



Surgical health policy 2025-35: Bespoke solutions needed in lower and middle-income countries

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The surgical health policy 2025-35 article is a comprehensive review of the lack of tangible progress of the 2015 Lancet Commission on Global Surgery's 2030 targets¹. Only 26% of Low-Middle-Income Countries (LMICs) are on track to meet the 2030 access target, 41% are on track for the workforce target, and none are on track for the surgical volume target¹. These findings are not surprising as these targets were set for all countries, and with regard to access to surgery, the target was for all countries to provide at least 80% of the population with access to a facility providing the Bellwether procedures (emergency laparotomy, caesarean section and open fracture management) within a 2-hour travel by 2030¹. The enormity of the problem is underscored by Nigeria's finances: the second-largest economy in sub-Saharan Africa, with a total annual health budget of approximately \$3 billion and an estimated \$16.8 billion required over five years to implement a surgical plan¹. These are the same problems faced by almost all low- and LMICs in achieving universal health coverage².

75% of low-income countries (LICs) and 61% of LMICs have not achieved the target of having at least 20 surgical and anaesthetic, and obstetric care providers per 100,000 population by 2030, compared to only 7% in high-income countries (HICs)¹. This manpower problem is exacerbated by brain drain from LMICs to HICs, driven of numerous internal and external factors³. Both the access and workforce problems directly contribute of LMICs' failure to meet the surgical volume benchmark of 5,000 procedures per 100,000 population per year by 2030. Based on the Lancet Commission on

Global Surgery's benchmark for surgical volume, the unmet need has risen to 160 million operations annually¹.

The article identified barriers to progress in global surgery as the absence of sustainable funding, fragile infrastructure, and essential workforce gaps. Solutions proposed included improving surgical pathways, building systems reliance, implementing telemedicine, using artificial intelligence, and harmonising electronic medical records. Other solutions include health education and screening programs, encouraging females in leadership roles and research, community engagement, and prioritising adaptive research to the needs of the developing world.

There are, however, immediate needs that can be addressed by combining some of the progress with some of the current short-term solutions. The Nigerian Ministry of Health recently announced that spending on medical tourism dropped from \$2.38 million in the first half of 2024 to \$0.09 million in the same period in 2025. This was attributed to significant investments in private and public health infrastructure⁴. This is likely to be more beneficial to those who can afford medical tourism and can pay out of pocket for health care. However, a private public, private nongovernmental organisations (NGOs) or public-NGO partnership in outreach programs is a way of tackling surgical volume. Over 500 outreach organisations in the United States alone undertake an estimated 6000 trips annually⁵. A model of such partnerships was demonstrated during a recently concluded outreach program in Ghana, in February 2026, under the auspices of the West African College of



Surgeons. Ghanaian surgeons and anaesthetists accounted for over 60% of the outreach doctors across 11 hospitals who operated on 913 patients in a 5-day working week, and at no cost to the patients. Operations included hernias, thyroidectomy, myomectomy, hysterectomy, cataract surgery, cholecystectomy and cleft palate surgery. Rather than rely only on foreign outreach teams, teaching hospitals, large district hospitals, and medium- to large-sized private hospitals should assume these roles in their countries. Twining these hospitals with smaller rural hospitals for fixed regular outreach programs with private or voluntary funding in the same vein as foreign outreach programs. Foreign outreach programs should also endeavour to recruit local volunteers. This should be seen as a social and moral responsibility, and it should become part of the cultural norm; it will make inroads into the surgical volume benchmark.

There is progress in the development of the National Surgical, Obstetric and Anaesthesia Plans, but with only Ethiopia, Zambia, Tanzania, Rwanda, Madagascar, Nigeria, Zimbabwe, Namibia and Ghana having developed NSOAP in Sub-Saharan Africa by 2024, there is still a long way to go as implementation is patchy, and benchmarks are unmet⁹. This is compounded by a shift away from donor-driven financing towards locally driven solutions. The emphasis needs to shift from communicable to non-communicable diseases (NCDs), especially given the rising life expectancy and the concomitant increase in NCDs. 78% of global NCD-related deaths occur in LMICs, and to achieve universal health coverage, it is estimated that \$1,398 per capita of pooled health spending is needed, but in 2018, the unweighted current health expenditure in LMICs was \$138².

Healthcare research in LMICs needs to focus on healthcare delivery systems capable of addressing their specific needs, as well as financing models, workforce types, training, and retention.

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