The 'axe man' departs, offering hard-won lessons

He may be remembered as 'the axe man' for his radical fiscal discipline, which included cutting beds in top tertiary hospitals, regulating private work and slashing commuted overtime, but Prof. Craig Household, who retired as Western Cape health chief in March, was above all a strategist.

Prof. Craig Household.

He willingly braved collegial umbrage when he believed a greater public good was at stake, and craftily confronted his political masters by deliberately provoking a near-uprising of doctors that made Pretoria so uncomfortable that seemingly threatened specialised Western Cape services were eventually retained.

Household, 65, earned his 'hard-core' reputation while serving as the first health chief of the Free State immediately after the country's first democratic elections, appointing and mentoring a raw but first-ever representative management team and integrating the former homelands of QwaQwa and Bophuthatswana. It was here that he stiffened regulation of the Remuneration for Work Outside the Public Service (RWOPS) and cut commuted overtime, earning the epithet of 'the butcher' as he grasped the nettle of limited resource allocation to deliver more care to more people, often at the expense and outrage of high-end specialists.

Household joined the ANC in the early 1990s after cutting his medicopolitical teeth in bringing together the skills, academic knowledge and resources of the University of the Free State to better serve Bloemfontein's majority black population (via a community project in Mangaung still significantly funded by the Kellogg Foundation). Once South Africa (SA)'s first democratic elections were over, the party wasted no time in seconding the Princeton, New Jersey-born and University of Cape Town (UCT)-trained paediatrician to co-ordinate the Free State's strategic health and welfare management team – and to help advise on the same issues at national level. Household was subsequently appointed chief specialist/head of the Free State University's Department of Paediatrics and Child Health (late 1988 to early 1995), where he had been lecturing for several years. Recalling his early days managing and transforming the Free State health department, Household said workdays were often 20 hours long

and 'weekends became workdays' – but he quickly learnt the 'trick of reducing seemingly complex healthcare issues to simplicity by getting the basics right'.

'Look for the simple in the complex'

Household described healthcare complexities as potentially paralysing, particularly for inexperienced managers, and advised: 'Look for the simple in the complex, because it is there if you look for it and once you have identified the key issues, deal with them.' Bemoaning the ongoing and now-accelerating healthcare delivery implosion in the Free State, he said that within 3 years of his leaving there in February 2001, everything he'd achieved had been dismantled (his provincial health department had consistently remained within budget and had built up a 'competent management team'). An analysis of why Free State delivery/management has failed so dramatically and what could have prevented similar situations elsewhere was essential 'for an effective government in SA, but also for the very future of democracy', he warned. When he retired from active public service last month, Household was the longest-serving head of health in the country, the last remaining incumbent from 1995. He openly admits that he owes his initial public service career to the ANC, but stresses that once he became a public servant he deliberately avoided membership of any political party. Of his unpopular move to the Western Cape, Household recalls doctors gathered in protest in Groote Schuur Hospital's Palm Court after his cutting of beds there, and at Tygerberg Hospital, repeated accusations of 'putting cash before care' and of 'destroying a national asset'. He claims the bed reductions were 'part of a predetermined strategy' to force the National Department of Health and the National Treasury to review funding to the Western Cape for highly specialised care. 'The furore created such discomfort nationally that the end result was an increased allocation to the Western Cape and the ability to retain specialised services at these hospitals – in effect, the bed reductions were reversed and funding secured,' he asserts. Household thanked his erstwhile opponents, who included top UCT surgeon Prof. Del Kahn and cardiologist and current UCT medicine chief Prof. Bongani Mayosi, for their help in 'stabilising health funding in the Western Cape', boasting that he fulfilled his remit, achieving financial stability in the province within 2 years of his appointment, with unqualified audits over the next decade.

Taking on the national health minister

More recently, in 2013, Household took the unprecedented step (for him) of publicly disagreeing with national health minister Dr Aaron Motsoaledi over the proposed R173 million cut to the Western Cape's conditional grants for funding highly specialised services and the intended centralisation of management of Groote Schuur and Tygerberg hospitals to Pretoria. Motsoaledi declared that the Western Cape was 'going to war' with his department, but reversed the proposed funding cut within a day, perhaps a telling mark of respect for Household's track record.

