White Paper

If better Weight-Loss Drugs keep improving, Consumer Health will be reshaped

A perspective on GLP-1 obesity medicines and the next rotation in Consumer Health

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Core thesis: GLP-1 and related obesity medicines will not simply disrupt the weight-loss market. They will redraw the consumer-health map around medically supported weight loss. Demand is likely to move away from weak appetite-control and slimming claims and toward products and services that help people preserve muscle, manage gastrointestinal (GI) side effects, maintain nutritional quality, protect appearance and stay on therapy.

Executive summary

Obesity is no longer a peripheral public-health issue or a niche commercial category. In many affluent markets, a majority of adults are already overweight or living with obesity. The arrival of highly effective GLP-1 and GIP/GLP-1 medicines changes the commercial baseline because clinically meaningful weight loss is now possible at scale, at least for people who can access, tolerate and remain on treatment.

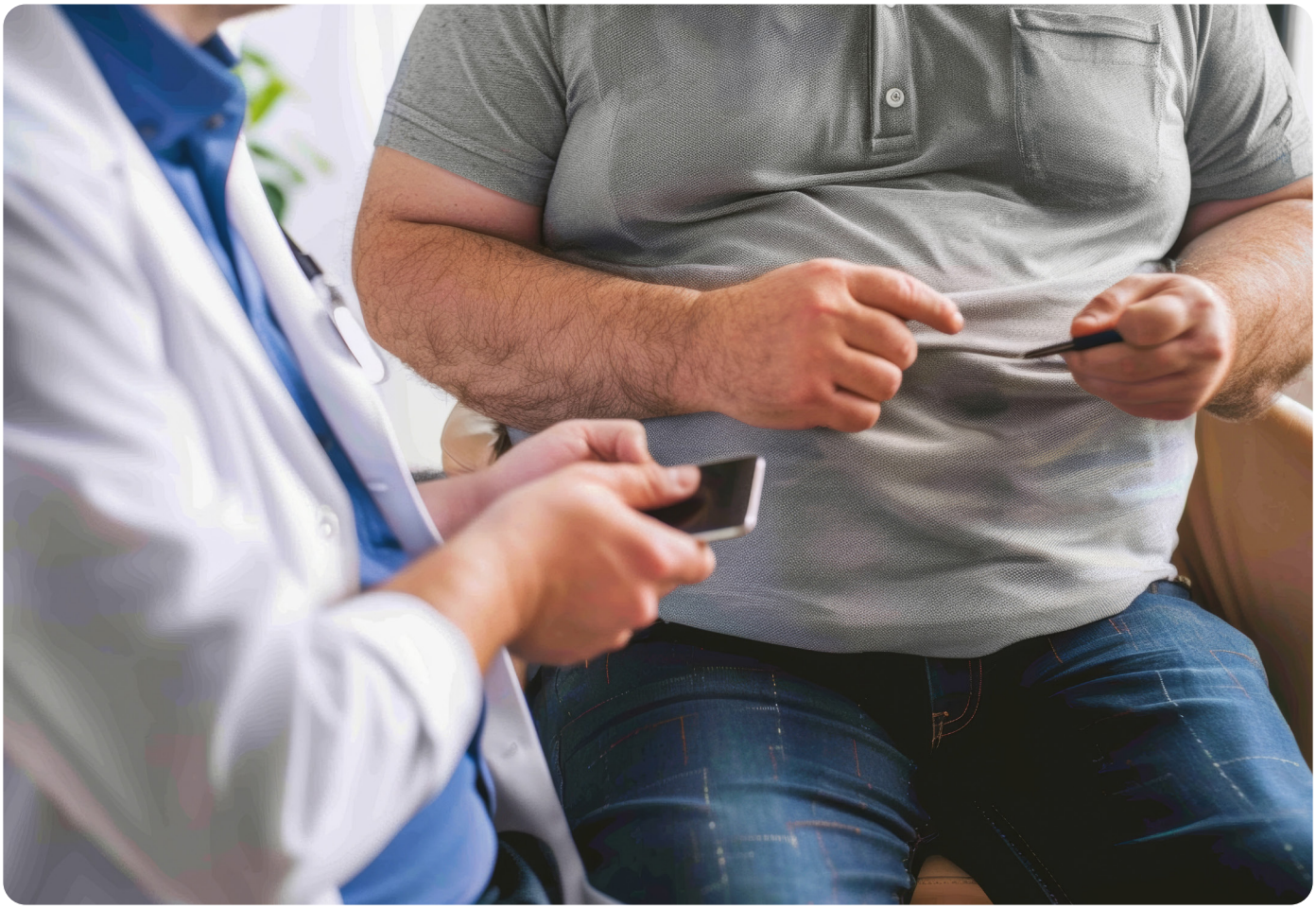
- The next decade is unlikely to "solve" obesity. A more realistic scenario is better control in high-access markets, with a meaningful share of adults moving out of the highest-risk obesity ranges.
- The decisive constraints are no longer efficacy alone. They are affordability, reimbursement, supply, tolerability, persistence, maintenance after weight loss and the service infrastructure needed to support long-term treatment.
- For Consumer Health, the larger story is rotation, not collapse. The opportunity is less in products that try to compete with highly efficacious prescription medicines, and more in products that make prescription obesity treatment easier to start, tolerate and sustain.
- The highest-confidence opportunities are likely to be those with a clear role in treatment support: muscle preservation, adequate protein and nutrient intake, gastrointestinal tolerance, hydration, micronutrient coverage, skin and hair support, counselling, adherence and dose-escalation support.
- The most exposed categories are those whose value proposition still depends on weak weight-loss narratives: detox products, poorly substantiated appetite-control claims, and products implying weight-loss efficacy without convincing evidence.

