

## Achieving health equity by eliminating health inequities

### Position statements

- The College is committed to achieving health equity in Aotearoa/New Zealand and believes the Government must place greater emphasis on eliminating health inequities between population groups.
- Focusing on the determinants of health is crucial if health inequities are to be eliminated. Initiatives in other sectors will have the biggest impact (e.g. labour, welfare, education, housing).
- Appropriate and accessible primary health care is also a key aspect of reducing health inequities in Aotearoa/New Zealand. General practitioners (GPs) are encouraged to take a population health, as well as individual, approach. This will involve monitoring inequities within practice populations and regularly reassessing their own practices to ensure treatment and management decisions contribute to improving health equity for individuals and communities.
- The College supports health services being better integrated with other community services, such as whānau ora, as a means of addressing inequities for at-risk families. GPs are encouraged to make links with integrated services, including whānau ora providers, and contribute where appropriate.
- The College supports a review of the funding model for primary health care to ensure funding is targeted towards the most disadvantaged. Funding models are required for primary health care that provide extra financial support to ensure high-quality and appropriate care for disadvantaged patients and population groups.
- As evidence has demonstrated the impact of low income on health inequities and that health inequities begin early and compound over the life course, the College believes Government should fund free primary health care for low-income families.
- Other actions to reduce health inequities caused by the health system need to include:
  - a focus on health inequities and the determinants of health in early and ongoing training for GPs and other health professionals
  - ongoing measures to raise the level of cultural competency of all GPs and other health professionals
  - measures to increase the number of Māori and Pacific GPs and other primary health care professionals.
- The College supports a focus on measures to eliminate smoking, and to increase healthy food options for low-income families by reducing existing barriers.

### What is health equity/inequity?

Health inequities are defined as differences which are unnecessary and avoidable, but in addition are considered unfair and unjust.<sup>1</sup> Inequalities are not always inequities as they may not be avoidable or unfair. For example, some conditions or diseases can only occur in males or females. Health inequities do not occur naturally and are not random, but are the result of social and economic policy and practices.<sup>2</sup>

<sup>1</sup> Whitehead M. 1992. The concepts and principles of equity and health. *International Journal of Health Services* 22: 429. 445 cited in P Reid, B Robson. Hauora: Māori standards of health IV. 2007. Chapter 1 Understanding Health Inequities.

<sup>2</sup> Ministry of Health. 2004. A health equity assessment tool (equity lens) for tackling inequalities in health.

In all countries, more socially disadvantaged groups have poorer health, greater exposure to health risks and poorer access to health services.<sup>3</sup> Achieving health equity does not mean that resources are equally shared; rather, it acknowledges that unequal resource distribution may be essential to ensure different groups enjoy equitable health outcomes. Equity is an ethical concept based on the principle of fairness, which sees that resources are allocated to ensure everyone has their minimum health needs met.

This position statement uses the terms *inequities*, *inequalities* and *disparities* interchangeably. In all cases, this position statement is referring to inequities as defined above.

## What are the causes of health inequities?

Inequities in health arise because of inequities in society . in the conditions in which people are born, grow, live, work and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is considered a good marker of progress towards creating a fairer society.<sup>4</sup> The negative differences (e.g. rates of mental illness, obesity and imprisonment) between more and less equal societies are large . from three to 10 times as common in more unequal societies . and these differences apply to the whole population, not just to a small proportion of the population or to the poor.<sup>5</sup>

Some determinants are closer to the individual, such as biological or lifestyle factors, while others are more distant, such as social, cultural and economic factors, and their effect is mediated through closer factors. For instance, a person's low income may hinder their access to healthy food, such as fruit and vegetables, which in turn may contribute to increased susceptibility to infection or to heart disease and diabetes.<sup>6</sup> Individual behaviours, such as smoking, only partly explain inequities, and such behaviours themselves are strongly related to social and economic factors.<sup>7</sup>

Differential access to health care services and differences in care for those receiving services also has a considerable impact on health status and mortality. For example:

- M ori populations still have higher levels of unmet need for GP care than non-M ori (see the New Zealand Health Survey) and receive a lower quality of care once under treatment for some conditions. Ministry of Health information shows M ori avoidable and ambulatory sensitive hospitalisation rates are over one and a half times higher than those of non-M ori.<sup>8</sup>
- Pacific peoples experience high rates of ambulatory sensitive hospitalisation, indicating that high-quality primary health care may not be reaching Pacific peoples as effectively as other New Zealanders,<sup>9</sup> for example Pacific peoples

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<sup>3</sup> Ministry of Health. 2002. Reducing inequalities in health.