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Philosophising during a valedictory lecture at UCT, Household said that defining the correct fiscal priorities was essential: 'If one cannot purchase what one cannot afford, it is also important that *what* one can afford must be what is essential.' This no-frills approach to the allocation of resources in the health sector conflicted with the unique doctor-patient relationship in which the doctor would strive at all times to do the best for his or her patient. Having been in clinical practice for 20 years, he was acutely aware of this responsibility, but as a health manager who was also a doctor he had been forced to 'elevate my view to deal with the greater common good. This … placed me in direct conflict with clinical colleagues,' he admitted.

Delegating responsibility to the coalface

One tool Household fashioned to manage this inherent conflict creatively was the hospital 'functional business unit', headed by a clinician who was allocated a budget with staff to deliver an agreed amount of service with a suite of data allowing the clinician to measure, monitor and manage the service – for which they then took full responsibility. While the job was often viewed as a 'poisoned chalice', Household said it allowed doctors to be more involved in decisions that affected their practice, given that hospital doctors created expenditure by (for example) ordering X-ray probes and blood tests, prescribing medication and deciding on surgery. 'I was encouraged by instances where clinicians enthusiastically accepted this responsibility instead of being frustrated by the "pen pushers" in Dorp Street [the Western Cape health department's headquarters]', he said.

Turning to the much politically abused truism that the Western Cape is a privileged, well-resourced province that suffers less from the legacies of apartheid than other provinces, Household said that anyone using this argument to justify the challenges faced in the health sectors in other provinces 20 years into the country's democratic transition was less than convincing. Many health departments wasted much time sitting in meetings, strategising, writing documents and talking about problems when it was 'the individual' who took decisions. 'My recipe for effective service delivery is empowering people in management to make decisions and then take responsibility for them. Support people if they make a genuine mistake … we all do. I have an intolerance of incompetence – but a greater intolerance of people who just don't care.' Reminiscing on the AIDS denialism days of Mbeki and Tshabalala-Msimang, he said that he sat through numerous presentations of 'quack' cures by now-infamous denialists such as Dr David Rasnick, Dr Peter Duesberg and Dr Matthias Rath and his Foundation, not to mention the Presidential Advisory Panel that submitted a highly contentious report to President Mbeki in March 2001. 'It was surreal to be present at some of these interactions, and some of my academic colleagues sought me out to try and understand what was going on.' He recalled being confronted by 'incredulous' fellow paediatrician Professor Jerry Coovadia, asking for advice on how to approach Tshabalala-Msimang. 'Needless to say I was not of much assistance – for me the ultimate humiliation as a South African was witnessing the fracas around the SA exhibition at the 2006 World AIDS conference in Toronto when the national health minister taunted the international media with cloves of garlic.'

Working for change 'from within'

Asked whether he should have resigned, he said he was 'still troubled' by having participated, albeit indirectly, in a system that 'allowed people to die and babies to be unnecessarily infected as a result of the unavailability of antiretroviral therapy'. 'My justification for deciding to stay was that I could do more working within the system then I would have

been able to achieve outside of it – I leave it to others to pass judgement on the validity of my decision,' he added, pointing to the Western Cape's pioneering of antiretrovirals via various trials and non-profit organisations, plus his department's ground-breaking treatment for prevention of mother-to-child transmission of HIV, despite the political antipathy prevailing at the time. In a fascinating allusion to the oft-cited cause of nationwide dysfunctional healthcare delivery (the federal government system that gives almost complete autonomy to provinces), Household revealed that this was the very reason he turned down the job of national health Director-General in 2009.

Despite believing he could do the job, he thought he was the wrong person to 'manage the political interface' and that he would have been unable to directly influence healthcare delivery in the provinces. Despite many people accusing him of having let 'them and the country down', he still believed it was the correct decision, because he was able to contribute more by remaining the Western Cape health chief.

Household will be succeeded by Dr Beth Engelbrecht, a previous Director of District Health Services for the Free State who joined the Western Cape DoH in 2001 as Deputy Director-General. She was effectively Chief of Operations with responsibilities that included specialist health services, emergency services, and district and primary health services.

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S Afr Med J 2015;105(3):245-247.
DOI:10.7196/SAMJ.9589

In his second undergraduate year, Max Klein developed meningococcal meningitis. Within a few hours he was moribund and pulseless. As the senior house officer on duty, I was obliged to attend to him until expert help could be summoned. After the event, he claimed that his brain had never been clearer! This did not restrain him from admonishing us for perceived lapses in patient care, and throughout his professional life he viewed diagnosis and treatment from a patient perspective and expected his staff to do likewise.

