Great expectations

Michael Marmot sees his appointment as the next president of the BMA as another way of promoting action on the social determinants of health, finds **Zosia Kmietowicz**

There is something of Charles Dickens about Michael Marmot. The author and the professor of epidemiology and public health at University College London share a preoccupation with the nuances of society, both dedicating their lives to describing in detail the traits that determine a person's life, and ultimately their death, and serving them up for public consumption.

Marmot, who takes up the post of BMA president at the end of June, says he feels a resonance with the author. He read two of Dickens' novels last year, and the opening of *Great Expectations*, where Pip stands in a cemetery surveying the gravestones of both his parents and the "five little stone lozenges" that belonged to his brothers brought home to him his life's work—the social causes of premature death.

Early calling

Literature has been a lifelong passion for Marmot. In his first year as a house officer in Sydney, where he gained his medical degree, he did one year of an English literature degree in his spare time, turning up to lectures in blood stained shoes with his bleeper in his pocket. It was a break from clinical medicine, he says, and a diversion that reflects the path his career took.

Born in north London, Marmot grew up in Sydney "because it wasn't China." His father, who had been in Shanghai during the 1920s, returned there in 1948 after the war intending to set up in business. On arriving there, however, he decided that China held too few prospects and moved on to Sydney, where his family joined him.

Marmot was attracted to medicine because it offered further study of the science he enjoyed at school with the added dimension of having the potential to do some good. Although he loved contact with patients, during his second year in a house job he started to question the "social side of things," and this led him out of the clinic and into academia.

"I used to walk around the hospital wards and I'd say, 'We saw this chap three months ago, and he came in in acute cardiac failure, we treated him' or 'chronic respiratory failure; we treated him, sent him home. Here he is back again.' And I used to think that medicine, and particularly surgery, is just failed prevention—that if we could treat these people properly, and, particularly, if we could do something about prevention, we could empty the hospital wards," he said in an interview at Berkeley University in 2002.

While Marmot was doing his house job, his consultant returned from a meeting with the word

Video on bmj.com
Michael Marmot explains how credit contraction offers an opportunity to close gaps in health inequities (bmj.com/video/credit.dtl)

epidemiology on his lips and the contact details of two professors in the United States. Once he had worked out what epidemiology meant, Marmot wasted no time in writing to them with his view that health was a manifestation of the way society is organised and to get to the bottom of health you have to examine society—a path he has been pursuing ever since.

In 1976 Marmot sealed his name in epidemiology when he took over as lead in the Whitehall studies, the groundbreaking research that first linked social status with health outcomes when it was found that people at the bottom of the civil service hierarchy had higher rates of heart attacks and other major causes of death than those at the top.

Despite his achievements, there is a genuine humility about Marmot and also an enchanting excitable innocence. He looks behind his chair when I ask what his initial reaction was to the BMA's request for him to become its next president, as though searching for someone more worthy of the post. His response was, "My name is Michael Marmot. Have you got the right number?"

International action

He was appointed chair of the World Health Organization's commission on the social determinants of health in March 2005. A theme of the commission's report, "Why treat people . . . without changing what makes them sick?" asks the question which had perplexed him on the wards of Sydney's Royal Alfred Hospital a generation earlier.

He describes the experience of chairing the WHO commission as "life changing at every level." And the response to the report, published in August 2008, has left him "over the moon."

"I am used to the cut and thrust of academic life and thrive on it. It is exciting and wonderful and a privilege to have an academic career. When I started as chair of the commission I thought that other members too would be from an academic background. There were a few, including one Nobel laureate. But the others weren't. It was a bit shocking for me to find out that the way I knew things as an academic was perhaps a bit limited and that there were other ways of knowing things—for example, by being out in the world doing things. Working with them was amazing and I learnt so much," he says.

His biggest fear was that the report would have a similar fate to many other such publications and wind up being moved "from the desk, to the floor, to the bookshelf and that is the end of that. But that hasn't happened," he said.

