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

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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. The result has been a system that incentivizes resource consumption, not health improvements. Healthcare economists and policymakers have reacted by proposing a number of policies designed to control costs without sacrificing quality. One approach is to reimburse providers on the basis of health outcomes obtained. Under a pay-for-performance strategy, providers are incentivized to deliver healthcare in ways that are both efficacious and efficient. This means providers are no longer paid for simply doing a given "something" but, rather, are paid for doing "something effective."

The criminal justice system is plagued by many of the same distorted individual and organizational incentives seen in health care. 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. An outcome-oriented, pay-for-performance framework borrowed from healthcare economics might, if applied to criminal justice, improve its efficacy and efficiency.

This Article focuses on the similarities between health care and criminal justice, the ways in which an outcome orientation might provide a useful framework for controlling criminal justice costs without sacrificing public safety, and the suggestion that we begin considering sentencing choices within that framework.

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> This is what I gathered. That in that country if a man falls into ill health, or catches any disorder, or fails bodily in any way before he is seventy years old, he is tried before a jury of his countrymen, and if convicted is held up to public scorn and sentenced more or less severely as the case may be. There are subdivisions of illnesses into crimes and misdemeanours as with offences amongst ourselves . . . . But if a man forges a cheque, or sets his house on fire, or robs with violence from the person, or does any other such things as are criminal in our own country, he is either taken to a hospital and most carefully tended at the public expense, or if he is in good circumstances, he lets it be known to all his friends that he is suffering from a severe fit of immorality, just as we do when we are ill, and they come and visit him with great solicitude, and inquire with interest how it all came about, what symptoms first showed themselves, and so forth,—questions which he will answer with perfect unreserve; for bad conduct, though considered no less deplorable than illness with ourselves, and as unquestionably indicating something seriously wrong with the individual who misbehaves, is nevertheless held to be the result of either pre-natal or post-natal misfortune.
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> Samuel Butler, *Erewhon*[1]

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.[2] 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 treatment resulting in a patient rehospitalization could be a financial gain to the hospital despite being a bad outcome for the patient. The

1. SAMUEL BUTLER, EREWHON 49 (Xist Publ'g 2015) (1872).
2. *See infra* Part I.

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 employs Professor Michael Porter's formulation of pay-for-performance, value creation, where value is measured in terms of health care outcomes per dollar spent.[3] 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 resources possible. 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. At the same time, parsimony is embedded; *ceteris paribus*, treatments which use the fewest resources are preferred. Under a value-based system, a hospital is paid for results, not processes. For 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 and the patient were healed, it would break even or make a little money. But if it treated the condition effectively through other, lower-cost means (including effective aftercare), 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 structural relationships and organizational incentives of "providers" in the criminal justice system (e.g., 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 in a manner similar to 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 cardiac 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 failed 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.

Such an approach would have several advantages: providing economic incentives for non-carceral (and non-criminal) alternatives, promoting the development of evidence-based practices that are less resource-intensive, and providing incentives to adopt the state-of-the-art in criminal

3. *See infra* notes 47–50 and accompanying text.

justice policies. At the very least, it would require agencies to justify their existing practices on efficacy and efficiency grounds—a justification that, in our era of mass incarceration, will likely be found wanting.

This Article is 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 a long and difficult process—and yet progress has been made.[4] 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.[5] It suggests new ways to harmonize social welfare with the welfare of individual organizations. The main thrust of the argument is to actually give weight to the invocation of criminal justice goals—in this case, public safety—by making sure that what criminal justice agencies are doing achieves that goal 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 agencies which decide to pursue other options will have to pay the difference in cost. One can readily imagine some policy changes that might result. Some problems might not be worth any criminal sanctions at all, as the risk-needs-responsiveness principle has taught us.[6] Mentally ill offenders get worse, at great expense, in prisons and jails;[7] under pay-for-performance

4. *See infra* Part II, Section IV.A.

5. *See infra* Part III.

6. *See* D.A. Andrews, James Bonta & R.D. Hoge, *Classification for Effective Rehabilitation: Rediscovering Psychology*, 17 CRIM. JUST. & BEHAV. 19, 20 (1990) ("Higher levels of service are reserved for higher risk cases . . . . [L]ower risk cases do as well or better with minimal as opposed to more intensive service."); *see also* Christopher T. Lowenkamp & Edward J. Latessa, *Understanding the Risk Principle: How and Why Correctional Interventions Can Harm Low-Risk Offenders*, TOPICS COMMUNITY CORRECTIONS, 2004, at 3, 3 ("[W]e see intensive treatments and supervision leading to no effect or increased recidivism for low-risk offenders.").

7. *See* E. FULLER TORREY ET AL., MORE MENTALLY ILL PERSONS ARE IN JAILS AND PRISONS THAN HOSPITALS: A SURVEY OF THE STATES 9–11 (2010), http://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf (finding that mentally ill inmates are more likely to stay longer, commit suicide, and be abused, while incurring greater costs).

they might be removed from the criminal justice system entirely. Lengthy criminal sentences might not be worth the cost (both human and financial) in terms of what they add to public safety and could be shortened.

The approach taken in this Article differs from my prior work in the way it treats incarceration.[8] 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 individuated, where individual institutions begin to specialize in various subpopulations with particular risks and needs. This means that a system would no longer consider that prison time and jail time are fungible, 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" custodial sentences, which, at most, considers only how much time in a generic prison or jail an offender should get.[9]

There are a few assumptions that underlie this analysis. First, this Article does not assume that "nothing works" in rehabilitating criminals, a phrase often attributed to Robert Martinson, albeit one he did not write, and one which flies in the face of recent criminological research.[10] The Article does not take a position on any particular rehabilitative program but is, instead, 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 provides financial incentives for the development and dissemination of the most effective programs need not be locked into a particular theory or method. Second, this Article assumes that data is better than intuition about "what is right" or "what works," and because people often make claims about what criminal justice is, what it 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. Intuition is subject to implicit biases that are both harder to detect and correct than those embedded in actuarial instruments—provided, of course, that those instruments are open to public scrutiny (which is not always the case). Given the overwhelmingly racialized nature of American criminal justice, the greater potential transparency of actuarialism could allow us to more easily diagnose problems and adjust policies.

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8. *See infra* notes 83–89 and accompanying text.

9. *See, e.g.*, United States v. Booker, 543 U.S. 220, 245, 249–50 (2005) (discussing tailoring in terms of sentence length and matching offense and offender facts to the federal sentencing guidelines); *see also* Kimbrough v. United States, 552 U.S. 85, 100–01 (2007) (discussing tailoring in *Booker* and only referring to time sentenced).

10. *See* Robert Martinson, *What Works?—Questions and Answers About Prison Reform*, 35 PUB. INT. 22, 48–50 (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 & OFFENDERS 101, 103–06, 110–11 (2009).

This Article proceeds in five parts. Part I outlines the similarities between the healthcare and criminal justice systems, emphasizing how fee-for-service reimbursement 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 discusses some shortcomings of this approach and attempts to address them.

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 beginning with the New Deal, but efforts to adopt it failed due to opposition from the American Medical Association (among other factors).[11] 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 end of World War II.[12] 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 medical care provided by a mix of independent doctors, practice groups, Healthcare Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs).[13] 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.[14] Doctors are not necessarily expected to get feedback about what eventually happens to their

11. David Blumenthal, *Employer-Sponsored Health Insurance in the United States—Origins and Implications*, 355 NEW ENG. J. MED. 82, 82–83 (2006).

12. *Id.* at 83–84.

13. Julie Barnes, *Moving Away from Fee-for-Service*, ATLANTIC (May 7, 2012), http://www.theatlantic.com/health/archive/2012/05/moving-away-from-fee-for-service/256755.

14. For a review of the subject, as well as an introduction to the Cochrane Collaboration, an international clearinghouse for "what works" in medicine, see John N. Lavis et al., *Working Within and Beyond the Cochrane Collaboration to Make Systematic Reviews More Useful to Healthcare Managers and Policy Makers*, 1 HEALTHCARE POL'Y 21, 23–32 (2006).

patients because those problems are often passed on to other "downstream" institutions and doctors.[15]

Fee-for-service reimbursement was, until recently, the dominant system for reimbursing healthcare providers.[16] 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.[17] The problem with fee-for-service is that it incentivizes additional procedures and interventions.[18] 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 are not paid for doing something that works, just for doing something at all—and, in fact, sometimes more interventions result in worse outcomes.[19] 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."[20]

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).[21] Providers are paid per service, giving them no financial incentives 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 beyond the purview of dollars and cents. One of the enduring questions is which group—if any—is really steering health policy. Is the ultimate decision maker the insurer, who pays? The doctor, who treats? And who benefits? The patient, who is healed? Society, who is made safe from communicable diseases?

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15. Michael E. Porter, *A Strategy for Health Care Reform—Toward a Value-Based System*, 361 NEW ENG. J. MED. 109, 110–11 (2009).

16. John T. Preskitt, *Health Care Reimbursement: Clemens to Clinton*, 21 BAYLOR U. MED. CTR. PROC. 40, 40–44 (2008).

17. *See* Robert A. Berenson & Eugene C. Rich, *US Approaches to Physician Payment: The Deconstruction of Primary Care*, 25 J. GEN. INTERNAL MED. 613, 613 (2010).

18. 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, 1240 (2013) ("[T]his literature mainly finds that doctors provide more services in fee-for-service systems . . . .").

19. Ezekiel J. Emanuel, Op-ed, *Are Good Doctors Bad for Your Health?*, N.Y. TIMES Nov. 21, 2015, at SR7. For the systemic effects of overprescribing antibiotics, see Sarah Childress, *Dr. Arjun Srinivasan: We've Reached "the End of Antibiotics, Period,"* PBS: FRONTLINE (Oct. 22, 2013), http://www.pbs.org/wgbh/frontline/article/dr-arjun-srinivasan-weve-reached-the-end-of-antibiotics-period.

20. Alan Maynard, *Health Reform: Reinventing the Wheel*, HEALTH AFF. BLOG (Oct. 12, 2006), http://healthaffairs.org/blog/2006/10/12/health-reform-reinventing-the-wheel.

21. For a suitably consumer-focused treatment of the problem, see Leslie Goldman, *How Much Is This Gonna Cost Me, Doc?*, O MAG., July 2015, at 72, 72.

It is well known that the U.S. health care system is exceptional (although not in a good way), and the country has recently made significant changes under the Affordable Care Act (Obamacare).[22] All along, however, 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.[23] 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.[24]

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.[25] The economics of prison provision used to be different: governments got (or at least thought 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).[26] If prisons do a good job rehabilitating, it means less work for police. If police arrest marginal criminals, it places more stress on courts and jails. The system as a whole passes costs from agency to agency and fails, in many cases, to treat the offender in a consistent and

22. *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified in scattered sections of 42 U.S.C.).

23. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 23–28 (1982) (discussing doctor resistance to change generally); *id.* at 252–54 (discussing doctor resistance within the progressive era); *id.* at 271 (discussing doctor resistance during the New Deal); *id.* at 280 (discussing the introduction of "socialized medicine"); *see also* Sven Steinmo & Jon Watts, *It's the Institutions, Stupid! Why Comprehensive National Health Insurance Always Fails in America*, 20 J. HEALTH POL. POL'Y & L. 329, 330–35 (1995) (identifying structural reasons in the U.S. political system as well as resistance from medical professionals).