We met again as neonatal research colleagues at Groote Schuur Hospital. Here I got to know the post-meningococcal brain intimately. Its originality of thought was astounding, and I shall be ever grateful for being advised to read *The Art of Scientific Investigation* by W Beveridge. Research time became playtime, and we pursued numerous exciting ideas in the hope of making discoveries. Now for the sad part. A discovery does not exist until it is in print, and Max had a writing block. His numerous unpublished findings languished for decades – surprising, for later in his career he became a prolific author. Nevertheless he imparted his treasures to those around him, and his clinical acumen was unsurpassable. He developed special surgical skills, probably as a result of a stint in Chris Barnard's animal unit in his student years. His simple yet unique methods of tracheostomy and chest drain insertion were adopted by all.

Inevitably our ways parted, as each pursued a subspecialty. After a stint at the Californian Cardiovascular and Pulmonary Institute, Max returned to Red Cross Children's Hospital where he established a department for lung ailments and an intensive care unit. The latter took its toll, for when he retired, he stated: 'I have experienced the deaths of 2 200 children, and that's enough.' He never tolerated fools or injustices, but in later years he could be infuriatingly unco-operative. This, I believe, was the result of unrelenting exposure to sick and dying children.

In retirement we were reunited, and each week for ten years we walked the length and breadth of Cape Town and Sydney discussing ideas, books and characters. Several months before Max's untimely death he gave up walking because of a knee ailment and concentrated on cycling. This he enjoyed immensely, and it was during a ride that he quietly and suddenly departed from this world. He was unique, and with his inexplicable creative powers, a genius – the like of which will not be seen again.

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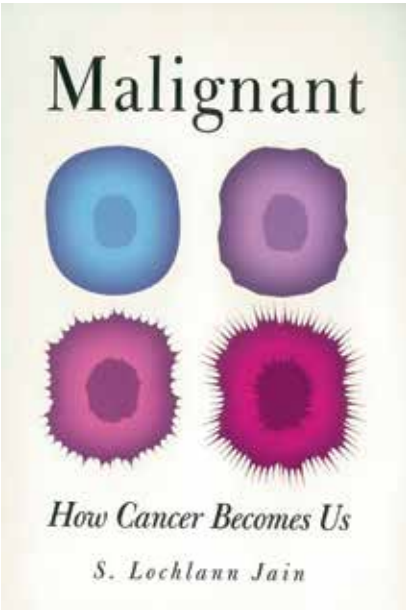
BOOK REVIEW

Malignant: How Cancer Becomes Us



By S Lochlann Jain. Berkeley, CA: University of California Press, 2013. ISBN 9708520276574

Lochlann Jain is a cancer survivor. She is also an anthropologist living in the USA. *Malignant* is in part the personal story of what she aptly terms 'living in prognosis' after an ordeal of misdiagnosis and subsequent treatment for breast cancer. The book is also her detailed investigation of our profoundly diseased society.

Nearly half of all Americans will be diagnosed with an invasive cancer. The time lag between exposure to carcinogens and diagnosis makes pinpointing exact causes difficult, other than overt instances such as smoking and lung cancer, or asbestos exposure and mesothelioma. Many known and unregulated carcinogens are in our food, plastics, dyes and water. Fallout from war, even from medical treatments, adds to risk. Modern life evolves in a soup of hormones and chemicals, driven by our quest for youth, fertility, fast food, easy travel, gizmos and wealth. There is a massive price to pay, and the cost is often borne by those who do not benefit.

Jain unearths disturbing information, e.g. companies that make both carcinogen-containing products and chemotherapy drugs. Stating that she doesn't believe there is evil intent, she remarks that the way to make a fortune is to give cancer to someone who has health insurance, and then test, monitor and treat her for the rest of her life.

Jain's personal narrative informs and enhances her research. Her ability to present her emotional turmoil, vulnerability and even humour, as she finds herself ensnared by the big machine of what she terms 'the medical industry', is a thread that holds together an appalling story of the cover-ups and collusion between capital fearful of mass claims, the legal system that is too costly for individuals to seek redress, the health professionals who ask too few questions about causation, and the government agencies that are unwilling to regulate hazards.

There are no easy answers to the questions she poses. *Malignant* lifts the lid off cancer, showing it to be largely uncontrollable, unknowable, endemic to our culture, and metastasising into every aspect of life on earth, from our economic system to traces of lead found in Arctic ice. We are paying too high a price for our way of life, and we need to know this.

Malignant is essential reading for anyone involved in cancer care, who is affected by cancer, or who might contract the illness. Going by the stats, that's pretty much everyone.

Dawn Garisch
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