White Paper

The Landscape for Obesity Medications in Australia

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Executive summary

Australia's National Obesity Strategy 2022–2032 — a 10-year framework focused on prevention, food environments, and health literacy — was written before the GLP-1 receptor agonist revolution reshaped the treatment landscape.[1] In the last five years, over 1 million Australians have moved to pharmacotherapy, an exclusively private ecosystem has emerged, and bariatric surgery has declined materially. Consequently, there is a structural misalignment with the market moving faster than the system designed to govern it.

SIX THEMES DEFINE THE AUSTRALIAN LANDSCAPE:

- **Obesity is now Australia's leading modifiable risk factor**, overtaking tobacco in 2024 — responsible for 8.3% of total disease burden and costing the economy $45 billion annually in healthcare costs and lost productivity
- **A structural market shift is underway**. Second-generation obesity medications now account for 68% of the total chronic weight management market. Over the same period, OTC products have halved and bariatric surgery is declining at 17% per year. Just over a million people were dispensed at least one prescription of a GLP-1-based obesity medication within the past year, exclusively through private prescriptions
- **The consumer is informed, engaged and transforming the landscape**. In the last 12 months, over 85,000 social mentions of GLP-1 therapies were captured, reflecting a highly engaged patient segment managing their own care, comparing brands, cost strategies, and reshaping the consumer landscape
- **Novo Nordisk and Eli Lilly are competing on comorbidity platforms, not kilograms**. Cardiovascular outcomes, CKD, MASH, and obstructive sleep apnoea now define the competitive battlefield. Engagement strategy is moving to evidence beyond weight loss
- **The pipeline will intensify competition from 2027**. Boehringer Ingelheim's survodutide is expected to break the duopoly. With a total of 193 medicines in development globally, the next wave will compete not just on weight loss but comorbidity breadth, formulation, dosing convenience, and long-term maintenance
- **The system lags the market**. Australian guidelines remain the most conservative of major global frameworks while international consensus has moved to complication-driven care with earlier pharmacotherapy integration. PBAC advice to the Minister for Health focused on a slow managed rollout of obesity medication for priority populations with no PBS funding for broader preventative use of medication

This whitepaper draws on IQVIA's proprietary data and analytical capabilities to provide a comprehensive view of Australia's obesity inflection point.

Australia's obesity inflection point

The burden of obesity

In December 2024, the Australian Institute of Health and Welfare confirmed what clinicians have long suspected: overweight and obesity overtook tobacco smoking as Australia's leading modifiable risk factor for disease burden. An estimated 8.3% of total disease burden is now attributable to excess weight, compared with 7.6% for tobacco — a reversal driven by decades of tobacco control and rising obesity prevalence.[2]

Almost two-thirds (65.8%) of Australian adults are overweight or obese — 34.0% overweight and 31.7% obese — an increase of 3% from 2011-12. More than two in three adults (67.9%) have a waist circumference placing them at increased risk of chronic disease.[3]

The inequity is pronounced. Aboriginal and Torres Strait Islander adults are 1.5 times as likely to be obese as non-Indigenous Australians, with 76.8% living with overweight or obesity compared with 66.3% of non-Indigenous adults.[4] Socioeconomic gradients persist; adults in the most disadvantaged areas are more likely to have a waist circumference of increased risk than those in the least disadvantaged (68.6% vs. 64.4%), and those in outer regional and remote areas face higher rates of overweight or obesity than those in major cities (70.8% vs. 64.3%).[3]

The economic case compounds the clinical one. A recent study calculated the economic burden from obesity and overweight to be $45 billion in 2025 with $10.5 billion from direct healthcare costs and $34.5 billion from productivity losses.[5]

The private market for obesity medication

Against this backdrop, the GLP-1 market has grown rapidly, driven entirely by private-pay demand. Based on IQVIA NostraData Longitudinal Prescription analysis, over one million unique people — approximately 5% of Australian adults — were dispensed at least one prescription of a GLP-1-based obesity medication in MAT May 2026 — growing at a 4-year CAGR of 60%.

The TGA approval of semaglutide (Wegovy) and tirzepatide (Mounjaro) for obesity management in August 2024 and resolution of supply challenges from sponsors of these medications have resulted in a dramatic increase in prescriptions and people accessing treatment.

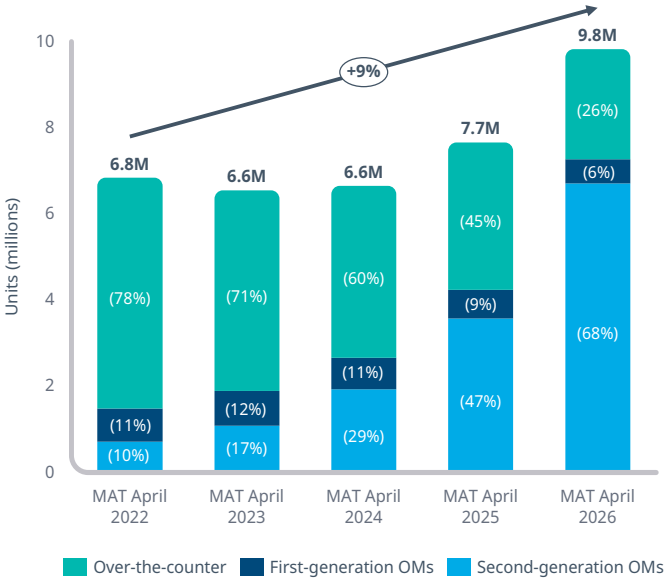
These second-generation OMs (liraglutide, semaglutide and tirzepatide) now account for 68% of total volume, up from just 10% four years ago and continue to grow the market.

