

Australia's severe obesity crisis deepens as people like Matt struggle to find care

Matt Bright was virtually confined to his bed before he obtained Mounjaro through the public health system. With thousands of lives on the line, many others with severe obesity are missing out.

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Weight-loss therapies have become Australia's biggest-ever off-label drug-prescribing market while remaining inaccessible to hundreds of thousands of people with severe obesity who are largely cast adrift from essential healthcare, in a hidden epidemic that exacts a devastating human and economic cost.

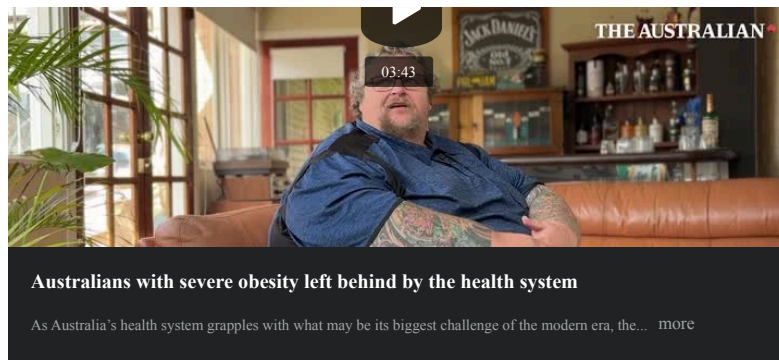
New analysis by The Australian's Health and Wellbeing team reveals how comprehensively Australia's health systems have failed to adapt to rising rates of severe obesity, which threaten to reverse life-expectancy increases and swamp public hospitals.

An investigative series across coming weeks will detail the impacts of this neglect on patients who in some cases can barely walk, cannot work and are, in the worst cases, confined to their beds, unable to access any healthcare at all.

The Weighting Game series will reveal:

- How big the private market in weight-loss drugs has become while state hospitals desperately attempt to provide workarounds to [subsidise GLP-1 drugs](#) to those in critical need.
- The severe impacts on the health, wellbeing and livelihoods of people with severe obesity and those who care for them, and the extraordinary steps people are taking to pay for [weight-loss drugs](#).
- The widespread lack of clinical care for [severe obesity](#) including "clinical deserts" with no metabolic clinics and very little bariatric surgery access in the states with the most vulnerable Indigenous patients.
- Exclusive first-stage economic modelling that analyses the cost-benefit case of funding weight-loss drugs for obesity as a primary indication in Australia.





Health regulators are struggling to control an at-times exploitative market in weight-loss telehealth prescribing, now a multibillion-dollar industry. Yet many people who need therapies desperately – both clinical and medicinal – are largely cut off from healthcare. At the severe end, where people’s health is at critical risk, patients cannot access care and cannot afford to pay up to \$700 a month for medicines.

The picture is alarming.

“People are not getting treated,” says Weight Issues Network advocate Andrew Wilson. “They just get turned away from treatment. And delayed treatment gets to the point where it’s just too much and there’s very limited options. We’re talking about people reaching end-of-life stage. I don’t want to sound dramatic, but that’s happening a lot.”

Overweight and obesity affect two-thirds of people. Six-and-a-half million Australians live with obesity. Two million fall into the serious stage, and one million suffer severe obesity, classified as a body mass index (BMI) over 40.

In the Weighting Game series, The Australian uncovers a critical shortage of services within public-health systems for [obesity](#), including [scarce access to bariatric surgery](#). Preventive and primary care for much of the population to maintain a healthy weight is also under-resourced and expensive.

“There is no easy answer to this,” says the Obesity Collective’s director, Sydney University honorary professor Timothy Gill. “But there are some situations in healthcare where you cannot delay. Clinicians will tell you that some people just won’t survive another six to 12 months without intensive intervention.

“It’s a terrible thing. My reaction to that is: how has it been allowed to get this far down, where people’s health is so poor?”

‘You start to almost give up’

As the health system grapples with what may be its biggest challenge of the modern era, the equity gulf is no better exemplified than in the immense daily struggle experienced by Matt Bright from Geelong in Victoria.

About a year ago, the 49-year-old weighed 340kg. He is stepping forward to communicate the devastating reality of living with severe obesity and to issue a call to arms to governments.

Though he has tried very hard to change his situation, the realities of his size have meant few services can help.

