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EDUCATIONAL SERIES

Prescribing obesity management medications in New Zealand



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About the expert



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ABOUT RESEARCH REVIEW

Research Review is an independent medical publisher producing electronic publications in a wide variety of specialist areas.

Educational Series provide a summary of the most important international and local literature which impacts on treatment of a specific medical condition. These Reviews provide information on a disease, current treatment and local /international guidelines. They are intended as an educational tool.

Abbreviations used in this review:

BMI = body mass index
CBT = cognitive behavioural therapy
CNS = central nervous system
CVD = cardiovascular disease
GDP = gross domestic product
GLP-1 = glucagon-like peptide 1
GORD = gastroesophageal reflux disease
IWQOL = Impact of Weight on Quality of Life
MAFLD = metabolic dysfunction-associated fatty liver disease
MAOI = monoamine oxidase inhibitors
MASLD = metabolic dysfunction-associated steatotic liver disease
MDT = multidisciplinary team
NAION = non-arteritic anterior ischaemic optic neuropathy
NICE = National Institute for Health and Care Excellence
OSA = obstructive sleep apnoea
OECD = Organisation for Economic Co-operation and Development
PCOS = polycystic ovary syndrome
POMC = pro-opiomelanocortin
QoL = quality of life
SC = subcutaneous
SF-36 = Short-Form Survey 36
T2D = type 2 diabetes
UK = United Kingdom

This Educational Series discusses the role of pharmacotherapy in obesity management in New Zealand. Obesity management medications are indicated in conjunction with a reduced-calorie diet and lifestyle interventions for patients living with obesity (BMI ≥ 30 kg/m²) or who are overweight (BMI ≥ 27 kg/m²) with ≥ 1 obesity-related complication. All the Medsafe-approved obesity management medications are effective at reducing and maintaining clinically significant weight loss, however they are not currently funded in New Zealand, resulting in inequitable access to treatment. This review is sponsored by Radiant Health Ltd.

Background

Obesity is a progressive and complex chronic disease characterised by excessive adiposity and requiring long-term management.¹⁻⁴ Recently, the concept of clinical obesity was introduced and defined as a chronic, systemic illness characterised by alterations in the function of tissues, organs, the entire individual, or a combination thereof, due to excess adiposity.⁵ This new definition represents an evolution in thinking such that obesity as a disease state can now be accurately diagnosed and more appropriately managed, similar to other chronic diseases.⁵

People living with obesity and overweight are at increased risk of comorbidities including type 2 diabetes (T2D), hypertension, cardiovascular disease (CVD), obstructive sleep apnoea (OSA), chronic kidney disease, osteoarthritis, metabolic dysfunction-associated steatotic liver disease (MASLD), gallbladder disease, gout, multiple malignancies including liver, kidney and gynaecological cancers, and premature mortality.⁶⁻⁹ In New Zealand, 5.1% of cancers are potentially attributable to excess body weight, including 16.1% of cancers in Pacific females.¹⁰ It is estimated that every two-point increase in body mass index (BMI) is associated with a one year decrease in life expectancy.⁴ Excess body weight accounted for 4 million deaths worldwide in 2015 and 120 million disability-adjusted life years.¹¹ It is estimated that the economic impacts of obesity will on average equal 3.6% of gross domestic product (GDP) by 2060.¹²

Obesity prevalence is at pandemic levels globally.^{13,14} New Zealand has the third highest rate of adult obesity among Organisation for Economic Co-operation and Development (OECD) nations, with one in three people aged >15 years classified as living with obesity.⁶ In 2023/24, one in eight children in New Zealand were classified as living with obesity.¹⁵