Obesity is already a mass-market condition

The first commercial point is scale. Obesity is not a cosmetic concern affecting a small minority; it is a baseline condition that now shapes healthcare demand, consumer spending, workplace productivity and public budgets. Across OECD countries, more than half of adults were overweight or obese in 2023 using self-reported data, and the share rises to about 60% where measured data are used.[1] In England, 64.5% of adults were overweight or living with obesity in 2023 to 2024, including 26.5% living with obesity.[2] In the United States, adult obesity prevalence reached 40.3% during August 2021 to August 2023.[3] This population scale is now translating into a major therapeutic and commercial market: IQVIA estimates that the global obesity medicines market reached $66 billion in list-price sales in 2025 and will continue to expand sharply over the remainder of the decade.[4]

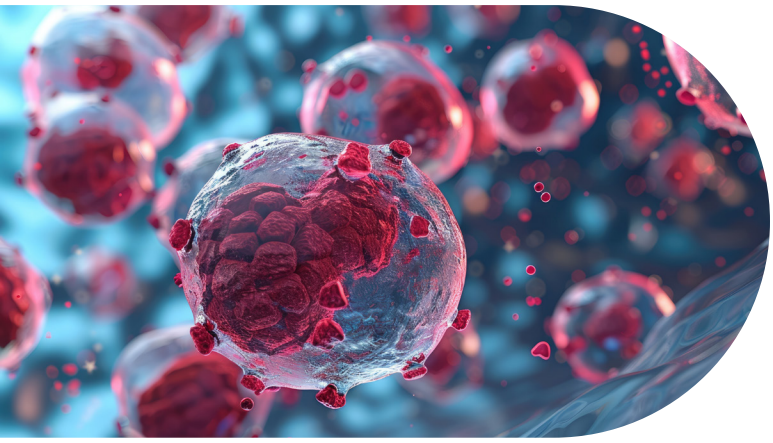
The burden is also unevenly distributed. In England, overweight and obesity are more common in the most deprived areas.[2] In the United States, obesity prevalence is meaningfully higher among adults without a college degree than among those with a bachelor's degree or more.[3] That matters commercially because access to treatment will shape not only who benefits clinically, but also which consumer segments participate in the new support categories that emerge around obesity medicines.

