

Submission to the Productivity Commission

Delivering quality care more efficiently – Interim Report (Public Consultation)

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Executive summary

The Interim Report rightly emphasises prevention but fails to explore the issues and opportunities that lie beyond *primary prevention* – missing emphasis on the substantial value of *secondary prevention*. Notably, the hospital system is mentioned as providing acute care, without addressing effective hospital-based interventions for secondary prevention. There are highly impactful and cost-effective secondary prevention strategies that can be provided by hospitals to stop disease progression, prevent complications, and reduce demand for acute care in the future.

This submission highlights metabolic (bariatric) surgery as the clearest exemplar: one of the most cost-effective examples of hospital-based secondary prevention – but with systemic barriers blocking its adoption – leading to much more costly and less impactful downstream interventions.

The same barriers likely apply to other poorly recognised high-value interventions: namely failure to prioritise cost-effectiveness, prioritisation of acute care over more effective early interventions, and stigma or misconceptions dominating decision-making.

Recognising and addressing these barriers would allow the Commission to illustrate how public hospitals can also deliver quality care more efficiently, (beyond contributing to primary prevention) not only through metabolic-bariatric surgery, but as a broader principle of service design.

Why secondary prevention is essential

Primary prevention is essential but never complete. Even with optimal policies, diseases such as obesity, diabetes, cardiovascular disease and cancer will persist. No primary prevention strategy for any of these diseases is completely effective, and even if they were, those already with or developing the disease also deserve consideration.

Secondary prevention delivers earlier returns. Hospital-based interventions like metabolic bariatric surgery can reduce complications, hospitalisations and costs within short government budget cycles, and in many cases become cost-saving. (James 2017, Lloyd 2025)

Hospitals already do this well. Examples include removing colonic polyps to prevent colon cancer, or eradicating Hepatitis C to prevent liver disease. Metabolic bariatric surgery should be considered in this category of secondary prevention, but is neglected due to pervasive misconceptions on the causes, nature, and effective treatments of obesity. (Rubino 2020)

Metabolic Bariatric Surgery: The Exemplar

Metabolic (bariatric) surgery highlights the opportunity and barriers clearly. It is the most effective and cost-effective intervention for obesity – the condition causing the highest burden of lived disease in Australia, along with huge productivity cost. It is also complimentary to primary prevention efforts, as after surgery people are better able to participate in lifestyle initiatives due to control of their obesity.

Metabolic (bariatric) surgery has:

- **Effectiveness and durability.** Consistently achieving long-term improvements across diabetes, cardiovascular disease, liver disease, sleep apnoea, musculoskeletal conditions, along with other disease as well as overall morbidity, mortality and quality of life. (Syn 2021, Eisenberg 2022, Chang 2016, Benito 2020, Dowsey 2022 – Extensive further evidence if required).
- **Cost-effectiveness and potential cost-saving.** Evidence and modelling frameworks confirm value in high-risk groups (James 2017, Lloyd 2025, Noparatayaporn 2021, Migliore 2021, Sloan 2025, McGlone 2025).
- **Policy recognition.** Every major review, parliamentary inquiries into diabetes, national obesity strategies, and international guidelines recognise its impact (Commonwealth of Australia 2022).
- **Feasibility.**
 - *Funding:* recognised for Activity-Based Funding with clear NWAU allocation.
 - *Facilities:* Level 3+ hospitals can deliver low-risk procedures safely, and most level 4+ facilities could provide broad access (Newbold 2021).
 - *Workforce:* In many public hospitals, staff willing and able to provide this treatment are intentionally and specifically blocked from doing so (clinicians for interview on request).
 - *Framework:* Guidance exists for service design, along with case selection and prioritisation for maximum cost effectiveness. (ANZMOSS 2020).
- **Systemic blockage.** Despite this, over 95% of Australian public hospitals decline to provide bariatric surgery, even where clinicians request to provide it (ANZMOSS state of the nation 2020, Aly 2022). This denial of service is specific and unique to metabolic bariatric surgery.

This paradox exists not because of cost, workforce, or other practical constraints, but due to stigma, misconceptions, and misaligned prioritisation (Brown 2022). At the same time, enthusiasm for new obesity medications is growing, often without equal cost-effectiveness scrutiny (Lauren 2022).

Broader implications

The metabolic bariatric surgery case illustrates three systemic failures:

- **Cost-effectiveness is sidelined.** Less effective and less efficient services are prioritised over proven, cost-effective or cost-saving interventions.
- **Acute care dominates.** Systems prioritise treating complications rather than preventing them with earlier interventions. The Productivity Commission itself has previously highlighted that addressing obesity “would enable our healthcare sector to do more with less.” (Productivity Commission 2024)
- **Stigma distorts decision-making:** Obesity is treated as a low-status condition, leading to inequitable denial of effective treatment. Comparable biases may affect other marginalised populations.

Recommendations

The Commission should:

- 1 **Explicitly recognise hospital-based secondary prevention** as a complement to primary prevention in the Final Report.
- 2 **Use bariatric surgery as a case study** – to illustrate with a clearly cost-effective example of effective care delivery, how systemic barriers that limit uptake should be addressed.
- 3 **Recommend modelling, pilots and progressive roll-out** of bariatric surgery for high-value, low-risk patient cohorts, to demonstrate the efficiency of impactful secondary prevention.
- 4 **Embed secondary prevention exemplars into collaborative commissioning**, requiring LHNs, PHNs, ACCHOs to incorporate them into joint plans, so that clear pathways to secondary prevention (such as metabolic bariatric surgery for obesity) are available where cost-effective.
- 5 **Promote transparency and accountability** by publishing national metrics on access, wait times, and outcomes.

Conclusion

Primary prevention will always be vital, but it cannot stand alone. Hospital-based secondary prevention can be implemented rapidly, producing measurable improvements in efficiency and equity within existing funding structures. Bariatric surgery is the clearest example: effective, affordable, feasible – yet systematically blocked.

By recognising bariatric surgery as an exemplar, the Commission can demonstrate a broader lesson: that **delivering quality care more efficiently requires public hospitals to adopt cost-effective secondary prevention interventions, not just respond to acute care demand.**

I would welcome the chance to provide any further information that may assist the commission in recognising and addressing this key area of cost-effective care provision.

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