Health Equity for All: Addressing the Need for Treatment for People with Obesity in Australia

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Obesity is a major driver of chronic disease and rising healthcare costs. There is currently no funded access to pharmacotherapies for obesity. **We ask the Australian Government to provide funded access to safe and effective pharmacotherapies for obesity treatment** to improve health outcomes, address health inequities and achieve national obesity strategy goals.

> Given the significant costs, as a **first step**, we ask that adults with **clinical obesity** are prioritised for **PBS-funded access** to pharmacotherapies for treatment. Specifically, this should include individuals who meet the following criteria:
>
> - **Body mass index (BMI) ≥ 40** or ≥ 35 for Aboriginal and Torres Strait Islander (First Nations) peoples with adjustments for other specific populations*, **and**
> - Either:
> - At least **three serious** obesity-related health impairments** regardless of severity, **or**
> - **One severe** obesity related health impairment**

This approach follows the model proposed by the UK's National Institute for Health and Care Excellence (NICE) in March 2025 which prioritises pharmacotherapy for specific obesity cohorts where the greatest health and economic benefits are realised.

Australia faces one of the highest rates of obesity globally — affecting 14 million people (two in three adults, one in four children) in 2022. Obesity contributes to 16,400 deaths annually, represents 8.4% of the national disease burden, and costs over $11.8 billion per year in direct healthcare costs.

Despite the **National Obesity Strategy 2022-2032** providing a clear framework to reduce obesity prevalence, progress has stalled. Urgent targeted action is needed to:

- **Improve health outcomes** and **reduce premature mortality**
- Address **long standing health inequities** among those disproportionately affected by obesity
- Align with **national strategy goals** to reduce obesity prevalence and long-term system pressures

This is a critical opportunity for the Government to lead decisive action to enable equitable health reform for people living with obesity in Australia.

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Background

Australia faces one of the world's highest rates of obesity affecting approximately 14 million people in 2022 — one in four children/adolescents and two in three adults[1]. This reflects a sharp rise since 1995 when one in five children and just over half of adults were affected[2].

The health impacts of obesity can be severe and are well-established. Excess adiposity causing clinical obesity (a chronic, systemic illness characterised by alteration in the function of tissues, organs, the entire individual, or a combination thereof) can cause progressive and irreversible health impairments including more than 30 chronic diseases such as cardiovascular disease, type 2 diabetes, cancer, and dementia[3]. Clinical obesity reduces physical capacity, impairs mental wellbeing, and significantly diminishes quality of life.

National Obesity Strategy 2022-2032

Recognising this urgent challenge, the Australian Government endorsed the National Obesity Strategy 2022-2032, a 10-year framework to reduce obesity through prevention and treatment[4]. However, three years on, **obesity rates remain persistently high with no clear evidence of progress** raising serious concerns about the adequacy and urgency of current national efforts.

Since the Strategy's release, significant **advances have been made in obesity pharmacotherapy** with multiple large clinical trials confirming the safety and efficacy of Semaglutide (Wegovy®) and Tirzepatide (Mounjaro®). Both are now approved by the Therapeutic Goods Administration (TGA) for the treatment of obesity but there is **no PBS-funded access** to these obesity management medications.

Purpose of the Proposal

We call on the Australian Government to provide targeted funding to ensure equitable access to evidence-based safe and effective pharmacotherapies for obesity. This investment is essential to improving health outcomes, reducing the long-term burden of obesity-related disease and advancing the objectives of the National Obesity Strategy.

All Australians with obesity who seek treatment should have access to the full range of evidence-based options. Bariatric metabolic surgery and supportive care from allied health practitioners (such as dietitians, psychologists, and exercise physiologists) are already funded components of effective obesity treatment models. A growing body of evidence also demonstrates that pharmacotherapies can significantly improve health and wellbeing for people with obesity. However, despite their safety and effectiveness, these treatments currently receive **no funding support from the government**.

