South Islands of New Zealand from inspecting Figure 3 of our original paper. Before North and South Islanders contact us to ask which island is doing better, we should point out that the narrowing he observed is between the life expectancy of men and women in New Zealand. He misread the key to Figure 3. There is no difference between mean life expectancy of the population of the two main islands of New Zealand—a broad geographical equality few other territories can emulate when their populations are divided so simply.

Fourth, Harper is cautious about our interpretation that growing economic inequality during the late 1980s and early 1990s in New Zealand is a driver of the corresponding widening geographical differential in health. He states that:

"...the longer term trends show that economic inequality declined sharply in New Zealand from the end of The Second War to the mid-1980s, which would be inconsistent with the rise in health inequality Pearce and Dorling show from 1981 to 1986. (Harper, 2006, p. 605)

However, our results show that geographical inequalities in health increased only very slightly between 1981 and 1986 (~0.3 years for males and females), and, hence, we are making no great claims for this time period. Rather, the rapid increase in health inequalities took place in the 10 year period after 1986, a period which coincided with a rapid rise in income inequality in New Zealand.

Finally, Harper is probably mistaken in attempting to reduce the observed rise in inequality in health into a single explanation. It is unlikely that the sharp rise in social and spatial inequalities in health in New Zealand is the product of just one explanation or process. Rather, as noted elsewhere, rising geographical inequalities in health are likely to be a manifestation of many complex and socially patterned factors, which operate at a range of scales across the life course. Therefore, in New Zealand rising geographical inequalities in health probably reflect a range of multifaceted explanations of which growing income inequality and selective migration are two key intertwined drivers. We would argue that the processes of selective migration and economic inequality are inextricably linked—as economic inequality increases so the patterns of migration become more selective and over time there are some places to which, increasingly, only the most wealthy have the resources to be able to move.

In conclusion, while we agree with Harper's assertion that migration is likely to play an important role in explaining rising geographical inequalities in health in New Zealand, it is unlikely that population change by itself fully explains New Zealand's widening spatial health divide. Further, we would argue that increasing levels of income inequality in New Zealand are also an important component of the explanation for rising health inequalities. While Harper is right to note that other New Zealand studies have found that income inequality and health are not related, it is perhaps not surprising that given New Zealand's small population the evidence tends to be inconsistent. Because of the high proportion of New Zealand residents who were born overseas, the high levels of age-specific emigration and the high levels of internal migration within the country, New Zealand is an important setting to study the effects of selective migration upon health. However, studying cohort by cohort 'multiple age- and cause-specific pathways' is problematic but could well be worthwhile given the extent of inequalities within the two main islands.

References


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Obesity prevention: life course approach vs continuing environmental ‘detoxification’

From MIRANDA J PALLAN, KK CHENG and PEYMANÉ ADAB

Editor—In their editorial, Lawlor and Chaturvedi devote much attention to the potential for obesity prevention by brief intervention at critical periods of development, particularly the perinatal period, infancy, and puberty. This approach to obesity prevention appears interesting, but there are issues that need to be considered. First, although no definition of ‘brief intervention’ is given, the implication is that a short-lived, relatively simple intervention delivered at a critical

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Treatment and prevention of obesity—are there critical periods for intervention?

From SUMMER SHERBURNE HAWKINS* and CATHERINE LAW

Lawlor and Chaturvedi’s editorial, from the special themed issue on obesity, reviewed the evidence on treatments for obesity and considered whether there are critical periods for preventing obesity. We concur with the authors about the importance of identifying critical periods to inform interventions; however, in contrast to them, we believe that there is a substantial body of evidence to support infancy and early childhood as potentially important periods for obesity prevention.

A recent systematic review by Baird et al. found that infants who were the ’biggest’ or grew rapidly over the first 2 years of life were at the greatest risk for later obesity. Infant growth may reflect programming in utero, post-natal environmental factors, or a combination of both. Three recently published systematic reviews on breastfeeding and later obesity found evidence for a protective effect of breastfeeding and support for a dose–response relationship. The systematic review by Owen et al., which Lawlor and Chaturvedi cite, examined the impact of breastfeeding on mean BMI. Despite finding limited evidence for a relationship, they concluded that it remains possible that breastfeeding provides some protection against obesity. While there is a relatively small body of research on risk factors in preschool children for subsequent obesity, behaviours in early life may place children at risk. For example, television viewing in children under age 5 years is a risk factor for obesity in childhood and adulthood.

We would argue that interventions for obesity prevention should focus on early childhood when health-related behaviours are developing. However, additional research will be needed to develop and evaluate interventions targeting infancy and early childhood.

References