THE McKell Institute

MENZIES RESEARCH CENTRE

A preventable crisis

TACKLING THE LONG-TERM IMPACTS OF OBESITY ON AUSTRALIANS' HEALTH AND PROSPERITY

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ABOUT THIS REPORT

This report is a joint study by the **McKell Institute** and the **Menzies Research Centre**, commissioned by Novo Nordisk.

McKell and Menzies have partnered to examine this long term and structural health and economic challenge, bringing a broad ideological and analytical framework to the study.

Foreword

Australia is commonly perceived as a healthy country. It has an active population and an advanced and accessible health system. But many would be surprised to learn that around 66% of Australian adults are living with overweight or obesity. This places Australia higher than average for developed countries, and rates in Australia have been climbing over recent years.

These are not just statistics, they carry real personal and economic consequences. Around 27,500 Australians die each year from preventable diet related causes, and obesity now accounts for a leading share of the national burden of disease.

Obesity does not just shorten lives, it contributes to lower productivity and costs the government and taxpayer in the long run. Through higher public health costs and a decreased workforce.

Yet Australia spends only around 2 per cent of total health expenditure on prevention, below the OECD average of 3 to 4 per cent. The system remains overwhelmingly geared towards managing chronic disease rather than preventing it.

This report, a collective effort between the McKell Institute and the Menzies Research Centre, frames the challenge using the latest data from Australia and around the world. The report charts a course for reform and provides several recommendations and policy options for a willing government to consider.

EDWARD CAVANOUGH
CEO, McKell Institute

DAVID HUGHES
Executive Director, Menzies Research Centre

Executive Summary

Obesity is the defining public health challenge of our times. Obesity levels globally have reached pandemic proportions, placing unprecedented strain on healthcare systems and economies around the world. Australia is a notable party to this trend. With more than two thirds of adults and one in four children classified as living with overweight or obesity, Australia ranks above the OECD average.

In 2024, overweight and obesity were the leading cause of preventable health loss and responsible for 8.3% of the total burden of disease in Australia.

The consequences of this trend extend far beyond public health. Obesity leads to worsening economic outcomes and entrenches social inequities. The 2022 National Obesity Strategy forecast that the economic impact of obesity would reach AUD $87.7 billion annually by 2032. Without intervention, this is projected to grow to 3.49% of GDP by 2060, or around USD $158 billion.

These costs are driven not only by direct healthcare expenditure but also by indirect costs, including reduced productivity, absenteeism, early retirement due to disability and premature death. Moreover, obesity disproportionately affects socioeconomically disadvantaged groups and rural and regional populations, reinforcing health inequities.

Current strategies are not working. Australia spends only about 2 per cent of its total health budget on prevention, which compares unfavourably with the OECD average of 3 to 4 per cent. Responsibility for obesity policy is split across various Commonwealth departments and State governments. There is no single agency empowered to enforce measurable national targets. Consequently, no single entity is accountable for its success or failure.

Obesity is more than just an individual lifestyle issue or solely a public health issue. It is also an economic and social challenge that requires a co-ordinated policy response.

The policy recommendations in this report aim to enhance public health outcomes, strengthen workforce productivity, improve long-term fiscal sustainability and boost quality of life across the population.

Key Findings

FINDING 1:

Obesity is widespread in Australia, which has among the highest rates of obesity in the OECD. Approximately **67% of Australian adults** (two in three) are classified as living with overweight or obesity. Between 1995 and 2022, the proportion of adults in this category rose from 56% to 66%.

FINDING 2:

Australia has an alarming rate of childhood obesity. Around **one in four Australian children** aged 5-17 is living with overweight or obesity. This is particularly concerning because **80% of obese adolescents** suffering from obesity continue to live as with obesity as adults, creating a dangerous intergenerational cycle.

FINDING 3:

The cost to the Australian economy is the equivalent of 2 per cent of GDP. The total economic cost of obesity in Australia was estimated at AUD $39 billion in 2019 (1.9% of GDP). Without intervention, this burden is forecast to reach $87.7 billion annually by 2032.

FINDING 4:

Obesity is exacerbating Australia's productivity challenge. 60% of the economic burden of obesity ($23-25 billion annually) is attributed to lost productivity. This includes costs from absenteeism, "presenteeism" (reduced productivity while at work), and premature death.

FINDING 5:

Obesity contributes to 8.3 per cent of Australia's preventable disease burden. In 2024, overweight and obesity were the leading cause of preventable health loss in Australia, responsible for 8.3% of the total burden of disease. Obesity is a major driver of non-communicable diseases, **contributing to 54.5% of the total burden of type 2 diabetes** in Australia. It is also linked to cardiovascular disease, at least 13 types of cancer, and mental health issues like depression.

FINDING 6:

Severe obesity is increasing rapidly among Australians**.** The number of Australians living with severe obesity (body mass index (BMI) ≥40) more than doubled from **2.2% in 2008 to 4.6% in 2023**. Over one million adults are now estimated to be in this highest obesity category.

FINDING 7:

Entrenched Health Inequities. Obesity disproportionately affects those in **lower-income groups** and **regional/remote areas**. Children from the lowest income quintile are nearly twice as likely to experience obesity as those from the highest quintile.

FINDING 8:

Underinvestment in Prevention. Australia spends only about **2% of its total health budget on prevention**, which is consistently lower than the OECD average of 3% to 4%.

FINDING 9:

There is an inconsistent approach to treating and preventing obesity across Australia. Without a single funded, coordinated national framework with enforceable commitments, fragmented state-level strategies limit overall effectiveness, perpetuate inequities, and hinder progress in reversing rising obesity rates and their substantial health and economic burden.

FINDING 10:

Obesity is treatable and preventable. Effective treatment options, medicines, and approaches are available to meaningfully address obesity, but they are currently under-utilised due to barriers in access and implementation. Governments should pursue an 'all of the above' strategy to maximise their impact.

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Part 1:
Understanding the Nature of Obesity in Australia and Beyond

Obesity is among the most pressing public health challenges of the twenty-first century. It is anticipated that one in seven adults around the world are expected to be living with obesity by 2030.[1] Overweight is defined as a body mass index (BMI) of 25.0 to 29.9 kg/m², and obesity as a BMI of 30.0 kg/m² or higher.[2] More severe forms of obesity are also classified using higher BMI thresholds, with Class I obesity defined as 30.0–34.9 kg/m², Class II obesity as 35.0–39.9 kg/m², and Class III (severe obesity) as a BMI of 40.0 kg/m² or above.[3]

Once perceived primarily as an individual lifestyle issue, obesity is now widely recognised as a complex condition shaped by biological, environmental, social, and economic determinants. Globally, it has reached pandemic proportions, placing unprecedented strain on healthcare systems and economies. Australia is no exception. With two in every three adults classified as living with overweight or obesity, the nation ranks among the worst affected countries in the developed world.[4] The consequences of this trend extend far beyond health outcomes, influencing productivity, healthcare expenditure, social equity, and broader policy priorities. For policymakers, understanding the nature of these trends and their consequences is essential to designing and implementing interventions to minimise and mitigate these impacts.

OBESITY IN THE GLOBAL CONTEXT

Obesity is now a defining feature of global health. According to the World Health Organization (WHO), adult obesity has more than doubled since 1990, and adolescent obesity has quadrupled.[5] By 2030, it is projected that more than one billion people will be living with obesity.[6] The condition is no longer confined to high-income nations; low- and middle-income countries are increasingly burdened as urbanisation, dietary shifts, and sedentary lifestyles take hold.[7]

Despite numerous prevention campaigns, no country has succeeded in reversing its obesity epidemic in the last 40 years. For example, while the most recent Center for Disease Control (CDC) data shows a small reduction in overall obesity prevalence (from 42.4% in 2017-2018 to 40.3% in August 2021-August 2023), there is a continued rise in severe obesity (from 9.2% to 9.7%).[8] On present trends, the world will not meet the World Health Assembly's 2025 targets for the prevention and control of non-communicable diseases (NCDs), which include a "halt in the rise in diabetes and obesity" and a "25% relative reduction in overall premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases", based on 2010 baselines.[9]

This suggests that traditional interventions, often focused narrowly on personal responsibility and behaviour modification, are insufficient. At the same time, understanding obesity requires a broader multi-factorial lens that recognises the interaction between structural influences and individual-level biological and medical drivers. While food environments, urban planning, advertising, and socioeconomic inequality shape population risk and opportunity for healthy behaviours,[10] hereditary predispositions, the effects of certain medicines, and underlying medical conditions can also play a significant role in weight gain and metabolic health. We must

