White Paper

The Belgian Shift in Anti-Obesity Medicines

How physicians, pharmacists, and patients are reshaping demand

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Executive summary

IQVIA Belgium initiated this white paper in response to strong indicators from its sales data: the Anti-Obesity Medication (AOM) market in Belgium is expanding rapidly, because of a high prevalence of obesity, despite the absence of reimbursement. With recent product launches and a robust pipeline of AOMs, the IQVIA team aimed to provide a comprehensive, up-to-date view of this evolving market — examining both Healthcare Professional (HCP) prescribing behaviour and patient perspectives. The findings presented here offer a multi-angle assessment of obesity care in Belgium as of 2025.

Obesity is a growing public health challenge in Belgium, with 49% of the population overweight and 18% living with obesity.[1] Projections for 2030 suggest further increases. In response, the use of Anti-Obesity Medications (AOMs) has surged, with the number of treated patients tripling between 2022 and 2025. This growth marks a tipping point in obesity care, with General Practitioners (GPs) increasingly initiating treatment, signalling a shift into mainstream primary care management.

Despite similar obesity prevalence across genders, women represent ~70% of AOM users, probably due to higher commitment due to prior weight-loss attempts. In contrast, men primarily consult their GPs, and due to their cardiometabolic profiles, AOM treatment may be a lower priority for them. Pharmacists, though trusted and accessible, remain underutilized in guiding patients toward AOMs, despite frequent interactions with patients with obesity and early signals of intent, such as supplement purchases.

Persistence and adherence remain a challenge: Most patients discontinue treatment within six months, and those who remain on treatment are not consistent in their schedule. Reasons are probably linked to mismatched expectations, side effects, and cost concerns. The first 8–12 weeks of therapy are critical, requiring structured support, realistic goal setting, and milestone tracking beyond weight loss alone.

IQVIA's national patient survey (see Appendix III) reveals strong willingness to pay for effective weight loss, with preferences shaped by income, age, comorbidities, and prior experience. Four distinct patient personas — Empowered Doers, Overwhelmed Fighters, Isolated Aware, and Weight Conformists — highlight the diversity of motivations and barriers across the population. Tailoring communication and support to these personas can improve engagement and outcomes.

For pharma companies, the evolving landscape calls for broader GP engagement, pharmacist activation, and patient-centric onboarding strategies. Monitoring early signals and aligning treatment experiences with patient expectations will be key to sustaining long-term demand and improving health outcomes.

Introduction

People living with excess weight are increasingly common across Belgium. According to Sciensano's 2022–2023 Food Consumption Survey, nearly half of Belgians (49%) are overweight, with approximately 18% classified as obese.[1] These figures are not just statistics, they highlight the need of addressing obesity not merely as a lifestyle issue, but as a chronic disease with far-reaching implications for individuals, healthcare systems, and society at large. The trends are troubling. Obesity rates for both men and women have risen in recent years, with growth rates among men being higher than for women, and with the overall burden continuing to grow.[1, 2] Regional disparities are observed, with Wallonia showing higher prevalence rates than other regions in Belgium.[2] Socioeconomic factors play a significant role, as individuals with lower educational attainment and financial hardship are disproportionately affected. Alarmingly, the issue extends to younger populations — overweight and obesity are increasingly prevalent among adolescents, with projections for 2030 indicating a continued rise, particularly among children and teenagers. Projections for 2030 suggest that these patterns will intensify, with obesity expected to affect over a quarter of adult men and nearly one-fifth of women.[3]

Recognizing obesity as a chronic disease, the Belgian Association for the Study of Obesity (BASO) calls for a comprehensive, multidisciplinary response. This is especially relevant as the therapeutic landscape evolves. Anti-obesity medications (AOMs through this article refer to both on-label medications for obesity or medications commonly used in weight management (see Appendix I). In Belgium, none of the AOM are reimbursed, therefore, all data shown below means that the patient paid fully out of pocket. AOMs are gaining traction, not only for their direct impact on weight but also for their potential to address related conditions such as, amongst others, type 2 diabetes, cardiovascular disease, and kidney disease. These innovations will likely reshape treatment pathways, introduce new competitive dynamics, and demand coordinated decision-making across healthcare specialties.

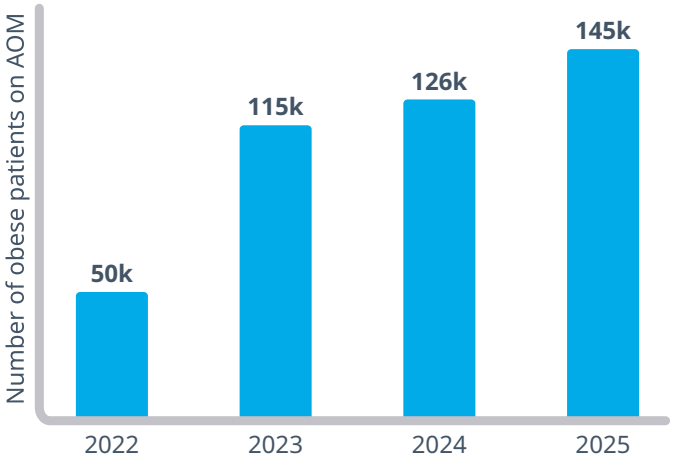
This white paper offers a deep dive into the current state of AOM use in Belgium. It explores patient demographics, prescribing patterns across general practitioners and specialists, and the growing demand of these therapies despite the lack of reimbursement — highlighting patients' willingness to pay out-of-pocket and what factors are at play. We also share insights from a national patient survey that explores the journey to AOM initiation, motivations for treatment and the patient perspectives on the roles of various healthcare stakeholders. Additionally, IQVIA is exploring insights from social media listening to reveal the most discussed themes and concerns surrounding obesity in the public discourse. Previous insights from such a study in other countries revealed that obesity management generates extensive online discussion, with patient experiences largely positive but accompanied by concerns about side effects and costs. Healthcare professionals significantly influence treatment decisions, highlighting the need for ongoing insights into patient perspectives as the AOM market evolves.[4, 5] Results for Belgium are not shown here, but are available upon request.

By bringing together patient perspectives and market dynamics, this white paper aims to provide an up-to-date landscape assessment on the use of AOM in Belgium.

Market tipping point

Belgium's obesity burden is rising while care remains fragmented. The question is no longer whether AOMs will reshape care, but how fast and through whom. In just a few years, Belgium's (prescription bound) AOM market almost tripled the number of on-drug patients, from around 50,000 patients in 2022 to more than 145,000 today (see Figure 1). These numbers are related to sales towards patients with obesity. Note that AOMs are not reimbursed and refer not only to brands like Mounjaro, Ozempic, or Wegovy but also to others like Orlistat or Mysimba, the full list can be consulted in Appendix I.