“Our health services should be able to care for me because I’m not the only person going through this,” Mr Bright said. “I’m not a one-off.

“You have to search so far and wide to get healthcare. There’s only two ambulances in Victoria that can cater for me. I’ve had a fall and had to spend three hours just laying on the ground because they can’t get an ambulance here to help pick me up and get me to hospital. I’ve had to wait six weeks to get a tooth extracted because I was just too difficult to deal with.



The Australian is investigating the human and economic cost of obesity.

“You start to almost give up. It’s easier for services to hand you on to the next person, then the next person, until you stand up for yourself and say ‘okay, this isn’t good enough’.”

Obesity has overtaken tobacco as the leading risk factor contributing to ill health and death in Australia. It is the primary driver of an array of chronic diseases including type 2 diabetes, hypertension, cardiovascular disease, sleep apnoea and osteoarthritis. Yet it is systematically undertreated. Research funding for the condition has been slashed by 60 per cent from \$41m to \$16m in the past decade even as severe obesity rates have steadily risen.

The devastating situation is occurring out of public sight even as a massive private market of more than half a million scripts a month in GLP-1 drugs has developed, sometimes preying on vulnerable people amid inappropriate prescribing and predatory practice.

As the private scripts flow, waitlists for the tiny number of public-hospital metabolic clinics stretch as long as five years, with hundreds in the queue.

Western Sydney endocrinologist Nic Kormas, who works at the public system coalface, said: “What we’re doing is we’re just putting Band-Aids on the problems.”

He’s part of a collective of doctors pushing for a reorientation of obesity care. “There are people drowning out there,” he said. “We need to get a move on.”

Special access to drugs

Mr Bright is one of those patients. At his largest, his BMI surged well over 100.

Mr Bright has since been [prescribed Mounjaro](#), receiving cheaper medication through a public system workaround.

Hospitals have struck special deals direct with pharmaceutical companies for people such as Mr Bright to provide medicines access, but millions more people require multidisciplinary care and appropriate pharmacotherapies that they have no hope of accessing or affording.

Mr Bright doesn't know how long his special access to Mounjaro will remain in place. The drug has been highly effective, including for his diabetes, when [Ozempic](#) (which is subsidised for diabetes) and other drugs did little. Mounjaro is not listed on the PBS and so does not attract a public subsidy.

A few months after starting Mounjaro, Mr Bright's diabetes marker dropped into the normal range. He has stopped taking high blood pressure medication. His weight has now reduced by almost 60kg.

The Geelong born-and-bred gentle giant came very close to losing his life to sepsis two years ago. The infection's source was a complication of his lymphodema – a condition where skin tissue swells and seeps fluid because drainage is so poor.

Mr Bright's mobility is impaired, among other causes, by a large sac that hangs between his legs, which fills with bodily liquids. It's the size of a basketball.



Mr Bright and his wife, Dianne Cunningham, in their garden. Mr Bright has improved his mobility since losing weight. Picture: Arsineh Houspian

Surgery is impossible at his size due to untenable risks presented by anaesthetics. Doctors have told Mr Bright he would be “beyond life support” in the event of disaster.

“They’ve said ‘we can’t resuscitate you ... one thing we could maybe do is stick a tube into your neck to keep you breathing: are you okay with that?’” he said.

Mr Bright’s wife, Dianne Cunningham, at one point had to give up work entirely to be her husband’s full-time carer.

“If I didn’t have Di, I would need to be in a facility where they could pretty much provide 24/7 care,” he said.

Before losing weight, Mr Bright could not get in and out of the shower unassisted, and could only walk for about 10m. He was rushed to hospital a week ago, his life again at critical risk from sepsis. It had happened before, two years ago. This time, doctors could not even find the source of the infection.

Mr Bright has recently completed qualifications in psychotherapy and hypnosis to help others like him, and is determined to advocate for others. He’s now able to work, and has given his burgeoning enterprise a sunny name: Bee Right Communications.

His optimism is remarkable in the face of the immense challenges he has faced. Aged six, he lost his 36-year-old father to a fatal cardiac arrest.

As a teenager, Mr Bright sought acceptance and connection that often revolved around food – unhealthy food such as hot chips with mates after school. And later, too much alcohol. As the years unfolded he got larger and larger. Public jibes followed; discrimination was overt even when seeking healthcare.