On the contrary, the report has spurred action in several countries. It has inspired governments in Argentina, Brazil, Chile, Costa Rica, and Sri Lanka to examine the factors that drive health inequalities among their citizens. Spain, which took over the European Union presidency in January, has also vowed to make health inequalities a priority of its tenure. Eleven countries from central and eastern Europe have also spent a week discussing how they can take forward the findings of the report.

"There have also been calls from several countries which led to a resolution at the World Health Assembly in 2009 to call on the WHO to take action and report back on what has happened around the world to address health inequalities," he says.

"If you ask me if the health of one single person has improved as a result of the commission then honestly I don't know and perhaps it is too early to tell. But there certainly has been a lot of action and the report has not died."

In the UK the Marmot effect has taken a firm hold. In February Marmot will publish his post-2010 strategic review for tackling health inequalities in England, commissioned in November 2008 in the light of the WHO work by the then secretary of state for health, Alan Johnson.

Although it has been a long time ambition of the Labour government to narrow the health gap between the most disadvantaged and the most well off, the truth is that this has not improved since the late 1990s. On some measures—such as infant mortality—it has even widened from 13% in 1997-9 to 17% in 2004-6.

"If you take life expectancy as a measure then you see that over the last 8-10 years, when the government had a programme for action on health inequalities, life expectancy for the worst off has improved. In fact, it has improved so much that it is now better than the average life expectancy was eight years ago. But what also happened was that the average life expectancy also went up so that the gap between the worst off and the best off has not narrowed," he says. "Things have got better, but what I would like to see is things getting better for everybody and the gap to narrow."

The key drivers of health and health inequalities lie outside the healthcare system. What is important are those variables beloved by Dickens—where people are born, where they grow up, their work, and how they live and age.

For those in the health sector reducing health inequalities takes work on three fronts—making universal access to good quality health care a reality, collaboration with other sectors, such as transport and social services, and understanding and measuring outcomes.

Addressing health inequalities is apolitical, says Marmot. He is a passionate advocate of the NHS and expects whatever party is in power after the general election to take forward his review with purpose and commitment.

"It is the business of doctors not only to wait until people get sick but also to be advocates for what they can do to prevent them getting ill"

"The NHS is a very powerful expression of a social commitment. When Nye Bevan launched the NHS he said he had done the most civilised thing he could—to put the health of people before other concerns. Let's keep doing that," said Marmot. "Let's keep the health of people uppermost and let's keep the wonderful principle on which the NHS is based intact."

His words echo those of the BMA's *Look After Our NHS* campaign and may be part of the reason for the association choosing Marmot as its next president. Whatever the BMA's motivation, Marmot is not interested in being just a figurehead and has no doubt that his acceptance of the role will help carry forward his own agenda.

"If choosing me and my being there allows me and the BMA to make the health equality issue more visible then that is more than a figurehead—it is galvanising some activities around the agenda and it is saying that the BMA is positioning itself and wants to take more of a public stand on health inequalities; so I am delighted."

He says that medical associations in Sri Lanka and Canada have already reacted positively to his appointment and are discussing how they can get their own medical associations to adopt the health inequalities agenda. "After all, it is the business of doctors not only to wait until people get sick but also to be advocates for what they can do to prevent them getting ill."

It is no surprise that Marmot has been thinking about what he will say in his speech when he is inaugurated as president at the BMA's annual representatives' meeting at the end of June. It is this speech that often sets the tone of the forthcoming tenure. No prizes for what the contents are likely to be.

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The unions are back in town

Are the health service unions regaining influence now that Labour is feeling the financial squeeze, asks **Nick Timmins**

Health secretary Andy Burnham has been publicly uttering a phrase that we never heard from any of his five predecessors since Labour took office in 1997: "Our trade union colleagues." And this is more than just rhetoric. NHS employers, the private and the voluntary sectors, and the health service trade unions all say the unions currently receive a hearing in Richmond House, the health department's Whitehall headquarters, that they have not enjoyed for many years.

Social Partnership Forum

Not many people in the NHS may have heard of the Social Partnership Forum. It brings together the unions, NHS employers, and the department of health. Its nominal role is to discuss the workforce implications of policy. Since Mr Burnham took office, however, it has become a place where NHS policy is not merely debated but negotiated.

