LIFE AND DEATH Iona Heath

Exploitation and apology

It is hypocritical to say sorry for slavery while continuing to take from poor countries in other ways

Over four centuries slavery coerced, distorted, and destroyed the lives and relationships of countless men, women, and children—and its reverberations continue to damage lives today. It is impossible to know exactly how many people were subjected to slavery, but it is estimated that at least 12 million Africans were loaded on to transatlantic slave ships and that about three million died on the journey.

This year, in the United Kingdom, the bicentenary of the 1807 Abolition of Slavery Act has been marked by a number of formal apologies. These have been more or less fulsome but must, at best, be considered hypocritical in the context of the world's richest countries' continuing and systematic exploitation of the poorest, particularly in Africa.

Rich countries, the UK prominent among them, are systematically recruiting trained healthcare professionals from among the poorest countries in the world. The extent of the problem was made very clear by *Working Together for Health*, the World Health Organization's world health report for 2006.

In 2005, of a total of 17 903 doctors admitted to the General Medical Council's medical register, only 5163 were trained in the UK. The others came from across the world, including 2922 from India, 288 from Nigeria, and five from Sierra Leone. With less than a third of new registrants having been trained in the UK, it seems clear that standards of medical care in the UK totally depend on those doctors who have trained in other countries. The UK has about 2.3 doctors per 1000 people in the population; India has 0.6, Nigeria 0.28, and Sierra Leone a shocking 0.03. When Sierra Leone loses five doctors, it loses 8% of its medical workforce—equivalent to the UK losing more than 11 000 doctors.

These statistics are important because there is a linear relation between health outcomes and the density of healthcare workers. Life expectancy at birth is 78.7 years in the UK, 62.2 in India, 45.5 in Nigeria, and a tragic 38.7 in Sierra Leone. Infant mortality is five per 1000 live births in the UK, 62 in India, 103 in Nigeria, and 165 in Sierra Leone. These public numbers conceal a horrifying and immeasurable amount of private grief and suffering. Current policies of recruiting doctors from poor countries are a real cause of premature death and untreated disease in those countries and actively contribute to the sum of human misery.

The situation with nurses and midwives is, if anything, worse, particularly because essential public health interventions such as immunisation depend more on provision of nurses than of doctors. Background papers to the 2006 world health report show that in 1994 almost 90% of people admitted to the UK's nursing and midwifery register had been trained in the UK. By 2002 this percentage was down to less than 50%. The UK recruits substantially more nurses from low income countries than do equivalent countries such as Ireland, Norway, and Australia. The largest supplier of nurses to the UK is the Philippines—but recruitment from sub-Saharan Africa has also increased substantially over this period.

Clearly, healthcare professionals who have trained in low income countries have just as much right as those from high income countries to migrate and seek work and opportunity in other places. Like all other migrants, their reasons will be personal, political, economic or professional—either singly or, more usually, in combination. Such migration provides obvious benefits to destination countries, as we see every day in the UK health service, and

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also has the potential to provide some benefits to the countries of origin in terms of the proportion of income returned to families and communities at home. Some governments of low income countries, most notably the Philippines, seem to have deliberately promoted the migration of healthcare professionals for just this reason. Despite this, the net benefit moves undeniably from country of origin to that of destination and from the poor to the rich. Unless systems can be found to provide compensation for the losses sustained by low income countries of origin, the situation will remain profoundly exploitative and a direct continuation of the attitudes that led to slavery.

Is there a practical and moral way forward in a situation where redress is hard to define and even more difficult to deliver? Surely, at a minimum, each vacant post in the UK that is filled by a healthcare professional who has been trained in a low income country where (almost inevitably) there is a workforce shortage should be formally redressed. This redress could be in the form of some kind of transfer fee paid to the health service of the country of origin or through a reciprocal exchange of professionals whose training and experience is equivalent. This would clearly demand additional training for professionals moving from high income to low income countries if they are to match the effectiveness of those they seek to replace.

Only if current exploitation is redressed by such a system of reparation can any apology for past abuse become in any sense authentic. Regrettably, in its cautious response to the bicentenary of the abolition of slavery, the current UK government has made no such link.

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I thank Dela Doe, senior forensic mental health nurse at HM Prison Wandsworth, for helping me to understand the extent of current exploitation and its direct relation to slavery.