of state felony cases are resolved by plea, and citing statistics that 97 percent of federal cases are resolved by plea).

collaboration.

This Article proceeds in five parts. Part I outlines the similarities between the healthcare and criminal justice systems, emphasizing how each tends to promote overuse, not effective and efficient use. Part II briefly summarizes what value-based healthcare economics is and how it promises to control costs in healthcare without sacrificing health outcomes. Part III sketches out the ways in which a focus on value provides new possibilities for a law and economics analysis of criminal justice systems, while building on the policy and analytical work already being done. Part IV lays out possible new models for the funding and administration of criminal justice, building on some of my own prior work as well as that of others. Part V anticipates some criticisms of this approach and attempts to address them.

Throughout the Article I focus only on the ways in which existing treatment could be made more effective. Healthcare economics has also pointed out another valuable lesson: that prevention is much more efficient than treatment. A future article will explore the prevention model and draw heavily on work being done in criminal justice cost-benefit analysis by the Washington State Institute for Public Policy, the Justice Reinvestment Initiative, and others.<sup>6</sup> A third article will explore how both treatment and prevention initiatives might be combined to retool the juvenile justice system. The ultimate goal of this project is to outline a research agenda that might be useful for others to use as they seek to improve the administration of criminal justice. I know I do not have all the answers; I simply hope to identify some of the important questions.

#### I. A TALE OF TWO SYSTEMS

The model of medical care provision and reimbursement in the United States after World War II is notable for its complexity, perverse incentives, and uniqueness among industrialized countries. There is nothing logically or legally necessary about it. Universal healthcare was considered and rejected during the New Deal due to opposition from the American Medical Association (among other factors).<sup>7</sup> Employer-provided health insurance filled the gap, gained traction as the federal government froze private-sector wages but not private-sector benefits (including health benefits), and became solidified with favorable tax treatment after the war.<sup>8</sup>

---

<sup>6</sup> See Part III, *infra*.

<sup>7</sup> David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 N.E. J. of Medicine 1:82, 83 (July 6, 2006).

<sup>8</sup> *Id.* at 83-84.

The healthcare “system” that resulted was far from systematic in terms of who pays and who is paid. It is a complex amalgamation of government-run and private for-profit and non-profit providers, paid for by private and public health insurance (the latter starting with Medicaid and Medicare), with independent doctors, practice groups, HMO’s and PPO’s.<sup>9</sup> Different parts of the system have coordination problems across health provider and insurance networks, specialists, emergency medicine, long-term care, and the like. There has always been a need for more data—and more incentives to study that data—on what works. Doctors are not necessarily expected to get feedback about what eventually happens to their patients because those problems are often passed on to other “downstream” institutions and doctors.

Fee-for-service reimbursement was, until recently, the dominant system for reimbursing healthcare providers. Fee-for-service pays providers per procedure—whether a doctor’s visit, MRI, blood test, or other procedure—as long as it follows generally established protocols. The problem with fee-for-service is that it incentivizes additional procedures and interventions.<sup>10</sup> Providers are paid for doing something whether or not it leads to demonstrated improvements. Even as health is invoked, there is little financial pressure to improve health, since reimbursements are not made on that basis. In other words, providers aren’t paid for doing something that works, just for doing something at all—and, in fact, sometimes more interventions result in worse outcomes.<sup>11</sup> It is hard to control costs under this system: one critic described the “perverse incentives” in the U.S. healthcare system as “producing what they are designed to deliver: cost inflation, inefficiency, and inequity.”<sup>12</sup>

---

<sup>9</sup> Julie Barnes, *Moving Away from Fee-for-Service*, *The Atlantic* (May 7, 2012), available at <http://www.theatlantic.com/health/archive/2012/05/moving-away-from-fee-for-service/256755/>.

<sup>10</sup> Hendrik Schmitz, *Practice budgets and the patient mix of physicians—The effect of a remuneration system reform on health care utilization*, 32 *J. Health. Econ.* 1240 (2013) (“this literature mainly finds that doctors provide more services in fee-for-service systems....”).

<sup>11</sup> Ezekiel J. Emanuel, “Are Good Doctors Bad for Your Health?”, *New York Times*, Nov. 21, 2015, available at [http://www.nytimes.com/2015/11/22/opinion/sunday/are-good-doctors-bad-for-your-health.html?\\_r=0](http://www.nytimes.com/2015/11/22/opinion/sunday/are-good-doctors-bad-for-your-health.html?_r=0). For the systemic effects of overprescribing antibiotics, see Sarah Childress, *Dr. Arjun Srinivasan: We’ve Reached ‘the End of Antibiotics, Period.’*, Oct. 22, 2013, available at <http://www.pbs.org/wgbh/frontline/article/dr-arjun-srinivasan-weve-reached-the-end-of-antibiotics-period/>.

<sup>12</sup> Alan Maynard, “Heath Reform: Reinventing the Wheel,” Oct. 12, 2006, available at <http://healthaffairs.org/blog/2006/10/12/health-reform-reinventing-the-wheel/>.



Under the fee-for-service system, participants have incentives at odds with each other. Consumers want health care but do not bear the full cost of consuming it (even with co-payments).<sup>13</sup> Providers are paid per service, giving them no financial disincentives to do less or even to know what a procedure costs. Insurers cover the costs that result, but they have no real control over them. The result is that costs balloon. There is little investment on the front end of prevention, there is rationing of one kind or another (price or services offered), and the drive to cut costs is met with justifiable resistance by a population that views health as at least extremely important, if not a right. One of the enduring questions is which group—if any—is steering the ship, and for whose benefit. Is the ultimate consumer or decision-maker the insurer, who pays? The doctor, who treats? The person, who is healed? Society, who is made safe from communicable diseases?

It is well known that the U.S. system is exceptional (although not in a good way), and the country has recently made significant changes under the Affordable Care Act (Obamacare). But all along attempts to change the system have been met with fierce resistance by insiders who fear lost rents or lost discretion to treat patients as they see fit.<sup>14</sup> In many instances, the very idea that medical care could be subject to cost effectiveness analysis by outsiders was rejected. Only doctors knew what was medically necessary, and they had to be given complete freedom to pursue what was best for the patient.

The model of criminal justice provision and reimbursement in the United States is also notable for its complexity, perverse incentives, and uniqueness among industrialized countries. There is nothing logically or legally necessary about it. States did not originally pay for prisons, and there were no state prisons at the time of the founding.<sup>15</sup> The economics of prison provision used to be different: governments got (or at least thought

---

<sup>13</sup> For a suitably consumer-focused treatment of the problem, see Leslie Goldman, “How Much is This Gonna Cost Me, Doc?” *O: the Oprah Magazine* (July 2015), available at <http://www.lesliegoldmanwrites.com/pdfs/cost.pdf>.

<sup>14</sup> See, generally, Paul Starr, *The Social Transformation of American Medicine* (1982) (doctor resistance generally, 23-28, within the progressive era, 253, during the New Deal, 271, introducing “socialized medicine,” 280). For a shorter treatment of the topic, see, e.g., Sven Steinmo and Jon Watts, “It’s the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America”, 20 *J. Health. Policy, Pol’y and Law* 329 (1995) (identifying structural reasons in the U.S. political system as well as resistance from medical professionals).

<sup>15</sup> This treatment largely reproduces that in a prior article, W. David Ball, *Why State Prisons?* 33 *Yale L. & Pol’y Rev.* 75 (2014).

they would get) revenues from prison labor and this meant that control over carceral populations was an economic benefit, not a loss. State-provided prisons became the norm under different economic circumstances and remained even when the value of prison labor vanished. The criminal justice “system” that resulted was far from systematic in terms of who pays for it and who controls access to it. It is a complex amalgamation of government-run and private for-profit prisons, local jails, and treatment facilities, paid for by state, local, and federal funds. Each part of the system has effects on the workload and efficiency of other parts but there is little coordination among them (with the exception of the few states with unified corrections systems). If prisons do a good job rehabilitating, that will be less work for police. If police arrest marginal criminals, that will place more stress on courts and jails. The system as a whole passes costs and burdens and fails, in many cases, to treat the offender in a consistent and coordinated manner. There is little data—and too few incentives to study data—on what works. DA’s and judges are under no pressure to get feedback about what eventually happens to criminals in their cases because those problems are passed on to other “downstream” institutions and practitioners. Even as public safety is invoked, there is little financial pressure to improve public safety, since reimbursements are not made on that basis (though there is some political pressure, an element of the equation discussed at length in the literature).

Under the prison subsidy system, participants have incentives at odds with each other. Local taxpayers want public safety but do not bear the full cost of consuming prison beds (even though they pay for police and, sometimes, local courts). The same is true of District Attorneys and judges: except in states like Missouri,<sup>16</sup> they are not required to consider the cost of sentencing outcomes, and in no case must they systematically consider whether the cost paid is either an efficient or efficacious use of resources. The value of prison is assumed to be greater than zero, but the costs are not borne by the local officials whose decisions drive prison admissions. More interventions or prison time does not always improve criminal justice outcomes—they can make them worse.<sup>17</sup> The state government covers the prison costs that result, but it has little control over prison utilization (in part because the legislature continually expands the penal code, as William Stuntz has observed).<sup>18</sup> The result is that costs

---

<sup>16</sup> Chad Flanders, *Cost as a Sentencing Factor: Missouri's Experiment*, 77 *Mo. L. Rev.* 391 (2012).

<sup>17</sup> Francis T. Cullen, Cheryl Lero Johnson, & Daniel S. Nagin, *Prisons Do Not Reduce Recidivism: The High Cost of Ignoring Science*, 91 *Pris. J.* 48S, 50-51S (2011).

<sup>18</sup> William Stuntz, *The Pathological Politics of Criminal Law*, 100 *Mich. L. Rev.* 505,

balloon. There is too little investment on the front end of prevention, there is rationing of one kind or another (overcrowding or conditions of confinement), but the drive to cut costs is met with justifiable resistance by the Eighth Amendment of the Constitution, which prohibits cruel and unusual punishment. One of the enduring questions is which group—if any—is steering the ship, and for whose benefit. Is the ultimate consumer or decision-maker the citizen, who pays? The DA or judge, who charges and sentences? The inmate, who is incarcerated? The public, who is made safe from crime? The legislature, who writes expansive penal codes?

It is well-known that the U.S. penal system is exceptional, and not in a good way. As with medicine, attempts to change the system have been met with fierce resistance by insiders who fear lost rents (such as prison guards) or lost discretion to treat crime as they see fit. In many instances, the very idea that criminal law could be subject to cost effectiveness analysis by outsiders is rejected. Only prosecutors know what is best for public safety, and they need to be given complete freedom to pursue what is best for society. The myth of our criminal justice system is like the myth of the heroic doctor doing everything she can for her patients in each case: we do not use the full complement of criminal procedures outlined in the Bill of Rights and the system fails as much as it succeeds. DA's are, in many ways, the entire system, able to charge under expansive penal codes and drive bargains; John Pfaff has made a convincing argument that changes in prosecutorial charging patterns helped drive increases in incarceration.<sup>19</sup>

To say that the criminal justice and healthcare systems are similar is not to say that crime and disease are similar (though perhaps contagious diseases and crime waves are not so far apart). But one need not address crime when one is talking about incarceration: crime is a necessary but not sufficient condition for incarceration.<sup>20</sup> Crime goes unreported, unsolved, and unprosecuted. Although poor health also goes undetected, undiagnosed, and untreated, crime is much more a result of human agency—choices about activities to engage in that are criminal as well as choices about which activities will be made criminal—than is disease

---

519 (2001–2002).

