

## Editorial

# A decade of diversity: or is diversity decadent?

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This is the International Year of Biodiversity, so it might be seen as a ‘good year’ for human diversity, too, and indeed for the concepts and ideals that underpin this journal. In this context it is instructive to look at what is meant by this word *diversity* and the various concepts that are associated with it. A quick search on the Internet will give you over 13 million hits that include rappers, games, dance troupes and a wide range of definitions drawn from biology (alpha biodiversity is the range of plants within a specific area), politics, law and huge corporations. All of them emphasise heterogeneity, namely that even within a specific group or species there appear to be multiple differences. Thus, in human terms, diversity is associated both with differences in ‘race, ethnicity, gender, sexual orientation, socio-economic status, age, physical abilities, religious beliefs, political beliefs, or other ideologies’ and with the exploration of these differences ‘in a safe, positive, and nurturing environment’ (<http://gladstone.uoregon.edu/~asuomca/diversity/init/definition.html>).

Other definitions go further. Unexpectedly, we located the following definition from Anchorage Municipality Alaska, the home turf of Sarah Palin, often thought to be one of the USA’s more unusual free-market thinkers:

Diversity in this Administration’s book means, in addition to differences based on ethnicity, gender, age, religion, disability, national origin and sexual orientation, an infinite range of individuals’ unique characteristics and experiences, such as communication styles, career, work, life experience, educational backgrounds and other variables. Diversity focuses on tapping the talents of people of different backgrounds, experiences and perspectives as a means of improving the workplace environment and productivity. Diversity awareness works to create an environment that recognizes values and utilizes the unique skills and abilities of everyone. The goal of diversity

awareness is to create an inclusive, respectful and equitable work environment and community.

([www.muni.org/Departments/equal\\_opportunity/diversity/Pages/Definition\\_of\\_diversity.aspx](http://www.muni.org/Departments/equal_opportunity/diversity/Pages/Definition_of_diversity.aspx))

Diversity would therefore appear to be of some value, bringing benefits to others and even to whole communities. To give an example, three years ago the birth of conjoined twin girls in Babanki Tungo, a village in north-west Cameroon, was considered a shocking event. The girls and their parents were shunned and blamed for bringing such evil to the village. Surgery in Saudi Arabia successfully separated the girls, and although more operations are needed, they are thriving. More importantly, their trip to Saudi Arabia attracted funding and now the village has an Islamic centre that includes a mosque, a nursery, a primary school and a health centre (Niba, 2010). The girls and their parents no longer have to endure the social stigma of a conjoined twinship, and their diversity has been reconfigured as a good thing for the whole community. Diversity then can bring advantages and is thus now associated with respect for difference, because the skills and perspectives of people who have different ways of doing and seeing have the potential to improve the lot of others. In other words, diversity is not just about being nice to others, as you can do yourself some good at the same time. It is a win–win scenario.

It therefore comes as something of a surprise to find that diversity does not meet with universal acclaim, and that it is challenged or even set aside in favour of a different concept, *equality*. Lack of equality is clearly a bad thing, unless perhaps you happen to be the beneficiary of that imbalance, and all three of the major UK political parties that are campaigning as we conclude this editorial have included the word ‘fairness’ somewhere in their sloganising. Regrettably, there are also some signs that a simplification of what fairness and

equity mean may be in hand, at the expense of those who believe that achieving equity is compatible with recognition of diversity. John Denham, a UK Government minister, unleashed quite a storm when he appeared to be claiming that there was no longer any need to consider racism or ethnic inequality, and that the primary inequality was an issue of socio-economics and class (Travis, 2010). Those who reacted to this headline, as well as, to be fair, he himself, pointed out that socio-economic status and wealth are affected by many factors, such as gender, race/ethnicity, geography and education, and that these all interact with each other. The UK National Equality Panel reported that:

Wide inequalities erode the bonds of common citizenship and recognition of human dignity across economic divides. ... Most people and all the main political parties in Britain subscribe to the ideal of 'equality of opportunity.' The systematic nature of many of the differentials we present, and the ways in which advantages and disadvantages are reinforced across the life cycle (as we describe in Chapter 11), make it hard, however, to sustain an argument that what we show is the result of personal choices against a background of equality of opportunity, however defined. Inequality in turn then acts as a barrier to social mobility.

(Hills *et al*, 2010, p. 2)

Michael Marmot's review specifically examining inequality in health, which followed hot on the heels of the Hills report, made the point very clearly:

the more favoured people are, socially and economically, the better their health. ... We do have an ideological position: health inequalities that could be avoided by reasonable means are unfair. Putting them right is a matter of social justice. But the evidence matters. Good intentions are not enough.

(Marmot, 2010, Chair's introduction, p. 4)

These are sentiments that we as a journal echo but, and it is a big BUT, we also note that this remains contested territory. Marmot's review tended to focus more on the socio-economic differences, and appeared to ignore the impact of ethnicity and faith/belief, racism and other societal cleavages, the themes to which our journal is dedicated. We would like to remind those (especially our politicians) who seek simple solutions and easy diagnosis that inequality in health harms the UK economy, in Marmot's estimate to a considerable extent:

If everyone in England had the same death rates as the most advantaged, a total of between 1.3 and 2.5 million extra years of life would be enjoyed by those dying prematurely each year as a result of health inequalities. ... The estimated cost of these illnesses accounts, per year, for productivity losses of £31–33 billion and lost taxes and higher welfare payments in the range of £20–32 billion.

