

Falling short of the target: effective cataract surgical coverage and the road to 2030

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Cataracts are the leading cause of blindness worldwide. Fortunately, a highly effective and cost-efficient surgical treatment is available that can restore functional vision in most patients when performed with appropriate quality and followed by optical correction. The persistent global burden of cataracts

reflects not a lack of effective treatment but rather limitations in access, quality, and continuity of care. In 2021, the World Health Assembly set a target of a 30 percentage-point increase in effective cataract surgical coverage (eCSC) by 2030^[1]. Cataract surgical coverage (CSC) measures the volume of surgeries performed based on the need for cataract surgery. eCSC incorporates postoperative visual outcomes, making it a more comprehensive measure of both access and quality. Therefore, it is a more appropriate indicator of health system performance than CSC.

McCormick *et al*^[2] provide an important update on the progress toward the global target for eCSC. They utilized the largest available data set to date and employed modeling techniques to project trends up to 2030. The authors analyzed 233 datasets from 68 countries collected between 2003 and 2024. This data represent a significant expansion compared to previous analyses. However, important gaps remain. Some regions, particularly high-income countries, had limited data, necessitating the use of modeling assumptions, including estimates from the Americas for Europe.

Based on the observed trends, the study estimated that the global eCSC would increase by only 8.4 percentage points between 2020 and 2030. This indicates that the current trajectories are insufficient to meet the 2030 target. The study makes a significant contribution by identifying the causes of suboptimal visual outcomes. Residual refractive error accounted for 26.4% of non-good outcomes, highlighting the importance of accurate intraocular lens (IOL) power calculation, lens availability and selection, and postoperative spectacle correction. Intraoperative complications accounted for 20.2% of non-good outcomes, with a higher prevalence in Africa (27.5%). Posterior capsule opacification contributed 11.0% of non-good outcomes. Ocular comorbidities accounted for a similar proportion of non-good outcomes as refractive errors, suggesting that not all poor visual results are due to surgical quality. The authors estimate that addressing residual refractive error could increase effective eCSC by 3.7 percentage points globally. The findings indicate that improvements in effective coverage can be achieved through both increased surgical volume and enhanced quality of care. Therefore, integrating surgical and refractive error services is a crucial strategy.

Regional differences in eCSC are notable. Africa has the lowest eCSC (23.6% in 2025), compared to 50% or higher in other WHO regions. Progress is also slowest in Africa. In addition to lower coverage, the region exhibits a larger quality gap and a higher proportion of non-good outcomes due to intraoperative complications. This suggests deficiencies in surgical training, supervision, and health system capacity. Furthermore, the study identifies a significant sex disparity, with women being less likely to achieve effective coverage than men.

The implications for clinical practice and health system policy are evident. Achieving higher eCSC requires coordinated efforts across the entire cataract care pathway^[3]. Priority areas include improving access to preoperative biometry, standardizing surgical training, and ensuring the availability of equipment and expertise for managing postoperative complications, such as posterior capsule opacification. Ensuring an appropriate refractive correction after surgery remains a challenge.

Strengthening routine health information systems to collect data is crucial. Population-based surveys (as used here) provide valuable insights into coverage, but they are not suitable for quality monitoring. Facility-level data on surgical outcomes and complications are essential for quality improvement. The WHO eye care indicator menu offers a framework for such monitoring, but implementation is challenging due to resource constraints^[4]. Financial barriers to accessing cataract surgery also remain a significant issue. Improving affordability and financial protection is necessary to increase service uptake. Without addressing these barriers, progress towards universal access to cataract surgery will be limited. It is important to consider the potentially unintended consequences of the current performance target. eCSC is defined using a threshold for postoperative visual acuity. Patients with ocular comorbidities who may not achieve this threshold may be excluded from surgery, even if they would benefit from it. Incorporating patient-reported outcome measures, such as the Cat-PROM 5, alongside visual acuity may provide a more comprehensive assessment of surgical benefit and help mitigate this risk^[5].

This study has several limitations that should be considered

when interpreting its findings. Data availability is uneven, especially in high-income countries. Therefore, statistical modeling is necessary to generate global estimates. Projections are based on continuing past trends and do not account for potential changes in policy or practice. However, the consistency of findings across regions and datasets supports the conclusion that progress toward the 2030 target has been insufficient. On the other hand, examples of substantial improvements at the (sub)national level demonstrate that progress is possible. These examples emphasize the importance of sustained investment, workforce development, and system-level coordination to achieve universal access to cataract surgery. Currently, the global target for eCSC is unlikely to be met. However, McCormick *et al*^[2] have identified clear opportunities for advancement: improving surgical quality, integrating refractive services, and strengthening routine health information systems to monitor cataract surgery indicators, along with addressing financial and equity barriers, are all necessary to accelerate progress^[6]. Hopefully, the required level of commitment and investment can be mobilized within the timeframe of 2030.

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Conflicts of Interest: Wiedemann P, None.

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