<sup>19</sup> John Pfaff, *The Micro and Macro Causes of Prison Growth*, 28 Ga. St. U. L. Rev. 1239 (2010). See also Daniel P. Kessler and Anne Morrison Piehl, *The Role of Discretion in the Criminal Justice System*, 14 J. of L., Econ. & Org. 256 (1998) (examining sentencing evidence in California to conclude that prosecutors seek to maximize prosecution).

<sup>20</sup> See, e.g., W. David Ball, *Tough on Crime (on the State's Dime): How Violent Crime Does Not Drive California Counties' Incarceration Rates - And Why it Should*, 28 Ga. St. L. Rev. 987 (2012) (reported crime rates in California counties explain only 3 percent of the variance in in new felon admissions).

(although some lifestyle choices, such as smoking, increase risks of disease and some conditions, such as female hysteria in the first half of the 20<sup>th</sup> century, were products of which behaviors were deemed “sick”). There is a mental model that crime is a deed, disease is a thing. Ultimately, the way we choose to treat crime depends in part on our diagnosis of it—but diagnosis and treatment operate in a virtuous circle. Our understanding of disease is driven in part by what is successful in treating it, and our ability to design successful treatments is similarly affected by our understanding of disease. So perhaps the reason we treat crime differently from disease is that our treatment models have yielded so few insights. We are still in the “four humours” stage of our understanding.

## II. THE VALUE CREATION MODEL

Fee-for-service has been challenged by pay-for-performance, a term that describes a system in which providers are paid for improving health outcomes by whatever means the provider chooses. Providers are no longer paid by the procedure, but by the case. This, in theory, improves efficiency, and one recent study found that “financial incentives significantly influence physicians’ supply of health care”<sup>21</sup> and that value based payments “hold the promise of curbing costs without jeopardizing quality.”<sup>22</sup> These incentives are designed so that doctors will only order those interventions that are, at the margin, necessary to treat the patient. Doctors should be less inclined to order interventions than under fee-for-service, which reimburses the interventions even if they are not demonstrably tied to the outcome.

Pay-for-performance is part of a very long project that is still very much in progress, a project that seeks to improve the quality of doctors and their treatments.<sup>23</sup> Part of the explanation for the time consumed is that both the healthcare system and disease itself are complex, and measuring quality and outcomes is difficult. Part of the explanation is that it is also very difficult to make major changes in the healthcare system without running into intense opposition from doctors and other players in the system—a problem that would certainly also be true of attempts to change criminal justice along the lines proposed. Pay-for-performance has built on earlier attempts

---

<sup>21</sup> Jeffrey Clemens and Joshua D. Gottleib, *Do Physicians’ Financial Incentives Affect Medical Treatment and Patient Health?*, 104 *Am. Econ. Rev.* 1320 (2014), PAGE 18 [NOTE: this is not the final pagination].

<sup>22</sup> *Id.* at 19.

<sup>23</sup> For a recent history that focuses on the beginning of the quality movement in the 1980’s, using a framework that, like this Article, combines economics and “what works” and ultimately employs a “value-for-money competition”, see Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 *Health Affairs* 24 (1993).

to standardize medical treatment, measure quality of care, and audit providers and institutions.<sup>24</sup> This has all been part of the professionalization of medicine so meticulously detailed in Paul Starr's the Social Transformation of American Medicine.<sup>25</sup> Pay-for-performance has also proceeded in parallel with certain structural changes, such as the creation of HMO's, which seek to save money by focusing on prevention, coordinating care, and internalizing inter-departmental externalities. These structural changes will be addressed in a subsequent Article.

Though quality improvements have been taking place at least since the 1870s, with reforms to medical education and the re-imposition of licenses for doctors, one early example of the recent pay-for-performance trend is the emergence of Diagnosis-related Groups (DRGs). DRGs classify patient conditions and tie them to Medicare and Medicaid reimbursement. If a patient needs a hip replaced, for example, his treatment is billed according to that DRG, and the provider is paid a set amount to treat the condition. DRGs give providers incentives in the average case to follow some form of the state of the art, on which the DRG payment is based, while simultaneously offering incentives to adopt new techniques that are as effective but cheaper, in order to save the difference between the cost of the procedure and the amount of reimbursement.

In a series of articles<sup>26</sup> and a book,<sup>27</sup> Michael Porter (and, occasionally, co-authors) refined the idea of pay-for-performance in a particular way, identifying the key problem in health care as a lack of value creation. He criticized some pay-for-performance schemes as encouraging cost control without necessarily maintaining health. A provider reimbursed for a DRG procedure might cut corners, not just costs. Porter's contribution is to define value as health outcomes obtained per unit of cost spent. Value

---

<sup>24</sup> Malpractice cases have already created some penalties for grossly substandard quality. The focus of this Article is on incentives to improve quality. The Eighth Amendment, like malpractice, penalizes grossly substandard interventions. For the most influential early theoretical work on quality in healthcare, see Avedis Donabedian, *Evaluating the Quality of Medical Care*, 44 *Millbank Mem. Fund Q.* 166 (1966).

<sup>25</sup> Paul Starr, *the Social Transformation of American Medicine* (1982).

<sup>26</sup> See, e.g., Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Competition in Health Care*, *Harv. Bus. Rev.* 1 (June 2004); Michael E. Porter, "A Strategy for Health Care Reform—Toward a Value-Based System," 361 *N.E. J. of Medicine* 109 (2009); Michael E. Porter, *What is Value in Health Care?*, 363 *N.E. J. of Medicine* 2477 (2010); Robert S. Kaplan and Michael E. Porter, "The Big Idea: How to Solve the Cost Crisis in Health Care," *Harv. Bus. Rev.* (Sept. 2011); Michael E. Porter and Thomas E. Lee, "The Strategy That Will Fix Health Care," *Harv. Bus. Rev.* (October 2013).

<sup>27</sup> Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (2006).

is created only when patients get healthier and/or costs decrease. Porter is not the only one to have latched on to this idea—the Jackson Hole Initiatives, for example, also proposed accountability on health outcomes and cost<sup>28</sup>—but I prefer his formulation because it combines efficacy and efficiency in a concise phrase. One cannot focus only on outcomes or cost—one must focus on *both*. As with the mainstream of pay-for-performance advocates, Porter diagnosed the problem with fee-for-service as incentivizing individual organizations to maximize their own reimbursements and/or pass costs on to others without improving patient outcomes. Porter argued that the healthcare system should promote the creation of real value in the system, as opposed to revenues or cost-cutting in particular parts of it, by focusing on how the patient did from beginning to end, even if she passed from one doctor in one department to another doctor (or several others).

The value concept rejects a simple focus on cost cutting, because if cost cutting comes at the expense of health outcomes, no value is added. Cost-cutting at the expense of health simply shifts costs to another part of the system. On the other hand, value is created when a cheaper method produces similar or better outcomes. The incentives built in to the system—the “pay” in pay-for-performance—mean that evidence-based ideas, ones that can demonstrate real improvements in health outcome, are favored. It also means that improvements can be disseminated more rapidly because there is a disincentive to continue business as usual. Porter’s value concept, then, is compatible with and an improvement on pay-for-performance. It simply defines performance to include efficacy and efficiency.

At its most radical, pay-for-performance calls for a restructuring of the healthcare system; at the other end of the spectrum, pay-for-performance simply encourages existing procedures to be done more effectively and efficiently. There is still considerable autonomy within the system for doctors to pursue different treatments—and the incentives are either in terms of doing what will make a patient healthier or as healthy at a lower cost.<sup>29</sup>

---

<sup>28</sup> Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheridge, “The Jackson Hole Initiatives for a Twenty-First Century American Health Care System,” 1 *Health Econ.* 149 (1992). See also Randall P. Ellis and Thomas G. McGuire, “Provider Behavior Under Prospective Reimbursement,” 5 *J. Health Econ.* 129 (1986) (concluding that a mixed lump sum and fee for service system would encourage better outcomes while controlling costs).

<sup>29</sup> Indeed, one pair of doctors wrote to endorse the Affordable Care Act on the basis that it might enhance physician autonomy. Ezekiel J. Emanuel and Steven D. Pearson, Physician Autonomy and Health Care Reform, 307 *JAMA* 367 (Jan. 25, 2012).

There are several different ways to implement pay for performance models.<sup>30</sup> Some focus on particular treatments, some on institutions, and some on overall allocation of resources to maximize social welfare by, e.g., focusing on prevention instead of treatment in the emergency room. All of these, again, are compatible with Porter's theories, since he merely provides a definition of performance (value) that can be used in pay for performance. One pay-for-performance scheme that has recently been deployed is readmission penalties for certain procedures: the heart surgery example mentioned in the introduction.<sup>31</sup> Hospitals get reduced payments for excessive readmissions following heart attacks, heart failure, and pneumonia. Excessive readmissions are defined as the risk-adjusted rate of readmission within 30 days relative to the national average.<sup>32</sup> A hospital now has an incentive to promote surgical aftercare, a patient-outcome-centered approach that will lead to better results without incurring additional expensive hospital stays.<sup>33</sup> These bonuses are a net gain to all parties: the patient is healthier and the cost savings can potentially be split between the government and the provider.

A second scheme is to pay for chronic conditions that can't be cured, such as diabetes.<sup>34</sup> The outcomes evaluated here include management of symptoms, quality of life, survival times, and cost of treatment. These two separate types of performance-based programs deal with different types of cases and employ different incentives and metrics. The goal with hospitalization is health; the goal with chronic conditions is

---

<sup>30</sup> For a general overview, see Meredith B. Rosenthal, "Beyond Pay for Performance—Emerging Models of Provider-Payment Reform," 359 N.E. J. Med. 1197 (2008).

<sup>31</sup> Hospital readmissions among Medicare patients are both "prevalent and costly." Stephen F. Jencks et. al, *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*, 360 N.E. J. Med. 1418 (Apr. 2, 2009).

<sup>32</sup> Centers for Medicare & Medicaid Services, *Readmissions Reduction Program*, available at <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>.

<sup>33</sup> Another scheme is paying lump sums to manage a general population of patients (the Accountable Care Organization model). Providers are paid bonuses if they are able to treat these populations at a lower cost than public medical programs would have, presumably by promoting prevention over responsive treatment. Since this is more aligned with prevention and restructuring, I will not discuss it in detail. See, e.g., Alison Ritchie et. al, "Shifting reimbursement models: The risks and rewards for primary care," Apr. 8, 2014, available at <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/aca/shifting-reimbursement-models-risks-and-rewards-primary-care?page=full>.

<sup>34</sup> For a study that evaluated long-term care for co-morbid chronic conditions, see Wayne J. Katon et. al, *Collaborative Care for Patients with Depression and Chronic Illnesses*, 363 N. E. J. Med. 2611 (Dec. 30, 2010).

maintaining quality of life (or slowing its decline). One has easy to measure outcomes (readmission within a certain time), the other does not (quality of life per unit of cost). This points out an operational problem with pay-for-performance. The goal of measuring and rewarding value for money can be the same, but the means of getting there are often different.

