

Beyond Medication



Why sustained weight loss takes more than medicine

A clinical and behavioural case for treating obesity as a managed, longitudinal condition



About this report

Beyond Medication sets out Discovery Vitality’s case for integrated obesity management, arguing that obesity should be treated as a chronic condition requiring sustained, ongoing care rather than a once-off prescription.

Bringing together global clinical evidence, emerging real-world data, and early findings from Discovery’s HealthyWeight programme, the report demonstrates that while the new generation of anti-obesity medicines offers unprecedented efficacy, they deliver the best outcomes when embedded within a structured model of nutrition, physical activity, behavioural coaching, and ongoing clinical follow up, in line with their registered indications.

The report reflects a multidisciplinary collaboration across Discovery Group’s clinical, data science, actuarial, product and marketing teams. Combining leading global evidence with the scale and richness of Discovery’s proprietary data assets and real-world experience, it offers a clinically rigorous and data-driven perspective on the role of integrated obesity management in achieving sustainable health outcomes.

Report structure

- 1

The clinical reality: Why obesity persists

Why obesity is increasingly prevalent, biologically persistent and difficult to reverse; the health and economic burden it creates; and how a new generation of anti-obesity medicines has transformed what is possible in treatment.
- 2

The durability gap: Why the medication alone approach is not sustainable

The growing body of real-world evidence showing why medication alone does not consistently deliver durable outcomes, including early discontinuation, weight regain following discontinuation, loss of lean muscle mass and the erosion of healthy habits that support long-term weight management.
- 3

The integrated response: What delivers sustainable outcomes

Discovery’s evidence on why combining medication with structured behaviour-change support, nutrition guidance, physical activity and ongoing clinical care delivers better outcomes than medication alone, and how the Vitality HealthyWeight programme operationalises this integrated model at scale.



A note on data and methodology

This report synthesises evidence from published clinical literature and proprietary Discovery datasets. The published evidence includes peer-reviewed trial data, systematic reviews, clinical practice guidelines and epidemiological studies, all cited in the reference list. Discovery evidence includes Discovery Health Medical Scheme claims data, Discovery Vitality behavioural, retail and wearable datasets, and early findings from the HealthyWeight integrated care pilot.

All Discovery analyses were conducted on anonymised, aggregated datasets. No individually identifiable member information is included. Where analyses compare groups, results were adjusted for relevant demographic, behavioural, and health-related confounders.

Detailed methodology, cohort definitions, adjustment methods, and analytical limitations for each reported finding are provided in **Appendix A**.

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Executive summary

Obesity is a highly prevalent chronic disease that places a substantial and growing burden on health systems. Globally, one in eight people were living with obesity in 2022, a figure projected to rise to one in five by 2030. South Africa faces an even greater burden: approximately one in two adults are overweight or obese, with prevalence among women surpassing 70%.

The consequences extend far beyond weight itself. Obesity is associated with a higher risk of chronic disease, substantially higher healthcare costs, and a condition trajectory that is difficult to reverse. Discovery's data show a clear gradient in healthcare expenditure, with costs rising by up to 27% among individuals living with obesity relative to healthy-weight individuals. Longitudinal analysis highlights the persistence of the condition: seven in 10 people living with obesity remained obese 15 years later. Together, these findings reinforce the need to treat obesity as a chronic condition requiring sustained, long-term management rather than short-term intervention.

For most of medical history, sustained non-surgical weight loss was largely unattainable. That has changed. A new generation of incretin-based medicines now delivers 12% to 18% average body-weight loss, approaching, for the first time, outcomes previously achievable only through bariatric surgery. Demand has surged accordingly, and the therapeutic pipeline continues to expand. These medicines represent one of the most significant advances in obesity treatment in decades and have expanded what is clinically possible for people living with obesity.

Yet efficacy alone does not guarantee durable outcomes, and this is the central challenge explored in this report. In real-world settings, individuals prescribed anti-obesity medication, often without

structured support, typically discontinue treatment within six months, well before the full clinical benefit is realised and long before the treatment durations seen in landmark clinical trials. The consequences are significant. Approximately two-thirds of weight lost is regained within a year of stopping treatment, while up to 40% of weight lost may be lean mass rather than fat. Without structured support, the habits that underpin long-term success also begin to erode: physical activity levels may decline, and purchasing patterns may shift away from nutrient-dense foods such as fruit, vegetables and legumes towards more convenient, less nutritious alternatives.

