

The stark reality facing people needing GLP-1 drugs to lose weight

These patients consider their drugs ‘lifesaving’ but struggle to afford them without government subsidy.

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Imagine having to enrol in a clinical trial just to access a type of care that’s worked well for you in the past but you can no longer afford. And not knowing if you are taking a placebo. Or having to ask your pensioner parents for money to help cover the cost of your private prescription.

These are some of the lengths Australians are going to in order to obtain the new wave of [injectable weight-loss medications](#) to help reduce their weight to improve their health after trying and failing alternatives.

Health Minister Mark Butler estimates 600,000 people are already accessing GLP-1 drugs privately. While he says the drugs “[must](#)” [be subsidised for a small number of people with high levels of obesity](#), negotiations with pharmaceutical companies to make that happen have not yet been successful, with price a major sticking point.

Neale Cohen, from the Baker Heart and Diabetes Institute, says obesity must be recognised as a chronic health condition [rather than a disease of a person’s own doing](#), adding patients need support, not judgment.

“The government has not [put an item on the PBS for managing obesity ever](#) in Australia,” Associate Professor Cohen said.

“What I find is that diabetes and obesity have a stigma attached, and there’s a lot of shame and blame associated with these conditions that really are not anyone’s fault. It’s a bit like hypertension; if you’ve got high blood pressure, no one blames you for having high blood pressure and you treat it long term. These are similar conditions with genetic predispositions.”

The arrival of the new GLP-1 classes of medication is providing patients with new options.

There are two main types of the injectables – glucagon-like peptide-1 receptor agonist (GLP-1), which includes the brands Ozempic and Wegovy. Then there are dual GIP/GLP-1 receptor agonists, which include brands like Mounjaro. Both work to slow digestion and lower blood sugar to make people feel fuller.

However, their high cost means they remain out of reach for some of the patients most likely to benefit most.

One of those is Ebony Pedersen, 41. The mum of three gained weight after being prescribed an antidepressant in her 20s. Since then, she's found it next to impossible to shed and her BMI has shifted into the "obesity" range.

"I've been trying to lose weight for more than a decade and just get nowhere," she said. "I've tried dieting, I've gone to personal trainers pretty intensely, I've even gone to nutritionists, I go to the gym regularly; I can tone up but I can't lose weight.

"One thing that worked was when I was pregnant with my last child – for some reason I was able to lose weight while I was pregnant! But as soon as I gave birth and the hormones left my system the weight came back."



Ms Pedersen's weight gain has affected her mental and physical health. Picture: Arsineh Houspian

Her weight gain has affected her mental and physical health and left her with an uncomfortable feeling of pressure around her organs. She tried one injectable but reacted poorly and became too fatigued to go to the gym, so came off it. She had a better response to a different [GLP-1/GLP agonist drug](#), losing 12kg.

Due to her shorter height, that was enough to shift her BMI from the "obese" to "healthy" range. She felt healthier and was able to do more.

Then the cost of living started to bite and she could no longer afford the drug's \$380-a-month price tag. When she came off the drug, her weight returned.

She's now signed up to an 18-month clinical trial involving a GLP-1 drug candidate not yet approved for use. Each month, she makes a six-hour round trip to Melbourne to participate. It's a huge commitment and an even bigger gamble given there's a chance she's taking a placebo.

Jessica is another woman who goes to extraordinary lengths to afford her GLP-1 medication. Previous interventions failed and, for medical reasons, she can't have bariatric surgery.

Jessica has multiple sclerosis, several disabilities, and uses a wheelchair. Due to chronic pain and reduced mobility, she can only work part time and gets support through the NDIS.

"Financially it's been pretty devastating," she said of trying to afford the medication privately. Sometimes, she forgoes her other drugs just to afford her GLP-1. Other times, she has to ask for financial help.

“My parents are older and on a pension and at times they’ve had to lend me the money to pay for it. It’s so embarrassing,” she said.

“It becomes this situation where being healthy is a privilege because you’re rich. That’s not how Australia should be.”



Jessica is not her real name. She’s too afraid to be identified due to the stigma and shame directed towards people with obesity. She regularly takes around 10 medications to help manage various conditions, which comes at a high cost even with the PBS safety net activated. The safety net only applies to private prescriptions in rare circumstances and does not apply to her GLP-1.

Some of the medications contribute towards her weight gain and, in recent years, she’s experienced joint injuries and pressure sores. She was advised she would soon need to shift to a motorised wheelchair due to her weight. Doing so would require extensive retrofitting around her home and, she fears, reduce her independence.