While this vagueness is undoubtedly a weakness when viewed from one perspective, it also, like many legal terms (e.g., “reasonable”), has the advantage of being flexible enough to encompass a variety of circumstances. Different definitions of health will have to be hashed out for relevant sets of cases. Asking what outcome to measure in a given circumstance assuredly involves decisions about the particular measurement, but, crucially, it does not question the importance of measuring and evaluating itself. The act of negotiating what outcomes to measure and how—considering the costs of measuring a particular outcome, the feasibility of measuring that outcome, issues concerning precision and inter-rater reliability, and the like—cannot be made once and set permanently for all cases, particularly since those governed by pay-for-performance need to buy into the quality measurements selected or they will not effectively implement them. There are also issues with co-morbidity—what counts as a condition? People have more than one disease, and the treatment for someone suffering from more than one condition is not always a matter of combining the individual treatments—the regime can change entirely.

Finally, an outcome-orientation also needs to consider the mechanism of pay-for-performance and who the target audience for a given incentive is.<sup>35</sup> Is it hospitals, as they make their decisions about capital purchases or staffing of departments? Doctors, as they prescribe treatment? Insurers, as they decide what to cover and how much to pay for it? Individuals, as they choose treatments? Pay-for-performance has a wide range of applications, but it needs to be tailored depending on the constituency. The selling points are different. Hospitals can free up resources by doing things that are cheaper but as effective. Insurance companies can improve fiscal health through lower costs and less need for care as health improves. Individuals benefit by suffering less. Doctors can have more autonomy. Health care is a complex system; changing it will play out in complex ways. Having the goal of improving outcomes per unit of cost spent provides a criterion for improvement, some kind of yardstick, even if the units of measurement on that yardstick (mortality, health, time to recover, pain) might be different.

---

<sup>35</sup> Laura A. Petersen et. al, “Does Pay for Performance Improve the Quality of Health Care?” 145 *Annals of Internal Medicine* 265 (2006).



Any attempt to move towards a pay-for-performance system has certain prerequisites<sup>36</sup> built into it. First, providers need to know information about cost structure, which involves learning about staff costs, staff time per intervention, drug costs, and time waiting for rooms to open up or schedules to align. Providers need to dig deep into their procedures and understand where potential efficiencies can be exploited. Second, reimbursement must be based on a standardized measure of health outcomes. Some of this is definitional on the part of the initial diagnoses—which hip replacements are garden variety and which present other factors that will make them either easier or more difficult to treat? Some of this also depends on the ways in which health outcomes are defined—time to recovery, pain and suffering, or mortality. Third, outcomes need to be stored in an apples-to-apples data format for easy comparison across institutions and patient populations in order to compare the value created by a particular intervention or institution. Fourth, the healthcare system needs to move beyond the viewpoint of the provider (whether an institution or a department within that institution) and take a more holistic approach to the health of an individual. What combination of action will improve his or her health the most? This means avoiding cost-shifting from one department or organization to another and focusing, instead, on the total cost of treatment. Such a focus might reveal that outpatient procedures are just as effective as inpatient procedures, or that phone calls rather than nurse visits are effective forms of aftercare. Finally, some changes might imply new types of organizations to better treat certain segments of the patient population. Porter envisages the creation of integrated patient units (IPUs) for the treatment of certain standard and/or chronic conditions. By specializing in, say, diabetes, an IPU can develop expertise that should allow it to treat diabetic patients more efficiently and effectively than a jack-of-all-trades, master-of-none medical practice could.

There are many criticisms of pay for performance, focusing primarily on the difficulties of defining and measuring outcomes. Because these criticisms also apply in a criminal justice context, and because criminal justice is the focus of this essay, I will address them in Part IVA. I should also note that Porter's analysis assumes that there is a market for medical providers. Even though hospitals employ a mix of for-profit and non-profit models, they do compete for patients and for insurance dollars. Porter's framework assumes that more money can be directed to good performers and that incentives—both positive and negative—can be given

---

<sup>36</sup> Robert S. Kaplan and Michael E. Porter, "The Big Idea: How to Solve the Cost Crisis in Health Care," *Harv. Bus. Rev.* (Sept. 2011).

to poor performers. Without a shift in funding and resources, the incentives available to promote value-creation are limited.

### III. CURRENT APPROACHES IN CRIMINAL JUSTICE ECONOMICS

The general features of the fee-for-service model map well onto the criminal justice context, with some obvious modifications, and the introduction of pay-for-performance models can also be easily adapted to the criminal justice context. I should note at the outset that the two biggest growth areas in terms of government spending have been health care and criminal justice.<sup>37</sup> There is very little downward cost pressure in either.<sup>38</sup> Also, health care is the centerpiece of the most significant prison case in a generation, *Brown v. Plata*.<sup>39</sup> *Plata*, however, is about minimum standards—avoiding carceral malpractice. The value model goes further, to incentivize quality and efficiency improvements.

Prison, in particular, is free to local decision-makers, except in unified corrections systems. No prosecutor or judge ever needs to measure prison's efficacy or efficiency, because the system does not demand evidence of efficacy and a good that is free is perforce efficient from the consumer's point of view (even if inefficient from society's). Providers in the criminal justice system are not accountable in terms of creating value. Various parts of the system can get blamed for cost overruns or for particular outcomes, but the structure and operation of the system as a whole are seldom blamed. On the contrary: the decentralized nature of criminal justice practically encourages the shifting of cost and blame. The prisons blame parole, parole blames the prisons, the county blames the state, and the state blames the county. There is too much focus on individual points of the process and parts of the system and not enough on the way in which a lack of coordination among criminal justice providers is the rule.

Even where there is some discussion of total costs of interventions,

---

<sup>37</sup> Brandon C. Welsh and David P. Farrington, "The Benefits and Costs of Early Prevention Compared With Imprisonment: Toward Evidence-Based Policy," 91 *Pris. J.* 120S, 123S (2011) [NOTE: this is a citation to a secondary source]. This would, of course, obviously apply to prison healthcare systems, which are a large source of liability to these systems.

<sup>38</sup> But see Hadar Aviram, *Cheap on Crime*, for an analysis of the economic downturn on criminal justice systems. She also points out that this focus on costs could result in substandard care, a valid complaint about the present system that a value focus would address.

<sup>39</sup> *Brown v. Plata*, 131 S. Ct. 1910 (2011).

these costs do not drive policies. In Missouri, for example, judges are presented with the costs of various sentencing options, but not their efficacy or efficiency—the exact kind of misplaced incentives that Porter’s value formulation seeks to avoid.<sup>40</sup> A judge knows that jail is X dollars and prison is Y dollars, but she does not know which works better—indeed, the very question would probably either seem strange or be answered with reference to an individual judge’s experience, a dataset that is rife with sampling error and a lack of systematic longitudinal analysis. In general, there is no drive towards efficiency in prison because the cost is not borne by decision-makers.<sup>41</sup> Best practices across jurisdictions and departments are diffused slowly, if at all. No fire is being lit under criminal justice organizations, there are no incentives to improve—or, alternatively, there are incentives to cut costs without improving outcomes. Even if good policies are deployed, there are no internal institutional incentives to train people to deploy those policies with fidelity to their design, to follow up about quality control, and, generally, to ensure that the policies are implemented well. Those policies are all costs whose external benefits accrue mostly to other agencies, whose jobs get easier. A prisoner reformed by prison means more work for prison employees but less work for police.

There are a wide variety of policies “on the ground” even within the same state, operating under the same set of statutes. There is not necessarily any convergence within states or across the country. There are siloed organizations that fail to take into account the externalities—both positive and negative—of their actions which might either affect public safety (as in the prison that doesn’t rehabilitate) or affect the budgets of other organizations (zero tolerance policing leading to an increased workload in the courts). Claims about deterrence and the effectiveness of particular sentences are never put to the test, making them essentially empty claims. The general rule is no data collection, no follow up, no outcome tracking and no feedback loops to decision-makers such as judges and DA’s. This means there is little opportunity to learn, little opportunity to improve, and little accountability. All sentencing is treated as downstream, someone else’s problem. In fact, many law schools, which train the judges and prosecutors who drive sentencing and charging, teach nothing about prisons, even as first year law criminal law classes routinely address the

---

<sup>40</sup> Chad Flanders, Cost as a Sentencing Factor: Missouri’s Experiment, 77 Mo. L. Rev. 391 (2012).

<sup>41</sup> See, e.g., Adam Gershowitz, An Informational Approach to the Mass Imprisonment Problem, 40 Ariz. St. L. J. 47 (2008). See also Russell M. Gold, Promoting Democracy in Prosecution, 86 Wash. L. Rev. 69 (2011) (proposing that the costs of prosecution be made public but using prosecutorial elections as the mechanism for internalizing the externality).

purpose of punishment.

Comparing criminal justice and healthcare economics also comports with a long line of viewing prisons themselves through the lens of medicine. 19<sup>th</sup> century prison reformers were on board with the centralization of prisons under state control because they thought it would make them more professional and rehabilitative.<sup>42</sup> Wardens expressly invoked medical metaphors to advocate on behalf of indeterminate sentences, saying that they alone knew when an offender was cured. The medical model has waxed and waned inversely with the punishment model, but the most recent ascendancy of the medical model was in the mid-20<sup>th</sup> century around the time of *Williams v. New York*.<sup>43</sup> This Article proposes a measured return to the medical model, albeit one that corrects for certain shortcomings. The historical emphasis on treatment is made with better (but not perfect) social science and much better ability to crunch the data.

There is a lot of great work being done now that I will not attempt to reinvent, particularly in terms of measuring the costs and benefits of early interventions. Criminal justice cost-benefit analysis (CBA) approaches have received in-depth treatment from a few scholars. Darryl Brown outlined the approach in 2004, discussing CBA in detail (using, *inter alia*, environmental law as a comparison) and concluding, in part, that “offender treatment ... has fared well in cost-benefit analyses.”<sup>44</sup> Brown’s analysis is extensive, analyzing the wide-ranging effects of criminal justice policies, discussing how prevention is effective and efficient, but his policy prescriptions focus primarily on how CBA could be incorporated into the executive branch (prosecution and police). Though he discusses the decentralized nature of criminal justice, he does not discuss the implications of the prison subsidy, nor does he advocate pay-for-performance. A recent issue of *Criminology and Public Policy* focused on the use of CBA in criminal justice, with articles by Patricio Dominguez and Steven Raphael (providing a comprehensive summary of the issue),<sup>45</sup> Michael Tonry,<sup>46</sup> and Brandon C.

---

<sup>42</sup> For a general background and extensive footnotes to more detailed historical treatments, see W. David Ball, *Why State Prisons?* 33 *Yale L. & Pol’y Rev.* 75 (2014).

<sup>43</sup> 337 U.S. 241 (1949).

<sup>44</sup> Darryl K. Brown, *Cost-Benefit Analysis in Criminal Law*, 92 *Cal. L. Rev.* 323, 351 (2014).

<sup>45</sup> Patricio Dominguez and Steven Raphael, “The Role of Cost-of-Crime Literature in Bridging the Gap Between Social Science Research and Policy Making,” 14 *Criminol. & Pub. Pol.* 589 (2015). The authors are particularly concerned about the way in which the income levels of rich victims might skew the costs of crime and promote inequitable distributional effects of resources like police, as well as the methodological problems with estimating the costs of crime by either the contingent valuation or the willingness to pay

Welsh and David P. Farrington,<sup>47</sup> among others.