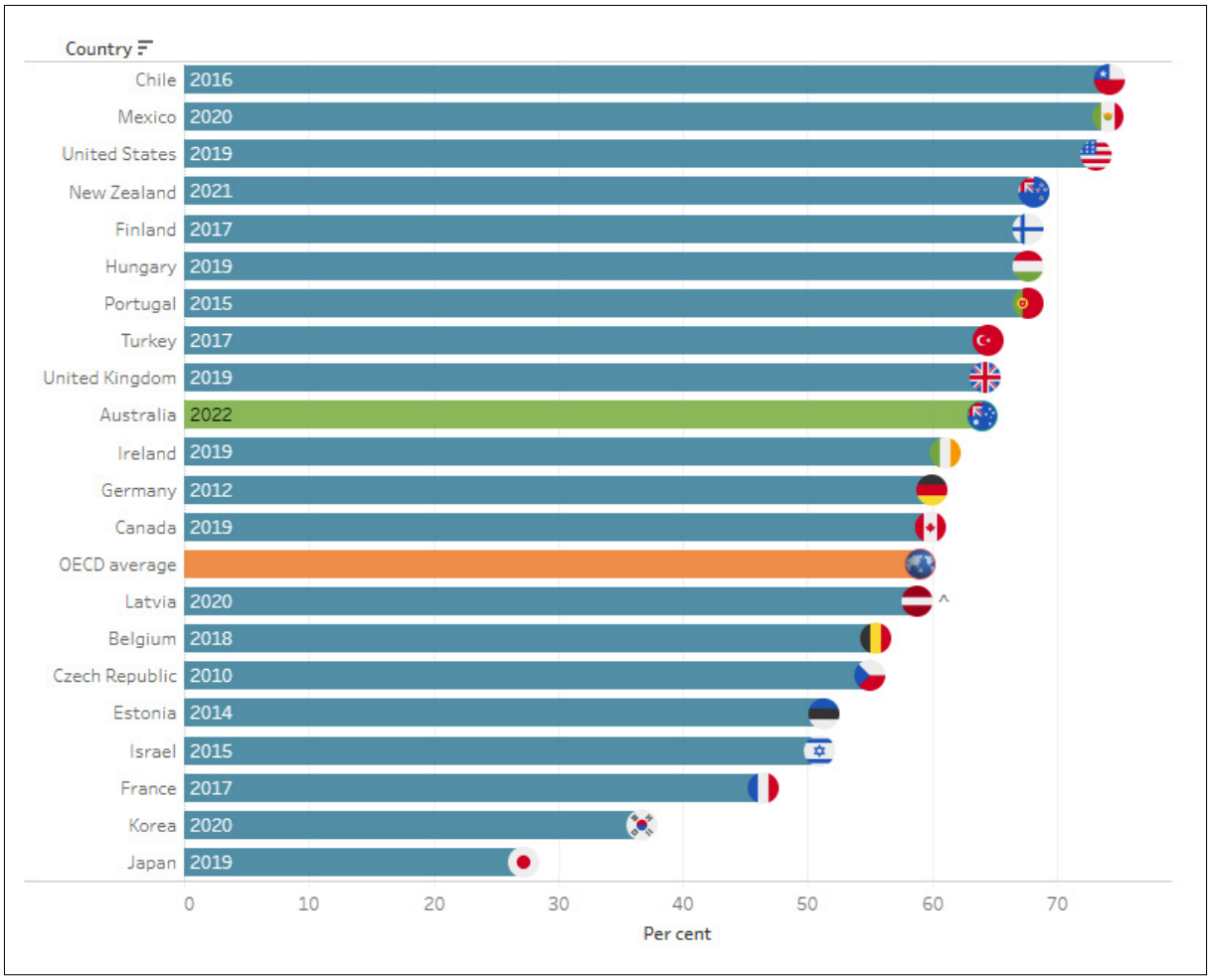
frame obesity as a complex, multi-factorial condition shaped by the interaction of structural determinants with clinically and genetically mediated pathways, so that prevention and treatment strategies can respond effectively to diverse causes and lived experiences.

The global burden is not only measured in health outcomes but also in economic costs. The worldwide economic impact of overweight and obesity in 2020 was estimated at 2.19% of GDP, projected to rise to 3.29% by 2060 without effective interventions.[11] This represents trillions of dollars in healthcare expenditure and productivity losses annually. However, this is not an inevitable outcome. A reduction in projected obesity prevalence by only 5% annually from current trends will translate into average annual reductions of USD$429 billion globally.[12]

THE STATE OF OBESITY IN AUSTRALIA

Australia's rates of obesity are among some of the highest in the Organisation for Economic Cooperation and Development (OECD). Approximately 66% of Australians are living with overweight or obese, placing the country above the OECD average.[13] Alarmingly, the prevalence of severe obesity (class III, BMI ≥40 kg/m^2) is also rising, with significant implications for health services and life expectancy.

FIGURE 1: ADULT OVERWEIGHT AND OBESITY PREVALENCE IN OECD COUNTRIES (APPROXIMATE VALUES, OECD COMPARISON).

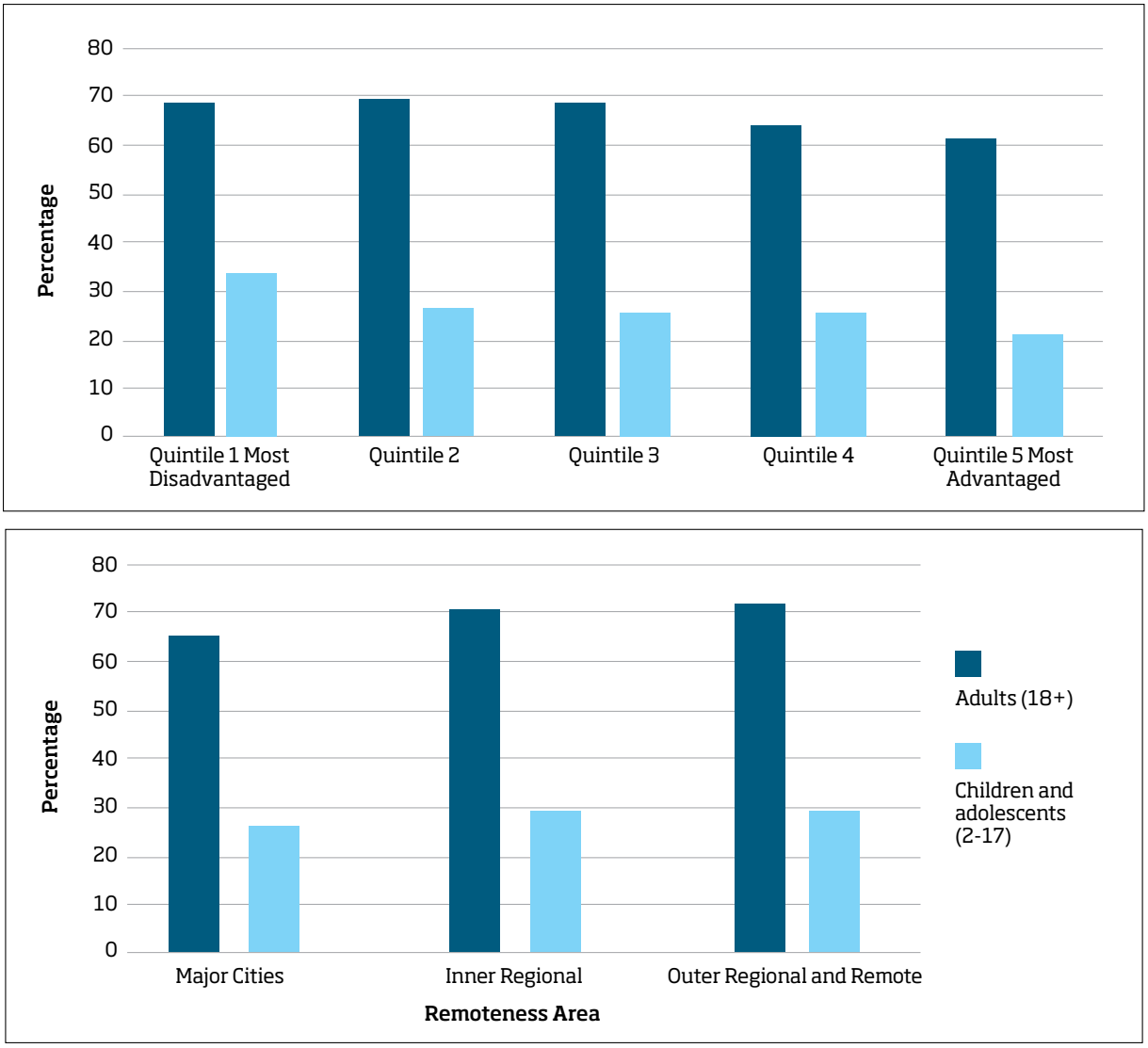


Sources: AIHW

In recent decades, Australia has witnessed a significant and troubling rise in the prevalence of obesity, marking a critical public health concern. The multifaceted nature of this issue encompasses lifestyle issues, dietary habits, societal, and economic factors, creating a complex web that demands comprehensive attention. Without intervention, the negative impact on Australia's GDP looks likely to grow to USD$158 billion (approximately AUD $240–250 billion, depending on exchange rates) by 2060, representing approximately 3.49% of GDP.[14]

