10.1 Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage

Contents

In focus

*The Executive Board at its 135th session agreed to include strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage on the provisional agenda of its 136th session and that a new version of the report that it had noted would be prepared. Strengthening capacity to deliver basic surgical and anaesthetic services at first referral facilities can contribute to reducing death and disability from both communicable and noncommunicable diseases and support progress towards universal health coverage. On that basis, the Board is invited to consider (*in EB136/27*) specific country-level and Secretariat actions for supporting improved service delivery in this area.*

EB136 will be asked to consider a draft resolution on surgery for recommending onwards to the WHA68 (sponsored by the US, Australia and Zambia amongst other countries). The focus of the resolution will be on strengthening surgical programs in low resource settings, including the mobilisation of financial and technical support. A road map for such developments will be needed including country-specific health services research and planning.

This topic may have been considered at the regional committees in the lead up to EB136.

Background

EB136/27 is a revised version of EB135/3 (considered by EB135 in May 2014). The paper reviews the global burden of surgical conditions, the importance and cost effectiveness of surgery and reviews some significant gaps in surgical and anaesthetic services globally. The report surveys a number of areas for action at the country level and current action at the Secretariat level.

Highlighted in the section on country level action were: awareness raising, access to and quality and safety of emergency and essential surgical services, strengthening the surgical workforce

better data on surgery for policy making, monitoring and evaluation, and global collaboration and partnerships.

Actions by the Secretariat which are highlighted include: the Integrated Management for Emergency and Essential Surgical Care (IMEESC) toolkit; the WHO-CHOICE project on cost-effectiveness of interventions; and the WHO Global Initiative for Emergency and Essential Surgical Care. The Secretariat will work with MS "surgical services at district and subdistrict levels of care are assessed and monitored".

There was an extended discussion on this issue at EB135 (here) where there was widespread support for progressing this issue. The case for strengthening essential and emergency surgical and anaesthetic services was not contentious.

The US spoke of rational and cost-effective service provision and spoke of task shifting. Cuba, South Africa, Maldives emphasised the need to consider different levels of service delivery and the referral and support relationships between levels. Namibia emphasised the need to locate service development within a comprehensive PHC framework. This was supported by Korea and Argentina. The UK supported by Australia emphasised rational use of antibiotics in surgical practice. DRC emphasised the need for a stocktake before adopting general strategies and plans. Nepal endorsed the inclusion of anaesthetic services but pointed out that human resources were a big constraint.

It seems that a resolution (apparently led by the US) is being developed for WHA68 which will call for a strategy and plan of action. This resolution will provide the focus of discussion at EB136.

PHM Comment

This is an important area and it is good that WHO is moving to adopt a formal integrated strategy and plan of action.

The issues canvassed in the Secretariat paper (EB136/27) are important. The following issues are of particular importance to PHM:

- models of service organisation and service delivery,
- surgical and anaesthetic task distribution within the health workforce,
- efficacy and effectiveness: evidence, clinical guidelines, clinical audit,
- safety and quality, clinical governance and clinical accountability,
- professional accountability and public policy control over training, regulatory frameworks and financing,
- the role of informed public and community involvement in policy, planning, management and institutional accountability.

It will be important to explore and evaluate the options with respect to service organisation and service delivery in different settings as part of planning this initiative. This will involve surveying existing models and developing criteria for assessing options.

Ensuring a high return on investment with respect to any expansion of surgical services will depend on: focusing surgery for conditions where surgical treatment has demonstrated efficacy; ensuring high quality and safety with respect to environments and practice; sustainable financing and payment arrangements; and appropriate workforce policies.

There are many lessons from the experience of surgery in rich countries including what to avoid: unreasonable reimbursement, exploitation of professional monopoly power, inappropriate and unsafe practices. Likewise there are valuable models from resource poor settings (eg the Aravind Eye Care System).

One of the key issues for L&MICs is ensuring appropriate workforce profiles. Surgery in rich countries is highly specialised, relatively autonomous both in clinical decision making and entry control (associated with long training programs), and generously remunerated. However, many surgical (and anaesthetic) procedures can be performed by personnel with more limited training and less generous remuneration. The use of such practitioners in a supportive organisational context can ensure greater cost-effectiveness, reach and access. Carefully designed training programs for these practitioners, including rich continuing in-service training, is critical.