Figure 1: Evolution of on-drug obese patients on AOM



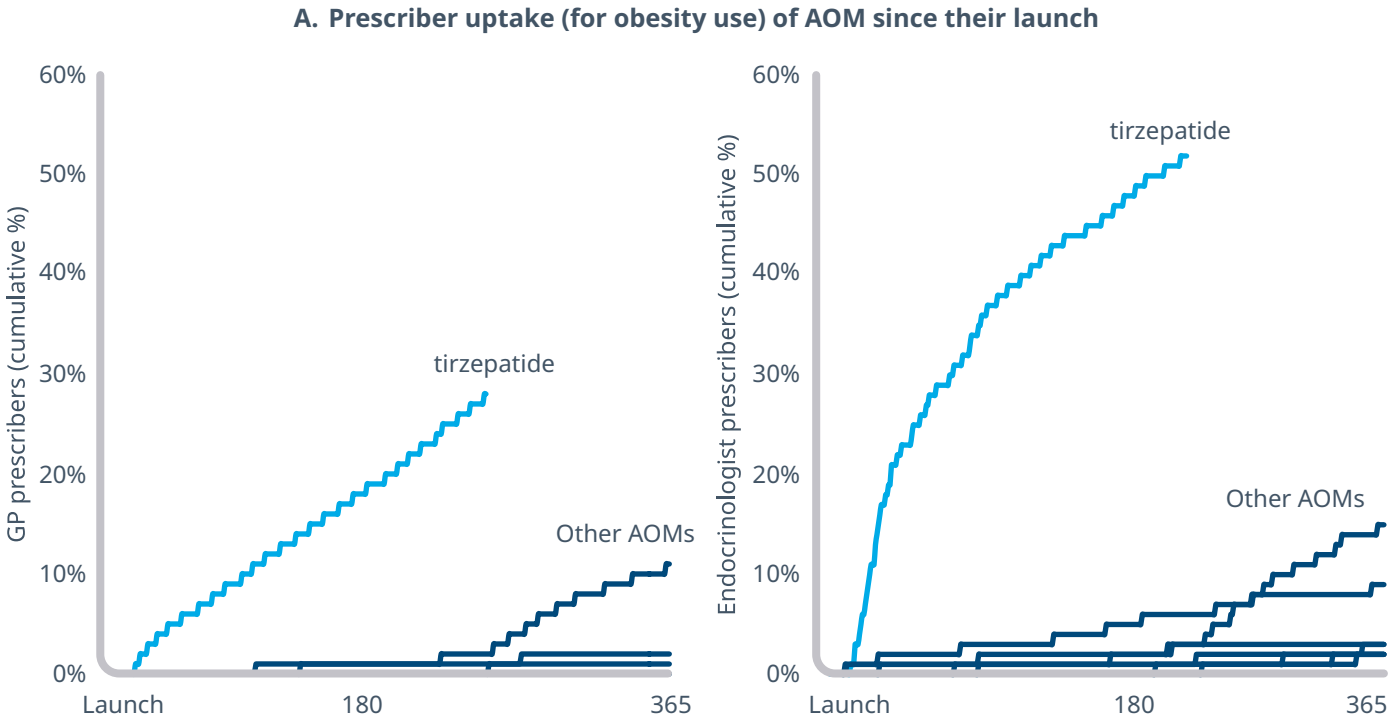
Source: IQVIA longitudinal patient prescriptions data (LRx) – extrapolated patient counts
Notes: Each period (year) represents a moving annual total from May (eg. "2025" is data covering MAT May 2025, which is June 2024 until May 2025). The AOM market includes: buproprion/naltrexone, dulaglutide, liraglutide, orlistat, semaglutide and tirzepatide (excluding diabetes use)

It means that for a meaningful amount of people living with obesity, pharmacotherapy has become an accepted part of care. The way prescribers behave confirms this shift. Before the most recent launch wave, AOM brands built slowly where prescribing uptake sat with a reduced group of early-adopting GPs (~10%) and Endocrinologists (~15%). The pace and breadth of GP adoption following tirzepatide's launch (November 2024) stands out as uncommon for new therapies in this domain, as illustrated in Figure 2A. Tirzepatide reached

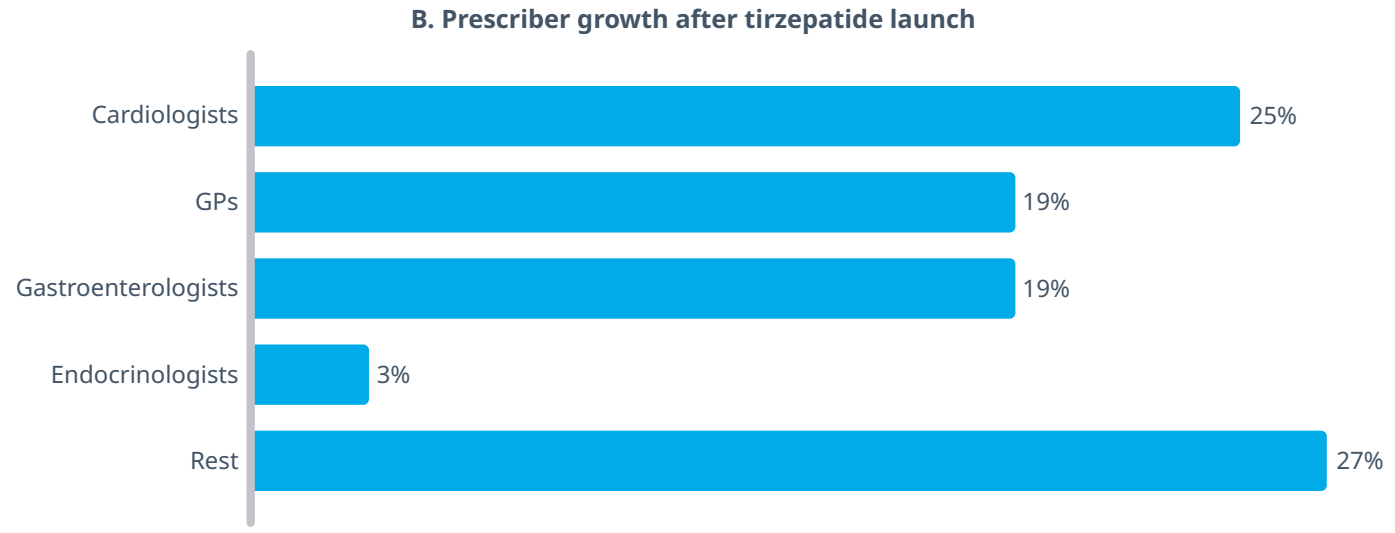
roughly 30% of GPs and about half of endocrinologists in around six months. This is the pattern of a category tipping point, once efficacy is believed to be meaningful and predictable, momentum begins to build and diffusion follows in the peer network, especially in primary care, rather than remaining restricted by specialist initiation.

Since tirzepatide's launch, the number of GP prescribers of AOMs has risen from approximately 6,000 to 7,300, representing a 19% increase. Given that Belgium has around 15,000 active GPs, this reflects a notable expansion in engagement. Cardiologists, gastroenterologists, and other specialties have also shown double-digit growth in prescribing activity (see Figure 2B).

Figure 2: Prescriber uptake of AOM since their launch



Source: IQVIA LRx data
Note: Each AOM uptake was normalized to its launch date



Source: IQVIA LRx data
Notes: Growth represents increase in number of prescribers between May 2024–Oct. 2024 and Nov. 2024–April 2025, as tirzepatide was launched in Belgium in November 2024

Concentration adds a useful nuance. The rise in AOM prescribing is not driven by a handful of existing high-prescribing doctors increasing their volume. Rather, it reflects modest contributions from a growing number of new prescribers (Figure 2B), pointing to broader engagement across the medical community.

This pattern signals true market expansion, more physicians are entering the market, not just deepening activity within a narrow cohort. However, the high increase in prescribers after Mounjaro's launch might be due in part to an effect of Belgium's rules. Belgium enacted a Royal Decree in 2023 restricting GLP-1

prescribing during shortages, describing curbs on a list of AOMs for weight and prioritization of diabetes, however, Mounjaro (tirzepatide) is not subject to the decree.[7]

For pharma, that changes the route to impact. The job is not to intensify a small cohort already familiar with AOM, it is to support a much broader set of clinicians who are relatively new to AOM, who may have different habits, e.g. around patient monitoring and follow-up, so support and education must be tailored accordingly.

This diffusion pattern also reframes obesity care itself. Following the results from the SELECT trial, GLP-1 based regimens might now be considered alongside blood pressure treatment, lipid lowering, and diabetes control as a tool for reducing cardiometabolic risk.6 When treatment options address both obesity and its associated cardiovascular burden, GPs may feel more confident initiating care for obese patients.

As more patients begin therapy and more prescribers engage, obesity care is becoming part of mainstream primary care. The next frontier is not just starting treatment — but sustaining it.

Who purchases AOM?

A notable characteristic of the current treated population is its gender distribution: approximately 70% of anti-obesity medication (AOM) users are women (*source: IQVIA LRx data, measured in July 2025*). This female predominance is unlikely to reflect the underlying epidemiology. Instead, it likely stems from pathway effects (how people enter care and who converts), alongside differences in access, healthcare-seeking behavior, affordability, and treatment channels.[8,9]

In June 2025, IQVIA conducted a single-wave quantitative survey among patients with overweight or obesity (BMI ≥ 27 kg/m^2), yielding 133 completed responses (see Appendix III). The survey showcases how women report high engagement with self-management (60% of them follow a diet and 65% also exercise). Women also report higher rates of depression (23% vs 10% for men) and are more likely to visit no clinician at all (28%). By contrast, men seek more GP contact (86% vs 41% for women), have more often cardiometabolic issues, more cases of diabetes (24% vs 5%) and high cholesterol (22% vs 12%), and more men have hypertension (29% vs 17%), see Table 1.

