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# Anti-Obesity Medications: Faster, Broader Access Can Drive Health and Wealth in the UK

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# Executive Summary

In 2024, the National Institute of Health and Care Excellence (NICE) published draft guidance on tirzepatide, a new class of weight-loss drug. It recommended that the NHS make it available to anyone with a body mass index of 35 or more with at least one obesity-related condition.[1]

Had the guidance been implemented, NHS England would have been the first public-health system to reimburse a GLP-1 medication for weight loss, the first to make it available in primary care and the first to deploy digital-first services to prescribe and monitor it. More than that, it would have made 2.8 million people eligible for the drug in the first year and 3.4 million people eligible within five years.[2]

However, despite edicts that would usually see NICE guidance implemented within 90 days, NHS England submitted a funding-variation request, asking for an extension to the implementation period. As a result, final guidance recommended that the NHS roll out tirzepatide to 220,000 patients within the first three years and 3.4 million within 12 years. Unfortunately, UK obesity rates look set to rise faster over this period than the NHS can deliver anti-obesity medications (AOMs).[3]

NHS England had its reasons for objecting to the guidance: GLP-1s are expensive, primary care is busy and it felt unable to guarantee equity of access across the country. These objections are understandable but there are ways to mitigate these factors that do not seem to have been explored as part of NHS England's calculations. Recent reports suggest that the government understands this and has commissioned a study into new ways to deliver the drugs – over the counter in some places – with a pilot scheme expected imminently.[4]

In this paper we set out how government could achieve this vision of faster, broader access to AOMs by changing the way it thinks about prevention and, in particular, how it evaluates, funds and delivers preventative medicines.

This is important, because while the cost of treating obesity may be high, the cost of not treating it is higher. Previous analysis set out in the Tony Blair Institute for Global Change (TBI) paper *Unhealthy Numbers: The Rising Cost of Obesity in the UK* estimates that it costs society about £98 billion a year. Two-thirds of this falls on people with obesity themselves and the rest on wider society, through higher NHS treatment costs, increased welfare payments and decreased productivity. Obesity is a leading cause of chronic ill health in the working-age population and significantly impacts the number of working days lost each year to ill health as a result.[5] Tackling obesity as part of a wider prevention agenda should be a key priority for any government looking to drive health and wealth in the economy.

There are also ways to lower or mitigate the cost that aren't considered in current rollout plans: price negotiations with the pharmaceutical industry, for example, or more widespread adoption of new digital-first care models. The current proposed care model assumes that, in any given year, each patient initiated on tirzepatide will require 21 GP appointments, five psychologist sessions, five dietitian visits, four nurse consultations, three clinical pharmacist meetings and one health-care assistant appointment.[6] Not only is this wildly resource intensive, it is also hugely expensive. The cost per patient is more than £1,200 in the first year alone, equivalent to the annual cost of the medication itself.[7,8] Consideration of these cost-saving measures could make a faster, broader rollout plan far more affordable in the short term.

Capacity constraints in primary care are also a valid concern. The pressures in general practice are well recognised and the rollout of GLP-1s at scale through this route is probably both infeasible and unreasonable. However, data from life-sciences analytics company IQVIA suggest that approximately 1.4 million people in the UK every month already access these drugs through private online pharmacies,[9] and the market continues to grow. As long as strict clinical governance standards were set, the NHS could expand access to AOMs far faster than under current plans by commissioning private-sector providers to deliver weight-management services using established digital-first delivery mechanisms.

The NHS is also right to insist on equity and fairness, but NHS England's current rollout plan won't deliver it. Obesity is already more prevalent in people of higher socioeconomic need;[10] a slow rollout of these medications on the NHS will perpetuate access based on ability to pay rather than need, and will only widen those health inequalities. The NHS's ten-year health plan rightly plans to pivot health services from treatment to prevention and tackle deep-rooted unfairness in health equity – but without a credible obesity strategy that can deliver at scale and pace, it will simply not achieve it. There must be recognition of the vital role that AOMs will play.

A different future is possible, in which obesity is not just treated but obesity-related conditions are actively prevented. However, this will require a fundamentally different approach to prevention – one that sees it as an investment in the health and wealth of our nation rather than a just a cost to be borne by the taxpayer.

In 2023, TBI published *Moving From Cure to Prevention Could Save the NHS Billions: A Plan to Protect Britain*, proposing a new nationwide preventative-health programme (called Protect Britain) to provide increased access to preventative vaccines and therapeutics for everyone at heightened risk of a preventable or chronic disease.

The following year, in *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK*, we modelled the impact of people enjoying longer, healthier, more productive working lives and predicted that a 20 per cent reduction in the incidence of six common long-term conditions would have a significant impact on the economy, with GDP set to increase by 0.74 per cent within five years and 0.98 per cent within ten.

In our accompanying paper, *The Economic Case for Protect Britain, a Preventative Health Care Delivery Programme*, we modelled the fiscal case for Protect Britain, with a proposed initial focus on the identification and reduction of cardiovascular-disease risk. This showed that even this foundational version of Protect Britain would create about £0.6 billion per year in net fiscal savings by the end of this parliamentary term and £1.2 billion per year by the end of the next.

In this paper we extend this macroeconomic modelling to look at AOMs, comparing rollout under current NHS plans with TBI's plan for Protect Britain. Under TBI's plan, eligibility for the drug would be broadened to all those with a body mass index of 27 or above, while delivery would be predominantly through digital channels and access to free treatment would be means-tested. For those not eligible for free prescriptions, patients could either self pay or share the cost with their employer through workplace-based schemes.

We recommend that the programme is delivered by a new function within government – Protect Britain – designed to lead on new models of prevention that deliver high-impact macroeconomic benefits. This new function should have the power to evaluate, fund and deliver prevention differently. Ringfenced funding should come directly from the Treasury, but costs could be further contained by reaching a negotiated price settlement with pharmaceutical companies. To maximise the macroeconomic benefit, the programme should be targeted at those of working age over 40.

In the first instance, this programme could be delivered using existing contracts and data-exchange mechanisms, such as the Pharmacy First contract and GP Connect data-exchange mechanism. In this case, rollout could proceed at speed by agreeing national contracts with a handful of private providers that already prescribe AOMs, have broad population coverage and are able to offer both digital and in-person services. However, over time Protect Britain should commission other providers through the Any Qualified Provider contract and establish a data-exchange platform to maintain patient health records and monitor outcomes-based contracts.

Under these assumptions, TBI modelling shows that Protect Britain could be expected to deliver:

- A boost to GDP of 0.3 per cent at five years and 0.55 per cent at ten years.
- A reduction in DWP spending of £2.08 billion at five years and £3.47 billion at ten years.
- Cost-benefit neutrality for the government within ten years, with cumulative fiscal benefits estimated at £52 billion by 2050.

These findings support a faster, broader approach to the rollout and our recommendations are as follows:

1. A new function within government called Protect Britain should be established to lead on models of prevention that deliver high-impact macroeconomic benefits. Protect Britain should have direct, ringfenced funding from the Treasury and the power to evaluate, fund and deliver prevention activities differently. In the first instance, Protect Britain should focus on the rollout of AOMs to target obesity.

2. Protect Britain should make weight-management services available to citizens through the NHS App. The NHS App team should establish a unique NHS identifier for each citizen, so that patients are able to validate their NHS identity with accredited providers of weight-management services.

3. Protect Britain should promote the uptake of prevention services, including weight management, through the expansion of the UK's Health Check programme (though patients should be able to self-refer to weight-management services at any age if they are eligible).

4. The government should expand the remit of NICE to consider the macroeconomic benefit of large-scale, high-impact innovations. This modelling should take into account the impact of moving to a more cost-effective, digital-first delivery model, the potential for cost savings from a bulk-buy deal with pharmaceutical manufacturers, and the potential to share costs with employers and individuals. Protect Britain and NICE should also work with the Office for Budget Responsibility to ensure the benefits of preventative treatments are scored positively, to unlock Treasury funding for prevention.

5. Protect Britain should lead negotiations with pharmaceutical companies to secure better terms for purchasing drugs at scale. These terms could include a lower unit price, a transfer of risk through outcomes-based contracting terms, a contribution to health-system transformation costs and/or a commitment to invest in UK R&D and manufacturing.

6. Protect Britain should means-test access to AOMs so that only patients who are eligible for free prescriptions can access them at no cost through Protect Britain.

7. Protect Britain should support employers in providing weight-management services to their staff through the creation of an accredited list of providers, which would have access to drugs at a lower unit cost than the market price.

8. Protect Britain should commission weight-management services based on outcomes and price, rather than specifying the model of care.

9. Protect Britain funding should come directly from the Treasury but sourced from the budgets of both the Department of Health and Social Care and Department for Work and Pensions, with the cost split based on the relative benefits expected to accrue to each department. Additional funding could be raised through negotiations with pharmaceutical companies.

10. To deliver prevention at scale, Protect Britain should establish an accredited framework of providers to deliver direct-to-consumer services for weight loss. For speed and scale, these services should already prescribe AOMs, have national reach, offer both digital and in-person services and adhere to agreed clinical-governance and data-governance standards.

11. Protect Britain should establish data-exchange mechanisms with accredited providers in order to manage contracts, acquire real-world data for research and ensure patient safety. In the short-term, existing GP Connect and Pharmacy First contracting mechanisms can be used. In time, a bespoke data-exchange platform should be used, connected to individuals' digital health records and the NHS App.

12. The government should build on existing plans for a Health Data Research Service and establish the UK as a world leader in the generation of real-world evidence for AOMs by investing in public-private partnerships and the development of centres of excellence, such as that in Manchester.

Despite multiple public-health efforts and various drugs, obesity rates have soared (*see Fit for the Future: A Fair Deal on Food for a Healthier Britain*) and wrought havoc on citizens' health and the UK economy. Now, finally, a class of medications is available that is effective, well tolerated and highly scalable. The government must follow its instincts and be bolder: it is time to make this medication available faster and distribute it more broadly.

02

# The GLP-1 Story So Far

Until relatively recently, few people had heard of Ozempic (semaglutide) – now it's a household name. Originally developed to treat type-2 diabetes, its popularity surged five years ago when its appetite-suppressing qualities became more widely known. This prompted temporary shortages of the drug in some countries and at one point saw Novo Nordisk, the Danish manufacturer of Ozempic, exceed Denmark's GDP in terms of its market capitalisation. Since then, other drugs acting on the GLP-1 receptor have emerged, such as Wegovy (a higher dose of semaglutide) and Mounjaro (tirzepatide). A staggering one in eight Americans are now thought to have used a GLP-1 drug.[11]

They are highly effective. In fact, compared to previous treatments for obesity, they are orders of magnitude more effective. Their effects are in a class with bariatric surgery,[12] which has always been considered the gold standard for obesity management but is more invasive and resource intensive to deliver than anti-obesity medications (AOMs). When used in conjunction with a good diet and regular exercise, Wegovy can help patients to achieve an average of 14.9 per cent weight loss in a year,[13] while Mounjaro delivers, on average, a 17 per cent drop in the same timeframe.[14] There is even evidence that the drugs are having an impact at population level. Obesity rates in the United States stalled for the first time in decades in 2024,[15] which is thought to have been an effect of the drugs.[16]

While more than half the people using GLP-1s experience side effects, they are mostly mild.[17] The most common are gastrointestinal – nausea, vomiting, diarrhoea and constipation[18,19] – and can often be managed with simple measures such as changes to diet and exercise, anti-nausea medication or slowing dose escalation. There are, of course, more serious side effects (which have prompted caution and which we consider below) and concerns about the loss of lean muscle mass – but, broadly, the tolerability of the AOMs' side-effect profile has been a key driver of their success.