<sup>4</sup> Fair Society, Healthy Lives. 2010. The Marmot Review Executive Summary (strategic review of health inequalities in England post-2010).

<sup>5</sup> Richard Wilkinson and Kate Pickett. 2010. The Spirit Level . why equality is better for everyone.

<sup>6</sup> Public Health Advisory Committee. 2005. A guide to health impact assessment: a policy tool for NZ.

<sup>7</sup> Ministry of Health. 2002. Reducing inequalities in health.

<sup>8</sup> Ministry of Health. 2010. Tatau Kahukura: M ori Health Chart Book.

<sup>9</sup> Ministry of Health. 2004. Tupu Ola Moui . Pacific Health Chart Book.

require hospitalisations for cellulitis at a rate 1.5 times that of the total New Zealand population.<sup>10</sup>

One of the largest determinants of health is income. In general, lower incomes are associated with higher morbidity and mortality for many illnesses and injuries.<sup>11</sup> The differential position of M ori in the labour market (i.e. both having a job or not and the type of job or occupation) accounted for a significant proportion of the widening gaps in mortality rates between M ori and non-M ori during the 1980s and 1990s.<sup>12</sup>

In all countries, socioeconomic differences are linked with differences in health outcomes for children.<sup>13</sup> People with higher socioeconomic position in society have a greater array of life chances and more opportunities to lead a flourishing life. They also have better health. What matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society.<sup>14</sup>

Substantial international evidence shows that adult unemployment, welfare dependence, violence and ill health are largely the results of negative factors in the early years.<sup>15</sup> Factors such as parental income and maternal education are associated with almost every measure of child health and wellbeing. Two common explanations for unhealthy children becoming unhealthy adults are learned behaviours from parents and the long-term impacts of childhood exposure to environmental hazards, such as cigarette smoke and mouldy housing. Poor health is directly linked to poor housing and housing infrastructure.<sup>16</sup> The quality of the in-utero environment has also been identified as contributing to health into adulthood.<sup>17</sup>

There are some differences in the burden of disease between races that are determined by genetics. However, persistent ethnic disparities suggest there are other features of society that produce ill health in M ori and other groups, such as Pacific people. Institutional racism and the effects of colonisation and land confiscations (e.g. by narrowing the M ori economic base and reducing M ori political influence) may play an important part in contributing to inequalities.<sup>18</sup> Racism affects health partly because indigenous and minority populations tend to experience less favourable social and economic circumstances and access to health care, and partly because of the more direct psychosocial stress that racism engenders.<sup>19</sup>

Analysis of the 2002/03 New Zealand Health Survey showed M ori reported the highest prevalence of ever experiencing racial discrimination (34 percent), followed

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<sup>10</sup> F Sopoaga et al. 2011. Causes of excess hospitalisations among Pacific peoples in New Zealand: implications for primary care. J Prim Health Care 2010 cited in BPAC. Best Practice Journal. Skin Infections in Pacific peoples.

<sup>11</sup> B Robson, D Cormack, F Cram. 2007. Hauora: M ori standards of health IV. Chapter 3 social and economic indicators.

<sup>12</sup> B Robson, D Cormack, F Cram. 2007. Hauora: M ori standards of health IV. Chapter 3 social and economic indicators.

<sup>13</sup> Public Health Advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.

<sup>14</sup> Richard Wilkinson and Kate Pickett. 2010. The Spirit Level . why equality is better for everyone.

<sup>15</sup> Public Health Advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.

<sup>16</sup> Gary Garner. 2006. The inter-relationship between housing and health outcomes. In Proceedings Pacific Rim Real Estate Society Conference University of Auckland.

<sup>17</sup> Public Health Advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.

<sup>18</sup> Public Health Advisory Committee. 2005. A guide to health impact assessment: a policy tool for NZ.