Table 1: Characteristics of the obesity study population (*see Appendix III*)

	OVERALL	WOMEN	MEN
Sociodemographics			
Sample	133	75 (56%)	58 (44%)
Age, mean	52	49	56
Time dealing with obesity			
1-2 years	14 (11%)	9 (12%)	5 (9%)
3-5 years	27 (20%)	16 (21%)	11 (19%)
More than 5 years	64 (48%)	33 (44%)	31 (53%)
Comorbidities			
None	26%	28%	24%
High blood pressure/Hypertension	23%	17%	29%
Arthritis	17%	17%	16%
Depression	17%	23%	10%
High cholesterol	17%	12%	22%
Diabetes	14%	5%	24%
Heart disease	11%	8%	14%
Obstructive sleep apnea	8%	5%	10%
Fatty liver disease	4%	7%	0%
Other	8%	12%	3%

Table 2: Weight loss efforts (*see Appendix III*)

WEIGHT LOSS ATTEMPTS	OVERALL *(N = 133)*	WOMEN *(N = 75)*	MEN *(N = 58)*
Are you currently trying to manage your weight or lose weight? (yes)	76%	75%	78%
Exercise	72%	65%	82%
Diet	51%	60%	39%
OTC food supplements	9%	10%	8%
Anti-obesity medication (Rx)	8%	10%	6%
Behavioral or psychological support	5%	5%	6%
Bariatric surgery	3%	3%	2%
Have you ever paid out of pocket for any weight loss or program? (yes)	39%	44%	33%
Less than €50	21%	21%	21%
Between €50 and €200	54%	48%	63%
More than €200	12%	18%	0%
Who do you see to treat your condition?			
GP	61%	41%	86%
Nobody	20%	28%	9%
Dietitian	19%	23%	14%
Pharmacist	12%	11%	14%
Cardiologist	8%	5%	12%
Physiotherapist	5%	7%	2%
Psychologist	1%	1%	0%
Endocrinologist	7%	9%	3%

Before outlining two illustrative treatment funnels derived from these market insights, note that they are simplified signals. Real patient journeys are often hybrid, especially for people managing multiple conditions, who may follow paths involving both General Practitioners (GPs) and specialists at different stages of care.

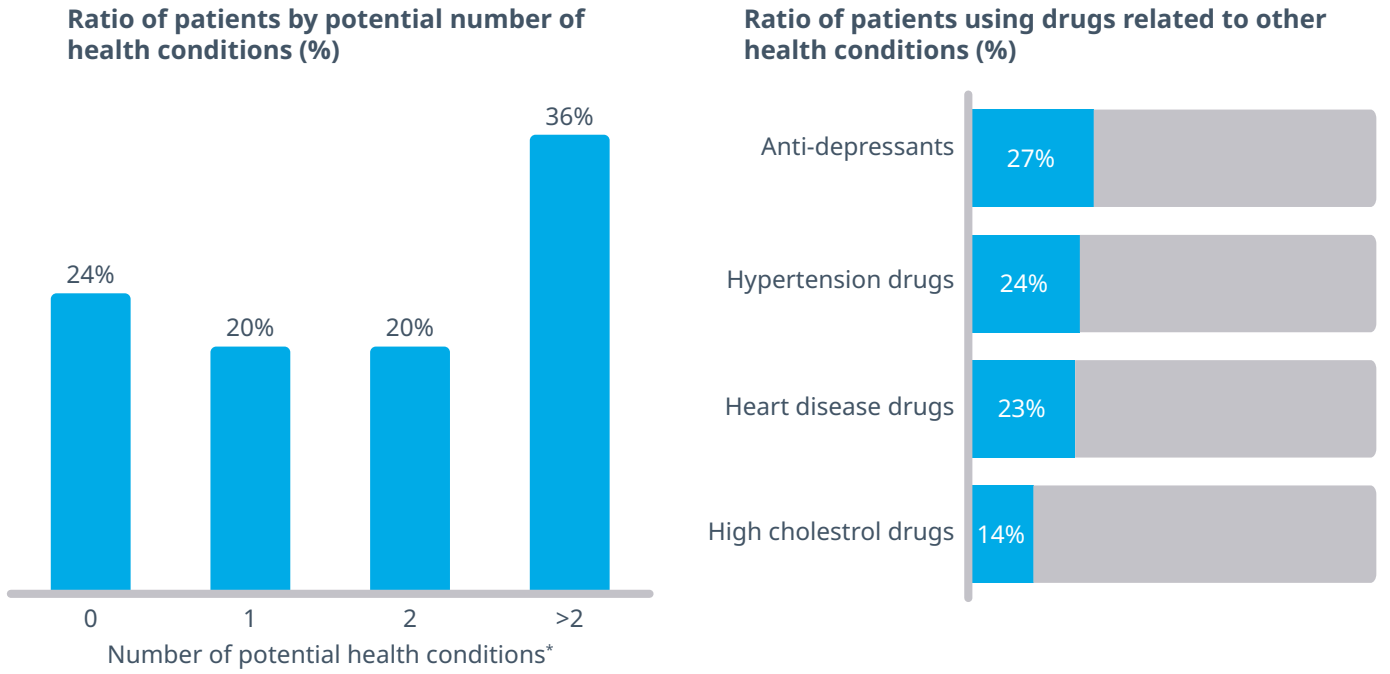
Funnel one is self-management-centric: individuals (often women) begin with lifestyle changes (diet, exercise), paid weight-loss programs (44% women vs 33% men), OTC supplements (10% women vs 8% men), and they consult dietitians more (23% women vs 14% men). One third of the people in this funnel do not have any HCP contact to manage their condition. When they do not see progress, they arrive at their GP primed to escalate and ready to discuss AOMs. This combination (accumulated effort, clear intent, and an available prescribable option) produces high conversion from request to prescription.

Funnel two is GP-centric: individuals (often men) with clear cardiometabolic risk factors present in primary care, where Anti-Obesity Medication (AOM) is considered as part of a broader risk management strategy alongside statins, antihypertensives, or diabetes treatments. GP adoption of AOMs has risen as seen before, but not every visit results in an AOM start.

There is another layer, the comorbidity picture among treated patients. Using longitudinal patient data (LRx), it was found that 24% of AOM users did not take any treatment associated with comorbidities, however, a sizeable share purchased treatments for

depression (27%), hypertension (24%), heart disease (23%), or high cholesterol (14%), see Figure 3. Note that diabetic patients were not included in this analysis (by excluding all metformin users), see Appendix II. While purchase history does not equal diagnosis, it might indicate that there is a substantial share of obese patients suffering from other health conditions. Having said that, this mix likely includes both people with diagnosed, risk-driving conditions and people at earlier or under-recorded stages. For pharma teams, that heterogeneity matters. Some patients will be motivated by a clear promise of risk reduction (e.g., blood pressure and glycemic improvements alongside weight loss). Others respond to everyday gains they can feel (less tiredness, better sleep, better mobility, fewer aches, and more capacity for work and family activities), even when no formal diagnosis is on record.

Figure 3: Distribution of obese patients taking AOM with other potential health conditions*



Source: IQVIA LRx data

*"Potential health conditions" refers to patients purchasing products related to other health conditions. See Appendix II for more information

Spending patterns from our survey in obese patients reinforce the gender split, see Table 2. Women report meaningful monthly spending on weight-loss programs and products (48% between €50–€200 and 18% over €200, monthly spending over the last 6 months). Men concentrate in the €50–€200 band (63%). This does not map neatly to AOM conversion, which might suggest it is not willingness to pay that drives the gender skew. The decisive factor appears to be the presence of a bridge from self-management to prescribing. When the entry point is a dietitian or pharmacy, conversion occurs when there is a clear hand-off to GP or endocrinology and realistic expectation-setting about treatment journey, escalation, and cost. When a patient with a high-risk cardiometabolic profile starts their journey with a GP visit, AOM may not be the primary focus of the consultation. For companies, understanding where each group starts, and what signals trigger escalation, helps explain today's mix and points to where tomorrow's growth will come from.

