Australian Government
Department of Health, Disability and Ageing

Equitable access to GLP-1 medicines for the treatment of obesity

Summary of public consultation submissions

Contents

Introduction

Glucagon-like peptide-1 receptor agonists (GLP-1s) are medicines that help control blood sugar levels. They slow digestion (which makes you feel full for longer), may act on the brain to reduce hunger, and may reduce inflammation.

There are several GLP-1s registered for use in Australia by the Therapeutic Goods Administration (TGA) for the treatment of a variety of conditions. A summary is provided in Table 1.

Table 1 GLP-1s registered for use in Australia

Medicine	Summarised TGA-approved uses	PBS subsidised (at November 2025)
Semaglutide (Ozempic®)	• Type 2 diabetes (blood sugar lowering) • Type 2 diabetes and chronic kidney disease	Yes
Dulaglutide (Trulicity®)	• Type 2 diabetes (blood sugar lowering) • Type 2 diabetes and high cardiovascular risk	Yes
Liraglutide (various brands)	• Weight management (adults only)	No
Semaglutide (Wegovy®)	• Weight management (12 years and over) • Established cardiovascular disease in people who are overweight or obese	No
Tirzepatide (Mounjaro®)	• Type 2 diabetes (blood sugar lowering) • Weight management (adults only) • Obstructive sleep apnoea (adults with obesity)	No

Because GLP-1s can reduce appetite, they are used to help people lose weight. This can be especially useful for people living with obesity who have not been able to lose weight using other methods. Currently, GLP-1s are not subsidised through the PBS for the purpose of losing weight. People who want to use GLP-1s to lose weight must pay for the medicines themselves.

Pharmaceutical Benefits Advisory Committee

The Australian Government relies on advice from the Pharmaceutical Benefits Advisory Committee (PBAC) when making decisions to list medicines on the PBS. The PBAC is an independent committee made up of health professionals, such as doctors and pharmacists, health economists and consumer representatives. Most undertake work for the PBAC on top of their roles delivering healthcare in the Australian community. They have extensive experience assessing medicines and interpreting evidence from clinical studies and other sources.

The PBAC is required to assess how well new medicines work and how safe they are compared to existing care funded in Australia. The PBAC considers whether the benefits

justify any additional costs to Australian taxpayers. The committee then makes recommendations to the Government about which medicines should be subsidised through the PBS and any restrictions on their use. Further information on the PBAC, including membership, meeting agendas and outcomes, is available on the PBAC website.

At its meeting in November 2025, the PBAC discussed equitable access to PBS-subsidised GLP-1 medicines for the treatment of obesity.

Public consultation

Medicines that the PBAC considers usually go through a public consultation process on the Office of Health Technology Assessment consultation hub. This is an important way for the PBAC to understand how the medicines are currently used, how effective they are and if their use causes any adverse events (side effects). Anyone can provide input. For this item, public consultation was open to consumers, healthcare providers and organisations from 5 to 24 September 2025.

Consumer inputs

Submissions were received from:

- 458 people who have used GLP-1s for their own health condition
- 33 people who either
  - would like to access GLP-1s to treat their own health condition but have never used them (although some of these people may have misclassified themselves, as it appeared that some had tried a GLP-1 in the past but were not currently taking it)
  - are a parent or partner of a person who uses, or would like to use, GLP-1s for their health condition
  - are an interested person who may have been a family member, friend or general member of the public.

All submissions supported PBS listing.

Reasons for using GLP-1s

Many people said they had long-term personal challenges with overweight and obesity, and weight loss was the reason for taking the GLP-1. Life circumstances that were cited as factors in the weight gain included:

- having a family history of obesity
- going through perimenopause or menopause
- having polycystic ovary syndrome (PCOS)
- having autoimmune disorders such as thyroid disease (including Hashimoto's disease)
- having children (specifically, factors such as time-consuming carer responsibilities and post-partum depression)
- having surgery that affected hormonal balance, such as the removal of adrenal glands
- having difficulty exercising due to pain, disability or living with obesity
- taking medicines for other conditions (comorbidities) that caused weight gain.