This growth has driven structural displacement across the weight management ecosystem (Figure 1):

- OTC weight management products such as very low-calorie diet meal replacement shakes fell from 5.3 million units to 2.6 million units over the same period
- First-generation OMs (phentermine, naltrexone/bupropion, orlistat) have declined from 779,000 units to 556,000
- Bariatric surgery has declined from 24,200 MBS services (MAT April 2022) to just 11,600 (MAT April 2026) — a CAGR of -17% over 4 years

Figure 1: Evolution of obesity management in Australia

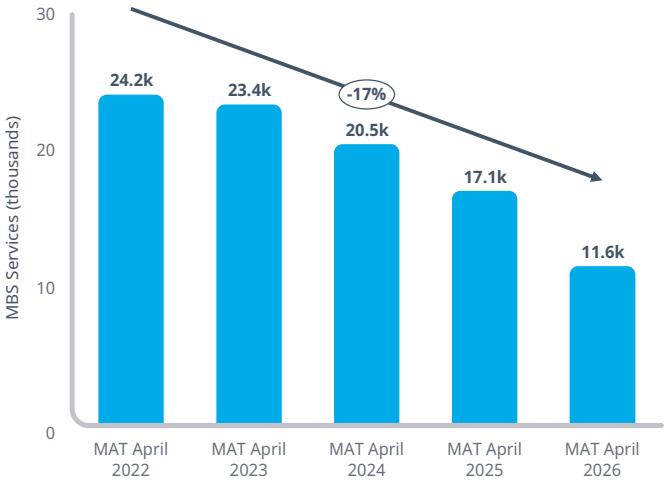
A. Volume sales for obesity management products by class



First-generation OMs: phentermine, naltrexone/bupropion
Second-generation OMs: liraglutide (Saxenda), semaglutide [Ozempic (non-PBS), Wegovy], tirzepatide (Mounjaro)

Source: IQVIA PROFITS May 2021 to April 2026

B. MBS services for bariatric surgery in Australia



MBS Item Codes 31569 Gastric Band, 31572: Roux-en-Y Gastric Bypass, 31575: Sleeve Gastrectomy, 31581: Biliopancreatic Diversion Gastric Bypass

Source: Medicare Benefits Services May 2021 to April 2026

The unprecedented demand has been observed by HCPs, with RACGP reporting in May 2025 that 49% of GPs now receive daily inquiries about weight loss medication and 14% receive multiple inquiries within a day.[6] The demand has also led to the evolution of care pathways, with telehealth platforms such as Juniper and Mosh emerging as significant prescribing channels, bypassing traditional prescribing and referral pathways entirely.[7] The rise of telehealth prescribing more broadly is leading to development of national safety and quality standards for virtual care by the Australian Commission on Safety and Quality in Health Care. Supported by the Commonwealth and the Minister for Health, these standards are due to be published by end of 2027.[8]

IQVIA's social media analysis shows there were over 85,000 social mentions of obesity in the 12 months up to April 2026 and over 427,000 Google search queries for weight loss medication in April 2026 alone.