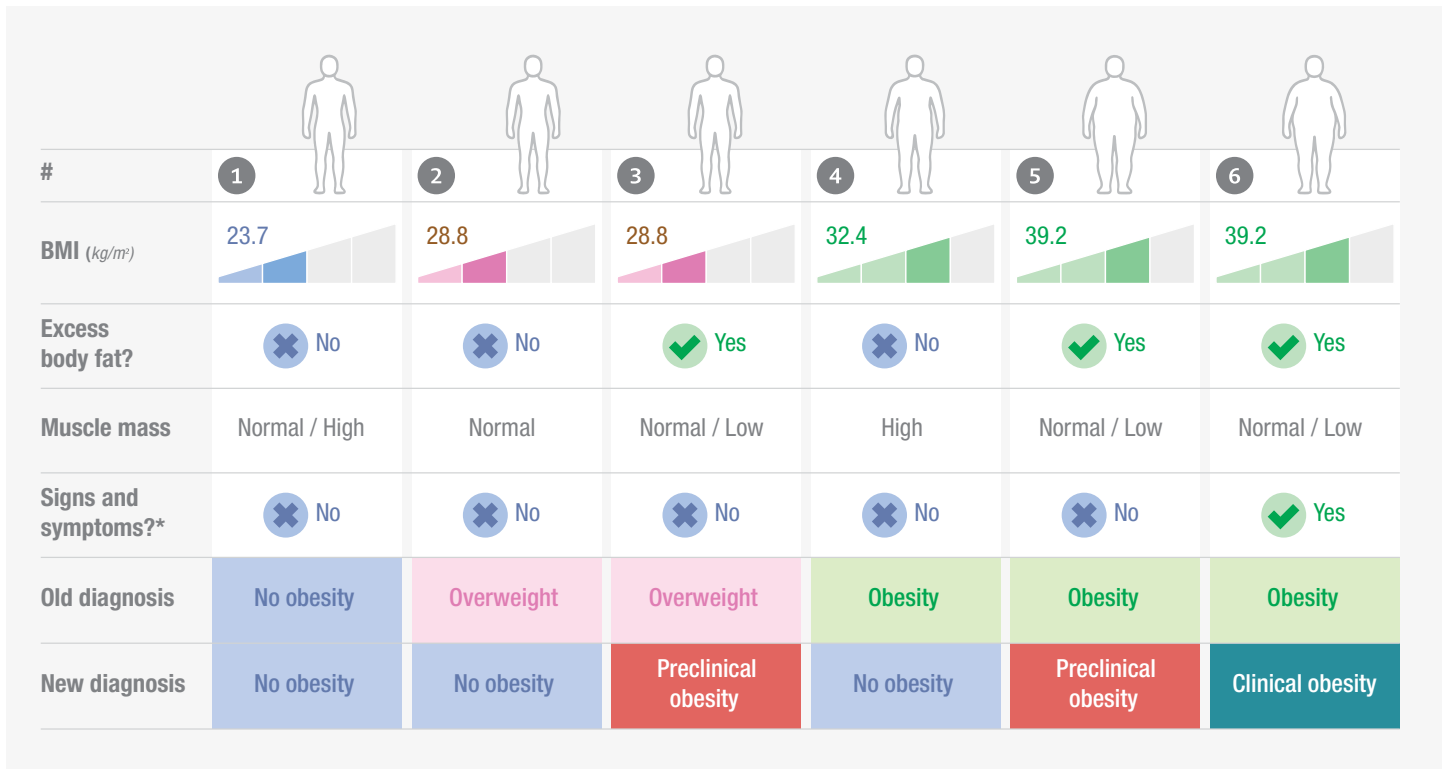
Despite the recent recognition of clinical obesity as a diagnostic entity with signs and symptoms that impact target organs, obesity management medications are not currently funded in New Zealand.⁴ Cost therefore remains a significant barrier to obesity management that results in inequitable access to treatment and likely contributes to the increased rates of obesity-related complications seen in Māori and Pacific peoples and those in lower socio-economic communities.^{5,15,16}

Managing patients living with obesity

People living with excess body weight often experience weight-based stigma and bias, including from healthcare professionals (HCPs).^{2,4,5,17} Consequently, people living with obesity often do not initiate conversations about weight management, mainly because they believe that weight loss is their responsibility and that they already know what they need to do to achieve it.⁵ An Australian survey of 1,000 people living with obesity reported a mean delay of 8.9 years from first starting to struggle with body weight to an initial discussion with an HCP.¹⁸ The constant effort required to maintain significant weight loss may also result in some people feeling exhausted with a sense of inevitability about weight regain, with three-quarters of people living with obesity surveyed reporting prior attempts at weight loss.^{18,19}

A multidisciplinary approach is required for obesity management strategies to be successful.² All patients should undergo a clinical evaluation including their history with obesity, lifestyle habits, physical examination, psychological status and routine laboratory testing.^{2,17} Medications should be reviewed to determine if they may be contributing to the patient's body size and whether any treatment adjustments might be appropriate.^{7,14} Excess adiposity should be confirmed via waist circumference, waist-to-hip ratio, or waist-to-height ratio, in addition to BMI.^{5,20} It is now recognised that relying on BMI alone can inaccurately classify people and lead to under-diagnosis of people with impaired health and over-diagnosis of those who are healthy (**Figure 1**).