Common comorbidities included:

- heart disease (especially high blood pressure and high cholesterol)
- chronic pain (including back pain)
- pre-diabetes and diabetes
- mental health disorders
- obstructive sleep apnoea (OSA).

People discussed different reasons for wanting to lose weight. Common reasons included to:

- improve overall physical health, mental health and wellbeing
- avoid life-threatening comorbidities, such as cancer and diabetes
- relieve some of the symptoms of their comorbidities, including
  - reducing high blood sugar levels caused by pre-diabetes and diabetes

  - reducing inflammation and other symptoms caused by diseases such as PCOS and arthritis
- help manage pain
- increase the chance of successful in vitro fertilisation (IVF)
- be eligible to undergo surgery, especially for joint replacement
- improve mobility and energy.

Dosing, duration of use and treatment regimen

People usually self-administer GLP-1s as a weekly injection. Many people said they had been taking GLP-1s for 12 to 18 months, but some reported taking the medicine for several years. Lifestyle changes, such as healthy eating and exercise, are often a part of the treatment regimen.

Once the target weight loss is achieved, many people said that they reduce the GLP-1 dose to a point where weight loss is maintained.

Some people said that they plan on using GLP-1s for life, either because they have other conditions or they believe they need to for weight management.

Other interventions tried

Many people reported that they had tried numerous other interventions before starting on GLP-1s, including diet and exercise. Some people reported that they had some success with diet and exercise, but it was not sustainable because of the drastic measures they had to take, such as extreme caloric restriction.

Some people said that trying to exercise while living with obesity led to injury and being unable to continue exercising. It can also be difficult to exercise when living with disability or other conditions that affect physical activity, even after some weight loss. People also mentioned that healthy eating and exercise can be difficult to afford and access, for reasons such as the high cost of healthy food and gym memberships.

Some people said they had tried bariatric surgery or other non-GLP-1 weight loss medicines, with different degrees of success.

Wraparound care

Some people noted the importance of having a support team during their weight loss journey, to provide both support and education. Some people noted that it was important that weight loss medicines such as GLP-1s are not considered a ‘quick fix’ for obesity. The support team may include a general practitioner (GP), nurse practitioner, dietitian and exercise physiologist. Many people did not mention how they accessed a support team, but many people said they had regular appointments (every month to every 3 months) with a GP or nurse practitioner at a weight loss clinic, either in person or via telehealth. Consumers considered telehealth as a way to improve access for patients living in regional, rural and remote areas.

Clinical benefits

Consumers highlighted that GLP-1s had been the most successful treatment they had tried in helping them lose weight. Consumers reported general clinical benefits such as:

- improved mental health
- better cholesterol levels
- lower blood pressure
- lower blood sugar levels
- reduced joint pain
- reduced inflammation
- improvements in liver function levels
- reduced symptoms of obstructive sleep apnoea (OSA)
- reduced use of medicines for comorbidities, such as for pain and high blood pressure.

Although many consumers had not yet experienced the long-term effects of GLP-1s, they expected that the medicines would lead to:

- a decreased risk of other conditions, especially
  - stroke
  - cardiovascular events
  - dementia
  - cancer
  - diabetes
- fewer joint replacement surgeries
- less use of the healthcare system because they are healthier.

Adverse events

Some consumers reported that they tolerated tirzepatide (Mounjaro®) better than other GLP-1s, but people had different experiences with different GLP-1s. Many people had only tried one GLP-1.

For all GLP-1s, common adverse events reported were:

- constipation (can be significant if not managed)
- diarrhoea
- nausea
- reflux
- headache
- fatigue
- muscle pain.

Most people reported that these adverse events were tolerable and manageable. Many of the adverse events were associated with starting the medicine or increasing the dose, and people generally felt better after a few days.

Some people reported struggling to drink enough water (because they were not thirsty) and some reported that it was hard to meet their dietary requirements due to the decreased appetite.