Criminal justice CBA approaches are not just theoretical; they have gained traction in the policy realm as well.<sup>48</sup> The Washington State Institute for Public Policy (WSIPP) has long been considered the model program in terms of evaluating what Porter would call value creation, analyzing proposed policies in terms of their effectiveness and efficiency.<sup>49</sup> WSIPP is now actively distributing its model via a partnership with the Pew-MacArthur Results First Initiative<sup>50</sup> and has posted an exhaustive technical documentation that breaks down exactly how it models costs and benefits.<sup>51</sup> The Vera Institute and the Bureau of Justice Assistance have also partnered to promote cost-benefit analysis in criminal justice and have produced a series of extremely informative, practitioner-centered publications.<sup>52</sup> The Justice Reinvestment Initiative of the Bureau of Justice

---

methods.

<sup>46</sup> Michael Tonry, “The Fog Around Cost-of-Crime Studies May Finally Be Clearing: Prisoners and Their Kids Suffer Too,” 14 *Criminol. & Pub. Pol.* 653 (2015) (emphasizing problems with the cost of crime literature, pointing out that the costs of punishment (in terms of hedonic losses to prisoners and collateral effects on their families) are not included in some of the most influential cost of crime estimates).

<sup>47</sup> Brandon C. Welsh and David P. Farrington, “Monetary Value of Early Developmental Crime Prevention and Its Policy Significance,” 14 *Criminol. & Pub. Pol.* 673 (2015) (suggesting that if costs of offending are high, many social welfare programs will be justified).

<sup>48</sup> For an excellent overview, see Cameron McIntosh and Jobina Li, *An Introduction to Economic Analysis in Crime Prevention: the Why, the How, and So What* (2012), available at <https://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/cnmc-nlss/cnmc-nlss-eng.pdf>; see also the Pew-MacArthur Results First Initiative, “States’ Use of Cost-Benefit Analysis,” (2013), available at [http://www.pewtrusts.org/~media/legacy/uploadedfiles/pes\\_assets/2013/pewresultsfirst50staterreportpdf.pdf](http://www.pewtrusts.org/~media/legacy/uploadedfiles/pes_assets/2013/pewresultsfirst50staterreportpdf.pdf).

<sup>49</sup> Steve Aos, Marna Miller, Elizabeth Drake, “Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates,” 19 *Fed. Sent. Repr.* 275 (2007).

<sup>50</sup> For a report on the New York State experience, see, e.g., Marc Schabes, “Cost Benefit Analysis for Criminal Justice: Deployment and Initial Application of the Results First Cost Benefit Model” (Oct. 2013), available at [http://www.criminaljustice.ny.gov/crimnet/ojsa/resultsfirst/technical\\_report\\_cba1\\_oct2013.pdf](http://www.criminaljustice.ny.gov/crimnet/ojsa/resultsfirst/technical_report_cba1_oct2013.pdf).

<sup>51</sup> Washington State Institute for Public Policy, *Benefit-cost technical documentation* (Dec. 2015), available at <http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf>.

<sup>52</sup> See, e.g., Carl Matthies, *Advancing the Quality of Cost-Benefit Analysis for Justice Programs* (2014), <http://cbkb.org/wp-content/uploads/2014/03/Advancing-the-quality-of-CBA.pdf>; Carl Matthies and Tina Chiu, *Putting a Value on Crime Analysts: Considerations for Law Enforcement Executives* (2014), available at

Assistance is also working to promote data-driven policies that improve public safety in a cost-effective manner, taking a holistic approach that includes all parts of the criminal justice system (redistributing from less cost-effective programs, like prison, towards more cost-effective programs dealing with prevention).<sup>53</sup> There have also been attempts for private entities to fund criminal justice improvements using “social impact bonds”, with payment contingent on successful outcomes.<sup>54</sup>

There is certainly much to admire in the CBA literature and policy. What I think is missing, however, is a systematic discussion that goes beyond the desirability *vel non* of individual policies and moves towards a more holistic critique of why diffusion of sensible policies is not more widespread, and the ways in which the structure of criminal justice—both institutional and budgetary—might contribute to this problem. I also think that there is too little attention paid to prisons themselves as potential sources of improvement.<sup>55</sup> The thrust of this Article is not, then, to replace CBA, but to provide a framework in which prisons and the individuals who sentence (and charge) offenders have incentives to insist on best practices at the ground level. CBA will do very little if prison is free to local decision-makers and they have no incentive to pursue the social good. One alternative is, of course, to centralize at the state level, but, absent that, an option that is free to decision-makers will be overused, even if it is socially inefficient. Ultimately, good policies can only go so far on their merits. How can the system be structured to encourage wider rollout and diffusion?

Some of the economic literature engages with the incentives faced within the system by providers of criminal justice. These articles are a

---

<https://www.bja.gov/Publications/Vera-CrimeAnalysts.pdf>; Christian Henrichson, Using Cost-Benefit Analysis for Justice Policymaking (2014), available at <http://cbkb.org/wp-content/uploads/2014/04/Using-Cost-Benefit-Analysis-for-Justice-Policymaking.pdf>; and Christian Henrichson and Joshua Rinaldi, Cost-Benefit Analysis and Justice Policy Toolkit (2014), available at <http://www.vera.org/sites/default/files/resources/downloads/cost-benefit-analysis-justice-policy-toolkit.pdf>.

<sup>53</sup> Office of Justice Programs, What is JRI?, available at [https://www.bja.gov/programs/justicereinvestment/what\\_is\\_jri.html](https://www.bja.gov/programs/justicereinvestment/what_is_jri.html).

<sup>54</sup> Chris Fox and Kevin Albertson, Payment by Results and Social Impact Bonds in the Criminal Justice Sector: New Challenges for the Concept of Evidence-based Policy? *Criminol. & Crim. Justice* 1 (2011) (noting advantages of payment by results and difficulties in determining outcomes).

<sup>55</sup> Though Brown discusses the larger framework of criminal justice, including issues of diffusion, alternative sentencing, and tailoring programs to needs in community prosecution, his otherwise outstanding Article gives only one paragraph to prison treatment itself. Darryl K. Brown, Cost-Benefit Analysis in Criminal Law, 92 *Cal. L. Rev.* 323, 351 (2014). He does discuss alternatives to incarceration later in some detail. *Id.* at 367-371.

recent discovery on my part, and many advance the argument that misalignment is bound to happen when the state subsidizes prison while local governments control who goes there—an argument that predates the same analysis from Zimring and Hawkins (the “correctional free lunch”) that I relied on in earlier articles.<sup>56</sup> So, while Zimring and Hawkins coined the phrase, the idea predates them, and these prior formulations deserve to be more widely acknowledged in the legal academy. This is my attempt to correct my own errors in this regard. Many of the arguments discussed below are summarized in Kenneth Avvio’s excellent 1998 survey of the economic literature, “The Economics of Prisons.”<sup>57</sup>

In 1983, Robert Gillespie of the University of Illinois observed the disjuncture between state payment for prison and local control over who is sent there, proposing, as his solution to the inevitable overcrowding that results, that the state instead allocate prison bed spaces to counties and have locals buy or sell them to other counties as needed.<sup>58</sup> Fred Giertz and Peter Nardulli, also from Illinois, made similar observations in 1985, describing the “basic misalignment” between local governments who benefit from prison and the fact that “these services are provided by state government at virtually a zero cost to localities.”<sup>59</sup> They suggested, as I also did recently, a complete decentralization of the system, where incarceration is provided by local government and funding is replaced with block grants.<sup>60</sup> Nardulli had earlier developed this idea in 1984, in an article which analyzed county usage of prisons in Illinois, again starting with the premise that “local politicians have funded law and order campaigns at state expense.”<sup>61</sup>

---

<sup>56</sup> Franklin E. Zimring Gordon J. Hawkins, *The Scale of Imprisonment* (1991). For my own elaboration on the subject, see W. David Ball, *Tough on Crime (on the State’s Dime): How Violent Crime Does Not Drive California Counties’ Incarceration Rates - And Why it Should*, 28 Ga. St. L. Rev. 987 (2012), W. David Ball, *Defunding State Prisons*, 50 Crim. L. Bull. 1060 (2014), W. David Ball, *Why State Prisons?* 33 Yale L. & Pol’y Rev. 75 (2014), and W. David Ball, “*A False Idea of Economy*”: *Costs, Counties, and the Origins of the California Correctional System*, 664 *Annals Am. Acad. Polit. & Social Sci.* 26 (Mar. 2016).

<sup>57</sup> Kenneth L. Avvio, “The Economics of Prisons,” 6 *Eur. J. of L. and Econ* 143 (1998).

<sup>58</sup> Robert W. Gillespie, “Allocating Resources to Prison Space: An Economic Approach Incorporating Efficiency and Equity,” Sep. 1, 1983, available at <https://www.ideals.illinois.edu/bitstream/handle/2142/29260/allocatingresour977gill.pdf?sequence=1>.

<sup>59</sup> J. Fred Giertz and Peter F. Nardulli, “Prison overcrowding,” 46 *Public Choice* 71 (1985).

<sup>60</sup> *Id.* at 75-77. For my own treatment, see *Defunding State Prisons*. For a similar idea, see Chris Fox and Kevin Albertson, “Could economics solve the prison crisis?” 57 *Probation J.* 263, 277 (2010).

<sup>61</sup> Peter F. Nardulli, “The Misalignment of Penal Responsibilities and State Prison

Alfred Blumstein and Richard Larson, in 1969, analyzed the disjointed nature of the criminal justice system, remarking that the independence of agencies inhibited the effective deployment of interdependent policies, and that criminal justice organizations failed to get feedback about the downstream effects of those policies on other agencies.<sup>62</sup>

Some literature has, in fact, focused on criminal justice performance. In 1993, Charles Logan wrote an article entitled *Criminal Justice Performance Measures for Prisons*, but he focused on processes, not outcomes, and did so from a retributive perspective.<sup>63</sup> There is also little attention paid to the decentralization/organizational incentives problem, whereby, say, poor rehabilitation by prison might result in increased workloads for police. Logan's approach is also typical of the other works cited here, including my own, in that it assumes that there are no differences—or no differences that can be measured—in custodial programs designed to rehabilitate.<sup>64</sup> The main gains are from early prevention and diversion. As I stated in the introduction, this article assumes that there are better and worse prisons and programs and thus, that prison should be differentiated as more than simply a locale for incapacitation.

Much of the rest of the economics literature's focus is on “factors that affect the supply of criminal activities”—that is, what incentives and policies tend to make people more or less likely to engage in criminal activity in the first place.<sup>65</sup> This is also true of the most influential analyses in law and economics. To cite perhaps the most influential example, Richard Posner's treatment of the law and economics of criminal law is all about the supply of crime and the ways in which criminals might respond to the relative costs of gainful and illicit employment, based on the risks and

---

Crises: Costs, Consequences, and Corrective Actions,” 1984 U. Ill. L. Rev. 365, 368 (1984).

<sup>62</sup> Alfred Blumstein and Richard Larson, “Models of a Total Criminal Justice System,” *Operations Research* 199 (March-April 1969).