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*Signs and symptoms of organ dysfunction due to excess body fat

Figure 1: Traditional measurement of obesity versus new diagnostic method. Adapted from Lancet infographic – Clinical Obesity.²¹

Obesity management should focus on improving the health of the patient (i.e. metabolic, mechanical, mental, and/or QoL) and outcomes that the patient considers important, and not solely weight reduction.²⁰ Lifestyle optimisation, including a healthy, well-balanced eating pattern and regular aerobic exercise is universally recommended as a cornerstone of obesity management.^{3,17,22}

In isolation, however, lifestyle optimisation is typically associated with modest weight loss of approximately 3-5% of bodyweight and in the long-term, most patients experience weight regain.^{3,23-25} For many patients, lifestyle optimisation alone is likely to be insufficient to prevent the development of obesity-related complications that typically require at least a 5% reduction in bodyweight to reduce the risk of onset.^{4,8}

EXPERT COMMENTARY

Weight bias, which is prevalent in various aspects of social interaction, including home, schools, and workplaces, can be defined as the negative evaluation of an individual based on their body weight. It includes prejudice, preconceived notions, stereotypes, or outright discrimination. It has been shown that weight bias harms the mental and physical health of the individual affected, and it can lead to eating disorders, avoidance or reduced physical activity, further weight gain, and subsequently internalised weight bias. Longitudinal studies have shown that weight bias in adolescents can lead to maladaptive coping strategies that become ingrained and can persist over a lifetime, having a long-term impact on weight gain and obesity.^{26,27}

Internalised weight stigma, which describes the belief that the negative perception is valid and applicable to the person themselves, can lead to self-blame, body image problems, and significant physical and mental health consequences. Recurrent failed weight loss attempts have shown to increase internalised weight stigma; hence it is essential to be mindful that any weight management plan needs to be done with the appropriate support, clinical oversight, and long-term perspective, as the short-term or intermittent use of powerful weight management medication outside such stringent supervision may be more detrimental than beneficial, as internalised weight stigma by itself is a poor prognostic factor for weight loss maintenance.²⁸

Healthcare provider bias impacts the quality of the care provided, patient satisfaction, and engagement in treatment. It is well described that healthcare provider bias leads to underutilisation and delayed care presentations, e.g. no-shows to clinics, as patients are afraid of embarrassment and disrespect.²⁹ Three simple steps can be taken:

1. Awareness of and work on implicit personal biases and assumptions
2. Designing healthcare facilities that are suitable and welcoming for people with a larger weight
3. Using a respectful, supportive and empowering language. Even nonverbal expressions need to be considered, including body language, facial expressions, eye contact, and other unintended behaviours.

Ask for permission to discuss weight after addressing the main presenting problems. Do not assume that all problems are related to weight. Use a person-first language, such as 'person with or affected by obesity', or words such as 'weight', 'BMI' and avoid shaming words such as fat, morbidly obese, or chubby. It may pay to ask, "How would you like me to address weight in our conversation?" For children and adolescents, model the language and behaviour you want their parents to use.