<sup>19</sup> Ministry of Health. 2002. Reducing inequalities in health.

by similar levels among Asian (28 percent) and Pacific groups (25 percent). In that survey, experience of racial discrimination was significantly linked to poorer health outcomes for all ethnic groups and, combined with socioeconomic differences, appeared to account for many of the health inequalities between Māori and Europeans.<sup>20</sup> Māori, Pacific and Asian groups all reported higher levels of unfair treatment by a health professional (ever) compared with Europeans.

These inequalities exist throughout life – from birth, through childhood, adolescence and adulthood, and into old age. Disadvantage early in life also influences disadvantage and health in later life. Disadvantage therefore takes a cumulative toll on an individual's health over his or her lifetime, as well as across generations.<sup>21</sup>

### **What kind of health inequities do we have in New Zealand?**

There is considerable evidence in New Zealand of significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions and males and females.<sup>22</sup> A national survey identified the populations subject to inequalities and disadvantage as Māori, Pacific, low socioeconomic quintile, low-income workers, who had difficulty accessing health services during working hours, rural, elderly, disabled, migrants, refugees, those with poor English language skills, and those living in specified localities.<sup>23</sup> As described above, the health system itself also contributes to health inequities.

In New Zealand, ethnic identity is an important dimension of health inequities. Māori and Pacific people experience lower life expectancy and health disadvantage across most mortality and morbidity indicators compared to Europeans, as well as socioeconomic disadvantage in areas such as housing, education, income and employment.<sup>24</sup> In New Zealand, ethnic inequalities between Māori and non-Māori are the most consistent and compelling inequities in health.<sup>25</sup> An analysis of socioeconomic position and health status data identifies three distinct types of ethnic inequalities in health in New Zealand. These have been described as the distribution gap, the outcome gap and the gradient gap.

- The **distribution** of the ethnic Māori group is sharply skewed towards the most deprived deciles, with only 3 percent in decile 1 and 26 percent in decile 10 meshblocks.<sup>26</sup> In society where privilege and deprivation are independent of ethnicity, Māori and non-Māori would be equally distributed through the deciles.

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<sup>20</sup> R Harris et al. 2012. The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science & Medicine* 74.

<sup>21</sup> Ministry of Health. 2002. Reducing inequalities in health.

<sup>22</sup> Ministry of Health. 2004. A health equity assessment tool (equity lens) for tackling inequalities in health.

<sup>23</sup> Sheridan et al. 2011. Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health*.

<sup>24</sup> R Harris et al. 2012. The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science & Medicine* 74.

<sup>25</sup> P Reid and B Robson. 2007. *Hauora: Māori standards of health IV*. chapter 1 Understanding health inequities.

<sup>26</sup> The meshblock is the smallest geographic unit for which statistical data is collected and processed by Statistics New Zealand. A meshblock is a defined geographic area, varying in size from part of a city block to large areas of rural land. Each meshblock abuts against another to form a network covering all of New Zealand, including coasts and inlets, and extending out to the 200-mile economic zone. Meshblocks are added together to build up larger geographic areas, such as area units and urban areas. They are also the principal unit used to draw up and define electoral district and local authority boundaries.

- The health **outcomes** of Māori are different from non-Māori even after controlling for deprivation.
- The **gradient** gap describes the relationship between ethnicity and increasing deprivation. It is as if the effect of increasing deprivation compounds risk for Māori whereas Pākehā do not seem to be subject to this effect. The gradient gap is demonstrated in mortality data, but is generally not evident in hospitalisation data.<sup>27</sup>

New Zealand research suggests life expectancy and other measures of health status are similar in rural and urban areas. The gap between Māori and non-Māori life expectancy is present in both rural and urban areas and rural Māori have a slightly shorter life expectancy than urban Māori.<sup>28</sup> In rural areas, a larger proportion of Māori are in NZDep quintile five (high deprivation) areas than are Māori in urban areas. There is a direct correlation between rural areas with high levels of deprivation and the proportion of Māori in the community. Deprivation accentuates the impacts of rurality, and together they can result in poorer health outcomes. Many rural Māori have high levels of deprivation and poor health.<sup>29</sup>

