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EDITORIAL

The neglected stepchild at risk: reimagining global surgery of shifting priorities

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Global surgery, once described by Paul Farmer as 'the neglected stepchild of global health' [1] is at risk of sliding back into this role without significant action. This requires confronting the uncomfortable truth that we are not on track to achieve the goals defined by the Lancet Commission on Global Surgery (LCoGS) 2015 [2]. In fact, the global unmet need for surgery has increased from 143 million in 2015 to an estimated 160 million in 2025, reflecting a widening mismatch between surgical capacity and population needs [3]. This is unlikely to improve in the short term, with 75% of low-income countries and 61% of lower-middle-income countries currently falling short of the target of 20 surgery, anaesthesia, and obstetrics (SAO) providers per 100,000 population [3]. Postoperative deaths continue to exceed many major global disease burdens, with an estimated 3.5 million adults dying within 30 days of surgery each year; this is more than the total deaths attributed to HIV, malaria, and tuberculosis in adults [3]. These figures remain as estimates, since most countries do not publish reliable statistics for surgical metrics, making cross-country system-level comparisons of surgical care difficult [4].

Longstanding challenges with financing global surgery have been compounded by dramatic shifts in the geopolitical landscape. The United States of America has pivoted away from multilateral global health funds and initiatives, as exemplified by its withdrawal from the World Health Organisation (WHO), toward bilateral agreements designed primarily to advance U.S. strategic interests [5]. This has resulted in an estimated 60 billion dollar funding gap originating from the dismantling of 83% of United States Agency for International Development (USAID)-administered projects alone [6]. As a result, the U.S. official development assistance (ODA) to gross national income (GNI) ratio is projected to fall from 0.24% in 2023 to approximately 0.02–0.1% in 2026 [7].

European donor nations have followed suit, shifting national spending towards increasing defence capabilities. The United Kingdom plans to partly fund its defence spending increases by cutting its ODA budget, with the Foreign, Commonwealth & Development Office (FCDO) reducing its health-related ODA by 70% between 2023–24 and 2025–26 (from £1.77 billion to £527 million) [8]. Germany, traditionally a major donor towards global health initiatives, multilateral development, and health organisations, has experienced a fundamental realignment of its foreign and security policy (so-called 'Zeitenwende') towards rearmament. As a result, Germany's ODA to GNI ratio is projected to decline from 0.67% in 2024 to 0.43% by 2029 [9]. Similar trends have been observed in multiple donor countries, contributing to a decline in total developmental assistance for health of 22% between 2024 and 2025 globally, likely followed by further decreases until 2030 [10]. USAID cuts alone could result in an additional 14 million deaths by 2030, and the full impact of global cuts could impact tens or hundreds of millions of people [11].

As low- and middle-income countries adapt to this new global development landscape, mortality and morbidity from surgically treatable conditions are likely to rise, particularly in rural communities and in areas affected by conflict or natural disasters. This will almost certainly translate into greater unmet surgical need and an increasingly overwhelmed workforce, exacerbating the gap between population needs and care provision. Reduced career opportunities for healthcare providers could accelerate brain drain, further depleting SAO workforces in the most fragile health systems. Reduced research funding will make large-scale, cross-border projects less feasible, jeopardising existing networks and infrastructure and resulting in less evidence to guide better care for vulnerable populations. As funding opportunities contract, there is a real danger that global surgery will slip down the priority list altogether, as progress in this field often requires complex, systems-based approaches that are hard to communicate to funders, donors, and voters. Finally, this new reality will likely diminish the space for advocacy, as the focus shifts away from multilateral institutions and equity issues.

To survive these uncertain times, the global surgery community must diversify its goals, methods, and political messaging. On the ground, the focus of collaboration must increasingly turn towards more flexible, locally

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embedded partners, such as EMERGENCY's surgical initiative in Afghanistan, which has sustained free surgical and obstetric care throughout prolonged conflict and political upheaval. At the same time, researchers must broaden their focus, finding new points of contact between global surgery and emerging priorities, such as robotic surgery, to tap into alternative funding streams. This has been illustrated by a recent Impact Surgery analysis of robotic platforms across 60 countries, including hospitals in low-, middle-, and high-income countries [12, 13]. Finally, advocates for safe and affordable access to surgical care must reframe their message through the lens of health security rather than focusing solely on equity. They need to make a clear, data-driven case for investing in safe surgery, which strengthens health systems, protects populations in times of crisis, and enables societies to prosper in times of peace. This requires robust benchmarks for the efficiency and effectiveness of surgical care, as the ALLIGATOR study is developing, using appendicitis as a tracer condition for emergency care performance [14]. Amidst a changing landscape, the global surgery community must think laterally, turning to locally funded partners, tapping into new funding streams, and positioning global surgery as a critical part of resilient health systems. It won't be easy, but it can be done.

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