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Comment

Healthcare Equity and Public Access to Infant Male Circumcision. Comment on Ananthapadmanabhan et al. Privatisation of Request Infant Male Circumcision in Australia—An Equity-Focused Assessment of Impacts on Religious Communities in Greater Sydney. *Soc. Int. Urol. J.* 2026, *7*, 51

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Australian circumcision practice sits at the intersection of cultural tradition and private-sector delivery [1]. Australian Medicare Benefits Schedule (MBS) data show that early childhood circumcision patterns changed substantially between 2000 and 2019 [2]. The value of the article at hand is that rather than asking whether the procedure is privately or publicly funded, it considers the real-world implications of moving a culturally significant practice into a mostly private system.

The primary goal is its focus on equity. In the Greater Sydney suburbs, nevertheless, it raises a key concern: privatisation may shift cost and safety burdens onto disadvantaged families. This matters clinically. Circumcision, although common, is a non-risk-free procedure, and recent evidence supports structured pain-control strategies rather than inadequate or inconsistent analgesia [3]. Safe care therefore requires more than technical completion of the procedure; it requires appropriate counselling, analgesia, asepsis, aftercare advice, and access to urgent review if bleeding, infection, pain, or wound concerns arise. These safeguards should not become less important because a procedure is performed outside the public hospital system.

Financial barriers also extend beyond the procedural fee. Recent qualitative evidence shows that low-income families may face hidden costs, transport barriers, difficulty securing appointments, time away from work, and challenges navigating healthcare systems [4]. Health literacy compounds this problem: a 2025 systematic scoping review found a consistent association between low income and limited health literacy across multiple domains [5]. In this setting, families may struggle to assess provider credentials, understand risks and benefits, follow post-operative instructions, or recognise complications early.

The significance of this paper lies less in proving that circumcision carries risk [6], and more in reminding us that surgical safety is context-dependent [7]. When a service is removed from the public but demand remains due to cultural or religious reasons, the procedure does not simply disappear; it may become less visible, less measurable, and harder to regulate. This is an often-overlooked consequence of privatisation: harm may emerge not from the policy's intention, but from the gaps it leaves behind. For infant circumcision, the central policy question is therefore not only whether the procedure

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should be supported, but how health systems can prevent safety and equity from becoming collateral damage.

A constructive response should therefore focus less on choosing between unrestricted public provision and complete privatisation, and more on whether a safe, equitable replacement exists when public access is withdrawn. In our view, the real contribution of this paper is that it exposes a policy blind spot: removing a service from the public system does not remove demand, but may make access, provider quality, and complications less visible. The study should therefore be read less as a definitive population count and more as a warning about unmeasured policy harm. Equity in urology is not an abstract principle; it is a clinical governance issue. The most relevant examples come from the same clinical and policy space. The Greater Manchester circumcision quality-assurance model offers a constructive example: by defining provider standards, supporting midwives to signpost families, and engaging community providers, hospital admissions following community circumcision complications fell from 27 infant boys in 2009 to 13 in 2016 [8]. The Oxford incident provides the cautionary comparison. In a setting where religious circumcision was not available through the National Health Service (NHS), 32 children were circumcised over three days in an unregulated community setting; among the 29 children with follow-up information, 13 developed complications requiring medical intervention [9].

For Australia, the implication is that urologists, paediatric surgeons, primary care clinicians, regulators, and affected religious communities should be involved before policy is implemented, not only after complications emerge. Socioeconomic status, health literacy, provider availability, cultural need, complication surveillance, and referral pathways must be considered at the point of policy design.

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