GLP-1s also have other proven health benefits that go above and beyond the management of obesity and diabetes. The SELECT trial of semaglutide, for instance, showed a 20 per cent reduction in cardiovascular events for high-risk individuals on the drug, independent of weight loss;[20] semaglutide is now licensed for the treatment of cardiovascular disease (CVD) in the US, the United Kingdom and Canada. Meanwhile, the SURMOUNT-OSA trial showed tirzepatide to be effective in treating obstructive sleep apnoea,[21] with the drug having now been licensed for that indication in the US.

Potential new uses for GLP-1s seem to emerge daily. There are reported benefits of GLP-1 use in metabolic disorders other than diabetes (such as polycystic ovarian syndrome[22]), in other cardiovascular conditions (such as high blood pressure[23,24]), some neurocognitive disorders (Alzheimer's[25] and dementia[26]), a handful of obesity-related cancers[27] and even addiction (including smoking, alcohol and recreational drug use[28,29]). Most of these associations are still at the research stage but some are now in trials. The SYNERGY-NASH trial, for instance, is looking at tirzepatide in the treatment of fatty liver disease,[30] while the FLOW trial reports positive findings for the effect of semaglutide on chronic kidney disease.[31]

As might be expected, a whole host of "me too" medications are now on the way: AOMs that are more effective, have fewer side effects and are easier to administer (in oral rather than injectable form), which could improve compliance. Some of the pipeline drugs even have completely new mechanisms of action, or target more than one receptor. Retatrutide, for example, targets three hormone receptors – GLP-1, GIP and GCGR (a glucagon receptor) – achieving more than 24 per cent weight loss in clinical trials.[32]

The rapid development of new AOMs has led to a rapidly evolving market for the drugs. This market will continue to mature as competitor products enter the market over the next two to three years and generics become available in the next eight to nine years.

It is difficult to be precise about the timings for generics because pharmaceutical companies are typically tight-lipped about patents. Core patents are expected to expire fairly soon: Medicines UK suggests that the ones for semaglutide and tirzepatide will expire in 2028 and 2032 respectively.[33] But even if that is true, secondary patents are expected to expire much later: in the early 2030s for semaglutide[34] and the late 2030s for tirzepatide. This would see Novo Nordisk and Eli Lilly maintaining market exclusivity for some years to come.

Competition will arrive earlier, however. There are nine new AOMs in phase III clinical trials or later, and more than 150 in the overall pipeline. Three of the phase III trial drugs are Chinese – unlikely to be released in US or European markets – which means that the UK can expect six new products to emerge in the next two to three years. This will put pressure on AOM prices, despite the fact that both the new and existing medications are patented. The rapid evolution of this market highlights the potential for lower-cost drugs in the near future and the importance of agility in the procurement and delivery of these medications as part of any rollout plans.

03

# Concerns about GLP-1s

GLP-1s are not without controversy and it is important to consider these concerns in considering what a faster, broader rollout might look like.

## Cost

Tirzepatide costs the NHS between £92 and £122 per patient per month.[35] Private patients pay slightly more (between £130 and £269[36]) and, while not in the same bracket as some new, patented drugs, compared to established off-patent drugs such as atorvastatin – an anti-cholesterol drug that costs about £2 a month – this is high.

Apart from this high unit price, the other factor driving up cost is the number of people eligible for these new drugs. The Medicines and Healthcare products Regulatory Agency (MHRA) has licensed tirzepatide for all patients with a body mass index (BMI) of 27 or over, which equates to about 26 million people in the UK. If all 26 million were treated, the annual cost of this drug alone would be about £38 billion, which is about 17 per cent of total health spending.

It is also unclear how long people will need to be on the drugs for. Some believe that the drugs could be used for a short period of time and discontinued (this is the NICE-recommended length of treatment with Wegovy, for instance[37]), while others – particularly those who view obesity as a chronic disease (see next paragraph) – think patients may need to be on them for life. Some weight-management services see evidence of a hybrid approach emerging, whereby patients cycle on and off AOMs throughout life to maintain a healthy weight.[38]

There is a growing call for obesity to be considered a chronic disease rather than a lifestyle choice (in *The Lancet*[39] and by the US Food and Drugs Administration,[40] for example). This may be right: weight regain is common in those who discontinue AOM use, in the same way that blood pressure and cholesterol go up when medication is stopped.[41] However, viewing

obesity as a chronic disease has implications for the long-term cost of these drugs. If patients need to be on AOMs for life, there is likely to be a significant uplift in the annual health budget on an ongoing basis.

## Side Effects

As with all drugs, there are side effects. The most serious of these, pancreatitis, is a potentially fatal condition that affected 0.2 per cent of patients in trials,[42] while gallbladder inflammation was also reported in some patients.[43]

It is unclear at present whether side effects are more or less common with real-world use compared to trials, and whether they affect different cohorts differently. Recent studies in patients with no underlying health conditions (other than obesity) indicate that the risk of some conditions may actually be lower for this group,[44] and that GLP-1s may even be protective against pancreatitis.[45] However, recent data collected through the Yellow Card scheme in England showed higher-than-expected deaths in patients taking GLP-1s.[46] Admittedly it is impossible to infer causality from Yellow Card data because of how "noisy" they are. That said, the findings do highlight the importance of ongoing research into GLP-1 use and the vital work of the MHRA in post-market surveillance.

## Clinical Governance and Misuse

Intense public demand for these medications has spawned a relatively underregulated private market as well as a smaller (but not insignificant) illicit market, trading in real and fake drugs.[47]

The fact that a private market has emerged is not in itself a challenging issue – in fact, private providers have led the way in innovative design of light-touch, low-cost delivery models. However, there have been issues with the clinical governance of some providers. Incidences of people accessing the drugs inappropriately and ending up in A&E through misuse have been reported, highlighting the importance of effective regulation.[48] Stricter

guidelines published in early 2025 by the General Pharmaceutical Council put greater onus on the verification of a patient's weight, alongside other eligibility criteria, before initiating GLP-1s.[49] This should be welcomed.

Patients have also reportedly misused drugs obtained legitimately, by sharing injectable drugs with others or underdosing to extend supply, for example;[50] there have also been issues with the use of fake drugs.[51] As a result, Eli Lilly and the MHRA have intensified monitoring efforts to identify and shut down illegal drug sales, including the use of AI tools to identify illicit trading sites.[52] While it is important that this kind of illegal activity is shut down quickly, it also makes a good case for broadening access to legitimate AOMs through safe, affordable means.

There have also been concerns about the level of wraparound support provided by private online pharmacies. Wraparound services provide advice on diet and exercise as well as psychological support, and have been shown to improve adherence, long-term weight loss and clinical safety;[53,54] however, these services are rarely taken up by patients. In addition, some online pharmacies are flouting rules around the advertising of prescription-only medications.[55] These issues highlight the important role that regulators and commissioners play in setting and enforcing high standards of clinical governance.

04

# GLP-1s and the Prevention Agenda

There is growing interest in AOMs and their role in prevention. Not just because of their role in treating obesity, but because of the impact they could have in reducing the incidence of many obesity-related conditions (ORCs), helping to control health and welfare spending and drive economic growth through increased rates of labour-force participation and in-work productivity.

Obesity places an intolerable strain not just on people's health but also the country's health system, benefits system and the economy. In our paper *Unhealthy Numbers: The Rising Cost of Obesity in the UK*, we estimated the cost of obesity to be about £98 billion per year. Two-thirds of this falls upon individuals and the rest on wider society, through increased NHS expenditure, soaring welfare payments and lost productivity. This includes the more-than £19 billion incurred by the NHS each year as a result of obesity-related illnesses, and more than £15 billion in lost productivity annually across wider society.

Details of the relationship between obesity and work are also becoming clearer. Research conducted by the Obesity Health Alliance shows that economic inactivity is significantly higher for those with a BMI over 40;[56] while the same relationship with economic inactivity does not exist for those with obesity but a BMI under 40, there is undoubtedly a correlation with reduced in-work productivity for this latter group. The six conditions identified by the Department of Work and Pensions (DWP) as accounting for the most working days lost to illness each year are cancer, CVD, chronic obstructive pulmonary disease (COPD), diabetes, musculoskeletal problems and poor mental health – and obesity is a risk factor for all of these conditions.[57]

The fact that obesity is a risk factor for so many chronic conditions is what makes it such a good target for prevention, rendering GLP-1s a good option for preventative delivery. Not because they are a "cure all" as such – it is more that obesity is a "cause all" and that in tackling it, an array of future adverse health events can be avoided.

In fact, the multi-modal effect of GLP-1s has prompted some health experts to suggest that they become part of a core "backbone therapy" to reduce cardiovascular risk through a combined effect on obesity, diabetes, heart failure, kidney disease, strokes, high blood pressure, hyperlipidaemia and fatty liver.[58]

Alongside their effectiveness, tolerability and breadth of action, the other factor drawing attention to GLP-1s as part of the prevention agenda is their speed of action. There have always been very good reasons for employers, insurers and governments to invest in prevention but by the time benefits have been realised, employees may have moved on, policyholders may have switched to another insurer or governments may have been voted out of office. However, improvements to diabetes control, blood pressure, blood lipids and quality of life are seen immediately with GLP-1s[59] (the effect on cardiovascular risk can take slightly longer).[60] This changes the maths on prevention and makes it a more attractive proposition.

There is sometimes a concern from public-health experts that focusing so much on GLP-1s detracts from other measures to support weight loss. Clearly, they are not a silver bullet; the likes of green spaces, cycle lanes and a regulated commercial food environment are still vital. In fact, in the age of broad access to AOMs through the state, these kinds of measures may be needed now more than ever. Supporting people to lose weight with medication is one thing, but without changes to the commercial food environment, there is a higher likelihood that people will need to remain on these medications long term to maintain weight loss. For the UK's obesity strategy to be successful, sustainable and affordable, broader access to drugs must be offered in conjunction with measures to drive primary prevention. According to Sir Steve Powis, national medical director at NHS England, drugs such as tirzepatide are "a powerful part of our arsenal" against obesity and ORCs.[61]

For years, obesity has seemed an intractable problem. Despite numerous government strategies, multiple public-health efforts and a range of drugs (see *Fit for the Future: A Fair Deal on Food for a Healthier Britain*), obesity rates have soared. But the effectiveness of GLP-1s is changing the conversation around obesity management – and changing the approach to prevention more generally.

05

# The Current State of Access to GLP-1s in the UK

The first GLP-1 licensed for weight loss in the UK was semaglutide in 2021, followed swiftly by tirzepatide in 2023. The MHRA licensed both for use (alongside dietary measures and increased physical activity) in patients either with a BMI of 30 or more, or a BMI of 27 to 30 with at least one obesity-related condition.[62] Technically this makes many millions of patients in the UK eligible for these medications, but in practice access to these drugs is more limited because of their high cost and low availability on the NHS.

The NHS provides access to semaglutide (for weight loss) only through Tier 3 weight-management clinics: specialist, mainly hospital-based services commissioned by local systems.[63] Only patients with the most complex needs, who have already failed to lose weight through diet and exercise alone, qualify for these services. Places are not offered equally across the country and even where they are offered, waits of a year or more are common.[64] For instance, there are more than 130,000 eligible patients in southeast London but only enough weight-management places for 3,000.[65] Tirzepatide was recommended by NICE for use in primary care but the rollout plan is in its very early stages.