Obesity is also not evenly distributed across the Australian population. Rates are higher in regional and remote areas compared with metropolitan centres, and in lower-income groups compared with higher-income households,[15] among people from culturally and linguistically diverse (CALD) backgrounds, and among Aboriginal and Torres Strait Islander peoples.[16]

FIGURE 2: PROPORTION OF AUSTRALIAN ADULTS (18+) AND CHILDREN AND ADOLESCENTS (2-17) LIVING WITH OVERWEIGHT OR OBESITY, BY SOCIOECONOMIC AREA AND REMOTENESS AREA

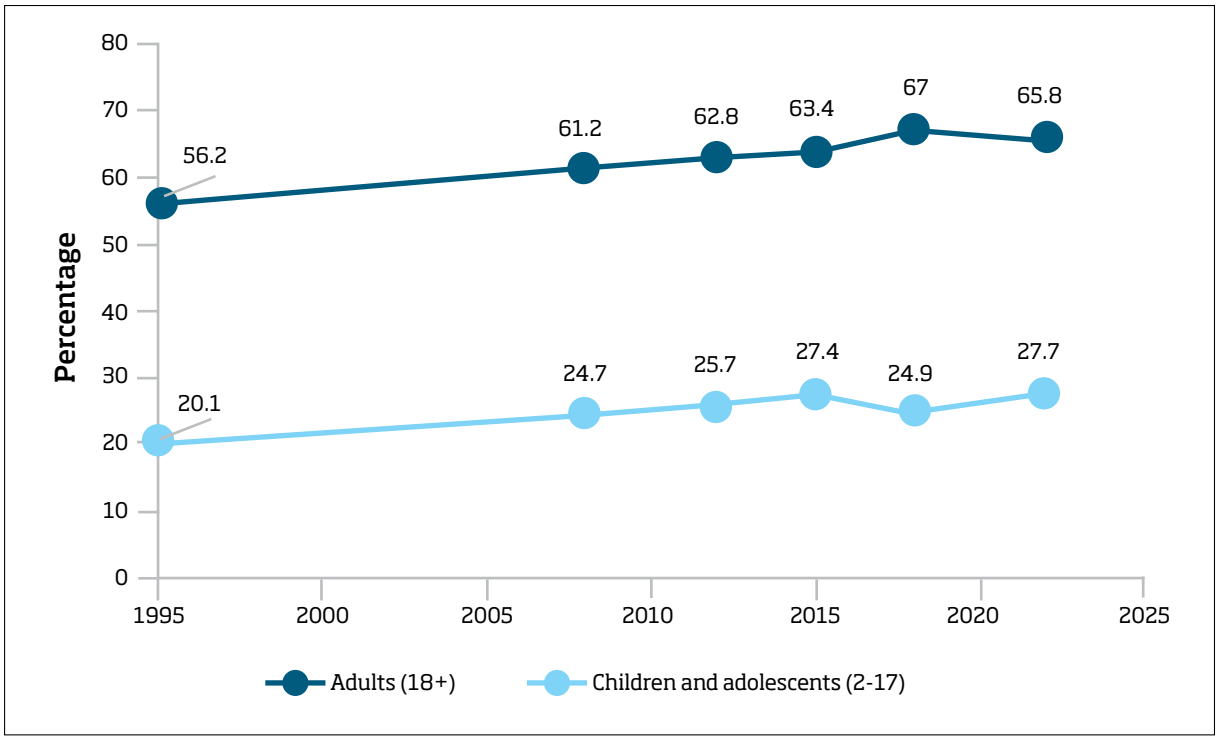


Source: AIHW (2020)

Adult Obesity

Between 1995 and 2022, the proportion of Australian adults classified as living with overweight or obesity rose from 56% to 66%.[17] Middle-aged Australians are particularly affected. By the ages of 45-54, 83% of men and 74% of women are living with overweight or obesity.[18] These patterns indicate that the prevalence of overweight and obesity increases across adulthood, consistent with longitudinal evidence that body weight status often tracks over time.[19] While childhood overweight and obesity remain significant public health concerns, absolute prevalence rates are substantially lower than those observed among adults,[20] underscoring the importance of life-course approaches that address risk accumulation and changing exposures at different stages of life.

FIGURE 3: PROPORTION CHILDREN AND ADOLESCENTS AGED 5–17, AND ADULTS AGED 18 AND OVER LIVING WITH OVERWEIGHT OR OBESITY, 1995 TO 2022



Source: Australian Institute of Health and Welfare (2024), Overweight and obesity, AIHW

Australian Children are Experiencing Increasing Obesity Rates

Childhood obesity represents one of the most concerning trends. Around one in four Australian children aged 5-17 is living with overweight or obesity.[21] Although this prevalence has stabilised since 2007-08, it remains at historically high levels. Evidence shows that 80% of adolescents living with obesity, continue to live with the disease as adults.[22] This creates a dangerous intergenerational cycle of poor health, increasing healthcare costs, reduced workforce participation, and worsening social and economic outcomes.

Moreover, childhood obesity is socially stratified. Children from the lowest income quintile are almost twice as likely to experience obesity as those from the highest quintile. This entrenches health inequalities and foreshadows future burdens on disadvantaged communities.

Childhood obesity is particularly troubling as it not only increases the immediate risks for children but also sets the stage for potential long-term health issues in adulthood.

DRIVERS OF OBESITY

Obesity in Australia is driven by a complex interplay of social, environmental, behavioural, and biological factors. A key driver is dietary patterns, particularly high consumption of ultra-processed and energy-dense foods. Studies have linked ultra-processed food intake in Australians to higher obesity risk.[23] Overconsumption stems not just from personal choice but from the nature of the food and beverage market, including the ready availability of fast-food outlets, large portion sizes, and aggressive marketing by the food and beverage industry.[24]

Physical inactivity is another major contributor. Many Australians do not meet recommended exercise benchmarks, resulting in an energy imbalance (more calories consumed than expended). Urban planning, car dependence, and sedentary work/lifestyle patterns reinforce low activity levels. Socioeconomic disadvantage, health inequities, and lower levels of physical activity also influence obesity rates. As the data shows, people in lower-income and non-metropolitan areas face higher obesity prevalence and fewer healthy food and exercise opportunities.

Biological and genetic factors further play a role: metabolism, appetite regulation, and fat distribution differ between individuals, affecting weight gain risk.[25] These drivers clearly demonstrate that obesity is not merely a matter of individual willpower, but a systemic public health issue shaped by social determinants, markets, and environments.

OBESITY LEADS TO FURTHER HEALTH COMPLICATIONS

The consequences of obesity are profound, extending across physical, psychological, and social dimensions. In Australia, overweight and obesity were the leading cause of preventable health loss in 2024, responsible for 8.3% of the total burden of disease.[26]

Obesity is a major risk factor for several NCDs, including cardiovascular disease, type 2 diabetes, musculoskeletal disorders, and certain cancers. It is estimated to contribute to 3.6% of all cancers globally, including colorectal, breast, ovarian, and pancreatic cancers.[27] In 2019, obesity-related ill-health accounted for more than five million deaths worldwide, with over half occurring before the age of 70.[28]

Researchers have found that the risk of mortality increases in line with the number of years lived with obesity.[29] This is important when considering the population health burden associated with obesity. Evidence suggests that while the relative increase in all-cause mortality risk for people in the 'overweight' BMI range is generally small, the risk rises more substantially with increasing BMI, particularly with each additional five-unit increase and at higher levels of obesity. This highlights that mortality risk is better understood as increasing progressively across the BMI spectrum rather than being confined only to severe obesity.[30]

To calculate combined fatal and non-fatal burden of disease, researchers use the concept of 'disability-adjusted life years' (DALYs), which assigns a numeric value to the years of healthy life lost due to illness. For example, four years lived with a chronic illness might become 2 DALYs. In 2024, overweight and obesity in Australia contributed to 54.5% of the total burden (in DALYs) from type 2 diabetes, and a substantial proportion of the burden from hypertensive heart disease, uterine cancer, gout, chronic kidney disease, gall bladder and bile duct disease, oesophageal cancer, atrial fibrillation, coronary heart disease burden and osteoarthritis.[31] This reflects both the high prevalence of excess weight and its strong association with chronic disease risk. Over time, the total burden from type 2 diabetes has also grown markedly. Global Burden of Disease estimates for Australia suggest that DALYs attributable to type 2 diabetes increased from 70,348 in 1990 to 169,763 in 2019, representing an absolute increase of around 99,000 healthy life years lost and a relative increase of approximately 140% over that period.[32]

As outlined in Table 1 below, excess weight is associated with a wide range of physical and mental health conditions across multiple body systems, reflecting both metabolic and mechanical pathways through which overweight and obesity contribute to disease burden over time.