<sup>63</sup> Charles H. Logan, “Criminal Justice Performance Measures for Prisons,” in *Performance Measures for the Criminal Justice System* (1993), available at <http://www.bjs.gov/content/pub/pdf/pmcjs.pdf>.

<sup>64</sup> In *Defunding State Prisons*, for example, the analysis focused on prisons versus jails and probation. I argued that unless prisons were demonstrably superior, they should not be subsidized. I did not distinguish among prisons, however, and, for the purposes of the analysis presented, was agnostic about their capacity to rehabilitate.

<sup>65</sup> Richard B. Freeman, “The Economics of Crime,” in *Handbook of Labor Economics*, Orley Ashenfelter and David Card, eds., vol. 3, 3530, 3541 (1999). See, e.g., Samuel Cameron, “The Economics of Crime Deterrence: A Survey of Theory and Evidence,” 41 *Kyklos* 301 (1988).



rewards of each.<sup>66</sup> In so doing, Posner buildt upon Gary Becker’s seminal 1968 article, which itself is also primarily about the economics of criminal activity.<sup>67</sup> Frank Easterbrook also uses the prevention/deterrence model in his argument that criminal procedures are merely price mechanisms in a plea bargaining market.<sup>68</sup> Both Becker and Posner treat the system as a passive respondent to homo economicus, rather than something that, through treatment, could actively alter criminal tendencies one way or another. Incapacitation is taken as the primary means by which crime can be controlled, subject to the supply elasticity of other criminals (i.e., as one exits the market and heads to prison, another enters).<sup>69</sup> In general, this approach is an example of what Thomas Bernard and Robin Engel have criticized as an overly narrow theoretical approach to the criminal justice system: too much analysis is bounded by organizational silos, and too little takes on a broader, system-wide, cross-agency perspective.<sup>70</sup>

I propose that reformers should combine cost-benefit analysis that identifies promising programs with organizational incentives to adopt them, all within the framework of value creation: improving public safety outcomes per dollar spent.

#### IV. CREATING VALUE IN CRIMINAL JUSTICE

What are the ways in which we might restructure the criminal justice system—or particular parts of the system—in order to create value? In Part A, I discuss some groundwork that must be laid, both practical and theoretical, to implement value creation. As stated in the introduction, this Article is not model legislation ready to be implemented—it is a map into relatively uncharted territory with only the core defining features sketched out. In Part B, I focus on particular applications in sentencing that could be fit into a performance-based system. In Part C, I outline the advantages of such a system.

---

<sup>66</sup> Richard A. Posner, “An Economic Theory of the Criminal Law,” 85 Col. L. Rev. 1193 (1985).

<sup>67</sup> Gary S. Becker, “Crime and Punishment: An Economic Approach,” NEED FULL CITE.

<sup>68</sup> Frank H. Easterbrook, Criminal Procedure as a Market System, 12 J. Legal Stud. 289 (1983).

<sup>69</sup> For a law and economics analysis of how crime moves from jurisdiction to jurisdiction due to enforcement and policy differences, see Doron Teichman, “The Market for Criminal Justice: Federalism, Crime Control, and Jurisdictional Competition,” 103 Mich. L. Rev. 1831 (2005).

<sup>70</sup> Thomas J. Bernard and Robin Shepard Engel, “Conceptualizing Criminal Justice Theory,” 18 Justice Q. 1 (March 2001).

*A. Measurement Issues, Theoretical and Practical*

If the health experience is any indication, the initial move to begin to categorize similar cases (the criminal equivalent of DRGs) and improve quality will be a long, iterative process that involves some theoretical work and a lot of on-the-ground work. In fact, criminal justice might not even be ready for outcome-based measurements—health care first went through a series of procedural fixes (qualifications, training, accreditation, professionalization) from the mid-1850’s to the present that parts of the criminal justice system might still need.<sup>71</sup> Measurements in medicine are proposed, tested, adopted, refined, and sometimes replaced. The question is not whether it works in theory, but in practice. Porter, for example, has been criticized for glossing over the logistical problems of defining and measuring health outcomes in the real world,<sup>72</sup> but Medicare and commercial insurers recently agreed to common health outcome measurements.<sup>73</sup>

The problems in health care have analogues in criminal justice, and I will only identify them here, not solve them. In criminal justice, the notion of quality may seem difficult to even get our heads around, even as there is

---

<sup>71</sup> Michele Deitch and Michael Mushlin have long argued for some form of correctional oversight to promote and enforce best practices. See, e.g., Michele Deitch and Michael B. Mushlin, *What’s Going on in Our Prisons?* New York Times, Jan. 4 2016, available at <http://www.nytimes.com/2016/01/04/opinion/whats-going-on-in-our-prisons.html?ref=opinion>.

<sup>72</sup> See, e.g., Uwe E. Reinhardt, “HEALTH REFORM: Porter and Teisberg’s Utopian Vision,” Oct. 10, 2006, available at <http://healthaffairs.org/blog/2006/10/10/health-reform-porter-and-teisbergs-utopian-vision/>. There are other criticisms as well. Doctors do not see themselves as contributing to cost overruns, for example, Alvin Tran, “Study: Doctors Look to Others to Play Biggest Role in Curbing Health Costs,” 7/23/2013, available at <http://khn.org/news/study-doctors-look-to-others-to-play-biggest-role-in-curbing-health-costs/>, some doctors see data collection as interfering with medical treatment, Robert M. Wachter, “How Measurement Fails Doctors and Teachers,” 1/16/2016, available at <http://www.nytimes.com/2016/01/17/opinion/sunday/how-measurement-fails-doctors-and-teachers.html>, and the current data do not support the efficiency of pay for performance, see, e.g., Martin Emmert et. al, “Economic evaluation of pay-for-performance in health care: a systematic review,” 13 Eur. J. Health Econ. 755 (2012). For an overview of some of the key questions that need to be answered in order to actualize a pay-for-performance system, see Laura A. Petersen et. al, “Does Pay for Performance Improve the Quality of Health Care?” 145 *Annals of Internal Medicine* 265 (2006).

<sup>73</sup> Bruce Japsen, “Medicare, Commercial Insurers Agree On Uniform Health Quality Measures,” 2/16/2016, available at <http://www.forbes.com/sites/brucejapsen/2016/02/16/white-house-says-medicare-commercial-insurers-agree-on-health-quality-measures/>.

growing support in general for data collection and evidence-based practices. Stakeholders will need to gather and figure out what quality treatment of offenders means and how we will measure it. Again, if healthcare reform is any indication, the attempt to start to measure and hold accountable certain members of the criminal justice system will be met with huge pushback from DA's, judges, and others at the power centers of today's criminal justice system. These definitions cannot be generated by academic fiat. A careful study of the history of health quality measurements should provide some insights into the political and organizational dynamics that underlay the gradual shift. Space and time do not permit me to construct a detailed history of these changes, but it should certainly be among the top priorities of a criminal justice performance-based research agenda.

What follows are some problem areas to be addressed. Perhaps they cannot be resolved at all. But the same has also been said of medicine, and even if existing measures of health are not perfect or subject to revision, they are widely accepted enough to be driving policy (and preferable to a fee-for-service alternative).

One initial observation is that outcomes should be measured across the system, not in terms of the individual, media-generating case. There will be failure in the system; that does not mean the system has failed or is a failure itself. People die of cancer at the best cancer hospitals; so, too, might we expect some degree of failure with any treatment. This means shifting the focus to success rates, not individual cases: to how the system is doing overall and at what cost. The examination of sensational individual cases too often results in "Never again, no matter what the cost" policies.

The general framework for value creation in criminal justice should be public safety improvements per cost unit spent. Public safety is often invoked politically, but, like "health," it needs to be further defined, with the understanding that different conditions and treatments will need to be measured with different metrics. There is a rich literature both in terms of what should matter (recidivism, desistance from crime, pro-social metrics, victim impacts) and how to measure it. The healthcare economics literature, for example, does not have an exclusive focus on a single measure, but, instead, looks to multiple measures. Porter, for example, divides health outcomes into three general categories: mortality, recovery, and health.<sup>74</sup> These might be mapped onto recidivism, modality of

---

<sup>74</sup> Michael E. Porter, What is Value in Health Care?, 363 N.E. J. of Medicine 2477, 2479 (2010). See also Porter's Supplementary Appendix 1, which goes into much greater detail about the value concept, and Supplementary Appendix 2, which discusses issues with

treatment, and desistance from crime.

Mortality is the most obvious measure in health; in criminal justice, that measure is recidivism. Although there is no consensus on what constitutes recidivism,<sup>75</sup> that is another way of saying a variety of measures could be used, provided they lent themselves to apples-to-apples comparisons across jurisdictions and/or institutions: arrest for any offense, rearrest for the same crime, return to prison, and the like. It is an open question as to which definition is preferable. Is it total desistance from crime? A reduction in the number of offenses? A reduction in offenses by each person or an average reduction across populations of similar offenders? A reduction in the severity of the types of crime (moving from violent offenses to property offenses)? Reductions which control for certain variables (aging out)? These choices might depend on the type of offender or on which garners the most support from practitioners.

The next thing to consider is the modality of treatment through the lens of efficacy and efficiency. Bentham's utilitarianism, for example, explicitly takes the prisoner's cost (hedonic and otherwise) of punishment into account, meaning that, *ceteris paribus*, the least restrictive alternative that yields the same result is the most welfare-promoting. Prison is expensive and incurs a variety of collateral harms on a prisoner's family (both in terms of criminogenic effects on children and economically, due to a variety of wealth-extracting contracts for telephones, commissary money, etc.). Prison might also be criminogenic. If so, it is both inefficient *and* ineffective. But, assuming prison "works," its efficacy might not be enough to outweigh its inefficiency. These are empirical questions already being studied. My argument is simply that these questions are important and should be answered; I am not claiming to have the answers myself.

In the health care realm, Porter suggests that a successful treatment that is shorter and less painful is more desirable than one that is longer and more painful. I think this is noncontroversial. The same should be said of punishment. We should seek to do the least amount necessary to get results, and we should explicitly consider suffering. I am not, in theory, opposed to the idea that prison should not be pleasant, but only provided that that suffering works. If people can stop being criminals as effectively without suffering, then what is the point of suffering?<sup>76</sup>

---

outcome measurement and how to categorize outcomes into a hierarchy.

<sup>75</sup> Robert Weisberg, Meanings and Measures of Recidivism, 87 S. Cal. L. Rev. 785 (2014).

<sup>76</sup> In making this suggestion, I take no position on the recent scholarship that explores

Finally, where Porter suggests “health” as the ultimate measure, I would substitute desistance from crime and other pro-social metrics. This might look different for certain subpopulations—looking at the state of the art for homeless offenders might mean hospital days avoided or days without them being assaulted, looking at the mentally ill might involve medication usage or stability of housing, looking at drug-using offenders might vary by drug (heroin users might have one set of metrics, meth users might have another, recidivist DUI offenders might have still others). Again, the framework states that any criminal justice intervention should make people better (or the same) for the same amount of resources (or less). What “better” means depends on political and organizational will, as well as the state of the art in rehabilitative programming.