Many consumers stated that they would stop taking GLP-1s if they experienced severe adverse events. A small number of consumers noted serious adverse events from using GLP-1s.

Quality-of-life benefits

People raised the extreme negative stigma that overweight and obese people faced every day, including from some health professionals. After losing weight, many people discussed the increases in quality of life they experienced. People specifically mentioned:

- being able to focus on other parts of their life because of the reduced ‘food noise’
- being happier
- having a better social life
- having more self-confidence
- sleeping better
- having more energy and better mobility
- being more in control of their food intake
- being more productive at work.

Barriers to access

Nearly all submissions stated cost as the major barrier to access, with many consumers making personal or family sacrifices to afford GLP-1s each month. Some were pausing treatment based on when they could afford it or using a lower dose to reduce the cost. Others purchase larger doses than needed, store them in the fridge, and use an insulin needle and syringe to draw out smaller amounts, to decrease the cost per dose. Many consumers were anxious about being able to afford GLP-1s in the long term.

Some people reported that they were treated like they were ‘cheating’ by using GLP-1s, and this had detrimental effects on their mental health and social and professional life. This was particularly apparent when access to semaglutide (Ozempic®) was temporarily restricted to patients with diabetes during periods of medicine shortage.

Some consumers flagged that availability of the medicines may become an issue if they are listed on the PBS because more people would be able access them. Some reported access and supply issues in the past and feared this would happen again if the medicines were listed on the PBS.

PBS eligibility

Some consumers were anxious about being ineligible for potential PBS-subsidised GLP-1s since they were no longer living with obesity. Many felt they would not be able to sustain their weight loss without continuing to use GLP-1s.

Other consumers were concerned that the eligibility criteria would be too relaxed, making it harder for those who really need the medicines to access them.

Disadvantages

Some consumers preferred a weekly injection over taking tablets daily, whereas others would prefer a tablet if it became available. Some consumers stated that the injection pen could be hard to use.

A few consumers flagged that GLP-1s are not a ‘quick fix’ and expressed concern that some people may depend too much on the medicines and not be committed to lifestyle changes and seeking support.

Health professional inputs

Submissions were received from 25 health professionals. All submissions were supportive of subsidising GLP-1s for obesity treatment.

Reasons for using GLP-1s

Almost all health professionals reported that their patients use GLP-1s to help manage obesity, including:

- severe obesity associated with serious medical conditions and disability
- as a bridge to joint replacement or other surgery.

Some submissions discussed use in children and adolescents. Others mentioned that GLP-1s could be effective in controlling alcohol use disorder in some patients.

Health professionals noted that weight loss helps to alleviate symptoms of weight-related comorbidities such as:

- cardiovascular disease
- pre-diabetes, insulin resistance and type 2 diabetes
- OSA
- PCOS
- liver disease
- depression.

Dosing, duration of use and treatment regimen

Health professionals noted that some patients will require GLP-1s long term if they are insulin resistant.

Other interventions tried

Many submissions noted that most patients use lifestyle changes, especially dietary changes, as a prior treatment to GLP-1s, including with guidance from allied health professionals such as dietitians and exercise physiologists. Many noted that other medicines are commonly tried before using GLP-1s, such as metformin.

Wraparound care

Submissions highlighted the importance of supportive wraparound care to ensure patients receive adequate counselling and support to offset risks. This includes a multidisciplinary team comprising a GP, nurse, physiotherapist, exercise physiologist, dietitian and psychologist.

Many submissions noted the importance of accompanying nutritional therapy, physical activity, behaviour modification and cognitive behavioural therapy alongside medicine use.

Clinical benefits

Health professionals stated that GLP-1s are effective for weight loss for most people and that weight loss brings many benefits to consumers, carers and the healthcare system. Clinical benefits include:

- reduced lipids
- lower blood pressure
- lower cardiovascular risk
- reduced joint strain
- increased mobility
- reduced pain from osteoarthritis
- reduced sleep apnoea
- prevented or decreased severity of conditions such as
  - diabetes
  - cancer
  - ischaemic heart disease
  - dementia
  - kidney disease
- allowing other necessary treatments and surgeries to occur
- improved effectiveness of comorbidity treatments, such as continuous positive airway pressure (CPAP) for OSA
- reduced polypharmacy and medication burden
- decreased alcohol intake and smoking.

