PREKURE CLINIC

THE PREKURE CLINIC APPROACH · WEIGHT

Weight loss, GLP-1 medicines and behaviour

Stop starting again.

GLP-1 medicines such as Wegovy (semaglutide) and Mounjaro (tirzepatide) are the most effective weight-loss medicines yet made, and they have a place in care. PREKURE supports their use as a tool within lifestyle medicine, chosen with full knowledge of the real-world results, the harms, the costs and what is still unknown.

Professor Grant Schofield and Dr Jenni Hurling

The PREKURE Clinic · Lifestyle medicine · Metabolic medicine · Behavioural medicine · Clinically reviewed November 2026

PART 1

The PREKURE Clinic approach at a glance

How these medicines work. GLP-1 is a hormone the gut releases when we eat. It tells the pancreas to release insulin when blood glucose is high, turns down glucagon (a hormone that raises glucose), slows the stomach so food stays there longer, and acts on the parts of the brain that control appetite. The medicines copy this hormone but last about a week rather than a few minutes, and tirzepatide also copies a second gut hormone, GIP. Like GLP-1, GIP boosts insulin release after meals, and it also acts on fat tissue and the brain. Exactly what it adds is still being worked out, but in a head-to-head trial tirzepatide gave more weight loss than semaglutide (20.2% against 13.7% at 72 weeks) (Aronne, NEJM 2025). Because the insulin effect only works when glucose is high, they rarely

cause low blood glucose on their own. Most of the weight loss comes through the brain. People feel full sooner, are less hungry, and often describe quieter "food noise", meaning constant thoughts about food. In one trial, people on semaglutide ate about a third less at a lunch where they could eat as much as they liked, and reported fewer cravings (Friedrichsen, DOM 2021). Some of these effects soften over months, even while the medicine is still being taken, and they stop when it stops.

Food noise and food addiction. We treat both as real and worth asking about. Researchers now describe food noise as a heightened, persistent response to food cues (Hayashi, Nutrients 2023). Food addiction describes a loss of control over highly processed foods that mirrors other addictions. It is not yet a formal diagnosis and is still debated, but it can be measured, and about 1 in 7 adults meet the criteria on the standard questionnaire (Gearhardt, BMJ 2023). Where it seems relevant, we screen with CRAVED, a six-question tool, and follow up with a fuller assessment. GLP-1 medicines reduce cravings and food noise for many people, though for some the effect fades over time, and early trials suggest they also reduce alcohol craving and drinking. For gambling and other addictive behaviours there are only individual reports so far.

How common and how harmful. About a third of New Zealand adults live with obesity (32.5% of men and 35.8% of women). On average it shortens life by 2 to 4 years at a BMI of 30 to 35 and by 8 to 10 years at 40 to 45, similar to smoking. It also raises the risk of type 2 diabetes, heart disease, 13 cancers, osteoarthritis and sleep apnoea. Modest weight loss pays off. In people with raised blood glucose, about 7% weight loss plus regular activity cut new diabetes by 58%.

What to expect. In trials, about half of people on semaglutide and 7 in 10 on top-dose tirzepatide lose 15% or more of their weight over 16 to 17 months. Real life is different. About half of people stop within a year, mostly because of cost, and average loss at one year is about 9% rather than 15 to 21%. A person should plan around real-world results, not trial results.

Health benefits. Proven benefits are in specific groups. They include fewer heart attacks and strokes in people with heart disease (1 in 67 over about 3 years), far less progression from prediabetes to type 2 diabetes (1 in 9 over 3 years), and benefits in kidney disease, heart failure, sleep apnoea and fatty liver. In people with heart disease, the heart benefit was similar whatever their starting weight

and however much weight they lost, so it is not only due to weight loss (Deanfield, Lancet 2025). Benefit for people with obesity but no other disease has not yet been tested.

Harms. Nausea, vomiting and constipation are common, especially early. In trials, 6 to 7 in 100 stop because of side effects. In real life, side effects are the second most common reason for stopping, after cost. Gallstones and reflux are slightly more common. Rare harms, including a possible link with sudden vision loss, are reported but still debated. Rare means few people, not no one. Lean tissue (muscle, water and organ tissue) is lost along with fat, in about the same proportion as with dieting. Trials of these medicines at weight-loss doses run only about 4 to 5 years. The drug class has about 20 years of use, almost all in type 2 diabetes.