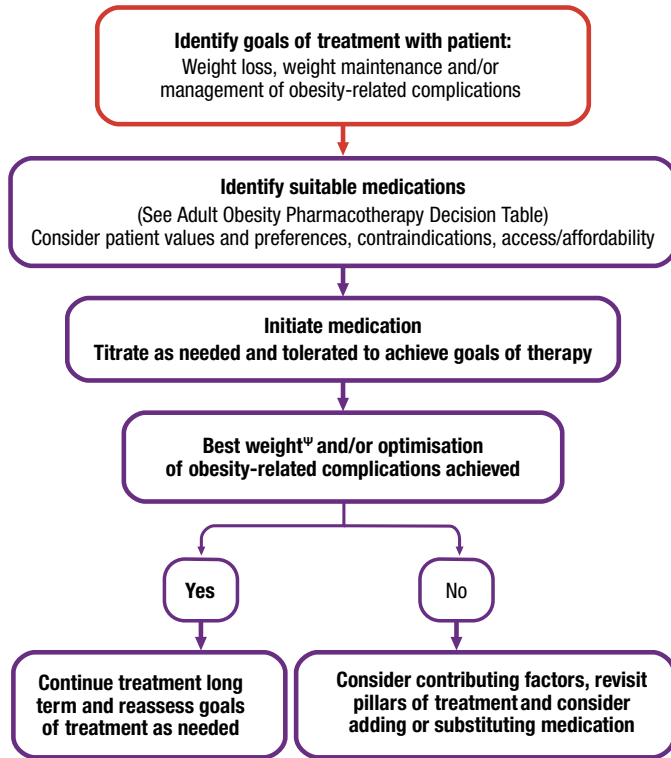
A powerful intervention is to state that weight gain has a biological basis and is not solely the responsibility of the individual. This approach alleviates the burden of self-stigma and facilitates a more engaging therapeutic relationship. Other options are to prioritise positive health outcomes over the scale.^{3,30}



Obesity management medications

Pharmacotherapy is a pillar of obesity management (Figure 2).²⁰ Obesity management medications are recommended early in the natural history of obesity in conjunction with healthy lifestyle interventions for individuals with:^{3,17,20,22,31}

- BMI ≥ 30 kg/m²; or
- BMI ≥ 27 kg/m² with ≥ 1 adiposity-related complication.



²⁰ The weight that a person can achieve and maintain while living their healthiest and happiest life

Figure 2: Adult obesity pharmacotherapy decision tool. Adapted from Pedersen *et al* (2025).²⁰

Currently, there are five obesity management medications registered with Medsafe as adjuncts to lifestyle and behaviour change:^{32–36}

- Contrave® tablets (8 mg naltrexone, 90 mg bupropion)
- Duromine® capsules (15 mg or 30 mg phentermine)
- Saxenda® subcutaneous injection (0.6–3.0 mg liraglutide)
- Wegovy® subcutaneous injection (0.25 mg or 2.4 mg semaglutide)
- Xenical® hard capsules (120 mg orlistat).

The results from multiple placebo-controlled clinical trials demonstrate that each of the Medsafe-registered obesity management medications are effective in reducing body weight and maintaining weight loss, in combination with lifestyle and behaviour change.^{39–44}

Even relatively small reductions in bodyweight of 5–15% can result in clinically meaningful health improvements that improve and/or prevent the progression of obesity-related co-morbidities.^{37,38} Figure 3 shows the mean predicted weight loss needed to improve obesity-related complications. Individual treatment goals should be agreed with the patient using a shared-decision making approach.³

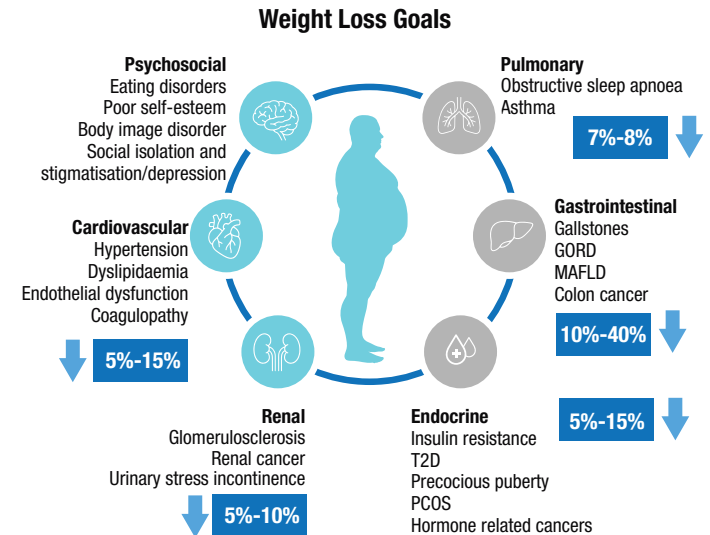


Figure 3: The expected mean percentage weight loss required to prevent obesity-related complications. Adapted from Kim and Kim (2025).⁸