The economic burden is already substantial. The CDC has estimated direct annual medical costs of adult obesity in the United States at roughly $173 billion in 2019 dollars.[5] OECD modelling also shows that obesity-related disease will continue to exert a major burden across OECD, G20 and EU countries if current trajectories persist.[6] For Consumer Health companies, this means obesity should be understood not as one product category, but as a condition that influences many categories at once.



The disease footprint is wider than the weight-loss conversation

Excess weight is linked to a wide disease footprint: cardiovascular disease, stroke, type 2 diabetes, metabolic dysfunction, sleep apnoea, fatty liver disease, reflux, asthma, osteoarthritis, gout, gallbladder disease, pancreatitis and chronic kidney disease. Even modest weight loss can have clinically relevant effects. NIDDK describes 3% to 5% body-weight reduction as a level that can improve certain health measures, with greater weight loss producing broader benefits.[7]



Cancer is also part of the obesity story, although it is often underweighted in commercial discussions because the benefits of prevention take longer to appear. U.S. health authorities link overweight and obesity to increased risk of at least 13 cancer types, including colorectal, endometrial, kidney, liver, pancreatic and postmenopausal breast cancer.[8] These are long-latency outcomes, so they will not be the first indicators of impact. But they matter when assessing the 10- to 15-year implications of better obesity control.

For Consumer Health, the important implication is that many "weight-related categories" are really downstream categories: reflux, joint pain, sleep problems, reduced mobility, skin-fold irritation, fatigue and appearance concerns. If obesity becomes more controllable, demand will not disappear. It will move. Some symptom-relief categories may soften over time, while new support categories grow around medically induced weight loss.

The new medicines reset what is possible, but the caveats remain

By 2026, GLP-1 and related medicines have transformed the therapeutic standard. In the United States, FDA-approved options include Wegovy as both a weekly injectable and an oral semaglutide tablet, Zepbound for chronic weight management and obstructive sleep apnoea in adults with obesity, and Foundayo, Lilly's oral orforglipron, for long-term weight reduction and maintenance in adults with obesity or overweight plus at least one weight-related comorbidity.[9–12] In Europe, tirzepatide is authorised as Mounjaro for adults with obesity or overweight with a BMI of at least 27 kg/m^2.[13]

The trial results explain the scale of interest. In STEP 1, once-weekly semaglutide 2.4 mg produced a mean 14.9% reduction in body weight at 68 weeks, compared with 2.4% with placebo.[14] In SURMOUNT-1, tirzepatide produced mean body-weight changes of -15.0% to -20.9% at 72 weeks across dose groups, compared with -3.1% with placebo.[15] These are not marginal effects. At the higher end, they are large enough to move many patients out of obesity if treatment is sustained.

The field is also moving beyond weight loss alone. Wegovy reduced major adverse cardiovascular events from 8.0% to 6.5% in SELECT, a trial of more than 17,600 adults with cardiovascular disease and overweight or obesity.[16] Zepbound's FDA approval for moderate to severe obstructive sleep apnoea in adults with obesity illustrates the same shift toward comorbidity outcomes.[17] Semaglutide has also moved into MASH (Metabolic dysfunction-associated steatohepatitis). In the United States, Wegovy is approved for MASH in adults with moderate-to-advanced fibrosis, while in the European Union semaglutide has received conditional marketing authorisation for non-cirrhotic MASH with moderate or advanced fibrosis under the brand name Kayshild.[18, 19]

Access is changing but remains the central constraint. U.S. self-pay prices for selected Wegovy doses now start at $149 per month through NovoCare.[20] In India, semaglutide patent expiry in March 2026 triggered low-

cost generic launches, with Natco announcing multi-dose vial prices starting at about US$14 to US$15 per month.[21] Canada has approved generic semaglutide.[22] Separately, private and digital channels are expanding access to branded GLP-1 medicines in markets such as the UK.[23]

