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Editorial

Postoperative Poverty; The hidden surgical dilemma

Ameliyat sonrası yoksulluk; Cerrahinin gizli ikilemi

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ABSTRACT

A term describing the financial difficulty experienced by sick people after surgical procedures, postoperative poverty, remains poorly understood but it is a severe outcome of surgical care in low- and middle-income countries (LMICs). Surgery, though life-saving, mostly causes catastrophic out-of-pocket spending which puts families in a bad economic position.

This editorial addresses the maladies of oversight in the financial incomes of surgical planning in LMICs. On the basis of the data obtained in Uganda, Sierra Leone, and Tanzania, we demonstrate that transportation, lost wages, rehabilitation, and longer hospital stays are paid by the patients, even in case they have been treated in a publicly accessible/subsidized facility, which contributes to their medical impoverishment. Such economic aftershocks are highly felt by women and entrench the cycle of intergenerational poverty. Even though the world has promoted Universal Health Coverage (UHC), postoperative rehabilitative treatment and financial risk coverage are glaringly missing in most surgical policies.

The traditional focus on surgical volume at the expense of financial safety has to be changed. We call for the inclusion of post-surgery care and financial protections into the basic surgical service package and UHC programs. Policymakers should understand that recovery following surgery is not clinical but it is economic as well.

Keywords: Postoperative poverty; financial fallout; global surgery; systemic neglect.

ÖZET

Ameliyat sonrası yoksulluk, cerrahi müdahalelerden sonra hastaların yaşadığı mali zorlukları tanımlayan bir terim olarak tam olarak anlaşılamamış olsa da, düşük ve orta gelirli ülkelerde (DMOÜ) cerrahi bakımın ciddi bir sonucudur. Ameliyat, hayat kurtarıcı olsa da, çoğunlukla aileleri ekonomik olarak zor durumda bırakan felaket düzeyinde cepten harcamalara neden olur.

Bu yazı, DMOÜ'lerde cerrahi planlamanın mali gelirlerindeki denetimsizlik sorunlarını ele almaktadır. Uganda, Sierra Leone ve Tanzanya'da elde edilen verilere dayanarak, ulaşım, kaybedilen ücretler, rehabilitasyon ve daha uzun süreli hastane kalışlarının, kamuya açık/sübvansiyonlu bir tesiste tedavi edilmiş olsalar bile hastalar tarafından karşılandığını ve bunun da tıbbi yoksullaşmalarına katkıda bulunduğunu gösteriyoruz. Bu tür ekonomik artçı sarsıntılar kadınlar tarafından yoğun bir şekilde hissedilmekte ve nesiller arası yoksulluk döngüsünü derinleştirmektedir. Dünya, Evrensel Sağlık Kapsamını (UHC) teşvik etmiş olsa da, ameliyat sonrası rehabilitasyon tedavisi ve finansal risk teminatı çoğu cerrahi poliçede açıkça eksiktir.

Finansal güvenliği göz ardı ederek cerrahi hacme odaklanan geleneksel yaklaşımın değişmesi gerekiyor. Ameliyat sonrası bakım ve finansal korumaların temel cerrahi hizmet paketine ve Genel Sağlık Sigortası (UHC) programlarına dahil edilmesini talep ediyoruz. Politika yapıcılar, ameliyat sonrası iyileşmenin klinik değil, aynı zamanda ekonomik olduğunu anlamalıdır.

Anahtar kelimeler: Ameliyat sonrası yoksulluk; mali yoksunluk; ameliyat; sistemik ihmal.

INTRODUCTION

Surgery is widely recognized as a lifesaving procedure, but in most low- and middle-income countries (LMICs), it usually runs at a high monetary price, resulting in an implicit crisis of postoperative poverty. Estimated annual 33 million individuals globally face financial crisis through payment for surgery (1). In rural Uganda, nearly 29% patients suffered catastrophic costs, while 31% fell into medical impoverishment postoperatively; even when public hospitals offered 'free' care (2). Post-operative poverty, encompasses the additional costs of surgery including: transportation, lost wages, follow up appointments and family care giving. These unseen, unsuspected expenses and long-term destabilization of the economy contribute to the financial cost of the procedure. Collectively, they usually counterweigh the planned advantages of the intervention. Therefore, the assessment of surgical results must move beyond perioperative mortality and morbidity to include other measure of patient well- being such as post discharge economic stability and social recovery.