TABLE 1: SELECTED HEALTH CONDITIONS ASSOCIATED WITH OVERWEIGHT AND OBESITY

Category	Health Problems	Impacts on Health
Metabolic disorders	Type 2 diabetes	Obesity causes excess fat accumulation, particularly around the abdomen, which disrupts insulin sensitivity and leads to insulin resistance and impaired glucose regulation[33] and an increased risk of developing type 2 diabetes. Glucose therefore builds up in the blood, which can result in serious complications including damage to the kidneys and eyes, and heart disease and stroke. High blood glucose levels can also result in circulation problems (peripheral vascular disease) and nerve damage (peripheral neuropathy), which can cause foot ulcers and skin infections.[34]
Cardiovascular diseases	Heart disease, hypertension, stroke	Obesity is strongly linked to cardiovascular risk factors such as high blood pressure, atherosclerosis, and elevated blood glucose levels, which translates into greater risk of coronary heart disease, stroke, and cardiovascular mortality.[35]
Cancer	Colorectal; uterine; kidney; breast; oesophageal; liver; gallbladder; pancreas; thyroid; ovary; gastric cardia (part of the stomach); multiple myeloma (a blood cancer) and meningioma (a type of brain tumour)	Excess weight can lead to cancer as a result of metabolic and hormonal changes and chronic inflammation that may cause the body to produce abnormal cells.[36] The International Agency for Research on Cancer has linked overweight and obesity to at least 13 different types of cancer.[37]
Liver disease	Non-alcoholic fatty liver disease	Excess weight is associated with an increased risk of non-alcoholic fatty liver disease (NAFLD), which is when fat tissue builds up in the liver. In time, this accumulation of fat can cause inflammation and the formation of scar tissue, in a condition called non-alcoholic steatohepatitis (NASH) which can then lead to cirrhosis of the liver, a type of liver damage where healthy cells are replaced by scar tissue.[38]

Category	Health Problems	Impacts on Health
Mental Health and Neurological impacts		There is a growing body of evidence that obesity is a risk factor for dementia and Alzheimer's Disease,[39] which may be due to inflammation, insulin resistance and cellular stress in areas of the brain thought to be involved in progression of the disease.[40 41] Obesity is also linked to depression with the results of a major Australian diabetes, obesity and lifestyle study finding that depression was nearly twice as common among people with obesity compared to those who did not have obesity[42]
Musculoskeletal disorders	Osteoarthritis, chronic pain	Musculoskeletal disorders including osteoarthritis and low back pain are associated with excess weight, due to inflammation[43]
Respiratory issues	Obstructive Sleep Apnoea, Reduced Lung Function	Obesity is strongly linked with respiratory symptoms and diseases including asthma, chronic obstructive pulmonary disease (COPD) and obstructive sleep apnea, due to its physical effects (for example, weight gain is associated with decreases in lung volumes) and systemic inflammation[44]

ECONOMIC COSTS OF OBESITY

The economic burden of obesity in Australia is staggering. The 2022 National Obesity Strategy forecast that the economic impact of obesity would reach AUD $87.7 billion annually by 2032[45]. Without intervention, this is projected to grow to 3.49% of GDP by 2060, or around USD $158 billion[46].

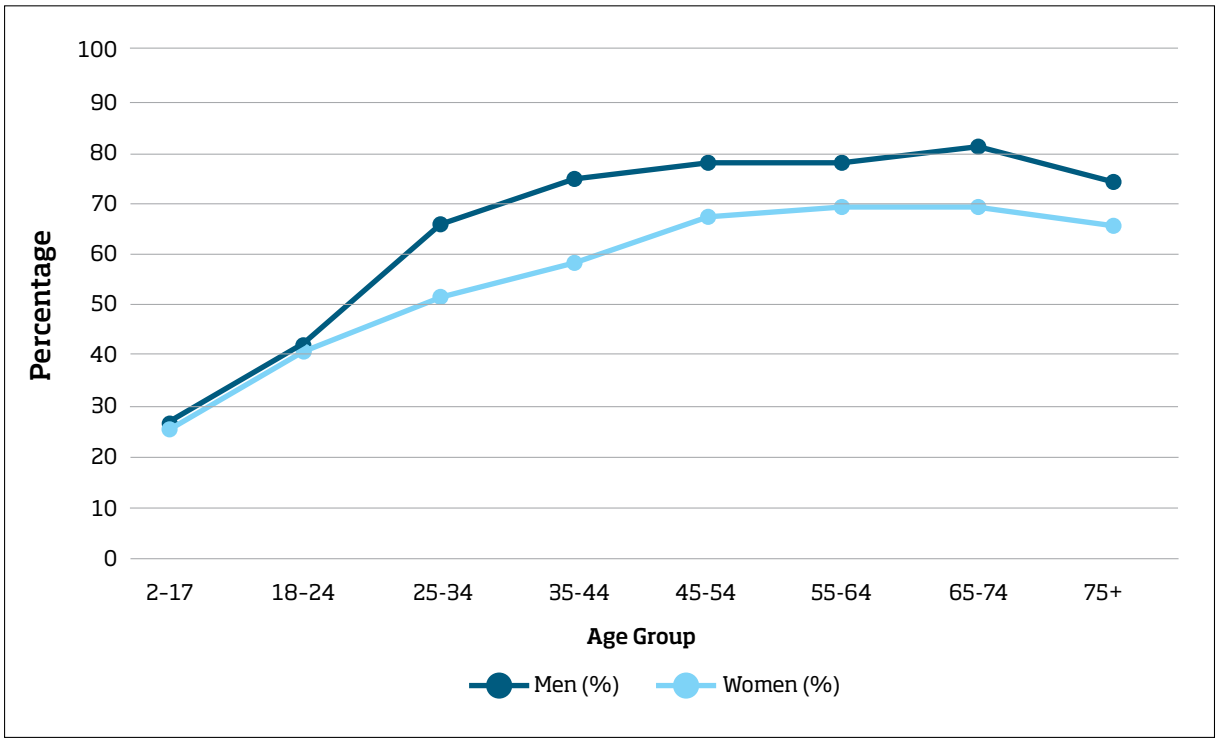
These costs are driven not only by direct healthcare expenditure but also by indirect costs, including reduced productivity, absenteeism, and early retirement due to disability.

At the individual level, the lifetime economic cost of childhood obesity has been estimated at between AUD $19,700 and $46,000 per capita. Achieving the National Obesity Strategy's modest target of reducing childhood obesity by 5% by 2032 could save AUD $7.44 billion in lifetime costs.[47]

LIFE-COURSE DIMENSION OF OBESITY

Obesity is considered a cumulative, chronic disease. Most adults with obesity developed it before the age of 25, and excess weight is commonly gained between adolescence and early adulthood. Figure 4 below demonstrates the cumulative proportion of adults overweight or obese in 2022.

FIGURE 4: PROPORTION OF ADULTS WHO WERE LIVING WITH OVERWEIGHT OR OBESITY BY AGE AND SEX, 2022



Source: ABS.[48]

This life-course perspective is critical for policymakers. Investments in early prevention can generate substantial long-term health and economic benefits. Childhood overweight and obesity are associated with higher likelihood of obesity in adulthood and increased risks of chronic disease and premature mortality, while modelling suggests that even modest reductions in prevalence can produce significant lifetime healthcare and productivity cost savings.[49]

Worryingly, in Australia, for every 200 children who visit their family GP, 60 are living with overweight or obesity, but only one is offered weight management support.[50]

POLICY RELEVANCE: WHY OBESITY MATTERS

For policymakers, obesity represents a nexus between public health, economics, and social equity. Addressing it is essential to maintaining a sustainable health system, ensuring workforce productivity, and improving quality of life across the population.

Strain on the Health System

Obesity exacerbates demand for primary care, emergency departments, and specialist services. By 2032, the economic cost of obesity is expected to exceed AUD $88 billion,[51] straining government budgets and limiting investment in other health priorities. Policymakers therefore face a dual challenge: mitigating the growth of obesity while expanding access to effective treatment.

Preventive vs. Curative Policy

Current strategies in Australia have been criticised as inadequate, with a tendency to prioritise awareness campaigns over structural reforms. Voluntary measures, such as the Health Star Rating system for packaged foods, have fallen short, with only 36% of eligible products carrying the label.[52] International evidence suggests stronger interventions–such as taxes on sugar-sweetened beverages, restrictions on junk food advertising, and urban planning to encourage active living–can deliver measurable outcomes.[53]

Social Equity

Obesity disproportionately affects socioeconomically disadvantaged groups and rural and regional populations, reinforcing health inequities. For policymakers committed to equity, addressing obesity is not only about reducing BMI averages but about ensuring all Australians have access to affordable healthy food, safe spaces for exercise, and equitable access to treatment services.