“It got harder and harder to move, harder to do anything,” he says. “You start to almost give up. It becomes your identity.

“It seems like overweight people in larger bodies are the last group of people where it’s okay to be subject to discrimination. You walk out into the street and people look at you and point and make jokes. I guess for me personally, I almost accepted it.

“I have got to the point now where I don’t need to care what anyone else thinks of me. They don’t know my story. They don’t know anything about me. So if people want to prejudge, and think it’s all my fault, that’s on them.”

Continuing access to GLP-1 medications is vital but uncertain for the Geelong local. He lives with a pervasive sense of anxiety that frequently intrudes into the peace of his garage woodwork activities and garden pottering – new activities now that he can walk 120m and get about slowly on crutches. It’s the terror of losing his life.

Situation critical

Mr Bright is correct when he says he is not a one-off. A million Australians are living with severe obesity. One third of all people live with the chronic condition in all classes of the disease.

The phenomenon is feeding a pharma profits boom as commonwealth health policymakers encounter a roadblock with the [PBS listing of the weight-loss drug Wegovy](#).

There are no obesity management drugs listed on the PBS, and none are being considered for obesity-specific indications, even for patients with severe chronic disease. Wegovy is being reconsidered for listing on the PBS for established cardiovascular disease for people with obesity in November.

A collective of the nation's leading endocrinologists and specialist general practitioners with extended skills in obesity management are now advocating for an alternative, clinician-led approach to securing funding for evidence-based obesity management.

A policy position paper obtained by The Australian calls for obesity medications such as semaglutide and tirzepatide to be made available to patients alongside care in specialised obesity service clinics within NSW.

The proposal is for a four-year pilot program across three NSW public hospital sites, to prove the cost effectiveness of this model of care.

NSW has only five large multidisciplinary public clinics and five smaller services to treat obesity. Victoria has even fewer, and Western Australia and the Northern Territory, which have large Indigenous populations suffering high rates of severe obesity, have no adult clinics.

The NSW pilot proposal would provide access to two years of funded pharmacotherapy for capped cohorts of 200 patients per hospital per year, totalling 600 new patients a year statewide.

It would embed strict hospital-based subsidised prescribing structures that are used for other drugs.

"Health-economic modelling shows that, over the four-year pilot, the program will avoid between 265 and 315 acute hospital admissions, generating \$1.98m to \$2.36m in direct hospital admission savings and achieving a net fiscal program surplus of \$4.4m," the proposal says.

It is in line with new first-stage economic modelling by Australian National University professor of medicine [Stephen Robson](#) that will be detailed in the Weighting Game next week. Professor Robson's discussion paper is the first to analyse the cost benefits of subsidising medicines for obesity as a primary indication in Australia.

"No one would like to see Medicare or the PBS placed in jeopardy due to uncontrolled cost of one group of medications," said regional Victorian GP Remon Eskander, a member of the obesity specialist clinicians group. "But we are advocating for life-changing solutions that would save governments a significant amount of funding in hospital and other services every year."

Selling their homes

While public hospital metabolic clinics struggle to keep pace even with patients with a body mass index of more than 50, GPs say some patients are sacrificing their financial future to afford the medications. Churches are even stepping in to subsidise therapies.

"I have seen patients selling their own home or downsizing their homes or going into rental accommodation just to afford medication," said Dr Eskander, who runs a weight-loss primary care clinic in Bendigo. "I've seen mums working two jobs, or moving their children from private school to public schools.

"There are hundreds of stories like that from GPs. It leaves doctors feeling frustrated, feeling heartbroken.

“Australia has reached a point where access to evidence-based obesity and metabolic disease treatment is increasingly determined by the patient’s ability to pay rather than their clinical needs.”

Western Sydney is one of the nation’s hotspots for severe obesity. The few metabolic clinics that exist are overwhelmed, with 500 people on the waiting list and delays in care of up to five years. Some patients confined to their beds can’t get care at all.

Milan Piya, a clinical academic endocrinologist at the School of Medicine at Western Sydney University, said: “I’ve seen better quality-of-life scores in cancer surviving patients than what we’re seeing in the people we’re treating.”

Dr Piya’s colleague Dr Kormas said the situation was dire if national policy didn’t catch up quickly to a deepening epidemic.

“Although our life expectancy increased over the last 20 years, it’s actually going to turn a corner and go the other way,” Dr Kormas predicted. “People are going to live less and we’re going to be spending a lot more on health care than we should – a lot more.