Discovery's data points to a clear conclusion: the long-term value of these medicines depends on the model of care in which they are delivered. Early findings from the Vitality HealthyWeight pilot show that when medication is supported by nutrition coaching, exercise reinforcement and digital support, these drop-offs in health outcomes and behaviour can be resisted. The number of members who reached their weekly Vitality Active Rewards physical activity goal increased from 50% to 67%, while physical activity levels increased by 38%. Members increased their spending on healthy foods by 46% without increasing overall grocery expenditure, while first-month weight loss increased progressively with dietitian engagement from less than 1% among members with no engagement to 6.5% among those engaging daily.

The case in numbers



1 in 2

South African adults were overweight or obese in 2024

70%

of those living with obesity remained obese 15 years later

6 months

average treatment duration on GLP-1 or GIP/GLP-1 medicines

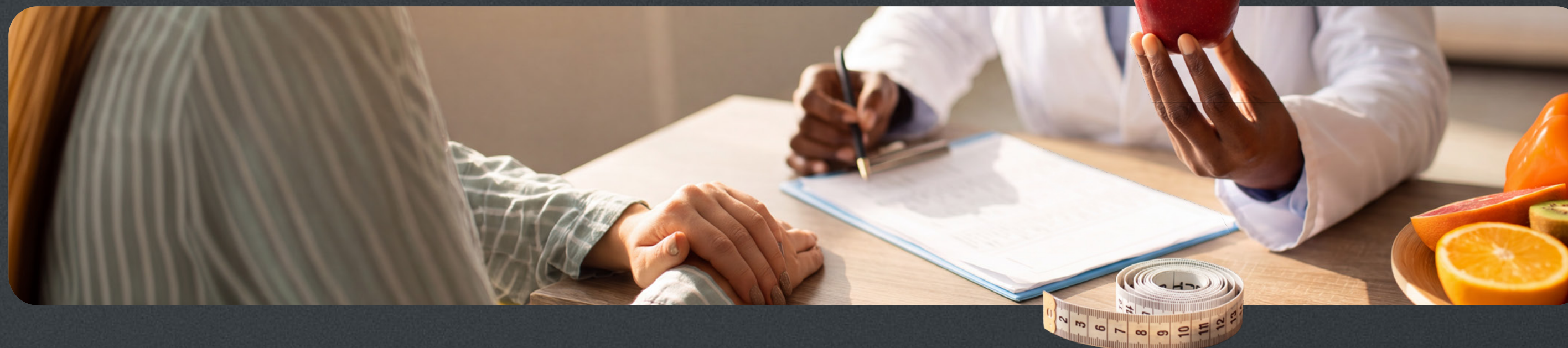
46%

increase in healthy food spend among HealthyWeight pilot participants



In response, Discovery Vitality has developed the Vitality HealthyWeight programme. It is an integrated obesity management model that combines medication with nutrition support, behavioural coaching, physical activity and ongoing clinical follow-up, delivered through Vitality's behaviour-change platform. Designed to treat obesity as a chronic condition requiring long-term management, the programme aims to translate the clinical potential of new medicines into more durable health outcomes through sustained behaviour change, clinical support and ongoing engagement.

These medicines have changed what is possible in obesity treatment. The challenge now is sustaining their benefits over time.



Foreword

There are moments in healthcare when scientific advances redefine what is possible. Obesity care is at one of those moments. For decades, people living with obesity were told to eat less and move more. The advice was not wrong, but it was incomplete. It underestimated the biology of weight, the persistence of the condition and the difficulty of sustaining change without structured support.

Medicine may be necessary; but integrated support is what helps sustain durable health outcomes.

The scale of the challenge is now impossible to ignore. One in two South African adults are overweight or obese, and among women the figure exceeds 70%. Discovery's own longitudinal data show how persistent the condition becomes once established: seven in 10 people living with obesity remained obese 15 years later. The persistence of obesity reflects the biology of a chronic condition, not a lack of motivation. Its consequences extend across individuals, families, employers and the healthcare system.

The new generation of anti-obesity medicines has changed the clinical frontier. For the first time, non-surgical treatment can produce levels of weight loss approaching those previously associated with bariatric surgery. That is a genuine breakthrough. The harder task is helping people sustain the health gains they achieve.

We recognise that the cost of newer anti-obesity medicines remains a significant barrier to access for many people. Encouragingly, increased competition and the introduction of lower-cost alternatives in South Africa and globally are beginning to improve affordability. This may support broader access to treatment and more sustainable long-term treatment as obesity care continues to evolve.

This report makes the case that medication alone is not enough. In the real world, treatment often stops too early, healthy habits do not automatically improve and the quality of weight loss matters as much as the quantity.

The opportunity now is to move beyond medication and build obesity care around the person.