24. STARR, *supra* note 23, at 26–28.

25. This treatment largely reproduced that of a prior article. *See* W. David Ball, *Why State Prisons?*, 33 YALE L. & POL'Y REV. 75, 89 (2014) [hereinafter Ball, *Why State Prisons?*]. For a California-specific treatment, see W. David Ball, *"A False Idea of Economy": Costs, Counties, and the Origins of the California Correctional System*, 664 ANNALS AM. ACAD. POL. & SOC. SCI. 26, 28–31 (2016) [hereinafter Ball, *A False Idea*]. For a lengthier treatment on the origins of state prisons (one which does not focus on political economy), see generally REBECCA M. MCLENNAN, THE CRISIS OF IMPRISONMENT: PROTEST, POLITICS, AND THE MAKING OF THE AMERICAN PENAL STATE, 1776–1941 (2008).

26. . For background on unified corrections, see generally BARBARA KRAUTH, NAT'L INST. OF CORR., U.S. DEP'T OF JUSTICE, A REVIEW OF THE JAIL FUNCTION WITHIN STATE UNIFIED CORRECTIONS SYSTEMS (1997), http://static.nicic.gov/Library/014024.pdf.

coordinated manner. There is little data on what works, and few incentives to study what data there is.[27] District Attorneys (DAs) and judges are under no pressure to get feedback about what eventually happens to individual 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 perhaps actors face some political pressure, an element of the equation discussed at length in the literature).[28]

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). DAs and judges are not required to consider the cost of sentencing outcomes (except in states like Missouri)[29] 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 its 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.[30] 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).[31] The result is that costs balloon. There is too little investment on the front end of prevention, there is rationing of one kind or another (overcrowding or programming and treatment), but the drive to cut costs is met with justifiable resistance by the Eighth Amendment of the Constitution, which prohibits cruel and unusual punishment.[32] Again, one of the enduring questions is which group—if any—is really steering criminal justice policy. Is the ultimate decision maker the legislature, who writes expansive penal codes? The DA or judge, who charges and sentences? And who benefits? The inmate, who is incarcerated? The public, who is made safe from crime? The victim, who is vindicated?[33]

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27. For a more detailed discussion of this point, see Samuel R. Wiseman, *The Criminal Justice Black Box*, 77 OHIO ST. L.J. (forthcoming 2017).

28. For a skeptical view on the efficacy of prosecutorial elections, see Ronald F. Wright, *How Prosecutor Elections Fail Us*, 6 OHIO ST. J. CRIM. L. 581, 583 (2009).

29. Chad Flanders, *Cost as a Sentencing Factor: Missouri's Experiment*, 77 MO. L. REV. 391, 391 (2012).

30. Francis T. Cullen, Cheryl Lero Jonson & Daniel S. Nagin, *Prisons Do Not Reduce Recidivism: The High Cost of Ignoring Science*, 91 PRISON J. 48S, 50S–51S (Supp. 2011).

31. William J. Stuntz, *The Pathological Politics of Criminal Law*, 100 MICH. L. REV. 505, 519 (2001).

32. U.S. CONST. amend. VIII.

33. Not all crimes have victims in a tangible sense—who is the victim in a consensual drug sale or in resisting arrest? Moreover, victims do not drive decisions—the prosecutor does. In some cases, for example, prosecutors seek the death penalty over the objections of surviving family members. *See, e.g.*, Wayne A. Logan, *Declaring Life at the Crossroads of Death: Victims' Anti-Death Penalty Views and Prosecutors' Charging Decisions*, 18 CRIM. JUST. ETHICS 41, 43–45 (1999).

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 (e.g., 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. DAs 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 from 1994 to 2008.[34]

To say that the criminal justice and healthcare systems are similar is not to say that crime and disease are identical. Crime and disease share some similarities, but also have important differences. But one need not address crime when one is talking about incarceration; crime is a necessary but not sufficient condition for incarceration.[35] Crime goes unreported, unsolved, and unprosecuted. Poor health also goes undetected, undiagnosed, and untreated.[36] Crime is seen as much more a result of human agency than is disease—choices about engaging in activities that are criminal as well as choices about which activities will be deemed criminal—although some lifestyle choices, such as smoking, increase risks of disease and some conditions, such as female hysteria in the 19th century, were the result of which behaviors society deemed abnormal or worthy of treatment.[37] Some might say that crime is always bad and health is always good, but consider whether using the criminal justice system as a form of social control is universally acknowledged to be desirable, or whether extending the life of a terminally ill patient through treatments with many unpleasant side effects is desirable.[38]

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34. *See* John F. Pfaff, *The Micro and Macro Causes of Prison Growth*, 28 GA. ST. U. L. REV. 1239, 1241 (2012); *see also* Daniel P. Kessler & Anne Morrison Piehl, *The Role of Discretion in the Criminal Justice System*, 14 J.L. ECON. & ORG. 256, 258 (1998) (examining sentencing evidence in California to conclude that prosecutors seek to maximize prosecution).

35. *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. U. L. REV. 987, 994, 1035–49 (2012) (noting reported crime rates in California counties explain only three percent of the variance in new felon admissions).

36. Nate Silver makes this point in his book. NATE SILVER, THE SIGNAL AND THE NOISE: WHY SO MANY PREDICTIONS FAIL—BUT SOME DON'T 217–19 (2012). Silver states that disease reports tend to increase with news about the disease, citing one expert's opinion that the statistical signs that swine flu was spreading rapidly "may have come from people reporting symptoms to their doctors which they might otherwise have ignored." *Id.* at 219. In other words, knowledge about disease depends on perceptions of disease. In the next paragraph, Silver explicitly likens the situation to crime reporting: if the police report an increased number of burglaries in a neighborhood, is that because they are being more vigilant and are catching crimes that they had missed before, or have [they] made it easier to report them? Or is it because the neighborhood is becoming more dangerous? *Id.*

37. Carroll Smith-Rosenberg, *The Hysterical Woman: Sex Roles and Role Conflict in 19th-Century America*, 39 SOC. RES. 652, 652–55 (1972).

38. To cite an example from the lives of economists (and the psychologists who influenced them), Richard Thaler recounts that psychologist Amos Tversky decided not to seek cancer treatments

Our understanding of disease is ultimately 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 medical analogy might seem strange is only because we are in the "four humours" stage of our understanding.[39] We treat crime in a uniform fashion because we do not understand it, and we do not understand it because we have not experimented with treating different crimes and criminals in different ways.

II. THE VALUE CREATION MODEL

In healthcare, 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.[40] In pay-for-performance, providers are no longer paid by the procedure, but by the case, and they have freedom to treat cases according to their judgment, with two limits: they are budgetarily limited from doing too much, and they are limited by malpractice from doing too little (or doing something harmful). Pay-for-performance is designed to improve efficiency, and one recent study found that "financial incentives significantly influence physicians' supply of health care" and that value-based payments "hold the promise of curbing costs without jeopardizing quality."[41] 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 unnecessary 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 lengthy project that is still very much in progress, a project that seeks to improve the quality of doctors and their

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at the end of his life: "[R]uining his final months with pointless treatments that would make him very sick and at best extend his life by a few weeks was not a tempting option." RICHARD H. THALER, MISBEHAVING: THE MAKING OF BEHAVIORAL ECONOMICS, at xiv (2015). Medicine more generally has had to grapple with what "health" exactly means, as is seen in, e.g., the concept of quality-adjusted life years (more life of lower-quality might be less desirable than a shorter life of higher quality). Abraham Mehrez & Amiram Gafni, *Quality-Adjusted Life Years, Utility Theory, and Healthy-Years Equivalents*, 9 MED. DECISION MAKING 142, 142–43 (1989).

39. GUIDO MAJNO, THE HEALING HAND: MAN AND WOUND IN THE ANCIENT WORLD 178 (1975).

40. Health care costs are also controlled by capitation systems whereby large organizations will be paid a certain per-person amount for a large population on the theory that the individual health differences (and financial risks) of each member of the population will even out. *See* Meredith B. Rosenthal, *Beyond Pay for Performance—Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197, 1198–99 (2008). I do not address this model in this article but note this only to complete the view of recent trends in healthcare economics.

41. Jeffrey Clemens & Joshua D. Gottlieb, *Do Physicians' Financial Incentives Affect Medical Treatment and Patient Health?*, 104 AM. ECON. REV. 1320, 1347 (2014). *Contra* Marina N. Bolotnikova, *Are Hospital Pay-for-Performance Programs Failing?*, HARV. MAG. (June 29, 2016), http://harvardmagazine.com/2016/06/are-hospital-pay-for-performance-programs-failing.

treatments.[42] This project has taken a long time, in part, because both the healthcare system and disease itself are complex, and measuring quality and outcomes is difficult. Part of the explanation is also that it is 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 to standardize medical treatment, measure quality of care, and audit providers and institutions,[43] part of the professionalization of medicine so meticulously detailed in Paul Starr's *The Social Transformation of American Medicine*.[44]

Though quality improvements have been taking place at least since the 1870s,[45] one early example of the more recent pay-for-performance trend was the emergence of Diagnosis-related Groups (DRGs).[46] 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[47] and a book,[48] Michael Porter (and, occasionally, co-authors) refined the idea of pay-for-performance, identifying the

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42. For a recent history that focuses on the beginning of the quality movement in the 1980s 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 AFF. 24, 25–28, 38–39 (Supp. 1 1993).

43. 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, but it does not promote quality improvements beyond the minimum. For the most influential early theoretical work on quality in healthcare, see Avedis Donabedian, *Evaluating the Quality of Medical Care*, 44 MILBANK MEMORIAL FUND Q. 166, 166–70 (1966).

44. STARR, *supra* note 23, at 37–40. Pay-for-performance has also proceeded in parallel with certain structural changes, such as the increased uptake of vertical integration in the provision of healthcare (via HMOs and the like), which seeks to save money by focusing on prevention, coordinating care, and internalizing inter-departmental externalities. This Article focuses only on the concept of pay-for-performance; an analysis of greater structural integration will be left to another article.

45. *Id.* at 102–06 (discussing reforms to medical education and the re-imposition medical licensing).

46. Robert B. Fetter et al., *Case Mix Definition by Diagnosis-Related Groups*, 18 MED. CARE, at i, 3 (Supp. 2 1980).

47. *See, e.g.*, Robert S. Kaplan & Michael E. Porter, *How to Solve the Cost Crisis in Health Care*, 89 HARV. BUS. REV. 46, 49–50, 58–61 (2011); Porter, *supra* note 15, at 109–10; Michael E. Porter & Elizabeth Olmstead Teisberg, *Redefining Competition in Health Care*, 82 HARV. BUS. REV. 64, 66, 75–76 (2004); Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, 91 HARV. BUS. REV. 50, 51–53 (2013); Michael E. Porter, *What Is Value in Health Care?*, 363 NEW ENG. J. MED. 2477, 2477–78 (2010) [hereinafter Porter, *What Is Value*].

48. MICHAEL E. PORTER & ELIZABETH OLMSTED TEISBERG, REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS 6–9 (2006).

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 or improving health. For example, a provider reimbursed for a DRG procedure might cut corners, not just costs. Paying on the basis of the state-of-the-art without measuring whether the intervention worked does not incentivize effective healthcare. Porter argues that value is created only when patients get healthier, when costs decrease, or both.[49] One cannot focus only on outcomes or cost—one must focus on both. The healthcare system can only evaluate outcomes by following the patient's progress from beginning to end, even if she passes from one doctor in one department to another doctor (or several others).[50]

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.[51] 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 (including, sometimes, not at all). There is still considerable autonomy within the system for doctors to pursue different treatments.[52] 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 outcomes, are favored. It also means that improvements can be disseminated more rapidly because there is a financial disincentive to continue ineffective or inefficient practices.