There are program and policy implications to choosing what to measure. These variables must also control for exogenous factors—i.e., a macroeconomic downturn resulting in higher overall unemployment will affect ex-offender unemployment, as might sector-specific unemployment (such as that for unskilled labor). Variables must also consider the full spectrum of treatment—not just interventions given in prison, but interventions in community supervision. These variables should be scalar and avoid the presumption of perfection—measuring better or worse, not success or failure. Binary measures will, by and large, measure failure, since most of the justice-involved have below-average skills, economic endowments, and pro-social networks. We might therefore consider survival rates before returns to custody (assuming that this is a true measure of criminal activity, not simply a problem of non-detection—which is also a confounding variable in medicine).<sup>77</sup>

It is unlikely that there will be a single metric for every case, but it is nevertheless important to remind ourselves that public safety should be the organizing principle. Our theories of punishment involve incapacitation, deterrence, retribution, and rehabilitation, but these justifications need to be

---

the effects of hedonic adaptation on the typical prison experience. See, e.g., Jonathan Masur, John Bronsteen & Christopher Buccafusco, "Retribution and the Experience of Punishment," 98 Cal. L. Rev. 1463 (2010). My criticism is not with the way suffering is measured, just with the assumption that suffering itself advances other penological goals such as deterrence, conveying a message of disapproval, etc. Hedonic adaptation has some empirical basis; the idea that the rational-expectations hypothesis works for the justice-involved, and that the suffering of prison is part of it, has much less.

<sup>77</sup> For an example of just such an approach, see Peter Schmidt and Ann Dryden White, Predicting Criminal Recidivism Using “Split Population” Survival Time Models, 40 J. Econometrics 141 (1989).

ties to their effects on public safety and measured using common definitions in common data formats. Proponents of a particular theory should have a falsifiable theory about why and how their theory (and the mechanisms that apply to it) works, then measure and test those hypotheses. Within the concept of value creation, we will avoid cost cutting for its own sake—as well as stated claims about efficacy that do not consider efficiency.

Is “public safety value creation” too vague to be useful? Consider that the focus on value creation is now embedded within the healthcare policy community. There is substantial agreement that costs and quality must be considered, and the discussion explicitly references these goals, even as particular measurements of these goals and means to achieve them are disputed. The same is not true now of criminal justice. We seldom consider costs of individual interventions even as we bemoan the costs in aggregate. We almost never operationalize the idea that prison treatment programs might meaningfully affect public safety outcomes. At least agreeing that our criminal justice system should be as effective as possible for the money we spend on it is, I think, an important step. Most of the work will not take place at the level of abstraction that “public safety value creation” implies. It will instead involve meetings with stakeholders, policymakers, and consumers and will involve much painstaking, granular work. But having public safety outcomes as a guiding principle will tie together the many strands of policy and theoretical work currently taking place. The alternative is to throw up our hands, avoid the difficult work, and accept a system that few would or could defend as just, effective, and economical.

### *B. Value Creating Policies*

In this section I will sketch out what policies might arise from a public safety value creation framework. A few caveats before the discussion continues. First, this is a framework, not a particular endorsement of any one metric or program. I am not enough of a social scientist to engage in that, but, moreover, it is important to be open to new data and new studies. The principle of measuring, analyzing, and incentivizing outcome-oriented programs is a procedure: a formula which isolates the variables but does not necessarily solve for  $x$ . Second, the rest of the discussion will not focus on deterrence or crime avoidance. That is the subject of my next article. This Article, again, is just about treatment, not prevention. Finally, I assume that it is possible to know what works, and also possible that something will work—or at least that something will

not work as badly as other things or be as bad but cheaper. That is, there are at least efficiency gains to be had, even if there are not efficacy gains to be had.

There are also certain conditions that I assume would be built into the system, as I have noted in prior articles. In an outcome-based system, localities would be prevented from dumping crime and criminals on other jurisdictions. Criminals would stay for a period of years in the county of conviction, at a time horizon appropriate to measure outcomes. (The term of years would depend on the outcome being measured and, to some extent, on both the social science and the policy preferences of a jurisdiction about the costs of monitoring versus the benefits of monitoring.) I also assume that there would be some kind of validated risk-needs assessment tool used; both sending and receiving parties would have incentives to do so. Receiving institutions would not want to take on a harder case—with higher costs and higher risk of poor outcomes—than they were promised. Sending institutions would want to ensure that a prisoner received the treatment needed. This would solve the cream-skimming problem so often seen in the private prison context. Finally, to the extent that localities were given block grants to approach crime in the manner of their choosing, these grants would have to be subject to income adjustment.

A pay-for-performance criminal justice system would first begin with financial and budgetary reforms that would give decision-makers some incentives to save money and promote effectiveness. Second, the system would have to include some relatively non-controversial data collection requirements that would largely complement initiatives that are already underway. Third, it would continue with a system that actually tailored sentences to the risk factors a given offender presented. It would make the entire menu of sentencing options look a lot like probation does now, with some attempt to link offender characteristics to penological conditions. “Probation” is an umbrella term that includes a variety of approaches. “Prison” or other forms of incarceration should, too. Finally, pay-for-performance might also include indeterminate sentencing, whereby offenders were released as soon as, but not until, they were “better.” Within a pay-for-performance framework, however, both prisoners and parole boards would have specific indicia of readiness to return—whether a prisoner addressed his or her underlying diagnosis--rather than generic estimates of threats to society.

First, budgets would have to be revamped along performance-oriented lines. I have previously proposed that states no longer fund prison,

per se, but that they fund on the basis of crime. This is a potential restructuring that would enable greater local freedom of choice in how offenders are treated, but it is not the only way to encourage pay-for-performance. The federal government has less of a financial impact with criminal justice than it does in medicine: Medicaid and Medicare are significant enough by themselves to generate change, while JAG<sup>78</sup> grants are not. Still, federal funds could be linked to outcome measurement or data collection,<sup>79</sup> and states could then base funding streams on certain baseline standards. Depending on the funding approach used, jurisdictions could conceivably experiment with different approaches to incarceration. Some might invest in mass lockups to incapacitate—subject to Eighth Amendment limitations. Others might pay to make people better. This, too, would provide valuable feedback on the efficacy of various approaches—approaches which, it should be noted, currently take place at the intra-state level but which are opaque to voters and officials alike.

Second, the relatively uncontroversial issues that would need to be implemented to make pay-for-performance viable are, in most cases, issues that need to be addressed for the system to be effectively managed. This means collecting data in standard formats, data that includes a sufficiently long time horizon that is linked to offender behavior in other jurisdictions. This is not a new idea, and it is one where having the idea is a small part of the job. Most of the work needs to take place at the institutional and cultural level, getting buy-in from practitioners and hashing out what those standard measurements and formats will be. Another uncontroversial issue would be using current best practices and being open to revising those individual practices as new best practices develop. Institutions need to think critically about their current policies, training, and practices. Change needs to be ongoing and iterative. Those who pay to use these institutions can tie budgets to best practices, incentivizing the propagation, diffusion, and experimentation needed. Finally, data needs not only to be collected, it needs to be analyzed and shared. A judge now, for example, really only sees the results of her decisions when they fail and an offender returns to court. Judges should, instead, be educated about how their populations performed in aggregate, looking at success and failure rates, survival times,

---

<sup>78</sup> Zack Cooper et. al, *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured* (Dec. 2015), available at <http://www.nber.org/papers/w21815> (criticizing studies that rely only on Medicare data while noting that Medicare covers 20 percent of total health care spending).

<sup>79</sup> Darryl Brown has also suggested that the federal government fund cost-benefit studies. Darryl K. Brown, *Cost-Benefit Analysis in Criminal Law*, 92 Cal. L. Rev. 323, 353 (2004).



prosocial indicators, and the like for all of those they deal with, not just the individuals who return to court for an infraction. They should, moreover, be encouraged to look not just at successes, but whether their successes came with the minimum effective dose of resources. Medicare initially paid local jurisdictions to collect data; the criminal justice equivalent would be a welcome start.

The third issue the system would deal with is tailoring. What is a DRG for criminal justice? In order to measure the outcomes generated by the intervention—as opposed to the selection effects of a given population—we must control for variations in initial condition (which includes risk). That is, if remuneration is based upon doing a good job, we have to be able to distinguish between results that stem from a given *population* being better than another and a given *treatment* being better than another. How do we control for differences between cases and among populations? Consider the following individual examples. The crime of arrest might understate the risk a given individual poses—as, for example, a traffic charge for an organized crime kingpin. The crime of arrest might overstate the risk an individual poses—as, for example, a battered wife killing her abusive husband. This is certainly among the thorniest parts of actuarialism, as making decisions on risk alone can verge on preventive detention. It is hardly an answer to say that risk assessment tools might at least do a more accurate job than the clinical, gut-level assessment of judges and prosecutors. The larger question, though, of what constitutes a “similar” offense and a “similar” offender is vexing.

In medicine, this, too, is a problem. There is a column in the New York Times magazine called “Diagnosis” that seeks to diagnose difficult cases.<sup>80</sup> There are biological markers for diseases (though prostate cancer, for example, might actually be several different diseases<sup>81</sup>), but other than DUI there aren’t many for criminal law (and the shameful history of phrenology suggests that we might be well served to avoid biological markers). There is also a problem of co-morbidity, where those who suffer from two or more diseases need to be treated differently, have different survival rates, and the like.<sup>82</sup> This is also a problem in criminal law, given

---

<sup>80</sup> See, e.g., <http://www.nytimes.com/column/diagnosis>.

<sup>81</sup> Charlie Cooper, Prostate cancer could actually be five different diseases, say scientists, the Independent (Jul. 29, 2015), available at <http://www.independent.co.uk/life-style/health-and-families/health-news/prostate-cancer-could-actually-be-five-different-diseases-say-scientists-10424973.html>.

<sup>82</sup> For criticism of Porter’s ideas on these grounds, see, e.g., Gail R. Wilensky, “Thinking Big, But Ignoring Big Obstacles,” 10/16/2016, available at <http://healthaffairs.org/blog/2006/10/16/health-reform-thinking-big-but-ignoring-big->

how many of the justice-involved have mental health or addiction problems. The issue of how big or how small a DRG should be in order to both have a large enough sample to be statistically significant and tailored enough to be meaningful are also present in medicine—see the criticisms of certain medical protocols as ineffective on the basis of gender or race.<sup>83</sup> The healthcare approach outlines some typical hazards without necessarily pointing out easy solutions.

Some of the discussion about distinguishing and tailoring has already taken place in the offense/offender literature and suggests that we could combine criminal history and offender characteristics (though even criminal histories can be problematic on disparate impact grounds, as well as on accuracy and completeness). One place to start would be with regular risk-needs assessments (RNAs) as a non-exclusive foundation for criminal justice programming, perhaps adding additional data collection on risk factors that might potentially be of interest. Best practices for risk-needs assessments involve re-validation on local populations every couple of years. One would expect that as data collection and outcome measurement improve, risk-needs assessment tools would also improve. Risk-needs assessments have potential problems with disparate impact that need to be addressed.<sup>84</sup> The problems with risk-needs assessments, however, are dwarfed by the problems with gut decisions of judges and DA's, which are even less transparent and accountable—and more subject to bias, explicit or implicit—than RNA's.