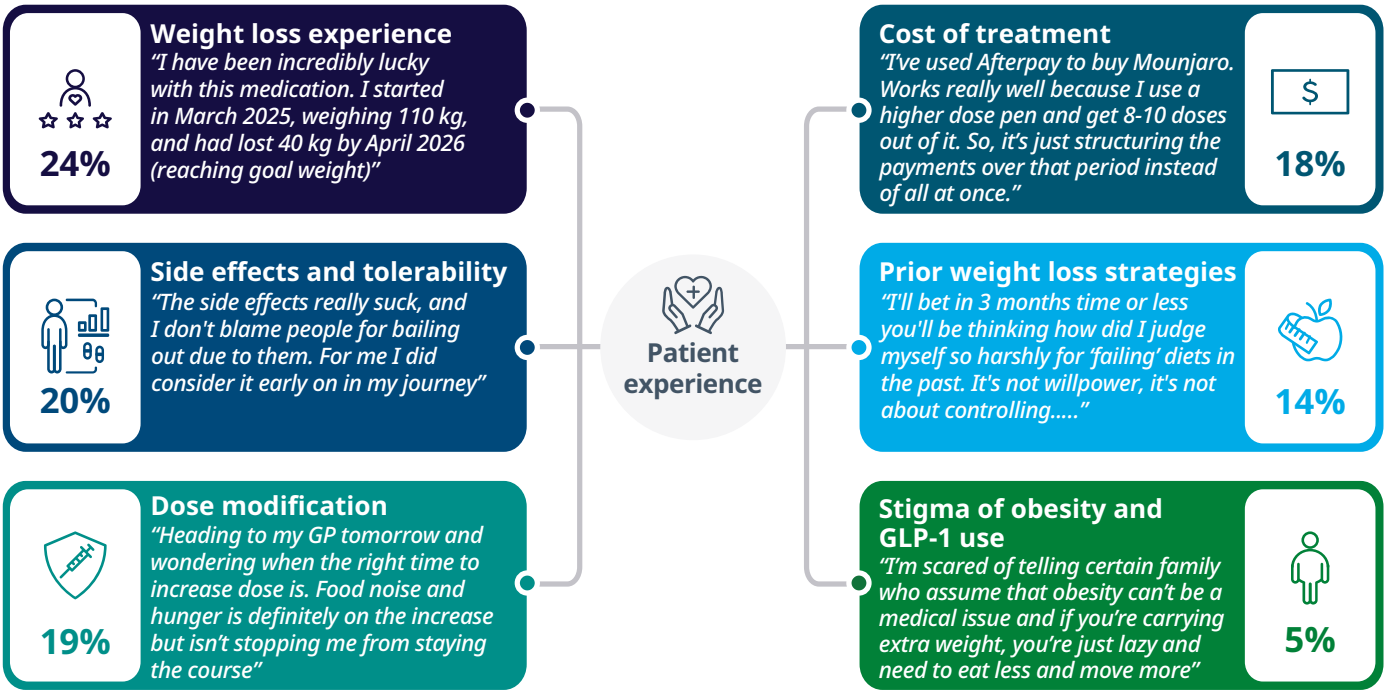
However, the private market also remains inequitable with prices ranging from $260-700 per month; access is determined by ability to pay. Research has shown that people in Western Sydney (median income $107,000), where obesity prevalence is highest, are 34% less likely to access second-generation OMs than those in affluent inner-city Sydney (median income: $113,000). In rural and regional NSW, fewer than one in ten people are accessing treatment.[9]

The obesity medication consumer

Understanding the consumer

Given the high private market uptake and consumer appetite for obesity medication, it is essential to understand the consumer and the drivers behind the use of these novel medications. We analysed 1,088 social media mentions of obesity medication with six themes standing out on patient experience while on treatment (Figure 2) and people actively seeking and sharing advice on key themes.

Figure 2: Top consumer themes for obesity medication



WEIGHT LOSS EXPERIENCE

A quarter of posts focused on the weight loss experience, including sharing success stories, treatment timelines, before and after photos, and advice sought for weight loss plateaus. While the primary focus was on weight loss, a segment of posts also focused on improvements in lipid and liver function blood work suggesting that the consumer is invested in not just tangible outcomes but the broader health trajectory.

SIDE EFFECTS AND TOLERABILITY

Nearly one in five posts focused on side effects and tolerability of therapies particularly during the initiation period. Dominant themes included gastrointestinal discomfort, nausea, and constipation. Responses showed other patients are actively engaged in peer-to-peer support, comparing remedies and reinforcing that tolerability is a short-term challenge with long-term payoff as drug levels stabilise within the body.

DOSE MODIFICATION

Another one in five posts focused on understanding dose modifications and when to up-titrate and what to consider. Interactions show consumers not only rely on HCP advice but also seek to understand others' views of sustainable weight loss rates, stalls, side effects and how to have discussions with their provider.

COSTS OF TREATMENT

The high cost of treatment remains one of the most prominent barriers to persistence within a purely private ecosystem. Consumers are actively developing and sharing affordability strategies including use of buy-now-pay-later schemes to split payments, discounted pharmacy gift-card promotions, private health insurance extras for non-PBS pharmaceuticals, and dose splitting.

Dose splitting, i.e., using a higher-strength pen to deliver lower doses, effectively extending the life of a pen, was a recurring tactic to manage costs and support treatment persistence, a practice which has been previously reported within media.[10]

PRIOR WEIGHT LOSS STRATEGIES

A segment of consumers compared their journey on medical treatment to their previous failed attempts solely via diet and exercise. These posts mentioned relief with the launch of these medications and prior self-judgement for 'failure' when weight loss attempts had failed.

STIGMA OF OBESITY AND GLP-1S

A small fraction of online commentary is on the wider societal stigma of obesity perceived as the lack of willpower from a person and purely treated as a lifestyle disease. This was then translated to unwillingness to disclose use of medication to achieve weight loss goals due to the perception that laziness was the primary cause of obesity.

The consumer profile

Beyond what patients say online, their purchasing behaviours tell an equally compelling story. To deepen understanding of the consumer, we analysed their spending within pharmacy by understanding what they buy and who the consumers are. Longitudinal retail shopper analytics reveal that people on obesity medication are a premium, high-value consumer segment with distinctive purchasing behaviours that reshape how they interact with the healthcare system.