Meanwhile, the private sector is booming. Data from life-sciences analytics company IQVIA suggest that, despite high user fees of up to £267 a month, approximately 1.4 million people in the UK now access GLP-1s privately every month, predominantly through online pharmacies.[66]

However, while the private sector has expanded access to these drugs for UK citizens over a relatively short period of time, a two-tier system has problems.

### HEALTH INEQUALITIES

A two-tier system is creating highly unequal access to AOMs based on ability to pay rather than need. IQVIA data show that while approximately 1.4 million people in the UK access GLP-1s every month through private online pharmacies, only an estimated 200,000 are doing so through the NHS, with the majority of these people accessing these drugs for type 2 diabetes, not weight management.[67] This is amplifying health inequalities. Obesity rates are already about 15 per cent higher in the most deprived areas compared to the least deprived areas[68] and the arrival of these drugs – available predominantly to people who can pay – is only deepening those divides. In addition, the private online services currently doing much to broaden access to these medications are only expanding them for use by people with a relatively simple risk profile. People with learning disabilities or severe mental illness on anti-psychotic medication, for instance, will require far more personalised and high-touch services – and this is not a group currently catered for by the private online-pharmacy market.

### INTEGRATION OF PUBLIC AND PRIVATE SERVICES

There have been real issues integrating public- and private-sector services. Under current rules, private providers are not mandated to notify a general practitioner when one of their patients is initiated on an anti-obesity drug. Some do, but not as a matter of course, and only if the patient consents to it. Even then, some experts who contributed to this paper report that GPs often do not have the time or resources to review these updates.

This leads to an incomplete longitudinal care record in general practice, making it harder for doctors to join the dots. This in turn makes it harder to track pathways, monitor side effects and coordinate care, and underscores the need for better sharing of data between the public and private sectors.

## NICE Review of Access to GLP-1s in the UK

In 2024, the National Institute of Health and Care Excellence (NICE) reviewed access to tirzepatide for weight loss in England.[69] Its draft guidance recommended the drug be made available on the NHS to anyone with a BMI

of 35 or over with at least one obesity-related condition (or 32.5 or over with at least one obesity-related condition for patients of South Asian, Chinese, other Asian, Middle Eastern, Black African or African Caribbean ethnic backgrounds).

Had NHS England implemented the guidance, it would have been groundbreaking. The NHS would have been the first public-health system to reimburse a GLP-1 medication for weight loss, the first to make it available in primary care and the first to deploy digital-first services to prescribe and monitor it. More than that, it would have made 2.8 million people eligible for the drug in the first year, and 3.4 million people eligible within five years.[70]

However, despite edicts that would usually see NICE guidance implemented within 90 days, NHS England submitted a funding-variation request, asking for an extension to the implementation period. As a result, final guidance recommended the NHS roll out tirzepatide to 220,000 patients within the first three years and 3.4 million within 12 years. Unfortunately, this plan is unlikely to touch UK obesity rates, which look set to rise faster over this period than the NHS can deliver AOMs.[71]

The reasons cited for this delay were affordability, capacity and an inability to assure equity.

**AFFORDABILITY**

NHS England calculated that about 2.8 million people would have been instantly eligible if it implemented the draft guidance set out by NICE within 90 days, costing the NHS £15.2 billion over five years to roll out (assuming 70 per cent of those people were initiated on the drug).[72] The estimated cost of the drug alone was £2.9 billion in the second year of use, threatening to eclipse 20 per cent of the primary-care medicines budget.[73] This breached the Budget Impact Test, prompting NHS England's funding variation request to NICE.[74]

The Budget Impact Test is designed to act as a break between NICE draft guidance and NHS England implementation, and is triggered when the estimated budget impact of a medicine exceeds an agreed amount. At the time this was £20 million in any of the first three years of a medicine's use; now the threshold is £40 million in the same time period.

In addition, no additional Treasury funding could be unlocked based on the guidance of the Office for Budget Responsibility (OBR), which does not currently recognise the benefits of prevention in its calculations. "Much weight is rightly given by the OBR to experts," wrote Adam Smith, former chief of staff to then chancellor Jeremy Hunt, in a column in March 2025. "So at one point the Treasury even took the chief medical officer to a meeting with the OBR to impress upon them the significant impact increased funding for musculoskeletal disorders and obesity programmes would have on the labour market. This didn't work. They wouldn't score anything positive, so we didn't provide any of these proposals with funding."[75]

This suggests a previous frustration with the OBR that might now be unfounded. The OBR's most recent Economic and Fiscal Outlook[76] gave the Treasury credit for planning reforms, which indicates the potential to progress conversations about the economic value of prevention in future.

**CAPACITY**

Capacity constraints were another reason that NHS England applied for a slower rollout of GLP-1s. Modelling by NHS England estimated that rolling out NICE draft guidance would consume 18 per cent of all GP appointments and the entirety of dietetic capacity in the second year.[77]

Unsurprisingly, NHS England's request for a funding variation was strongly supported by Integrated Care Boards (ICBs), as the commissioning of future weight-management services would come from their budgets. In its submission to NICE, NHS England stated that "in attempting to comply with the recommendation, ICB representatives have told us that they would be required to take tough decisions regarding the decommissioning of other critical services in order to free up the capacity and resources to offer this medicine".[78]

**EQUITY**

NHS England was also worried about the impact that NICE's guidance would have on equity of NHS services. It said: "In the absence of [a funding variation] there is a high likelihood of an inconsistent rollout of tirzepatide, with inequalities of access and patient outcomes both within and between ICBs based on different patterns of patient demand and health-seeking behaviours rather than on clinical need and prioritisation."[79]

Fundamentally, this conflicted with principles in the NHS Constitution, which state that the health-care system must provide a comprehensive service available to all.[80]

## NHS England's Plan to Extend Access to GLP-1s in the UK

NICE's guidance on tirzepatide was finally published and accepted by NHS England in December 2024.[81] The core recommendations around eligibility matched those in the draft guidance but the implementation period was extended. There were also plans for a phased rollout and a new model of care.

The phased access means that those patients with the most complex needs (those already enrolled in specialist weight-management services) will get access first, followed by successively lower-risk cohorts, until it is eventually rolled out to the full 3.4 million eligible patients within 12 years. These cohorts will be successively identified by NHS England and referred for treatment in the following order:

- BMI of 40 or more with three ORCs
- BMI of 40 or more with two ORCs
- BMI of 40 or more with one ORC
- BMI between 35 and 39.9 with at least one ORC

This new model of care will mean a series of pilots over the next three years,[82] after which NICE will evaluate their cost effectiveness.[83] In the terms of its funding-variation request, NHS England wrote: "This requires the NHS

to stand up an entirely new tier of weight-management services in circumstances where consensus on a service model is yet to emerge."[84] NICE hopes that this review of different delivery models will support ICBs in commissioning the most cost-effective services in future and also to potentially speed up the rollout of the drug.

Ultimately, what NHS England envisions is the creation of a Primary Care Weight Management service, commissioned by local ICBs.[85] GPs would identify eligible patients from their list and refer them to this service for support with weight loss. In the meantime, while it designs this vision, NHS England will issue guidance to 42 ICBs on how to extend the remit of their existing weight-management services (which currently reside in specialised settings) to include patients in primary care.[86]

## Concerns about NHS England's Plan

NHS England's plan to expand access to AOMs in the UK lacks pace, scale and agility.

### PACE

The NHS's aim to roll out tirzepatide to 220,000 people within the first three years seems unambitious given the private sector already delivers GLP-1s to almost five times that number in the UK every month.[87] The intended rollout to a further 3.2 million people over the subsequent nine years is also painfully slow – and unlikely to touch projected rates of obesity, which look set to rise faster than the NHS can deliver AOMs.[88]

This will significantly slow progress on the prevention agenda and further entrench existing health inequalities. The NHS's ten-year health plan has a huge ambition to pivot health services from treatment to prevention and to tackle deep-rooted unfairness in health equity - but without a credible obesity strategy that can be delivered at scale and pace, it will simply not achieve it. There must be recognition of the vital role that AOMs play in that.

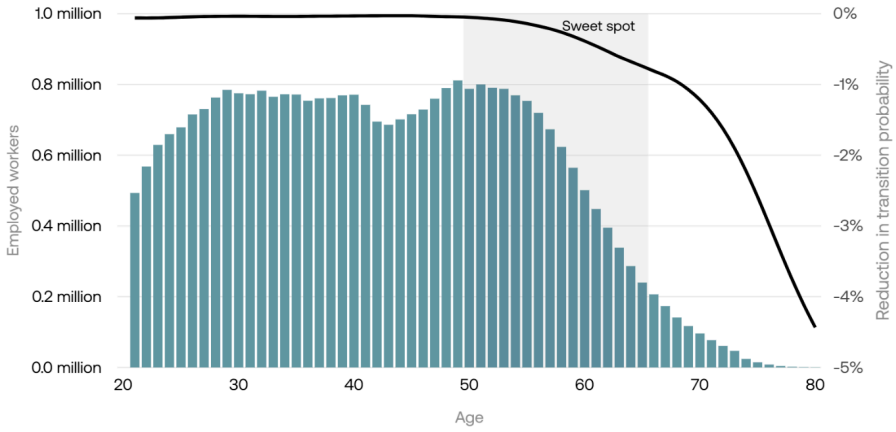
**SCALE**

A 2024 report by the Tony Blair Institute for Global Change, *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK*, suggests that greater access to preventative medications (such as GLP-1s) could be justified through increased tax receipts, reduced NHS use and reduced welfare expenditure – but eligibility is restricted. Any macroeconomic benefits that do end up accruing from NHS England's plan are unlikely to be felt any time soon. TBI modelling from the same paper shows that the quickest route to economic benefits from prevention is to treat those in mid to late life, rather than those who are sickest.

The reason for this is that in older age groups, the incidence of disease is high but only a small proportion of this group is in work, so prevention has very little impact on labour-force participation or DWP benefits. For younger groups, a higher proportion is in work but the incidence of disease is low, so prevention has little impact for the next 20 to 40 years. People in their 40s, 50s and 60s are in the "sweet spot" for prevention: both the incidence of disease and the proportion of that population in work is high. Preventative actions at this stage prevent significant health events (such as a heart attack) from occurring in the next five to ten years and taking people out of work.

FIGURE 1

# The sweet spot where interventions have high impact on a large number of workers




Source: Authors' calculations based on Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Disease in the United Kingdom"

As such, NHS England's plan – to roll out GLP-1s to the sickest patients first – makes complete sense for NHS England, but not necessarily the country. One of the core reasons for the health service existing is to maintain a healthy working population, but when that service is designed to treat the sick, it is inevitable that prevention will be deprioritised.

This points to a tension at the heart of the NHS, between prevention on one hand and sickness on the other. It also reveals how the NHS regards AOMs: as a treatment for obesity (and thus a cost that must be borne) rather than a measure designed to prevent obesity-related conditions (and thus an investment in the health and wealth of the country).