Pay-for-performance can be implemented in several ways, with a focus on particular treatments, on institutions, or on overall allocation of resources to maximize social welfare (by, e.g., focusing on prevention instead of treatment in the emergency room).[53] One pay-for-performance

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49. 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—but I prefer his formulation because it combines efficacy and efficiency in a concise phrase. *See, e.g.*, Paul M. Ellwood, Alain C. Enthoven & Lynn Etheredge, *The Jackson Hole Initiatives for a Twenty-First Century American Health Care System*, 1 HEALTH ECON. 149, 149–50 (1992); *see also* Randall P. Ellis & Thomas G. McGuire, *Provider Behavior Under Prospective Reimbursement*, 5 J. HEALTH ECON. 129, 148–49 (1986) (concluding that a mixed lump sum and fee for service system would encourage better outcomes while controlling costs).

50. Porter, *supra* note 15, at 110.

51. The individual case is not always the sole focus of pay-for-performance—sometimes pay-for-performance looks at the population level. Accountable Care Organizations, for example, are paid bonuses if they are able to treat their patient populations at a lower cost than public medical programs would have, presumably by promoting prevention over responsive treatment. Since this policy is more aligned with prevention and restructuring of care rather than care improvements, I will not discuss it in detail but for more see, for example, Alison Ritchie et al., *Shifting Reimbursement Models: The Risks and Rewards for Primary Care*, MED. ECON. (Apr. 8, 2014), http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/aca/shifting-reimbursement-models-risks-and-rewards-primary-care.

52. Indeed, one pair of doctors wrote to endorse the Affordable Care Act on the basis that it might enhance physician autonomy. Ezekiel J. Emanuel & Steven D. Pearson, *Physician Autonomy and Health Care Reform*, 307 [J]AMA 367, 367–68 (2012).

53. For a general overview, see Rosenthal, *supra* note 40, at 1199.

scheme that has recently been deployed by Medicare and Medicaid is hospital readmission penalties for certain procedures—the heart surgery example mentioned in the introduction.[54] Hospitals get reduced payments for excessive readmissions following heart attacks, heart failure, and pneumonia.[55] Excessive readmissions are defined as the risk-adjusted rate of readmission within thirty days relative to the national average. 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. 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. Another pay-for-performance scheme pays for chronic conditions that cannot be cured, such as diabetes.[56] The outcomes evaluated in this instance include management of symptoms, quality of life, survival times, and cost of treatment.

Performance-based programs have to be adjusted; different types of cases employ different incentives and metrics. The end goal in the cardiac readmission example is a return to health; the end goal with chronic conditions like diabetes is maintaining quality of life (or slowing its decline). The former has outcomes that are easier to quantify (readmission within a certain time), the latter outcomes are much harder to quantify (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 situations. Different definitions of health will have to be hashed out for different sets of cases.[57] Asking what outcome to measure in a given case assuredly involves decisions about the particular measurement, but, crucially, it does not question the centrality of measuring and evaluating itself. The act of

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54. *See supra* Introduction. Hospital readmissions are a focus because they are both "prevalent and costly" among Medicare patients. Stephen F. Jencks, Mark V. Williams & Eric A. Coleman, *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*, 360 NEW ENG. J. MED. 1418, 1418 (2009).

55. *Readmissions Reduction Program (HRRP)*, CMS.GOV, https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html (last modified Apr. 18, 2016, 5:08 PM).

56. Porter & Lee, *supra* note 47, at 55 (discussing "patients with complex chronic conditions such as diabetes, or disabled elderly patients"). Note that there are often issues with comorbidity in chronic conditions: patients often 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. For a study that evaluates long-term care for comorbid chronic conditions, see Wayne J. Katon et al., *Collaborative Care for Patients with Depression and Chronic Illnesses*, 363 NEW ENG. J. MED. 2611, 2611–12 (2010).

57. The Patient-Centered Outcomes Research Institute was established to fund studies on effective treatments and then to disseminate information and training based on those studies. PATIENT-CENTERED OUTCOMES RESEARCH INST., 2015 ANNUAL REPORT 3 (2015), http://www.pcori.org/sites/default/files/PCORI-Annual-Report-2015.pdf.

negotiating what outcomes to measure and how to measure them cannot be made once and set permanently for all cases because each case presents different challenges.[58] 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. Even if it were possible to set uniform outcomes from on high for all cases, it would not be desirable because those governed by pay-for-performance need to buy into the quality measurements selected or they will not effectively implement them.

Finally, an outcome orientation also needs to consider who the target audience for a given incentive is.[59] 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 is flexible enough to appeal to all of them. Hospitals can free up resources by treating conditions in ways that are cheaper but as effective. Insurance companies can improve fiscal health through lower-cost treatments and lower demand as health improves. Individuals benefit by suffering less. Doctors benefit through greater autonomy.

Any attempt to move towards a pay-for-performance system has certain prerequisites built into it.[60] First, providers need to know information about cost structure, which involves learning about staff costs, staff time per intervention, drug costs, and time spent waiting for open rooms or open slots in a schedule. 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 measure 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 the patient's 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

58. Factors include the costs of measuring a particular outcome, the feasibility of measuring that outcome, and issues concerning precision and inter-rater reliability.

59. Laura A. Petersen et al., *Does Pay-for-Performance Improve the Quality of Health Care?*, 145 ANNALS INTERNAL MED. 265, 265 (2006).

60. *See* Kaplan & Porter, *supra* note 47, at 52–58.

as effective as inpatient procedures, or that phone calls rather than nurse visits are effective forms of aftercare. More—and more intrusive—is not always better, even in terms of efficacy.[61] An efficiency focus pushes institutions to act on what they learn about efficacy, whereas fee-for-service pays institutions to ignore what they learn—if they bother to learn anything.[62]

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 Article, I will address them in Part IV.A.[63]

III. CURRENT APPROACHES IN CRIMINAL JUSTICE ECONOMICS

The general shortcomings of the medical fee-for-service model help explain similar problems in the criminal justice context. A pay-for-performance approach might provide similar potential solutions. Comparing criminal justice and healthcare economics comports with a long line of viewing prisons themselves through the lens of medicine. Nineteenth 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.[64] Wardens expressly invoked medical metaphors to advocate on behalf of indeterminate sentences, saying that they alone knew when an offender was cured. Health care also happens to be the centerpiece of the most significant prison case in a generation, *Brown v. Plata*,[65] though *Plata* is about minimum standards—avoiding carceral malpractice—rather than incentivizing quality and efficiency improvements above the minimum.[66] This Article proposes a measured return to the medical model, albeit one that corrects for certain shortcomings ad-

61. More can also be worse in medicine. Atul Gawande, *Foreword: Positive Deviance and Health Care* to RICHARD T. PASCALE ET AL., THE POWER OF POSITIVE DEVIANCE, at ix, xi (2010) ("[S]tudies find that . . . where doctors order more frequent tests and procedures, more specialist visits, and more hospital admissions than the average—the patients do no better, whether measured in terms of survival, ability to function, or satisfaction with care. If anything, they seem to do worse.").

62. Some changes might imply new types of organizations to better treat certain segments of the patient population. Porter envisages the creation of integrated practice units (IPUs) for the treatment of certain standard or chronic conditions. Porter & Lee, *supra* note 47, at 53 (describing IPUs as organized not by department and service, but "around the patient's medical condition"). 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.

63. I should also note that Porter's analysis assumes that there is a market for medical providers. Porter & Teisberg, *supra* note 47, at 65. Even though hospitals are a mix of for-profit and nonprofit institutions, they all compete for patients and for insurance dollars. Porter's framework assumes that more money can be directed to good performers and that positive and negative incentives can be directed at poor performers. Without a shift in funding and resources, the incentives available to promote value-creation are limited. The same is true for corrections: dollars have to flow to promote value-creation.

64. For a general background and extensive references to more detailed historical treatments, see Ball, *Why State Prisons?*, *supra* note 25, at 90–92.

65. 563 U.S. 493 (2011).

66. *Id.* at 500.

dressed infra in Part V. The historical emphasis on treatment is reintroduced with better (but not perfect) social science and much better ability to crunch the data.

To start, health care and criminal justice are two of the fastest-growing areas of state budget expenditures.[67] There is very little downward cost pressure in either.[68] Prison, in particular, is free to local decision makers, except in unified corrections systems.[69] This means that prison, the most expensive—and maximally intrusive—treatment is likely to be used even when it is unnecessary or when less intrusive and expensive alternatives exist. No prosecutor or judge ever needs to measure the efficacy or efficiency of a prison sentence; providers in the criminal justice system are not accountable in terms of creating value.[70] 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.

Even where there is some discussion of total costs of interventions, 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.[71] 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 seem strange. Best practices across jurisdictions and departments are diffused slowly, if at all. There are no financial incentives to improve outcomes; at best, there are incentives to cut costs without improving outcomes. Even if good policies are deployed, there are no financial incentives to train people to deploy those policies with fidelity to their design, to follow up about quality control and, generally, to ensure

67. Solomon Moore, *Study Shows High Cost of Criminal Corrections*, N.Y. TIMES, Mar. 3, 2009, at A13.

68. However, for an analysis of the economic downturn on criminal justice systems, see HADAR AVIRAM, CHEAP ON CRIME: RECESSION-ERA POLITICS AND THE TRANSFORMATION OF AMERICAN PUNISHMENT 14–15 (2015). Professor Aviram also points out that this focus on costs could result in substandard care, what she calls "tough 'n' cheap," a valid complaint about the present system that a value focus would address. *Id.* at 164.

69. The following paragraph largely replicates the analysis found in W. David Ball, *Defunding State Prisons*, 50 CRIM. L. BULL. 1060, 1061–63, 1075–78 (2014).

70. Two proposals in this regard serve as apt examples. *See* Adam M. Gershowitz, *An Informational Approach to the Mass Imprisonment Problem*, 40 ARIZ. ST. L.J. 47, 50 (2008) (proposing prosecutors be regularly informed of the status of prison capacities); Russell M. Gold, *Promoting Democracy in Prosecution*, 86 WASH. L. REV. 69, 72–73 (2011) (proposing that the costs of prosecution be made public but using prosecutorial elections as the mechanism for internalizing the externality). But DAs might not care at all about these costs unless they have to pay for them, either via their budgets or at the ballot box.

71. Flanders, *supra* note 29, at 391.

that the policies are implemented well. Better policies are costs whose external benefits mostly make the jobs of those in other agencies easier. A prisoner reformed by prison means more work for prison employees but less work for police. A police officer who successfully defuses a situation without arresting anyone might make more work for herself even as she makes less work for the rest of the system.