That means clinical assessment, nutrition support, physical activity, behavioural coaching and ongoing engagement delivered as one integrated model. It also means treating obesity with the same seriousness and continuity we apply to other chronic conditions.

Vitality's HealthyWeight programme is Discovery's response to this evidence. It draws on more than two decades of behaviour-change experience and combines it with the new clinical possibilities created by modern obesity medicine. The ambition is to help more people achieve durable improvements in health in a way that creates shared value for members, employers, healthcare professionals and the broader healthcare system.

This paper is therefore both an evidence review and a call for a higher standard of obesity care. It describes a model that is clinically led, behaviourally informed and built for durability. If we get this right, the breakthrough will not be measured only in kilograms lost, but in health maintained over time.

Dinesh Govender,
Discovery Vitality
CEO



Introduction: why obesity, why now

The question is no longer whether obesity deserves attention. It is whether we intervene early enough, and support people for long enough, to change its trajectory.

Obesity is a chronic, relapsing condition that influences health across multiple disease pathways. It raises the risk of type 2 diabetes, hypertension, cardiovascular disease, several cancers and depression, while interacting with other risk factors in complex and compounding ways.

Its effects also extend across other pillars of health. Poor sleep increases the risk of obesity, while obesity in turn contributes to conditions such as obstructive sleep apnoea, a relationship explored in Discovery's *The Sleep Factor* white paper.

Treating obesity effectively, therefore, improves far more than a number on a scale; it has the potential to influence health outcomes across multiple dimensions of wellbeing.

For decades, the central challenge in obesity care was efficacy. Lifestyle interventions alone typically produced modest average weight loss, while the most effective treatment (bariatric surgery) was invasive, costly and accessible to relatively few people. The emergence of a new generation of incretin-based anti-obesity medicines has fundamentally changed that equation. These therapies can deliver levels of weight loss previously achievable only through surgery, making clinically meaningful weight reduction possible at a scale never before seen in obesity care.

Yet as one challenge has been addressed, another has emerged. These medicines are highly effective, but long-term outcomes depend on more than weight loss alone. Real-world persistence remains low, the quality of weight lost matters as much as

the quantity, and the behaviours that underpin long-term health do not automatically improve with treatment. The opportunity, and responsibility, is to build models of care that translate a powerful clinical intervention into durable health outcomes.

The long-term success of obesity treatment depends on the ability to build and sustain healthier habits. Through its behaviour-change platform, Vitality has spent more than two decades helping members achieve exactly that. The Vitality HealthyWeight programme extends this approach to obesity management, combining innovative medicines with the support needed to deliver more durable outcomes.

