Editorial

Shop till they drop

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Shopping is so easy nowadays if you live in a wealthy western country. Simply pop into your local super-market for a jar of coffee and you will come out with at least three, maybe four, other things you had no idea you needed and probably don't. Buy one get one free; that special offer that was just too good to ignore. We know we really should support the smaller shops, buy more locally produced food, cut down on the air miles. The farmer's market is very good, when we make the effort to go, but it is more expensive. It's the convenience that the large retailers offer; the choice and the low cost.

The fashion industry is also in on the act. There was a time, not so very long ago, when most families had at least one member who could sew, make simple clothes, carry out running repairs. Now there is little point in doing all this, not when you can buy three tops for £5, tee shirts for £6. No one cares if the garments fall apart in the washing machine or the zip goes. Low prices mean garments can just be thrown away and if anything does last long enough for us to get fed up with it, well, there's always the clothes bank or the charity shop. As with food, fashion retailers offer us choice. No need to shop around when you can get the same garment in four different colours and all at rock bottom prices.

Well how rock bottom exactly? And who is paying? Let's start with the coffee. Over 20 million farmers try to earn a living from growing one of the most sought after crops in the world (Fairtrade, 2002) supplying an industry that employs over 100 million people world-wide. The farmers should be wealthy. Instead they are among the world's poorest people, working in areas with limited infrastructure and thus dependent not only on buyers for their crop but also on someone to transport it. In 1994, robusta coffee beans, that are used to make instant coffee, sold for about 180 cents per pound. In 2001 the price dropped to 17 cents per pound and today the average weighted price is 92.68 cents per pound (International Coffee Organisation,

2007). Someone is making money out of coffee, but it isn't the farmers.

Bananas provide a similar story. One of the most popular fruits, bananas are a source of cheap, filling food but the consumer doesn't see the conditions in which they are produced. Wages as low as a dollar a day; the serious harmful effects of agricultural chemi-cals, used to boost production, but without proper and enforced health and safety regulations; the hos-tility of employers towards the formation of workers' organisations that might lobby for improvements all conspire to ensure that plantation workers remain poor, suffer serious health problems and have no right of redress (Banana Link, 2007; Fairtrade, 2000).

Workers in the clothing trade fare no better. Those who try to earn a living sewing clothes are almost always women, with families to support, and thus easy to exploit. For example, in Bangladesh, it is not unusual for women employed in clothing factories to work for 80 hours or more per week for a salary of £17 a month, far less than the £22 required for a living wage (War on Want, 2006). They are allowed one day off per week but 'overtime is not an option. When management decides, workers are bound to work extra hours or lose their jobs. Worse still, overtime is often not paid' (War on Want, 2006 p. 4). As with banana production, lack of awareness of workers' rights and a lack of trade unions mean that employees remain vulnerable. Added to this is the risk of sexual harassment by managers and employers who know that they will not be chal-lenged.

Considering the evidence, it is tempting to conclude that a comfortable life is dependent on the exploi-tation of others. Commercial companies exist to make money. The objectives of the Coffee Trade Federation, for example, state its intention to protect business interests in every way possible. However, placing all the blame on corporate interests is far too simplistic. Trade is an essential factor in developing and sustain-ing any nation's economy and the richest countries

have used it to their full advantage. For centuries trading companies and politicians have aligned their interests, creating a playing field that is weighted in their favour; what poorer traders need is a playing field that is at least level enough to allow them a chance to make a decent living. The challenge is how to achieve this.

Western food and clothing retailers are making voluntary commitments to improving working conditions, paying fair wages and upholding workers' rights (War on Want, 2006). If nothing else it makes good business sense. If enough customers complain, if they insist that changes be made, companies have to be seen to make some sort of response. Shopping is a political act; as a supermarket manager wryly observed to one of us, the difference between a customer and a terrorist is that you can negotiate with the terrorist. Customers, therefore, do have some power in effecting change.

However, even when there is genuine commitment to action, sustainable improvements can be difficult to achieve. For example, in 2002, GAP was widely criticised over working conditions in its factories in Indonesia, Lesotho, El Salvador and many other countries. Exploitation, long hours, poor pay, hazardous conditions were among the many problems identified by employees and a coalition of groups pressing for improvements. GAP pledged that changes would be made. The company was highly praised for its own, highly damning, investigation into factory conditions and sensible plans to address the situation (GAP, 2004). Making these plans work was very challenging and not altogether successful. In each country there were multiple issues to be addressed including the lack or inadequacy of employment laws, helping employees understand the need for certain safety regulations, local customs and practices, how to monitor factory conditions and determine what constituted progress (GAP, 2004). One year later some improvements had been made but there were still many problems, such as the continued use of child labour and restricted access for company inspectors, which continue to require constant and sustained effort (GAP, 2005, 2007).