DISCUSSION

Resource limitation in LMIC

In low- and middle-income countries (LMICs), persistent gaps in surgical facilities exacerbate the burden for patient's post-surgery. Though surgical skills have globally advanced, LMICs remain stuck in grossly insufficient surgical workforce that often lags behind the recommended 20 provider per 100,000 population. (3). Postoperative rehabilitation continues to be sporadic and unavailable in areas outside of large cities, prolonging recovery and complication (4). Adding to these problems, most households are required to pay directly for treatment, and high out-of-pocket fees for 3 surgery and follow-up commonly place families in financial crisis (5). The national health policies often focus more on surgical quantity than quality outcomes, leaving postoperative care, rehabilitation, and social support systems poorly financed and neglected (6). Consequently, for many patients, the end of surgery is not recovery, but the beginning of economic vulnerability.

The financial fallout post-surgery

Every year, as many as 33 million individuals globally experience catastrophic surgery bills. In developing nations, the combined weight of direct expenditures like hospital charges, drugs, and dressing, together with indirect costs like transport, lost wages, and long-term disability, can economically destroy families. A cross-sectional study conducted in Sierra Leone revealed that among 335 surgical patients, the mean expenditure at the household level was 243 US dollars, equivalent to almost 7% of the median annual household budget of 3,569 US dollars. Eighteen percent of households had catastrophic health expenditure and 9% incurred poverty. Interestingly, 84% used personal savings to pay for expenses, and 2% only had some type of insurance (7). In Tanzania, almost 40 percent of orthopedic patients spent extra 9 days in intensive care, spending 12 percent more in total expenses just to clear their bills before discharge (8). These statistics show how a simple surgery can leave families in extreme crisis. Cost protection against financial risks must be at the center of surgical system planning, not as an afterthought.

Intergenerational and social impact

In (LMICs), the economic burden of surgery frequently forces families into asset sales, school withdrawal of children, or decreased household food intake to cover medical costs. Though these are short-term coping mechanisms, they have long-term consequences exacerbating poverty, worsening health, and interrupting education generationally (6). Women, often as chief caretakers, are disproportionately impacted, bearing more in-home burdens while confronted with restricted opportunities for earnings (9). These economic shocks reinforce gender inequalities and fuel an ongoing cycle of privation that radiates far beyond the patient undergoing surgery (5).

Systemic neglect and what needs to change

The surgery systems in the majority of low-and-middle-income nations (LMICs) are primarily aimed at increasing surgical volumes without any consideration for the financial burden that a patient incurs after being operated on. Perhaps one of the most critical and yet most unaddressed states of surgical care is the postoperative financial burden involving charges on rehabilitation, medication, and follow-ups. Such expenses usually end up being borne by patients and their relatives themselves, adding and compounding any existing financial vulnerability and driving many people into poverty.

While the world is also paying attention to Universal Health Coverage (UHC) systems encouraging not only access to cheap essential health care, but also protection against financial risk, the reality is that postoperative care is, rarely, covered by national insurance or subsidization programs (10).

It is evident that despite the explicit recognition of the risk of medical impoverishment, the frameworks of UHC have underfunded the postoperative rehabilitation and financial protection that are not uniformly applied around the world (10,11). Evidence in Sierra Leone and Uganda shows that even in the event of policies delivering on their promises in terms of financial risk safety, patients still receive the entire costs of postoperative care, showing a large disparity between theory and practice.

In order to address such a systemic lacuna, high priority should be given to incorporating postoperative rehabilitation and follow-up in the minimum surgical services packages and to getting these services financially covered under UHC programs. This would obviate major barriers to the recovery process and improve favorable patient outcomes in the long run. The implementation of targeted mechanism of financial support, e.g., subsidies or conditional cash-transfer programs, has been effective in minimizing out-of-pocket expenses as well as in encouraging the use of health services by socio-economically disadvantaged communities (11) There is a need to implement UHC policies to explicitly incorporate the guarantee of continuity of postoperative care in order to make sure that patients do not become impoverished due to surgical care.

Impoverishing reductions in health expenditure are a measure of a well-functioning surgical system by the world's top health experts, including the Lancet Commission on Global Surgery and World Health Organization (12). According to the Lancet Commission on Global Surgery and the WHO, leading global health-oriented organizations, patients must have the opportunity to recover their health with the help of surgery without being driven into poverty (6,12). The concept of surgery as a life-changing opportunity must also include not only clinical recovery, but also economic recovery, so that patients do not have to become poor on the way to getting the needed care.

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