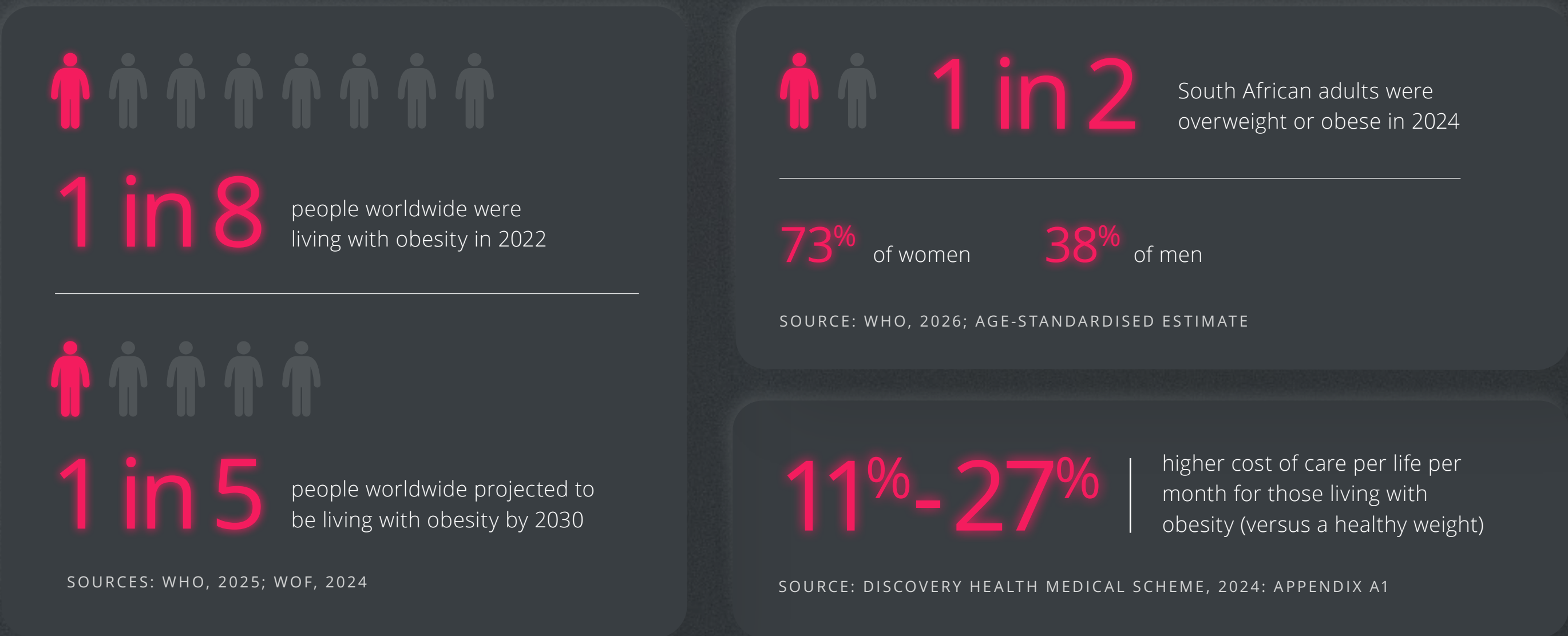


SECTION 01

Obesity is common, costly, and difficult to reverse

Obesity is a growing health challenge worldwide, with significant clinical and economic consequences. Globally, one in eight people were living with obesity in 2022, and current trajectories suggest that figure could rise to one in five by 2030. South Africa faces an even greater burden, with approximately one in two adults classified as overweight or obese in 2024. The prevalence is particularly high among women, affecting 73%, compared with 38% of men. These patterns have important implications for population health and highlight the need for prevention and treatment strategies that reflect the populations most affected.

The burden at a glance



The clinical burden of obesity is matched by its economic impact. Discovery's data show a clear gradient in healthcare expenditure, with the cost of care 11% to 27% higher for individuals living with obesity relative to those at a healthy weight.

The window for reversal is real, but it narrows

Obesity is difficult to reverse, but not uniformly so. Discovery's longitudinal analysis of Vitality members who completed Vitality Health Checks in both 2010 and 2025 shows that 70% of people living with obesity remained obese 15 years later, highlighting the persistence of the condition once established.

At the same time, around half (48%) of those who were overweight returned to a healthy weight over the same period. Opportunities for reversal exist, but they diminish as excess weight becomes more entrenched, reinforcing the importance of early intervention.