Even the outcomes that are discussed, such as political claims about deterrence and the effectiveness of particular sentences, are never put to the test. The general rule is no data collection, no follow up, no outcome tracking, and no feedback loops to decision makers such as judges and DAs.[72] 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 little about prisons, even as first-year criminal law classes routinely address the purpose of punishment.[73]

There is a spate of recent research analyzing the costs and benefits of various approaches to crime. Darryl Brown outlined the approach in 2004, discussing cost-benefit analysis (CBA) in detail (using, *inter alia*, environmental law as a comparison) and concluding, in part, that "[o]ffender treatment . . . has fared well in cost-benefit analyses."[74] Brown's analysis is extensive, analyzing the wide-ranging effects of criminal justice policies and 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

72. For an overview of the problem that focuses on California, see W. David Ball, *E Pluribus Unum: Data and Operations Integration in the California Criminal Justice System*, 21 STAN. L. & POL'Y REV. 277, 277–78, 280 (2010).

73. Sharon Dolovich, *Teaching Prison Law*, 62 J. LEGAL EDUC. 218, 218 (2012) ("It is during the administration of punishment that the state's criminal justice power is at its zenith, and at this point that the laws constraining the exercise of that power become most crucial. Yet it is precisely at this point that the curriculum in most law schools falls silent.").

74. Darryl K. Brown, *Cost-Benefit Analysis in Criminal Law*, 92 CALIF. L. REV. 323, 351 (2004).

(providing a comprehensive summary of the issue),[75] Michael Tonry,[76] and Brandon C. Welsh and David P. Farrington,[77] among others.

Criminal justice CBA approaches are not just theoretical; they have gained traction in the policy realm as well.[78] The Washington State Institute for Public Policy (WSIPP) has long been considered a model program, analyzing proposed policies in terms of their effectiveness and efficiency.[79] WSIPP is now actively distributing its model via a partnership with the Pew-MacArthur Results First Initiative[80] and has posted an exhaustive technical documentation that breaks down exactly how it models costs and benefits.[81] The Vera Institute and the Bureau of Justice Assistance have also partnered to promote CBA in criminal justice and have produced a series of extremely informative, practitioner-centered publications.[82] The Justice Reinvestment Initiative of the Bureau of Justice Assistance is also working to promote data-driven policies that improve public

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75. Patricio Domínguez & Steven Raphael, *The Role of the Cost-of-Crime Literature in Bridging the Gap Between Social Science Research and Policy Making: Potentials and Limitations*, 14 CRIMINOLOGY & PUB. POL'Y 589, 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 unequitable 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 methods. *Id.* at 599–600.

76. Michael Tonry, *The Fog Around Cost-of-Crime Studies May Finally Be Clearing: Prisoners and Their Kids Suffer Too*, 14 CRIMINOLOGY & PUB. POL'Y 653, 660–62 (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).

77. Brandon C. Welsh & David P. Farrington, *Monetary Value of Early Developmental Crime Prevention and Its Policy Significance*, 14 CRIMINOLOGY & PUB. POL'Y 673, 675–76 (2015) (suggesting that if costs of offending are high, many social welfare programs will be justified).

78. For an excellent overview, see CAMERON MCINTOSH & JOBINA LI, AN INTRODUCTION TO ECONOMIC ANALYSIS IN CRIME PREVENTION: THE WHY, HOW AND SO WHAT 3–11 (2012), https://www.publicsafety.gc.ca/cnt/rsrcs/pblctns/cnmc-nlss/cnmc-nlss-eng.pdf. *See also* PEW-MACARTHUR RESULTS FIRST INITIATIVE, STATES' USE OF COST-BENEFIT ANALYSIS: IMPROVING RESULTS FOR TAXPAYERS 9–12 (2013), http://www.pewtrusts.org/~/media/legacy/uploadedfiles/pcs_assets/2013/pewresultsfirst50statereportpdf.pdf.

79. *See, e.g.*, STEVE AOS, MARNA MILLER & ELIZABETH DRAKE, WASH. STATE INST. FOR PUB. POLICY, EVIDENCE-BASED PUBLIC POLICY OPTIONS TO REDUCE FUTURE PRISON CONSTRUCTION, CRIMINAL JUSTICE COSTS, AND CRIME RATES 2, 8–16 (2006), http://www.wsipp.wa.gov/ReportFile/952/Wsipp_Evidence-Based-Public-Policy-Options-to-Reduce-Future-Prison-Construction-Criminal-Justice-Costs-and-Crime-Rates_Full-Report.pdf.

80. For a report on the New York State experience, see MARC SCHABSES, DIV. OF CRIMINAL JUSTICE SERVS., N.Y. STATE, COST BENEFIT ANALYSIS FOR CRIMINAL JUSTICE: DEPLOYMENT AND INITIAL APPLICATION OF THE *RESULTS FIRST* COST BENEFIT MODEL 1 (2013), http://www.criminaljustice.ny.gov/crimnet/ojsa/resultsfirst/rf-technical_report_cba1_oct2013.pdf.

81. WASH. STATE INST. FOR PUB. POLICY, BENEFIT-COST TECHNICAL DOCUMENTATION 6–175 (2016), http://www.wsipp.wa.gov/TechnicalDocumentation/WsippBenefitCostTechnicalDocumentation.pdf.

82. *See, e.g.*, CHRISTIAN HENRICHSON & JOSHUA RINALDI, VERA INST. OF JUSTICE, COST-BENEFIT ANALYSIS AND JUSTICE POLICY TOOLKIT 4 (2014), http://cbkb.org/wp-content/uploads/2014/12/cba-justice-policy-toolkit.pdf; CHRISTIAN HENRICHSON, VERA INST. OF JUSTICE, USING COST-BENEFIT ANALYSIS FOR JUSTICE POLICYMAKING 1 (2014), http://cbkb.org/wp-content/uploads/2014/04/Using-Cost-Benefit-Analysis-for-Justice-Policymaking.pdf; CARL MATTHIES, VERA INST. OF JUSTICE, ADVANCING THE QUALITY OF COST-BENEFIT ANALYSIS FOR JUSTICE PROGRAMS 1 (2014), http://archive.vera.org/sites/default/files/resources/downloads/advancing-the-quality-of-cba.pdf; CARL MATTHIES & TINA CHIU, VERA INST. OF JUSTICE, PUTTING A VALUE ON

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).[83] The Obama Administration rolled out the Police Data Initiative in 2015,[84] the Data-Driven Justice Initiative in 2016,[85] and recently published *Economic Perspectives on Incarceration and the Criminal Justice System*, summarizing a host of cost-benefit research.[86] There have also been attempts for private entities to fund criminal justice improvements using "social impact bonds," with payment contingent on successful outcomes.[87]

There is certainly much to admire in the CBA literature and policy. What is missing, however, is a systematic discussion that goes beyond the desirability vel non of individual policies. The literature needs a more holistic critique of why diffusion of sensible policies is not more widespread, a critique that includes the ways in which the incentive structure of criminal justice—both institutional and budgetary—might contribute to the problem. Prisons themselves are also inadequately considered as potential sources of improved public safety.[88] 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. Ultimately, good policies can only go so far on their merits. How can the system be structured to encourage wider rollout and diffusion?

The economic literature engages with the incentives faced within the system by providers of criminal justice. These articles are a recent discovery on my part and many advance the argument that misalignment is bound

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CRIME ANALYSTS: CONSIDERATIONS FOR LAW ENFORCEMENT EXECUTIVES 4 (2014), https://www.bja.gov/Publications/Vera-CrimeAnalysts.pdf.

83. *Justice Reinvestment Initiative*, OFF. JUST. PROGRAMS, https://www.bja.gov/programs/justicereinvestment/what_is_jri.html (last visited Mar. 18, 2017).

84. Megan Smith & Roy L. Austin, Jr., *Launching the Police Data Initiative*, WHITE HOUSE: BLOG (May 18, 2015, 6:00 AM), https://www.whitehouse.gov/blog/2015/05/18/launching-police-data-initiative.

85. Christopher I. Haugh, *The White House Has a New Data-Driven Criminal-Justice Project*, ATLANTIC (June 30, 2016), http://www.theatlantic.com/politics/archive/2016/06/white-house-data-criminal-justice/489614.

86. EXEC. OFFICE OF THE PRESIDENT OF THE U.S., ECONOMIC PERSPECTIVES ON INCARCERATION AND THE CRIMINAL JUSTICE SYSTEM (2016), https://obamawhitehouse.archives.gov/sites/whitehouse.gov/files/documents/CEA%2BCriminal%2BJustice%2BReport.pdf.

87. Chris Fox & Kevin Albertson, *Payment by Results and Social Impact Bonds in the Criminal Justice Sector: New Challenges for the Concept of Evidence-Based Policy*, 11 CRIMINOLOGY & CRIM. JUST. 395, 395–400 (2011) (noting advantages of payment by results and difficulties in determining outcomes).

88. 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. *See* Brown, *supra* note 74, at 351. He does discuss alternatives to incarceration later in some detail. *Id.* at 367–71.

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") I explored in earlier articles.[89] So, while Zimring and Hawkins coined the "correctional free lunch" phrase, the idea predates them, and these prior formulations deserve to be more widely acknowledged in the legal academy. What follows is my attempt to correct my own errors in this regard. (Many of the arguments discussed below are summarized in Kenneth Avio's excellent 1998 survey of the economic literature, *The Economics of Prisons*.)[90]

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 who can then sell them to or buy them from other counties as needed.[91] Fred Giertz and Peter Nardulli 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."[92] Giertz and Nardulli suggested a complete decentralization of the system, where incarceration is provided by local government and funding is replaced with block grants.[93] 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."[94] 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.[95]

89. FRANKLIN E. ZIMRING & GORDON HAWKINS, THE SCALE OF IMPRISONMENT 140 (1991). For my own elaboration on the subject, see Ball, *A False Idea*, *supra* note 25, at 27; Ball, *supra* note 69, at 1061–62; Ball, *supra* note 35, at 988; Ball, *Why State Prisons?*, *supra* note 25, at 77—82.

90. Kenneth L. Avio, *The Economics of Prisons*, 6 EUR. J.L. & ECON. 143, 143–44 (1998).

91. Robert W. Gillespie, *Allocating Resources to Prison Space: An Economic Approach Incorporating Efficiency and Equity* 1–6 (Univ. of Ill. Coll. of Commerce & Bus. Admin., Working Paper No. 977, 1983).

92. J. Fred Giertz & Peter F. Nardulli, *Prison Overcrowding*, 46 PUB. CHOICE 71, 71 (1985).

93. *Id.* at 75–77. For my own treatment, which unintentionally duplicates theirs, see Ball, *supra* note 69, at 1072–75. For a similar idea, see Chris Fox & Kevin Albertson, *Could Economics Solve the Prison Crisis?*, 57 PROB. J. 263, 276–77 (2010).

94. Peter F. Nardulli, *The Misalignment of Penal Responsibilities and State Prison Crises: Costs, Consequences, and Corrective Actions*, 1984 U. ILL. L. REV. 365, 368 (1984).

95. Alfred Blumstein & Richard Larson, *Models of a Total Criminal Justice System*, 17 OPERATIONS RES. 199, 199–200 (1969).

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.[96] He paid little attention to the decentralization and organizational incentives problems, whereby, say, poor rehabilitation by prisons 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—among particular institutions' custodial rehabilitation programs.[97] The main gains are from early prevention and diversion. This Article, however, assumes that there are better and worse prisons and programs and thus, that prisons should be differentiated.