**AGILITY**

Prevention activities, by their very nature, need scale: they target the "well" population, which is inevitably larger than the "sick" population on any given day. However, to achieve scale you need low-cost, light-touch models to be sustainable. By contrast, any delivery model that places GPs at the centre will be limited in its ability to scale.[89]

Despite this, the model of care proposed by NHS England for its Primary Care Weight Management service is almost comically over-resourced. Based on Eli Lilly's SURMOUNT-1 trial of tirzepatide, it assumes that, in any given year, each patient will require 21 GP appointments, five psychologist sessions, five dietitian visits, four nurse consultations, three clinical pharmacist meetings, and one health-care assistant appointment.[90] Not only is this wildly resource intensive but it is also hugely expensive. The cost per patient is more than £1,200 in the first year alone – equivalent to the annual cost of the medication itself.[91,92]

The model is also outdated. There is no presumption of a digital-first offer and no effort to step out of the clinic and into the community. Prevention models need to meet people where they are: online, at home and in the high street, as well as at work. NHS England's plans are based around an outdated community-clinic model and there's very little agency involved. Patients are not encouraged to be proactive; rather, they are expected to wait for NHS England to draft eligibility criteria, wait for ICBs to identify them and then wait for a GP to refer them. It's more than a touch paternalistic.

Online pharmacies have issues of their own (as discussed earlier), but the fact that they are operating at scale and at a fraction of the price of the NHS cannot be ignored.[93] And given that the private sector has already made the leap to these digital-first delivery models, why is the NHS reinventing the wheel by doing three years' worth of pilots? There are already a range of NICE-recommended digital weight-management platforms that provide tailored programmes and support to patients – spanning doctors, nurses, dietitians and psychologists – that could be scaled.[94,95]

There are interesting global models to learn from. In the US, for instance, both Eli Lilly and Novo Nordisk have their own direct-to-consumer digital health-care platforms (LillyDirect and NovoCare Pharmacy respectively). These platforms partner with independent health-care providers to simplify access, connecting patients with telehealth providers for consultation and prescription, facilitating remote monitoring and home delivery and providing access to digital wraparound services in a single, streamlined pathway.[96] Although these models cannot be repeated in the UK because pharmaceutical companies are not permitted to market direct to consumers, there are lessons that can be taken from this integrated digital-first model.

The decision to devolve the commissioning of weight-management services to 42 separate ICBs is also an odd choice. Digital services are ultra-scalable and inherently national; there is no need to tie them to a local geography. In fact, commissioning them locally could have a negative impact, multiplying the commissioning effort 42 times while giving patients zero choice at a local level. In addition, this is in the context of impending 50 per cent job cuts at ICBs, which will result in even more confusion and resource constraint at a local level.[97] With all this going on, it seems unwise to commission locally when services could be commissioned more effectively at scale.

Existing plans to roll out AOMs lack the agility required to get the best deal for patients and taxpayers in the coming years. By 2037, the UK will be home to an obesity-treatment market where semaglutide is off patent and there are multiple new GLP and non-GLP agents, with new delivery mechanisms (including orals and long-acting injectables) and fewer side effects (including muscle-preserving features). In addition, prices will have come down and there will be new data on a range of issues that are currently unresolved. It seems more important than ever that, whatever apparatus the UK establishes to procure and deliver these medications, it is agile enough to adapt in the face of this change.

06

# A New Way Forward: Transforming the UK's Approach to Prevention

In 2023, TBI published *Moving From Cure to Prevention Could Save the NHS Billions: A Plan to Protect Britain.* We proposed a new nationwide preventative-health programme – Protect Britain – to provide increased access to preventative vaccines and therapeutics for everyone who is at heightened risk of a preventable or chronic disease.

The following year, in *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK*, we modelled the impact that people enjoying longer, healthier, more productive working lives would have on the economy. We forecast that a mere 20 per cent reduction in the incidence of six common long-term conditions (LTCs) would lead to the following gross macroeconomic impacts:

- **GDP:** An uplift in GDP of 0.74 per cent within five years (and 0.98 per cent within ten years)
- **Debt:** A drop in government debt of £6 billion within five years (and £30 billion by 2040)
- **Welfare:** A drop in welfare spending of £2.7 billion within one year (and £41.7 billion by 2030)

A companion paper, *The Economic Case for Protect Britain, a Preventative Health Care Delivery Programme* modelled the cost of rollout for Protect Britain with a proposed initial focus on the identification and reduction of CVD risk. Fiscal modelling showed that this foundational version of Protect Britain would create about £0.6 billion per year in net fiscal savings by the end of this parliamentary term and £1.2 billion per year by the end of the next.

In this paper, we are proposing that GLP-1s are also made available through Protect Britain. We have compared the expected macroeconomic benefits of the current NHS rollout plan with a broader, faster rollout plan through

Protect Britain. We have then considered the powers that Protect Britain would need to achieve that aim, including new powers to evaluate, fund and deliver preventative treatments.

## The Macroeconomic Case for Faster, Broader Access to GLP-1s

In calculating the macroeconomic case for GLP-1s we have used the same model as used in *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK* to consider cardiovascular prevention, but amended to include new assumptions about how AOMs impact the six LTCs.

This model takes three macroeconomic outcomes – GDP growth, NHS spend and welfare spending – to calculate the impact of a hypothetical reduction in disease incidence:

- **Improved GDP growth:** realised as a result of greater workforce participation, both in terms of more people being in work (as opposed to being economically inactive) and more people choosing to work full time (as opposed to part time)
- **Reduced NHS spending:** realised as a result of lower rates of ill health
- **Reduced welfare spending:** realised as a result of fewer people falling out of the workforce through ill health

To understand the net benefit of rollout, the following costs are also considered:

- **Delivery:** the costs of rollout (drugs themselves and wraparound care)
- **Pensions:** the expected increase in pension payments, incurred through people living longer as a result of better health

Ideally, the model would have looked at the direct impact of a reduction in obesity rates on these economic outcomes – but a strong causal link between obesity and economic outcomes using microeconomic data does not yet exist, so proxy measures were used. Instead of modelling the direct

impact of obesity on the economy, we made assumptions about the impact of obesity on six LTCs and then modelled the impact of these conditions on the economy.

Those conditions – CVD, musculoskeletal conditions, diabetes, COPD, cancer and mental health – were chosen because they are significant obesity-related conditions and the most common causes of people taking time off work for ill health (as identified by the DWP).

In modelling scenarios for an NHS England rollout and a Protect Britain rollout, a number of assumptions were made regarding:

- the size of the eligible population
- the proportion of those eligible patients that would take up the drug
- how long those patients would stay on it
- the cost of the medication
- the wraparound services provided
- the rollout period
- who would fund the rollout: whether the cost is borne by government or shared between government, pharmaceutical companies, employers and individuals, and then whether individual contributions would be means-tested
- the impact of longer, healthier lives on pension costs for government

**SCENARIO 1: NHS ENGLAND ROLLOUT**

For the NHS England scenario we have assumed that 220,000 people will be initiated in the first three years and then 3.4 million after 12 years. Current plans state that the drug will be rolled out first to those with the highest BMI and, while we know that the demographics of this population are different to the general population (especially in terms of baseline levels of health and economic activity), it was not possible to incorporate this into the model.

Of those initiated, we have assumed a dropout rate of 35 per cent by six months. If they pass the six-month mark, we have assumed that treatment continues for two years and then they split into thirds: one-third continues

treatment for life, another third stops treatment and the final third cycles on and off treatment throughout life, taking the medication for three months out of every 12.

For the model of care we have used NHS England's funding-variation request that was used to inform the final NICE guidance on rollout. This assumes that patients require 21 GP appointments, five psychologist sessions, five dietitian visits, four nurse consultations, three clinical pharmacist meetings and one health-care assistant appointment.

On pricing we have assumed that the cost of the drug is £122 per patient per month until 2033, when the patent on Wegovy is expected to expire; after this the cost of the drug falls to £50 per month as the NHS switches to a generic. The cost of wraparound care is calculated according to NHS England's estimates: £1,239.21 per patient for the first year of treatment and £355.18 thereafter.

We have assumed that both the drug and wraparound cost would be entirely covered by the NHS. (An annex of the full methodology is available as a downloadable PDF.)

FIGURE 2

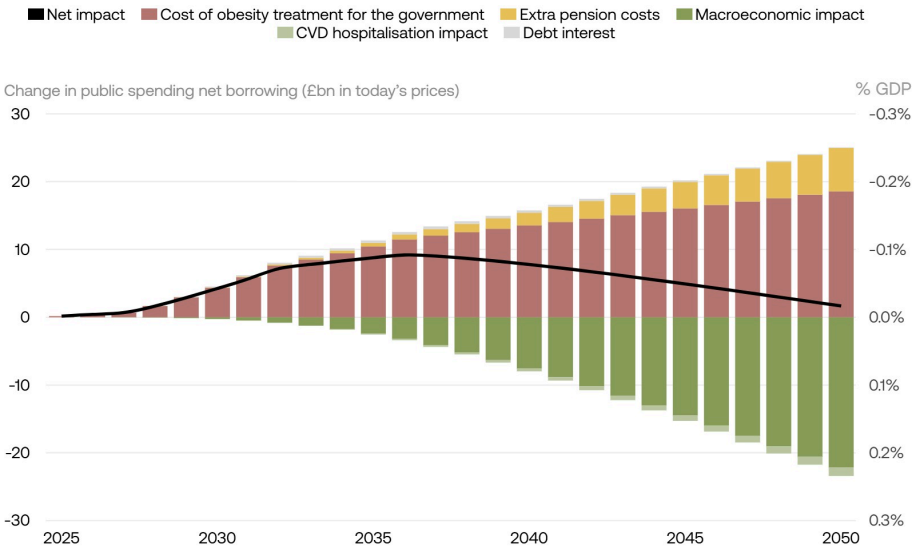
# Assumptions for Scenario 1: NHS England rollout of anti-obesity medications

| Feature | Assumption |
|---|---|
| Eligibility | Adults in England with a BMI of 35 or more, with at least one ORC. |
| Rollout | Gradual rollout with 220,000 people treated within three years and 3.4 million people within 12. Under NHS plans, priority will be given to cohorts in this order:<br>BMI of 40 or more with three ORCs<br>BMI of 40 or more with two ORCs<br>BMI of 40 or more with one ORC<br>BMI between 35 and 39.9 with at least one ORC |
| Dropout | After an average of six months, 35 per cent of patients drop out. |
| Length of treatment | At six months, 35 per cent of patients drop out.<br><br>At one year, a further 8 per cent of patients drop out and 4 per cent are assumed to cycle on and off it for life.<br><br>At two years, roughly one-third of the remaining group (17.5 per cent) take the drug for life, 17.5 per cent stop the drug, and 17.5 per cent take the drug on and off for life (for the purposes of this model, we assume they are on treatment for three months out of every 12). |
| Model of care | The presumed model of care is as described in NHS England's funding variation, whereby each patient initiated on an AOM will require 21 GP appointments, five psychologist sessions, five dietitian visits, four nurse consultations, three clinical pharmacist meetings, and one health-care assistant appointment. [98][99] |
| Drug cost | The cost of the drug is £122 per patient per month until 2033, when the patent on Wegovy is expected to expire.[100] After this, the cost of the drug falls (as expected for generic drugs) to £50 per month. |
| Wraparound care | The cost of wraparound care is annual: £1,239.21 for the first year of treatment and £355.18 thereafter.[101] |
| Rollout costs | Not considered in NICE or NHS England guidance. |
| Funding split | All costs are borne by government, including the prescribing, dispensing and monitoring of the drug. Also includes wraparound diet and exercise support. There is no means-testing of the service. |