Developing models of service delivery will involve identifying in broad terms the types of surgery which might be carried out in local (often quite isolated) hospitals, those which might be restricted to the referral centres, and the more complex but less urgent surgery which can be scheduled for visiting teams. In many L&MICs properly equipped mobile surgical teams play a critical role in facilitating access. Mobile teams can also play an important role in providing in-service training. Surgery should be integrated within existing PHC programs; it should not be constructed as a new vertical program. Provision should be made for adequate supplies, maintenance and technical support to ensure that surgical facilities in isolated areas and for mobile teams are safe for both patients and staff. It may be necessary to include security for mobile teams in some settings.

PHM urges a return to the district health system model. The roles assigned to the district hospital are critical. These include both the provision of first level hospital services, including basic surgery and anaesthetics, but also a range of functions that would strengthen and support primary health care and other district-level services.

Organisational policies and information systems to ensure that surgical services provided are efficacious and effective are critical. This will require systems for reviewing and synthesising evidence and the availability and observance of clinical guidelines. Safety and quality are critical. This will require clinical governance arrangements which ensure professional accountability - to peers, to management, to communities and to families and patients. Excessive professional autonomy of the surgical and anaesthetic professions is to be avoided.

This requires that arrangements are in place for effective public policy control over training, regulatory frameworks and financing (including remuneration).

The process of expanding access to surgery in low resource settings will be fraught with risks and challenges. One of the prerequisites for success will be to ensure that policy making, service planning and operational management are all embedded within an environment of public and community accountability.

There will be no 'one size fits all' model for expanding surgical services. While general principles and strategies can be elaborated, institutional arrangements and operational details will need to respond to local and national context. Adapting general principles to local context will require developing local capacity for operations research before, during and after the roll out.

The development of any future strategy and action plan for WHO will need to break away from the prevailing culture of prolonged training, high specialisation, high clinical autonomy, private practice and high remuneration. We urge that whatever expert committees are assembled for this exercise they include people with experience in delivering surgery in low resource settings and that the process includes careful documentation and analysis of existing models of service delivery.

Notes of discussion

Documents:

- EB136/27
- EB136/CONF./1

UK: pleased with reference to 1. comprehensive surgery and anaesthesia services as a building block against AMR, 2. safety of surgery, 3. strengthening surgical workforce. lancet commission on surgery is to be noted, to be published in 2015.

China: support the adoption of resolution. use of basic techniques will promote accessibility. investment in health workforce is a must. hospital infection surveillance also important.

Namibia (AFRO): appreciate inclusion of this topic. primary prevention is possible by promoting peace and security, reducing alcohol consumption , lifestyle challenges. surgical treatment conditions often go untreated and lead to morbidity and mortality. Concerned that investment in HS remains inadequate. many countries have lack of access to tools for treatment. some are high tech, some are basic yet fundamental. Many MS still lack access to basic essential medicines. district level is key. we cannot speak of UHC as a minimum package of essential services if surgical care is not part of PHC and available and affordable at district level.

Malaysia: The report show some lacks in human resources in poor countries. WHO must help on this. concern with draft resolution, that focus on hospitals could weaken primary care, requests flexibility as per country conditions.

Lebanon: surgery care - integral for people-centred HS. case management where PHC or higher levels. need for skilled personnel for safe surgery. support and cosponsor draft resolution

Japan: Support the proposal to develop surgery as part of the universal health coverage. surgical care and anaesthesia depends on specific locations...

USA: committed to facilitating access in LMIC. strong support for AFRO. access to surgery is integral to reaching UHC. access to essential medicines (ketamine) can help facilitate safe surgical care. AMR in hospitals underscore importance of control. encourage WHO to intervene for safe surgical care

Russie: support the resolution. recognises need for decentralisation, but also possibility of providing technological assistance in centralised hospitals.