“People with obesity don’t want to have severe obesity. They need help.”

Obesity clinic deserts

From western Sydney to Geraldton, much of the country is a wasteland for those struggling to reverse chronic obesity.

The National Association of Clinical Obesity Services’ most recent framework for obesity management found there were only about 12 to 15 multidisciplinary obesity management services in public hospitals that offered bariatric surgery. It was completed in 2019 and there are a few more services now, but 95 per cent of bariatric surgeries are still carried out in the private system.

“The situation I think is incredibly severe,” said bariatric surgeon Wendy Brown, head of the Monash University Department of Surgery. “Obesity is a disease that disproportionately affects people from the lower socio-economic quintiles and also people and vulnerable populations.

“It’s estimated that 55 per cent of people with obesity are dependent on the public health system for their health care needs and at the moment we just don’t have sufficient access to effective treatments.”

Many patients with severe obesity can’t access the tiny number of public services even if they make it onto the waitlist of a bariatric clinic, because their weight is too high.



Drug company Eli Lilly failed to come to an agreement with the federal government for a public subsidy for Mounjaro on the Pharmaceutical Benefits Scheme. Picture: Getty Images

Mr Bright was told he would need to lose 100kg to be a candidate for such surgery.

“The first thing they always say is you need to lose weight, [you need diet and exercise](#),” Mr Bright said. “But it gets to a point where losing weight just becomes really difficult no matter how much diet and exercise that you do. If you want to lose five, ten kilos, yep, no worries that’s ideal. If you want to lose anything more than that then it becomes a whole complex issue.”

Defeat Diabetes founder Peter Brukner, a GP, said weight-loss drugs could be useful for some people, but it was imperative to make credible, evidence-based health care accessible for those in severe need amid a telehealth industry boom in weight-loss drugs.

“There are good programs available for those people who don’t have hundreds of dollars and don’t want to have injections for the rest of their life and so on,” Dr Brukner said. “And they’re not promoted, because as we know, drug companies are very good at promoting their products and they’ve got a lot of money to spend. It’s disappointing that governments do not promote alternative programs. I mean, diabetes is a massive, massive problem in our country that people don’t acknowledge.”

Stigma, bias and discrimination

There are multiple factors why reversing obesity and providing healthcare is complex and difficult, not least to fund. But it’s hard to avoid the conclusion that Mr Bright articulates, that stigma and bias have translated to systemic discrimination against larger people seeking healthcare. Many clinicians agree.

Priya Sumithran, head of the obesity and metabolic medicine group in Monash University’s department of surgery, said: “I don’t know how to describe it other than to say the situation is just so inequitable,” said. “It doesn’t mean that people that can afford to pay in the private market shouldn’t be using these medications. But your access to healthcare shouldn’t depend on your ability to pay.

“Obesity is not people’s fault. Some people will say, ‘well, you know, people can choose what they’re going to eat and whether they’re going to exercise and how much they’re going to exercise’. And yes, there are certain things that are within our control, but the playing field is not level. And apart from biology there are environmental and societal factors that make it difficult for people to have full autonomy over their choices.”



Negotiations are continuing over a listing of Wegovy on the PBS for weight loss. Picture: AFP

The Weight Issues Network, as the peak body for people living with obesity, is calling for change.

“We believe, in Australia, there’s a two-tiered system,” said Mr Wilson. “People in large bodies with eating disorders are often invisible in the system. People with a low body weight are likely to be recognised as having an eating disorder. They get urgent care, specialist services, public funding and a lot of compassion.

“But people in high-weight bodies with eating disorders are frequently misdiagnosed or ignored. Binge-eating disorder in the larger body is the most common eating disorder in Australia, but it’s underdiagnosed. Instead of being treated with care, people with high weight are encouraged to diet, which can worsen the disorder.

“The bottom line is that people with severe obesity face some of the highest health needs, but have the lowest access to appropriate care.

“We think it is discrimination. We think that’s a human-rights issue. Because for many other chronic conditions, there are treatments and pathways for people. There is treatment without judgment.

“You would assume if you’re sick in our country that everybody would be treated for their condition. But the way it’s still viewed is that we are blamed. We’re blamed for our own condition, when we know there’s very many reasons for obesity.

“We just feel that we’re being overlooked.”

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