Evidence and Justification

There is clear evidence that treating obesity improves a wide range of health impairments[5], including:

- Cardiovascular diseases
- Chronic kidney disease
- Hypertension
- Dyslipidaemia
- Non-diabetic hyperglycaemia
- Type 2 diabetes
- Metabolic dysfunction-associated fatty liver disease
- Obstructive sleep apnoea
- Obesity hypoventilation syndrome
- Idiopathic intracranial hypertension
- Hip and knee osteoarthritis
- Male hypogonadism
- Menstrual irregularities and polycystic ovary syndrome
- Cancer risk

Patient-centered outcome measures related to mental wellbeing, physical function and quality of life also improve with obesity treatment.

Health Impact

Evidence supporting the positive health outcomes of treating obesity with pharmacotherapies is highlighted by recent clinical data.

Semaglutide (Wegovy®) is approved by the TGA for chronic weight management in people with obesity. It has also been shown to reduce cardiovascular death, stroke and myocardial infarction over four years in people with obesity and established cardiovascular disease but without diabetes[7]. Wegovy® is now TGA approved (but not PBS listed) as an adjunct to standard of care therapy to reduce the risk of major adverse cardiovascular events (death, heart attack, stroke) in adults with established cardiovascular disease and a BMI $\geq$ 27 and without diabetes.

Tirzepatide (Mounjaro®), also TGA approved for chronic weight management in people with obesity, recently received TGA approval for the treatment of moderate-to-severe obstructive sleep apnoea in adults with obesity but is not PBS listed.

Economic Impact

In 2018, obesity cost Australia **$11.8 billion** in direct healthcare costs — a figure projected to rise to **$87.7 billion** by 2032 without effective intervention[4]. Investing in obesity treatment offers substantial economic benefits, including:

- **Reduced healthcare expenditure** through lower chronic disease rates
- **Improved workforce productivity** and reduced absenteeism
- **Positive return on investment** from both direct health savings and broader economic gains

Equity Impact

Obesity disproportionately affects vulnerable populations including Aboriginal and Torres Strait Islander (First Nations) peoples (with four in ten children/adolescents and three in four adults affected) and individuals in the lowest socioeconomic groups[8].

The National Obesity Strategy 2022 Ambition 3 commits to ensuring:

> *"...all Australians have access to intervention and supportive health care.*"

Strategy 3.3 specifically recognises the need for:

> "...*a shift in the health system… to provide equitable access to medical and surgical obesity treatments.*"

Addressing obesity through equitable access to pharmacotherapies is essential to closing long-standing health gaps and achieving national commitments on obesity care.

NHS England's Approach to Obesity Care

In March 2025, the National Institute for Health and Care Excellence (NICE) in the UK released interim commissioning guidance for the implementation of funded access to Tirzepatide (Mounjaro®) for the treatment of obesity[6]. NICE has identified a cohort of individuals prioritised for access to Mounjaro® via a phased rollout of treatment based on cost-effective analyses. Eligibility for treatment includes individuals with:

- BMI $\geq$ 40 and four obesity-related health impairments in year one
- BMI $\geq$ 35 and four obesity-related health impairments from year two
- BMI $\geq$ 40 and three obesity-related health impairments from year three

The NICE framework recognises the need to focus on individuals where the greatest health and economic benefits are likely to be realised. This targeted approach provides a strong policy model for Australia to adopt, ensuring that access to safe and effective pharmacotherapies and co-ordinated care is prioritised for those most in need.

Proposed Policy Recommendations

We urge the Australian Government to adopt a **structured model for obesity care**. All Australians with obesity who seek treatment should have access to the full range of evidence-based options. This includes bariatric metabolic surgery and allied health practitioner support in addition to pharmacotherapies for obesity.

As a **first step** to providing access to funded pharmacotherapies for obesity, given the significant costs, we recommend prioritising adults with **clinical obesity** for PBS-funded access to evidence-based pharmacotherapy. Specifically, this should include individuals who meet the following criteria:

- **Body mass index (BMI) ≥40** or >35 for Aboriginal and Torres Strait Islander (First Nations) peoples with adjustments for other specific populations*, **and**
- **Either:**
    - At least **three serious** obesity-related health impairments** regardless of severity, **or**
    - **One severe** obesity related health impairment**

This cohort represents individuals with obesity with the **greatest clinical need and the highest potential for health gain and economic benefit**. Prioritising their access to pharmacotherapies will maximise health gains, reduce long-term healthcare costs and deliver on national commitments to health equity.