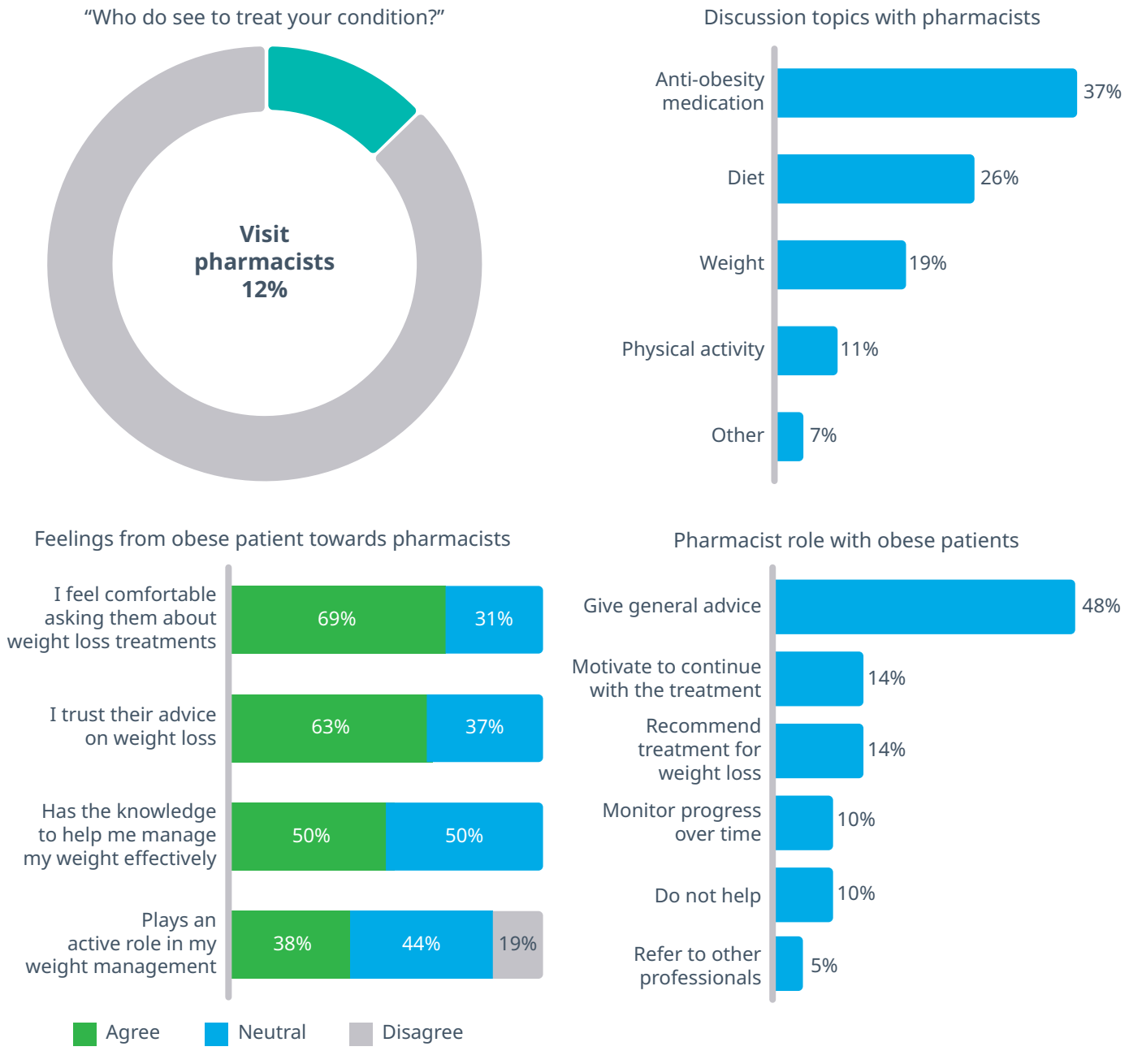
Women dominate AOM use because self-management-first pathways bridge to GP prescriptions. Men dominate GP-led care, but with multiple cardiometabolic risk factors, these contacts may focus on other solutions prior to AOM.

What is the role of the pharmacist?

Before a patient ever takes their first dose of an AOM, many leave a trail of intent. One of these trails is in the pharmacy channel, 11% of AOM starters bought weight-loss supplements beforehand according to our most recent data (LRx data), it therefore excludes online purchases, the true figure will therefore be higher.

Another trace appears in our patient survey. In our obesity survey, 46% of the respondents who visit pharmacies felt that pharmacies play an active role in weight management, see Figure 4. About 12% of patients report engaging a pharmacist on weight-related topics. When they do, the discussion often touches directly on AOMs (37%), diet (26%), or weight in general (19%). However, according to an IQVIA study, a clear role that pharmacists could play is the discussion of nutritional support during the use of AOMs.10 Yet what obese patients report discussing with pharmacists is mostly general advice (48%), with smaller shares dedicated to motivating continuation (14%) or recommending treatment (14%).

Figure 4: Pharmacist role with obese patients



Source: IQVIA obesity study with 133 respondents, see appendix III

Pharmacists are trusted (63% of obese patients agree), approachable and seen as accessible sources of information (69% agree), and close to the lived reality of adherence and side effects. The combination of frequent, relevant conversations but modest action (only 14% of the patients stating that their pharmacist recommended a treatment for weight loss, 10% monitored them and 5% referred them to other professionals) defines a “near-miss” moment in the journey. Many patients are ready to talk, are already investing on weight-loss products, and are curious about medicines. Yet they leave without a clear next step. Pharmacies also sit on rich, real-time signals. Patients purchasing weight-loss supplements could often precede doctor visits. Add to that the telling behaviors (e.g., asking about side effects, requesting a different brand, price sensitivity at the counter), and pharmacies become the earliest window into a patient’s readiness and barriers. Understanding which pharmacies sell weight loss supplements more often can be very interesting learning opportunities for pharmaceutical companies in addressing the drivers and barriers more broadly. Without a strong, shared protocol with local GPs and specialists, it is natural that often the conversation stays cautious between pharmacists and patients, but in the case of AOM, where initiation is linked to pathways, this is a missed bridge.

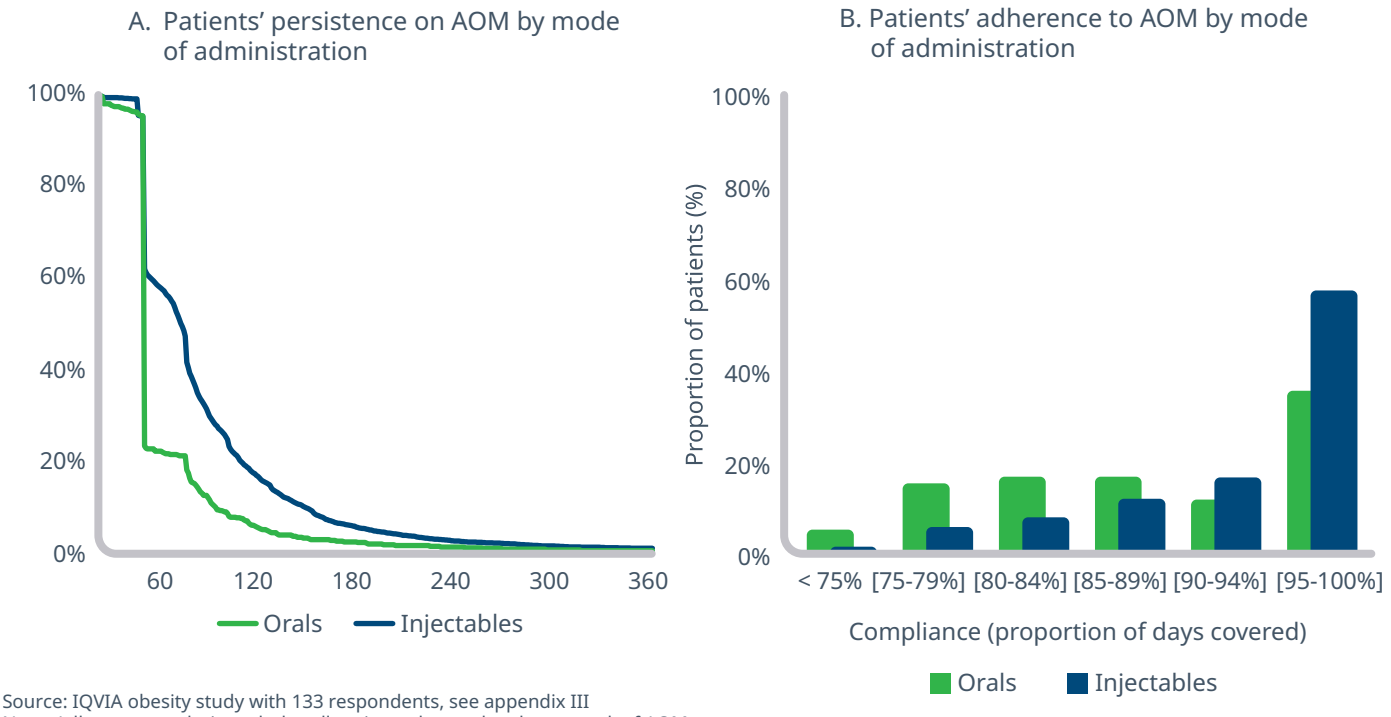
Pharmacists are perceived as trusted and accessible HCPs, but they often miss the opportunity to recommend treatments or refer patients to doctors. By enhancing tools, training, and collaboration with other HCPs, pharmacists could significantly strengthen their role in supporting patients through the obesity journey and see it as a source of business for themselves in the nutritional support area.