When people stop. Most of the weight returns within one to two years, and most of the health gains go with it. Keeping the benefit generally means staying on the medicine, at about $4,400 to $10,500 a year in New Zealand, where it is not funded for weight loss.

Behavioural care. Intensive lifestyle programmes give smaller losses but carry almost none of the medicines' risks or costs, and they work on the causes. In the longest trial, half kept at least 5% off and a quarter kept at least 10% off after eight years (against 36% and 17% with usual care). Whether a programme can help people come off medication and keep the weight off has not been properly tested. That is a gap in the evidence, not proof that it cannot work.

Our stance

1. The causes of obesity and related chronic disease are environmental, biological and behavioural. A medicine addresses only part of one of these.
2. Lifestyle medicine comes first and continues throughout, with or without medication.
3. Intensive behavioural care is a primary pathway in its own right, with re-engagement when weight returns. Many people succeed after more than one attempt.
4. Medication is a tool scaled to risk: used where benefit is clear, at the lowest effective dose, reviewed regularly (at least every 3 to 6 months), and stepped down where that is safe and planned.
5. Long-term medication is not our preferred default, given the cost and the unknowns. For some people, especially those with heart disease, it may be the right choice.
6. Every decision is made with the real-world numbers in front of the person.
7. We judge success by how many people who start keep meaningful weight off at two years and beyond, counting those who stop, and we will publish what we find.

PART 2 · THE EVIDENCE

Obesity and health

Obesity is common, shortens life, and drives many chronic diseases. Losing even 5 to 10% of body weight brings measurable benefits. Most of the evidence on harm is observational, from very large cohorts.

Measure	Finding	Source
How many New Zealanders	32.5% of men and 35.8% of women, 2024/25	Figure.NZ, NZ Health Survey

Measure	Finding	Source
Life expectancy	Median survival 2 to 4 years shorter at BMI 30 to 35, and 8 to 10 years shorter at BMI 40 to 45 (900,000 adults)	Prospective Studies Collaboration, Lancet 2009
Risk of death in never-smokers without disease	1.45 times at BMI 30 to 35; 1.94 at 35 to 40; 2.76 at 40 or more (10.6 million people, including Australia and NZ)	Global BMI Mortality Collaboration, Lancet 2016
Health loss in New Zealand	Overweight and obesity caused 9.2% of all health loss in 2013, behind dietary risks (9.4%), such as too little fruit, vegetables and whole grains and too much salt, red meat and sugar, and ahead of tobacco (8.7%)	Ministry of Health 2016
Cancer	Sufficient evidence for links with 13 cancer types, including bowel, kidney, liver, pancreas, womb and postmenopausal breast	IARC, NEJM 2016
WHAT WEIGHT LOSS IMPROVES		
Diabetes prevention	About 7% weight loss plus 150 minutes of activity a week cut new diabetes by 58% over 2.8 years (randomised trial)	Diabetes Prevention Program, NEJM 2002
Glucose, blood pressure, lipids	Losing 5 to 10% of body weight improved HbA1c, blood pressure, triglycerides and HDL; 10 to 15% gave larger gains	Look AHEAD, Diabetes Care 2011
Heart disease	Losing 10% or more in the first year was linked to 21% fewer cardiovascular events over 10 years (observational analysis within a trial)	Look AHEAD, Lancet Diabetes Endocrinol 2016

Whether intentional weight loss lowers cancer risk has not yet been proven in trials.

What to expect: trials versus real life

Trials give the drug for free, with regular contact and highly motivated volunteers. In STEP 1 and SURMOUNT-1, both the drug and placebo groups also had diet and activity counselling, so trial results are drug plus lifestyle advice against placebo plus lifestyle advice. Real-world results are roughly half as good, mainly because people stop or stay on low doses.

Measure	Trials	Real world
Lose 15% or more	50% semaglutide 2.4 mg; 71% tirzepatide 15 mg, at 16 to 17 months (STEP 1; SURMOUNT-1)	Not reported for all starters
Lose less than 5%	About 14% semaglutide 2.4 mg; 9% tirzepatide 15 mg	Not reported for all starters
Average loss at about one year	15% semaglutide 2.4 mg; 21% tirzepatide 15 mg	8.7% across both drugs, 7,881 US patients (Gasoyan, Obesity 2025)
Still on the medicine at one year	Most participants	35% (US adults without diabetes) to 51% (Denmark) (Rodriguez 2025; Mailhac 2026)
Main reason for stopping	Side effects	Cost (48% of those who stopped), then side effects (15%), then supply shortages (12%) (Gasoyan 2025)
On a full maintenance dose	Most participants	19%; most stayed on lower doses (Gasoyan 2025)