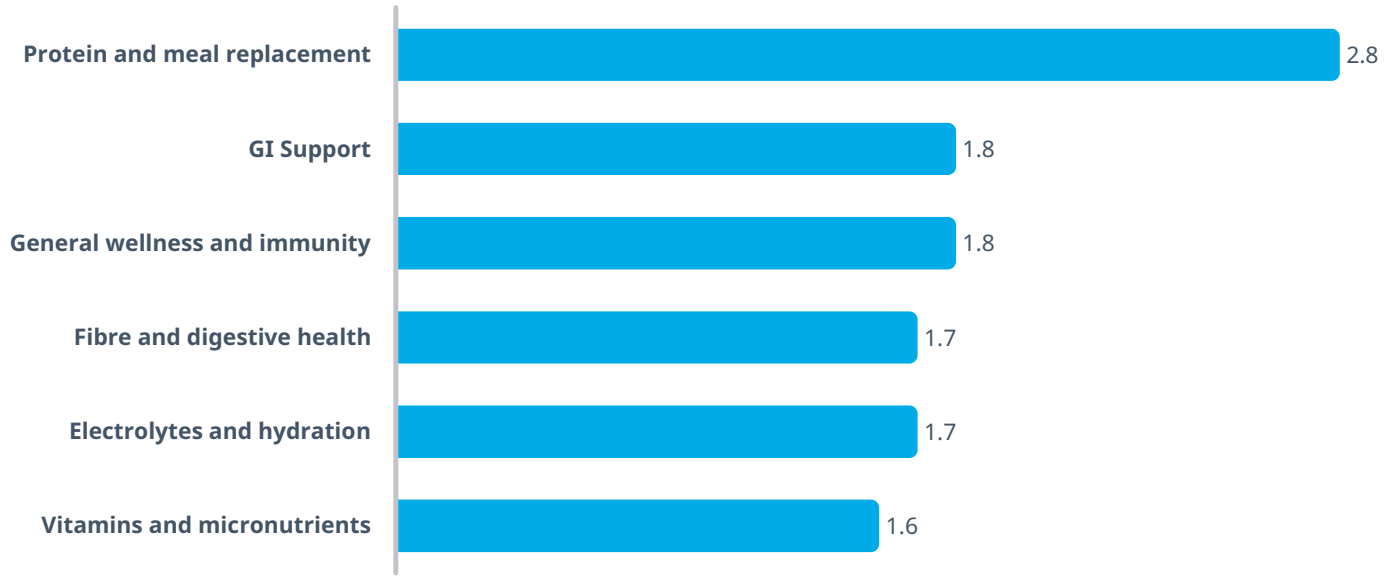
DEMOGRAPHICS

Among consumers with identifiable gender in the dataset, 71% of OM consumers are female. The female skew is even stronger for dedicated weight-management brands — Mounjaro and Wegovy both sit at 75% female — while PBS-subsidised Ozempic (for T2D) is the only near gender-balanced segment at 51.5% female.

SPENDING BEHAVIOUR

People on OM spend twice as much at a pharmacy as a typical consumer with ~94% of GLP-1 shoppers purchasing beyond their GLP-1 prescription, on adjacent consumer health categories. They over-index dramatically against non-GLP-1 shoppers and post-initiation remains high across all relevant categories. This halo of spending highlights that once medication is initiated, the shift is behavioural with impacts across the ecosystem to support several areas such as side-effect management, nutrition support to help ensure healthy weight loss (Figure 3).

Figure 3: Indexation of obesity medication consumer compared to a typical pharmacy consumer



The impact has been observed beyond pharmacy with Australia's largest retailers adapting; Coles reports double-digit growth in high-protein and fresh snacking categories and Woolworths launching GLP-1 support bundles with high-protein yoghurts seeing quarterly growth of 45%.[11]

Consumer engagement

Similarly, both sponsors have invested in direct-to-consumer disease-awareness campaigns — Novo Nordisk's "*You've Tried Everything*" and Eli Lilly's "*We Won't Weight*" campaigns with social media and physical advertisements, and dedicated websites providing consumers with resources on understanding obesity and initiating discussions with healthcare providers about medical weight management.[12,13] Broader engagement initiatives also include Novo Nordisk's partnership with Shane Warne Legacy on free health checks at the 2024 Boxing Day Test and Eli Lilly's collaboration with Oprah Winfrey on her 2025 Australia tour.[14,15]

Telehealth providers are also engaging directly with consumers via various campaigns. However, concerns have been raised in the media about the unique direct-to-consumer nature of the engagement, which has led to the TGA updating its guidance on advertising of prescription medicines to the public, guidance which applies broadly across prescription medicines and is not restricted to weight loss medication.[16,17]

The competitive landscape

Comorbidity as commercial strategy

The obesity ecosystem has evolved from a weight-loss race to a multi-indication platform competition. While efficacy in weight loss remains central to prescribing decisions, the commercial battleground has shifted to comorbidity breadth, where regulatory approvals, reimbursement narratives, and long-term defensibility are built. Real-World Evidence (RWE) was a major contributor in uncovering some of these unexpected benefits and since then Novo Nordisk and Eli Lilly have actively secured TGA approvals for comorbidity-specific indications, transforming their obesity assets into cardiometabolic franchises with further approvals expected as the evidence matures (Table 1).[18,19]

These are significant outcomes for obesity-linked comorbidities as both Wegovy became the first approved GLP-1-based obesity medication for MASH and Mounjaro the first approved medication for obstructive sleep apnoea.[20,21]