In a different arena, organisations such as Fairtrade, Oxfam, Banana Link and others have lobbied tirelessly for change and have done much to educate people in wealthy countries about what can be done. Boycotting imports does not solve the issue; it simply drives very poor people further into poverty and despair, particularly when certain crops or goods can only be sold in one marketplace. For example, the bananas produced by farmers in the Windward Islands can only be sold in the European Union (Friends of the Earth, 2001). The combined efforts of the Windward Island Farmers' Association, consumers, international trades unionists and others led to the development of Fairtrade in which growers are paid better prices for their crops and have better working conditions so that 'by the end of 2005, over half of the four islands' exports were certified Fairtrade with some 40 community-based farmers' groups involving nearly 3000 farms' (Banana Link, 2007). In addition to better prices, Fairtrade agreements mean that farmers' groups receive a premium to invest in business and community developments such as roads and schools (Fairtrade, 2007). However, this does not solve all the problems as both banana growing and the international markets are continually changing. What both the Fairtrade and the GAP examples show is some of the complexity of poverty. There are no simple solutions or quick fixes. Poverty is the outcome of multiple disadvantages and addressing only one factor does not bring about sustained improvements.

Recognising this complexity and acting upon it requires multiple strategies and constant effort from all concerned. Poverty blights lives affecting every aspect of existence including health. This issue of *Diversity in Health and Social Care* is published as part of a world-wide initiative by the Council of Science Editors (www.councilscienceeditors.org/global themeissue.cfm) to highlight poverty as a major factor affecting health. As a part of this we are pleased to begin with an editorial from Eunice Seekoe who reminds us of the iniquities of apartheid in South Africa. She outlines the detrimental effect this had on families and the poverty that ensued. South Africa is working hard to address the legacy of apartheid through investment in education and healthcare but this takes money and time.

Poverty is more than a lack of money; an individual may be quite well off financially but still poor in other terms. In our first paper, Papadopoulos and Lay demonstrate this point. Gypsies and Travellers are the most marginalised minorities in Europe, stigmatised for their refusal to abandon their nomadic way of life or to conform to the mores of those who live settled lives in houses. Discrimination against them 'appears to be the last "respectable" form of racism. It is still considered acceptable to put up "No Traveller" signs in pubs and shops and to make blatantly prejudiced remarks about Gypsies and Travellers' (Commission for Racial Equality, 2004).

Gypsies are not a single cultural or ethnic group but a mixture of several different traditions and, consequently, it is important not to generalise. What does seem clear is that Gypsies and Travellers have the lowest life expectancy in Europe; high rates of arthritis, respiratory diseases, miscarriage, stillbirth and neonatal death. Ironically it is those who travel least, who have caved in to the pressure to settle in one place, who seem to have the worst health (Parry *et al,* 2004). Almost all the participants in this study were unemployed and probably unemployable because of their

low levels of education attributable, in part, to travelling. Continuity is hard to maintain and so the school drop-out rate is high. Lack of education is also associated with cultural values about honour and shame, particularly for girls, whose purity is closely guarded because each must prove, on her wedding night, that she is a virgin (BBC, 2004). Lack of education is a major obstacle to information about health, particularly in societies in which women have very limited rights and in which any perceived complaint or dissatisfaction on their part may be construed as damaging the family's good name (Asylum Aid, 2002). Nevertheless, as Papadopoulos and Lay point out, women may be the key to change but such change can only be part of the need to tackle more deep-seated issues about poverty and discrimination.

Our second paper continues the focus on marginalised communities. Palmer's study of Somali refugees in London paints a picture of serious and multiple forms of deprivation. Somalia is a very poor country and fighting between rival clans and warlords has led to the breakdown of civil society. At least 60% of the population live on less than $1 a day; education and health services are extremely limited; there is no security or protection for individuals and so human rights abuses are commonplace (Foreign and Commonwealth Office, 2007). Whilst Somalis, particularly men, have a long history of travelling abroad to earn money, those leaving the country in the last 20 years have tended to be women and children (Harris, 2004). Husbands and fathers are either dead or fighting. The Somali diaspora is now worldwide and includes other African states, Australia, North America, Europe and the UK. It is not clear how many Somali people there are in the UK but it is believed to be at least 95 000 with the majority living in the London area (Harris, 2004). Whilst individual health and social care professionals may have some insight into their needs there is little systematically collected data about Somalis; little is known about their cultural values, traditions, health, education or other needs. They are, for the most part, invisible as a minority (House of Commons, 2004). Lack of money and employment, stringent asylum regulations, unfamiliarity with the British way of life, the trauma of events that led to migration all contribute to the near destitution in which many live (Harris, 2004; House of Commons 2004). It is little wonder that their mental health suffers as a result. Added to this are the burdens of stigma, racial discrimination and lack of access to support and services, those developed for black Caribbean, South Asian and other established minorities being unsuited to their needs. Palmer's paper provides a rare insight into the lives of Somali people in the UK and provides useful advice for practitioners and policy makers alike.