People who did stay on a full dose did about as well as trial participants (14% on semaglutide, 18% on tirzepatide at one year). Other factors matter less but still play a part. Type 2 diabetes roughly halves the effect (STEP 2), women lose more than men, and genes have only small effects (Su, Nature 2026). Slow starters are not failures. Of people on tirzepatide who had lost under 5% at 12 weeks, 90% reached 5% by 72 weeks (Ard, DOM 2025). The body also pushes back against weight loss. In a study of a different diabetes medicine (canagliflozin), which causes weight loss without suppressing appetite, people ate about 100 kcal a day more for each kilogram they lost (Polidori, Obesity 2016). GLP-1 medicines hold

that drive down while they are taken, which helps explain why weight returns when they stop.

Food noise, cravings and food addiction

Many people describe eating that feels driven rather than chosen. We assess this directly because it changes what care is likely to help. Trials show GLP-1 medicines reduce food cravings, but part of the effect can fade over months. The evidence for alcohol is early, and for other addictions it is anecdotal.

Question	Finding	Source
How common is food addiction?	14% of adults and 12% of children, pooled from 281 studies in 36 countries using the Yale Food Addiction Scale	Gearhardt, BMJ 2023
How we screen	CRAVED: six yes or no questions based on the criteria used for other addictions, with three or more "yes" answers suggesting an addictive relationship with food. In 117 adults it picked up 94% of those with food addiction on the fuller Yale scale, but also flagged about a third of those without it, so it is a screen, not a diagnosis	Bennett, Front Public Health 2026
Cravings on semaglutide	In a randomised trial of 72 adults, people ate about a third less at a lunch where they could eat freely, and reported fewer cravings and better control of eating	Friedrichsen, DOM 2021
Food addiction on semaglutide	Among 113 adults with obesity, the share meeting food addiction criteria fell from 58% to 4% after four months. There was no comparison group	Nicolau, J Addict Dis 2024
WHY CRAVINGS EASE, AND WHETHER IT LASTS		
How it may work: the brain	GLP-1 medicines appear to shrink the bursts of dopamine that tasty food and food cues trigger in the brain's reward centre, while leaving the steady background level alone. This has been measured directly in rats and mice. In people the evidence is indirect: brain scans, eating behaviour and cravings	Volkow and Wargo, Science 2026

Question	Finding	Source
How it may work: the stomach	They also slow how fast the stomach empties, which adds to feeling full sooner and for longer	Drucker, Cell Metab 2018
Does the brain effect last?	In a crossover trial of 20 adults with type 2 diabetes, liraglutide reduced brain responses to pictures of food at 10 days compared with insulin, but the difference was gone at 12 weeks, even though weight loss continued. A small study of an older medicine	ten Kulve, Diabetes Care 2016
Do cravings stay down over two years?	Compared with placebo, semaglutide lowered hunger and raised fullness at 20 weeks only. Sweet cravings were lower at one year but not at two. Better control of cravings lasted the full two years	STEP 5, Obesity 2023
Does the stomach effect last?	On a constant GLP-1 drip, the slowing was clearly weaker for a second meal four hours later (9 healthy volunteers). On weekly semaglutide it softens but does not disappear: after 12 weeks, 37% of a meal was still in the stomach at four hours, against none on placebo (20 women)	Nauck, Diabetes 2011; Jensterle, DOM 2023
Animal evidence	In mice, semaglutide suppressed the reward dopamine neurons only for a time. After weight loss, eating for pleasure returned	Zhu, Science 2025
What people describe	In 31 interviews, everyone still losing weight reported little or no hunger. Of 15 whose weight had levelled off, 5 described hunger coming back, and some said food noise had partly returned, gradually and less than before	Chong, Clin Obes 2025
BEYOND FOOD		
Alcohol: randomised trial	In 48 adults with alcohol use disorder, nine weeks of low-dose semaglutide reduced craving, drinks on drinking days and alcohol drunk in a laboratory test, but not the number of drinking days. Smokers in the trial also cut back on cigarettes	Hendershot, JAMA Psychiatry 2025