The WHO's conditional recommendations should therefore be read not as a rejection of GLP-1 medicines, but as a recognition that long-term safety, maintenance after discontinuation, affordability, health-system readiness and equity still need to be addressed as use expands.[24] WHO has warned that even with rapid supply expansion, GLP-1 therapies may reach fewer than 10% of people who could benefit by 2030.[24]

Persistence is the other major constraint. In a large U.S. real-world cohort, one-year discontinuation reached nearly 65% among patients without type 2 diabetes and about 47% among those with type 2 diabetes.[25] In the STEP 1 extension, participants who stopped semaglutide regained roughly two-thirds of their prior weight loss within a year.[26] These medicines work well. Their population-level impact depends on whether patients can access, tolerate and sustain treatment over time.

The realistic future is better control, not a solved problem

If the next decade delivers cheaper products, broader reimbursement, more tolerable oral formulations and better adherence support, obesity in affluent Western markets could shift from "still rising" to "materially more controllable." That distinction matters. Current medicines already produce double-digit percentage weight loss, oral options are entering the market, and WHO frames obesity as a chronic, relapsing condition requiring long-term care, not as a short-lived therapeutic trend.[24]

Social listening gives an early view of what this chronic-care future may look like. Recent IQVIA research from Germany identified more than 463,000 obesity-related online mentions between December 2024 and November 2025, with around 11% focused specifically on anti-obesity medicines and strong brand recognition for Ozempic, Wegovy and Mounjaro.[27] The patient-led conversations are strikingly practical. People discuss kilograms lost, appetite control, the disappearance of "food noise", dose adjustments, side effects, costs, switching and what happens after a target weight is reached.

That behaviour supports a key point. GLP-1 medicines are not being experienced as short-term lifestyle aids. Many patients are already treating them as long-term tools for managing a chronic condition. At the same time, the same conversations expose the limits of the model. Gastrointestinal tolerability, discontinuation, self-pay costs and uncertainty about maintenance therapy remain major barriers. Social media therefore offers an early signal of both sides of the next decade: the potential for better obesity control and the practical frictions that will determine whether that potential is realised.

A reasonable directional estimate for a strong-access, better-tolerated scenario is that wealthy Western countries could have roughly 7% to 15% fewer adults living with obesity by the mid-2030s than today's trajectory would otherwise predict. This is not a forecast. It is a scenario-based estimate anchored in the early U.S. signal. Gallup reports that adult obesity fell from a record 39.9% in 2022 to 37.0% in 2025, equivalent to about 7.6 million fewer adults with obesity, while reported use of GLP-1 injectables for weight loss more than doubled from 5.8% in early 2024 to 12.4% in 2025.[28]

The association is not proof of causality, and Gallup's BMI estimates are based on self-reported height and weight. But the direction is important. Where uptake becomes substantial, obesity prevalence can begin to move at population level. In a more favourable scenario with broader access, better tolerability, oral options and long-term adherence support, that early relative reduction could plausibly deepen. It should still be treated as a directional scenario, not a formal projection.

In prevalence terms, this would translate into roughly 2 to 5 percentage points lower obesity rates in many wealthy Western markets, depending on the baseline prevalence. In a U.S.-like market with obesity prevalence close to 40%, the upper end could be somewhat higher. The broader "overweight or obesity" category would probably improve less, perhaps by 1 to 3 percentage points, because many successful users would move from obesity into overweight rather than directly into the healthy-weight range. This should not be read as a simple contraction of demand. As fewer people remain in the obesity category, more people would enter a post-obesity maintenance population, still needing support to sustain weight loss, avoid regain and remain metabolically controlled. The uncertainty remains wide.

For related health conditions, OECD modelling offers useful context. If countries achieved top-quartile obesity prevalence, total non-communicable disease incidence would fall by about 11% and premature mortality by 5.6% over 2026 to 2050.[6] The earliest visible gains would likely appear in diabetes risk, sleep apnoea, reflux and weight-bearing joint pain. Cancer, with its long latency, would be the last to respond. Medication alone will not fix food environments, physical inactivity or deprivation. But it could push a meaningful share of the population out of the highest-risk zone, and that matters commercially as well as clinically.