Individual patient responses to pharmacotherapy may vary due to the heterogeneity and complexity of obesity and there are few prospective head-to-head trials of obesity management medications. It is therefore currently not possible to predict which medication will be most effective, although patient phenotyping (see below) may increase the likelihood of achieving satisfactory results.^{20,45–47} The choice of medication should account for the patient's clinical profile, preferences and tolerance, co-morbidities and contra-indications, as well as the mechanism of action of the medicine, its method of administration and its long-term affordability (Table 1).^{3,14,20,24,48} A retrospective review of 132 Korean patients who were administered phentermine, phentermine/topiramate (unavailable in New Zealand), liraglutide, naltrexone/bupropion or orlistat for ≥ 6 months found that all medications were effective at inducing and maintaining weight loss.⁴⁹

In general, treatment should be reviewed at 12 weeks and if weight loss of $\geq 5\%$ of bodyweight has not occurred, consideration should be given to withdrawing treatment and an alternative obesity management medication trialled.^{17,24,20} If the patient achieves significant weight loss while taking an obesity management medication, treatment should generally be continued long-term, although pharmacotherapy is sometimes used as a bridging strategy in patients undergoing endoscopic procedures or bariatric surgery.^{3,20,25}

Withdrawal of obesity management medications generally results in weight regain, with a corresponding loss of cardiometabolic benefits.^{13,20,24} One study found that one year after withdrawal of glucagon-like peptide 1 (GLP-1) receptor agonist treatment, participants regained approximately two-thirds of their previous weight loss, with a corresponding decline in cardiometabolic variables.⁵⁰

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


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Table 1: Obesity management medications available for use in adults in New Zealand^{14,32–36,51}

	Contrave®	Duromine®	Saxenda®	Wegovy®	Xenical®	
Mechanism	Reduces appetite by activating POMC neurons in the hypothalamus and reducing cravings and influencing eating behaviours via modulation of the mesolimbic reward system pathways	Sympathomimetic amine that suppresses appetite	Reduces appetite and increases satiety by binding to GLP-1 receptors involved in glucose regulation	Reduces appetite and increases satiety by binding to GLP-1 receptors involved in glucose regulation	Decreases dietary fat absorption by inhibiting gastric and pancreatic lipases	
Formulation	 Modified-release tablets containing 8 mg naltrexone and 90 mg bupropion	 Modified-release capsules containing 15 mg or 30 mg phentermine	 Solution for SC injection containing 18 mg liraglutide in 3 mL	 Solution for SC injection containing 1 mg semaglutide in 1.5 mL or 2 mg in 1.5 mL or 4 mg in 3 mL or 6.8 mg in 3 mL or 9.6 mg in 3 mL	 Hard capsules containing 120 mg orlistat	
Dosage	Titrate over a 4-week period to two 8 mg/90 mg tablets twice daily	15 mg or 30 mg daily in the morning	Initially 0.6 mg SC once daily, increased gradually in steps of 0.6 mg with at least weekly intervals to a maintenance dose of 3 mg once daily	Initially 0.25 mg SC once weekly, increased every 4 weeks to 0.5 mg, 1 mg and 1.7 mg respectively, with a weekly maintenance dose of 2.4 mg after 16 weeks	One 120 mg capsule taken 3 times daily with each main meal, in conjunction with a low-fat diet	
% placebo-subtracted weight loss	-6.3% at 56 weeks ⁴²	-5.1% ⁴⁴ 15 mg at 28 weeks	-5.4% at 56 weeks ⁴⁰	-12.4% at 68 weeks ³⁹	-2.9% at 52 weeks ⁵²	
Commonly reported adverse effects	Nausea, headache, dizziness, vomiting, constipation, dry mouth, insomnia	Tachycardia, palpitations, hypertension and precordial pain	Nausea, vomiting, diarrhoea, constipation, dyspepsia, upper abdominal pain, headache, dizziness, fatigue, injection site reactions	Nausea, diarrhoea, constipation, vomiting, headache, abdominal pain, fatigue, injection site reactions	GI, e.g. oily spotting, flatus with discharge, faecal urgency, fatty stool, increased defaecation, faecal incontinence, abdominal pain, liquid stools, rectal pain	
Patient reported outcome measures ²⁰	QoL	IWQOL - improvement	Data not available	SF-36 - improvement IWQOL - improvement	SF-36 - improvement IWQOL-Lite-CT - improvement	Not studied
	Physical function	IWQOL subscale - improvement	Data not available	SF-36 - improvement IWQOL - improvement	SF-36 - improvement IWQOL - improvement	Not studied
	Cravings	Craving Control subscale improved	Data not available	Not studied	Craving Control subscale improved	Not studied
Cost per month ⁵³	\$210 for 112 tablets (28 days' maintenance)	\$79.99 or \$96.99 for 1 month of 15 mg or 30 mg respectively	\$479.99 for 5 x 18 mg in 3 mL (1 month maintenance)	\$459.99 for 4 x 2.4 mg doses (1 month maintenance)	\$129.99 for 84 tablets (28 days' maintenance)	