SOURCE: DISCOVERY VITALITY, 2010 - 2025: APPENDIX A2



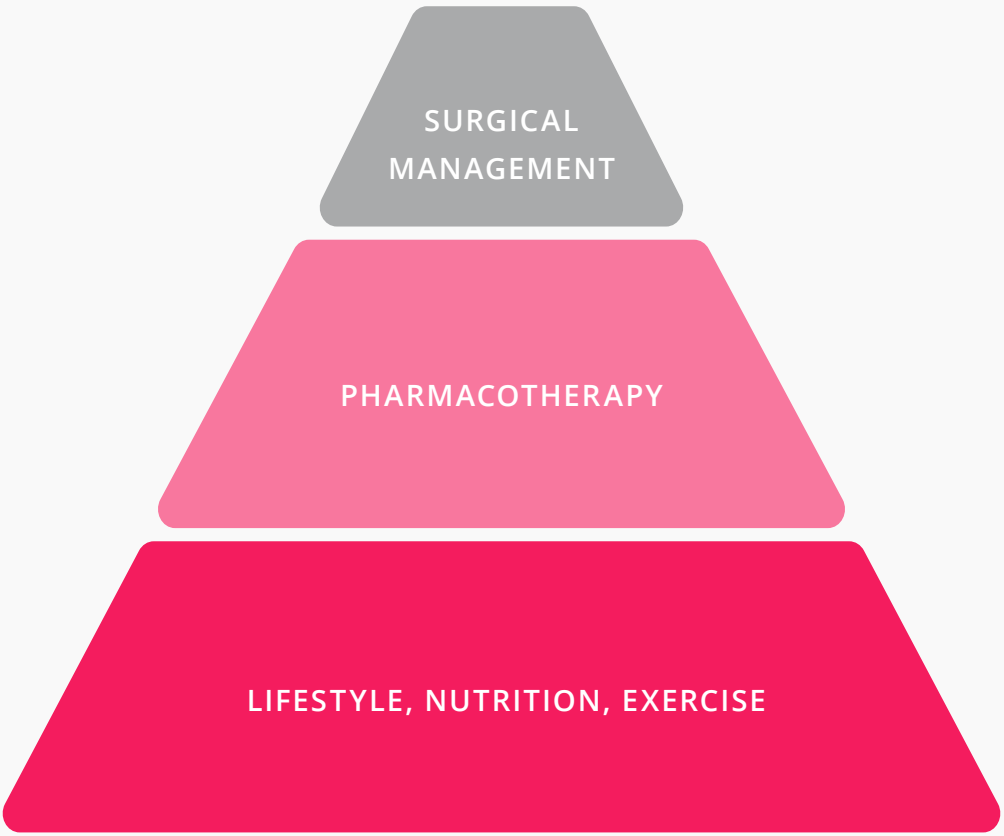
SECTION 02

New anti-obesity medicines have changed what is possible

For the first time, non-surgical treatment is approaching surgical levels of weight loss efficacy. The treatment of obesity is at an inflection point. For most of medical history, the therapeutic landscape followed a clear hierarchy: lifestyle interventions formed the foundation, producing modest average weight loss for most individuals; a limited range of medicines offered incremental benefit; and bariatric surgery remained the only intervention capable of delivering substantial and sustained weight reduction. The emergence of a new generation of incretin-based anti-obesity medicines, including GLP-1 receptor agonists and dual GIP/GLP-1 receptor agonists, has fundamentally changed that landscape, bringing levels of weight loss previously associated with surgery within reach of pharmacological treatment.

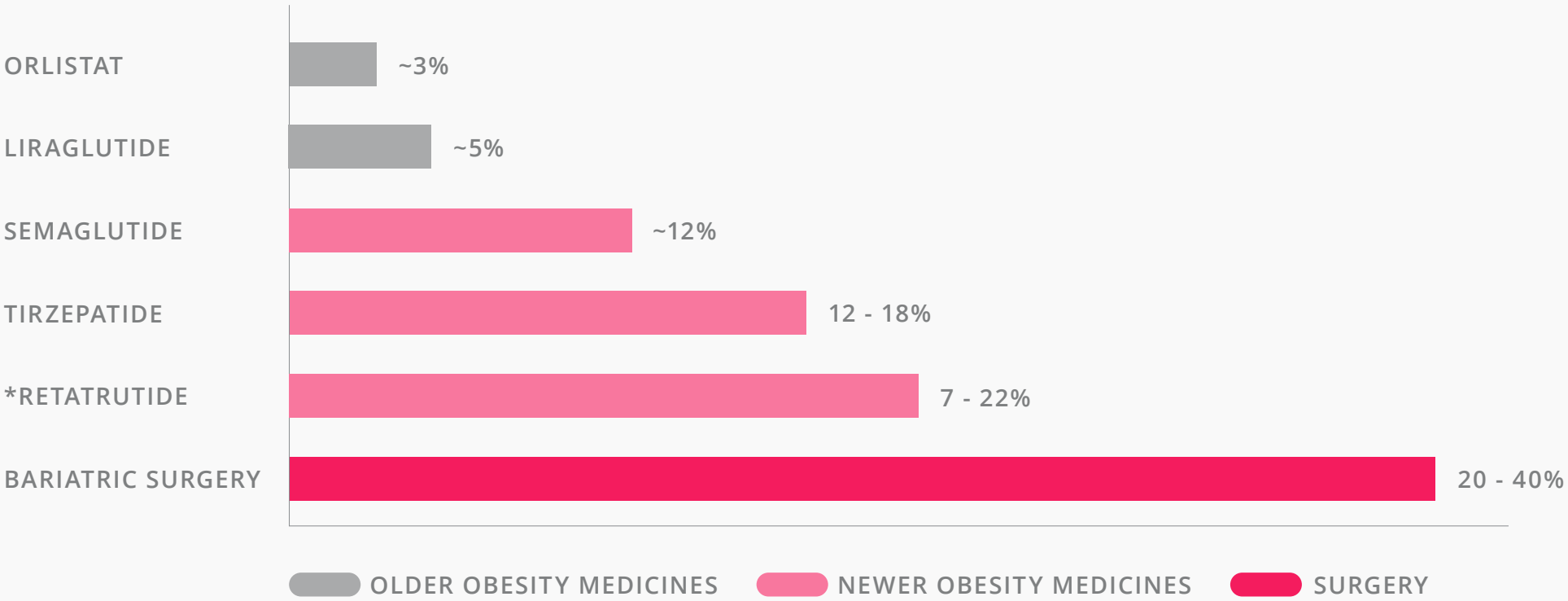
A step change in efficacy

The difference between older and newer generations of anti-obesity medicines is substantial. Established therapies such as orlistat and liraglutide typically achieve average weight loss of 3–5%. In contrast, newer incretin-based therapies such as semaglutide and tirzepatide deliver average weight loss of approximately 12–18%, with next-generation agents such as retatrutide demonstrating even greater reductions in clinical trials. These results increasingly overlap with those historically associated with bariatric surgery, marking a step change in what can be achieved through pharmacological treatment.



