Pharmaceutical Benefits Advisory Committee

Reply to: PBAC@health.gov.au

The Hon Mark Butler MP
Minister for Health and Aged Care
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

Dear Minister

Thank you for your letter of 6 March 2025 requesting the advice of the Pharmaceutical Benefits Advisory Committee (PBAC) on equitable access to glucagon-like peptide-1 receptor agonist (GLP-1) obesity treatments in Australia.

The PBAC recognises the significant burden of obesity on individuals and the community and the importance of ensuring access to affordable treatments that are safe, effective and cost-effective. Pharmacotherapies present a promising intervention within a broader approach to the prevention and management of obesity in Australia.

On 28 August 2025, I wrote to provide you with an update on PBAC's approach and progress to providing this advice. I noted that the PBAC had requested that the Department prepare research on:

1. Epidemiological modelling of population cohorts that may benefit most from subsidy of obesity treatments through the Pharmaceutical Benefits Scheme (PBS).
2. An analysis of international subsidy arrangements, with a focus on the Uniting Kingdom and Canada.
3. Horizon scanning for obesity treatments in development, including biosimilars.
4. An analysis of the private market supply of obesity treatments available in Australia.

At the November 2025 meeting, the PBAC considered the research prepared by the Department. The PBAC welcomed the substantial volume of inputs received through public and targeted consultation processes with consumers, health professionals, industry and key stakeholder groups. The subsequent advice formulated by PBAC on this topic is summarised below and in **Attachment A**.

Also at this meeting, the PBAC recommended the listing of the GLP-1, semaglutide (Wegovy®), on the Pharmaceutical Benefits Scheme (PBS) for people with established cardiovascular disease (eCVD) and obesity, contingent on a price reduction and risk sharing arrangement.

Summary of PBAC advice on equitable access to GLP-1 obesity pharmacotherapies

The PBAC considered that to support equitable access, the PBS, or a single-funder model, was the most appropriate mechanism for subsidy of GLP-1 obesity treatments in Australia. The

PBAC considered that the following populations should be prioritised for potential future PBS subsidy of GLP-1 obesity treatments and invited submissions from sponsors for these populations:

- People with eCVD.
- People with syndromic obesity, such as Prader-Willi Syndrome.
- Aboriginal or Torres Strait Islander people with Body-Mass Index (BMI) ≥ 32.5 kg/m^2, and at least one of the following comorbidities: eCVD, obstructive sleep apnoea, chronic kidney disease, or type 2 diabetes.
- People with BMI ≥ 35 kg/m^2 taking obesogenic medicines, such as antipsychotics and steroids.
- People who cannot have safe surgery, or cannot be waitlisted for surgery, due to weight, including renal transplant, hip and knee replacement, or bariatric surgery.

The PBAC noted that any PBS listing would be subject to the legislative requirements to demonstrate clinical and cost-effectiveness. The PBAC advised that, if listed, a slow and managed roll-out of access to PBS-subsidised GLP-1 treatments in the Australian health care system would help to limit use outside of the subsidised populations and uncertainties around long-term use, outcomes, and emerging adverse events. The PBAC considered that wraparound support services, such as diet and exercise support, were an important component of obesity care. However, the Committee considered that PBS-subsidised access to GLP-1s should not be contingent upon use of wraparound services as this would create a barrier to accessing therapy, leading to further inequity.

The PBAC considered that there may be merit in broader subsidy of GLP-1 medicines for early intervention and prevention of obesity-related comorbidities but concluded that it was unlikely that sponsors would agree a cost-effective price for providing obesity medicines through the PBS for these broader purposes at this time.

Next steps

Following standard PBAC processes and timelines, a public outcome statement for this item will be published on the PBS website on 19 December 2025 (**Attachment B**). With your agreement, this letter, a redacted copy of the PBAC Minutes for this item, and a summary of consumer inputs received, will be published on the PBS website after the outcomes are published. As submissions are received by the PBAC for GLP-1 obesity treatments, the Committee may request the Department to undertake further work to support its consideration of the cost-effectiveness of subsidised access for the priority populations noted above.

The PBAC appreciates the opportunity to provide advice on this important matter.