It wasn't always thus. First set up in 1998 to encourage "partnership working" with NHS staff, it had by the mid-2000s, fallen into desuetude.

End of the forum

"It wasn't very strong to start with," Michael Jackson, national officer for health with Unison remarks. In the early days, he says, "it existed. But it wasn't taken very seriously."

After the 2005 election, however, it fell apart—in large measure because, more or less out of the blue, Nigel Crisp, the then NHS chief executive, issued a notorious circular telling primary care trusts they had to get rid of their provider arms, outsourcing them to the private and voluntary sectors if need be.

"That severely damaged trust," Mr Jackson says. The move caused such outcry among the quarter million staff employed by primary care trusts, among the unions, and among Labour MPs who had no idea that this was about to happen, that Patricia Hewitt, the then health secretary, had a torrid Labour party conference that autumn. She had to row back—rapidly and humiliatingly—even if the policy has subsequently re-emerged in modified form.

On top of that, the NHS, despite record spending increases, was plunging into deficit. The unions were fearful of compulsory redundancies as the service moved to balance its books in 2006 and 2007. Amid acrimony, meetings of the forum more or less ceased.

In the midst of all this, the callow 36 year old Mr Burnham was appointed minister of state for health. Seen as a rising Blairite star, he was thought to be a firm advocate of the prime minister's agenda of clearly separating the purchasing of health care from provision, and introducing an element of choice and competition into the NHS. He certainly made speeches advocating that.

But he found the experience a bruising one. In April 2007 he was visibly distressed when he found himself heckled by those he thought of as his own when he spoke at Unison's health conference in Brighton—jeered not just over the need to achieve financial balance, which he defended, but over charges that he was "privatising" the NHS.

The experience left a mark that lasts to this day. As he told the NHS Confederation last summer in his first speech as health secretary, he came to worry "that the top down reform process was beginning to lose hearts and minds, that the system was being pushed too hard, and that the sense of collective endeavour was fracturing. Without that," he added, "the NHS is nothing."

Resurrection

Back in 2007, he was instrumental in rejuvenating the Social Partnership Forum. "Burnham was a key player in ensuring that happened," Mr Jackson says. Since then, he says, "it has been going from strength to strength." It does a wide variety of jobs—not least recently helping persuade NHS staff that they should be vaccinated against swine flu.

But such now is the forum's influence that when Mr Burnham announced his controversial policy shift last summer, declaring that the NHS is now the "preferred provider" of NHS care—with NHS organisations to be given a first and second chance to improve, with existing services put out to tender only if they are still "significantly" underperforming—the details were spelt out not in a departmental circular or a ministerial speech but in a letter from Mr Burnham to Brendan Barber, the Trade Union Council (TUC) general secretary, who, through the forum, had helped broker the deal.

Too close for comfort?

That closeness to the unions left some providers of NHS services, and indeed some of Mr Burnham's Labour party colleagues, not to mention some senior health department officials, stunned.

David Worskett, director of the NHS Partners Network which represents private providers of NHS care, said: "We were completely taken aback. Of course the unions have a legitimate view about government policy. They have the right to be consulted like everybody else. But the idea that they have a unique position in helping decide a government policy that affects many more people than just their members—other staff, patients, the taxpayer and other providers, including the private and voluntary sectors—is wrong. It feels like something from another era."

"Preferred providers"

Even so, when the "preferred provider" details became known in September, the unions, which include the BMA, were still sceptical as to whether this was really a change of policy, rather than a piece of placatory rhetoric.

They are a lot clearer now. How vigorously primary care trusts were seeking to tender existing NHS services varied widely, Mr Jackson says. But for those really pushing the issue, "the brakes have been put on. Certainly primary care trusts are now giving NHS providers the opportunity to improve before any move to tendering services. It is having an effect. We are beginning to see a change in attitudes and behaviour. Great Yarmouth and Waveney is an example of that."

Indeed the Great Yarmouth primary care trust in Norfolk has become a cause célèbre. It originally put its provider arm out to tender, inviting bids not only from NHS organisations but the private and voluntary sectors. After Mr Burnham's speech, however, it withdrew the invitation to both parts of the independent sector, stating that it was now "only able to accept bids from NHS organisations."