Our third paper, by Williams *et al*, focuses on one of the poorest parts of the UK. Wales has a total population of just under three million and the highest rates of child poverty, teenage pregnancy, unemployment and long-term health problems (Oxfam, 2007). Poverty affects all age groups; 28% of children live in poverty and 15% live in households in which no adult has paid work; 25% of 19 year olds lack basic educational qualifications (Joseph Rowntree Foundation, 2007). Charities such as Oxfam, normally associated with relieving poverty in developing countries, work with community and voluntary organisations to address issues such as the exploitation of home workers, child care facilities for working parents and free school breakfasts (Oxfam, 2007). Members of minority groups are the hardest hit. Of those with jobs, most are employed in low-paid work in hotels, catering or the health and social care sector (The Poverty Site, 2007).

Wales has long been treated as a region of England and, many would argue, suffered as a result. It is actually a separate country, a kingdom until the 13th century, with its own language, culture, values and traditions. As Williams *et al* point out devolution has provided an opportunity for a fresh look at many issues and to try to find solutions that are best suited to Wales. The Welsh Assembly Government has certainly adopted this approach, publishing its own strategies for tackling child poverty and improving living conditions (Welsh Assembly Government, 2005). Williams *et al* reflect a similar line of thought in seeking to redefine and assert Welsh identities and Welsh approaches to health and social care issues through research.

In our next paper, by Bowl, we turn again to mental health and the experiences of black people. There have been many investigations into the ways in which black people are disenfranchised by the institutional racism and cultural incompetence of the mental health system (see for example Department of Health, 2003a,b; Keating and Robertson, 2004; Norfolk, Suffolk and Cambridgeshire Health Authority, 2003; The Sainsbury Centre for Mental Health, 2002). It is, therefore, depressing to see that there has been so little response from those responsible for the provision of care and services. In the face of such a seemingly immutable situation it is sometimes tempting to give up but Bowl's paper reminds us of the human suffering involved. It is important not to give up the struggle for social justice and we look forward to a time when black people with mental health problems will receive the help that they so desperately need.

As a part of achieving equity for all we have been long-term advocates for ethnicity data collection and proper monitoring of service delivery and need. Jones and Kai bring that story up to date, as the new NHS Quality and Outcomes Framework (QOF) system purports to encourage good practice in primary care by awarding a single quality point to practices achieving 100% in data capture for all new patient registrations

in the year. Regrettably, it looks as if the costs and barriers exposed by their study of general practitioners will far outweigh the small reward that this represents. As they demonstrate, there is previous evidence that such practice profiling is possible, desirable and useful and that everyone else agrees that primary care is the best place to begin as is the case for nearly everything in healthcare. However, while Everybody thinks this, and Anybody could do it, it seems to be Somebody Else's responsibility and Nobody has, as ever, ended up doing it. Jones and Kai do at least knock on the head the myth of patient resistance: the fault is not with the users of services refusing to give the information, or being offended by the questions, but with the lack of commitment and perhaps an underestimate of the resource costs in terms of time and effort, on the part of the healthcare providers' support teams. It does seem surprising that with electronic notes, problems arose in flagging whether or not the question had been asked or needed to be asked when the patients next came to surgery but the paper provides some useful pointers for the future and emphasises the need for training, ownership and team-building, factors which seem similar to the basic prophylaxis for burnout in mental healthcare services discussed by Ryan and colleagues (2007). Maybe the prescription for the health services' own health is not so complex?

In our final paper we are pleased to return to another aspect of social justice, that of civil rights for LGBT people. It is now 40 years since homosexuality was decriminalised in the UK. This in itself did not change attitudes but gradually legislation has eroded and demolished obstacles to equality. Progress has been slow and not always in the right direction; sometimes everything has had to move backwards before going forwards. We have written elsewhere about the ways in which discrimination against LGTB people has continued and the risks associated with *coming out* (McGee and Johnson, 2006). Nevertheless it was shocking that, even in 2007, the Roman Catholic Church could campaign against the new Equality Act because it outlawed discrimination against gay people wanting to adopt.