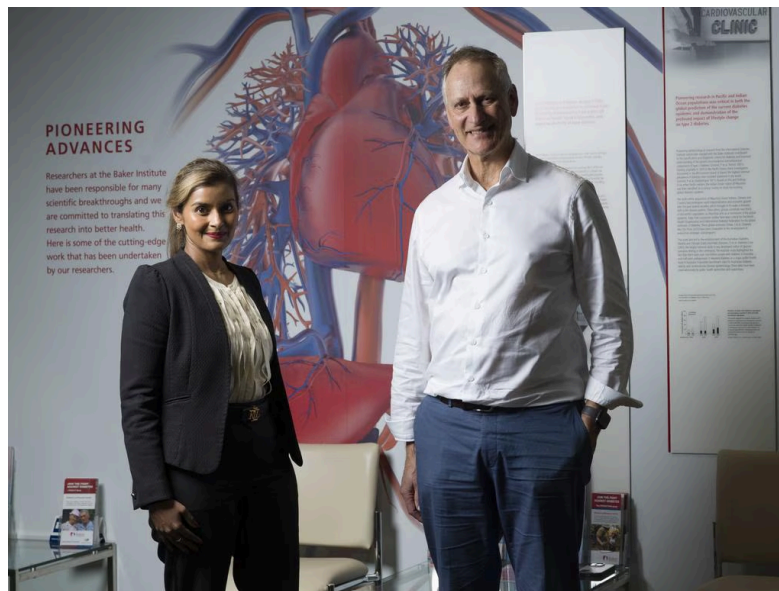
“I’ve fought so hard for my independence as a woman who became disabled in her 20s and to still be living independently,” she said. “If I didn’t lose weight, I would keep getting sick and put more pressure on the NDIS and health systems.”

It’s why a specialist prescribed her a form of GLP-1 on a private prescription three years ago. She reacted badly to the first one, but had a better response to another, which she takes at a half dose to make it last longer.

“I’ve had a very slow weight loss, maybe because of the lower dose. I’ve lost 14 kilos, which may not be much for other people but for me is significant,” she said. “Physically, I’m in a better state than I was three years ago. For someone with a progressive disability, that’s huge.”

Natalie Nanayakkara is a clinical and academic endocrinologist who says Jessica is far from alone. “I’ve had patients potentially looking at having joint replacements, or who have limited mobility,” she said. “But losing weight with the aid of medications in conjunction with lifestyle and exercise has hugely turned their lives around.

“There’s numerous studies to say there is a biological basis to excess weight and obesity, and these agents have been developed to target those. It’s unfortunate that some of the people who would benefit the most from these medications are unable to access them because of cost.”



Associate Professor Nanayakkara and Associate Professor Neale Cohen of the Baker Heart and Diabetes Institute. Picture: Elke Meitzel

Associate Professor Nanayakkara is co-leading the trial Ms Pedersen is enrolled in and hopes prices reduce as more competition enters the market, including tablet versions GLP-1s.

The medications are not suitable for everyone and [come with the potential of serious side effects](#), including vomiting, diarrhoea, suicidal ideation, mood changes and issues with muscle and bone loss. There are also concerns about their influence on diet-culture, especially on people who have disordered eating.

Jason Free is a specialist obesity surgeon and the president of the Australian and New Zealand Metabolic Obesity Surgery Society. He cautions against overconfidence in the drugs.



Australian and New Zealand Metabolic and Obesity Surgery Society president Dr Jason Free.

“For 20 per cent of people, they just don’t work,” Dr Free said. “Some people just give up due to the bowel changes or the changes in mood, or they’re expensive ... but the main reason we’re seeing in our surgical and metabolic clinics is people are aware that they have to be on them forever.”

In his view, greater investment is needed in public multidisciplinary support services. He also wants more GPs to refer patients to clinics, even private ones.

“[We want to see people like Matt Bright](#) being treated in specialist units like obesity management metabolic services where you’ve got a physician, a surgeon, nursing, dietitians, exercise physiologist, psychologist – the whole group – these people need to be treated by entire team, not just a practitioner just giving out medications once every month or so.

“If GPs could refer to surgical bariatric centres, that’s a start.

“A lot of these private community clinics will actually have the capacity to refer into their nearby public system, making it easier for the patients, rather than GPs trying to refer directly to a public system where a lot of the time there will be a lot of pushback and administrative declines.”

He agrees obesity is an overlooked issue.

“We recognise this as a disease with a lot of medical comorbidities which are life threatening and people are dying. However, the health system is just not caught up in terms of funding adequate treatment for those people in that scenario.”

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