CONCLUSION

Obesity in Australia must be understood as both a national crisis and part of a global epidemic. Its rising prevalence reflects deep structural and environmental factors rather than individual failings. The consequences–ranging from poor health outcomes and social exclusion to spiralling healthcare costs–make obesity one of the most urgent issues for public health and policymakers.

The broader economic costs of obesity are clearly significant. However, of more pressing concern is the expected fiscal burden imposed on governments resulting from ongoing increases in obesity rates. Australian governments are already under considerable fiscal pressure within the healthcare system. As Australia's population gets older, the healthcare system will experience ongoing, increasing patient volume. Servicing this need will become increasingly challenging. Australia's high rates of obesity, particularly childhood obesity, foreshadow a future of compounding health and economic challenges if left unaddressed. Yet the situation is not irreversible. Evidence demonstrates that even modest reductions in prevalence can yield significant health and economic benefits.[54] Governments must consider strategic policy and programmatic interventions to limit avoidable interactions with the primary health system. For policymakers, the imperative is clear: tackling obesity requires comprehensive, multi-sectoral action that addresses both prevention and treatment, and that confronts the social determinants underpinning the epidemic.

Gap Analysis and Policy Review

EFFECTIVENESS AND LIMITATIONS OF EXISTING AUSTRALIAN FRAMEWORK

Overweight and obesity affects over two-thirds of Australian adults and one in four children. Prevalence continues to rise, particularly in lower socioeconomic groups, placing increasing pressure on the health system, Commonwealth budgets, and national productivity.

Over the decade from 2012 to 2022 the proportion of adults living with overweight and obesity increased from 62.8 per cent to 65.8 per cent,[55] and where, more concerningly, the number of Australians living with severe obesity (BMI of 40 or more) has more than doubled from 2.2 per cent in 2008 to 4.6 per cent in 2023.[56]

An alternative indicator of living with overweight or obesity is the measurement of someone's waist circumference, which acts as a good indicator of total body fat. A higher waist measurement (above 94cm for men and 80cm for women) is generally associated with increased risk of disease. The average waist measurement of an Australian adult is 95.1cm and more than two in three (67.9 per cent) of adults have a waist circumference that puts them at an increased risk of disease.[57] Alongside waist circumference, BMI remains the most commonly used population-level indicator for monitoring weight status. As shown in Table 2, national data indicates that around one-third of Australian adults fall within the healthy weight range, while the majority are classified as either living with overweight or obesity.

TABLE 2: BMI BREAKDOWN (ADULTS, AUSTRALIA)[58]

BMI Category	BMI range (kg/m²)	Population share (approx.)
Normal weight	18.5-24.9	~34%
Overweight (not obese)	25.0-29.9	34%
Obese (all classes)	≥30.0	32%

Source: AIHW 2024[59]

Of Australia's 22,190,000 people aged over 18,[60] more than 7 million people are estimated to live with obesity (BMI above 30) and specifically, more than one million are in the highest category of obesity with a BMI above 40.

Continual rises in the number of Australians living with overweight and obese are coinciding with a steep rise in type 2 diabetes from around 400,000 people in 2000 to over 1.2 million now.[61] This accounts for between 85 to 90 per cent of all diagnosed diabetes cases in the country with the total cost coming to $9.1 billion per year.[62]

Previous estimates in 2020-21 put the cost at $3.4 billion and was broken down by:

- $373 million was attributed to type 1 diabetes
- $2.3 billion was attributed to type 2 diabetes
- $71.6 million was attributed to gestational diabetes
- $668.2 million was attributed to 'other/unspecified' diabetes.[63]

Type 2 diabetes in Australia isn't a disease shared evenly across age brackets–it is predominantly a disease affecting older people. In 2021, almost 1.2 million Australians (4.6% of the population) were living with type 2 diabetes. Prevalence increased markedly with age, with only 3.1% of people with the condition aged under 40, compared with 59% aged 65 years and over. Rates were highest among people aged 80-84.[64]

Type 2 diabetes is influenced by a combination of modifiable and non-modifiable risk factors. While the condition becomes more common with age and is shaped by genetic predisposition and life-course exposures, national evidence shows that healthy weight, physical activity and other preventive measures can reduce the risk of developing the disease.[65]

Between 2018 and 2020, the Commonwealth spent $481 million on certain GLP-1 RAs through the PBS to treat type 2 diabetes, with restrictions on how people can be prescribed and access the drug through the scheme.[66] Beyond that, in 2021-22 GLP-1 RAs had grown to the highest cost medicine, accounting for 26 per cent of PBS expenditure on type 2 diabetes and costing $194 million for the year,[67] and in the 2023-24 financial year, this number had grown to $284.6 million.[68]

AUSTRALIA IN AN OBESITY EPIDEMIC

Recent trends in rising waist circumference are cause for concern if they continue, given the potential to compound pressures across the health system and the economy. Increasing prevalence of excess weight is associated with higher hospital utilisation, reduced workforce productivity, and a growing number of older Australians being diagnosed with type 2 diabetes.

Yet despite this, Australia spends only about 2 per cent[69] of its total health budget on preventions and is consistently below the OECD average of 3 to 4 per cent.[70]

The lack of preventative measures has resulted in several consequences:

- **High Burden of Chronic Disease**: Nearly 60% of Australians live with a chronic illness, and over one-third of the total disease burden is preventable by addressing key risk factors like poor diet, physical inactivity, obesity, and tobacco use.
- **"Sickcare" System**: The health system is primarily geared towards managing and treating existing conditions, often referred to as a "sickcare" system, rather than a holistic healthcare system that prioritises prevention. This approach is better suited to last century's acute care needs than the current chronic disease incidence.
- **Avoidable Hospitalisations and Costs**: In 2018-19, $24 billion in healthcare expenditure was attributable to modifiable risk factors, representing significant ongoing avoidable costs. Poor management of chronic disease costs the healthcare system millions in avoidable hospital admissions each year. It is estimated that $320 million per year is spent on avoidable hospital admissions.[71]

The National Preventive Health Strategy 2021-2030 highlights the scale of diet-related health risks in Australia.[72] It estimates that around 27,500 people die prematurely each year due to unhealthy diets, while Australia has one of the highest obesity rates among comparable OECD countries, ranking sixth out of 22. Dietary patterns remain a key concern, with around 95% of adults failing to consume adequate fruit and vegetables, and a similarly high proportion of children not meeting recommended vegetable intake. Discretionary foods contribute about one-third of Australians' daily energy intake, rising to around 41% among teenagers. Much of the population's salt intake is also hidden in packaged and processed foods, which account for approximately 75% of total consumption. At the same time, the Strategy notes emerging evidence linking healthier dietary patterns with broader wellbeing outcomes, including an estimated 30% lower risk of depression among individuals consuming higher-quality diets. Front-of-pack nutrition labelling remains unevenly adopted, with the Health Star Rating displayed on about 36% of eligible packaged foods and drinks.[73]

Obesity Prevention

Despite more than a decade of national strategies and programmes, obesity prevalence has plateaued at historic highs. The legal and policy response remains fragmented across federal portfolios (Health, Treasury, Education, Sport, and Consumer Affairs) and between levels of government. This fragmentation interferes with desired outcomes, inflates costs, and undermines accountability for successful policy implementation.

Australia's response to rising obesity rates is constrained by fragmented governance and uneven policy coordination. When obesity is not addressed through integrated consumer protection, fiscal and accountability frameworks, the health system continues to bear escalating costs associated with largely preventable chronic disease. Establishing a more coherent national

approach, supported by clear statutory mandates and sustained investment in prevention, could strengthen public health outcomes, improve transparency and consumer protections, and deliver more efficient use of public resources over the long term.

POLICY ARCHITECTURE

Australia's obesity policy sits within a multi-layered governance structure that includes international, national, and sub-national entities. At the international level, the World Health Organization ('WHO') sets global targets and frameworks, including the Global Action Plan on Noncommunicable Diseases, which Australia endorses and implements.[74]

The Commonwealth government leads overarching national strategy but lacks binding authority over State and Territory health systems for its implementation. Country-wide coordination occurs through the Health Ministers Meeting, which agrees on joint priorities and develops the National Obesity Strategy (2022-2032), but it has no statutory enforcement power.

State and Territory governments are each responsible for implementing obesity-related policy measures, including school nutrition standards, health promotion initiatives and advertising regulations, leading to considerable variation across jurisdictions.

Finally, beyond formal government structures sits a wider ecosystem of non-government organisations and private actors, including peak industry bodies that operate under voluntary or self-regulatory codes. The result is a policy landscape that is expansive in scope but lacks a clear central point of strategic leadership for obesity policy development and implementation. This fragmentation is also evident in the number of national strategies and guidance documents that address obesity prevention across different policy domains.