Adverse events

Health professionals were aware of adverse events such as occasional diarrhoea, some nausea and not drinking enough water (as patients were not thirsty). They considered the gastrointestinal side effects that occur when starting treatment to often be short term and manageable through dose adjustments. They were also aware of possible rare but serious side effects including gall bladder disease, pancreatitis and gastrointestinal obstruction.

Quality use of medicines

Some submissions noted that some patients were:

- not taking doses as prescribed
- buying large dosage pens and using a syringe to make the pen last longer
- pausing treatment based on when they could afford it.

These quality use of medicines issues were directly related to patients aiming to reduce the cost of the medicine, which was identified as a significant barrier to access.

Quality-of-life benefits

Submissions from health professionals mentioned similar quality-of-life benefits as the consumer submissions, including:

- better mental health and wellbeing
- a return to the workforce or school
- improved quality of life for carers
- long-term decreased burden on the healthcare system if people lose weight and are healthier.

Barriers to access

Commonly identified barriers to access were costs and stigma towards people living with obesity. Some health professionals noted some groups who are disproportionately affected by obesity, such as:

- children and adolescents with obesity (who are more likely to develop comorbidities early in life)
- people with disability, including people with syndromic obesity
- people who have a history of trauma
- First Nations people
- culturally and linguistically diverse people.

Submissions also noted that GLP-1s are best used with multidisciplinary team care, which is not readily accessible in some communities. Some also mentioned that injectable medicines may be a barrier for some patients.

PBS eligibility

Submissions did note that patient eligibility for PBS subsidy should be restricted to mitigate potential issues such as:

- misuse and long-term dependence
- the risk of rare but serious side effects
- the lack of long-term evidence on efficacy and safety.

Some submissions suggested restrictions to people with a body mass index (BMI) of at least 30 kg/m^2, and some suggested timeframe restrictions. Some submissions advocated for access for certain paediatric and adolescent populations, or as a treatment for alcohol use disorder.

Disadvantages

Submissions noted several disadvantages of GLP-1s, including the lack of long-term data and, therefore, unknown long-term side effects. Some also mentioned the risk of overuse or long-term dependence, or a risk of misuse or ‘leakage’ outside the intended population.

Organisation inputs

Submissions were received from 23 organisations:

- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Amgen Australia Pty Ltd
- Australasian Sleep Association
- Australia and New Zealand Society for Paediatric Endocrinology and Diabetes (ANZSPED) Incorporated
- Australian and New Zealand Society for Vascular Surgery (ANZSVS)
- Australian College of Nurse Practitioners
- Australian Diabetes Society
- Cancer Council Australia
- Commonwealth Scientific and Industrial Research Organisation (CSIRO)
- Council of Therapeutic Advisory Groups (CATAG)
- Dexcom AMSL
- Diabetes Alliance
- Dietitians Australia
- Digital Wellness
- Eli Lilly Pty Ltd
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Paediatric Medicines Forum
- Novo Nordisk Pty Ltd
- NT Health
- Obesity Collective
- Patients Australia Limited
- Prader-Willi Research Foundation Australia (PWRFA)
- Rural Doctors Association of Australia.

All organisations were supportive of subsidising GLP-1s for obesity treatment.

Duration of use

Several submissions noted that obesity is a chronic condition and that some patients relapse. Therefore, if restrictions on timeframes were introduced, some people may not get the same health benefits.

Submissions noted that treatment may be stopped if patients experience severe or unwanted side effects, if a patient's health status changes, or if weight can be maintained through behaviour modification.

Treatment regimen, service delivery models and supportive wraparound care

Submissions emphasised that GLP-1s should not be used as a standalone measure. The medicines should be integrated with nutrition, physical activity and behavioural support.