### **How can we achieve health equity by eliminating health inequities?**

The College is committed to achieving health equity in Aotearoa/New Zealand and believes government must place greater emphasis on eliminating health inequities between population groups. The Ministry of Health has a framework for action which entails developing and implementing comprehensive strategies at four levels:

- The underlying social and economic determinants of health
- Factors that are intermediate between socioeconomic determinants and health, such as behaviour, environment and material resources
- Health and disability support services
- The feedback effect of ill health on socioeconomic position

A focus on the social and economic determinants of health has widespread support in the literature; however, most of these lie beyond what is traditionally seen as the mandate of the health sector. Despite this, the College believes the health sector can help target the social and economic determinants of health. The College supports:

- initiatives in other sectors that contribute to improving health outcomes (e.g. improvements in housing for low-income communities with poorer-quality housing could potentially prevent ill health and reduce inequalities<sup>30</sup>)
- Government routinely undertaking health equity assessment of all new and existing policies, programmes and initiatives across other sectors, such as education, housing, labour, economic development, justice, transport and social welfare
- health sector input into policies and services in other sectors to maximise health gain and address existing health inequities and ensure they are not exacerbated
- health sector advocacy for and actively encouraging inter-sectoral approaches to addressing the social determinants of health<sup>31</sup>

<sup>27</sup> P Reid, B Robson and C Jones. 2000. Disparities in health: common myths and uncommon truths. Pacific Health Dialog Vol 7 No 1.

<sup>28</sup> National Health Committee. 2010. Rural Health: Challenges of Distance, Opportunities for Innovation.

<sup>29</sup> National Health Committee. 2010. Rural Health: Challenges of Distance, Opportunities for Innovation.

<sup>30</sup> P Howden-Chapman et al. 2007. Effects of insulating existing houses on health inequality: cluster randomised study in the community. BMJ 39070.573032.80

<sup>31</sup> New Zealand Medical Association. Health Equity Position Statement. 2011

- working collaboratively with other sectors to address the social determinants of health.

The health sector also has a direct role at the strategic level; it should ensure its own policies are directed towards an equitable distribution of health resources in relation to inequalities in health status, including ethnic and geographical inequities.

Health and disability services can contribute to reducing inequalities if they:

- ensure equity of access to care by distributing resources in relation to need, as defined in collaboration with local communities (equity of access means access proportionate to need, not necessarily the same access for everyone)
- remove barriers, however defined, that inhibit the effective use of services by disadvantaged groups.<sup>32</sup>

The Public Health Advisory Committee and British Royal College of Physicians support health care services being better integrated into the community as a means to reduce access barriers for disadvantaged communities and improve child health. This requires engagement with the community to improve access to services. The College supports this position.

In New Zealand, integrated services for vulnerable families, such as whānau ora, provide a model for delivering whānau-centred services in an appropriate way. GPs are encouraged to make links with integrated services, including whānau ora providers, and contribute where appropriate. Such links will contribute to practices developing active relationships with local Māori organisations, providers, groups and whānau as required under *Aiming for Excellence*, the College's quality standard for general practice. They may also enable College members to refer patients on to other services. The College also supports whānau ora for Māori/for all approaches. These are co-ordinated, Treaty-based and provide self-determination. The College recognises that addressing health inequities for Māori is a matter of fairness and social justice, and is the responsibility of everyone, not just Māori.

### *Primary health care*

The World Health Organization notes that health care systems have better health outcomes when they are built on primary health care. The Ministry of Health has also emphasised the role of appropriate primary health care in addressing Māori and Pacific health inequities. The College agrees that appropriate and accessible primary health care is one key aspect to reducing health inequities in Aotearoa/New Zealand. A primary health care system can only improve health outcomes if it exists in an environment that encourages continuity of care for patients, is well coordinated and collaborative, is adequately funded, and primary and secondary services are well integrated.<sup>33</sup> General practice plays a pivotal role in providing primary health care.