N.B. Obesity management medications should not be prescribed to children or during pregnancy or while breastfeeding^{3,17} Prices reported from Chemist Warehouse as of 29 January 2026.

To further guide the selection of medications, a pragmatic 12-month trial in a multidisciplinary weight management centre randomly assigned 312 patients to phenotype-guided or non-phenotype guided treatment with obesity management medications.⁴⁶ Patients received different management according to the predominant phenotype they were categorised with:

- **Hungry brain** (abnormal satiation), i.e. more calories consumed per meal - low-calorie diet with pre-meal protein supplementation (3-5 meals per day), phentermine-topiramate extended release*
- **Emotional hunger** (hedonic eating), i.e. eating in response to negative and/or positive emotions - cognitive behavioural therapy (CBT), naltrexone/bupropion sustained release
- **Hungry gut** (abnormal satiety), i.e. appetite returns quickly after a meal - high-volume, high-fibre, low-calorie diet (1-2 meals per day), liraglutide
- **Slow burn** (low predicted energy expenditure), i.e. decreased metabolic rate and therefore insufficient calories burned, low-calorie diet with post-workout protein supplementation, supervised physical exercise with increased physical activity, phentermine.

Weight loss in the phenotype-guided therapy group (-15.9%) was 1.75 times greater than that in the non-phenotype-guided group (9.0%; $p < 0.001$).⁴⁶ Furthermore, the proportion of patients who lost >10% bodyweight at 12 months was 79% in the phenotype-guided group and 34% in the non-phenotype-guided group (Figure 4).

The New Zealand Eating Behavior Questionnaire (NZ-EBQ) is a validated obesity management tool that in the future could be used to help guide the selection of interventions such as lifestyle, selection of obesity management medications and metabolic surgery.⁴⁷

*Not available in New Zealand

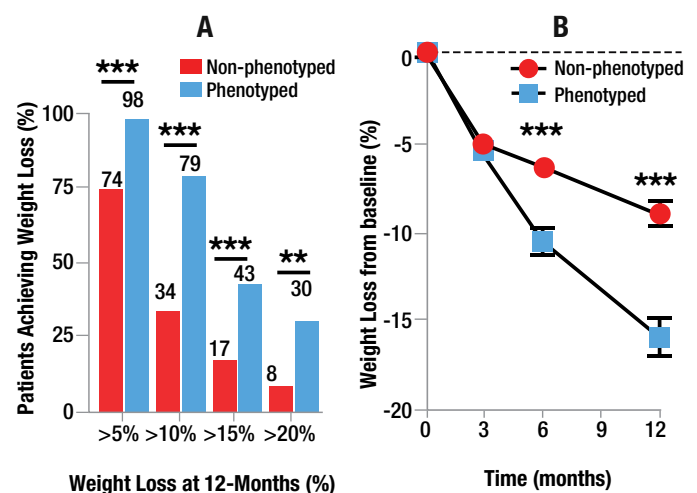


Figure 4: (A) Percentage of patients achieving levels of weight loss after 1 year of non-phenotype-guided treatment ($n=228$) or phenotype-guided treatment ($n=84$). (B) The mean percentage of total bodyweight loss from baseline in non-phenotype-guided treatment and phenotype-guided treatment. Adapted from Acosta *et al* (2021).⁴⁶ ** $P < 0.01$ *** $P < 0.001$



EXPERT COMMENTARY

With the recent availability of new weight management medications in New Zealand, particularly the introduction of more potent GLP-1 receptor agonists and co-agonists, the landscape of medical management for obesity is undergoing rapid change. Therefore, clinicians need to be aware of the potential benefits and risks associated with these medications.