Question	Finding	Source
Alcohol: population data	Among 227,866 Swedes with alcohol use disorder, periods on semaglutide were linked to 36% fewer hospital admissions for alcohol (observational)	Lähteenvuo, JAMA Psychiatry 2025
Gambling and other behaviours	One brief clinical report and many personal accounts online. No trials	Grant, J Clin Psychopharmacol 2026

What this means in practice. Quieter food noise is often the change people notice most, and it can make behavioural work easier to start. It may not last. The medicines seem to work partly by blunting the brain's reward response to food and partly by slowing the stomach, and both effects can soften over months, even while the medicine is still being taken. On average the effect on hunger fades within the first year, and some people find food noise partly returns as their weight levels off, usually less than before. When the medicine stops, the effects stop. So we treat the quiet as a window, and use it to build skills for handling cravings, routines and surroundings that keep working when the noise returns. The evidence on fading is still small, and most of the dopamine evidence comes from animals. A positive CRAVED screen does not by itself mean medication. Our first response is behavioural care, including cutting back the ultra-processed foods most often involved. GLP-1 medicines are not approved in New Zealand for alcohol or any other addiction, and we do not prescribe them for that.

Benefits, harms and costs per 100 people

These are the numbers PREKURE puts in front of anyone considering medication. Trial figures compare the drug with placebo, both alongside lifestyle advice. The "per 100" figures are our arithmetic from published rates.

Outcome	Per 100 treated	Time	Source
Lose 10% or more	69 vs 12 on placebo (semaglutide); 84 vs 19 (tirzepatide 15 mg)	16 to 17 months	STEP 1; SURMOUNT-1

Outcome	Per 100 treated	Time	Source
Heart attack, stroke or heart death, in people with heart disease	1.5 fewer (1 in 67)	About 3.3 years	SELECT
Type 2 diabetes, in people with prediabetes	12 fewer (1 in 9)	3 years	SURMOUNT-1 3-year
Major kidney events, in type 2 diabetes with kidney disease	4.5 fewer (1 in 23)	3.4 years	FLOW
Regain most of the loss after stopping, compared with continuing	83 vs 10	1 year after stopping	SURMOUNT-4
Nausea	31 vs 10 (tirzepatide 15 mg)	17 months	SURMOUNT-1
Vomiting	12 vs 2 (tirzepatide 15 mg)	17 months	SURMOUNT-1
Stop because of side effects	6 to 7 vs about 3	16 to 17 months	STEP 1; SURMOUNT-1
Stop because of side effects, adults aged 45 and over with heart disease and overweight or obesity, without diabetes	17 vs 8	About 3.3 years	SELECT
Gallstones	About 1 extra per 500	Trial durations	Gastroenterology 2025
Reflux	About 1 extra per 250	Trial durations	Gastroenterology 2025
Health effects of decades of use	Unknown	Not studied	No data

Why the stopping figures differ. Short trials in selected volunteers show 6 to 7 in 100 stopping for side effects. A longer trial (SELECT), in adults aged 45 and over

with heart disease and overweight or obesity, shows more (17 in 100), and in real life about half stop within a year, about 1 in 7 of them because of side effects. That suggests roughly 7 in 100 of all real-world starters stop for side effects in the first year (our rough estimate), with cost a far bigger driver.

Sudden vision loss (NAION). Regulators list it as very rare, up to about 1 in 10,000 (EMA 2025). Observational studies disagree with each other, and in people with obesity but no diabetes the link was not statistically significant (J Clin Pharmacol 2026). Treat it as possible but unproven, and report sudden vision loss urgently.

Other harms. Diabetic eye disease can worsen with rapid glucose falls in people who already have it. Because these medicines slow stomach emptying, food can still be in the stomach during an anaesthetic and be breathed into the lungs. People having a procedure under anaesthesia therefore need a 24-hour clear fluid diet beforehand (ANZCA). Links with suicidal thoughts and thyroid cancer are not supported by current evidence (FDA 2026; BMJ 2024). Claims that these medicines prevent cancer or dementia are not supported either. As of August 2026, about 4,100 federal lawsuits in the United States allege gut injuries (3,928 cases) or sudden vision loss (200 cases). The allegations are unproven, and no case has yet gone to trial or been decided (JPML, Aug 2026).

Muscle and bone. On scans, 25 to 40% of the weight lost is lean tissue (water and organ tissue as well as muscle), similar to dieting alone (DOM 2026). Resistance training reduces the loss, and in one trial it protected bone density that the drug alone reduced (Jensen, JAMA Netw Open 2024).