The College encourages GPs and general practices to think about the health of population groups alongside the health of individuals. Features of a population health approach, such as a concern for equity, community participation, teamwork and attention to the determinants of health, enhance general practice care rather than undermine it.<sup>34</sup> A population health approach to primary care delivers both high-quality individual care and places an emphasis on equity, community participation,

<sup>32</sup> Ministry of Health. Reducing inequalities in health. September 2002

<sup>33</sup> Royal New Zealand College of General Practitioners. The value of general practice. 2002

<sup>34</sup> Pat Neuwelt et al. Putting population health into practice through primary health care. NZMJ Vol 122 No 1290

and social determinants of health.<sup>35</sup> This will involve GPs communicating with patients in ways that support and encourage patients to self-manage their conditions. It will also include, but is not limited to, GPs monitoring inequities within their practice populations and regularly reassessing their own practices to ensure that treatment and management decisions contribute to improving health equity for both individuals and communities. This necessitates routine collection of ethnicity data. *Aiming for Excellence* involves the practice collecting, documenting and auditing patient ethnicity data consistent with the Health Information Privacy Code 1994 and the Ministry of Health ethnicity data protocols for the health and disability sector. The College also encourages general practice teams to work with whānau across primary care and offer whānau-centred services where possible.<sup>36</sup>

Both the Public Health Advisory Committee and the Marmot Review advocate for proportional universalism as a means of focusing action to reduce health inequities. Proportional universalism is a universal approach to policy and service provision with increasing scale and intensity across the gradient of inequities with those most in need receiving more intensive services. The blend is important from an equity perspective because it provides essential preventive services for the whole population while also targeting at-risk groups and providing treatment and support for those with existing needs.<sup>37</sup>

The College supports the principle of proportional universalism, as such an approach ensures those who are advantaged do not disproportionately benefit. This requires funding models for primary health care that provide extra financial support or incentives to GPs and other primary health care professionals to provide high-quality and appropriate care for disadvantaged patients and population groups.

If we are to continue with a capitation model, then capitation values should be based on epidemiological or socioeconomic need factors.<sup>38</sup> Funding models need to take into account the higher health needs of disadvantaged populations, the greater cost in delivering health care to health illiterate individuals, the effectiveness of the 15-minute consultation model, which does not distribute time according to need, and the reduced ability for these populations to meet the costs of the health services they need. The College recognises this as a matter of urgency as the present funding model provides financial disincentives to caring for these populations. The College supports a review of the funding model for primary health care to ensure funding is targeted towards the most disadvantaged.

Investment in the early years provides one of the greatest potentials to reduce health inequalities within a generation. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken. Giving every child the best start in life is crucial to reducing health inequalities across the life course.<sup>39</sup> The College urges the Government to reduce financial barriers to health services for low-income families by providing free primary health care, including after hours, to low-income families. This should be taken into account in a review of the funding model for primary health care.

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<sup>35</sup> Pat Neuwelt et al. Putting population health into practice through primary health care. NZMJ Vol 122 No 1290.

<sup>36</sup> The Royal New Zealand College of General Practitioners. 2011. *Aiming for Excellence 2011-2014*.

<sup>37</sup> Public Health Advisory Committee. 2010. *The Best Start in Life: Achieving effective action on child health and wellbeing*.

<sup>38</sup> Finn Diderichsen. 2004. *Resource Allocation for health equity: issues and methods*. World Bank.

<sup>39</sup> Fair Society, Healthy Lives. 2010. *The Marmot Review Executive Summary (strategic review of health inequalities in England post-2010)*.

## *Workforce*

One way to increase the effectiveness of primary health care services is to ensure greater numbers of Māori and Pacific GPs, and other health professionals, and to improve the cultural competence of all health professionals and providers. The College is committed to embedding education on health inequities and social determinants of health within the College's General Practice Education Programme (GPEP) curriculum, and ongoing training for GPs. Furthermore, the College has an expectation that both New Zealand- and overseas-trained medical graduates have a comprehensive understanding of these matters. GPEP curriculum domains and statements include a number of core competencies related to health equity that Fellows of the College are required to meet. For example, Fellows of the College are able to:

- demonstrate culturally competent behaviours in all aspects of practice
- understand and apply the principles of the Treaty of Waitangi to general practice
- identify the societal, cultural, economic, spiritual, gender, environmental, geographic, demographic, occupational and other factors that impact on health and illness
- identify a range of factors that impact on accessing health services and resources and develop appropriate responses.