In the *National Preventative Health Strategy 2021-2023* there are 11 related strategic guidance strategies or guidelines:

- National Obesity Prevention Strategy (under development)
- Australian Dietary Guidelines
- National Strategic Framework for Chronic Conditions
- Australian National Breastfeeding Strategy: 2019 and Beyond
- National Healthy School Canteen Guidelines
- Infant Feeding Guidelines
- Clinical Practice Care Guidelines: Pregnancy Care 2019 - Chapter 11 Nutrition and physical activity

- Australian Guide to Healthy Eating
- Aboriginal and Torres Strait Islander Guide to Healthy Eating
- National Aboriginal and Torres Strait Islander Health Plan
- The National Agreement on Closing the Gap

Consumer Protection

Australia's obesity policy is increasingly being framed through a consumer protection lens, reflecting the role of Commonwealth and State governments in regulating food marketing, labelling, nutrition claims and taxation.

A. Hard Law

At the Commonwealth level, Australian Consumer Law prohibits misleading or deceptive conduct, shaping how food and beverage companies can present health and nutrition claims. Products that make explicit therapeutic or health claims may also fall within the remit of the Therapeutic Goods Administration, and are therefore subject to its legislation, regulations and regulatory instruments.

The Food Standards Australia New Zealand (FSANZ) Code, established under the *Food Standards Australia New Zealand Act 1991* (Cth), also requires that food labelling must not mislead consumers, placing a statutory obligation on how product information is disclosed.[75] Where these requirements are breached, the Australian Competition and Consumer Commission may investigate and take enforcement action, as it does in other regulated markets.[76]

At the State and Territory level, complementary powers exist under fair trading laws and food Acts to regulate local advertising, retail display, and food safety, giving sub-national regulators authority to act on misleading claims or labelling in their jurisdictions. Meanwhile, the Commonwealth's fiscal levers, such as excise or levy authority over sugar-sweetened beverages, offer another regulatory dimension, allowing price signals to serve as corrective tools. [77]

B. Soft Law

In practice, much of the governance in obesity remains delegated to voluntary schemes: the Health Star Rating system remains voluntary, with only about one-third of eligible packaged foods displaying a rating–far short of the government's own 70% target for 2025;[78] and the Australian Association of National Advertisers codes governing junk-food advertising to children are self-enforced, with limited sanctions.[79]

In practice, what might operate as a coherent consumer protection regime instead functions as a hybrid mix of statutory requirements and voluntary frameworks. This can dilute regulatory effectiveness, limit transparency, and create space for information imbalances between food and beverage producers and consumers.

Fragmented Spending

Funding to address overweight and obesity is fragmented, with an estimated 186 funding allocations ($778 million) at the Commonwealth level alone spent on overweight and obesity prevention initiatives between 2013 and 2022.[80]

The exorbitant costs weigh heavily on the economy: it has been estimated that the costs of obesity-related diseases were $11.8 billion per year as of 2018 (excluding overweight-related costs), a figure that is projected to rise steeply without stronger preventive regulation.[81]

Most preventative expenditure is divided among dozens of small, uncoordinated initiatives: school canteen programs,[82] general practitioner ('GP') weight-management plans,[83] local sport grants, and ad-hoc communication campaigns.[84] Each is administered through separate funding streams with minimal integration, coordination, or oversight.

International evidence demonstrates that structural measures–such as mandatory reformulation standards–yield high economic payoffs on obesity within a relatively short timeframe.[85] Keeping basic, healthy foods GST-free generates favourable price signals for staples; in the same way, other measures may conceivably shape consumer behaviour away from a future of non-communicable and chronic disease. The failure to enact coherent fiscal or regulatory tools means health costs continue to rise while prevention remains inefficiently funded and uncoordinated.

Fragmented Authority

Responsibility for obesity policy is split across Commonwealth departments and State governments, with no single agency empowered to enforce measurable national targets. The National Obesity Strategy (2022–2032) articulates shared goals but has no statutory authority or ring-fenced funding: its implementation relies on voluntary cooperation between jurisdictions.

Despite numerous strategies (NPHS, National Obesity Strategy), Australia lacks a single funded, coordinated national framework with enforceable commitments. Prevention activities are fragmented, under-resourced, and insufficient to alter population risk trajectories.

The result is a varied policy landscape across jurisdictions. For example, South Australia introduced a ban on junk-food advertising on public transport in July 2025 and has established a dedicated agency, Preventive Health SA, to lead evidence-informed programs and partnerships with local government to improve community health outcomes.[86] Queensland has also taken a prominent role in strengthening preventive health capability through Health and Wellbeing

Queensland, which delivers statewide initiatives focused on nutrition, physical activity and healthy weight across schools, workplaces and communities. Together, these developments point to growing momentum in obesity prevention policy, but also highlight uneven institutional capacity and differing levels of coordinated action across states and territories.[87]

Without a clearly designed implementation strategy with embedded oversight mechanisms, obesity policy will remain unattributable to any one authority's success or failure.

Obesity policy in Australia has repeatedly suffered from:

- Short-term political cycles,
- Changes in departmental priorities,
- Little continuity across governments,
- Lack of public reporting on progress against national targets.

This inconsistency undermines long-term structural change. The core faults can be grouped into four domains:

Structural

- No unified, funded national implementation framework.
- Fragmented governance and accountability.

Regulatory

- Weak regulation of food environments.
- Overreliance on voluntary industry action.

Service Delivery

- No national clinical pathways.
- Limited access to treatment, including pharmacotherapy and bariatric care.

Funding & Data

- Underinvestment in prevention.
- Insufficient data infrastructure to monitor, evaluate, and optimise policy.

Together, these faults have left Australia with a policy response mismatched to the scale of the obesity epidemic.

THE COMPLEMENTARY ROLE OF GLP-1 DRUGS

GLP-1 receptor agonist drugs ('GLP-1 RAs', 'GLP-1s') now occupy a potentially transformative but complementary role in Australia's obesity policy architecture. These drugs work by mimicking endogenous hormones to delay gastric emptying, suppress appetite, and improve metabolic parameters, thereby delivering clinically meaningful weight loss in many patients.[88] Globally, and in the emerging WHO guideline consultation, GLP-1 therapy is being positioned as one intervention within a multimodal chronic-care model for obesity, not as a standalone fix.[89]

In Australia, the move towards incorporating GLP-1s into public subsidy schemes provides a test of how pharmacotherapy can be mixed into structural prevention and regulatory regimes, if designed with guardrails.

In March 2025, the Minister for Health formally requested advice from the Pharmaceutical Benefits Advisory Committee (PBAC) regarding equitable access to GLP-1 medicines for obesity treatment under the Pharmaceutical Benefits Scheme (PBS).[90] Following its November 2025 meeting, the PBAC published advice identifying priority populations for any potential subsidised access, including people with established cardiovascular disease, Aboriginal and Torres Strait Islander patients with obesity-related comorbidities, individuals with syndromic or medication-induced obesity, and patients requiring weight loss to become eligible for surgery. The PBAC noted that any PBS listing would remain subject to standard legislative requirements for sponsor-initiated submissions demonstrating clinical and cost-effectiveness. It also advised that a slow and managed roll-out would help address uncertainties around long-term utilisation, safety and budget impact, particularly given evidence of strong consumer demand, with around 420,000 Australians receiving privately supplied GLP-1 medicines as at July 2025. While acknowledging potential benefits from broader early-intervention use, the PBAC indicated that subsidy at scale may be difficult to accommodate within PBS cost-effectiveness thresholds and could require alternative program mechanisms.[91]

As of 1 October 2024, compounded (that is, locally manufactured replica) versions of GLP-1 RAs–often used off-label for weight loss–have been removed from pharmacy compounding exemptions, in response to safety concerns and evidence of unregulated replication.[92] This step reaffirms the Commonwealth's role in safeguarding quality, even as therapeutic access expands.

To function effectively within a mature system, GLP-1 integration must adhere to design principles which promote equity in access (avoiding a 'treatment for those who can afford it' tier), clinical integration (GLP-1s should be nested in multidisciplinary care pathways (such as nutrition, behaviour support, exercise, monitoring), and not in isolation), eligibility, and duration frameworks.

Whilst GLP-1 drugs are not the cure for obesity in Australia, pharmacotherapy should complement, not replace, structural reforms such as labelling, marketing, and preventive health measures. These therapies have the potential to assist those who are already obese, but to

strengthen the public health system they should sit within an accountable, prevention-anchored framework.

POLICY IMPLICATIONS

Obesity can usefully be understood as both a regulatory and fiscal policy challenge, rather than solely a matter of health or individual lifestyle. A central difficulty lies in fragmented governance and limited coordination across policy levers. More effectively linking health promotion efforts with fiscal and regulatory tools could help redirect public expenditure towards measurable, evidence-based interventions, supported by clearer strategic leadership and more coherent implementation arrangements.