Under these assumptions, the modelling shows that the cost (mainly comprising drug-treatment cost) rises faster than the macroeconomic benefits accrue for the first 11 years. This means that over the course of that decade, the government would face year-on-year increases to net expenditure on the programme. This is very similar to what the US's Congressional Budget Office found recently, when it modelled the cost of extending coverage to working-age people with obesity through Medicare.[102]

FIGURE 3

# Projected cumulative future economic benefits of broader access to anti-obesity medications (NHS rollout)




Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom", and TBI calculations

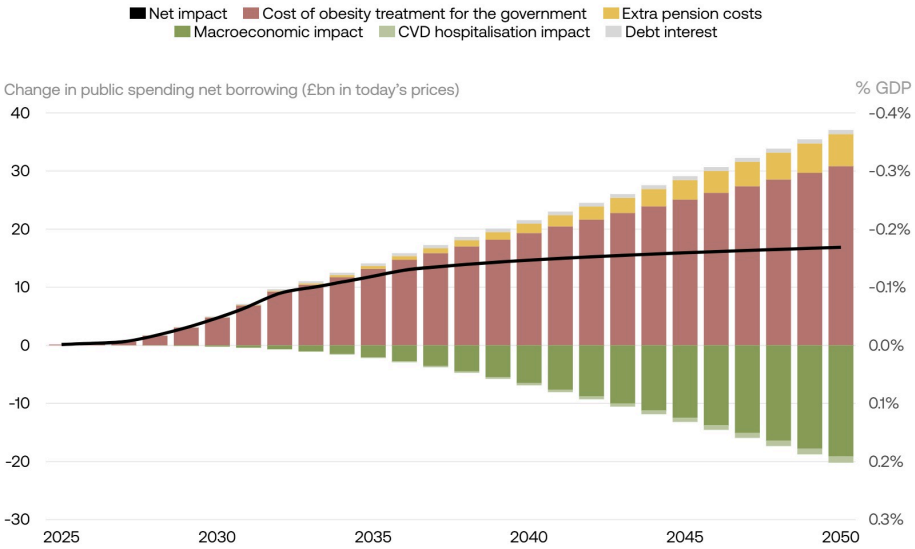
After 11 years, the accumulation of macroeconomic benefits accelerates and the year-on-year net cost of the programme starts to fall (despite ongoing drug and wraparound care costs, plus higher pension payments taking effect by this point). Under planned rollout assumptions, the government will achieve cost-benefit neutrality for the programme in 2053.

In fact, it is likely that this scenario overestimates the macroeconomic benefit of AOM rollout and thus the point at which the government would break even. The NHS plans to roll out to those with a BMI over 40 first, gradually extending to those with a BMI over 35; but evidence from the Obesity Health Alliance indicates that people with a BMI over 40 have higher rates of economic inactivity.

TBI then considered the macroeconomic impact of people staying on the medication for life. As might be expected, keeping all other assumptions the same, this would see an increase in year-on year costs for the rollout. The most striking effect, however, is that the government could never expect to break even: the macroeconomic gains would never exceed the cost. This highlights the importance of mitigating the cost in other ways (as per the Protect Britain rollout) if lifelong therapy is pursued as a policy.

FIGURE 4

# Projected cumulative future economic benefits of broader access to anti-obesity medications (NHS rollout) if patients stay on them for life




Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom", and TBI calculations

## SCENARIO 2: PROTECT BRITAIN ROLLOUT

For the Protect Britain scenario we have assumed a much broader, faster and cheaper (per person) rollout. The threshold BMI has been lowered to 27 (the level at which semaglutide and tirzepatide are licensed for weight loss by the MHRA) and we have assumed that about 40 per cent of eligible patients will take up the treatment. This means that we would expect 14.7 million people to initiate treatment in the first two years.

The rollout period has been shortened to two years to accelerate the benefits, based on most people being able to use a digital-first offer. Of those initiated, we assume a dropout rate of 35 per cent by six months. If they pass the six-month mark, we assume that treatment continues for two years and then they split into thirds: one-third continues treatment for life, another third stops treatment and the final third cycles on and off treatment throughout life, taking the medication for three months out of every 12.

On pricing we assume that the government is able to negotiate a deal that reduces the cost of the drug by 50 per cent until 2033 when generics become available. This could be achieved in a number of ways. One way would be to guarantee large volume sales and commit to these high volumes for eight years – five years past the point at which competition would be expected to enter the market. This could benefit both industry and patients, though it is not a very agile approach and would essentially lock the UK into a single drug for a long time. It also risks lowering the return on investment for the government if uptake is lower than expected.

Another approach would be to set aside a budget for AOMs, capping expenditure on them over a given time period such as years. For incumbent suppliers, this would guarantee high volume sales until competitors enter the market; thereafter, competitors would be considered in any tender from Protect Britain. Any spend on AOMs above the agreed budget would be repaid by industry through a rebate. This is how the Voluntary Scheme for Branded Medicines Pricing, Access and Growth (VPAG) currently works.

Though volumes for the incumbents could not be guaranteed past three years, this approach would ensure that the size of the market could be; competitors would simply be competing for market share. Incumbents would also be at an advantage, having had three years of consistent and well-tolerated use by patients.

The cost of the generic seems a reasonable assumption given that biologics (such as semaglutide and tirzepatide) typically experience a 60 per cent price erosion after market exclusivity ends. We have also assumed that

access to the drugs and the wraparound cost would be means-tested: free to those who are entitled to free prescriptions (about 50 per cent of the population) but paid in full (albeit at a reduced cost) by those who aren't.

(An annex of the full methodology is available as a downloadable PDF.)

FIGURE 5

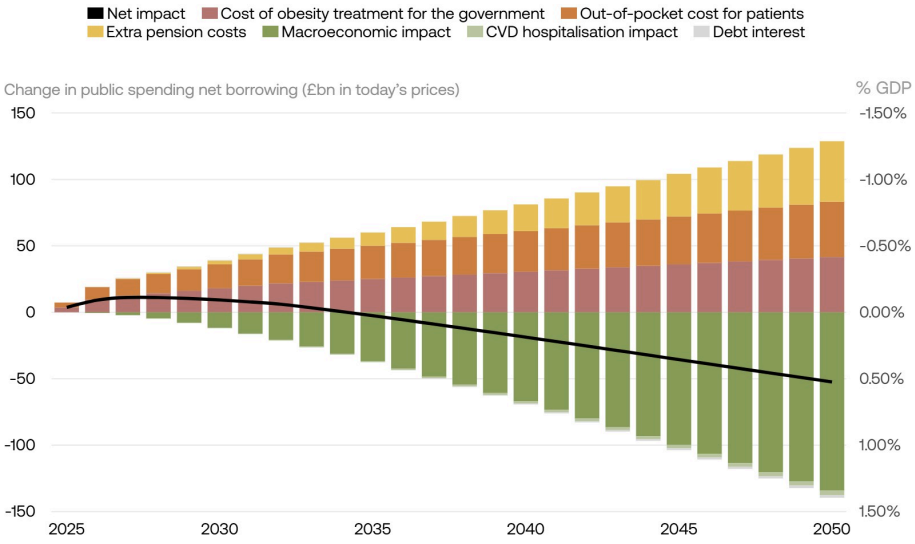
# Assumptions for Scenario 2: Protect Britain rollout of anti-obesity medications

| Feature | Assumption |
|---|---|
| Eligibility | Adults in England with a BMI of 27 or more, with no major contraindications.[103] It is assumed that 40 per cent of those eligible will decline treatment for reasons of personal preference so, in total, 14.7 million people would commence treatment. |
| Rollout | An estimated 14.7 million people are commenced on treatment in the space of two years. |
| Dropout | After an average of six months, 35 per cent of patients drop out. |
| Length of treatment | At six months, 35 per cent of patients drop out. At one year, a further 8 per cent of patients drop out and 4 per cent are assumed to cycle on and off it for life. At two years, roughly one-third of the remaining group (17.5 per cent) take the drug for life, 17.5 per cent stop the drug, and 17.5 per cent take the drug on and off for life (for the purposes of this model, we assume they are on treatment for three months out of every 12). |
| Model of care | Private providers commissioned to both prescribe and provide wraparound diet and exercise support where required. Predominantly digital-first model of care but with capacity to provide face-to-face care where required. |
| Drug costs | The cost of the drug is £61 per patient per month until 2033, when the patent on Wegovy is expected to expire.[104] After this, the cost of the drug falls (as expected for generic drugs) to £50 per month. |
| Wraparound care | The cost of wraparound care is £46 a month[105] for the first year, then drops to £355.18 annually thereafter. |
| Rollout costs | Rollout costs (including new digital- and data-infrastructure requirements) have not been considered, as these are accounted for elsewhere in health budgets. |
| Funding split | Access to the drug and wraparound cost is means-tested. Those eligible for free prescriptions (about 50 per cent of citizens) are entitled to both and costs are borne by the government. Patients not eligible for free prescriptions pay out of pocket at the cost set under the Protect Britain scheme. |

Based on these assumptions, the modelling shows that, for the first three years of rollout, the cost (mainly comprising drug-treatment cost) rises faster than the macroeconomic benefits accrue. This means that for those three years, the government faces year-on-year increases to net expenditure on the programme.

FIGURE 6

# Projected cumulative future economic benefits of broader access to anti-obesity medications (Protect Britain rollout)




Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom", and TBI calculations

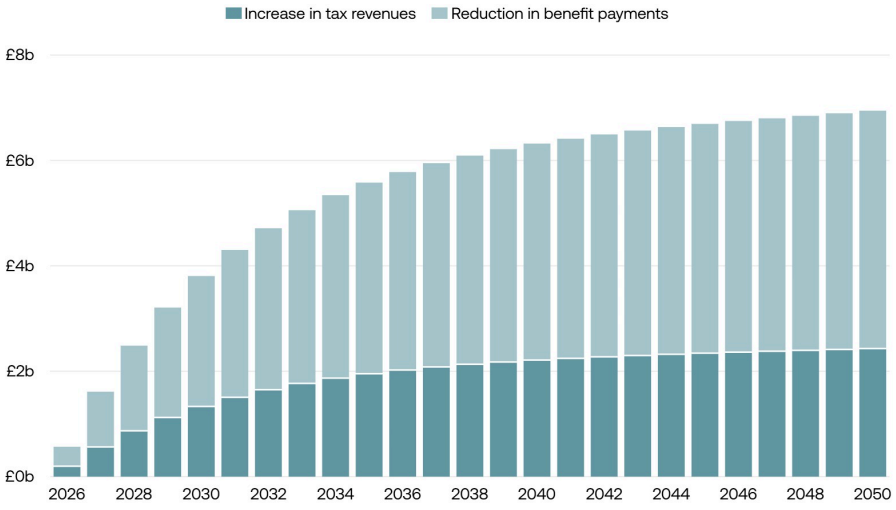
In those first few years, the cost of the programme is high - £3.7 billion in the first year and £6 billion in the second (equating to around 1.6 per cent and 2.7 per cent of the current NHS budget, respectively). After three years,

however, treatment costs plateau and, despite pension costs being more significant for the government by this point, the growth in macroeconomic benefits starts to accelerate. This means that after the third year, the year-on-year net cost of the programme starts to fall. By 2035 the government achieves cost-benefit neutrality for the programme and thereafter there is a net gain year on year, with cumulative fiscal benefits estimated at £52 billion by 2050.