Tailoring doesn't just stop with the diagnosis. It also, of course, includes treatment. This is where the criminal justice system as a whole should start to look a lot more like probation and diversion. Currently we do have diversion to probation and treatment, but we also just send people to "prison"—not different kinds of prisons (those decisions are made by prison officials during classification) or different kinds of programs (those are also done by the prison system). Tailoring prison sentencing just means "more" or "less." Prison is expensive. We should be considering what we

---

obstacles/ (noting that "Patients have a nasty habit of having more than one thing wrong with them" and observing that "multiple chronic conditions account for a disproportionate share" of Medicare spending); see also Uwe E. Reinhardt, "HEALTH REFORM: Porter and Teisberg's Utopian Vision," Oct. 10, 2006, available at <http://healthaffairs.org/blog/2006/10/10/health-reform-porter-and-teisbergs-utopian-vision/> (criticizing the idea that medical conditions are easy to identify, discrete, and easy to put into "a standard, finite life cycle.").

<sup>83</sup> Nicholas J. Schork, Time for one-person Trials, 520 *Nature* 609 (Apr. 30, 2015).

<sup>84</sup> Sonja Starr, Evidence-Based Sentencing and the Scientific Rationalization of Discrimination, 66 *Stan. L. Rev.* 803 (2014).

get for that money. It doesn't make sense to say "you are a criminal, you get prison" the same way it would not make sense for a doctor to say "you are sick, get medical help." Doctors diagnose patients with particular illnesses and prescribe particular treatments. This should be the goal of the criminal justice system—we should at least scrutinize fee-for-service subsidies of a treatment that is among the most expensive one we have. This kind of tailoring would be a radical change—albeit one that was common during the *Williams v. New York* era. There are questions of how much discretion a judge should have to find facts (subject to the underlying sentencing statutes and whether they, in turn, implicate Apprendi). There are also issues about whether long sentences would ever generate the kind of feedback a judge would need—presumably judges would die or retire before the end of certain extremely long sentences. But surely our currently broken system which simply enables long sentences with no questions asked is worse. Not asking questions does not mean such sentences are more effective or parsimonious; it simply means we have no way to know whether they are effective or parsimonious.

The value framework could obviously fit into contracts with private prisons, encouraging a focus not just on cost per prisoner, but paying for treatment of an offender's criminogenic needs. Jurisdictions could track and pay for outcomes, adjusting for the risk profile of those who went in. The alternative embeds undesirable outcomes. A contract that focuses only on price, for example, creates incentives for private prisons to "cream skim" only the most low-cost prisoners, meaning those who are younger, physically healthier, and less mentally ill. A value creation framework would adjust the reimbursement price of those prisoners down, making sure that the outcome is measured in terms of how people changed in prison, not just how they were upon release. The value framework could also provide incentives to maximize pro-social outcomes such as educational attainment in prison<sup>85</sup> or longitudinal outcomes such as employment and family relationships. Without some outcome measurement, contracts that pay a simple per-prisoner per day amount create a potential incentive not to treat prisoners in hopes of ensuring a future revenue stream from recidivism.<sup>86</sup> Others have suggested different pay-for-performance models, including a

---

<sup>85</sup> David M. Siegel, "Internalizing Private Prison Externalities: Let's Start with the GED," 30 N.D. J. of L., Ethics and Pub. Pol. (2016).

<sup>86</sup> Kenneth L. Avvio, "Remuneration Regimes for Private Prisons," 13 Int'l Rev. of L. and Econ. 35 (1993). See also Anita Mukherjee, "Do Private Prisons Distort Justice?" (2016), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2523238](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2523238) (evaluating empirical evidence that contractual incentives incentivize private prisons to prolong stays via disciplinary write-ups).

prison re-admission penalty similar to those used in hospitals.<sup>87</sup>

Beyond the private prison option, the state could also treat existing state-owned and administered prisons in a similar manner. State prisons could specialize in particular populations, charging differential rates to localities based on prisoners' underlying needs and on the treatments used. Currently the system does not generally differentiate among the prisons within the system. But why not make one prison for domestic abusers, another for addiction-driven behavior, and the like? Programming in prison can vary: perhaps some will specialize in restorative justice, others with gang members, others with mentally ill offenders. Prisons can also differ on the basis of location, size, practitioners and their training, and theory. Perhaps United States prisons can look internationally for other examples—Scandinavian prisons approach prisons and prisoners in dramatically different ways.<sup>88</sup> Variety in theory and practice is also a return to the historical origin of state prisons, when wardens had great leeway to pursue different methods.

Each prison could focus on needs, and those needs could be measured, treated, and the treatment assessed in terms of how well it worked and at what cost. Prisons could subsequently move toward best practices, nudged, in part, by the demands of those who are paying for prison beds. No longer would we treat all prisons and all prisoners the same. Systems would, instead, have some idea of what kind of prison and what kinds of programs would be in operation once someone got there.

Another option would be for sentence lengths to be limited at the time they are imposed and potentially extended before release—that is, a return to indeterminate sentencing (those sentences terminating in parole release). The problem with indeterminate sentences as they are practiced in some states like California is that the ultimate length of the sentence is unlimited: e.g., 25 years to life. There is no incentive for parole boards to release prisoners; their only incentive is to avoid the spectacular failure, not to promote the quiet success.<sup>89</sup> Other states have maximum limits on indeterminate sentences (e.g. 4 to 8 years, where release is possible after 4

---

<sup>87</sup> Stuart Butler, "How Hospitals Could Help Reduce Prison Recidivism," Aug. 18, 2015, available at [http://www.realeclearmarkets.com/articles/2015/08/18/how\\_hospitals\\_could\\_help\\_reduce\\_prison\\_recidivism\\_\\_101789.html](http://www.realeclearmarkets.com/articles/2015/08/18/how_hospitals_could_help_reduce_prison_recidivism__101789.html).

<sup>88</sup> John Pratt, *Scandinavian Exceptionalism in an Era of Penal Excess*, 48 *Brit. J. Criminol.* 119 (2008).

<sup>89</sup> W. David Ball, *Normative Elements of Parole Risk*, 22 *Stan. L. & Pol'y Rev.* 395 (2011).

years but must be done by 8). This would be a return to the medical model of imprisonment with a few improvements, notably that there was some understanding of what needs an offender had to address to be eligible for release (e.g., go to prison and work on your vocational skills or anger management).

Indeterminate sentences in a system that internalized costs and benefits would generate pressure to release safer prisoners and avoid the problem of life sentences “with the possibility of parole, hold the possibility of parole.”<sup>90</sup> Other parts of the system would be clamoring to use the money spent on incarceration to promote higher value interventions. The redistribution of funds spent on discretionary years of an indeterminate sentence could be accomplished through a number of different funding mechanisms. Payment by a jurisdiction might be for a certain amount of time for a given condition (X years for a domestic abuser), with the potential for earlier release (and cost savings to the carceral institution) but a delayed performance payment based on a certain length of time without recidivism. States could pay for a given amount of time that amounts to a valuation of just deserts, and localities could pay for more prison time to either vindicate local values or to promote treatment—and, of course, they would be able to shop around for prison beds at particular institutions that did a good job. Another option would be to localize parole board release decisions, where individuals from the community decided when a prisoner was ready to come home, knowing that additional funds would be released in order either to lower taxes or to redirect funds to prevention programs.

Indeterminate sentencing was criticized in the mid-1970s for a variety of reasons. I will not address one of the criticisms—that it did not promote uniformity of punishment—since one of the main advantages to indeterminate sentencing is the very fact that punishment can be tailored. The non-uniformity criticisms were, at their core, about racial preferences. Again, using risk-needs and having an outcome-based approach would make release decisions less opaque. Parole officials would actually know what they were looking for in terms of criminogenic needs to be addressed before release. Prison capitation fees could solve for the problem of indefinite retention—there would be pressure to let prisoners out in order to free up funds that could be put to use elsewhere. Indeterminate sentencing also has the advantage of incentivizing inmates to program. At the very least, it isn’t as though determinate sentences have been good for prison population reduction, nor have they proven to be particularly good at

---

<sup>90</sup> W. David Ball, *Heinous, Atrocious, and Cruel*, 109 *Col. L. Rev.* 893, 968 (2009).

reducing recidivism, in promoting equity and fairness, or reducing racial disparities. As with so much else, the inequality has merely shifted to differential charging and bargaining capacity.

It is certainly possible that a poorly-administered, poorly-supervised parole board could impose indefinite detention on the basis of dangerousness. Our present system already has this problem when it comes to sex offenders (arguably worse, since the nominally “civil” nature of the incarceration means that there are no guarantees about the right to counsel and the beyond a reasonable doubt standard of proof). This is also a potential reason why retribution could be helpful in imposing some limits, though I have expressly not taken a retributive approach in this article.

The point here is that implementation could involve a variety of choices after the sentencing moment in court. It is one thing to have an imprisonment policy and assume what goes on there is beneficial; it is another thing to incentivize the kind of treatment that the committing jurisdiction wants. No longer would an arbitrary, *ex ante*, one size fits all term of years be the sentence, with “whatever happens, happens” as the prescription for those responsible for the prisoner. It would be much more particular, with specific prescriptions given, not simply “get some drugs or get some surgery in one of several hospitals”, but “go here and treat your diabetes with insulin” or “get arthroscopic surgery on your knee from this doctor.”

There is nothing intrinsic about our current system of imprisonment, as I have noted in other articles. There is much that might seem speculative about this approach, but, of course, our system as it stands is huge, expensive, and a disgrace. Mass incarceration is the experiment; trying to unwind it is not. Historically, these proposals are much closer to the sentiments that prevailed in the mid 19<sup>th</sup> and mid 20<sup>th</sup> century, minus the phrenology and other dubious social science. In the mid-19<sup>th</sup> century, it was common to pick particular institutions at the time of sentencing, these institutions were often paid per prisoner, and the institutions had particular philosophies of rehabilitation. Wardens also wanted to release prisoners on an indeterminate schedule with the idea that they could keep prisoners until they were cured. Even if the particular modalities of treatment from this era are outdated, the idea that one should have a mode of treatment is not. We know things now. Or, put another way, the “nothing works” philosophy is misnamed. It should be called “nothing works—except prison” because it assumes that prison is worth doing even if nothing else is. Phrased that way, it is apparent that while prison may have something going for it in

terms of efficacy—though this is disputed—there is tremendous evidence that it is inefficient.

Criticism of the rehabilitative approach is much like the criticisms more generally leveled at actuarialism. I am not suggesting that evidence-based practices are immune to some of the harms attributed to them, most notably disparate impact on people of color—but it can hardly be claimed that our current system does not have ruinous effects on people of color. The causes are simply harder to discern with any exactitude, which means everyone and no one is to blame. That, to me, is not a virtue. The same is perhaps true of the state of evidence-based rehabilitation. It might not be perfect, but it is certainly better than what we have now. If I had more faith in the guts that tell a judge when someone needs prison, or the guts that tell a lawmaker that a ten-year sentence works better than a five- or eight-year sentence, then perhaps I would change my tune. I don't, however, have any faith in the guts of others (and know not to trust my gut when it tells me to trust it).<sup>91</sup>

The current system is both overdetermined and too discretionary. It is overdetermined in the sense that a given set of years is typically given for an individual offense, including via mandatory minimums. It is too discretionary in the sense that charging decisions are beyond review. The alternative of evidence-based indeterminate sentences keeps discretion but provides some limits, and it ensures that there is discretion on the back end of sentencing as well.