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.[98] 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 rewards of each.[99] In so doing, Posner built upon Gary Becker's seminal 1968 article, *Crime and Punishment: an Economic Approach*, which itself is also primarily about the economics of criminal activity.[100] 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., the extent to which new criminals enter the market to replace those sent to prison).[101] In general, this approach is an example of what Thomas Bernard and Robin Engel have criticized as an overly

96. Charles H. Logan, *Criminal Justice Performance Measures for Prisons*, *in* PERFORMANCE MEASURES FOR THE CRIMINAL JUSTICE SYSTEM 19, 19–21 (1993) (focusing "more on the satisfaction of certain standards, values, and constraints than on the production of particular consequences").

97. My analysis has previously focused on prisons versus local dispositions like jails and probation. *See, e.g.*, Ball, *Why State Prisons?*, *supra* note 25, at 76. I argued that unless prisons were demonstrably superior, they should not be subsidized. *Id.* at 87–88. I did not distinguish among prisons, however, and for the purposes of the analysis presented, was agnostic about their capacity to rehabilitate. *Id.* at 88.

98. Richard B. Freeman, *The Economics of Crime*, *in* 3 HANDBOOK OF LABOR ECONOMICS 3529, 3541 (Orley Ashenfelter & David Card eds., 1999); *see, e.g.*, Samuel Cameron, *The Economics of Crime Deterrence: A Survey of Theory and Evidence*, 41 KYKLOS 301, 301 (1988).

99. Richard A. Posner, *An Economic Theory of the Criminal Law*, 85 COLUM. L. REV. 1193, 1205–15 (1985).

100. Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 J. POL. ECON. 169, 169 (1968). Frank Easterbrook also uses the prevention/deterrence model in his argument that criminal procedures are merely price mechanisms in a plea-bargaining market. Frank H. Easterbrook, *Criminal Procedure as a Market System*, 12 J. LEGAL STUD. 289, 289–90 (1983).

101. 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, 1849–50 (2005).

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.[102]

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 Section A, I discuss some practical and theoretical groundwork that must first be laid. 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 Section B, I focus on particular applications in sentencing that could fit into a performance-based system. In Section C, I outline the advantages of such a system.

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-1850s to the present that parts of the criminal justice system might still need.[103] Measurements in medicine are proposed, tested, adopted, refined, and sometimes replaced. The question is not whether a given measurement 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,[104] but Medicare

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102. Thomas J. Bernard & Robin Shepard Engel, *Conceptualizing Criminal Justice Theory*, 18 JUST. Q. 1, 2–3 (2001).

103. STARR, *supra* note 23, at 22 ("Standardization of training and licensing became the means for realizing both the search for authority and control of the market."). 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 & Michael B. Mushlin, Op-ed, *What's Going on in Our Prisons?*, N.Y. TIMES, Jan. 4, 2016, at A19.

104. *See, e.g.*, Uwe E. Reinhardt, *Health Reform: Porter and Teisberg's Utopian Vision*, HEALTH AFF. BLOG (Oct. 10, 2006), 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. *See* Alvin Tran, *Study: Doctors Look to Others to Play Biggest Role in Curbing Health Costs*, KAISER HEALTH NEWS (July 23, 2013), 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, Op-ed, *How Measurement Fails Us*, N.Y. TIMES, Jan. 17, 2016, at SR5. The current data do not support the efficiency of pay-for-performance. Martin Emmert et al., *Economic Evaluation of Pay-for-Performance in Health Care: A Systematic Review*,

and commercial insurers recently did exactly that, agreeing to common health outcome measurements.[105]

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 begin to get our heads around, even as there is growing support for data collection and evidence-based practices. Stakeholders will need to gather and figure out what quality treatment means and how we will measure it.[106] 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 in health from fee-for-service to pay-for-performance. 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 subject to revision, they are widely accepted enough to be driving policy (and preferable to a fee-for-service alternative). They all revolve around a central question: which outcomes?

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. People die of cancer at the best cancer hospitals; so too might we expect some degree of criminal justice failure. 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.[107]

The second observation is that different conditions and treatments will need to be measured with different metrics. The healthcare economics literature, for example, does not have an exclusive focus on a single measure of health but, instead, looks to multiple measures. Porter, for example, divides health outcomes into three general categories: mortality, recovery,

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13 EUR. J. HEALTH ECON. 755, 756 (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 Petersen et al., *supra* note 59, at 265.

105. Bruce Japsen, *Medicare, Commercial Insurers Agree on Uniform Health Quality Measures*, FORBES (Feb. 16, 2016, 11:10 AM), http://www.forbes.com/sites/brucejapsen/2016/02/16/white-house-says-medicare-commercial-insurers-agree-on-health-quality-measures.

106. 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 resistance from DAs, judges, and others at the power centers of today's criminal justice system. *See supra* notes 23–24 and accompanying text.

107. Matt Taibbi, *Cruel and Unusual Punishment: The Shame of Three Strikes Laws*, ROLLING STONE (Mar. 27, 2013), http://www.rollingstone.com/politics/news/cruel-and-unusual-punishment-the-shame-of-three-strikes-laws-20130327 (discussing the history of the sensational cases that led to the passage of Three Strikes in California and reporting the results of polls that showed "[p]eople will pay for justice, no matter how much it costs").

and health.[108] These might be mapped onto recidivism, modality of treatment, and desistance from crime.

Mortality is the most obvious measure in health; in criminal justice, that measure is recidivism. A pessimist might rightly conclude that there is no consensus on what constitutes recidivism.[109] An optimist might look at the same set of facts and conclude that a variety of measures could be used. For example, metrics like arrest for any offense, re-arrest for the same crime, and return to prison could all be used to measure recidivism. Again, the minimum requirement is that measurements are agreed to and that they lend themselves to apples-to-apples comparisons across jurisdictions. 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.[110] This suggests that, at least in some cases, the harms caused by the criminal justice system outweigh any benefits. Net widening, in other words, is both resource intensive and ineffective, and pay-for-performance should help restrain it. For cases which require some response, pay-for-performance would help limit the size and scope of the intervention. Prison, for example, is expensive and imposes a variety of collateral harms on a prisoner's family (both emotional harms on families and children, as well as economic harms due to a variety of wealth-extracting contracts for telephones, commissary

108. Porter, *What Is Value*, *supra* note 47, at 2479–80; *see also id.* app. 1 at 1–12 (going into much greater detail about the value concept); *id.* app. 2 at 1–14 (discussing issues with outcome measurement and how to categorize outcomes into a hierarchy).

109. Robert Weisberg, *Meanings and Measures of Recidivism*, 87 S. CAL. L. REV. 785, 799–800 (2014).

110. Michael Tonry observes that, in Bentham's view, "everyone's happiness—including that of offenders—counts." Tonry, *supra* note 76, at 661; *see also* JEREMY BENTHAM, AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION 166 (Leslie B. Adams, Jr. 1986) (1789) ("But all punishment is mischief: all punishment in itself is evil. Upon the principle of utility, if it ought at all to be admitted, it ought only to be admitted in as far as it promises to exclude some greater evil.").

money, etc.).[111] Prison might also be criminogenic.[112] If so, it is both inefficient *and* ineffective. But even assuming prison "works," its efficacy might not be enough to outweigh its inefficiency: we might be able to do as well with less. 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.

Porter also considers patient experience during the "process of recovery": a successful treatment that is shorter and less painful is more desirable than one that is longer and more painful.[113] 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. Suffering should be tested like any other factor; it should be a goal only insofar as it works. If people can stop being criminals as effectively without suffering, then, unless suffering is desirable for its own sake, there is no point to it.[114]

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. Metrics for homeless offenders might mean hospital days avoided or days without them being assaulted. Metrics for the mentally ill might involve medication uptake or stability of housing. Metrics for drug-using offenders might vary by drug (heroin users might have one set of metrics, meth users might have another, recidivist drunk-driving offenders might have still others). Again, the value-creation framework states that any criminal justice intervention—including none—should make people better (or the same) for the same amount of resources (or less). For the above populations, alternatives to criminal justice involvement must be considered. There is much evidence to suggest that criminalizing the incidents of homelessness, mental illness, and drug abuse is not nearly as effective or efficient as the noncriminal alternatives. A complete analysis, in other words, must consider whether criminal justice is called for at all. We would not hospitalize

111. For emotional harms, see Joseph Murray, *The Effects of Imprisonment on Families and Children of Prisoners*, *in* THE EFFECTS OF IMPRISONMENT 442, 442–444 (Alison Liebling & Shadd Maruna eds., 2005). For economic harms, see Daniel Wagner, *Prison Bankers Cash in on Captive Customers*, CTR. FOR PUB. INTEGRITY (Sept. 30, 2014, 5:00 AM), https://www.publicintegrity.org/2014/09/30/15761/prison-bankers-cash-captive-customers ("Taken together, the costs imposed by [prison banking vendors], phone companies, prison store operators and corrections agencies make it far more difficult for poor families to escape poverty so long as they have a loved one in the system.").

112. Cullen, Jonson & Nagin, *supra* note 30, at 51S (arguing that, for some offenders, prison might have a criminogenic effect.).

113. Porter, *What Is Value*, *supra* note 47, app. 2 at 4.

114. In making this suggestion I take no position on the recent scholarship that explores the effects of hedonic adaptation on the typical prison experience. *See, e.g.*, John Bronsteen, Christopher Buccafusco & Jonathan S. Masur, *Retribution and the Experience of Punishment*, 98 CALIF. L. REV. 1463, 1463–64 (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 applies to the justice-involved and that the suffering of prison is part of each prisoner's net present value calculation has much less.

someone who arrived at the Emergency Room with a hangnail. We would tell them to go home. For at least some cases in criminal justice, the same principle applies.

In addition to goal-based considerations about what outcomes to measure, there are also program and policy implications. Outcomes should control for exogenous factors. A macroeconomic downturn resulting in higher overall unemployment will affect ex-offender unemployment, as might sector-specific unemployment (such as that for unskilled labor). Outcomes must also consider the full spectrum of treatment—not just interventions given in prison, but interventions in community supervision—subject to the principle of parsimony. 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: justice-involved individuals have below-average educational and economic endowments.[115] We might therefore consider time in the community before returns to custody as the measurement, not complete desistance from crime (assuming that a return to custody is a true measure of criminal activity, not simply an artifact of detection—which is also a confounding variable in medicine).[116] In other words, merely lumping in all returns to custody as failures of equal degree fails to account for the differences between those who stay out of trouble one day and those who stay out of trouble much longer.

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 tied to their effects on public safety and measured using common definitions in common data formats. Proponents of particular theories should have falsifiable tests to determine why and how their theories (and the mechanisms that apply to them) work, then measure and test those hypotheses. Within the concept of value creation, we will avoid both 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 improving health outcomes 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 the means

115. Bruce Western & Becky Pettit, *Incarceration & Social Inequality*, 139 DAEDALUS 8, 8–10 (2010).

116. For an example of just such an approach, see Peter Schmidt & Ann Dryden Witte, *Predicting Criminal Recidivism Using 'Split Population' Survival Time Models*, 40 J. ECONOMETRICS 141, 141, 144, 151–55 (1989).

to achieve them are disputed.[117] 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 an important step. This step must include asking whether a criminal justice response creates as much value as treating the problem non-criminally or even doing nothing. 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, or 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; 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, I assume both 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, our system can at least be made more efficient, even if not more effective.

