their thoughts in this arena, despite the crucial role they have played in other litigation, such as that over chemical and tobacco exposure. Indeed, in *Helling v. McKinney*, a case holding that exposing prisoners to secondhand smoke may constitute cruel and unusual punishment, the Supreme Court expressly recognized a role for “scientific and statistical inquiry into the seriousness of the potential harm and the likelihood that such injury to health will actually be caused by exposure to ETS.” In so holding, the justices issued an invitation for public health experts and epidemiologists to take a front seat in the courtroom. Accepting this invitation has the potential to improve health care for the approximately 2.3 million Americans behind bars.

Public health experts and epidemiologists have broadened our understanding of the burdens of morbidity and mortality in correctional facilities as well as the public health and policy considerations implicated in the provision of prison health care. But in a society with an insatiable appetite for incarceration yet with an insatiable appetite for incarceration yet limited access to providing services, once the prison door slams shut, litigation must serve as a tool to ensure that prisoners and detainees are kept healthy and safe. Just as epidemiology and public health played critical roles in litigation that resulted in safer products, a cleaner environment, and the control of infectious disease, they should play an equally important role in prison health litigation.

*Gabriel B. Eber, JD, MPH*

**WILPER ET AL. RESPOND**

The United States has embraced mass incarceration as social policy. We join the American Public Health Association in opposition to this practice and consider it to be a national disgrace. This convention violates the human and constitutional rights of many inmates, and damages communities and children raised with a parent behind bars. Incarceration of the mentally ill is especially egregious, common, and often preventable.

We believe that everyone has a right to high-quality health care, whether they are incarcerated or not. As a Bush administration surgeon general put it in a report that was suppressed for fear that it would force increases in government spending, “Often overlooked by the health system in the United States, incarcerated men and women have access to adequate health and mental health care and substance abuse treatment services inside the walls of correctional facilities. For these inmates, incarceration is an opportunity—a ‘reachable, teachable moment’—to learn what support they need for their health and mental health problems and substance abuse issues.”

Our study sheds light on a fact largely known only by inmates and those working in correctional health care: inmates carry a heavy disease burden, and often have limited access to the care that is supposedly guaranteed to them by the Supreme Court. The results of our study deflate the credibility of claims that inmates have access to adequate health care in the United States.

We concur with Eber’s call for a greater role for public health expertise in improving inmate health through litigation. Limited access to health care in jails and prisons certainly increases morbidity and mortality among inmates, but also increases the burden communities bear where released inmates return. Indeed, with approximately 1% of US adults behind bars, the public health implications of improved treatment of these individuals who have relatively higher rates of chronic conditions such as HIV, asthma, prior myocardial infarction, and diabetes are substantial.

Inmates rely entirely on their jailers for health care. Investigations into the health and health care of inmates focus attention on a politically unpopular but extremely vulnerable group. Funders and researchers aiming to improve health care for disadvantaged populations should devote additional resources for investigations into inmate health. The public health community ought to oppose mass incarceration and work to improve health care inside prisons.

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**References**


**HEALTH CARE AND SOCIAL SPENDING IN OECD NATIONS**

Farley calls for health reform in the United States to pay increased attention to social and behavioral determinants of health, rather than the typical single-minded pursuit of health care system reform. He convincingly argues that...
addressing underlying causes or disruptions of well-being is the most effective strategy for improving population health. Outcomes from nations emphasizing social investments over medical ones strengthen that assertion, and suggest that if better health is the goal, the United States is investing too much in the wrong place. Among nations of the Organization of Economic Cooperation and Development (OECD), increased social spending is linked to lower infant mortality and longer life expectancy.\(^2\) Compared with fellow OECD countries, the United States spends little on social investments (Table 1) while simultaneously hemorrhaging disproportionately large sums from a health care system that provides below-average results.\(^3\) Spending more on health care does not increase health, and increased health care spending does not necessarily correlate with higher social spending (Table 1).

Universal access to health care is a worthy goal, but it may do little to improve overall health in the United States. Even the wealthiest Americans who currently enjoy such access, 50 to 74 year-olds earning equal to or greater than $496000 per year, appear to manifest the effects of neglected social priorities with poorer health than do their European counterparts.\(^4\) Furthermore, although Scotland provides universal health care access, social inequities still cause the wealthiest Scots to live an average of 28 years longer than do the poorest.\(^5\) As we can see, more of the same health care is not necessarily the answer.