Lifestyle, nutrition, and exercise remain the foundation across all tiers; treatment intensity rises with clinical need.

TYPICAL MEAN % BODY-WEIGHT LOSS



Weight loss efficacy figures for individual anti-obesity medicines are average values from published trials, after subtracting placebo effects, and will vary by population, dose, and duration.

*Retatrutide remains an investigational medicine and has not yet received regulatory approval for clinical use.

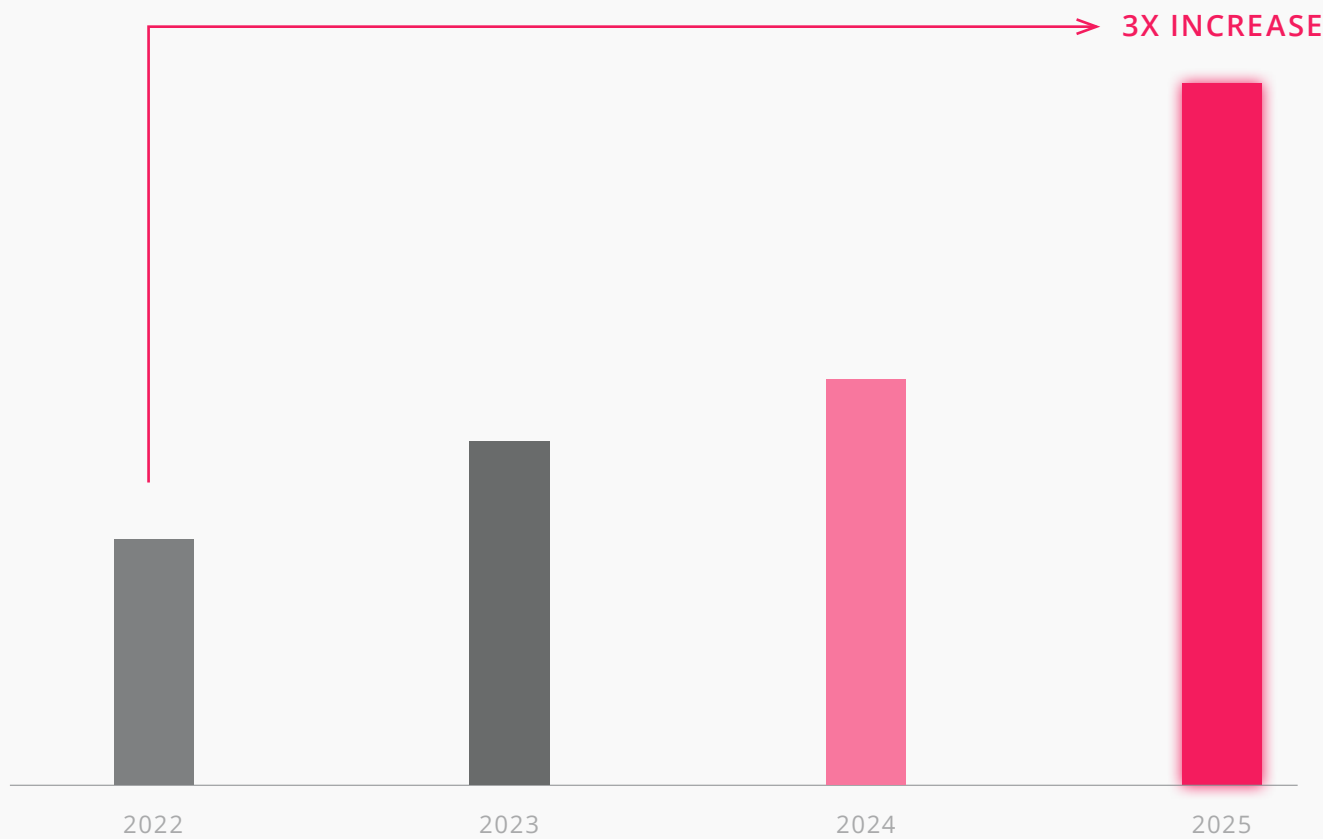
SOURCE: BIERTHO ET AL., 2020; JASTREBOFF ET AL., 2023; PEDERSEN ET AL., 2025

SECTION 02

Demand is surging, and the pipeline is expanding

Uptake has risen in step with efficacy. The number of people using these medicines has increased approximately threefold between 2022 and 2025, reflecting growing awareness, expanding availability, and the unprecedented outcomes achieved by newer incretin-based therapies. Additional agents are expected to enter the market in the coming years, and demand is likely to continue growing. The challenge is no longer access to effective treatment; it is about ensuring that treatment is delivered within a model of care capable of translating weight loss achieved with medication into sustained, long-term health outcomes.