Egypt (EMRO): quality and safety of surg care is an area of concern. access remains limited in LMIC. lack sufficient trained health professionals. unsafe surgery is a risk to patients. countries need WHO support for monitoring, such as WHO's tool kit - rec on minimum standards are included in this. PHC and UHC important.

South Africa: aligns with Namibia. would like to co-sponsor the resolution.

Australia: thanks Zambia for preparing resolution; pass floor to Zambia.

Zambia: as chair of negotiating team of resolution. res will allow for timely, safe, adequate surgical care in PHC. supports scaling up of skilled workforce. document has consensus. MS should adopt it.

DRC: insist on important aspect: assessments - important in the field. tools and equipment are needed - in the field an environment must be conducive to this tool - electricity for example is needed to use the equipment. a full assessment is needed of the environment for installation.

Brazil: access to essential medicines, and AMR as key issues. maternal mortality is positively affected by components of the resolution. reduction of unnecessary surgeries is a national challenge.

Republic of Korea: supports resolution. issue of gap in access between rural and urban areas. exchange of expertise and training for low income countries are welcome. supports the resolution.

Maldives: More than 230 millions of surgical operations in the world. emergency surgery reduce mortality and mortality for many conditions. issue raised by Malaysia with regard to challenge of access to resources in PHC settings. Support the project.

Belgium: surgical care is an essential component of UHC. supports report. endorse resolution. cosponsors resolution/

Cuba: surgical and anaesthesia are key components of UHC means there is a gap. many die of complications or lack of access. urgent need to act. need people with skill, and inputs and tools. political will is necessary, needs to be a priority. need referral systems, so that surgical care in PHC is linked to rest of system. needs to be not only supported and passed, but implemented.

Panama: we don't have UHC and essential surgical care to meet all needs. surgical care must meet safety and security standards, with key monitoring. capacity building of HC staff and training of professionals. necessary equipment and technologies. supports resolution.

Switzerland: welcomes draft resolution. approach of resolution will allow to expand UHC to regions and population that did not have access. contribute to interventions against communicable and NCD, including maternal health. wants to be co-sponsor.

Nepal: disabilities and lack of access a key problem. support resolution

Libya: share country experience. no PHC and sick emergency care. used McKinsey model and focus on access in golden hour. have also focus on coordination between ambulance and emergency institutions. trained staff on how to work in a team. and recruit more staff and train them in safe intervention. also training in specific skills.

Zambia: cosponsor resolution. a large number of gynae emergencies make up to 70% of health emergencies in rural areas in Zambia. has critical shortage of trained workers. inadequate infrastructure. practitioners are largely improvising. lack of surgical skills. shortage of essential surgical supplies and medicines. more needs to be done : need for district hospitals with app surgical facilities, and access. Ketamin; needs for financing for training posts. need for adequate financing of pub and private universities; enough finances should be provided to long term training at primary level of care. prioritise primary level. skills transfer to non-specialist doctor with continuous quality monitoring.

Germany: three points. 1 recommend to strengthen disease prevention in order to avoid surgical intervention when possible. 2. include well functioning health system and sustainability. 3 partnerships for learning and sharing of experience.

Senegal: coauthor of draft res. associates with AFRO statement. treatment of patients mainly in urban centres is difficult, due to reg but lack of trained staff mostly. a serious barrier. highly recommends adoption.

Thailand: UHC, universal access to health care services. integration of surgery services into health system is not so simple. requires infrastructure, staff to provide it with quality and equitably. production and training is not enough, geographical distribution is also important for equitable access. need to integrate in health care infrastructure, not good to implement resolution in silos.

Zimbabwe: cosponsor draft res. align with AFRO. need access to ketamine in LMIC

Togo: Supports Namibia. Wish to be cosponsor

NGOs

- International College of Surgeons (ICS)
- International Federation of Medical Students´ Associations (IFMSA)
- Medicus Mundi International – International Organisation for Cooperation in Health Care (MMI)
- Union for International Cancer Control (UICC)
- World Federation of Societies of Anaesthesiologists (WFSA)

ADG: access to surgery and anaesthesia is critical for UHC

Resolution EB136.R7, "Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage" adopted.