Exercise during treatment. Exercise changes what is lost and how healthy people end up, more than how much weight is lost. In the only published randomised trial, liraglutide plus supervised exercise gave 2.7 kg more loss than the drug alone (not statistically significant). But body fat fell about twice as much, and only the combination improved fitness, insulin sensitivity and HbA1c (Lundgren, NEJM 2021). An early tirzepatide trial with supervised resistance training, so far a conference abstract only, found similar weight loss with less lean tissue lost (3.6 kg against 4.7 kg). No published trial with semaglutide or tirzepatide yet shows that exercise increases weight loss on these medicines.

Costs. These are private prices in New Zealand. Because not everyone reaches 15% weight loss, about 2 people need to take Wegovy for 16 months for one extra

person to reach it, compared with placebo. At private prices that is about $15,000 of medicine for each extra person who gets there. For Mounjaro 15 mg it is about $20,000 (our arithmetic from trial results).

Cost (private, NZD, excluding consultation and dispensing fees)	Approximate amount
Wegovy, per year	$4,400 to $5,700
Mounjaro, per year	$5,200 to $10,500
Medicine cost for each extra person who reaches 15% loss (trial conditions)	About $15,000 (Wegovy); about $20,000 (Mounjaro 15 mg)

Weighing it up for yourself

Whether the benefits outweigh the harms is a personal decision, and it should be made with numbers, not words. People given words like "common" or "rare" misjudge risk badly. In randomised studies, side effects described as "common" (actually 2.5 to 10%) were estimated at 34 to 62% (Büchter, BMC Med Inform Decis Mak 2014). Decision aids that set out options, numbers and values help people make better-informed choices (Cochrane review, 2024: 209 trials).

Rare does not mean never. A harm affecting up to 1 in 10,000 users sounds negligible, but if a million people take the medicine, that is up to 100 people, and for each of them it is 100%. That is why the severity and permanence of a harm matter as much as how often it happens, and why lawsuits arise even over rare events.

The table below shows one medicine for 1,000 people over about 17 months, with benefits and harms on the same footing.

Out of 1,000 people (tirzepatide 15 mg, about 17 months)	Without the medicine	With the medicine	If it happens to you
Lose 10% or more of body weight	188	835	Benefit lasts while you stay on it
Lose 15% or more	88	706	As above

Out of 1,000 people (tirzepatide 15 mg, about 17 months)	Without the medicine	With the medicine	If it happens to you
Develop type 2 diabetes over 3 years (people with prediabetes)	133	13	Benefit largely lost if you stop
Regain most of the loss in the year after stopping	105 who continue	834 who stop	Cost and effort largely lost
Nausea	95	310	Usually mild, early and temporary
Vomiting	17	122	Usually early and temporary
Stop because of side effects	26	62	You lose the benefit
Gallstones	Not reported	About 2 more	May need surgery
Reflux	Not reported	About 4 more	Usually treatable
Sudden vision loss (NAION)	Very rare	Up to 0.1 more, if the medicine causes it (unproven)	Usually permanent
Health effects of decades of use	Unknown	Unknown	Unknown

Sources: SURMOUNT-1; SURMOUNT-1 3-year; Gastroenterology 2025; EMA 2025; SURMOUNT-4. These are trial figures. Real-world benefit is smaller because many people stop.

