Global surgery—going beyond the *Lancet* Commission

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In September, 2013, a small group met at the *Lancet* offices in London to begin planning for a *Lancet* Commission on Global Surgery. Our aim was to improve access to safe and affordable surgery and anaesthesia care. Our remit, to define the current global surgery landscape, review best practices, and make recommendations. The domains that we were to consider were health systems, workforce, information management, and finance.

In the ensuing 18 months, 25 Commissioners interacted with hundreds of people in 111 countries, held meetings in six continents, and completed dozens of new research studies to start to fill in the gaps in an otherwise evidence-poor field. These studies will be published in *The Lancet*, *The Lancet Global Health*, and other journals. The Commission's findings are presented on April 27, 2015, at the Royal Society of Medicine in London, UK.

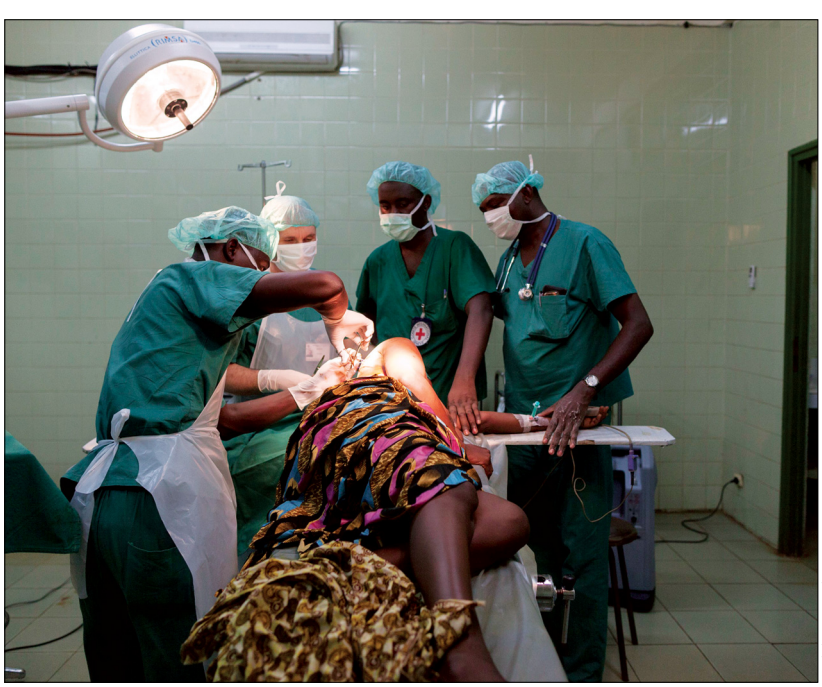
Among the five key messages,[1] the Commission describes the woeful lack of access to surgery for most of the world's population (ie, 5 billion people), and the number of individuals who become impoverished seeking and receiving surgical care (81 million). The key messages also describe the number of operations (143 million) needed to alleviate the gaps in access, and, crucially, the benefits to low-income and middle-income countries of remedying the situation (ie, a saving of 2% of gross domestic product). These are powerful messages indeed.

The Commission, combined with the recently published *Disease Control Priorities* 3 surgery chapter,[2] means that, for the first time, global surgery has a strong evidence base to describe the discipline and act as motivation for change. But it will take more than powerful messages and evidence to drive the changes required to help those people who are in need of surgery.

Surgery has an image problem. It is seen as expensive and complex; it comprises multiple treatment modalities for many different diseases, which makes it difficult to define as a cause around which people can easily unite; and it is perceived as peripheral to essential health care by many, from members of the public to policy makers, funders, and governments. Jim Kim and Paul Farmer understood surgery's image problem when, in 2008, they described surgery as the "neglected stepchild of global health".[3]

Against this backdrop, how can a Commission improve access to surgery for a girl in Africa who has a fistula due to obstructed labour, or a young man in Indonesia whose ability to provide for his family is cut short by a fractured femur from trauma owing to a road accident?

It is perhaps fortuitous that in 2015 we find ourselves at a crossroads. The Millennium Development Goal (MDG) period is ending and, although there is still work to do, the MDGs have shown that the global community can successfully unite around common causes. However, the MDGs were, by and large, oriented towards single disease-treatment silos, with achievements in these areas exposing the insufficient health systems of many low-income and middle-income countries. The global health community is therefore now turning towards health-system strengthening and universal health coverage.[4,5] Providing surgical services to those who need them is essential to both of these aims. Surgery is an interdisciplinary specialty that requires a strong—though not necessarily high technology (much surgery can be done in a primary care or district general hospital setting)—health system to be delivered safely and efficiently. Likewise, it is not possible to have a



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fully functioning health system without access to surgery. Certainly, neither communicable nor non-communicable diseases can be combated without surgery.[1]

One of the tasks of the Commission is to take this message to educators, funders, and policy makers. We will be presenting our findings and asking the communities with whom we speak: how can we work together to achieve our common goal?

Accountability is an essential part of monitoring progress towards our aim. In recognition of this, we have recommended six key metrics. With the strong support of members of the surgical community like the G4 Alliance, we have worked with WHO to ensure that some of these indicators will be included in the Global Reference List of 100 Core Health Indicators.[6] Over the coming years, we will work with country representatives, global health agencies, and academics to utilise and analyse these data to ensure that progress is assessed and, importantly, recorded. The indicators that we have recommended should be easily collectable by health systems. However, as data collection technology evolves, we will reassess and refine our recommended indicators. In addition, in our report, we provide high-level information on the benefits to the global economy of investing in surgical services. However, individual countries will doubtless be asking why they should invest in surgical services, and we will help to answer this question by collecting information to enable country-level financial calculations.

For the **WHA resolution** see http://www.who.int/surgery/en/

For the **G4 Alliance** see http://www.theg4alliance.org

We recognise that, to achieve our aims, we will need the support of the global community. Time is nearing when the ink will be dry on the Sustainable Development Goals (SDGs), but at present surgery is not mentioned in the most obvious place. Goal 3.8 currently describes access to essential medicines. For the SDGs to be effective in galvanising health system strengthening, essential procedures should be explicitly mentioned alongside essential medicines.

For the **SDGs** see https://sustainabledevelopment.un.org/topics/sustainabledevelopmentgoals

Universal access to safe, affordable surgical and anaesthesia care when needed—the Commission's vision—can only be achieved if all actors in this field come together with a common voice, setting aside small differences, and transition from calling out problems to defining and implementing solutions. The signs are good. At our first implementation meeting in Bellagio, Italy, in February, 2015, we convened 31 health-care leaders from around the world from varied backgrounds—public and private, industrial and philanthropic, academic and clinical—to set in motion plans to move towards our vision. The World Health Assembly resolution on Emergency and Essential Surgical Care had just been passed in January and will now go for ratification in May, 2015. All of this is positive; however, to succeed we must ultimately engage and accompany our global partners in resource-poor regions in true partnership to build resilient surgical systems, not isolated silos. We need to continue this momentum to ensure that by 2030 safe, affordable surgical and anaesthesia care is available for all who need it.

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