It is acknowledged that these core competencies have historically not been given the recognition that they deserve; however, the College is committed to ensuring these competencies are thoroughly embedded throughout the GPEP and valued as highly as other core competencies.

## *Lifestyle factors*

There are lifestyle factors affecting health over which individuals may have a greater level of control. These include whether someone smokes, exercises, eats healthy food and how much alcohol they drink. As outlined above, these factors are also influenced by income and the other determinants of health. Alcohol and smoking dependence and illicit drug use are both responses to social breakdown and significant contributors to further escalation of health inequities. These substances are a large drain on people's incomes, reduce participation in society, and are a large cause of ill health and premature death.<sup>40</sup>

Many of the key health behaviours significant to the development of chronic disease follow the social gradient: smoking, obesity, lack of physical activity, unhealthy nutrition.<sup>41</sup> Good nutrition is crucial and begins in utero with adequately nourished mothers.<sup>42</sup> Children in families with significant financial hardship are less likely to be able to eat healthy food. Obesity is greater and oral health status is poorer in children from food insecure families. Levels of obesity tend to be lower in countries where income differences are smaller.<sup>43</sup> Poor dental health compounds inequities and their effect on health. Chronic caries and periodontitis contribute to poor health outcomes including cardiovascular, respiratory and diabetes outcomes.<sup>44</sup> The high rates of

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<sup>40</sup> Australian Medical Association. 2007. Position statement . social determinants of health and the prevention of health inequities.

<sup>41</sup> Fair Society, Healthy Lives. 2010. The Marmot Review Executive Summary (strategic review of health inequalities in England post-2010).

<sup>42</sup> World Health Organization. 2008. Closing the gap in a generation . health equity through action on the social determinants of health.

<sup>43</sup> Richard Wilkinson and Kate Pickett. 2010. The Spirit Level . why equality is better for everyone.

<sup>44</sup> Sarah Wamala et al. Inequity in access to dental care services explains current socioeconomic disparities in oral health: The Swedish National Surveys of Public Health 2004-2005.



acute rheumatic fever in Pacific peoples have been attributed in part to socioeconomic factors, such as poor nutrition.<sup>45</sup> The College supports Government looking at measures to increase healthy food options for low-income families by reducing existing barriers.

Exposure to second-hand smoke in children is linked to middle ear infections, lower respiratory illness, onset of asthma, reduced lung growth and sudden unexplained death in infancy.<sup>46</sup> Making New Zealand tobacco free is probably the single most important activity to reduce inequalities in health after focusing on the socioeconomic determinants of health. Blakely, Simmers and Sharpe have estimated that making New Zealand smoke-free, compared to 2006 smoking rates continuing unabated into the future, might result in five years in life expectancy for Māori, three years for non-Māori and a two-year reduction in the life expectancy gaps.<sup>47</sup> Smoke-free legislation and some social marketing campaigns increase cessation rates and reduce exposure to second-hand smoke. Increased quit attempts are linked with providing cessation services and early brief intervention by health professionals.<sup>48</sup>

The College also supports the recommendation of the November 2010 Māori Affairs Committee report *Inquiry into the tobacco industry in Aotearoa and the consequences of tobacco use for Māori*, but believes that the recommendations for reducing tobacco consumption in Aotearoa/New Zealand are insufficient in light of tobacco's adverse health impacts, as well as the massive relative contribution to health inequities of the tobacco industry. That report recommended that the Government aim for tobacco consumption and smoking prevalence to be halved by 2015 across all demographics, followed by a longer-term goal of making New Zealand a smoke-free nation by 2025. The College advocates for more ambitious timeframes, as well as specific targets to reduce the startling differential rates of smoking for Māori compared to non-Māori.

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<sup>45</sup> BPAC. 2011. Best Practice Journal. Rheumatic fever: the neglected disease.

<sup>46</sup> Public Health Advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.

<sup>47</sup> T Blakely et al. 2011. Inequities in health and the marmot symposia: time for a stocktake. NZMJ, 8 July.

<sup>48</sup> Public Health Advisory Committee. 2010. The Best Start in Life: Achieving effective action on child health and wellbeing.