Due to the failure to recognize or define what is meant by surgical conditions and the high burden of these conditions, the provision of surgical services has been a low priority on the global health agenda.

While “safari” missions have provided not inconsiderable relief for people affected by, for example, eye disease, cleft lip, and palate, they have not addressed the longer term issues of infrastructure and finance. The efforts of nongovernmental organizations (NGOs) have been audacious but often have not made a sustained impact.

The Lancet Commission on Global Surgery[1] identified 5 billion people worldwide, largely the poor, marginalized, and generally rural, who face impossible hurdles in accessing surgery and for all practical purposes are excluded from what is often life-saving or disability-averting treatment. It was found that about 30% of the global burden of disease could be identified as surgical. In a study of major surgery in South India,[2] in the states of Telangana and Andhra Pradesh, a population socioeconomically representative of India and other countries with low and middle income, despite near universal access for major surgery, use continues to remain low, and strategies beyond traditional financing for care are required.

Surgery is an “indivisible, indispensable part of health care.” Surgical and anesthesia care should be an integral component of a national health system in countries at all levels of development. Surgical services are a prerequisite for the full attainment of local and global health goals in areas as diverse as cancer, injury, cardiovascular disease, infection, and reproductive, maternal, neonatal, and child health. Universal health coverage and the health aspirations set out in the post-2015 Sustainable Development Goals will be impossible to achieve without ensuring that surgical and anesthesia care is available, accessible, safe, timely, and affordable.[3]

As a measure of economic value, an important metric for a sound evidence base, Disability Adjusted Life Years (DALYs) is a useful tool for quantifying the burden of disease. One DALY can be thought of as one lost year of “healthy” life.[4] The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

The specific circumstances faced by surgical care providers in low-resource settings who care for impoverished patients and how those providers overcome these challenges were identified in the How project[4] and divided into four themes: impact of poverty on patient access; severity of financial difficulties facing providers of quality hospital care; local, regional, and national policies that do not reflect the needs of the low resourced; how providers make it work despite the deficits.

How does this impact on the provision of craniomaxillofacial services, in particular, the common problems such as cleft and craniofacial anomalies, craniomaxillofacial trauma, temporomandibular ankylosis, and tumors? For example, clefts which represent a major impact on appearance, speech and hearing, psychological well-being and communal integration with long-term consequences both for the affected individual of an emotional and cultural nature as well as a burden of care for the family and the state, and where the tensions of the economic status of a particular region are often at odds with cultural beliefs. Despite poverty, the rise in accessible communications has produced a society increasingly obsessed by appearance, an obsession that represents a challenge for the disfigured, in particular for those with compromised facial appearance, and demands for solutions that will meet ever increasingly higher expectations of a culture driven by opportunities for wealth and success. Craniofacial anomalies are drawn into this equation in as much as there is an increasing desire for patients and their families, not unreasonably, to continue their search for treatments that will eradicate all stigma of the anomalies. With an estimated population of 1.1 billion in India and an estimated 24 million births per year, there are roughly 30,000 children born with clefts each year. Inequalities of access to care and quality of cleft care with distinct differences in urban versus rural areas and accumulation over the years of unrepaired clefts make this a significant health care problem in India. Serious acknowledgement by such organizations as the World Health Organization, work by many NGOs and charitable organizations, and interest by politicians are not only required but must be stimulated and sustained.
In the spirit of the Sustainable Goals 2030, the importance of excellent surgical training, the provision of accessible hospital services with proper surgical and anesthetic facilities, adequate funding, and development of infrastructure are essential and must become the responsibility of, and be driven by, appropriately trained maxillofacial surgeons.

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