We ask the Government to adopt this evidence-informed approach, aligning with international best practice and fulfilling the vision set out in the National Obesity Strategy — ensuring Australians living with obesity receive meaningful, equitable, and effective treatment.

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*We propose that BMI adjustments for specific populations reflect World Health Organisation recommendations (usually reduced by 2.5 kg/m^2 for people of South Asian, Chinese, other Asian, Middle Eastern, Black African or African-Caribbean ethnic backgrounds) and consensus agreement for Aboriginal and Torres Strait Islander (First Nations) peoples.

**Obesity-related health impairments include cardiovascular diseases, non-diabetic hyperglycaemia, type 2 diabetes, chronic kidney disease, metabolic dysfunction-associated fatty liver disease, obstructive sleep apnoea, obesity hypoventilation syndrome, hypertension, dyslipidaemia, male hypogonadism, polycystic ovary syndrome, and hip or knee osteoarthritis.

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RACGP Specific Interests

anzos australian & new zealand obesity society

NACOS™ National Association of Clinical Obesity Services

References

1. **Australian Institute of Health and Welfare (AIHW)**, 2025. Overweight and obesity. [online] Australian Institute of Health and Welfare. Available at: https://www.aihw.gov.au/reports/overweight-obesity/overweight-and-obesity/contents/about [Accessed 7 May 2025].
2. **Australian Institute of Health and Welfare (AIHW)**, 2025. Overweight and obesity trends. [online] Available at: https://viz.aihw.gov.au/t/Public/views/PHE251_Fig1to3_9_17062024/DashboardFig3_new [Accessed 7 May 2025].
3. **Rubino, F., Cummings, D.E., Eckel, R.H., Cohen, R.V., Wilding, J.P., Brown, W.A., Stanford, F.C., Batterham, R.L., Farooqi, I.S., Farpour-Lambert, N.J. and le Roux, C.W.**, 2025. Definition and diagnostic criteria of clinical obesity. The Lancet Diabetes & Endocrinology, [e-journal] Available at: https://www.thelancet.com/journals/landia/article/PIIS2213-8587(24)00316-4/abstract [Accessed 7 May 2025].
4. **Department of Health and Aged Care**, 2022. National Obesity Strategy 2022–2032. [online] Australian Government. Available at: https://www.health.gov.au/resources/publications/national-obesity-strategy-2022-2032 [Accessed 7 May 2025].
5. **Ryan, D.H. and Yockey, S.R.**, 2017. Weight loss and improvement in comorbidity: differences at 5%, 10%, 15%, and over. Current Obesity Reports, 6(2), pp.187–194.
6. **NHS England**, 2024. Interim commissioning guidance: Implementation of the NICE technology appraisal TA1026 and the NICE funding variation for Tirzepatide (Mounjaro®) for the management of obesity. [online] NHS England. Available at: https://www.england.nhs.uk/publication/interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-nice-funding-variation-for-tirzepatide-mounjaro-for-the-management-of-obesity [Accessed 7 May 2025].
7. **Lincoff, A.M., Brown-Frandsen, K., Colhoun, H.M., Deanfield, J., Emerson, S.S., Esbjerg, S., Hardt-Lindberg, S., Hovingh, G.K., Kahn, S.E., Kushner, R.F. and Lingvay, I.**, 2023. Semaglutide and cardiovascular outcomes in obesity without diabetes. New England Journal of Medicine, 389(24), pp.2221–2232.
8. **Obesity Evidence Hub**, 2025. Obesity trends across socioeconomic groups. [online] Available at: https://www.obesityevidencehub.org.au/collections/trends/socio-economic-group [Accessed 7 May 2025].