How to weigh it up

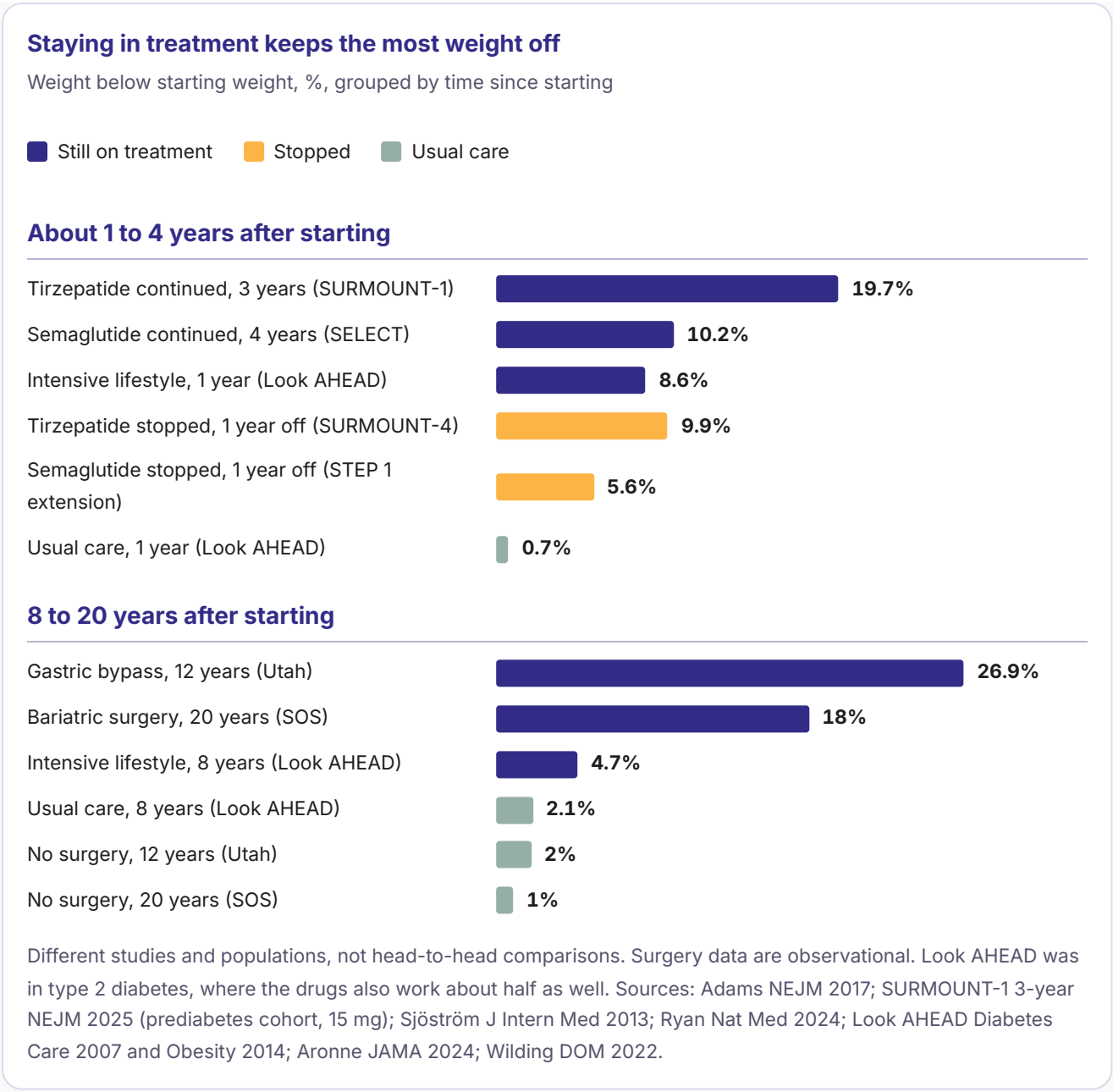
1. **Start with your own risk without the medicine.** Someone with heart disease or prediabetes has more to gain than someone at low risk.
2. **Compare like with like:** benefits and harms for the same 1,000 people over the same time.

3. **Ask how bad, how long and how reversible** each harm is, as well as how likely.
4. **Count the unknowns:** there are no trial data beyond about 4 to 5 years for these medicines at weight-loss doses, although the drug class has about 20 years of use, almost all in type 2 diabetes.
5. **Count the costs**, including what happens if you stop.
6. **Bring your own values.** Mobility, diabetes risk, cost, needles and comfort with uncertainty weigh differently for different people. Two people can make different, equally sound choices from the same numbers.
7. **Revisit the decision** at every review.

Questions to ask your doctor: What happens if I do nothing? What are my alternatives? What are my chances of benefit and harm, as someone like me? What happens if I stop? What will it cost over three years?

Stopping, durability and behavioural care

When the medicine stops, most of the weight comes back within one to two years. Surgery, and medication while it continues, keep the most weight off. Intensive lifestyle care keeps less off, with far fewer risks and costs.



After stopping. People who stopped semaglutide regained about two-thirds of their loss within a year, and most blood pressure, glucose and cholesterol gains reversed (STEP 1 extension). Two randomised trials switched some people to placebo after a period on the drug. In STEP 4, people first lost 10.6% of their weight over 20 weeks. Those switched to placebo then regained 6.9% over 48 weeks, while those who continued lost a further 7.9% (17.4% in total). In SURMOUNT-4, people first lost 20.9% over 36 weeks. Those switched to placebo regained 14% and ended 9.9% below their starting weight, while those who continued ended 25.3% below. Across 37 pooled studies, weight returned to baseline about 1.7 years after stopping, faster than after behavioural programmes (West, BMJ 2026).