Despite all of this, some things have got better. The introduction of civil partnerships means that, if one partner becomes ill or dies the other cannot be excluded or turned out of their home by relatives who do not approve of their relationship. Partners can now make long-term provisions for one another in the same way as heterosexual couples. There is still much to be done and, for some LGBT people these new civil liberties may have come too late, but Fish's exemplary account of legislative change shows how far UK society has come and will be a resource for anyone concerned with social justice for LGBT people.

Finally we recommend our Knowledgeshare section which, as usual, contains a great deal of useful information. If you would like to contribute to this section please email Professor Lorraine Culley at lac@dmu.ac.uk.

REFERENCES

Asylum Aid (2002) *Refugee Women's Resource Project, Romani Women from Central and Eastern Europe: a 'fourth world', or experience of multiple discrimination.* London: Asylum Aid.

Banana Link. www.bananalink.org.uk (accessed 25 July 2007).

BBC (2004) *Gypsy Child Brides World Weddings.* Script available at: http://news.bbc.co.uk/1/shared/spl/hi/programmes/this_world/transcripts/world_weddings_2june2004.txt

Coffee Trade Federation. www.coffeetradefederation.org.uk (accessed 25 July 2007).

Commission for Racial Equality (2004) *Gypsies and Travellers: a strategy for the CRE 2004–7.* Available at: www.cre.gov.uk

Department of Health (2003a) *Delivering Race Equality: a framework for action.* Mental Health Services. Consultation Document. London: DoH.

Department of Health (2003b) *Inside Outside. Improving mental health services for black and minority ethnic communities in England.* London: DoH.

Fairtrade Foundation (2002) *Spilling the Beans on the Coffee Trade,* revised edition. London: Fairtrade Foundation.

Fairtrade Foundation (2000) *Unpeeling the Banana.* London: Fairtrade Foundation.

Foreign and Commonwealth Office (2007) *Country Profiles: Somalia.* Available at: www.fco.gov.uk (accessed 26 July 2007).

Friends of the Earth (2001) *Trade Activists Guide. Trade, food and agriculture.* London: Friends of the Earth.

GAP (2004) *Facing Challenges. Finding Opportunities. 2004 Social Responsibility Report.* San Francisco: GAP Inc.

GAP (2005) *Factory Inspection Data.* Available at: www.gapinc.com/public/SocialResponsibility (accessed 25 July 2007).

GAP (2007) *Improving Factory Conditions.* Available at: www.gapinc.com/public/SocialResponsibility

Harris H (2004) *The Somali Community in the UK: what we know and how we know it.* London: Information Centre about Asylum and Refugees in the UK.

House of Commons (2004) *The Somali community in the UK: What we know and how we know it.* Launch of a report by the Information Centre about Asylum and Refugees in the UK (ICAR) available at: www.icar.org.uk (accessed 26 July 2007).

International Coffee Organisation. www.ico.org (accessed 24 July 2007).

Joseph Rowntree Foundation (2007) *Monitoring Poverty and Social Exclusion in Wales 2007.* Report published by the Joseph Rowntree Foundation, available at: www.jrf.org.uk (accessed 26 July 2007).

Keating F and Robertson D (2004) Fear, black people and mental illness: a vicious circle? *Health and Social Care in the Community* 12(5): 439–47.

McGee P and Johnson M (2006) Different, proud and well. *Diversity in Health and Social Care* 3(3): 157–60.

Norfolk, Suffolk and Cambridgeshire Strategic Health Authority (2003) *Independent Inquiry into the Death of David Bennett.* Report of an inquiry set up under HSG (94) 27 Chaired by Sir John Blofeld. Cambridge: HSCSHA.

Oxfam (2007) Our work in Wales. www.oxfam.org.uk (accessed 26 July 2007).

Poverty Site (2007) *Wales.* Available at: www. poverty.org.uk (accessed 26 July 2007).

Sainsbury Centre for Mental Health (2002) *Breaking the Circles of Fear. A review of the relationship between mental health services and African and Caribbean communities.* London: The Sainsbury Centre for Mental Health.

Ryan P, Anczewska M, Laijarvi H, Czabala C and Hill P (2007) Demographic and situational variations in levels of burnout in European mental health services: a comparative study. *Diversity in Health and Social Care* 4(2): 101–12.

War on Want (2006) *Fashion Victims. The true cost of cheap clothes at Primark, Asda and Tesco.* London: War on Want.

Welsh Assembly Government (2005) *A Fair Future for our Children. The strategy of the Welsh Assembly Government for tackling child poverty.* Cardiff: WAG.