Ladies and Gentlemen, Members of the Committee, it is indeed an honour to address this Committee here this morning. My name is Walt Johnson, I am the Lead of the Emergency and Essential Surgical Care Programme at WHO. My career has been in Academic Neurosurgery. I have been involved throughout my career with medical school education and surgical training programmes in the US, China and throughout Africa. More recently, I have become actively involved in Surgery as a Global Health Issue.

Currently, there is great momentum and a sense of urgency in Global Surgery due to the recent publication of The Lancet Commission on Global Surgery, the World Bank’s Disease Control Priorities, 3rd Edition, and the passage last May of the World Health Assembly Resolution 68.15: Strengthening emergency and essential surgical care and anaesthesia as a component of universal health coverage.

Surgery is an “indivisible, indispensable part of health care.” Universal health coverage and the health aspirations set out in the post-2015 Sustainable Development Goals will be impossible to achieve without comprehensive surgical and anaesthesia care.

My appeal to you this morning is that the unmet need of surgical care in this world is almost overwhelming and that restricting access to Ketamine will greatly endanger the ability to provide those desperately needed services to people living in the poorest countries.

Current data are rather horrifying. Globally, 5 billion persons lack adequate access to safe and timely surgical and anesthesia services, with 2 billion, 9 out of ten individuals in LMICs, lacking access to even the most basic services, such as simply washing out and suturing a wound. Of more than 300 million procedures done annually, only 5-6% are done on the poorest third of the world’s population. It is estimated 10% of all adults and 20% of all children in the developing world die prematurely because they lack access to basic surgical care.
Estimates are that 143 million additional surgeries are needed yearly to save lives and avert disability. This number is likely to rise as the entire world transitions from communicable disease to non-communicable diseases, as surgery is a much more requisite part of NCD care. And estimates are that NCD rate will rise 15% in this decade, with 20% growth expected in AFRO/SEARO/EMRO—areas of highest concentrations of unmet surgical need.

Over 5 million individuals die each year from the sequelae of injury, which is almost double the number of fatalities from HIV/AIDS, tuberculosis, and malaria combined. Approximately 270,000 women succumb secondary to childbirth, fortunately half of what it was a decade ago thanks in part to implementation of the MDGs.

Surgical care has shown to be cost effective. In fact, a modest investment in surgical care infrastructure can realize a 2% growth in GDP. It has also been shown that if this is not done, LMICs will continue to have losses in economic productivity, estimated cumulatively at US$12.3 Trillion (2010 US$, purchasing power parity) between 2015 and 2030.

Clearly, lack of access to surgical care has its greatest impact in LMICs and surgical care is not possible without anaesthesia. At the district and sub-district level, health personnel are expected to provide a range of anaesthesia services for the management of pregnancy-related complications and unsafe abortion; injuries such as road traffic accidents, domestic violence, burns, and falls; congenital anomalies; a host of other surgical conditions such as simple hernias; and many emergency situations such as a combative patient with severe postpartum hemorrhage needing manual uterine massage or a little child needing an acute fracture set or a burn dressing change. (Bull World Health Organ 2010; 88:637–639). At these Primary Health Care facilities, Ketamine which is part of the WHO Model List of Essential Medicines, is commonly and often the only anesthetic available because of its ease of use, low cost, safety record and its low equipment requirements.
The largest multi-country assessment of 22 low- and middle-income countries utilizing a standard WHO Situation Analysis Tool has shown that of the 590 health facilities reviewed, 72% had access to ketamine (J Anaesth Clin Res 2012; 3:207). This survey also highlighted scarce resources: uninterrupted electricity was available in only 59% of facilities; only 53% had functioning anaesthesia machines, uninterrupted access to oxygen in only 46%, while 35% reported no access to oxygen. Basic airway-management equipment, such as face masks, laryngoscopes, and endo-tracheal tubes, were lacking in 45% of facilities. Nurses and clinical assistants made up the majority of the anaesthesia providers. The limited skill of these providers and lack of safety equipment in LMICs contribute to the overall greater risk of complications with general anaesthesia. Ketamine can be administered i.v. or i.m. and does not require the availability of oxygen, electricity, anaesthetic equipment or trained anaesthesia providers. Ketamine has less risk of airway difficulties, does not require endotracheal intubation, has stable pulse and BP (hemodynamic) profile, thus, ketamine is the most widely used and is THE safest anaesthetic drug under these conditions.

Given the history seen with other drugs coming under International scheduling, it is highly likely that Ketamine, if so controlled, will be widely restricted and unavailable, especially in LMICs. If this were to occur, greatly needed basic surgical services will be largely unavailable and the massive current unmet need for surgical services will be greatly exaggerated.

So when we look at the Sustainable Development Goals—several will not be attainable if the most common and safe method of administering anaesthesia is unavailable.

SDG 1: Eliminate poverty—lack of surgical care will prevent attempts at escaping poverty at a massive regional cost

SDG 3: Good health and wellbeing for all

3.1 Reduce MMR to <70/100 000 live births—won’t happen and will likely increase
3.2 End preventable deaths of newborns and children <5—forget it
3.4 Reduce by 1/3 premature mortality from NCDs—not going to happen
3.6 Halve the number of global deaths and injuries from RTA—forget it
3.7 Ensure reproductive health—not a chance
3.8 Achieve UHC including access to essential health-care services—no way

The reduction in Maternal Mortality Rate nor the reduction in infant mortality seen with MDGs will not be sustainable and likely will rise. And we will be unable to fulfill the directives of resolution 68.15.

Finally, as restriction on Ketamine will have the greatest impact on surgical care in LMICs, it should be framed in the context of a social justice issue, which flies in the face of SDG 10: to reduce inequality both within and among countries. You can be certain that surgical care will not be reduced in NYC, London or Berlin, but there will be severe consequences in Liberia, Burundi, Somaliland, Bangladesh, Laos, Cambodia, Philippines and so many other countries. In a 1980 speech, soon after the Alma Ata Declaration, Director General Halfdan Mahler stated that “social injustice is socially unjust in any field of endeavour, and the world will not tolerate it for much longer. So the distribution of surgical resources in countries and throughout the world must come under scrutiny in the same way as any other intellectual, scientific, technical, social or economic commodity. The era of only the best for the few and nothing for the many is drawing to a close.” Will we, 35 years later, choose to go down the path that further deepens inequities, reversing years of significant progress in global health? Or will we choose rightly to strengthen surgical care and anaesthesia all over the world by preventing the restriction of Ketamine?

Thank you.