### *C. Potential Advantages of a Value Orientation*

There are several potential advantages that might result from a value-oriented system.

The first is to generate some momentum towards a creation of a penological state of the art. Measuring outcomes and rewarding value creation will create incentives for their widespread implementation. Put another way, why does it take so long for good ideas to diffuse? Why are there no standard criminological treatments? It could be that there is insufficient good research, or that local populations are different, but it is also the case that demonstrably ineffective programs (such as scared

---

<sup>91</sup> Adjustments to risk assessments can also exacerbate disparate impact. Jennifer Skeem, John Monahan, and Christopher Lowenkamp, *Gender, Risk Assessment, and Sentencing: The Cost of Treating Women Like Men* (Jan. 2016), available at [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2718460](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2718460).

straight) have not yet been fully eradicated. Again, very little discussion in the legal academy differentiates among alternative conditions of custody and programming in prison. The closest widespread practice on the ground that even approximates this is probation, where judges put conditions on probationers in an attempt to cure their problems, but even then some judges think “more is better” without using the risk responsiveness principle—which might mean more is ineffective—or considering what is not only effective but efficient, given that public safety resources, like all other resources, are scarce and need to be deployed wisely. One notable exception is pretrial statutes in jurisdictions such as the federal system and New Jersey, which require judges to attach conditions of pretrial release using the least restrictive means possible.

Tying funding to value creation will incentivize both innovation and diffusion. Part of the reason that change comes so slowly to criminal justice in general and prisons in particular is that there’s no incentive to change (part of it, of course, might also be that retributivism demands it). Prisons aren’t penalized for doing a bad job. Another problem is loss avoidance—the hedonic (and economic losses) of prison are not counted, just the speculative (and non-falsifiable) worry about the next Willie Horton. Criminal justice costing is certainly doable, as WSIPP and others have demonstrated, and one can readily think of damages that arise simply from arrest—namely, for those who cannot make bail, the economic losses from being in jail until the time of trial (not to mention the increased likelihood of being sentenced to a harsher penalty). Prisons are a major cost center in state government, and, as such, should be targeted. We could, of course, do the same thing via procedure. We could use the speedy trial right, for example, as a means to cut costs for both defendants and the state (assuming that the case could be investigated as effectively in a shorter period of time, which is perhaps doubtful), but that right is consistently waived. A procedural approach would invite just as much effort without necessarily improving outcomes.

If budgetary incentives are to be used, one size will not fit all. Paying for improvements in outcome might be seen as punishing agencies and institutions that already do things the right way, whereas pay for a certain standard of performance will be impossible for the lower-performing agencies and institutions to meet. High performing agencies, then, might be rewarded for meeting a certain standard, and lower-performing agencies might be rewarded based on improvement year over year until they meet a certain minimum, as they currently are under Medicare’s Hospital Value-



Based Purchasing Program.<sup>92</sup> Quality control might even need to start where medicine did, not with outcomes, but with training, education, and professional standards. The main lesson, though, is that quality improvement is a continual process, not a set it and forget it switch.

## V. CRITICISMS OF THE APPROACH

Perhaps the most obvious criticism of pay-for-performance is the old one: that nothing works, and that there is no evidence that one approach to incarceration and sentencing has better results than another. I have assumed that there is more than “nothing” that is promising, but I also would argue that even if there is no good evidence about effective programming, *pace* WSIPP, it could be that we have not found the evidence or found the program. In medicine, too, diagnoses and treatments change and improve all the time. There are, of course, some legitimate concerns about throwing one’s lot with science when it comes to criminal law. The experience of phrenology, eugenics, and race-based theories of criminality demonstrate the fallibility of the scientific state of the art when viewed by later generations. I am not suggesting blind faith in experts, but I do not think this problem is insurmountable.

At the same time, there is some reason to be skeptical that nothing will be shown to work in the penological context. Is quality in prison really harder than in medicine? Is it more difficult to research how to treat a violent person than it is to treat cancer? To improve survival rates of premature babies? Is it impossible or just not been done—or even really tried? Do we have an alternative to simply sighing and continuing to incarcerate, albeit wistfully?

Even if it were true that nothing works, not all equally ineffective programs cost the same. Some might be cheaper. Moreover, even if nothing works in terms of making people better, surely some things work at making them worse. Solitary confinement exacerbates problems with mental health. It is also extremely expensive. Even if it were true that being housed in a general prison population didn’t make someone “better”, it certainly does not damage someone nearly as much as solitary confinement.

A second criticism is retributive. As stated in the introduction, this

---

<sup>92</sup> <https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html>.

analysis has assumed an explicitly utilitarian framework. At this point, though, it is worth discussing whether this approach is consonant with retribution. I will not belabor the criticisms of retributivism here,<sup>93</sup> but will only suggest that a value orientation is compatible with notions of desert and redemption. The idea that prisoners can only be warehoused forecloses any redemption. Rehabilitation humanizes the offender and has the potential to demonstrate that she is worth saving and redeemable, and mercy is a part of retribution (albeit one seldom emphasized). Moreover, to the extent we want punishment to make someone learn a lesson, what better evidence could we have of that than an offender changing his or her ways? This is superior to a theory that an offender will (or must) have learned her lesson because she went to prison; it is, instead, a way of demonstrating that she actually did. This provides better evidence of the “meaning of punishment” than claims that are always asserted without proof that the legislature, judge, or warden meant the message or that it was ever received as such by the convicted. I would query also whether it is moral to warehouse people and do nothing for them (particularly given how little opportunity many of them had to participate meaningfully in society), or to spend money on prisons and not on schools or other generative endeavors. Socially, it isn’t at all clear what “values” mass incarceration is promoting, nor is it clear whether it even aligns with most people’s values. Perhaps it only aligns with the marginal voter or donor.

A moral concern related to retributivism (but not, strictly speaking, a part of it) would be that we shouldn’t care about the cost—that justice is worth any price. Alternatively, it could be argued that rehabilitation is also worth it no matter the price. These arguments necessarily ignore the fact that lots of worthwhile things cost money and that money spent on one thing cannot be spent on another. If we care about victims, what better tribute to them than to fix someone? If we care about offenders, what better

---

<sup>93</sup> For an overview, see, e.g., Christopher Slobogin & Lauren Brinkley-Rubinstein, *Putting Desert in Its Place*, 65 *Stan. L. Rev.* 77 (2013). See also Mark R. Fondocaro & Megan J. O’Toole, *American Punitiveness and Mass Incarceration: Psychological Perspectives on Retributive and Consequentialist Responses to Crime*, 18 *New Crim. L. Rev.* 477 (2015). For a criticism of how “limiting retributivism” has failed to provide any meaningful limits in an era of mass incarceration (unless “the sky’s the limit” counts), see Robert Weisberg, *Barrock Lecture: Reality-Challenged Philosophies of Punishment*, 95 *Marq. L. Rev.* 1203 (2012). For a study suggesting that white people’s notion of the proper level of punishment depends, in part, on how black and brown they perceive prison to be, suggesting that retribution depends on whether it is “them” or “us” we are talking about, see Rebecca C. Hetey and Jennifer L. Eberhardt, *Racial Disparities in Incarceration Increase Acceptance of Punitive Policies*, 25 *Psychological Science* 1949 (2014). For a discussion of CBA and retributivism, see Darryl K. Brown, *Cost-Benefit Analysis in Criminal Law*, 92 *Cal. L. Rev.* 323, 363 (2004).

way to show that than to try to heal them? We are giving up on them otherwise.

In terms of cutting costs by worsening conditions of confinement, the value approach is definitively superior. Yes, there is an Eighth Amendment limit to prison conditions that kicks in several years after a state like California stipulates that it is violating that portion of the Bill of Rights (as in Plata). In the meantime, there is a temptation to incarcerate on the cheap. Not providing programming is likely to make people more dangerous, in addition to making them bored. The same is likely true for not feeding prisoners a full 3 meals a day. The value argument does not replace rights-based arguments, but neither does it contradict them. It supplements them. Appealing to economic efficiency is a way of expanding the constituency supporting the unwinding of mass incarceration.

A penultimate objection is that criminals with different social backgrounds will be punished disproportionately: that diagnoses that take into account social deficits will just end up punishing the poor. If there are deficits, why only work on them in prison? With this objection, I agree. This is why efficacy and efficiency in treatment goes only so far, and why, ultimately, the wider-ranging reorganization of criminal justice funding will have to include prevention—which also means it will have to include social welfare programs that are not traditionally considered public safety programs but which might, nevertheless, prevent criminal activity. Most people would surely rather pay to subsidize poor children’s day care than pay to subsidize poor adults’ prison healthcare. We should have a system that incentivizes those investments and penalizes the misallocation of resources. We should not allocate social welfare resources only after crime and criminals have been generated. This is the argument I will address in my next article.

At the same time, the current focus on incapacitation offers no way out. Our existing system is full of poor people and people of color—those most disadvantaged by society. At least in a pay-for-performance system there are incentives to treat offenders, incentives for offenders themselves to get treatment, and incentives to release people when they are ready. Prison subsidies do none of that.

Finally, regulatory capture by service providers could also potentially be an issue. The treatment industry is big business—called by some the “treatment industrial complex”—and if there were a greater uptake of diversion instead of prison, there could be the potential that treatment

providers might lobby and skew the distribution of sentencing alternatives. To this I will only say that prison guards and the prison industry may have already effectively captured the state's interest in incarceration, and that some countervailing interests might serve to rescue the state from its current captors. Moreover, the value model assumes that data will be collected on effectiveness and treatment dollars will go only to those providers and programs that demonstrate efficacy and efficiency. This should serve to ensure that parties who get more traffic are getting it because they do a good job.

#### CONCLUSION

The preceding Article has attempted to lay out a vision for where criminal justice might go. It has not been intended to be overly conclusive, nor is the social science necessarily definitive. Instead, I have sought to introduce a goal-oriented framework into which the latest research and best practices might fit, in a way that promotes the dissemination and adoption of those best practices. If it does no more than complement the existing work being done on criminal justice CBA, it will have done enough.

As I have stated in prior articles, there are many different ways to structure and fund criminal justice systems, and many different ways have in fact been employed in the United States, from purely local criminal justice to unified corrections systems and other systems in between. In this Article I have proposed another option for us to consider alongside those alternatives. It is worth remembering that the system that has developed is historically contingent, not inevitable or constitutionally required.

Moving forward, it is also clear that academic and theoretical writing are not enough to unwind the carceral state. Policymakers and practitioners will have to engage with the system at the process level, working with those in the system to get their perspective, their detailed knowledge about policies and processes, to get them to buy in, and maybe even to restructure their own contracts and performance incentives.

There is a natural tendency to dismiss some or all of the preceding analysis as utopian. Indeed, this is a criticism leveled at Porter's work: that it can't work in real life, that costing is difficult, that there is no state of the art, that diagnoses are difficult, etc. I would certainly not claim that restructuring the criminal justice system along the lines I have suggested would be easy, but it would at least take seriously the idea of public safety and make it more than a rhetorical device to be invoked every time new

ground is broken on an unproven, inefficient prison construction project. In the end, there is nothing to be lost by trying to re-imagine our present system. Making change happen is always difficult, but making our present system better—given the very low bar set—is certainly worth the attempt.