The consumer-health thesis: Rotation, not collapse

The biggest commercial shift is away from "help me start losing weight" and toward "help me stay well while on a powerful obesity medicine." The nutrition literature building around GLP-1 therapy focuses on body composition, diet quality, gastrointestinal symptom management, nutrient adequacy, muscle and bone preservation, physical activity and ongoing support.[29,30] That changes the centre of gravity for OTC products, supplements, food formats, personal care and pharmacy services.

The consumer's question changes from "*how do I lose weight?*" to "*how do I preserve muscle, manage side effects, protect my appearance and stay on therapy?*" Companies that answer the second question credibly are better positioned than those still selling the first question in the old language of appetite control, detoxification or slimming shortcuts.

High-confidence winners: Products closest to the treatment journey

Protein, nutrient density and muscle preservation

The importance of nutritional support during GLP-1-based obesity treatment has been reviewed recently.[31] Protein supplements, high-protein snacks and nutrient-dense meal formats are probably the strongest structural winners. Expert guidance on GLP-1 therapy consistently flags concerns around lean-mass loss, low intake and diet quality during major weight reduction.[29,30] The recommended response is not simply "eat less." It is higher-quality intake, adequate protein, resistance training and ongoing nutritional support.

This creates a different commercial space from traditional dieting. GLP-1 users may have low appetite, early satiety, nausea or aversion to large meals. That favours compact, easy-to-consume formats such as ready-to-drink protein shakes, bars, yoghurts, soups, fortified snacks, small high-protein meals and products positioned around strength, function and maintenance rather than calorie restriction. The most credible brands will speak the language of muscle preservation and nutrition quality, not rapid weight loss.

Gastrointestinal support, hydration and electrolytes

The gastrointestinal side-effect profile written into FDA labelling for Wegovy, Zepbound and Foundayo creates a clear support-category opportunity. Across the three labels, common adverse reactions include nausea, vomiting, diarrhea, constipation, abdominal pain, dyspepsia and gastroesophageal reflux disease.[9–11] The clinical relevance goes beyond inconvenience. Wegovy and Foundayo flag acute kidney injury due to volume depletion, while Zepbound explicitly warns that acute kidney injury can follow dehydration caused by gastrointestinal adverse reactions, including nausea, vomiting and diarrhea.[9–11]

This makes nausea relief, constipation support, stomach-settling products, hydration guidance and electrolyte replenishment credible companion use-cases during treatment initiation and dose escalation, when tolerability problems are most likely to emerge. The opportunity is best framed as product-plus-advice: helping patients manage expected early discomfort while clearly directing persistent vomiting, severe abdominal pain or dehydration symptoms back to a pharmacist or prescriber. The opportunity is anchored in label language and clinical support needs, not consumer speculation.

Pharmacy-led counselling and adherence support

WHO recommends obesity pharmacotherapy as part of integrated, person-centred long-term care, and NHS England's tirzepatide rollout plan explicitly highlights the need for new services and training.[24,32] The same direction is visible in Scotland's Cardiometabolic Impact Study, SCoMIS, an IQVIA-run real-world evidence collaboration with Novo Nordisk, the Universities of Glasgow, Dundee and Edinburgh, and UK Government support, focused on how weight-loss medicines can be delivered equitably through care pathways for patients in deprived Scottish communities.[33] Together, these examples point to demand for product-plus-advice

models that combine nutrition support, adherence coaching, side-effect triage, hydration guidance and follow-up through dose escalation.