Yours sincerely

Professor Robyn Ward AM
Chair, PBAC

15 December 2025

Adjunct Associate Professor Jo Watson
Deputy Chair, PBAC

15 December 2025

Attachments

A Summary of PBAC advice on equitable access to GLP-1 obesity treatments – November 2025

B Public outcome statement - PBAC advice on equitable access to GLP-1 obesity treatments

Attachment A

Summary of PBAC advice on equitable access to GLP-1 obesity treatments - November 2025

Inputs received through public consultation

The PBAC welcomed and considered 540 inputs from individuals who have used GLP-1s (459), other individuals (33), health care professionals (25) and organisations (23).

The PBAC noted that the broad categories of people who had used the medicines and provided inputs included: people with inherited and genetic causes of obesity; people using obesogenic medications; and people who find it difficult to exercise due to their obesity or other conditions, such as disabilities and autoimmune diseases that affect joints. Consumers had a wide range of comorbidities, including cardiovascular disease, kidney and liver disease, type 2 diabetes, endocrine disorders, autoimmune disease, musculoskeletal conditions, obstructive sleep apnoea, and mental health conditions.

The PBAC noted that while cost was a concern and barrier to ongoing access for many consumers, private market data indicated that there was a high willingness to pay for obesity treatments among Australian consumers.

Australian cohorts most likely to benefit from PBS subsidy of obesity medicines

The PBAC considered that the following population groups should be prioritised for potential future PBS subsidy of GLP-1 obesity treatments and invited submissions from sponsors for these populations:

- People with established cardiovascular disease (eCVD).
- People with syndromic obesity.
- Aboriginal or Torres Strait Islander people with Body-Mass Index (BMI) ≥ 32.5 kg/m^2, and at least one of the following comorbidities: eCVD, obstructive sleep apnoea, chronic kidney disease, or type 2 diabetes.
- People with BMI ≥ 35 kg/m^2 taking obesogenic medicines, such as antipsychotics and steroids.
- People who cannot have safe surgery, or cannot be waitlisted for surgery, due to weight, including renal transplant, hip and knee replacement, or bariatric surgery.

At the November 2025 meeting, the PBAC recommended the PBS listing of semaglutide (Wegovy®) for people with eCVD and obesity, the first of these priority groups. The recommendation was contingent on a price reduction and risk sharing arrangement.

The Department supported the PBAC by providing population estimates based on national health survey data and other sources. The PBAC noted that preliminary estimates indicated that the above Aboriginal and Torres Strait Islander, and syndromic obesity, populations were relatively small (around 39,000 and 21,000 people, respectively).

The PBAC noted that the priority populations for access to GLP-1 obesity treatments may need to be revised as new evidence emerges regarding their clinical and cost-effectiveness, including from real-world data based on use in Australia and internationally.

The PBAC noted that any PBS listing would be subject to the legislative requirements to demonstrate safety, effectiveness and cost-effectiveness.

Wraparound allied health care and models of service delivery

The PBAC considered that wraparound support services, such as diet and exercise support, and multidisciplinary care models were an important component of obesity care that should

reflect the needs of the individual and be worked out in consultation with their health professional. The PBAC considered there should not be any mandatory requirements for use of specific wraparound services for PBS-subsidised access to GLP-1s, as this would create a barrier to accessing therapy. Such barriers may particularly impact people who were already at higher risk of obesity and its associated comorbidities, such as Aboriginal and Torres Strait Islander people, those socioeconomically disadvantaged, and those living in remote areas.

The PBAC noted that patients can access Medicare Benefits Scheme (MBS)-rebated allied health services through GP Chronic Condition Management Plans (GPCCMPs) and that the services available under GPCCMPs were currently being reviewed. The PBAC noted that many consumers provided input that they did not seem to have access to wraparound supports or multidisciplinary care.

The PBAC noted that digital delivery could assist in providing low-cost, scalable wraparound care, which if more widely available, may help patients to adhere to therapy and maintain the benefits of medicine use. The PBAC considered that funding for these services could be provided through tendering arrangements outside of the PBS/MBS. The PBAC noted that several states were already providing free, tailored health coaching to individuals.

Bariatric surgery

The PBAC noted that while bariatric surgery was currently more effective for weight loss, newer obesity treatments in development may be similarly effective. The PBAC considered that there were major barriers to accessing bariatric surgery in Australia including cost and availability. The PBAC considered that prior bariatric surgery should not preclude a person from accessing PBS-subsidised GLP-1 treatment as some people have a sub-optimal response to surgery. The PBAC also noted that some people with BMI ≥ 40 kg/m^2 may benefit from GLP-1 treatment prior to bariatric surgery to reduce surgery risks.