Each TGA-approved comorbidity indication expands the addressable market, strengthens payer narratives, and creates defensible commercial moats. These evidence bases are critical as the Pharmaceutical Benefits Advisory Committee (PBAC) in its advice to the Minister for Health has highlighted that PBS access to obesity medication will be prioritised for comorbidities of obesity and is unlikely to ever be funded for obesity management alone via the PBS due to the high budget impact.[22]

Table 1: Trial readouts for obesity medication in indications beyond obesity

	CV-OUTCOMES	CHRONIC KIDNEY DISEASE	PRE-DIABETES	HEART FAILURE	KNEE OA	OSA	MASH
Semaglutide (Novo Nordisk)	**SELECT** Risk reduction in MACE-3	**FLOW** Risk reduction in renal impairment, renal-/CV mortality (in T2D patients)	**STEP-10** Reversion to normo-glycaemia	**STEP-HFpEF** Functional benefits	**STEP-9** Reduction in OA-related pain; functional benefits		**ESSENCE** MASH resolution, fibrosis improvement
Tirzepatide (Eli Lilly)	**SURPASS-CVOT** MACE-3 reduction, renal protection (in T2D patients)		**SURMOUNT-1** (104-*wk extension*) Risk reduction of progression to T2D	**SUMMIT** Risk reduction in HFpEF outcomes; functional benefits		**SURMOUNT-OSA** Reduction in apnoea-hypopnea index	**SYNERGY-NASH*** MASH resolution, fibrosis improvement
Survodutide (Boehringer Ingelheim)							**SYNCHRO-NIZE-MASLD^** Liver fat reduction, normalisation; metabolic improvements
Retatrutide (Eli Lilly)					**TRIUMPH-4** Substantial reduction of OA-related pain; functional benefits	**TRIUMPH-1** Reduction in apnoea-hypopnea index	

*Indicates phase 2 trial; all others are phase 3 trials; ^Phase 3 LIVERAGE trial in progress on fibrosis improvement
Source: NCT03574597, NCT03819153, NCT05040971, NCT04788511, NCT05064735, NCT04822181, NCT04255433, NCT04184622, NCT04847557, NCT05412004, NCT04166773, NCT06309992, NCT05931367, NCT05929066

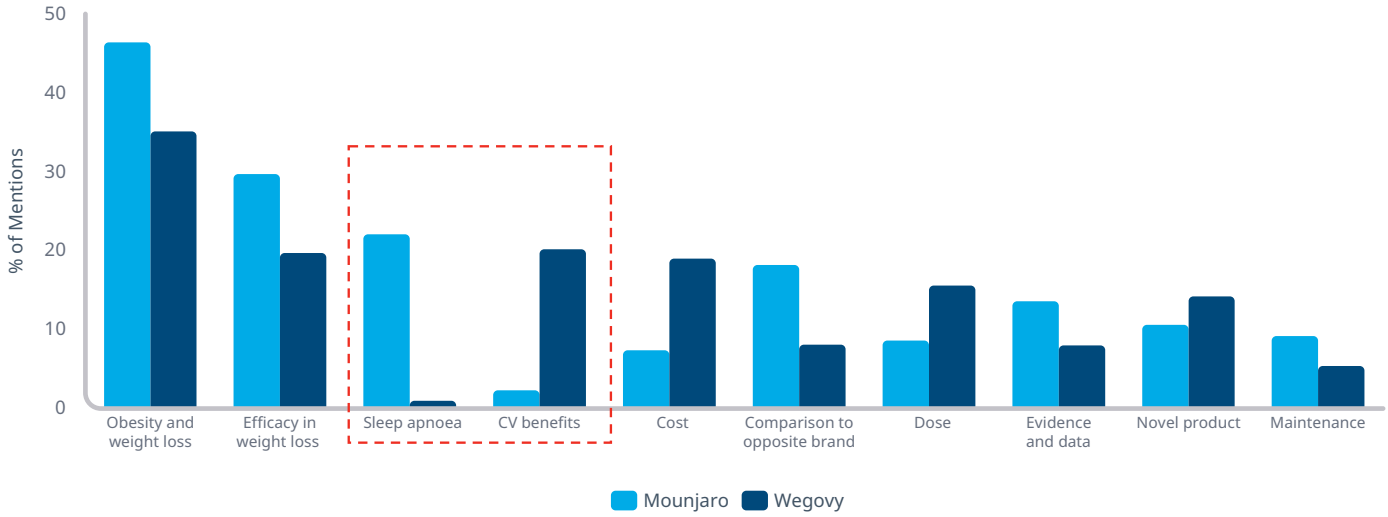
Additional approved indications

Under TGA Review

What HCPs are hearing

To understand the competitive dynamics and messaging further, we analysed HCP verbatims from over 2,000 interactions that sales representatives had for the two brands within the year up to April 2026 as captured within IQVIA Channel Dynamics (Figure 4).

Figure 4: Top 10 themes in messages to HCPs, according to verbatims



Note: n = 2,072 verbatims

These insights reveal that while both Mounjaro and Wegovy sponsors primarily focus on obesity and weight loss, the wider messaging is increasingly centred on differentiation of each brand with Wegovy sales representatives emphasising cardiovascular benefits. Mounjaro, on the other hand, led with efficacy-focused messages and comparison to Wegovy, likely based on the SURMOUNT-5 head-to-head trial readout and sleep apnoea being the main differentiator.