The expected benefit to GDP for this scenario is an in-year increase of 0.3 per cent at five years and a 0.55 per cent increase at ten years. The graph below shows a breakdown of the expected fiscal benefit, split between increased tax revenues and a reduction in DWP payments. Under Protect Britain assumptions, DWP spending could be expected to reduce by £2.08 billion at five years and £3.47 billion at ten years.

FIGURE 7

## An accelerated rollout through Protect Britain would result in fiscal benefits




Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom"; OBR ready reckoners

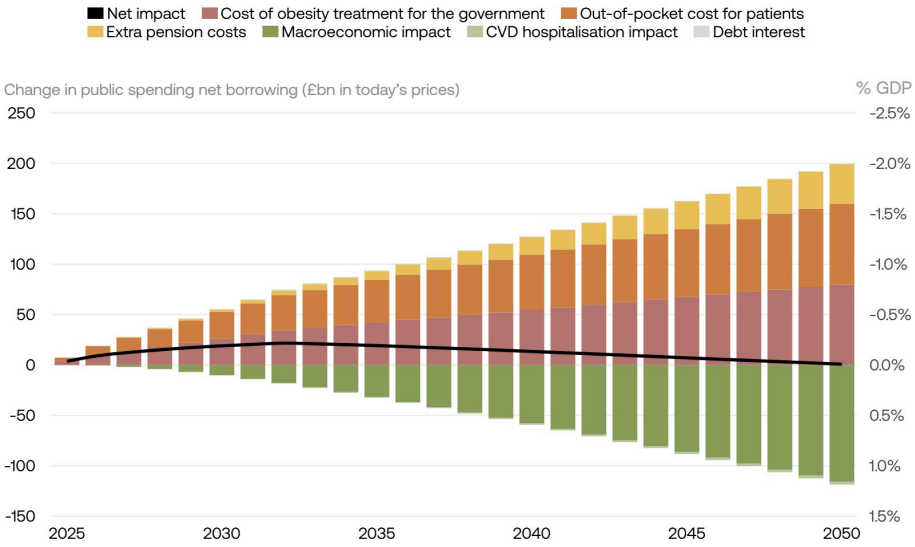
In fact, this scenario likely underestimates the fiscal benefit of AOMs. TBI's modelling considers the impact of obesity on public expenditure (NHS and DWP) and economic activity but not on in-work productivity. Recent analysis by business-management consultancy Lane, Clark & Peacock estimates this at a value of £5 billion per year.[106]

TBI then considered the macroeconomic impact of people staying on the medication for life. Keeping all other assumptions about the Protect Britain rollout the same, this would see increased year-on-year costs for the programme and a break-even point for the government in the year 2050, though it's important to note that, in contrast to the NHS rollout, the government would at some point be expected to break even. In the NHS rollout, this would not occur.

These findings highlight the importance of combining increased access to AOMs with other primary prevention activities that support people in their weight loss once their goal is achieved, such as regulation of the commercial food environment.

FIGURE 8

# Projected cumulative future economic benefits of broader access to anti-obesity medications (Protect Britain rollout) if patients stay on them for life

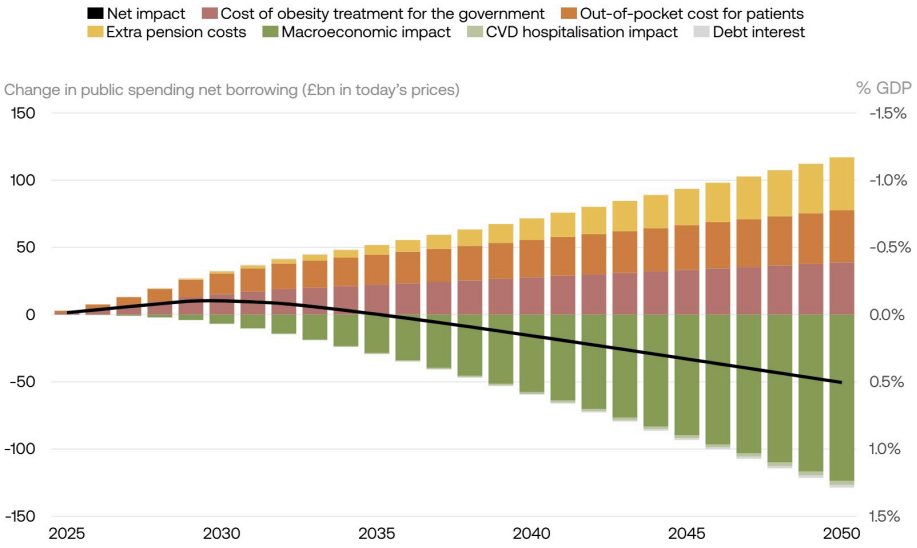



Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom", and TBI calculations

We also considered the macroeconomic impact of a slower rollout over five years instead of two. This had relatively little impact on the point at which the government would break even, which would happen in 2035, so this could be a viable alternative if capacity constraints are an issue in the short term.

FIGURE 9

# Projected cumulative future economic benefits of broader access to anti-obesity medications (Protect Britain rollout) if the rollout is five years instead of two

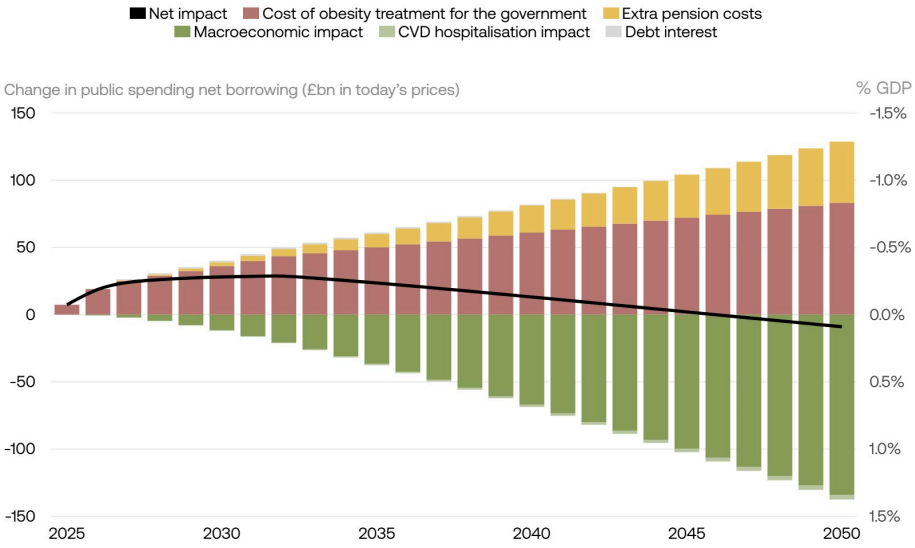



Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom", and TBI calculations

Finally, we considered the macroeconomic impact of not means-testing the benefit. If the government were to bear the full cost of the programme, this would almost double the cost of rollout and would not see the government break even until 2046.

FIGURE 10

# Projected cumulative future economic benefits of broader access to anti-obesity medications (Protect Britain rollout) with no means-testing of the benefit




Source: Yannick Schindler and Andrew Scott (2025), "The Macroeconomic Impact of Chronic Illness in the United Kingdom", and TBI calculations

07

# Implications for Policy: The Roadmap to a Healthier, Wealthier Britain

TBI's macroeconomic modelling clearly demonstrates the value of faster, broader access to AOMs through Protect Britain over existing NHS England plans for expansion. This has clear implications for the government's approach to health policy and, in particular, its approach to prevention for working-age adults.

## A New Offer: Establish Protect Britain to Invest in the UK's Health and Wellbeing

In the first instance the government should establish Protect Britain. This would be a new function within government to lead on new models of prevention that invest in the health and wealth of the country.

To ensure a joined-up approach to health, wealth and the economy across government, Protect Britain should have cross-departmental representation from the Department of Health and Social Care (DHSC), Treasury and the DWP. To ensure that prevention spending is prioritised, Protect Britain should have direct, ringfenced funding from the Treasury.

To deliver impact, Protect Britain should focus on large-scale innovations expected to deliver significant macroeconomic benefit. To move at pace, it should be agile and draw on learnings from the Covid Vaccine Taskforce. In particular, Protect Britain should be led by a trusted private-sector leader, reporting directly to the secretary of state for health and social care.

And to deliver effectively it should have the autonomy to take a different approach to the evaluation, funding and delivery of preventative treatments, as well as the ability to support ongoing research. In the first instance, Protect Britain should focus on the rollout of AOMs to target obesity.

**Recommendation 1:** *Establish Protect Britain, a new function within government to lead on new models of prevention that deliver high-impact macroeconomic benefits.*

### THE NHS APP: A NEW, INTERACTIVE PREVENTION OFFER FOR CITIZENS

The NHS App should become the fulcrum of a new prevention offer for citizens, pioneered by Protect Britain. The app should be connected to everyone's digital health record (DHR) and allow citizens to take ownership of their health and wellbeing. Rather than ICBs identifying patients, patients should be able to refer themselves with the NHS App; this would provide citizens with an overview of the services available to them.

The NHS should ensure that each citizen has a unique NHS identifier and this should be displayed in the NHS App. This unique identifier should be used to verify citizens' eligibility for weight-management services. To ensure that citizens are not digitally excluded, some commissioned providers of weight-management services ought to have both in-person and digital components of their direct-to-consumer offer.

**Recommendation 2:** *Protect Britain should make this new preventative offer available to citizens through the NHS App (though in-person services should also be available to those who need it, to avoid digital exclusion). To achieve this, Protect Britain should work closely with the NHS App team to develop an interactive interface and a unique NHS identifier for each citizen, so that patients can validate their NHS identity with accredited providers of weight-management services.*

### PRIORITY COHORTS

In our paper, *Prosperity Through Health: The Macroeconomic Case for Investing in Preventative Health Care in the UK*, macroeconomic modelling showed that the earliest economic benefits from prevention are achieved by treating those in mid to late life, rather than those who are sickest. For this reason, to ensure the early realisation of any macroeconomic benefit from the programme, Protect Britain should promote the uptake of weight-management services in working-age citizens over 40 through an

expansion of the UK's existing Health Check programme. This health MOT is available to anyone aged over 40 in the UK and can be repeated every five years, though currently only about half of eligible 40- to 74-year-olds use it.

**Recommendation 3:** *Protect Britain should promote the uptake of prevention services, including weight management, through the expansion of the UK's Health Check programme (though patients should be able to self-refer to weight-management services at any age if they are eligible).*

## A New Approach to Evaluation: Considering the Macroeconomic Benefits of Prevention

NICE already has an essential role in evaluating new medicines. It looks at the expected benefits to patients and the expected cost to the health service, then determines if the treatment is good value for money. This informs guidelines on the use of drugs – whether they should be first-, second- or third-line treatment – which in turn determines eligibility.

The NICE assessment of tirzepatide is an example of the institute at its best. It is the first national body to have formally recommended public reimbursement of GLP-1s for obesity management, the first to recommend rollout in primary care and the first to recommend the use of innovative digital-first mechanisms to deliver them. Had NHS England followed the mandate of implementing NICE recommendations within 90 days, 3.4 million people would have access to the drug today.