Although the tendency for Europeans to be generally healthier than Americans despite spending fewer health care dollars is well established,\(^3\,4\,6\) it should not be assumed that more efficient use and equitable distribution of health care is the principle contributor to their well-being. Those better outcomes are more likely a result of a greater emphasis on social policy. Correspondingly, the assumption that poor population health in the United States is primarily attributable to health care that is wasteful, inefficient, and not available to all citizens deserves reconsideration. Reforms in US health care delivery, access, and funding are certainly needed, and spending the OECD average of 9% of gross domestic product on health care should be sufficient to manage the burden of illness we face. But meaningful improvements in population health may require us to invest as heavily in social programs as the healthiest OECD nations (between 20-30% of gross domestic product; Table 1). Evidence increasingly indicates that social policies that care for people are the best investments for health.\(\textit{\textsuperscript{\textcircled{\textsection}}}\)

\begin{table}
\centering
\caption{Relative rankings of OECD countries for select expenditures and health outcomes: 2003–2005}
\begin{tabular}{|l|c|c|c|c|c|}
\hline
 & Health Care & Social Spending, & Infant Mortality, & Life Expectancy, \\
 & Spending, \% GDP & \% GDP & Rate Per 1000 Births & Mean Years at Birth \\
\hline
Australia  & 9.5 & 17.9 & 5.0 & 80.9 \\
Austria  & 10.2 & 26.1 & 4.2 & 79.5 \\
Belgium  & 10.3 & 26.5 & 3.7 & 78.7 \\
Canada  & 9.8 & 17.3 & 5.4 & 80.2 \\
Czech Republic  & 7.2 & 21.2 & 3.4 & 76.0 \\
Denmark  & 9.1 & 27.6 & 4.4 & 77.9 \\
Finland  & 7.5 & 22.5 & 3.0 & 78.9 \\
France  & 11.1 & 28.7 & 3.6 & 80.3 \\
Germany  & 10.7 & 27.3 & 3.9 & 79.0 \\
Greece  & 10.1 & 21.3 & 3.8 & 79.3 \\
Hungary  & 8.1 & 22.7 & 6.2 & 72.8 \\
Iceland  & 9.5 & 18.7 & 2.3 & 81.2 \\
Ireland  & 7.5 & 15.9 & 4.0 & 79.5 \\
Italy  & 8.9 & 24.2 & 4.7 & 80.4 \\
Japan  & 8.0 & 17.7 & 2.8 & 82.1 \\
Luxembourg  & 7.9 & 22.2 & 2.6 & 79.3 \\
Mexico  & 6.4 & 6.8 & 18.8 & 75.5 \\
Netherlands  & 9.2 & 20.7 & 4.9 & 79.4 \\
New Zealand  & 9.0 & 18.0 & 5.1 & 79.6 \\
Norway  & 9.1 & 25.1 & 3.1 & 80.1 \\
Poland  & 6.2 & 22.9 & 6.4 & 75.1 \\
Portugal  & 10.2 & 23.5 & 3.5 & 78.2 \\
Slovak Republic  & 7.1 & 17.3 & 7.2 & 74.0 \\
Spain  & 8.3 & 20.3 & 4.1 & 80.7 \\
Sweden  & 9.1 & 31.3 & 2.4 & 80.6 \\
Switzerland  & 11.6 & 20.5 & 4.2 & 81.3 \\
United Kingdom  & 8.3 & 20.6 & 5.1 & 79.0 \\
United States  & 15.3 & 16.3 & 6.8 & 77.8 \\
OECD average & 9.0 & 20.7 & 5.5 & 78.6 \\
\hline
\end{tabular}
\small
Note. GDP = gross domestic product; OECD = Organization for Economic Cooperation and Development. Data exhibit a high degree of stability over years, so for years where data were missing, adjacent years’ data were used to create a complete set. Source. \url{http://www.sourceoecd.org/factbook}
\end{table}

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FARLEY RESPONDS

Studies showing a link between social inequities and poor health are convincing, although the mechanisms by which social factors exert their effect on health are unclear. The question that many who work in public health struggle with is what our role should be in addressing those social factors, as they cannot be solved with the commonly used tools of public health. For instance, income inequality will not be lessened as a result of restaurant inspections, immunizations, or health education. There are, however, policy and environmental changes that we can implement for which the benefits in reducing the leading causes of death are clear and direct, such as smoke-free air policies, cigarette taxes, reductions in the sodium content of food, and provision of parks and other facilities for physical activity. Over the next few months at least, our elected leaders will be focused heavily on reforming our health care system. We should take this rare opportunity to expand their focus to include these health-promoting policy changes. Addressing social inequities is a longer-term battle to which we can contribute but in which we have less direct influence.

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