This mirrors global patterns observed by IQVIA across 14,000+ HCP interactions in the EU4, UK, and U.S.: messaging is shifting away from class-level education towards labelled benefits and supporting evidence. Cardiovascular benefits for Wegovy and sleep apnoea for Mounjaro/Zepbound show the highest growth in mention frequency.[23]

Crucially, our global analysis shows that efficacy in weight loss remains the message most strongly associated with high prescribing intent, while cost/reimbursement and route of administration are associated with lower intent — a finding with direct implications for oral GLP-1 launch strategy.

Future pipeline and competition

The competitive landscape is expanding beyond the Novo–Lilly duopoly with Boehringer Ingelheim announcing Phase 3 results for its GLP-1/Glucagon receptor agonist survodutide within obesity management. With a further 193 medicines currently in development for obesity — the majority GLP-1-based — the next wave of assets will compete on formulation convenience, comorbidity breadth, dosing innovation, tolerability, and affordability, not just weight loss.

IQVIA's global analysis frames the evolution in three eras: 2025–26 as the inflection point (oral launches, generic semaglutide in key markets); 2027–28 as the era of differentiation and long-term performance; and 2029–30 as the era of reckoning, where RWE determines which assets deliver system-level value.[24]

Trial readouts from selected assets under investigation highlight that several strategic signals are at play with investigational products showing maintenance strategies, new mechanisms of action, formulations, comorbidity implications, dosing frequency, and improved weight loss (Table 2). In particular, the launch of oral Wegovy and Foundayo (orforglipron), the first non-peptide GLP-1 receptor agonist will unlock a new consumer segment. Data from the first quarter of oral Wegovy launch in the U.S. showed two-thirds of patients were new to GLP-1-based obesity medication and did not cannibalise existing injectable use.[25]

Table 2: Selected readouts from phase 2 and 3 trials

	MECHANISM	TRIAL	AUSTRALIAN SITES	STRATEGIC SIGNAL
CagriSema (Novo Nordisk)	Amylin + GLP-1 Ra	REDEFINE 1	✓	Novel combination with amylin receptor agonist improving weight loss
Orforglipron (Eli Lilly)	Oral non-peptide GLP-1 Ra	ATTAIN-1	✗	First non-peptide product unlocks a new consumer segment with oral convenience
		ATTAIN-MAINTAIN	✗	Switch to oral for weight loss maintenance irrespective of primary GLP-1-based obesity medication
Tirzepatide (Eli Lilly)	GIP/GLP-1 Ra	SURMOUNT-MAINTAIN	✗	Majority of weight loss preserved with dose reduction; long-term maintenance dosing
Survodutide (Boehringer Ingelheim)	GLP-1/ glucagon Ra	SYNCHRONIZE-1	✓	Novel mechanism of action with glucagon receptor agonism; targeted visceral fat and liver fat reduction with lean mass preservation
Retatrutide (Eli Lilly)	GIP/GLP-1/ glucagon Ra	TRIUMPH-1	✓	Triple agonist; approaches bariatric surgery levels of efficacy with 29.3% weight loss
MariTide (Amgen)	Anti-GIPR Ab + GLP-1Ra peptide	MARITIME-1	✓	Monthly dosing; under investigation for improved quality of loss with muscle mass preservation. Phase 3 readout expected early 2027

Navigating the policy gap

The patient and the landscape have decisively moved ahead of the frameworks designed to guide them. Australian guidelines, reimbursement frameworks, and the national obesity strategy remain anchored to a landscape that no longer exists, creating a widening gap between how obesity is managed in practice and how the system anticipates treating it.

Where Australian guidelines sit globally

Three international and two Australian bodies have recently released or updated guidelines or consensus statements on use of obesity medication (Table 3).

The most consequential distinction is between Australian and international approaches to treatment initiation. Both EASO and AACE have transitioned to complication-driven pharmacotherapy initiation, matching treatment intensity to complication severity, with no requirement for documented behaviour modification failure.[26,27,28] In December 2025, WHO issued its first guideline on GLP-1 therapies for obesity, defining obesity as a chronic, relapsing disease and conditionally recommending long-term GLP-1 use for adults, though tempering this with calls for health system readiness, equitable access, and behavioural support alongside medication.[29] However, Australian frameworks retain behaviour modification as a prerequisite. The ADS algorithm maintains a stepwise ladder before pharmacotherapy.[30] The Heart Foundation consensus is more aligned to international consensus, removing the VLED failure requirement, maintaining the approved TGA label, i.e. BMI>27 for patients with established CVD, and naming specific obesity medications based on evidence. However, pharmacotherapy remains adjunctive to behavioural modifications, not independent of them.[31]

Table 3: Comparison of Australian obesity management guidelines/consensus to international guidelines