However, NICE's current remit is narrow. It is unable to include the broader macroeconomic benefits of expected GDP growth, reduced welfare spending and reduced long-term health spending that preventative medications such as GLP-1s could deliver. Were it able to, greater government spending on new medicines might be justified, allowing the UK to view drug expenditure as an investment in the economy, rather than a cost to the health system.

This does not necessarily mean that NICE needs greater powers of recommendation. The modelling of macroeconomic benefits is an uncertain business; the data are often incomplete, the projections speculative and the outcomes couched in risk. Ultimately it is not the job of an arm's-length body to take a big bet on preventative medications such as GLP-1s to boost health and wealth in the economy – but it could be a job for government.

To be clear, this is not a bet on health: it is a bet on the economy. The MHRA has approved and licensed these drugs for people with a BMI of 27 and over because, for this group, the clinical benefits outweigh the clinical risk. The bet, on the part of the government, would be on GLP-1s being able to drive economic growth, based on probable outcomes rather than formally validated economic evidence.

We suggest an additional step for NICE in its evaluation of preventative medicines. In addition to its value-for-money assessment, further modelling should be conducted to estimate the macroeconomic benefits. The modelling should consider the impact of moving to a more cost-effective, digital-first delivery model, the potential for cost savings from a bulk-buy deal with pharmaceutical manufacturers, and the potential to share costs with employers and individuals (discussed in more detail below).

This modelling should be conducted by NICE but considered and acted on by Protect Britain. The macroeconomic modelling should come with confidence intervals, reflecting the relative uncertainty caused by gaps in the data. It would then be the responsibility of Protect Britain to work with the OBR to score the benefits appropriately and secure funding from the Treasury for the extended rollout.

**Recommendation 4:** *The government should expand the remit of NICE to consider the macroeconomic benefit of large-scale, high-impact innovations. This modelling should take into account the impact of moving to a more cost-effective, digital-first delivery model, the potential for cost savings from a bulk-buy deal with pharmaceutical manufacturers, and the potential to share costs with employers and individuals. Protect Britain and NICE should also work with the OBR to ensure the benefits of preventative treatments are scored positively, to unlock Treasury funding for prevention.*

# A New Approach to Funding: Sharing the Cost of Prevention

It's all very well saying that AOMs are good value for money and that GLP-1s will improve health, save money and make health systems more sustainable in the long term. The bigger challenge for the government in the near term is affordability.

NHS England sought to limit the cost of GLP-1s by restricting eligibility and slowing product expansion; it may also be waiting for the patent to expire on the current cohort of branded medicines. But there are other ways to mitigate new medicine costs that don't require a 12-year wait – and one of the simplest is to simply share the cost with others.

Around the world, those in charge of health systems are considering this option as they grapple with the cost of prevention and how to pay for it. Citizens, employers, private insurers and governments all know that prevention is the key to long-term sustainability, but the cost is so high that no one stakeholder can afford to bear it alone. However, what our macroeconomic modelling shows is that all those stakeholders benefit from prevention. With that in mind, why shouldn't they all share the cost?

Countries are approaching the issue of cost-sharing in different ways. In Saudi Arabia, for instance, all health insurers are mandated by law to offer a prevention package;[107] there are similar rules in Japan.[108] In the US, GLP-1s are increasingly reimbursed through private insurance schemes. GLP-1s are typically much more expensive in the US (up to $1,349 a month)[109] so this is highly valued; employees in the US often rank GLP-1 coverage as more important than child-care reimbursement and unlimited, paid time off.[110] In the UK, the health insurer Vitality has recently started to reimburse GLP-1s for weight loss.[111]

## SHARING THE COST WITH PHARMACEUTICAL COMPANIES

Negotiating on drug price is a key means of sharing the cost with pharmaceutical manufacturers, but the NHS is ill equipped to leverage the full extent of its purchasing power. For instance, prior to its funding-variation request for an extended implementation period for tirzepatide, NHS England had the option of engaging in commercial discussions with a manufacturer, with the aim of managing the affordability challenge.[112,113] It is not clear if that happened but, even if it did, it is unlikely that a good deal would have been secured.

This is because, while lower unit prices *can* be agreed with pharmaceutical manufacturers, the manufacturer would require assurances over the volume of sales. By its own admission, NHS England was not confident in its ability to roll out the drug at scale. This is very similar to NHS England's experience with Inclisiran, a medication used to treat high cholesterol. A deal was reached on price with Novartis, the manufacturer of Incliseran, in 2021[114] but, despite the ambitious uptake targets promised by NHS England, ultimately it could not provide the assurances required for volume of sales because the terms of delivery had not been agreed with general practitioners.

So while it is entirely possible that the NHS could do a deal on the cost of GLP-1s in the future, it needs a credible delivery mechanism in place to deliver the drugs at scale. Protect Britain could provide this through a new contracting mechanism with suppliers of weight-management services.

The NHS would need to assure pharmaceutical companies of its ability to deliver volume – and pay for it. One way to achieve this would be through an exclusive access agreement, whereby the government would commit to these high volumes for one company for eight years – five years past the point at which competition would be expected to enter the market. This would guarantee volume and price but would lock the UK into a single drug for a long time, which could risk lowering the return on investment if uptake is lower than expected.

Another option would be the creation of bespoke budget for AOMs: capped expenditure on AOMs over a given time period, such as eight years. For incumbent suppliers this would guarantee high volume sales until competitors enter the market; thereafter, competitors would be considered but any spend above the agreed budget would be paid back to the government as a rebate from the pharmaceutical companies. This is how the VPAG investment programme currently works.

Under this "mini-VPAG" arrangement, volumes for incumbents could not be guaranteed past three years but the size of the market could, and competitors would simply be competing for market share. Incumbents would also be at an advantage, having had three years of consistent and well-tolerated use by patients.

This option would be even more attractive to industry (and therefore more likely to secure a 50 per cent discount on unit price) if GLP-1s were taken out of the current VPAG scheme to be part of this mini-VPAG arrangement. That is because, for the first three years, these drugs would be exempt from the 23.5 per cent rebate that industry currently pays for its branded sales in the UK.

Outcomes-based contracting is another way to share the cost with pharmaceutical manufacturers. This would see Protect Britain pay pharmaceutical companies according to how effective the drugs were in practice, rather than a regulated trials environment. In theory, the drugs should pay for themselves over time through GDP growth, reduced NHS expenditure and reduced welfare outgoings – but if those outcomes are not achieved, an outcomes-based contract means the government wouldn't have to pay.

This could be an attractive proposition for pharmaceutical companies. They have long made claims that preventative medicines drive population health and, therefore, economic wealth, and this would be an opportunity to prove that. It could potentially be a huge gain for them in terms of access (and hence UK sales), but it would mean backing their claim and assuming the financial risk of their not achieving it.

In negotiating with pharmaceutical companies, it is useful to think about what other benefits could be secured over and above lower unit prices. For example, Protect Britain's purchasing power could be leveraged to secure health-service transformation costs. An obvious candidate for this would be the digital infrastructure underpinning the new service. Data collection is hugely valuable to both government and industry, and could even be used to gather evidence for licensing.

The UK could also benefit from preferential access to new medicines. In exchange for large-volume orders that are stable over time (five to ten years, for example), Protect Britain could negotiate portfolio-type deals with industry. In this scenario, the country benefits from the latest drug that a manufacturer develops and not just the one that was originally ordered; so, for example, if a manufacturer has an oral preparation in the pipeline, UK citizens could have access to it as soon as it is licensed. Alternatively, Protect Britain's purchasing power could be leveraged to negotiate deals that include a commitment to investment in UK R&D or manufacturing.

While the NHS has significant purchasing power, it is not set up or incentivised to negotiate these kinds of deals, which not only benefit population health and the health system, but also play into the UK's industrial-policy objectives.

**Recommendation 5:** *Protect Britain should lead negotiations with pharmaceutical companies to secure better terms for purchasing drugs at scale. These terms could include a lower unit price, a transfer of risk through outcomes-based contracting terms, a contribution to health-system transformation costs and/or a commitment to invest in UK R&D and manufacturing.*

### SHARING THE COST WITH INDIVIDUALS

There is some precedent for this in the NHS, with prescription charges being the obvious example. And there are solid reasons for considering it, whether the approach is asking for a significant individual contribution or means-testing access to AOMs through Protect Britain.

First, patients stand to potentially save money while on the drug. Studies in the US show that households with at least one GLP-1 user typically spend around 6 to 9 per cent less on food,[115] equating to about $60 a week – roughly the cost per month of the medication .[116,117] The net impact on people's out-of-pocket spending could be minimised if the same is true in the UK.

Secondly, a significant individual contribution would considerably reduce the cost to the state and make it more feasible to roll out on a wider scale. At present, approximately 1.4 million people per month pay out of pocket to access these medications privately, predominantly through online pharmacies. If access were free, there is the potential for this group to move en masse to the state-funded scheme, generating a considerable deadweight loss for the state. However, if access to the drug were means-tested, this situation could be avoided. One way to do that would be to waive individual contributions for those who are already eligible for free prescriptions.

**Recommendation 6:** *Protect Britain should means-test access to AOMs so that only patients who are eligible for free prescriptions can access them at no cost through Protect Britain.*

### SHARING THE COST WITH EMPLOYERS

Employers benefit greatly from the improved health and wellbeing of their staff. In the US, for instance, employers are increasingly offering GLP-1 coverage for obesity as part of their benefits package because of the returns they see in terms of productivity, increased retention and reductions in absenteeism, medical costs and disability claims.[118,119,120,121]

This aligns with the government's *Get Britain Working* White Paper, which positions employers as key to promoting healthy workforces.[122] Protect Britain can be a key enabler by providing a tangible offer to employers to invest in the health and wellbeing of their staff. This would be through an accredited framework of weight-management providers that have access to AOMs at a reduced price negotiated by Protect Britain.

In this scenario, the employer would hold contracts with the accredited provider and could hold them to account. There could also be the opportunity for employers to contract on an outcomes basis, paying only if the services prove to be effective. This could be attractive to employers who would not simply be paying for a government-run service that may or may not benefit them; instead, payment would be directly linked to employer benefits.

This approach seems preferable to alternative means of accessing employer support in a number of ways. First, its implementation would not rely on tax. Relying on employer National Insurance contributions, while a straightforward approach, would likely be politically infeasible in the current climate. It also provides a framework through which small and medium-sized enterprises and self-employed people could access these services, rather than a tax break on employer health plans, for example, which is more suited to large corporate employers.

**Recommendation 7:** *Protect Britain should support employers in providing weight-management services to their staff through the creation of an accredited list of providers, which would have access to drugs at a lower unit cost than the market price.*

### SHARING THE COST WITH PROVIDERS

NHS England's proposed model of care is over-resourced and hugely expensive per patient. Protect Britain could facilitate a far broader rollout if it adopted the kind of light-touch, low-cost models of care deployed by innovative private-sector services. Cost and risk could then be further contained by negotiating outcomes-based contracts with these providers, or even changing the approach so that wraparound support is not provided as a matter of course but only initiated if and when patients are struggling to see benefit from AOMs and need additional support.

An outcomes-based contract would see Protect Britain paying providers conditionally based on how effective the drugs were in practice. This transfers some of the risk of successful trials not translating to successful real-life application onto providers, testing the effectiveness of the

wraparound support provided. These contracts could even be co-designed with industry to ensure that the right policy framework exists for this new model of commissioning to thrive.