This is consistent with GLP-1 supportive-care guidance, which highlights gastrointestinal side-effect management, nutrient adequacy, preservation of muscle and bone mass, long-term adherence, weight maintenance, dietitian support, telehealth and digital platforms as practical priorities alongside medication.[29,30] It also fits the direction of service innovation. NHS England describes digital weight-management support as nationally available through GP or community-pharmacy referral, and the UK government is testing obesity-care routes through pharmacies, digital platforms and community-based services.[34,35]

In a market where discontinuation is common and dose escalation is a predictable friction point, counselling becomes commercially relevant rather than merely educational. It can help patients stay on treatment, manage tolerability and make better use of companion products. For pharmacy, digital health and consumer-health companies, this could become a genuine commercial layer.

Moderate opportunities: Credible, but not all equally structural

Multivitamins and micronutrient coverage

Multivitamins and basic micronutrient products are likely moderate winners, especially as broad-coverage, everyday support products. The argument is not that GLP-1 therapy will create a deficiency epidemic. It is that reduced food intake, altered eating patterns and diet-quality challenges are practical realities during treatment.[29,30,31] The American Academy of Dermatology also notes that some GLP-1 users may fall short on the protein, vitamins and nutrients needed for hair growth and general health.[36]

The most credible positioning is therefore conservative: nutrient adequacy during reduced intake, not dramatic deficiency correction. Products with sensible formulation, simple claims and links to dietetic guidance will be better positioned than high-dose or overpromising formats.

Hair, skin, nails and post-weight-loss body care

Hair, skin, nails and body care may perform better than many investors initially assume, but the category needs careful framing. Some concerns are driven by rapid weight loss itself: thinning hair, loose

skin folds, facial volume loss, dryness, chafing and irritation. Others relate to diet quality and reduced intake. A smaller and less certain group relates to possible drug-associated cutaneous effects.[36]

The commercial opportunity includes hair-support supplements, gentle skin care, hydrating body care, products for skin-fold maintenance, anti-chafing formats and appearance support after substantial weight loss. Some spending may also migrate upward into dermatology and aesthetic procedures. The evidence base is mixed, however. Dermatology reviews describe possible anti-inflammatory benefits of GLP-1 receptor agonists in some conditions, while also reporting cutaneous adverse events.

The acne signal remains unresolved: a meta-analysis found no clear direct association between GLP-1 receptor agonists and acne vulgaris, while later observational work summarised in dermatology reviews has suggested a higher acne-diagnosis signal, particularly in women. the acne signal remains uncertain.[37,38] This is a watch-and-build category, not a high-certainty medical claim space.

Joint health, mobility and recovery

The case for joint-health products exists, but it is more nuanced and probably weaker than the opportunities around nutrition, GI tolerance, hydration and adherence. Weight loss can make people more mobile, and renewed activity may create incremental demand for sports-recovery products, topical pain relief, braces, muscle rubs, footwear and supplements positioned around mobility.

The stronger clinical effect, however, runs in the opposite direction: weight loss itself can reduce mechanical load, improve function and reduce pain in people with weight-related joint symptoms. In overweight and obese adults with knee osteoarthritis, each pound of weight lost has been associated with a four-fold reduction in knee joint load per step, and greater intentional weight loss has been associated with improved pain and function.[40,41] This direction is also visible in current pharmaceutical development. Lilly's Phase 3 TRIUMPH-4 trial is evaluating investigational retatrutide in adults with obesity or overweight and knee osteoarthritis, with body weight and knee-pain outcomes both central to the study.[42]

The commercial opportunity for Consumer Health is therefore likely to be narrow and behaviour-driven. It is centred less on long-term chronic pain dependence and more on the "return to movement" phase: helping people who have lost weight become more active, recover from renewed exercise, protect joints and sustain mobility.

Categories under pressure: Weak weight-loss propositions and mixed symptom categories

Traditional weight-loss supplements and detox products

Traditional weight-loss supplements, OTC appetite-control products, slimming teas and detox or cleanse products are the clearest structural losers. U.S. federal health agencies continue to state that there is little scientific evidence that most weight-loss supplements work, and no compelling evidence supports detoxes or cleanses for weight management or toxin removal.[43,44] Once consumers have access to medicines that deliver double-digit average weight loss and, in some cases, comorbidity benefits, the old value proposition becomes difficult to defend.