DIMENSION	AUSTRALIAN DIABETES SOCIETY	HEART FOUNDATION	EUROPEAN ASSOCIATION FOR THE STUDY OF OBESITY	AMERICAN ASSOCIATION OF CLINICAL ENDOCRINOLOGISTS	WORLD HEALTH ORGANISATION
Disease definition	BMI + waist circumference; complications guide escalation	Chronic, systemic condition driven by excess adiposity, BMI as primary screening + waist circumference	Adiposity-based chronic disease (ABCD): 'fat mass disease' + 'sick fat disease'	ABCD with 3-stage complication severity scoring	Chronic, relapsing disease; BMI for screening only
Treatment Gateway	Behaviour modification failure (diet → VLED → pharmacotherapy)	Behaviour modification insufficient (no VLED/dietary ladder required)	Complication-driven pharmacotherapy when behavioural changes alone insufficient	Complication severity-driven (independent of BMI)	Conditional on health system readiness; as part of multimodal long-term care
Pharmacotherapy threshold	BMI ≥ 30 after dietary failure	BMI ≥ 27 with established cardiovascular disease	BMI ≥ 25 with Waist to Height Ratio >0.5 and any impairment	Complication-driven — independent of BMI	BMI ≥ 30
Weight loss target	10-15% (BMI 30-40); ≥ 15% (BMI >40)	≥ 5% over six months	Individualised to comorbidity profile	≥15% for severe complications	No numeric target
Role of surgery	BMI ≥ 40 or ≥ 35 + comorbidities, after diet + pharmacotherapy failure		Earlier when metabolic complications present	Severe complications or inadequate pharmacotherapy response	Contingent on health system readiness

Two observations are relevant for sponsors:

- **Australian clinical consensus is no longer monolithic:** ADS and Heart Foundation diverge on threshold, sequence, and specificity. The Heart Foundation consensus statement is a meaningful step towards international alignment and acknowledgement of obesity medications in care
- **Widening gap between guidelines and practice:** With 5% of Australian adults having been prescribed obesity medication, patient willingness to seek treatment is operating well beyond the boundaries that current Australian frameworks anticipate

The PBAC journey and evidence gap

Wegovy's path to PBS listing illustrates the structural tension between clinical evidence, fiscal caution, and patient need. PBAC considered Wegovy three times and recommended on its final resubmission in November 2025 for patients with eCVD with obesity (BMI >35 or BMI > 32.5 for high-risk Aboriginal and Torres Strait Islander and Asian populations). The recommendation also proposed a risk share agreement with 100% rebate above the caps required to mitigate the budgetary impact of risk of use associated outside the proposed restriction.[32] However, PBS listing is still not guaranteed and as of June 2026, no agreement on listing arrangements has been made.[33]

Mounjaro for T2D was recommended by the PBAC on its fourth submission; however, Eli Lilly decided not to proceed with the PBS listing due to the disagreements on the proposed price, reinforcing broader challenges with reimbursement mechanisms.[34,35]

At the November 2025 meeting, the PBAC also provided formal advice to the Minister for Health on his request regarding equitable access to GLP-1 obesity treatments through the PBS.[36] PBAC's response identifies priority populations and conditions for a managed rollout:

Priority populations identified:

- Aboriginal and Torres Strait Islander patients with obesity-related comorbidities
- People with syndromic obesity
- People with medication-induced obesity
- Patients requiring weight loss to be eligible for surgery
- Incremental expansion into T2D + high CV risk, CKD, OSA, and MASH populations

PBAC also acknowledged "merit in preventative use of GLP-1s to avoid obesity-related complications" but stated this would not be possible under PBS funding due to budget impact. The message is clear: expansion will be incremental, comorbidity-driven, and fiscally constrained.

The need for Real-World Evidence

The common thread in the PBAC perception across Wegovy recommendation and advice to the Minister: insufficient RWE on long-term outcomes, cost-effectiveness in local populations, and system-level impact. The challenge is compounded by trial population demographics, with IQVIA analysis of seven Phase 3 trials finding that none were representative of the heterogeneity of people living with obesity in the real world.[37]

As obesity assets build evidence within comorbidities, it is important to build RWE demonstrating the impact of OMs on the patient journey, health outcomes, and cost offsets to the broader system. The Scotland Cardiometabolic Impact Study is an initiative funded by the UK Government and led by the NHS Scotland Chief Scientific Office and delivered by IQVIA, Novo Nordisk and the Universities of Glasgow, Dundee, and Edinburgh. The study is designed to address the disproportionate burden of obesity in low socioeconomic areas and its impact on cardiometabolic outcomes and healthcare resource utilisation to inform a wider roll out of GLP-1-based OMs.[38] Similar studies in Australia will be critical to understanding the impact of these therapies and accurately informing the Commonwealth's health and reimbursement strategy as further products are launched over the next few years.