Some providers of wraparound care have started to incentivise behaviour change through vouchers and discounts tied directly to healthy food. Additional incentives such as loyalty-card points or rewards for continued participation (proven to enhance weight loss), and partial refunds for maintaining healthy habits such as a balanced diet and regular exercise during and after treatment, could further strengthen outcomes.[123,124] Protect Britain could also form partnerships with other providers, such as sports centres and gym chains, to offer patients further incentives to join.

**Recommendation 8:** *Protect Britain should commission weight-management services based on outcomes and price, rather than specifying the model of care.*

### SHARING THE COST ACROSS GOVERNMENT DEPARTMENTS

Our macroeconomic analysis predicts that, in the long run, the Treasury will benefit from GDP growth and increased tax receipts, the DWP will benefit from reduced welfare payments and the DHSC will benefit from reduced health-care expenditure. Given that the benefits extend beyond the health system, funding should extend beyond the health budget.

**Recommendation 9:** *Protect Britain funding should come directly from the Treasury but sourced from the budgets of both the DHSC and DWP, the cost split based on the relative benefits expected to accrue to each department.*

## Delivering GLP-1s: Towards A New Model of Light-Touch, Low-Cost Prevention

Capacity constraints are a key reason behind NHS England requesting a slower rollout of tirzepatide in primary care. A lack of people, pathways, infrastructure and contracting mechanisms meant it was unprepared to deliver on NICE guidance within the usual 90-day implementation window.

This is in stark contrast with the private sector, where approximately 1.4 million patients already access GLP-1s every month, predominantly through online pharmacies.

### A FRAMEWORK OF QUALIFIED PROVIDERS

Protect Britain could expand access to GLP-1s faster than current NHS England plans by working with private companies that already provide this service. To achieve this, Protect Britain could establish a framework of qualified providers that meet agreed specifications and standards.

To simplify procurement, speed the pace of coverage and provide citizens with a range of options, providers should have the capacity to deliver national-level coverage immediately. Contracting with each provider once, and at a national level, is the simplest approach for both Protect Britain and the providers. If Protect Britain accredited a handful of national suppliers with reach across the UK, only five or so contracts would need to be maintained. If left to ICBs (as NHS England's plan sets out), it would require 42 contracts with an unspecified number of providers – and likely no choice for citizens at an ICB level.

The framework should also set agreed standards on clinical and data governance above and beyond regulator standards, if deemed necessary. For instance, on clinical governance, Protect Britain may wish to stipulate that providers have both an in-person and a digital-first offer, or for it to be mandatory for providers to notify a patient's GP when a patient is initiated on treatment. In addition, Protect Britain might set standards on how many Yellow Card notifications they expect to have from a provider of that size prescribing a new drug. On data governance, they may wish to stipulate extra requirements around data sharing to facilitate a move to outcomes-based commissioning.

However, too much stipulation regarding the service delivery model should be avoided. As long as contracts clearly stipulate both outcomes and price (and those contracts are managed appropriately), providers should have the freedom to innovate in how they deliver the service. This could lead to more than one service specification being commissioned. For instance, one

framework could be for providers of a service for relatively well people with few comorbidities or complications, while another might exist for services designed to treat harder-to-reach patients (such as those who don't speak English as a first language) or those with more complex needs. A different payment schedule for different cohort populations would allow services to be tailored to individuals' needs.

**Recommendation 10:** *To deliver prevention at scale, Protect Britain should establish an accredited framework of providers to deliver direct-to-consumer services for weight loss. For speed and scale, these services should already prescribe GLP-1s, have national reach, offer both digital and in-person services and adhere to agreed clinical-governance and data-governance standards.*

### DIGITAL HEALTH RECORD

To carry out its functions, Protect Britain would require a robust data-exchange platform – such as a DHR – to exchange, link and process clinical and administrative data. This would provide the digital underpinning of Protect Britain and allow it to contract more easily and safely with private providers.

Data-sharing will be critical to patient safety in the delivery of more widespread weight-management services through Protect Britain. When a patient is initiated on treatment, private providers are not obliged to disclose this information to the patient's GP, making GP records (the closest thing we have to a longitudinal care record) incomplete. A DHR would automate this process. It would also automatically link patient-level clinical data across public and private services, ensuring that providers across both sectors could access the medical history of their patients, and that NHS clinicians could have sight of any GLP-1 medications prescribed privately. This would make it safer to treat patients and easier to identify side effects and adverse reactions.

Efficiency and cost are another key consideration for effective data-sharing. Contract management requires trusted and accurate data to track cost, activity and outcomes. This is especially important in the management of outcomes-based contracting, whereby trusted and sometimes shared data are used to ensure that terms are met.

In the long run, a DHR or some other data-exchange platform will be required to provide the digital underpinning of Protect Britain. However, in the short term, it is possible to use existing contracting and data-exchange mechanisms. For instance, providers can be contracted through the Any Qualified Provider framework or the Community Pharmacy Contractual Framework (CPCF) if they are registered pharmacies. Meanwhile, existing mechanisms exist to facilitate the exchange of clinical data from pharmacies to GPs through the GP Connect system, the use of which will become mandatory under the new General Medical Services contract effective from October 2025.

To achieve the full vision of a comprehensive, digitally led, preventative health service, proper digital underpinning through a DHR (or other data-exchange platform) will be required. This is because the Pharmacy First contract excludes providers that are not pharmacies, and the Pharmacy First component of the CPCF is activity based rather than outcomes based, meaning outcomes-based contracting could not be activated. Moreover, while the GP Connect system will update GP records in the short term, ultimately the government is committed to a single patient record (or DHR) for every citizen to replace the GP record as the single source of truth for longitudinal patient records.

**Recommendation 11:** *Protect Britain should establish data-exchange mechanisms with accredited providers in order to manage contracts, acquire real-world data for research and ensure patient safety. In the short term, existing GP Connect and Pharmacy First contracting mechanisms can be used. In time, a bespoke data-exchange platform should be used, connected to individuals' DHRs and the NHS App.*

## Researching AOMs: Positioning the UK as a Global Leader in Real-World Evidence for Prevention

There is a prosperous future for the country that positions itself as a place to conduct research into AOMs: there are more than 150 new medications in the pipeline that have been manufactured by more than 70 companies.[125] These drugs are expected to deliver improved effectiveness, fewer side effects and easier administration, as well as offering new benefits such as reduced cardiovascular risk. Also ripe for research is gaining an understanding of how patients use existing medications in practice.

There is a misconception that people who discontinue the use of AOMs do so because of intolerable side effects. This is undoubtedly true in some cases, but other issues such as cost, insurance coverage, supply issues, patients increasing the dosage too quickly, quality and intensity of clinical support, and lifestyle considerations all factor into those decisions. People may also opt to discontinue after achieving a goal weight.[126]

FIGURE 11

# Anti-obesity medications that are either currently availability or in the pipeline

**CURRENTLY AVAILABLE**

| Drug name: generic/brand (manufacturer) | Target | Route of administration | Indication | Benefits |
|---|---|---|---|---|
| Orlistat (Roche; GlaxoSmithKline) | Other | Oral | Obesity | 8.5% mean weight loss[1] |
| Liraglutide/Saxenda (Novo Nordisk) | GLP-1 | Subcutaneous | Type-2 diabetes, obesity | 5.4% mean weight loss[2] |
| Semaglutide/Wegovy, Ozempic (Novo Nordisk) | GLP-1 | Subcutaneous | Type-2 diabetes, obesity | 12.4% mean weight loss[3] |
| Tirzepatide/Mounjaro (Eli Lilly) | GLP-1/GIP | Subcutaneous | Type-2 diabetes, obesity | 17.8% mean weight loss; high sensitivity rate[4] |

**PIPELINE (PHASE 3 TRIALS AND BEYOND)**

| Drug name: generic/brand (manufacturer) | Target | Route of administration | Indication | Benefits |
|---|---|---|---|---|
| Orforglipron (Eli Lilly) | GLP-1 | Oral | Type-2 diabetes, obesity | 7.1–12.3% weight loss[5] |
| Survodutide (Boehringer Ingelheim, Zealand Pharma) | GLP-1/GCGR | Subcutaneous | Type-2 diabetes, obesity, fatty liver disease, renal failure | 12.1% weight loss; high sensitivity rate; FDA fast track designation for fatty liver disease[6] |
| Semaglutide (Novo Nordisk) | GLP-1 | Oral | Obesity | 17.4% mean body weight loss[7] |
| CagriSema (Novo Nordisk) | GLP-1/Amylin | Subcutaneous | obesity | 12.6–20.4% mean weight loss; decreased loss of lean muscle mass[8,9] |
| Retatrutide (Eli Lilly) | GLP-1/GIP/GCGR | Subcutaneous | Type-2 diabetes, obesity, fatty liver disease | 22.1% mean weight loss[10] |
| Efinopegdutide (Hanmi Pharmaceuticals, Janssen) | GLP-1/GCGR | Oral | Obesity, fatty liver disease | 8.5% mean weight loss |

1 https://pubmed.ncbi.nlm.nih.gov/10757623/
2 https://www.nejm.org/doi/full/10.1056/NEJMoa1411892#t02
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The UK has a strategic opportunity to position itself as a global leader in AOM research. Building on existing models, such as the Eli Lilly Manchester partnership, should serve as blueprints for future collaborations.[127,128] Local strategic collaborations should be expanded to generate richer, longitudinal data on the secondary benefits of AOMs, such as improved cardiovascular health, diabetes prevention and enhanced workforce productivity. These efforts will strengthen regulatory submissions and improve the likelihood of securing approvals from health-technology assessment bodies across Europe and other global markets, enabling broader market access.

As next-generation AOMs emerge, investment in commercial research delivery centres (CRDCs) to increase capacity and innovation for clinical trials will bring enormous value to the UK health and life-sciences sector. The CRDCs, funded through industry contributions from the VPAG investment programme, create opportunities for the NHS and industry to collaborate and test new AOMs across the UK.[129] This is much needed because UK PLC has plummeted in its commercial R&D footprint, illustrated by AstraZeneca's recent withdrawal of its investment in a UK-based vaccine-manufacturing plant.[130] CRDCs can help to establish the UK as a world leader in the generation of real-world evidence for current and future AOMs, and other preventative interventions. In addition, opportunities to conduct research at a national level will be enhanced by the development of the government's planned Health Data Research Service.[131]

**Recommendation 12:** *The government should build on existing plans for a Health Data Research Service and establish the UK as a world leader in the generation of real-world evidence for AOMs by investing in public-private partnerships and the development of centres of excellence, such as that in Manchester.*

08

# Conclusion

The UK has an opportunity to redefine its approach to prevention. A commitment to protecting the UK, commencing with the identification and treatment of cardiovascular risk, alongside broadening access to GLP-1s, will change the way the country evaluates, funds and delivers preventative interventions. This will position the UK to lead the world in obesity innovation and research.

*Editor's note, 27 May 2025: The number of people accessing GLP-1s every month through private online pharmacies has been updated to approximately 1.4 million to reflect the most recent data. Similarly, the number of people accessing GLP-1s through the NHS every month has been updated to 200,000.*

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# Endnotes


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between 27–30 where a weight-related comorbidity is present, the modelling presented here considers the broader population with a BMI ≥27 and no contraindications for simplicity. This approach was taken due to the paucity of sufficiently granular demographic data to reliably identify the number of individuals within the 27–30 BMI range who also have a weight-related health condition. This assumption was made solely to support the modelling exercise and does not imply any recommendation to alter existing MHRA authorisation criteria.

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