It is paramount that these medications are used within a well-functioning multidisciplinary team (MDT) and prescribed in conjunction with a long-term management plan that includes suitable follow-up. Any short-term treatments without appropriate professional support have a high likelihood of weight rebound, often to a higher weight than before the start of the medication. Gleason *et al* analysed pharmacy and medical claims data from 16.5 million commercially insured US adults.⁵⁴ They found that the overall persistence of using GLP-1 agonists was 46.3% at 180 days and 32.3% at 1 year. In other studies, the median duration of use in real-world settings is approximately 4 to 7 months, and the one-year persistence is around 30%. This finding is due to multiple reasons, including medication side effects, limited wrap-around support, insufficient efficacy, and, most importantly, affordability.

With any substantial weight loss, regardless of the method used, whether surgery, medication, or dietary means, a person typically loses muscle mass. The average loss of muscle is in the range of 20 to 30% of the overall weight lost.⁵⁵ Muscle loss can be reduced with resistance training and strength exercises, which are effective strategies to mitigate muscle atrophy in conjunction with adequate protein intake to preserve muscle strength and support metabolic health.

Peralta-Reich *et al* presented, at the European Congress on Obesity in Spain in 2025, the findings from a six-month study of 200 adults treated with GLP-1 agonists where participants lost 13% of total body weight, but only 3% muscle mass when maintained on a protein rich diet, engaged in a regular resistance training and supervised by a trained medical provider.⁵⁶

Exercise is even more important when using these medications in older people with reduced functional capacity. Sarcopenic obesity, which can be brought on by rapid weight loss in older adults, can lead to decreased muscle strength, falls and reduced QoL.⁵⁷

Dietary support and management are crucial when using these agents, as many patients tend to eat only small amounts of food. It is essential to encourage patients to consume nutritious and high-quality foods to prevent nutritional deficiencies. Monitoring and treatment of nutritional deficiencies is necessary when patients lose a significant amount of weight.

Clinicians need to inform patients about potential side effects, including common complications such as nausea, vomiting, constipation and other gastro-intestinal side effects, rare complications such as the increased risk of developing gallstones (cholecystolithiasis) or pancreatitis, and also novel, rare side effects (e.g. non-arteritic anterior ischaemic optic neuropathy) reminding us of our responsibility to weigh potential risks against anticipated benefits.⁵⁸ Nevertheless, multiple weight management medications have their dedicated place in the management algorithm. Treatments need to be individualised as there are wide inter-individual treatment responses for all medications.

The first step is to identify medications that can increase weight and try to either reduce or replace them or discuss with relevant clinicians the need for particular medications, e.g. psychotropic and anti-epileptic medications with different weight-gaining potential. The second step is to identify potential contraindications for available weight management medications, as those should be excluded from the list of choices. Thereafter, it is good to look for medication that can have a dual benefit, such as GLP-1 agonists for the management of diabetes, cardiovascular protection, MASLD and weight loss, or combination naltrexone/bupropion that has been used in other countries for smoking cessation and depression (not approved in New Zealand). The next step could be identifying eating behaviour phenotypes and using medication based on actionable eating behaviour traits, e.g. Contrave® for patients with emotional eating. This evaluation can be conducted in the clinic through a comprehensive history-taking process, based on questionnaires or more detailed investigations, as outlined above.^{47,59,60} For example, the novel [New Zealand Eating Behaviour Questionnaire](#), a validated clinical tool to identify actionable eating behaviour phenotypes, has been able to identify patients who respond favourably to the naltrexone/bupropion combination, whereby those with emotional or hedonic eating lost approximately twice the percentage of their starting body weight over 24 weeks compared with those with reduced satiety (homeostatic eating) (4.69%, 95% CI: 0.23–9.15 vs. 2.82%, CI: 0.33–5.30).^{47,59,61}

Equally, it is critical to evaluate whether the patient can afford the medication for a reasonable timeframe or to explore cost-effective alternatives that are suitable. Once an agreement has been reached with the patient, it is essential to discuss potential side effects, the duration of treatment, and treatment targets with the goal of improving health.