NUMBER OF GLP-1 CLAIMANTS PER YEAR



SOURCE: DISCOVERY HEALTH MEDICAL SCHEME, 2022 - 2025: APPENDIX A3

Expert perspective:
obesity is biologically
regulated, not
simply chosen

Prof Carel le Roux,
University College
Dublin, Ireland



Obesity is still too often understood as a simple consequence of eating too much and moving too little. Modern research shows a more complex reality. Body fat is regulated by a biological system that works to keep energy stores within a defended range, much as the body regulates temperature or blood glucose. The body continuously monitors signals related to food intake, energy stores and body fat. Hormones such as leptin, produced by fat tissue, communicate these signals to subcortical brain areas that coordinate hunger, satiety, metabolism and energy use. Together, these systems help maintain a relatively stable amount of body fat over time.

When people lose weight, especially through calorie restriction, the body often responds

as if energy stores are under threat. Hunger increases, satiety decreases and metabolism slows to conserve energy. These compensatory adaptations make further weight loss difficult and increase the likelihood of weight regain, even among highly motivated individuals.

Obesity may develop when the body establishes a higher fat-mass set point. One possible contributor is inflammation in subcortical brain areas that leads to leptin resistance, where the brain becomes less responsive to leptin's signals. The body may then behave as though energy stores are insufficient, promoting increased food intake and reduced energy expenditure even when excess body fat is present.

Modern obesity treatments aim to address these underlying biological mechanisms. Newer medicines and metabolic-bariatric surgery do more than reduce calorie intake.

They alter hormonal signalling, improve appetite control and weaken the body's usual defences against weight loss, making it easier for the body to maintain balance at a lower level of fat mass.

“Many patients also describe a reduction in persistent food-related thoughts, often referred to as “food noise”.”

Current evidence suggests that effective obesity medicines and metabolic-bariatric surgery can both produce weight reductions approaching 30% in selected patients. Importantly, these treatments may help establish a new, lower fat-mass set point that can be maintained over time, provided treatment and support are sustained.

Understanding obesity as a chronic biological disease, rather than a failure of willpower, can help patients and clinicians approach treatment differently. It reinforces the need for ongoing care and supports continued research into improving leptin sensitivity, preserving muscle mass and developing more effective and sustainable obesity therapies.

This biological framing helps explain why obesity requires sustained treatment and why pharmacotherapy should be understood as part of long-term chronic care, not as a short-term intervention.