The persistence problem

Persistence and adherence remain low, with gaps visible even in the early weeks. On paper, one might expect obesity medicines to succeed if patients follow the regimen faithfully. Yet the data tells a different story. At 12 months, persistence is low across the board with just a few users of injectables and orals remaining on therapy, see Figure 5A. In fact, majority of users seem to use injectables for just a few months (1 to 3 months), and ~80% of oral users stop treatment after the first month.

Adherence was measured by excluding "one-shot" users, and the results show a weak compliance even during active treatment. Fewer than half of patients on injectables achieve high compliance (meaning that they went ahead and purchased another pack of injectables right after their current box was finished), and among oral users only about a third do so, see Figure 5B. This suggests not just early discontinuation, but also inconsistent use while on therapy.

Figure 5: Patient dynamics



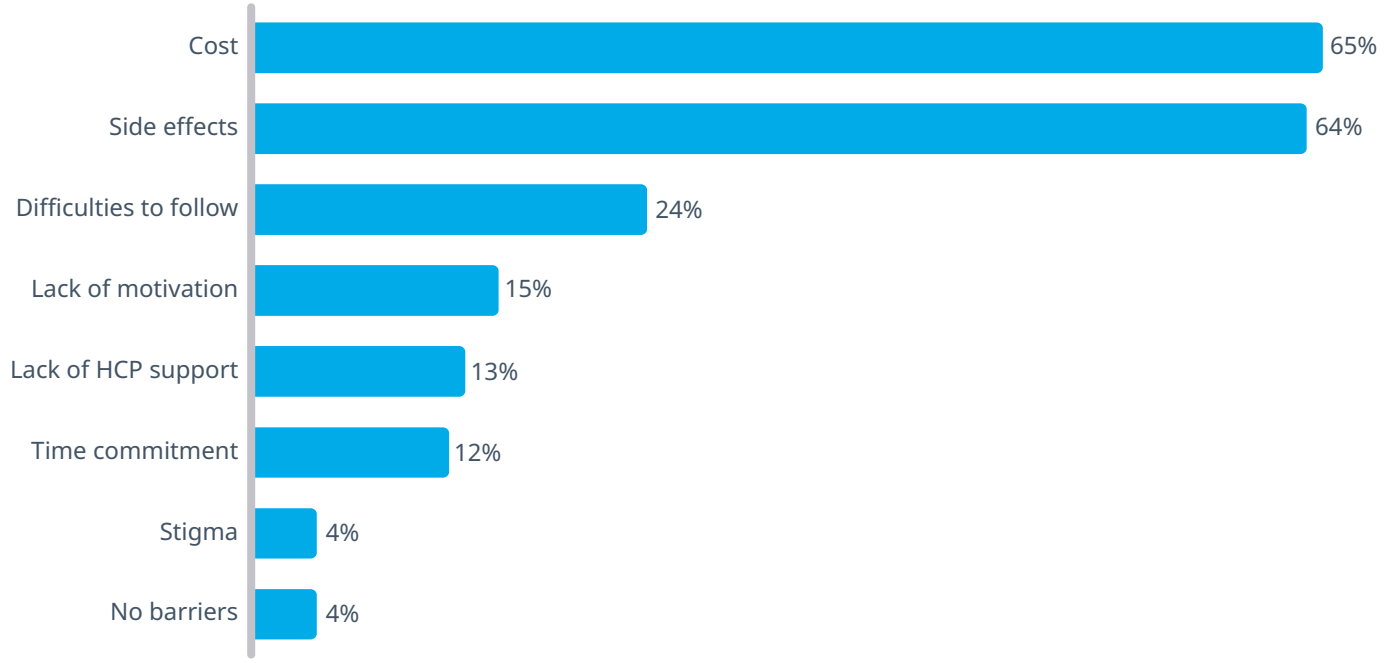
Source: IQVIA obesity study with 133 respondents, see appendix III
Note: Adherence analysis excludes all patients that took only one pack of AOM

The reasons can be found within the first 8–12 weeks, where expectations, side effects, affordability, and professional support collide. Patients often start therapy with high hope, driven by success stories from peers or social media. They expect rapid and visible weight change. But dose escalation schedules can delay the expected efficacy, while gastrointestinal side effects appear quickly after initiation. If those effects are not anticipated and normalized by healthcare providers, patients respond by skipping doses, stretching intervals, or self-adjusting regimens. For some, the calculation is pragmatic: if the scale does not move as imagined, and side effects add friction, the incentive to keep paying out-of-pocket weakens.

The oral versus injectable split adds texture. Injectables require more guidance, often related to titration, administration, and what to expect. This structured contact can improve consistency, even if persistence remains short. Orals, by contrast, feel simple at first, (no needles, no training, just a pill) but that very simplicity reduces the amount of early support. Patients left to self-manage side effects may cut back or alter dosing rather than seeking advice, leading to poor adherence well before discontinuation.

Affordability remains a consistent backdrop. In our survey, 65% of patients cited cost and 64% cited side effects as their primary barriers. Even when willingness to pay exists, the visibility of monthly costs and the perceived trade-off between expense and progress create moments of hesitation. When the weight loss curve lags behind expectations (or when support services add extra financial burden) patients quietly recalibrate their "value equation." They may not abandon therapy outright, but they change the way they take it, reducing dose intensity or frequency.

Figure 6: Patient barriers



Source: IQVIA obesity study with 133 respondents, see appendix III

In the STEP 4 withdrawal trial, after a 20-week run-in on semaglutide 2.4 mg, those who continued treatment lost another 7.9% from week 20 to week 68, while those switched to placebo regained ~6.9% over the same period.[11] The message is clear: continuity beyond the first months is critical to achieving clinically meaningful outcomes. Yet in real-world Belgian practice, both persistence and adherence drop early, limiting the chance to reach those benefits.

For pharma, the challenge to stabilize the early experience. Setting realistic expectations on the pace of weight loss, providing proactive side-effect management, and making the cost trajectory transparent could prevent patients from drifting into inconsistent dosing patterns that erode both efficacy and confidence. Without that alignment, the promise of next-generation obesity therapies risks being undercut by the lived reality of early discontinuation and poor adherence.