The additional NHS healthcare costs in England are well in excess of £5.5 billion.

(Marmot, 2010, p. 38)

It isn't all down to poverty, a fact that Marmot recognised in passing, as he listed the so-called wider determinants of health:

... inequities in power, money and resources. These social and economic inequalities underpin the determinants of health: the range of interacting factors that shape health and well-being. These include: material circumstances, the social environment, psychosocial factors, behaviours, and biological factors. In turn, these factors are influenced by social position, itself shaped by education, occupation, income, gender, ethnicity and race.

(Marmot, 2010, p. 16)

It is just, perhaps, that we might prefer to draw attention to those inequalities of diversity and a few further dimensions not listed in that catalogue, and recognise that inequalities of wealth and health are in fact the avoidable consequences. We might then suggest that it is no use seeking to level the playing fields of economic power until the rest of the barriers and contours have also been taken care of. At least, we hope, this attempt will be strengthened by the passage into law, just in time before Parliament was dissolved, of the Equality Act (Office of Public Sector Information, 2010). This creates a new public duty to address inequity across the disability strands, and at the same time widens their definitions by bringing, for the first time, *caste* discrimination within the purview of the race legislation. Furthermore, at least from the perspective of race and ethnicity, the communities have spoken clearly in time for the General Election debates, through the publication of the Afiya Trust's *Framework for Action* on health and racialised societies (Afiya Trust, 2010) (see our KnowledgeShare section in this issue), and the national Racial Justice Manifesto ([www.raceequalitypolicy.co.uk](http://www.raceequalitypolicy.co.uk)) supported by a plethora of black and minority-led community grassroots bodies, from the 1990 Trust via Operation Black Vote to the Northern Ireland Council of Ethnic Minorities (NICEM) and the Campaign for Better Banking. Put simply, we would rather celebrate *diversity*, as did the Queen when, as she celebrated the 60th anniversary of the Commonwealth, she drew attention to the diversity afforded by the network (Queen's Speech, 2009). The young people who were interviewed for the accompanying video also spoke about the attraction for them of the diversity of experiences provided through involvement in Commonwealth activity.

We would also like to hope that we are not premature in celebrating, along with many others, the passage into law of what is now being termed 'ObamaCare', at almost literally the 98th percentile, since it was passed by such a narrow margin, and since it is 98 years since

Theodore Roosevelt first tried to introduce universal health cover to America (Yamey, 2010). There seems, at last, to be some hope that President Obama's triumph will slightly level the playing field for minorities and the socially excluded, making a step towards reducing the estimated 45 000 deaths attributed to a lack of insurance in the USA alone. It is important to note that the National Institutes for Health and the Office of Minority Health in the US Department of Health and Human Services are playing their part through a National Plan for Action, which also brings up to date the situation in the USA in the same way that the UK reports have done, looking at the lack of progress since the Hechler Report of 1985 (Office of Minority Health, 2010).

Meanwhile, in this issue we have a variety of diversity strands to consider. Our themed guest editorials in this issue concern aspects of sexuality. Domenico Di Ceglie's guest editorial presents a discussion on gender dysphoria, dramatically illustrated by reference to Shakespeare and to an emergent Copernican revolution in attitudes to identity, gender and sexuality. This is complemented by Julie Fish's editorial argument in which she considers, with reference to the musical group 'The Kinks' (and some films), the particular case of the emergent category of trans people, namely those who live cross-gender, forming a new dimension of non-conformity that is now recognised in UK legislation. We note that we have now run several papers and editorials on the issue of gender transgression, and we hope that our readers have found this challenging of the limits of diversity helpful.

Among our regular features is the second in our new series, the Practitioner's Blog, from Mary Dawood, this time supported by Lizzie Lewis and addressing the issue of communication. This is a theme that we have often highlighted, but although there is indeed much good practice in relation to communicating with people who have learning disabilities (LDs) (or learning difficulties, as the social work world more often puts it), we do not seem to have seen much published on their needs or what we could learn from that good practice in relation to other diverse minorities. In this case, a salutary lesson was brought home to the practitioners through their experience in the A&E (ER) department, demonstrating that dual diagnosis is not just about substance misuse and mental health, but can also send false signals and confuse care providers when two unrelated conditions, epilepsy and LD, coincide, leading to problems of communication on both sides. Let the care provider beware.

Among our research papers is a strong representation from the other side of the Atlantic, and attention to less frequently considered minorities, along with our growing collection of papers on the Irish, and some guidance for managers on how best to

implement changes and address inequalities. Thus Miriam Stewart and an interdisciplinary team from Canada, a state that still sees benefits in accepting migrant settlers, examine the differences and similarities between two different kinds of newcomer, and the way in which the refugee experience affects perceptions of support and welfare services. It is clear that expectations matter and condition outcomes, and that the inverse care law propounded by Julian Tudor-Hart still obtains, so that 'poor health can diminish available support.' Conversely, they observe, good health leads to better relationships and facilitates integration. This looks like a win-win formula and an argument for providing better rather than worse support for migrants and refugees. Future research will benefit from the careful approaches and thoughtful insights that are embodied in this large study of two quite distinctive communities, which has extracted themes of broad applicability.