Optimal duration of GLP-1 subsidy

The PBAC considered that the optimal duration of subsidy was currently unknown and that there was no long-term trial data on use beyond a few years. The PBAC noted that trial data demonstrated weight regain following cessation of therapy.

Market dynamics and subsidy mechanism

The PBAC noted obesity treatments are a very active therapeutic market. The PBAC expressed concern that a PBS listing soon may benchmark prices for future listings and this may lead to higher costs to the PBS if newer medications are listed on a superiority basis.

The PBAC considered that the PBS, or a single-funder model, was the most appropriate mechanism for subsidy of GLP-1 obesity treatments in Australia. The PBAC advised that, if listed, a slow and managed roll-out of access to PBS-subsidised GLP-1 treatments in the Australian health care system would help to manage leakage and uncertainties around long-term use, outcomes and emerging adverse events.

The PBAC considered that there may be merit in broader subsidy of GLP-1 medicines for early intervention and prevention of obesity-related comorbidities. However, the PBAC concluded that such a subsidy would need to be established as a program outside of the PBS as it was unlikely that sponsors would agree a cost-effective price for providing obesity medicines through the PBS for these broader purposes at this time.

Attachment B

Public outcome statement for the November 2025 PBAC advice on equitable access to GLP-1 obesity treatments (Scheduled publication date: 19 December 2025)

The PBAC provided advice on priority groups to ensure equitable subsidised access to glucagon-like peptide-1 receptor agonists (GLP-1) for the treatment of obesity. Based on current evidence, PBAC considered this should include: people with established cardiovascular disease, Aboriginal and Torres Strait Islander patients with obesity-related comorbidities, people with syndromic obesity, people with medication-induced obesity, and patients requiring weight loss to be eligible for surgery. The PBAC invited sponsor submissions for these populations, noting that any PBS listing would be subject to the legislative requirements to demonstrate clinical and cost-effectiveness through a sponsor-initiated submission.

The PBAC welcomed and considered input from individuals who have used GLP-1s (459), other individuals (33), health care professionals (25) and organisations (23). The PBAC noted that the broad categories of people who had used the medicines and provided inputs included: people with inherited and genetic causes of obesity; people using obesogenic medications; and people who find it difficult to exercise due to their obesity or other conditions, such as disabilities and autoimmune diseases that affect joints. Consumers had a wide range of comorbidities, including cardiovascular disease, kidney and liver disease, type 2 diabetes, endocrine disorders, autoimmune disease, musculoskeletal conditions, obstructive sleep apnoea, and mental health conditions.

The PBAC noted that while cost was a concern and barrier to ongoing access for many consumers, private market data indicated that there was a high willingness to pay for obesity treatments among Australian consumers with around 420,000 people receiving a private market supply of semaglutide or tirzepatide in July 2025.

The PBAC advised a slow and managed roll-out of access to PBS-subsidised GLP-1 treatments in the Australian health care system would help to manage leakage and uncertainties around long-term use and outcomes. The PBAC considered that there may be merit in broader subsidy of GLP-1s for early intervention and prevention of obesity-related comorbidities, but such subsidy would need to be established as a program outside of the PBS as it would be difficult to achieve a cost-effective price of providing obesity medicines for these broader purposes at this time. The PBAC noted that if a large population were to be treated with GLP-1s, there would be an increased likelihood of rare, serious adverse events, which may outweigh the benefits in patients without pre-existing comorbidities and would inform ongoing appropriate use.

The PBAC noted the rapid emergence of research in obesity treatments and real-world evidence in this area, which is expected to drive significant changes in cost, supply, dosing, and utilisation over coming years. The PBAC noted the importance of real-world data to inform effective, equitable, safe and cost-effective use of GLP-1s.

The PBAC considered that there was a need to improve access to non-pharmacological interventions, such as diet and physical activity support, and that digital models may provide an equitable avenue for broad access to these supports. The PBAC considered that there should not be any mandatory requirements for use of wraparound services for PBS-subsidised access to GLP-1s, as this would create a barrier to accessing therapy, particularly for people who were already at higher risk of obesity and its associated comorbidities, such as Aboriginal and/or Torres Strait Islanders, those socioeconomically disadvantaged, and those living in regional and remote areas.