Economics of demand

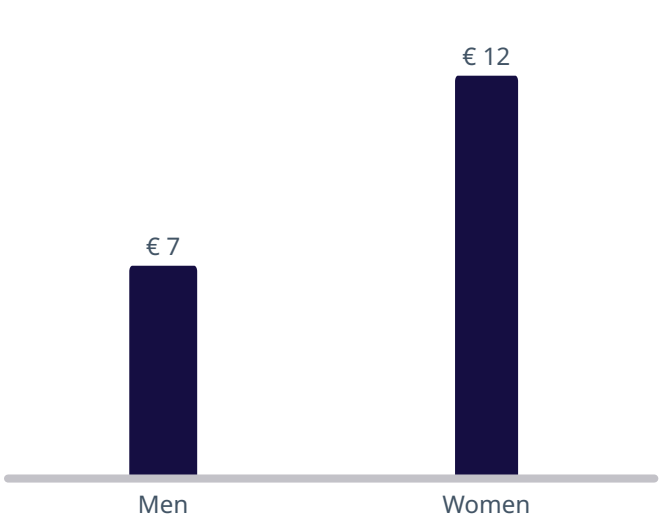
Not everyone values the same weight loss equally. Our Willingness-To-Pay (WTP) analysis puts numbers to that intuition (details in Appendix III). Participants indicated their preference for hypothetical treatments which have varied attributes: percentage of weight loss, delivery mode, side effects, and cost.

As efficacy rises from 5% to 25% weight loss, higher-income respondents move from around €125 to above €350 in WTP. Lower-income respondents move too, from about €4 to roughly €250, showing an increased WTP across the board, just from different starting points. Prior Out-Of-Pocket (OOP) experience matters as well, people who have paid for weight loss products or programs before show a higher marginal WTP (about €14) than those who have not (about €6). Younger people, women, and those with more comorbidities also place a higher value on each additional percentage point of weight loss, see Figure 7.

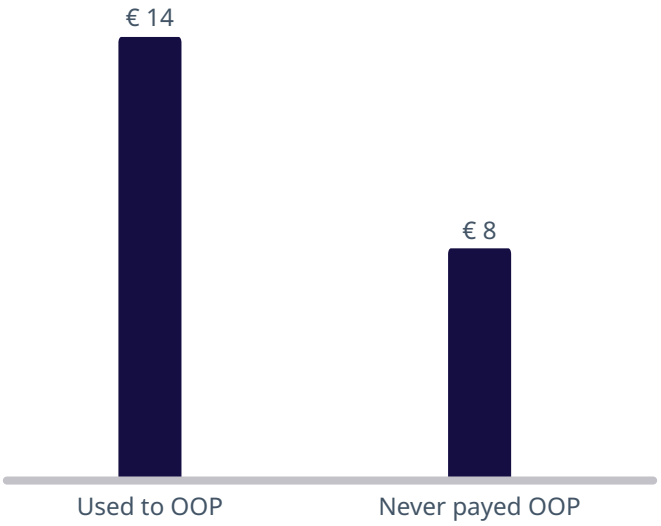
Figure 7: Willingness-to-pay of obese people

A. Willingness-to-pay of obese patients for AOM by weight-loss

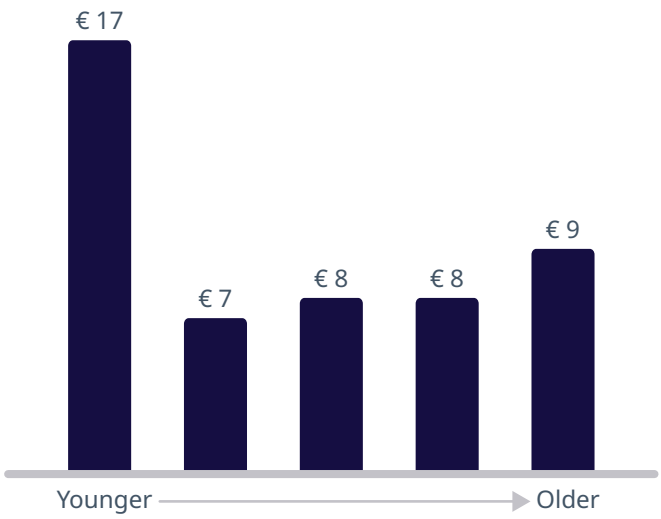
B. Marginal willingness-to-pay to have a better WL effficacy by gender



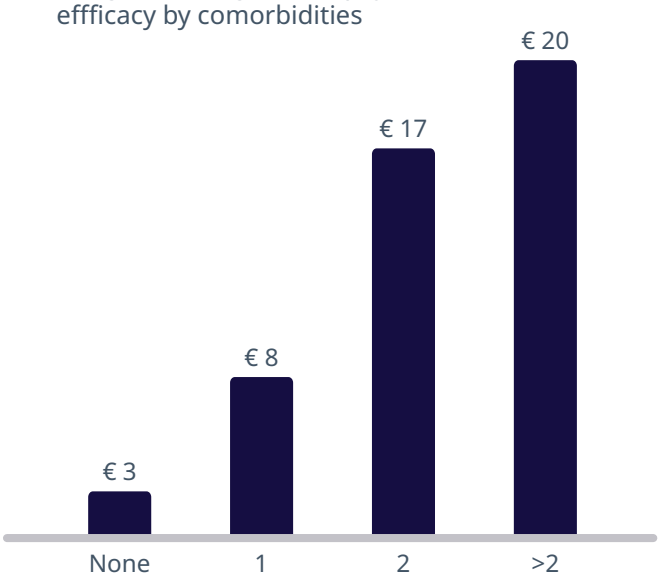
C. Marginal willingness-to-pay to have a better WL effficacy by OOP payers



D. Marginal willingness-to-pay to have a better WL effficacy by age



E. Marginal willingness-to-pay to have a better WL effficacy by comorbidities



Source: IQVIA obesity study with 133 respondents, see appendix III

These gradients help explain adoption patterns that line up with the rapid GP uptake for tirzepatide (see Figure 2). The perceived value per unit of weight loss is high enough, for enough people, to justify the effort of initiation and follow-up. Earlier products, with slower uptake, likely faced a tougher value story in the minds of GPs and patients: good, but perhaps not yet compelling enough to change routines at scale.

Personas add a human face to economics, see Table 3. A useful way to distinguish personas is through "medical need × HCP support", see Appendix IV. Using the results from the survey and a decision-rule tree, different "medical need", "HCP support" and "barriers" led to the personas in Table 3. Time dealing with obesity, body-mass index and comorbidity burden shape medical need. Number of specialists visited to discuss about their condition, and their trust/follow-up with them shape HCP support.[12] When both are high, only barriers to initiate AOM distinguish 2 types of personas: the overwhelmed fighters, who have high medical need and perceive high HCP support but encounter many challenges to start a medication, and the empowered doers, who do not see as many barriers and are more ready to start.

The isolated aware patients are those who although they have a high medical need, they do not trust or engage as much with the healthcare system. The weight conformists are those who do not see their condition as a big deal, they are more passive when it comes to managing their condition.

Table 3: Obesity personas

	THE ISOLATED AWARE (TIA)	THE OVERWHELMED FIGHTER (TOF)	THE EMPOWERED DOER (TOD)	THE WEIGHT CONFORMIST (TWC)
Description	Aware of obesity's seriousness, want to change, feel disconnected from healthcare, distrust providers, uncomfortable seeking help, facing weight management challenges alone	Health-conscious, actively follows medical advice, engages with professionals, tries multiple approaches, faces daily challenges (cost, time, stigma, lack of motivation), genuine motivation hindered by obstacles	View obesity as a medical issue and personal challenge, informed, engaged with healthcare professionals, follow diets and exercise routines, seek options rather than convincing	Don't view obesity as a major issue, perceive no health threat, may eat well or be active without weight loss goals, ignore judgment and pressure
Sample	31	31	14	57
Average Age	57	53	55	49
Dominant gender	Female (77%)	Male (65%)	Male (57%)	Female (60%)
BMI range	>=30 (100%)	>=30 (100%)	>=30 (100%)	27 – 29.9 (100%)
Approx. monthly gross household income range	€ 3,000 - €4,999 (42%)	€ 3,000 - €4,999 (32%)	€ 3,000 - €4,999 (29%)	€ 3,000 - €4,999 (30%)
Years dealing with obesity	More than 5 years (67%)	More than 5 years (74%)	3-5 years (46%) More than 5 years (46%)	Less than 5 years (53%)
Average number of health conditions	1.1	1.6	1.3	1.0

We map each persona across three phases that mirror real decisions and explain outcomes, summarized in Figure 8.