Many submissions noted that GLP-1s are most effective when the patient is supported to modify their lifestyle and behaviours. This requires the medicines to be embedded within multidisciplinary care models. Stakeholders considered that patients should also receive regular monitoring from a health professional.

Some submissions considered that, if subsidised through the PBS, primary care providers (such as GPs and Aboriginal Community Controlled Health Organisations [ACCHOs]) could prescribe GLP-1s and manage patients, rather than specialists. This would allow patients to access care earlier and make it easier to have continuity of care.

Submissions noted the importance of access to affordable weight management and structured physical activity support, which is currently not equitable across Australia. These services are even more difficult to access in regional, remote and very remote parts of Australia. Telehealth or online (that is, digital) services could improve equity for socially or geographically isolated communities. Submissions noted that existing digital solutions can also provide appropriate levels of support.

Clinical benefits

Submissions noted several clinical benefits, such as reduced:

- cardiovascular risks and resulting long-term benefits
- metabolic dysfunction-associated fatty liver disease
- burden of associated conditions such as osteoarthritis
- severity of OSA mediated through weight loss
- hospital admissions for obesity-related complications.

GLP-1s could also provide an important pre-surgical or alternative treatment option for those being considered for surgery but who face high anaesthetic and surgical risks due to severe obesity.

Adverse events

Submissions highlighted general gastrointestinal adverse events that are commonly reported. Long-term data are important to understand longer-term or rare adverse events.

Quality-of-life and financial benefits

Submissions noted patients' improved quality of life through better mobility and mental health. If people were able to lose weight, there would be reduced physical, emotional and financial impacts of obesity.

Barriers to access

Submissions highlighted several barriers to access, including:

- cost of GLP-1s
- cost and access to support services
- supply constraints.

These barriers are exacerbated for those living in regional and remote communities.

Submissions noted that, for Aboriginal and Torres Strait Islander people in remote communities, obesity is common and is compounded by poverty, food insecurity and the high cost of food in remote stores.

For the most severely affected young people, uptake in adolescents is limited due to the cost of the medicine and inequitable access through hospital services. Bariatric surgery is also generally unavailable in Australia for adolescents under 17 years of age, further limiting treatment options.

Stakeholders considered that people living with overweight or obesity face stigma from the public, but also from healthcare professionals. Many clinicians do not understand the complexities of weight loss and how to clinically manage this condition.

PBS eligibility

Several submissions suggested potential criteria for eligibility. Many proposed prioritising access for patients with obesity and multiple comorbidities (including cardiovascular disease). Some suggested that eligibility could be expanded in a phased approach, similar to the approach taken in the United Kingdom.

One submission noted that some state and territory medicine and therapeutic committees were providing access to semaglutide (Wegovy) and tirzepatide (Mounjaro) to some patients under strict eligibility criteria and specialist supervision, and that states and territories were working towards a consensus position on the use of these medicines in public hospitals. In one jurisdiction, the criteria for adults included BMI ≥ 45 kg/m^2 and either a weight-related barrier to hospital discharge, or weight as a barrier to life-saving treatment, such as transplant or cardiac surgery. For adolescents, the criteria for access generally included very high BMI and: presence of a weight-related condition, such as hypertension or pre-diabetes; requiring weight loss for surgery; syndromic obesity diagnosed with genetic testing; or mobility issues related to disability limiting exercise capacity.

Other

Several submissions mentioned the benefits to the Australian healthcare system that would be gained by reducing obesity in Australia. By preventing or delaying obesity-related complications such as type 2 diabetes, cardiovascular disease and metabolic dysfunction-associated fatty liver disease, GLP-1s have the potential to reduce hospitalisations, surgical interventions and medication use. This reduces burden on, and expense to, the broader healthcare system.

Acronyms and abbreviations

BMI	body-mass index
GLP-1	glucagon-like peptide-1 receptor agonist
GP	general practitioner
OSA	obstructive sleep apnoea
PBAC	Pharmaceutical Benefits Advisory Committee
PBS	Pharmaceutical Benefits Scheme
PCOS	polycystic ovary syndrome