Increasingly, health and social care professionals are expected not only to follow evidence-based practice, and guidelines such as those promulgated in the UK by the National Institute for Health and Clinical Excellence (NICE), but also to follow best practice in community engagement to involve user perspectives and values (Woodbridge and Fulford, 2004). A paper by Pauline Lane and Rachel Tribe explores the application of NICE guidelines on community engagement among black and minority ethnic (BME) groups, who are often omitted or excluded from the process. These authors provide practical, practice-based advice while demonstrating the benefits of an inclusive approach to user consultation. This four-step model outlines some of the pitfalls and problems in working with marginalised groups, including the risk of accepting an articulate spokesperson as a proxy for a whole community. To get round this may require the use of some innovative and creative techniques, of which the authors have extensive experience. It is also important to reflect on one's own values, and to consider the use of language and the value of hospitality (which can also make the process more enjoyable for the consultant!). Critically, for all our sakes, it is also important that action is seen to flow from such consultation.

In a contrasting paper from Latin America, Antonio Giuffrida presents a review of some highly quantitative analyses, and some robust statistical data, in an exploration of ethnicity and racialised health differentials in this large and increasingly emergent region. He draws out succinctly the links and differences between socio-economic status and cultural variation, and he highlights the potential role for education in affecting health. Unlike some other recent studies on health inequalities, this paper does not allow the one dimension to be reduced to or seen as a proxy for the other. Giuffrida also draws attention to the issue of *indigeneity*, a factor that is often neglected by Western

European researchers. We are delighted to welcome this contribution to our pages, and hope that it will mark the take-off point for a series of studies on this somewhat neglected region and its 540 million highly diverse residents. Furthermore, for those who are less familiar with the area, Giuffrida's bibliography provides a valuable starting point.

Rionach Casey revisits the continuing and distressing story of sub-optimal health among people of Irish descent in the UK, and identifies positive elements of resilience and self-management among the Irish in Yorkshire, a county renowned for self-reliance. Like other minority ethnic groups, community intermediaries (a term less prone to abuse than *leaders*, as suggested by Lane and Tribe) have a key role to play in improving community health. In this paper, too, we may detect echoes of our opening paper from Canada, demonstrating the significance of networks to health. These can provide both practical and moral forms of support, and may also be misunderstood by outsiders, especially in relation to faith. The paper also highlights the fact that private, paid-for medicine and dentistry is not solely the prerogative of the rich. This micro-study of a small and ageing community in a relatively minor town provides much insight, and nicely complements our earlier coverage of the Irish as a community.

Finally, we include a practice paper which develops a theme raised in a recent issue (Abrahamsson *et al*, 2009), and continues this concern with networks, further complementing the first two papers in this issue in showing how to open up dialogue and address the isolation of refugee communities. It is particularly pleasing to be able to publish an evaluation study from such a project, since all too often similar interventions are attempted and, whether they are successful or not, are then abandoned without trace, never to be added to the evidence base from which NICE derives its guidelines. We hope that *Diversity in Health and Care* can continue to provide a place for such papers, many of which struggle to find acceptance in more conventional journals, while demonstrating that community-engagement research is as rigorous and valuable as the more conventional meta-analyses of quantitative datasets. Andrea Newman's paper also addresses changes in social policy, and shows how an intensive programme of networking created opportunities and benefits for all of the participants, along with health improvements, while also demonstrating the problems of short-term approaches, to which we have alluded.

Last but not least, we present our two regular features, the 'Did You See?' and 'Knowledgeshare' sections. Paula McGee continues (fittingly, in the year of biodiversity) to focus our attention on matters environmental, as was so well begun by Lam *et al* (2010) on air pollution, by alerting us to what is going on in the hydro-cycle. Water matters to us all. In the

'Knowledgeshare' section, Lorraine Culley's selection brings to our attention the macro-issue of global health equity, highlights the BME health manifesto from the Afiya Trust in time for the UK General Election campaign (which has been running alongside our preparation of these texts for the printers), and contains a detailed report on two studies, one of ageing among ethnic minority elders, and the other focusing on issues associated with learning disabilities. Finally, we close with a new addition to the 'Knowledgeshare' section, namely a bi-annual round-up of additions to the NICE-sponsored NHS Evidence database on ethnicity and health, the Specialist Collection for Ethnicity and Health (SCEH), where many of our featured resources are indexed. And, as ever, we invite our readers to share their contributions or to join us in debate. Details of the journal's submission criteria can be found on our website ([www.radcliffe-oxford.com/journals/J26\\_Diversity\\_in\\_Health\\_and\\_Care/M10\\_Contributing.htm](http://www.radcliffe-oxford.com/journals/J26_Diversity_in_Health_and_Care/M10_Contributing.htm)).

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