There are also certain conditions that I assume would be built into the system.[118] In an outcome-based system, localities would be prevented from shifting crime and criminals to other jurisdictions—the "one-way bus ticket" model of crime control.[119] I also assume that there would be some kind of validated risk-needs assessment tool used, subject to some conditions I will discuss infra. Both sending and receiving parties would have incentives to measure risk: receiving institutions would not want to take on a harder case—with higher costs and higher risk of poor outcomes—than they were promised, and sending institutions would want to ensure that a prisoner's criminogenic needs were met. This would solve the cream-skimming problem so often seen in the private prison context,

117. Reinhardt, *supra* note 104 (criticizing the idea that medical conditions are easy to identify, discrete, and easy to put into "a standard, finite life cycle").

118. The following discussion draws on a prior article. *See* Ball, *supra* note 69, at 1061–63.

119. *Id.* at 1086–87.

where the average cost of a prisoner is equated with the marginal cost of that prisoner.

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. 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, giving more resources to poorer areas and those with higher crime.[120] The system would need to tailor 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. 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. I will now discuss each in turn.

Budgets and Data. Under pay-for-performance, 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 rates of reported violent crime.[121] 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. Federal funds could be disbursed with the requirement that states adopt outcome measurement or data collection.[122] States could then base funding streams to localities 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. Still others might decide that non-criminal responses are called for. 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.[123]

As for data, the relatively uncontroversial issues that would need to be implemented to make pay-for-performance viable are, in most cases,

120. *Id.* at 1082.

121. *Id.* at 1073.

122. Darryl Brown has also suggested that the federal government fund cost-benefit studies. Brown, *supra* note 74, at 353. Though 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 grants are not. *See* Zack Cooper et al., *The Price Ain't Right? Hospital Prices and Health Spending on the Privately Insured* 1 (Nat'l Bureau of Econ. Research, Working Paper No. 21815, 2015) (criticizing studies that rely only on Medicare data while noting that Medicare covers twenty percent of total health care spending).

123. *See* Ball, *supra* note 35, at 994.

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 also 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. Saying that the idea of data collection is uncontroversial does not mean its implementation would be; deciding what to measure and how to measure it is where most of the work would take place. Implementation would involve effecting institutional and cultural changes, getting buy-in from practitioners, and hashing out what those standard measurements and formats would be. Once data is collected, organizations must use it to drive practices and policies. Change needs to be ongoing and iterative. Those who subsidize 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, 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. More is not always better—and, indeed, can sometimes be worse.

Tailoring. The next 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 the initial condition of offenders. 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 involves non-actuarial decisions about what behavior should be modeled (and how). 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 and will probably never be conclusively resolved.[124]

124. *See* Ball, *supra* note 69, at 1064–70.

The problem with standardizing diagnoses, an obvious problem for criminal justice, is not without its analog in medicine. Witness the *New York Times Magazine* column "Diagnosis," which presents symptoms and asks doctors to figure out the cause (or causes).[125] There are biological markers for most diseases, but some, like prostate cancer, might actually turn out to be several different diseases.[126] Co-morbidity also makes diagnoses difficult: those who suffer from two or more diseases need to be treated differently, have different survival rates, and the like.[127] Co-morbidity is a readily apparent problem in criminal law, given how many of the justice-involved have mental health or addiction problems.[128] The issue of optimal research trial size poses problems in medicine: larger sizes are more statistically significant, but larger groups are also less tailored, resulting in medical protocols that are demonstrably ineffective for certain subpopulations on the basis of gender or race.[129] The healthcare approach, then, outlines some typical hazards without necessarily pointing out easy solutions, but reformers who, say, want to address offenders with co-morbid drug and mental health problems can look to the medical literature for ideas and approaches.

Some of the discussion about distinguishing and tailoring in criminal justice has already taken place in the offense/offender literature[130] and suggests that we could combine criminal history and offender characteristics at sentencing (though even criminal histories can be problematic on disparate impact grounds, as well as on accuracy and completeness). One

125. *See* Lisa Sanders, *Diagnosis*, N.Y. TIMES MAG., http://www.nytimes.com/column/diagnosis. "Dr. Lisa Sanders recreates hard-to-solve medical cases" in this column of the magazine. *Id.*

126. *See* Charlie Cooper, *Prostate Cancer Could Actually Be Five Different Diseases, Say Scientists*, INDEPENDENT (July 30, 2015, 00:16), http://www.independent.co.uk/life-style/health-and-families/health-news/prostate-cancer-could-actually-be-five-different-diseases-say-scientists-10424973.html. Other than DUI there are not many biological markers for criminal law. Criminology's main foray into biological markers was phrenology, which is a continuing stain on the discipline. *See* Paul Erickson, *The Anthropology of Charles Caldwell, M.D.*, 72 ISIS 252, 253–56 (1981) (detailing the career of an American phrenologist who used biological differences in head shape to support white supremacist views); Reginald Horsman, *Scientific Racism and the American Indian in the Mid-Nineteenth Century*, 27 AM. Q. 152, 155 (1975) (discussing Caldwell and "scientific" appeals to the racial inferiority of indigenous people); Nicole Rafter, *The Murderous Dutch Fiddler: Criminology, History and the Problem of Phrenology*, 9 THEORETICAL CRIMINOLOGY 65, 68 (2005) (arguing that criminologists should come to terms with phrenology's role in the development of criminology).

127. For criticism of Porter's ideas on these grounds, see Gail R. Wilensky, *Health Reform: Thinking Big, but Ignoring Big Obstacles*, HEALTH AFF. BLOG (Oct. 16, 2006), http://healthaffairs.org/blog/2006/10/16/health-reform-thinking-big-but-ignoring-big-obstacles/ (noting that "[p]atients 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).

128. "At midyear 2005 more than half of all prison and jail inmates had a mental health problem . . . ." DORIS J. JAMES & LAUREN E. GLAZE, BUREAU OF JUSTICE STATISTICS, DEP'T OF JUSTICE, MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES 1 (2006), https://www.bjs.gov/content/pub/pdf/mhppji.pdf. "In 2002 more than two-thirds of jail inmates were found to be dependent on or to abuse alcohol or drugs . . . ." JENNIFER C. KARBERG & DORIS J. JAMES, BUREAU OF JUSTICE STATISTICS, DEP'T OF JUSTICE, SUBSTANCE DEPENDENCE, ABUSE, AND TREATMENT OF JAIL INMATES, 2002, at 1 (2005), https://www.bjs.gov/content/pub/pdf/sdatji02.pdf.

129. Nicholas J. Schork, *Time for One-Person Trials*, 520 NATURE 609, 609–10 (2015).

130. *See, e.g.*, Douglas A. Berman, *Distinguishing Offense Conduct and Offender Characteristics in Modern Sentencing Reforms*, 58 STAN. L. REV. 277, 287 (2005).

place to start would be with regular risk-needs assessments (RNAs) as a non-exclusive foundation for criminal justice programming, with several caveats. RNAs need to have open algorithms and data so that the means by which risk scores are calculated can be examined and independently verified. Defendants should be allowed to challenge the methodologies in court.[131] RNAs should be normed to subpopulations to ensure that there is no disparate impact on the basis of race or other suspect classifications.[132] They should also be re-validated on local populations every couple of years. In short, the move towards evidence-based practices requires actual evidence—evidence that is subject to robust investigation, testing, and standards of proof. RNAs have to actually be accurate; it is not simply enough to put a number on risk and take it on faith. One would expect that as data collection and outcome measurement improve, risk-needs assessment tools would also improve. The problems with risk-needs assessments, however, are dwarfed by the problems with gut decisions of judges and DAs, which are even less transparent and accountable—and more subject to bias, explicit or implicit—than RNAs.[133]

Tailoring should not stop with the diagnosis. It also, of course, should include treatment. This is where the criminal justice system as a whole should start to look a lot more like probation and diversion. Some people are inpatients, some are outpatients, some are nonpatients. 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 terms at sentencing currently just means "more" or "less." Prison is expensive. We should be considering what we get for that money. It does not 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, including, sometimes, realizing that the situation will resolve itself. This should be the goal of the criminal justice system—we should at least scrutinize fee-for-service subsidies of prison, the most expensive treatment we use. Tailoring would be a radical change—albeit one that was common during the *Williams v. New York*[134] era.[135] There are questions of how much dis-

131. *See* Martinson, *supra* note 10, at 50.

132. ProPublica reported that a proprietary risk assessment tool used in Florida underestimated the risk posed by white members of the pretrial population and overestimated the risk posed by African-American members. Julia Angwin et al., *Machine Bias*, PRO PUBLICA (May 23, 2016), https://www.propublica.org/article/machine-bias-risk-assessments-in-criminal-sentencing. For a similar argument in the sentencing context, see Sonja B. Starr, *Evidence-Based Sentencing and the Scientific Rationalization of Discrimination*, 66 STAN. L. REV. 803, 805–08 (2014).

133. For a discussion of implicit bias and its impact on the law generally, see IMPLICIT RACIAL BIAS ACROSS THE LAW 1 (Justin D. Levinson & Robert J. Smith eds., 2012).

134. 337 U.S. 241 (1949).

135. *Id.* at 244–46.

cretion a judge should have to find facts (subject to the underlying sentencing statutes and whether they, in turn, implicate *Apprendi v. New Jersey*[136] and its progeny).[137] 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.

Which prisons? 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 private prison 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 reduce the reimbursement price of those prisoners, making sure that the outcome is measured in terms of how people changed in prison, not just how they were when they went in. The value framework could also provide incentives to maximize pro-social outcomes, such as educational attainment in prison,[138] 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.[139] Others have suggested different pay-for-performance models, including a prison re-admission penalty similar to those used in hospitals.[140]

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136. 530 U.S. 466 (2000).

137. *See id.* at 490 ("[A]ny fact that increases the penalty for a crime beyond the prescribed statutory maximum must be submitted to a jury, and proved beyond a reasonable doubt."); *see also* Blakely v. Washington, 542 U.S. 296, 313–14 (2004) (extending the doctrine to state sentencing guidelines).

138. *See* David M. Siegel, *Internalizing Private Prison Externalities: Let's Start with the GED*, 30 NOTRE DAME J.L. ETHICS & PUB. POL'Y 101, 109–10 (2016).

139. Kenneth L. Avio, *Remuneration Regimes for Private Prisons*, 13 INT'L REV. L. & ECON. 35, 45 (1993); *see also* Michael G. Anderson, *If You've Got the Money, I've Got the Time: The Benefits of Incentive Contracts with Private Prisons*, 34 BUFF. PUB. INT. L.J. 43, 85–88 (2015–2016) (suggesting payments based on drug and mental health treatment, as well as educational, vocational, and life skills attainment); Anita Mukherjee, Impacts of Private Prison Contracting on Inmate Time Served and Recidivism 9–10 (Aug. 10, 2016) (unpublished Ph.D. dissertation, University of Wisconsin–Madison), 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).

140. Stuart M. Butler, Op-ed, *How Hospitals Could Help Cut Prison Recidivism*, BROOKINGS (Aug. 18, 2015), https://www.brookings.edu/opinions/how-hospitals-could-help-cut-prison-recidivism.

Beyond the private prison option, the state could also treat 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 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,[141] others with animal-based rehabilitation.[142] Prisons can also differ on the basis of location, size, guard training, and theory. Perhaps prisons in the United States can look internationally for other examples—Scandinavian prisons approach prisons and prisoners in dramatically different ways.[143] 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 the localities 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.