Phase 1 — Patient background

Here, the weight conformist is the only persona that has low perceived need, weight is a nuisance, and their feeling of urgency is limited.

At this stage, raising awareness among weight conformist personas could make them more motivated to address their condition

Phase 2 — Obesity management

TOF, TED, and TWC visit mainly GPs to manage obesity, who tend to recommend more often to improve diet (35%, 50%, and 49% respectively) and/or do exercise (68%, 57%, and 68% respectively). Nonetheless, all personas (including TIA) end up changing their lifestyle without starting right away with AOM or surgeries. At some point, their condition may worsen, and that's when TOF, TED, TWD get recommendations (mainly from endocrinologists) to start an AOM.

During this phase, weight-loss supplements are used just by few obese patients (8%). At the same time, only 36% of the respondents invest in any activity related to weight loss. Although as seen in the previous section, "what's the role of the pharmacist?", as not all visit pharmacists to seek help in their weight management, they could really make the difference on increasing awareness about weight loss supplements. Our study also indicates that 13% of those who consult a pharmacist end up trying weight loss supplements, almost two times more than those who do not consult a pharmacist (only 6% purchased a supplement).

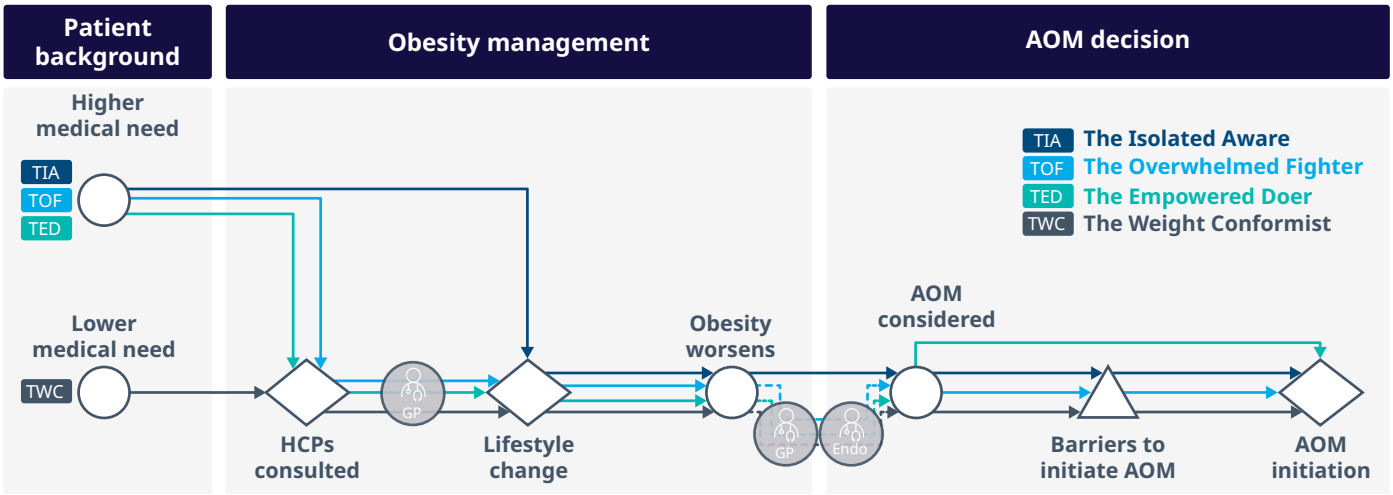
Phase 3 — AOM decision

AOM is considered after struggling to see improvements only with lifestyle changes. TOF, TED, and TWC tend to get general advice from endocrinologists (56%) and/or pharmacists(63%). However, GPs are also very relevant at this point as they are driving most AOM prescriptions.

After considering an AOM, high cost and fear of side-effects are the main barriers for TIP (55% and 45%), TOF (100% and 94%) and TWC (63% and 61%). However, if they overcome those barriers, when deciding for an AOM, injections are preferred by TED, while TOF and TWC are more inclined towards oral solutions (WTP of +€109 and +€59 respectively if oral).

Efficacy of the AOM also plays a role for each persona, the WTP decreases per persona: TED (highest WTP) ⟶ TOF ⟶ TIA ⟶ TWC (lowest WTP).

Figure 8: Obese persona journey*



Note: This patient journey is a constructed interpretation based on selected survey responses. Since the survey lacks a timeline, different questions were mapped to different stages. It should be viewed as directional

For companies, the task is to match credible efficacy with a credible journey. When patients can see how the next few weeks will feel, what results are normal, and what support looks like, the value they already see on paper becomes value they are willing to keep paying for in practice.

AOM demand is structured by income, experience, age, and health burden, and by the story people tell themselves about what progress should look like.

Pharma companies should understand the challenges or behaviors of the different personas. The empowered doers are the engine behind fast adoption, still vulnerable to persistence drop without milestone reinforcement. The overwhelmed fighter aligns strongly with early discontinuers (Figure 5), despite high adherence, barriers dominate outcomes. The isolated aware potentially overlaps with patients who want change but distrust/avoid HCPs, they have a latent demand at pre-AOM phase, they are potential patients to be activated by pharmacists. The weight conformists explain the 24% “no comorbidity” treated cohort’s (Figure 3) very different motivation set and likely shorter persistence.

Conclusions

Obesity is a growing concern in Belgium, with nearly half the population overweight and 18% living with obesity, a trend expected to worsen by 2030, especially among youth. The use of Anti-Obesity Medications (AOMs) has surged, with the number of treated patients tripling in just three years, signaling a shift toward mainstream acceptance of pharmacotherapy. GPs are increasingly driving this change, expanding their role in prescribing AOMs. Despite similar overweight prevalence, women lead in AOM usage. Women report higher OOP spend on weight efforts than men, and while this spend difference does not automatically mean AOM conversion, it creates commitment and readiness. When a bridge exists (from dietitian or pharmacy to GP prescription), intent converts to AOM initiation. According to the IQVIA patient survey, pharmacists, though trusted and accessible, remain underutilized in engaging with patients seeking weight reduction.

From patients' side, most discontinue treatment within six months, and those who remain on therapy do not follow consistent dosing patterns. This behavior is presumably due to mismatched expectations, side effects, and cost concerns. Patients show strong willingness to pay for increased weight loss efficacy, with preferences shaped by income, age, health status, and prior experience. Finally, four distinct patient personas: Empowered Doers, Overwhelmed Fighters, Isolated Aware, and Weight Conformists, help explain the varied motivations, barriers, and treatment outcomes across the population.

Implications and considerations for pharma companies

As obesity care increasingly shifts into everyday clinical practice, GPs are becoming key players in initiating and managing treatment. This transition reflects a broader integration of obesity management into primary care. However, many GPs may still be unfamiliar with newer anti-obesity medications or lack structured pathways for follow-up and patient support. Ensuring that GPs are equipped with clear guidance, practical tools, and opportunities for peer exchange can help them feel more confident in addressing obesity as a chronic condition. This support is especially important as treatment decisions now often extend beyond specialists and into routine consultations.

Many patients discontinue treatment within months as shown by their persistence and adherence. This points to the importance of shaping the first 8–12 weeks of therapy with realistic expectations, side-effect coaching, and milestone tracking (e.g., improvements in sleep, energy, or mobility, not just weight loss).

Tailored onboarding approaches that reflect patients' individual needs and concerns can improve engagement. Designed to match the patient's persona, whether they are motivated, overwhelmed, or disengaged. Personalized communication, milestone reinforcement, and support tools can help patients stay on therapy longer and achieve meaningful outcomes. This is where digital obesity management support can help.[13]

Tailoring also the approach to the different patient segments can enhance impact. Recognizing the diversity of patient experiences is key. Different personas, such as those who are motivated but overwhelmed, or those who are disengaged, require different types of support. Segmenting communication and interventions accordingly can improve outcomes.