GLP-1 RAs deliver much larger average weight loss than older medicines and show improvements in cardiometabolic risk in some trials–creating strong clinical interest in public funding.[93]

However, extending broad public subsidy could generate substantial and rapid budget pressures, given the high prevalence of obesity and the sharp rise in demand, including significant uptake in the private market. Health payers and insurers have already reported marked increases in expenditure associated with the growing use of GLP-1 medicines.[94]

Estimated annual government costs per treated patient vary depending on the assumed pricing scenario. Under a PBS-like arrangement, the cost is approximately AUD 1,236 per year. This estimate is derived from the PBS item list price of $134.60 per pack, less the standard patient co-contribution of $31.60, resulting in a government contribution of around $103 per pack. Assuming treatment requires 12 packs per year, this equates to an annual public cost of about $1,236 per patient.[95] By contrast, a private list-price scenario implies a higher overall treatment cost, with annual expenses of around AUD 2,000 per patient based on approximate retail pricing reported in media coverage and product launch materials.[96] A third scenario, reflecting a negotiated price reduction of 50 per cent relative to the PBS-like estimate, would reduce the annual government cost to approximately AUD 618 per treated patient.

Estimated cumulative government expenditure over five years varies significantly depending on eligibility settings and pricing assumptions. Under a targeted subsidy scenario limited to adults with a BMI of 40 or higher, total public expenditure is projected to reach around AUD 946 million over five years under PBS-like pricing assumptions, rising to approximately AUD 1.53 billion if treatment costs reflect private list prices. A negotiated price reduction of around 50 per cent would reduce cumulative spending to roughly AUD 473 million.

Expanding eligibility to a mid-target group of adults with a BMI of 35 or higher substantially increases projected fiscal exposure. Under this scenario, five-year government expenditure is estimated at around AUD 2.67 billion under PBS-like pricing, increasing to approximately AUD 4.33 billion at private list prices, or falling to about AUD 1.34 billion if prices were discounted by half.

A broad subsidy scenario covering all adults with a BMI of 30 or higher would result in markedly larger fiscal commitments. Over five years, cumulative government spending is projected to reach approximately AUD 6.58 billion under PBS-like pricing assumptions, rising to around AUD 10.65 billion at private list prices. With a 50 per cent price reduction, total expenditure would still be substantial at roughly AUD 3.29 billion.

Without correct targeting towards both preventative and those already suffering with the effects of obesity, the cost becomes the major factor prohibiting Government from adopting broad subsidies for GLP-1s in Australia.

This challenge is also faced overseas and in a recent policy paper discussing policy options for the UK Government to reduce obesity by 50 per cent by 2030, Nesta has estimated that a treatment only approach of extending weight loss drugs to the more than 3 million people in the UK living with obesity would cost 42 billion pounds over 5 years and would not reach the intended target.[97]

Part 2:
Fiscal and Social Impact Modelling

The Economic Burden of Overweight and Obesity in Australia

Overweight and obesity impose substantial economic costs on individuals, health systems, and societies, both directly and indirectly. Although preventing and treating overweight and obesity requires financial investment, the long-term costs of inaction are often projected to be significantly greater. Sufficient economic evidence exists to support action by governments at all levels and society to implement cost-effective interventions to address the high burden of obesity. This section will seek to summarise the findings of this body of research in the Australian context.

Contemporary modelling of the economic impacts of overweight and obesity consistently finds that direct and indirect costs are substantial, with indirect costs often surpassing direct costs.[98] Direct costs include costs related to treatment of overweight and obesity and its related comorbidities, as discussed earlier in this report. Indirect costs of overweight and obesity include reduced quality of life, stigmatisation, and reduced workforce participation and performance (through absenteeism and presenteeism among school-aged and working-aged people, or early retirement of those within the labour force). Indirect costs also include impacts on unpaid labour, such as reduced capacity for household and volunteering activities.

Costs (direct and indirect) are borne by a range of stakeholders, including:

- individuals (e.g., out of pocket healthcare expenses for managing and treating obesity and its associated comorbidities, reduced paid or unpaid labour),
- their carer(s) and families (for example, out of pocket costs related to healthcare, absenteeism related to caring),
- employers (for example, costs related to absenteeism [time away from work due to illness] and presenteeism [reduced productivity while at work] of employees with obesity and its associated comorbidities),
- health systems (for example, costs of medical care to manage and treat individuals with obesity, specialist hospital equipment),
- governments at all levels (for example, provision of health goods and services, lower tax revenue from reduced productivity of those within the labour force), and
- society at large (for example, lower economic growth).

A baseline estimate places the total economic cost of obesity in Australia at approximately AUD $39 billion in 2019,[99] representing about 1.9 per cent of GDP for that year. The economic burden comprises both direct healthcare expenditure and a large proportion of indirect costs arising from reduced workforce participation, absenteeism, presenteeism and premature mortality.

Productivity Losses Dominate Costs

A critical feature of this burden is the dominance of productivity losses. Recent research and quantification of costs associated with overweight and obesity in Australia finds that over 60% of the economic burden of overweight and obesity is attributed to lost productivity, including absenteeism, presenteeism and premature death. This productivity loss translates to roughly $23-25 billion annually.[100] The magnitude of the productivity impacts underscores that overweight and obesity is not only a public health issue but also a sizeable economic challenge with implications for economic growth, workforce participation and long-term budget sustainability.

Healthcare Costs are also Significant

Healthcare costs, while smaller than productivity losses, nonetheless represent a significant fiscal pressure point for federal and state governments. Analyses from the OECD and the Australian Institute of Health and Wellbeing (AIHW) indicate that 8-8.5% of Australia's total health expenditure is attributable to overweight and obesity related conditions.[101, 102] These costs are driven by higher utilisation of hospital and allied health services, chronic disease management and pharmaceutical interventions. As prevalence continues to rise, health systems — already under structural strain — face growing challenges in managing preventable diseases and overweight and obesity related comorbidities.

Fiscal Pressures Will Increase Over Time

Forward projections suggest these fiscal pressures will escalate sharply in the absence of effective intervention. Current modelling estimates that the economic burden could rise to $62 billion by 2030 and as much as AUD $228 billion by 2060 under a continuation of status quo trends.[103]

Preventative Interventions Can Deliver Significant Fiscal Returns

Evidence also demonstrates that preventative interventions can deliver significant fiscal returns. Modelling of the impacts of achieving the Australian Government's National Obesity Strategy goal of a 5% reduction in childhood obesity by 2030 estimates savings of approximately $7.44 billion,[104] predominantly through reductions in lifetime obesity-related healthcare costs and premature mortality. The lifetime cost savings would potentially offset the government expenditure needed to implement primary prevention strategies and improve access to health services to achieve the National Obesity Strategy's goal.

Such findings highlight the economic rationale for early, sustained prevention strategies and reinforce that the cost of inaction substantially exceeds the cost of targeted, population level intervention.

Modelling Approaches

The modelling behind these estimates draws on several well-established techniques. Population attributable fraction methods are commonly used to estimate the proportion of disease and associated health-system costs that arise from excess weight. Microsimulation and cohort projection models provide longer-term forecasts by tracking how BMI trajectories influence chronic disease incidence and healthcare utilisation over time. Macroeconomic models are sometimes applied to estimate wider economic effects, particularly reductions in GDP due to changes in labour supply and increased medical expenditure. Differences across models can produce varying estimates, particularly depending on how productivity losses are valued. Models that use a human-capital approach typically generate higher cost estimates because they assign a value to all future earnings lost due to illness, disability or premature death. By contrast, models that apply a friction-cost approach produce lower estimates, as they limit productivity losses to the shorter period required for employers to replace a worker and restore production.

Equity Considerations are Essential to Interpretation of Findings

Equity considerations are essential to any interpretation of these findings. Overweight and obesity prevalence is significantly higher among Aboriginal and Torres Strait Islander peoples, individuals living in regional or remote areas and people from lower socio-economic backgrounds.[105] These groups face intersecting barriers to healthy food access, supportive built environments and early preventive care. Because of these structural inequalities, the economic burden of excess weight disproportionately affects these populations. Many national models acknowledge this, but few fully quantify the distributional effects, which means policy discussions can overlook the unequal impacts borne by specific communities. The rapidly changing therapeutic landscape also presents uncertainty for long-term modelling. Highly effective pharmacotherapies, such as GLP-1 receptor agonists, have demonstrated substantial weight-reduction effects and could shift long-term disease trajectories, although existing cost models have not yet fully incorporated these treatments.

Part 3: Pharmacotherapy and Access Analysis

Barriers to Accessibility for Pharmacotherapies Such as GLP-1 Receptor Agonists

GLP-1 receptor agonists represent a major therapeutic advance: they combine clinically meaningful, reproducible weight loss with metabolic and cardiovascular benefits demonstrated in large randomised trials.[106 107, 108] Recent large-scale clinical trials of incretin-based pharmacotherapies for obesity have demonstrated substantial average reductions in body weight when used alongside lifestyle support, with some studies reporting weight loss of up to around 20.2%. Emerging evidence also indicates associated improvements in cardiometabolic risk factors and reductions in major adverse cardiovascular events among people with overweight or obesity and established cardiovascular disease, highlighting the growing role of medicines within comprehensive obesity management.[109] However, despite the clear clinical benefits, practical access to GLP-1 RAs in Australia is constrained by multiple, interacting barriers.