Strategic tensions to watch

Australia has already entered its obesity inflection point; the question that now remains is how quickly the policy and funding landscape can adapt to it. Our analysis highlights four tensions that will define the market over the next three to five years:

1. **Guidelines vs. market reality**: Australian consensus remains comparatively conservative; over a million people have already moved to pharmacotherapy. The Heart Foundation consensus is a step towards international alignment, but ADS maintains a stepwise ladder that no longer reflects how obesity is being managed in practice. The legitimacy gap will close — but given the recency of guideline update, the timing and direction of guideline evolution remain uncertain.
2. **TGA vs. PBAC**: TGA is approving comorbidity indications rapidly (four new indications since Aug 2024). PBAC reimbursement lags significantly, creating a growing asymmetry between what is approved and what is funded. Wegovy's narrow cardiovascular recommendation and Eli Lilly's decision not to proceed with Mounjaro PBS listing for T2D signal broader challenges with reimbursement mechanisms in Australia.
3. **Private vs. public access**: The exclusively private market system is unsustainable. The equity argument is sharpening, particularly for areas with high obesity prevalence and low incomes where people who need treatment most are least able to access it. The existing market also presents an evidence challenge with the largest real-world obesity medication cohort in Australia currently sitting outside any systematic outcomes collection, leaving policymakers, payers and sponsors without the data required to guide that transition.
4. **The informed consumer**: Patients on obesity medications are not passive recipients of care but active market participants. They are reshaping the consumer health landscape through purchasing behaviours, channels of care, peer-to-peer influence, and social media-driven brand comparison. Understanding their motivations, persistence drivers, and spending patterns is now equally important as understanding prescriber behaviour and clinical pathways. Strategies that do not engage the person on obesity medication fail to understand the ecosystem that has been rapidly created and continues to evolve.

About IQVIA

IQVIA is a global provider of advanced analytics, strategy advisory services, and clinical research services. We collaborate with policymakers, health systems, payers, life science companies, and researchers to uncover critical insights and deliver end-to-end solutions across the obesity landscape. IQVIA provides services based on best practices to help adapt to a rapidly evolving healthcare landscape.

- Launch strategy
- Product value proposition
- Access and pricing strategies
- Competitive intelligence
- Real-World Evidence generation and registry design
- Development and costing models of care

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Hassan is a Senior Consultant within IQVIA Australia and New Zealand Management Consulting team. Prior to joining IQVIA in 2019, he spent a decade in biomedical research. Hassan's experience includes advising sponsors on go-to-market strategy, market analysis, real-world data insights, and market access strategy. His recent focus spans obesity, cardiometabolic health, oncology and cell and gene therapy.

Hassan holds a Master of Business Administration from the University of Queensland and a Bachelor of Biomedical Science (Hons) from Monash University.

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Steven Wang, Principal, Data Science

Anna Williamson, Senior Consultant, Real World Evidence and Medical Affairs Solutions

Data sources and methodology

Patients on obesity medication

Patient-level dispensation data is captured by NostraData, which is based on anonymised patient-level longitudinal prescribing history and can delineate use for obesity management vs. Type 2 Diabetes. The information is collected directly from pharmacies and NostraData coverage for obesity medications is approximately 82% of retail pharmacies across Australia.

Volume sales

Volume sales are captured in IQVIA PROFITS capturing sales to 96% of retail pharmacies and hospitals within Australia.

HCP messaging

The data used for this analysis is from IQVIA Channel Dynamics™ database, which captures spontaneous HCP recall of messages communicated during interactions with customer engagement teams. HCPs responded to the following prompt:

"Please describe, in as much detail as possible, all of the points communicated by the representative during the product presentation"

2,072 verbatims from General Practitioners and Endocrinologists between May 2025 and April 2026 were analysed to develop themes in engagement messaging.

Social media intelligence

Social media mentions were captured for 12 months between May 2025 and April 2026 with analysis including but not limited to X (formerly Twitter), Facebook, Reddit, Instagram, and Tumblr.

Consumer health data

Shifts in consumer health categories were determined by using IQVIA point of dispense and point of sale data.

List of abbreviations

ABBREVIATION	DEFINITION
AACE	American Association of Clinical Endocrinology
ABCD	Adiposity Based Chronic Disease
ABS	Australian Bureau of Statistics
ADS	Australian Diabetes Society
AIHW	Australian Institute of Health and Welfare
BMI	Body Mass Index
CAGR	Compound Annual Growth Rate
CKD	Chronic Kidney Disease
CV	Cardiovascular
CVD	Cardiovascular Disease
CVOT	Cardiovascular Outcomes Trial
EASO	European Association for the Study of Obesity
eCVD	Established Cardiovascular Disease
EU4	Four largest European Union markets (France, Germany, Italy, Spain)
GI	Gastrointestinal
GIP	Glucose-dependent Insulinotropic Polypeptide
GLP-1	Glucagon-Like Peptide-1
GP	General Practitioner
HCP	Healthcare Professional
HFpEF	Heart Failure with Preserved Ejection Fraction
LED	Low Energy Diet
MACE	Major Adverse Cardiovascular Events
MASH	Metabolic Dysfunction-Associated Steatohepatitis
MAT	Moving Annual Total
MBS	Medicare Benefits Schedule
NHS	National Health Service
NSW	New South Wales
OA	Osteoarthritis
OM	Obesity Medication
OSA	Obstructive Sleep Apnoea
OTC	Over the Counter
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
RACGP	Royal Australian College of General Practitioners
RED	Reduced Energy Diet
RWE	Real World Evidence
T2D	Type 2 Diabetes
TGA	Therapeutic Goods Administration
UK	United Kingdom
US	United States
VLED	Very Low Energy Diet
WHO	World Health Organization

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