Pharmacists are frequently consulted and generally well-trusted by patients, yet their involvement in treatment decisions remains limited. Encouraging stronger collaboration between pharmacists and prescribers and providing pharmacists with tools to guide or refer patients, may help bridge gaps in care. Pharmacists are in a strong position to make recommendations regarding weight loss support (e.g., digital support tools, nutritional support during weight loss).

Early signals such as supplement purchases or pharmacy interactions may indicate readiness or hesitation. Monitoring these behaviors could help identify patients who might benefit from additional support before they disengage.

Lastly, the economic value of an AOM must be matched with experience. While the willingness to pay for increasing weight-loss effectiveness is generally strong, it's important that patients feel their investment is worthwhile. Aligning treatment experiences with expectations and offering reassurance throughout the journey can help sustain long-term engagement.

Appendix

Appendix I: Anti-obesity market definition

In-scope molecules/brands (dispensed in Belgium during the study window, some used on-label for obesity, others commonly used in weight management):

- **GLP-1-based:** Semaglutide (e.g., Wegovy, Ozempic, Rybelsus), liraglutide (e.g., Saxenda), dulaglutide (Trulicity)
- **Dual incretin:** Tirzepatide (Mounjaro)
- **Other AOM:** Orlistat, naltrexone/bupropion (Mysimba)

For the persistence and adherence analysis, we also distinguished their mode of administration:

- **Injectables:** Wegovy, Ozempic, Saxenda, Mounjaro
- **Orals:** Orlistat, Mysimba

Note that we did not include Rybelsus in orals and that none of the AOM brands are reimbursed for obesity in Belgium at the moment of this publication.

The adherence analysis shows how accurately patients took their medication. This is done by calculating the theoretical days on therapy associated with a given pack (e.g. a pack of 30 pills meant to be taken daily should last 30 days) and comparing it to the day the patient came back to the pharmacy for the following purchase. Therefore, patients that took any AON only once are excluded in this calculation.

Appendix II: Longitudinal patient data (LRx) study

IQVIA LRx is a pharmacy-level dataset that tracks non-identifiable individual longitudinal patients' dispensing over time. It includes information about product, strength, pack size, quantity, dispensing date, prescriber specialty (when available), and dispensing pharmacy. The database includes ~30% of retail pharmacies in Belgium.

First, obese patients were identified by those who took any AOM drug (see def appendix I), and, at the same time, do not have any record of purchasing metformin (associated to diabetes). This allows us to distinguish obese patients from diabetic ones.

An observation window of 5 years was used, where we identify the first transaction they had of an AOM. Once a patient's first dispensing is identified, there was a lookback window of 12 months prior to the start date to look for any comorbidity proxy flags or pre-AOM supplement use.

These were the comorbidity proxy flags used:

COMORBIDITY PROXY	PRIMARY ATC CLASSES	SUPPORTING ATC CLASSES
Arthritis	Immunosuppressants incl. biologic and targeted DMARDs, hydroxychloroquine, methotrexate, sulfasalazine	systemic glucocorticoids or NSAIDs
Respiratory disorders	Inhaled corticosteroids, fixed ICS/LABA, biologics for respiratory diseases	LTRAs such as montelukast or SABA fills
Depression	All antidepressants (SSRIs, SNRIs, NaSSAs, buproprion, etc.)	
High cholesterol	Statins, ezetimibe, PCSK9 inhibitors, bempedoic acid, and any other combination	Fibrates or omega-3 ethyl esters
Hypertension	ACEi/ARB/ARNI and combinations, thiazide(-like) diuretics, dihydropyridine CCBs	Beta blockers or centrally acting agents
Heart disease	Market of subcutril/valsartan, ACEi/ARB, beta blockers (metoprolol succinate, carvedilol, bisoprolol), MRAs, SGLT2 inhibitors	Diuretics

Appendix III: Obesity survey

IQVIA sent a survey to adults residing in Belgium who self-reported a BMI ≥ 27 kg/m^2. The survey was developed from feedback received from the pharma industry, literature review, and from patients suffering from obesity. The goal was to collect attitudes, pathways, and Willingness To Pay (WTP) for weight-loss efficacy across Belgian adults living with overweight/obesity.

The questionnaire included:

- **Demographics:** Questions related to demographics, weight history, work situation, income and comorbidities
- **Weight management:** Questions related to behaviors and approaches to weight management
- **Care seeking** primary HCPs visited/consulted to treat their condition, topics discussed, opinion and perceptions of the HCPs visited
- **Willingness-to-pay** questions related to reasons to start and stop an AOM, readiness to purchase, drivers and barriers to start an AOM, and a Discrete Choice Experiment (DCE) where respondents have to choose between a series of hypothetical drugs to later determine their WTP

The field-work was conducted during 3 weeks of June 2025 and resulted in 133 respondents.

WILLINGNESS-TO-PAY METHOD

In order to develop the WTP survey, a series of steps were undertaken, including a literature review, interviews with obesity experts and a review of product labels for currently available obesity therapies.

A literature review was undertaken to help conduct the development of the WTP survey. The review was not designed to be exhaustive; rather, it focused on literature pertaining to obesity and Health-Related Quality-Of-Life (HRQL) outcomes, such as obesity-related utility, obesity WTP or discrete choice studies, and other relevant qualitative data on obesity. Monthly cost of obesity therapies was sought from pharmacy prices in Belgium. The literature search was conducted using a variety of scientific databases (e.g., PubMed, EMBASE, Google Scholar) and obesity journals (e.g., International Journal of Obesity; Obesity Reviews; Diabetes, Obesity and Metabolism).

The participants completed a paired discrete choice section. Discrete Choice Experiments (DCE) involve presenting paired choices of hypothetical treatments with varying levels of attributes of interest (e.g., efficacy, side effects, cost). Participants were asked to think about what treatment they would prefer based on the attributes presented and their subjective interpretation of the trade-offs. Attributes and levels deemed to be of greater importance in decision making are associated with greater marginal rates of substitution and in a higher WTP out of pocket for benefits or avoidance of negative attributes. The DCE design included 4 attributes, with a maximum of 4 levels of variance, which means that four treatment attributes (e.g., weight-loss efficacy or mode of administration) included categorical and continuous levels (e.g., 15% of weight loss or injection vs. tablets). This DCE design resulted in 8 choice sets that would be valued by each participant. In each of the 8 paired choice questions, participants were asked to choose whether they preferred treatment "A," treatment "B," or neither. Each paired choice featured four attributes:

- Amount of weight loss (expressed as expected percentage of current body weight after 6 months of treatment)
- Treatment type (method of treatment administration)
- Side effects of treatment (patients had a description of mild, moderate or severe effects)
- Cost of treatment per month (expressed in euros)

Treatment type and side effects were treated as nominal changes in the analysis, and amount of weight loss and cost were presented as ordinal.

WTP STATISTICAL ANALYSIS

The demographics, medical, and obesity history sections were analyzed and described using descriptive statistics and frequencies. The DCE portion was analyzed using a multinomial logit (conditional logit)

model to evaluate choice responses after conditioning on attributes of the treatment options available within the choice set. Participants could also have chosen to not have either treatment, in which case they would choose “neither”. We estimated preference weights and marginal rates of substitution between attributes. The survey included an out-of-pocket cost attribute which was used to estimate WTP. WTP was calculated by estimating marginal rates of substitution between preference weights for the cost attribute and coefficients for the other attributes.

Appendix IV: Obesity personas decision tree

Four obesity personas were defined using a simple decision-rule tree grounded in three observable signals:

1. **Medical need:** High vs low (based on BMI, comorbidities, and time dealing with obesity). Low need maps to the weight conformist: low perceived urgency, low readiness to medicate
2. **HCP support:** Based on the number of HCPs visited to manage their condition, the type of advice received and level of trust
3. **Barriers:** Perceived cost, stigma, side effect worries, lack of motivation, etc.

These three signals let us link each persona to measurable behaviors:

- Low need leads to Weight Conformist
- High need and low HCP support leads to Isolated Aware
- High need, high HCP support and low barriers leads to Empowered Doer
- High need, high HCP support and high barriers leads to Overwhelmed Fighter

The journey framework is therefore divided into three phases: patient background, obesity management and AOM decision as in Figure 8.

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