This does not mean the entire supplement market is at risk. It means that weak weight-loss claims are at risk. Products that reposition around protein, fibre, nutrient adequacy, hydration, constipation support, muscle preservation or maintenance may still have a role. Products that continue to imply drug-like weight loss without drug-like evidence will face a less forgiving consumer and regulatory environment.

Classic low-calorie diet products

Classic low-calorie diet products face a different pressure. GLP-1 and GIP/GLP-1 medicines reduce appetite and food intake directly, so the consumer need shifts from imposed restriction to nutrient density. Not every meal replacement loses. Products built around protein quality, micronutrient coverage, satiety, convenience and small-portion adequacy can remain relevant. The formats most at risk are those still built around old-fashioned restriction and low-calorie language without adequate nutritional value.

Antacids, indigestion and reflux products

Antacid and indigestion products are a mixed case rather than a clean loser. Obesity is a significant driver of reflux, so lower body weight at population level should reduce one important underlying contributor over time.[45] At the same time, Wegovy, Zepbound and Foundayo all list dyspepsia or reflux-related adverse reactions.[9–11] The likely pattern is a short-run bump in demand during initiation and dose escalation, followed by softer long-run demand if obesity-related reflux declines.

Products tied to the physical burden of excess weight

Products tied directly to the physical experience of excess weight may soften over time, but not evenly and not immediately. Anti-chafing products, foot-care items, heavy-duty sleep and snoring aids, and osteoarthritis topicals all fall partly into this group. Weight reduction can improve sleep apnoea and joint pain, and Zepbound's sleep-apnoea indication makes that point commercially visible.[17,40,41] But rapid weight loss can also create loose skin folds and new irritation issues, so the transition may be uneven. The long-run direction is negative for some symptom-relief categories, but the timing is uncertain.

Acne and oily-skin products

Acne or oily-skin products should not be treated as a high-confidence forecast category. The evidence base is mixed. Dermatology reviews describe possible anti-inflammatory benefits of GLP-1 receptor agonists in some conditions, while also reporting cutaneous adverse events. The acne signal remains unresolved: a meta-analysis found no clear direct association between GLP-1 receptor agonists and acne vulgaris, while a later retrospective cohort study reported a higher acne-diagnosis signal, particularly in women. This is a watch-and-build category, not a high-certainty medical claim space.[37–39]

The more interesting dermatology signal is elsewhere. Lilly's ixekizumab and tirzepatide programme in psoriasis and psoriatic arthritis points to a broader obesity-and-inflammatory-disease interface, where weight loss, metabolic improvement and immune-mediated skin or joint disease are being studied together.[46,47] That is strategically relevant for dermatology and specialty care, but it does not make acne or oily-skin products a strong Consumer Health forecast category for now.

Strategic implications for consumer-health companies

The core implication is not that Consumer Health shrinks dramatically. It rotates. Spending moves away from products built on weakly substantiated weight-loss promises and toward products that support medically induced weight loss: protein, fibre, GI relief, hydration, micronutrient coverage, hair and skin support, adherence-oriented counselling and maintenance services.

That rotation will reward brands that position alongside evidence-based medicine rather than trying to replace it. Consumer-health companies should build propositions around the actual treatment journey: starting therapy, escalating dose, managing nausea or constipation, maintaining hydration, preserving muscle, adjusting diet, managing appearance concerns, staying adherent and planning maintenance.

The most exposed companies are those still selling a "slimming fantasy" in categories where clinical medicine now offers far stronger outcomes. The best-positioned companies are those that recognise obesity as a long-term, medically managed chronic disease and build products and services around that reality.

For manufacturers, retailers, pharmacies and digital health platforms, this means treating GLP-1 use as a new consumer context. The opportunity is not merely to sell more products to people losing weight. It is to help patients remain healthier, safer and better supported while using powerful obesity medicines over the long term.

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