We are writing to Margaret Chan (WHO), Jim Yong Kim (World Bank Group), and Raj Shah (USAID) on behalf of 100 global surgical, obstetric, trauma, and anaesthesia federations, societies, academic institutions, and non-governmental organisations, representing more than 400 organisations and 2 million members from more than 150 countries, with regards to the ongoing discussions regarding the core global health indicators set forth by the Global Health Agency Leaders and the International Health Partnership (IHP+).

We are concerned that the proposed Global Reference List of 100 Core Health Indicators fails to provide an adequate metric for global surgical care. Currently, surgical wound infection rate represents the only indicator pertaining to surgery. We believe that this is a flawed indicator that fails to track crucial elements of surgical care such as access, volume, safety, workforce availability, or financial protection.

Research suggests that as much as 11–30% of the global burden of disease requires surgical care or anaesthesia management, or both, 2 a figure that underscores the fundamental role of surgery as part of essential health care. Yet the present list of proposed indicators fails to reflect the integral role of surgical care and anaesthesia as part of universal health coverage and essential health service goals.

As stated by Jim Yong Kim in his recent address to the Lancet Commission on Global Surgery: “Surgery is an indivisible, indispensable component of health care.” He issued a challenge to the Commission to come up with “time bound targets” as a means of tracking progress towards universal access to safe, affordable, surgical and anaesthesia care when needed. In recognition of the essential role of surgical care in health systems, we urge you, as global health leaders, to consider inclusion of the following surgical indicators (in order of priority): first, perioperative mortality rate (collection of total annual surgical volume and all-cause mortality rate before discharge among post-operative patients as an indicator of realised access and surgical safety); second, surgical workforce density (number of trained and licensed surgical, anaesthetic, and obstetric providers who are working, per 100,000 population), which informs the availability and accessibility of human resources; and third, catastrophic and impoverishing expense (fraction of households protected against catastrophic expense and impoverishment from out-of-pocket payments for surgical care). This indicator represents a key element of universal health coverage and provides information about payment systems, insurance coverage, and balance of public and private services.

Including these metrics as part of the core 100 indicators and promoting transparent reporting at the national and international level will help to strengthen health systems through the delivery of safe, effective, and accessible surgical care and anaesthesia.

We thank you for prioritising these surgical anaesthesia care indicators and recognising their integral role as part of universal health coverage and essential health services.

I declare no competing interests.

Emmanuel Malabo Makasa, on behalf of 100 signatories and supporting organisations listed in the appendix

Department of Error

Em T, Sasso L, Hount S, Belovitz Y, Tamin A. Save a Child’s Heart project in Israel. Lancet 2014; 384: 1575–76.—In this Correspondence (Nov 1), authors’ affiliation should have read “Wolfson Medical Center”. This correction has been made to the online version as of Nov 14, 2014.

Lawitz E, Sulkowski MS, Ghalib R, et al. Simeprevir plus sofosbuvir, with or without ribavirin, to treat chronic infection with hepatitis C virus genotype 1 in non-responders to pegylated interferon and ribavirin and treatment-naive patients: the COSMOS randomised study. Lancet 2014; 384: 1756–65.—In the summary and methods of this Article, the assignment ratio should have been “2:1:2:1”. In figure 2, panel C, under the fourth graph, last bar, the percentage and n/N values should have been 88% (7/8), and under the fifth graph, last bar, should have been 93% (38/41). In the supplementary information, p 1, overall SVR12 rates should have been “96% (152/158)”, not “97% (154/158)”; in table 6 the 24 weeks, group 1, cohort 1 number should have been “N=23”, not “N=24” and that under Total should have been “N=79”, not “N=80”, and in figure 3 the n/N values for the last bar should have been “84/87”, not “87/87”. These corrections have been made to the online version as of Nov 14, 2014, and the printed Article is correct.

Pinal-Fernandez I, Callejas-Moraga EL, Roade-Tato ML, Simeon-Aznar CP. Groove sign in eosinophilic fascitis. Lancet 2014; 384: 1774–84.—Callejas-Moraga and Roade-Tato’s names were misspelt. These corrections have been made to the online version as of Nov 14, 2014, and the printed Clinical Picture is correct.