Follow-up

Weight regain following significant weight loss is a natural biological process.¹⁴ Weight loss is counteracted by compensatory systems that increase appetite and decrease energy expenditure, consistent with the 'hypothalamic set-point theory'.^{7,14} This is a complex process that involves a disproportionate decrease in the hormone leptin being released by adipose tissue, decreases in which result in increased appetite and reduced thermogenesis.¹⁴

Due to the complexity and chronicity of obesity, patients need lifelong monitoring and support to reinforce the importance of ongoing lifestyle optimisation and treatment adherence.^{2,62} Initially, follow-up is recommended at monthly intervals following the introduction of any obesity management medications, to assess tolerance and dosage.²⁴ Three-monthly intervals are appropriate in the long-term to assess progress, encourage treatment adherence and monitor co-morbidities.

TAKE-HOME MESSAGES

- Pharmacotherapy is indicated as adjunctive therapy for those living with obesity (BMI ≥ 30 kg/m²) or those who are overweight (BMI ≥ 27 kg/m²) with at least one weight-related complication in conjunction with a reduced-calorie diet and lifestyle interventions.
- All the Medsafe-approved obesity management medications are effective at reducing and maintaining clinically significant weight loss.
- Individual responses to obesity management medications may vary, and medication selection should be personalised to meet individual values, preferences, and treatment goals to support an approach that is guided by safety, tolerability, co-morbidities, accessibility, and cost for long-term adherence.
- The patient's clinical characteristics, the mechanism of action of the obesity management medications and the identification of eating behaviour phenotypes may help to guide pharmacotherapy selection.
- Obesity management medications are not currently funded in New Zealand, and there is a considerable cost differential between therapies. Initial cost should be discussed when selecting a medication, and ongoing affordability should be regularly assessed. Prices may range from \$80 for 28 days of phentermine 15 mg and \$105 for 28 days of naltrexone-bupropion, to \$460 for 1 month of semaglutide.
- A multidisciplinary approach to treatment is recommended for obesity management strategies to succeed.



EXPERT'S CONCLUDING REMARKS

The significance of obesity in New Zealand extends beyond the areas clinicians can directly impact and has societal ramifications. Ideally, obesity would be addressed as a whole-of-society problem, as it affects the QoL of a large proportion of New Zealanders and the sustainability of the healthcare system in terms of cost and deliverables.

Different countries have employed various approaches. In the UK, a sugar-sweetened beverage tax has led to a significant decrease in the purchase of soft drinks and a widespread shift in industry formulation, with companies using less sugar in their drinks to avoid the levy. For example, the UK government found a 46% reduction in sugar in soft drinks between 2015 and 2020.⁶² Modelling based on these observations predicts a significant decrease in childhood obesity and dental caries, with the most important benefit for more deprived households, and expected long-term gains in population health, including fewer cases of T2D, CVD, and improved life expectancy. Additionally, there are economic benefits, including revenue from the levies, which can be utilised for public health programmes and healthcare cost savings for the NHS budget. On the other hand, there was no negative impact on the industry. However, the most important outcome is a behavioural message that extends beyond the interventions and signals that high-sugar drinks are less desirable, an approach similar to smoking legislation.

In New Zealand, obesity management medications are not funded and it appears that this will remain the case in the near future. The partial funding of modern weight management medications via NICE within the UK NHS has so far yielded mixed results, and many predictions are still to be confirmed. Even if trial evidence shows significant weight loss benefit, real-world observations show less average weight loss due to early discontinuation or reduced dose titrations, which leads to reduced effectiveness. Based on the current NICE technical evaluation, patients with a BMI over 40kg/m², with ≥4 listed weight-related comorbidities, and who are enrolled in a specialist weight management centre with an MDT approach have access to fully funded weight management programmes for up to two years. However, there are significant concerns among providers and patients about weight regain, as approximately 60% of the weight is regained within one year after stopping semaglutide.

Conclusion: Providing a comprehensive medical assessment focused on obesity and its related complications, and developing a patient-centred, individualised treatment plan that can be enacted by a multidisciplinary team, including a clinician, dietitian, exercise physiologist, and, when needed, a psychologist, with regular reviews and a long-term focus, should be the cornerstone of medical obesity management. This approach should involve the whole whānau and be enacted in a supportive, non-judgmental environment. Such a change of mindset could have society-wide repercussions, reducing the intergenerational detrimental effects of obesity.

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