Counting everyone who starts. A fairer test of success counts everyone who started, including people who stopped treatment along the way. Both trials below did this.

Approach	Kept 10% or more off	Kept 5% or more off
Semaglutide, people with heart disease, 2 years (SELECT)	44% (placebo 7%)	68% (placebo 21%)
Intensive lifestyle, type 2 diabetes, 8 years (Look AHEAD)	27% (usual care 17%)	50% (usual care 36%)
Real-world prescribing, 2 years or more	Not yet reported	Not yet reported

The time frames differ, so this is not a head-to-head comparison. It does show that lifestyle care gives smaller losses, not that it fails.

Behavioural care in place of medication. This has not been properly tested, which is different from being shown not to work. One Danish randomised trial is encouraging. After a year of supervised exercise, people regained 3.6 kg in the following year, against 9.6 kg after a year of liraglutide alone (Jensen, eClinicalMedicine 2024). It was small, used an older drug, and lost 44% of participants to follow-up. The BMJ meta-analysis found no clear effect of support on regain, but that came from comparing different studies, not from a trial. Diabetes remission with intensive diet programmes does happen but fades as weight returns: 36% at 2 years in DiRECT, 13% at 5 years among those followed (DiRECT 5-year). Ongoing support slows regain modestly, by about 1.6 kg at a year (Dombrowski, BMJ 2014). Repeated cycles of intensive support are plausible, and DiRECT built in a rescue phase, but no trial has tested them as a strategy.

Stepping down and "microdosing". There is no trial evidence for microdosing as it is marketed: very small or irregular doses for weight, inflammation or longevity. Lower doses do work, but less well. Daily semaglutide at the lowest dose tested gave 6% loss at a year, against 13.8% at the highest and 2.3% on placebo (O'Neil, Lancet 2018). Stepping down after weight loss holds some of the loss. SURMOUNT-MAINTAIN (441 people, Lancet 2026) followed people for a year after 60 weeks on full-dose tirzepatide. Those who stayed on full dose kept their weight stable, those who stepped down to 5 mg regained about 7% of body

weight, and those switched to placebo regained about 15%. Measured against their weight before any treatment, they ended 21.9%, 16.6% and 9.9% lower. Rescue treatment was needed by 8%, 25% and 67% (reported in The Limbic). A step-down is a reasonable option, with partial regain expected and monitoring in place.

New Zealand: access, cost and equity

Wegovy and Mounjaro are approved in New Zealand for weight management but not funded, so access depends on paying privately with no end date. Obesity rates are set out under Obesity and health, above, and the gaps by ethnicity and deprivation under Equity, below.

Item	Status, late October 2026
Approvals	Wegovy approved March 2025 (Medsafe); Mounjaro approved for weight management, adults only (Medsafe, March 2026)
Pharmac funding for weight	None. Pharmac "cannot say when, or if" Wegovy will be funded (Pharmac)
Proposed criteria if funded	BMI 50+, or BMI 35+ with two or more related conditions; multidisciplinary input; renewal at 6 months only with 10%+ loss (Pharmac advisory group, Dec 2025)
Funded for type 2 diabetes	Dulaglutide and liraglutide, with access widened from 1 September 2026 (Pharmac)
Private cost	Wegovy about $370 to $475 a month; Mounjaro about $430 to $875, plus fees

Equity. Obesity affects 46.9% of Māori adults, 69.5% of Pacific adults and 46.8% of adults in the most deprived areas, against 27.6% in the least deprived (Pharmac advisory record, above). Because stopping predicts regain, people who can afford only a few months are the most exposed to paying, losing weight and regaining it. For many New Zealanders, an intensive behavioural pathway will be the only option, which makes its quality and reach an equity issue in itself.

Safe supply. Buy only through a New Zealand prescriber and pharmacy. Online "research peptides", compounded copies and retatrutide (not approved

anywhere) are unregulated (JAMA Medical News, Oct 2026).

Long-term use: the unknowns and the ethics

Long-term use can be ethical, but only with informed consent that covers what is unknown and mainly in people whose risk clearly justifies it. At best it is long-term management under uncertainty, not a solution.

