 Burns are a major public health issue across the globe with approximately 70 per cent occurring in low- and middle-income countries (LMICs). According to the World Health Organization, the injury accounts for an estimated 180 000 deaths yearly with the majority of these occurring in LMICs. Besides for every death from burns, a far greater proportion of burn survivors are left with permanent disabilities which may be compounded by poverty. In addition to dealing with the escalating infectious diseases, maternal and child health conditions and non-communicable diseases, LMICs have a huge burden of conditions requiring surgical interventions. These competing issues have further limited the burn care capacity of LMIC. Consequently, advanced care strategies such as tissue engineering, skin substitutes and scar management approaches may not be in the list of priority health interventions in LMICs.

As the availability of resources directly impact outcome and survival, the mismatch between the existing burden of burns and resources have adverse implications for universal health coverage (UHC) which could become a mirage for burns sufferers. Additionally, there are ethical issues of varying nature.

Robust preventive measures are either limited or non-existent in LMICs. Burn care is expensive and the occurrence of mass burn casualties usually accentuates the burden on healthcare systems in LMICs. Even more difficult to measure are the indirect costs for those who suffer burns, their caregivers and society. Injured persons at the pre-hospital phase are most likely to encounter untrained personnel who may apply various household agents such as egg, mud, sugar and toothpaste to the burn wound which could adversely affect clinical outcomes. Acute burn surgeries such as debridement, skin grafting, and contracture release may be delayed due to issues such as inadequate skin substitutes and shortage of skilled personnel. To ensure the progressive realization of UHC by its true definition, LMICs must also include burns in their essential health services packages.

Owing to the above-mentioned challenges, admission of a burn patient to an intensive care unit in some settings is primarily based on the likelihood of survival. Thus, burn patients with poor prognosis may not have access to some forms of critical care in order to make the space available for another patient with likely better outcomes. For patients who are unable to survive the injury, the end of life phase becomes another critical phase as palliative care has not been fully streamlined in the burn management process. Patients deemed survivable may not have access to rehabilitation services and as such, quality of life may be adversely affected in the long-term. Thus, irrespective of the path taken by the burn patient, concerns regarding ‘who gets access to what’ may persist.

Financial risk protection for burn patients is another major area requiring attention. The intensity of care required by severely burned patients and the corresponding scarce government resources may increase out of
pocket costs with a limited component covered by public health insurance schemes. In some developing settings, these can trigger discharge against medical advice and yet, these facilities lack outreach services that can support these patients after discharge. Consequently, the discrepancy between care required and care received may further deepen which affects the overall outcome.

Despite the plethora of ethical issues in burn care, *Walls and colleagues* have cautioned that LMICs should not allow these concerns to create a ‘sense of fatalism’ thereby leading one into the acceptance of ‘second best’ and ‘good enough’. Irrespective of the clinical course taken, the burn patient in LMIC settings requires ease of access to an appropriate service commensurate to their needs. This raises an interest as to how burn units in LMICs can move beyond the surface to deal with underlying issues. Access to care, inequality and justice, as implied in UHC aspirations, are critical issues that require attention in the management of burns. This could therefore serve as a call for action for LMICs to strive towards attaining UHC across the spectrum of burn care.