Cost Barriers and Lack of PBS Subsidy

The first and most visible barrier to access is cost, both for individual patients and for governments. Regimens of GLP-1 receptor agonists intended for weight management are expensive and can impose a meaningful out-of-pocket burden for individuals paying privately. At the same time, any broad public subsidy through the PBS would require robust randomised clinical trial evidence demonstrating clear health benefits in the specific population proposed for listing, consistent with the PBAC's evidentiary standards. Public Summary Documents from PBAC consideration of incretin-based therapies indicate that even for smaller, higher-risk populations, such as people with type 2 diabetes at elevated cardiovascular risk or those with severe obesity and related comorbidities, projected budget impacts can be substantial due to expected uptake and ongoing treatment duration. This suggests that extending subsidy to the much larger population living with overweight or obesity would involve significantly greater fiscal exposure and would require careful calibration of eligibility criteria, pricing and utilisation controls.[110]

These fiscal realities have been flagged repeatedly by the PBAC when deliberating the inclusion of GLP-1 receptor agonists on the PBS. The PBAC's deliberations in relation to PBS subsidy for obesity indications have emphasised uncertainty about the size of the eligible population, the duration of modelled treatment benefits and the potential budget impact, contributing to a cautious approach to broad listings in this therapeutic area, even as incretin-based therapies are already subsidised for narrower indications such as type 2 diabetes and have received positive recommendations in specific high-risk cardiovascular populations.

Supply and Prescribing Capacity

A related and practical barrier is supply and prescribing capacity. Global demand surges for GLP-1 receptor agonists have led to periodic shortages and to the emergence of non-regulated or compounded alternatives in some markets.[111] The TGA reported shortages of GLP-1 RAs during 2022 that have largely abated now. Regulators have also been required to take steps to restrict unsafe compounded or counterfeit products due to the safety risks associated with these products[112] that have become prevalent in a supply constrained environment for dedicated GLP-1

RA treatments. Supply volatility complicates any attempt to roll out a PBS subsidy at scale, since the health system needs predictable, sustained supply to avoid inequitable rationing and to support continuity of clinical care.

Equity Concerns

Equity concerns are a pervasive aspect of access considerations for these medications. Without a PBS subsidy for weight-loss indications in place, access through the private market is heavily skewed towards higher-income individuals who can afford ongoing out-of-pocket costs. These costs can be significant; the Royal Australian College of General Practitioners reports that at the time of the product's launch in Australia, the 2.4 mg dosage of a GLP-1, which is the 'recommended dose for the most effective results for weight management', cost approximately $460 per dose. While the 0.25 mg, 0.75 mg, and 1.0 mg cost $260, and the 1.7 mg is $380, with each dose lasting one month.[113] While retail prices have begun to moderate as market availability has improved, these medicines continue to represent a substantial out-of-pocket expense for many patients.

This is notable because, as this report has shown, overweight and obesity prevalence and its downstream cardiometabolic harms are often concentrated in lower-socioeconomic groups and in rural, remote and some Indigenous communities. The current private-market dynamic risks widening health inequalities; those who can pay obtain the clinical benefits, while those with the highest need remain unserved. Moreover, geographic disparities in specialist services and allied health compound these inequities–remote communities are less likely to have clinicians experienced in obesity pharmacotherapy and its monitoring. Peak bodies including the Royal Australian College of General Practitioners have explicitly argued for a considered PBS subsidy precisely to reduce inequity in access to proven obesity management medicines.[114]

Need for Ongoing Use

Beyond these core barriers lie more complex questions about the prospect of long-term treatment needs and real-world effectiveness. Randomised trials demonstrate impressive weight loss while patients remain on therapy, but multiple studies show that discontinuing GLP-1 receptor agonists typically leads to weight regain.[115] This pattern raises both clinical and economic questions. Current clinical guidance increasingly recognises obesity as a chronic disease that may require comprehensive and potentially lifelong management, including the use of pharmacotherapy in a manner similar to other long-term treatments for conditions such as hypertension or hyperlipidaemia. At the same time, medicines alone are unlikely to be sufficient, and effective care pathways typically involve complementary lifestyle, behavioural and, where appropriate, surgical interventions.[116]

ADDRESSING BARRIERS

Taken together, these barriers produce a policy dilemma. A broad PBS listing would expand equitable access and likely yield clinical benefits at the population level, but it also risks large budget impacts and may require difficult decisions about eligibility criteria. Narrow, targeted PBS listings (for example, limited to people with established cardiovascular disease or very high BMI and comorbidity) would improve the cost-effectiveness profile and reduce budget exposure, but they leave many patients without subsidised access and create uncertainty in equity and access that can impede timely clinical care. This tension is becoming more pronounced as uptake grows, with reporting suggesting that more than half a million Australians are already using prescription weight-loss medicines, increasing both the potential population health impact and the fiscal considerations associated with future subsidy decisions.[117]

Conditional approaches–such as time-limited listing tied to outcomes monitoring–can offer a pragmatic compromise by enabling subsidised access while collecting Australian, real-world data to resolve uncertainties. Implementing these conditional pathways, however, demands investment in the infrastructure and systems to collect a rich dataset of patient outcomes (such as weight trajectories, diabetes incidence, hospitalisations), and transparent evaluation frameworks to trigger delisting processes when outcomes fall short.

From an operational perspective, any move towards subsidy should be accompanied by explicit equity safeguards. These include targeted outreach and service models for rural and remote communities, culturally safe pathways for Aboriginal and Torres Strait Islander peoples, streamlined prescribing pathways for general practice (including workforce training), and subsidised allied-health packages that ensure pharmacotherapies are used as part of comprehensive care rather than as a stand-alone solution.

Monitoring should explicitly track uptake by socioeconomic quintile and remoteness area, time to initiation following referral, rates of adverse events leading to hospitalisation, and sustained weight and cardiometabolic outcomes at 12 and 24 months. Robust monitoring will allow policymakers to judge whether the expected public-health benefits are being realised and whether pricing or eligibility changes are required.

In summary, the difficulty of accessing GLP-1 receptor agonists in Australia is not a single problem but a complex web of interlocking challenges. High private prices and potential large PBS costs, a cautious reimbursement process that requires long-term evidence and careful modelling, supply and prescribing capacity constraints, and acute equity risks if access remains primarily private. Addressing these problems requires a comprehensive approach that combines outcomes-based contracts, targeted initial subsidy for highest-risk groups, investment in primary-care and allied-health capacity, and a rigorous real-world outcomes framework with equity-focused monitoring. This combined approach balances fiscal responsibility with the ethical imperative to ensure effective therapies do not become available only to those who can afford them.

Recommendations

1. Mandate Front-of-Pack Health Star Ratings (help individuals make informed choices)
Require all eligible packaged foods to display Health Star Ratings. Currently only 36% carry the label, falling well short of the 70% target. Mandatory labelling empowers consumers to make informed choices and addresses information asymmetry in the food market. States and the Commonwealth should consider adopting measures taken in South Australia, which recognised the challenges such adjustments may make on small businesses, and accommodate implementation requirements from small and medium businesses.

2. Introduce Incentives for Workplace Health Investments (helping productivity, and business)
Provide incentives for employers who invest in evidence-based preventive health programs such as dietitian services, and physical activity programs. This leverages the private sector to address the $23-25 billion annual productivity loss from obesity.

3. Establish a National Obesity Coordination Framework
Create binding coordination mechanisms between Commonwealth and State/Territory governments through the National Health Reform Agreement. This addresses the current fragmented governance where States bear hospital costs while the Commonwealth controls medicines, taxation, and national strategy. Include enforceable targets and shared accountability.

4. Expand Targeted Subsidy for Obesity Pharmacotherapy
Implement a phased subsidy for GLP-1 RAs, prioritising high-risk groups (BMI ≥30 with comorbidities, disadvantaged populations), subject to proper PBAC and TGA approvals and advice. Link subsidy to real-world outcomes monitoring to manage budget impact while ensuring equitable access beyond those who can afford private market prices.

5. Increase the Preventative Health Budget to OECD Standards

Raise preventive health spending from 2% to at least 3-4% of the total health budget (OECD average). Ring-fence funding for evidence-based interventions including childhood obesity programs, which could save billions in lifetime costs. Long term benefits.

6. Reform Cost-Benefit Assessment in Government Decision-Making

The Commonwealth Government should adopt a broader framework for evaluating health spending and policy decisions, one that accounts for downstream savings and offsets. Where clear evidence exists that an intervention reduces hospitalisation, chronic disease burden, or productivity loss, these savings could be weighed against upfront costs.

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