Discharge. Sentence lengths could be limited at the time they are imposed and potentially extended before release—that is, systems could 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., twenty-five years to life).[144] 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.[145] Other states have maximum limits on indeterminate sentences (e.g., four to eight years, where release is possible after four years but must be done by year eight).[146] A return to indeterminate sentencing would be a return to the medical model of imprisonment with a few improvements, notably that there was some

141. *See generally* HOWARD ZEHR, THE LITTLE BOOK OF RESTORATIVE JUSTICE (Howard Zehr ed., 2014).

142. *See generally* Gennifer Furst, *Prison-Based Animal Programs: A National Survey*, 86 PRISON J. 407 (2006).

143. *See generally* John Pratt, *Scandinavian Exceptionalism in an Era of Penal Excess*, 48 BRIT. J. CRIMINOLOGY 119 (2007).

144. For a detailed discussion of the California scheme, see W. David Ball, *Heinous, Atrocious, and Cruel:* Apprendi, *Indeterminate Sentencing, and the Meaning of Punishment*, 109 COLUM. L. REV. 893, 899–900 (2009).

145. *See* W. David Ball, *Normative Elements of Parole Risk*, 22 STAN. L. & POL'Y REV. 395, 398 (2011).

146. *See* 42 PA. CONS. STAT. § 9756(a)–(b) (2016) (establishing a maximum term of confinement and a minimum term of confinement that is one-half as long; parole may be granted after the minimum term and the prisoner must be released by the maximum term).

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."[147] Other parts of the system would be clamoring to use the money spent on incarceration to promote higher value interventions. Funds not spent on discretionary years of an indeterminate sentence could be redistributed. For example, local jurisdictions might pay prisons 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 survival time without recidivism. States could reimburse localities for a given amount of prison time that amounts to a valuation of just deserts, and localities could pay for additional prison time to either vindicate local retributive 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 boards. Individuals from a given community would decide when a prisoner was ready to come home, knowing that prison savings could go to lower taxes or to prevention programs. This would more accurately balance social costs and benefits.

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. Some of the non-uniformity criticisms were, at their core, about racial disparities in who was released and who was denied. Using risk-needs and having an outcome-based approach would make release decisions and their effects on racial subgroups less opaque. If risk assessments amounted to a policy, rather than the clinical assessment of an individual employee, they could actually provide those suffering disparate impact with a stronger claim to sue the agency for violations of constitutional rights under § 1983.[148] Parole officials would no longer have unfettered (and unguided) discretion; they would actually know what they were looking for in terms of criminogenic needs to be addressed before release. Prison capitation fees paid by locals 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. At the very least, it is not as though determinate sentences have been good for prison population reduction, nor

147. *See* Ball, *supra* note 144, at 968–69.

148. Monell v. Dep't of Soc. Servs., 436 U.S. 658, 693–94 (1978) ("[A] local government may not be sued under § 1983 for an injury inflicted solely by its employees or agents. Instead, it is when execution of a government's policy or custom, whether made by its lawmakers or by those whose edicts or acts may fairly be said to represent official policy, inflicts the injury that the government as an entity is responsible under § 1983.").

have they proven to be particularly good at reducing recidivism, promoting equity and fairness, or reducing racial disparities.

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).[149] The current system provides very few legal checks on permanent incapacitation on civil grounds, and pay-for-performance would do nothing to change the legal requirements. Where it would make a difference is in imposing parsimony. Our current system demands no proof of indefinite incapacitation in terms of efficacy or efficiency: it is a blank check. Making the system prove that it is doing something minimally costly and maximally effective would make indefinite detention more difficult.

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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 to this clinic 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. There is much that might seem speculative about the pay-for-performance 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-19th and mid-20th centuries.[150] In the mid-19th 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. These treatments, however, were often grounded in deeply compromised social science, whether that of Cesare

149. *See* W. David Ball, *The Civil Case at the Heart of Criminal Procedure:* In re Winship, *Stigma, and the Civil-Criminal Distinction*, 38 AM. J. CRIM. L. 117, 128–32, 179–80 (2011) (summarizing the procedural protections provided in civil commitment proceedings for sex offenders).

150. Ball, *Why State Prisons?*, *supra* note 25, at 89–93.

Lombroso's physical indicia of the "born criminal"[151] or the horrific testicular mutilations of Dr. Leo Stanley at San Quentin.[152] These are real concerns; we do not know the blind spots we have except in retrospect. Perhaps future generations will look with horror on contemporary criminology. But even if we are blind to better treatments, we should not blind ourselves to the idea of treatment in general. Put another way, the "nothing works" philosophy is misnamed. It should be called "nothing works—except prison" because it implicitly assumes that prison is worth doing even if nothing else is. Prison may arguably have something going for it in terms of efficacy—though the magnitude and even the direction of the effects are disputed[153]—but there is tremendous evidence that it is inefficient.

Criticisms of the rehabilitative approach, then, are 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 impacts 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 under our current system are simply harder to discern with any exactitude, which means everyone and no one is to blame. That, to me, is not a virtue.[154] Algorithms can be audited; policies can be improved. Intuition can be neither audited nor improved.

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 would keep discretion but provide some limits, and it would ensure that there is discretion on the back end of sentencing as well.

C. 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 are there no standard criminological treatments? It could

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151. *See generally* MARY GIBSON, BORN TO CRIME: CESARE LOMBROSO AND THE ORIGINS OF BIOLOGICAL CRIMINALITY (2002).

152. *See* Ethan Blue, *The Strange Career of Leo Stanley: Remaking Manhood and Medicine at San Quentin State Penitentiary, 1913–1951*, 78 PAC. HIST. REV. 210, 211 (2009).

153. For a review of the evidence generally, see Mark W. Lipsey & Francis T. Cullen, *The Effectiveness of Correctional Rehabilitation: A Review of Systematic Reviews*, 3 ANN. REV. L. & SOC. SCI. 297 (2007).

154. *See* Jennifer L. Skeem, John Monahan & Christopher T. Lowenkamp, *Gender, Risk Assessment, and Sanctioning: The Cost of Treating Women Like Men* 27–28 (Va. Pub. Law & Legal Theory Research Paper No. 10, Jan. 18, 2016), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2718460 (noting that adjustments to risk assessments can also exacerbate disparate impact).

be that there is insufficient research or that local populations are different, but it is also the case that demonstrably ineffective programs (such as scared straight) have not yet been fully eradicated.[155] 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. Even then some judges think "more is better" without using the risk-needs-responsiveness principle—which might mean more is ineffective[156]—or going beyond what is effective to what is efficient, given that public safety resources, like all other resources, are scarce and need to be deployed wisely. One notable exception is pretrial practices 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.[157]

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 is no incentive to change. Prisons are not penalized for doing a bad job. Another problem is loss avoidance—the hedonic (and economic) losses of incarceration on society, prisoners, and their families are not counted, just the speculative (and non-falsifiable) worry about the next sensational case of a parolee on a crime spree. Accounting for criminal justice costs 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, as well as the increased likelihood of being sentenced to a harsher penalty.[158] Prisons are a major cost center in state government and, as such, should be targeted.[159]

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 paying for a certain standard of performance will be impossible for the lower-performing agencies and institutions to meet. High-performing agencies, then, might

155. *See Justice Department Discourages the Use of "Scared Straight" Programs*, OJJDP NEWS AT A GLANCE, https://www.ncjrs.gov/html/ojjdp/news_at_glance/234084/topstory.html (last visited Mar. 18, 2017) ("[A] report presented in 1997 to the U.S. Congress reviewed more than 500 crime prevention evaluations and placed Scared Straight programs in the 'what does not work' category. Despite these findings, Scared Straight programs continue to be used throughout the United States and abroad.").

156. *See* Andrews, Bonta & Hoge, *supra* note 6.

157. For the federal system, see 18 U.S.C. § 3142(c)(1)(B) (2012) (release shall be granted "subject to the least restrictive further condition"), *invalidated by* United States v. Karper, 847 F. Supp. 2d 350, 361–62 (N.D.N.Y. 2011). For New Jersey, see N.J. STAT. ANN. § 2A:162-17(b)(2) (West 2017) ("The non-monetary condition or conditions of a pretrial release ordered by the court pursuant to this paragraph shall be the least restrictive condition, or combination of conditions . . . .").

158. CHRISTOPHER T. LOWENKAMP, MARIE VANNOSTRAND & ALEXANDER HOLSINGER, INVESTIGATING THE IMPACT OF PRETRIAL DETENTION ON SENTENCING OUTCOMES 4 (2013).

159. *See* Gershowitz, *supra* note 70, at 53.

be rewarded for meeting a certain standard, and lower-performing agencies might be rewarded based on annual improvements until they meet a certain minimum standard, as low-performing hospitals currently are under Medicare's Hospital Value-Based Purchasing Program.[160] 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

There are a number of criticisms that can be leveled at the pay-for-performance approach. I will discuss five. First, that it ignores important issues: the dignitary interests of people in prison and the retributive interests in punishment, neither of which can be priced or quantified. Second, that it cannot be operationalized since we do not know what works in prison rehabilitation. Third, that the medical approach might expand the scope of the criminal justice system (net widening). Fourth, that it might lead to bargain basement incarceration ("tough 'n' cheap" in Hadar Aviram's phrasing[161]). Fifth, that it punishes the disadvantaged for their social deficits. Before getting into these objections, it is important to emphasize that the pay-for-performance approach is not intended to be exclusive of all others. Mass incarceration has a number of things wrong with it. It is inhumane, arbitrary, and racist, to be sure. But it is also expensive and ineffective. There is no reason not to investigate these shortcomings in addition to or alongside others.

Non-pecuniary interests. A first criticism is that not all interests can be addressed via the value-creation framework, whether it is the dignitary interest of prisoners or the public's interest in retribution. Discussions about how to deploy social resources are, in many ways, discussions about social priorities. As a society, we are what we fund. There is no reason that we cannot say both that prisons violate dignity and that they do so in a way that wastes resources, including human potential. There is also no reason we cannot say that retributive interests might be met in a system that makes us safer in a more effective and efficient way.

Starting with the dignity point, I would query whether it promotes human dignity 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. Moreover, the idea that prisoners can only be warehoused forecloses any redemption. Rehabilitation humanizes the offender

160. *Linking Quality to Payment*, MEDICARE.GOV, https://www.medicare.gov/hospitalcompare/linking-quality-to-payment.html (last visited Mar. 18, 2017).

161. *See* AVIRAM, *supra* note 68, at 164.

and has, as its starting point, the idea that she is worth saving and redeemable. Mercy is, after all, a part of retribution (albeit one seldom emphasized).