The result has been an appeal to the Cooperation and Competition Panel. It is the body that advises Mr Burnham on the application of the NHS's existing competition rules—not yet the new ones he intends to draw up as a result of the preferred provider policy—while setting them against the background of EU competition law. Tellingly, the appeal has come not just from the private sector—the partners' network. It has been a joint appeal with the voluntary sector, lodged also by Acevo, the Association of Chief Executives of Voluntary Organisations.

Peter Kyle, its deputy director, says Great Yarmouth's decision and indeed Mr Burnham's new policy, has "system-wide" implications that could affect hundreds of voluntary organisations that already provide NHS care. "Preferred provider," he says is "having a dramatic effect on some commissioners of NHS services. They are feeling pushed to limit buying services from providers based on what sector they happen to come from—and not on the quality of care or services."

"We are left with the very real danger of global multinationals honing into our health service to extract maximum profits"

Voluntary organisations

Acevo is equally alarmed at what it sees as a broader union attack on voluntary organisations. Unite has been running a loud campaign against third sector organisations providing public services, and indeed against the idea that staff should have a "right to request" to formally leave the NHS and form a not for profit social enterprise that would then sell their services back—as nurses and therapists have done in central Surrey.

Despite having tens of thousands of members in the voluntary sector in addition to their bigger battalions of NHS staff, Tony Woodley, Unite's general secretary, argues that the not for profit sector indulges in a "race to the bottom on staff pay and terms and conditions."

In what Mr Kyle argues is "a remarkable lack of faith in his own members [in both the NHS and the voluntary sectors]" to win contracts, Mr Woodley says that when not for profit organisations win NHS tenders "there is no guarantee ... that they will hang on to those contracts next time round. We are then left with the very real danger of global multinationals honing into our health service to extract maximum profits." Unite, Mr Woodley says, is delighted that Mr Burnham "has listened to our arguments" that NHS organisations should be the NHS's own preferred provider.

Financial backers of the Labour party

Unite and Unison remain key financial backers of the Labour party at a time when a general election is on the way, and some of Mr Burnham's friends have been promoting him as potential deputy leader of the party after an election—a contest in which the union votes count. Mr Burnham is a member of both unions, and in the past his constituency has been supported by Unison. But it would be churlish to paint a direct link between those connections and policy, and it is not only unions affiliated with the TUC that have been delighted at the switch to a "preferred provider" approach.

BMA's view

It has been warmly welcomed too, for example, by the BMA, which is also a member of the Social Partnership Forum. The BMA has made repeated calls for an end to the "commercialisation" of the NHS.

Dr Hamish Meldrum, chairman of council of the BMA, says that "by background and instinct," Mr Burnham does seem "more a union type person" than his predecessors as health secretary.

As health minister, Dr Meldrum says, Mr Burnham did appear a wholehearted advocate of the Blairite reforms. "But I think, like us, he has come to realise it is not working. That to some extent it has alienated some of the staff within the NHS. And he feels that has been detrimental." There are, Dr Meldrum says, both "political and pragmatic reasons, not just ideological ones" for Mr Burnham's apparently changed stance.

Either way, as Thin Lizzy put it, "the boys are back in town."

The test—squeeze on spending

One test for patients and taxpayers of whether Mr Burnham's respect for his trade union colleagues is reciprocated will be over pay. In return for restraint, he is talking of some sort of "job guarantee" for staff—possibly area-wide, possibly region-wide—as the big squeeze comes on NHS spending over the next few years.

Sir David Nicholson, the NHS chief executive, says pay restraint will be "critical" to how the NHS copes as real terms growth ceases. The chancellor has announced a 1% cap for the two years after 2011. Sir David has emphasised that the 1% is "a cap, not an entitlement"—repeatedly implying he would like to see rises below that, given that "every 1% on pay is 10 000 jobs".

The electorate, of course, may not give Mr Burnham the chance to show that a closer relationship with the unions will produce a pay back. But if Labour does win the election, it will be interesting to see if the unions respond.

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