The drug class has about 20 years of use (exenatide from 2005, liraglutide from 2009), almost all in type 2 diabetes. Semaglutide has been available since 2017 and tirzepatide since 2022. The longest randomised trials of these medicines run 4 to 5 years. Safety monitoring of millions of users catches rare early harms but not slow ones. We do not know the effects of decades of use on bone, muscle and frailty with ageing, on nutrition, in pregnancy, or in adolescents who might start at 14.

Against that, untreated obesity has well-documented long-term harms, and most medicines taken for life were adopted on trials of 3 to 6 years. So the balance depends on the person.

Situation	Balance of benefit and unknown risk
Heart disease, type 2 diabetes with kidney disease, heart failure	Favourable: benefit is proven and the years of exposure are fewer
Prediabetes, severe obesity, serious weight-related illness	Generally favourable, with regular review
Younger, otherwise healthy, modest excess weight	Uncertain: no outcome benefit shown and the longest exposure to unknowns
Adolescents	Most uncertain: specialist care only

Ethical use means consent that names the unknowns, prescribing scaled to risk, the lowest effective dose, regular review (at least every 3 to 6 months), and a supported option to step down. It does not include marketing medication as a risk-free lifelong solution, or prescribing for mainly cosmetic loss without disclosing what is unknown.

What the PREKURE Clinic does

The PREKURE Clinic offers two pathways, chosen together with the person: intensive lifestyle care, or lifestyle care plus medication where risk and benefit justify it. Both work on the causes, not just the weight.

1. **Medical assessment** with a lifestyle-medicine-trained doctor, including blood tests and a frank discussion of the numbers above.
2. **Metabolic map:** a structured assessment of lifestyle, mental health and physical health, so care starts from the person's situation.
3. **A matched PREKURE health coach** working on the strategies below.
4. **Tracking body composition, strength and function,** not just weight.
5. **Regular medication review, at least every 3 to 6 months,** stepping down where safe and planned, with agreed regain thresholds that trigger re-engagement or a restart.
6. **Planned re-engagement** for anyone who regains, on either pathway.
7. **Outcome tracking:** how many people who start keep meaningful weight off at two years and beyond.

Strategy	Why	Evidence
Resistance training at least 3 times a week, plus 150 minutes of moderate activity	Protects muscle, bone and fitness; the only component with randomised evidence of less regain after stopping	Moderate (joint advisory, Obesity 2025; Jensen 2024)
Enough protein, commonly 80 to 120 g a day or about 1.2 to 1.6 g/kg	Food intake falls sharply on the medicine	Expert consensus
Whole, nutrient-dense food; less ultra-processed food	Habits that persist when appetite returns	Consensus; no diet pattern proven best alongside these medicines
Side-effect skills: slow dose increases, small meals, fluids, fibre	Side effects are a leading reason for stopping	Clinical consensus

Strategy	Why	Evidence
Regular self-weighing with an agreed regain threshold	Catches regain early	Moderate: daily weighing halved regain in STOP Regain
Sleep, stress, alcohol, mood and the home and work environment	Drive appetite and adherence	Indirect evidence
Ongoing contact	Slows regain modestly	Moderate (Dombrowski 2014)

Gut health. Eating less food often means eating less fibre, and constipation is common on these medicines, so coaching includes fibre, plant foods and fluids. Whether the medicines change the gut microbiome in ways that matter for health is not yet known. A 2025 systematic review found only nine human studies, none of semaglutide or tirzepatide, and most found no change (Gofron, Nutrients 2025).

Access. Private coaching also costs money. PREKURE reaches people through employers and insurers (including AIA, nib and Southern Cross) as well as self-pay.

What PREKURE will not claim: that our programme lets most people come off medication and keep the weight off; that medication alone is a solution or that long-term use is risk-free; that one pathway works for everyone; that these medicines prevent cancer or dementia; or that trial results are typical in everyday practice.

PREKURE CLINIC

Lifestyle medicine · Metabolic medicine · Behavioural medicine. Online, anywhere in New Zealand.

This page is general information based on published evidence as at November 2026. It is not personal medical advice. Talk with your doctor or a PREKURE Doctor about what is right for you.

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Trial figures are from published abstracts, open full texts or official pages, checked 29 to 30 October 2026. Absolute numbers ("1 in X") are our arithmetic from published event rates.

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