As for retribution, I will not belabor the criticisms of retributivism here,[162] but will only suggest that a value orientation is compatible with notions of desert and redemption. It is, of course, difficult to summarize the wide variety of retributive theories, and I will not attempt to do so here. At its most basic, retributivism can be characterized as sounding in desert, with punishment involving the imposition of suffering on the offender proportional to the crime she committed.[163] Pay-for-performance does not target offender suffering, but it is not incompatible with it either. For sentences involving mixed theories of retribution and rehabilitation, an outcome-orientation could simply apply to the rehabilitative part of the sentence.[164] To the extent that the retributive theory is a limiting one, the parsimony imposed on punishments under the scheme dovetails nicely with the idea that punishment should not exceed the crime. Expressive theories of punishment, such as those espoused by Joel Feinberg[165] and Jean Hampton,[166] argue that punishment serves to express society's outrage and send a message to the offender. To the extent we want punishment to make someone learn a lesson, outcomes are a superior method of demonstrating that the lesson has, in fact, been learned. A change in behavior is superior to a mere 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 learned it. These changes also provide better evidence of the "meaning of punishment[]" than claims that are always asserted—without proof—that the legislature, judge, or public meant the message or that it was ever received as such by the convicted.[167] Finally, theories that sound

162. For an overview, see Christopher Slobogin & Lauren Brinkley-Rubinstein, *Putting Desert in Its Place*, 65 STAN. L. REV. 77, 82 (2013); *see also* Mark R. Fondacaro & Megan J. O'Toole, *American Punitiveness and Mass Incarceration: Psychological Perspectives on Retributive and Consequentialist Responses to Crime*, 18 NEW CRIM. L. REV. 477, 503 (2015). For a criticism of how "limiting retributivism" has failed to provide any meaningful limits in an era of mass incarceration, see Robert Weisberg, *Reality-Challenged Philosophies of Punishment*, 95 MARQ. L. REV. 1203, 1227–28 (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 & Jennifer L. Eberhardt, *Racial Disparities in Incarceration Increase Acceptance of Punitive Policies*, 25 PSYCHOL. SCI. 1949, 1949–51 (2014). For a discussion of CBA and retributivism, see Brown, *supra* note 74, at 335.

163. *See* Mirko Bagoric & Kumar Amarasekara, *The Errors of Retributivism*, 24 MELB. U. L. REV. 124, 127 (2000).

164. For a discussion of what I have called "split purposes" sentencing, see Ball, *supra* note 144, at 938.

165. Joel Feinberg, *The Expressive Function of Punishment*, 49 MONIST 397, 400 (1965).

166. Jean Hampton, *Correcting Harms Versus Righting Wrongs: The Goal of Retribution*, 39 UCLA L. REV. 1659, 1659 (1992).

167. *See* Dan M. Kahan, *What Do Alternative Sanctions Mean?*, 63 U. CHI. L. REV. 591, 593, 639 (1996) (discussing the "message of condemnation" involved in various forms of criminal sanctions).

in moral failing or poor choice-making would also be consonant with treatment regimes that seek to identify and correct these failings.

Nothing works. A second criticism is perhaps the most obvious 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 simply not yet found the evidence or found the program, not that such a discovery is impossible. 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.[168] We have very real evidence of the ways in which science has been used to mistreat people, particularly those who are the most powerless in society.[169] Here again, it will be crucial to have transparency about what is being done and why and to include a robust system of monitoring and public comment as we proceed.

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 or to improve survival rates of premature babies? Is it impossible or just not been done—or even really tried?

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;[170] it is also extremely expensive.[171] Even if it were true that being housed in a general prison population did not make someone "better," it certainly does not damage someone nearly as much as solitary confinement.

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168. For a general discussion skeptical of the ability of science to correct itself, see John P. A. Ioannidis, *Why Science Is Not Necessarily Self-Correcting*, 7 PERSP. ON PSYCHOL. SCI. 645, 645–46 (2012).

169. *See* Allan M. Brandt, *Racism and Research: The Case of the Tuskegee Syphilis Study*, 8 HASTINGS CTR. REP. 21, 21–22 (1978) (relaying the history of a United States government experiment on syphilis that deliberately withheld treatment from black male subjects, more than a hundred of whom died).

170. Craig Haney, *Mental Health Issues in Long-Term Solitary and "Supermax" Confinement*, 49 CRIME & DELINQ. 124, 130 (2003).

171. *See* Carrie Johnson & Bill Chappell, *Solitary Confinement Costs $78K Per Inmate and Should Be Curbed, Critics Say*, NPR (Feb. 25, 2014, 9:44 PM), http://www.npr.org/sections/thetwo-way/2014/02/25/282672593/solitary-confinement-costs-78k-per-inmate-and-should-be-curbed-critics-say (estimating the cost of federal solitary confinement beds at three times the cost of a general population bed).

Net widening. There is a fear that a focus on rehabilitation, particularly using a medical model, could somehow expand the size and scope of the carceral state or social control more generally.[172] These fears are certainly worth addressing, given the most recent decades' explosion of penal control. But net widening is a function of a lack of accountability: the net can only widen in a system where criminal justice is subsidized and claims about public safety are asserted without proof. In a system where efficacy and efficiency must be demonstrated, and funding is tied to that demonstration, an unjustifiable widening of the net will be much more difficult, not easier. Not every solution to a problem will be carceral—just as in medicine, not every malady requires hospitalization (or even, as with viruses, any real medical response at all). Diagnosis does not always require treatment, nor, certainly, does it require the most intrusive treatment. Some criminal problems will require "inpatient" solutions, some "outpatient" solutions, and some "non-patient" solutions. The key is forcing these interventions to be justified in terms of results. Programs implemented on the basis of fiscal responsibility have often resulted in a shrinkage of the criminal justice system—not just re-entry, but "non-entry."[173]

It is, of course, true that not everyone gets better in the criminal justice system, particularly those with mental illnesses.[174] It is the ineffectiveness and expense of jail and prison as a response to mental illness that have provided the impetus for non-entry, problems more easily uncovered when there is a systematic commitment to looking at outcomes.[175]

Net widening is objectionable, in part, because it is not worth the money and does not actually work. These are the very criteria on which

172. For a discussion of net widening in the mental health context, see Jeffrey L. Geller et al., *Involuntary Outpatient Treatment as "Deinstitutionalized Coercion": The Net-Widening Concerns*, 29 INT'L J.L. & PSYCHIATRY 551, 551–52, 554 (2006).

173. *See* Eric Kurhi, *How to Keep Mentally Ill Out of Jail Is Focus of Santa Clara County Panel*, MERCURY NEWS (Mar. 11, 2016, 8:16 AM), http://www.mercurynews.com/2016/03/11/how-to-keep-mentally-ill-out-of-jail-is-focus-of-santa-clara-county-panel (quoting County Supervisor Cindy Chavez as asking "[W]hat does a non-entry center look like?").

174. *See* TORREY ET AL., *supra* note 7, at 1.

175. *See* Michael Ollove, *New Efforts to Keep the Mentally Ill Out of Jail*, STATELINE (May 19, 2015), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/5/19/new-efforts-to-keep-the-mentally-ill-out-of-jail (reporting, inter alia, that programs to keep the mentally ill out of jail in Miami-Dade County cut thousands from the jail population and resulted in the closure of a jail). The same is true for homeless people who are swept up in the system. *Graves, Yu: Palantir, UCSF Partner with Santa Clara County on Homelessness Breakthrough*, MERCURY NEWS (June 28, 2016, 9:02 AM), http://www.mercurynews.com/2016/06/28/graves-yu-palantir-ucsf-partner-with-santa-clara-county-on-homelessness-breakthrough (reporting on a social impact bond that targeted homeless people who used many county resources for supportive housing, saving money and improving health outcomes). For an analysis of risk-based pretrial that results in lower costs and lower jail populations, see Jane Wiseman & Stephen Goldsmith, *Fairness Is Fiscally Responsible*, PRETRIAL JUST. INST. (July 6, 2016), http://www.pretrial.org/fairness-fiscally-responsible. One could imagine that low-level drug offenders—say, those primarily arrested for possession offenses—might be addicted and thus incurable by being jailed. This hypothetical seems eminently likely, but it is not fatal to a pay-for-performance approach. A focus on an effective and parsimonious use of resources would foreground the idea that incarcerating this group of people incurs a loss of money, a loss of time, and significant hardship to the "offender" while advancing no end. Any justification remaining would have to come from retributive concerns, which again are not affected by this framework.

programs would be penalized under pay-for-performance. In short, it is much harder to justify net widening in terms of costs, benefits, and efficacy than it is on other theories such as retribution. The same is true for onerous terms of probation or heavy collateral consequences. Only when the inefficiency and ineffectiveness of the net are hidden can the net get wider.

Tough 'n' cheap. Pay-for-performance can easily handle concerns that systems will cut costs by worsening conditions of confinement. The key, again, is that value creation requires not just cost-savings, but improved outcomes. Cutting meal services, for example, is likely to make prisons more dangerous,[176] just as cutting rehabilitative services both undermines discipline and diminishes prospects for successful re-entry.[177] In a pay-for-performance scheme, these dangers would be foregrounded. The external harms they would impose would be resisted by other "downstream" agents in the system—not just public-interest lawyers, but agents of the state who would have to devote more of their resources to cleaning up the mess. Ultimately, the value-creation approach requires that systemic resources be considered, not just local budgets. 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. It might even be more effective. The Eighth Amendment limit to prison conditions leaves much to be desired in terms of speed; it was only several years after California *stipulated* that it was violating the Eighth Amendment that the Supreme Court finally forced it to address the causes of the violation in *Plata*.[178] A value focus might provide quicker feedback and would give other actors within the system financial incentives to address problems.

Punishing the have-nots. A final 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 work on them only 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. Criminal justice funding reform will have to encompass social welfare programs that are not

176. Alysia Santo & Lisa Iaboni, *What's in a Prison Meal?*, MARSHALL PROJECT (July 7, 2015), https://www.themarshallproject.org/2015/07/07/what-s-in-a-prison-meal (observing that cutbacks in meals have led to increased violence); *see also* Maria Godoy, *Ramen Noodles Are Now the Prison Currency of Choice*, NPR (Aug. 26, 2016, 12:47 PM), http://www.npr.org/sections/thesalt/2016/08/26/491236253/ramen-noodles-are-now-the-prison-currency-of-choice.

177. *See* Logan, *supra* note 96, at 28–30 ("Idleness and boredom can be seen as wrong in themselves, from a work ethic standpoint, or as so fundamentally related to mischief as to be undesirable for that reason.").

178. Brown v. Plata, 563 U.S. 493, 507 (2011) ("After this action commenced in 2001, the State conceded that deficiencies in prison medical care violated prisoners' Eighth Amendment rights.").

traditionally considered public safety programs but which might, nevertheless, prevent criminal activity. Most people would surely rather pay a few thousand dollars to subsidize poor children's day care than pay tens of thousands to subsidize elderly prisoners' healthcare—yet our system, through neglect and underinvestment, means those forgotten children of yesterday become the geriatric prisoners of tomorrow. We should have a system that incentivizes front-end 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 that must be addressed in future research.

Still, it must be noted that our current focus on incapacitation of millions of people 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.[179]

CONCLUSION

This 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.

Throughout the Article, I have focused only on the ways in which existing treatment could be made more effective. Healthcare economics has also pointed out another valuable lesson: prevention is much more effective and efficient than treatment. Future research should 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.[180] The real gains in efficacy and efficiency will only come when we realize that crime prevention outside the criminal justice system is less intrusive and more effective than post facto treatments. Because this approach would require, at a minimum, greater reorganization of government to allow for greater fungibility of

179. 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.

180. *See supra* Part III.

resources—including not just criminal justice, but programs such as housing, education, and income supplements—I will leave it for another time. 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 have identified some of the important questions.

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.[181] 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, though perhaps not as utopian as the quote from Samuel Butler's novel with which I began the Article. Indeed, utopianism is a criticism leveled at Porter's work: it cannot work in real life, costing is difficult, there is no state of the art, diagnoses are difficult, etc.[182]

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.

181. *See* KRAUTH, *supra* note 26, at 2.
182. *See* Ball, *supra* note 69, at 1081–82.