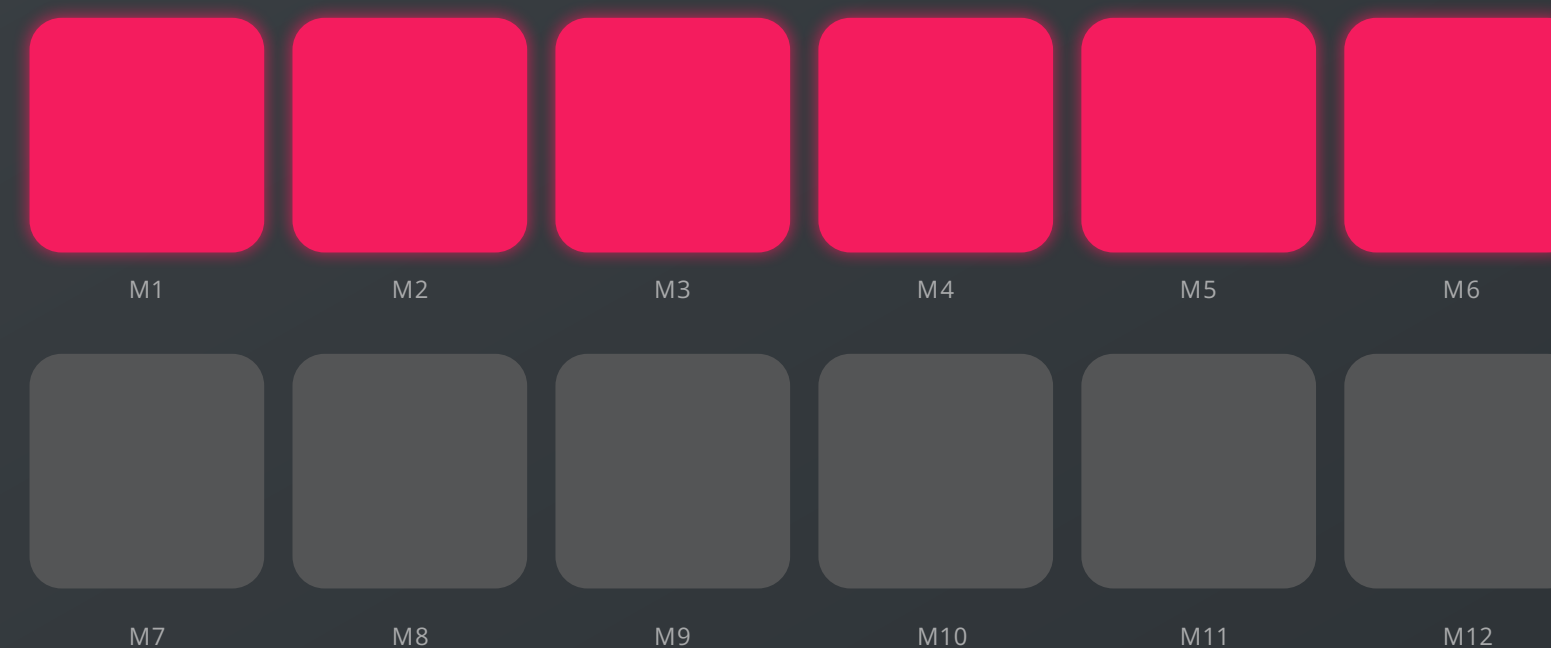
SECTION 03

The sustainability gap: why medication alone is not enough

Achieving weight loss is becoming increasingly possible. Sustaining it remains the greater challenge. The clinical trials that established the efficacy of these medicines followed participants for 48 weeks or longer, within structured care environments. Real-world treatment journeys look very different. One of the strongest predictors of long-term outcomes is whether people remain on treatment long enough to realise its full benefit. External real-world evidence indicates that adults prescribed incretin-based anti-obesity medications often discontinue treatment within approximately six months, substantially shorter than the duration of landmark clinical trials. In a large real-world cohort study, the median initial treatment duration among patients who discontinued therapy was 176 days (5.8 months). Discovery's internal data indicates that members who use GLP-1s stop claiming for them on average after 5.4 months.

It is after discontinuation that the risks of weight regain, unfavourable changes in body composition and the erosion of healthy habits begin to emerge.

The gap between short-term weight loss and sustainable outcomes



6 months

average treatment duration on GLP-1 or GIP/GLP-1 medicines

vs. 48 weeks or more (11+ months)

Typical follow-up period in landmark clinical trials of these medicines

SOURCE: RODRIGUEZ ET AL., 2025; JASTREBOFF ET AL., 2023

65%

of adults living with overweight or obesity prescribed GLP-1 receptor agonists discontinued treatment within a year

SOURCE: RODRIGUEZ ET AL., 2025



SECTION 03

Four ways medication alone falls short

1 Erosion of healthy habits

Perhaps most importantly, medication alone does not necessarily strengthen the behaviours that underpin long-term health. Discovery’s data show that approximately 13% of previously active Vitality members stopped regular exercise in the months after initiating GLP-1 therapy. Grocery purchasing data reveal a similar pattern, with spending shifting away from fruit, vegetables and legumes and towards convenience foods and protein products. Appetite suppression may reduce how much people eat, but it does not automatically improve what they eat.

SOURCE: DISCOVERY HEALTH MEDICAL SCHEME AND DISCOVERY VITALITY, 2019 - 2025 AND 2025: APPENDIX A4 AND A5

2 Loss of lean muscle mass

Weight loss is not synonymous with fat loss. Evidence suggests that up to 25–40% of weight lost during GLP-1 therapy may be lean mass (including muscle), particularly in the absence of adequate protein intake and resistance training. Preserving muscle is important for metabolic health, physical function and long-term weight maintenance, making body composition as important as the number on the scale.

SOURCE: MOCCIARO ET AL., 2025

3 Early discontinuation

Persistence remains a major challenge in real-world obesity care. Many patients discontinue treatment within the first year, with drop-off beginning as early as three months after initiation. Factors including cost, side effects, supply constraints and the absence of structured support can all contribute to discontinuation before the full clinical benefit has been realised.

SOURCE: DO ET AL., 2024

4 Weight regain

Weight loss achieved during treatment is often difficult to maintain after discontinuation. Studies suggest that nearly two-thirds of weight lost is regained within a year of stopping treatment. Weight regain is also associated with reversal of many of the cardiometabolic gains achieved during weight loss. Evidence shows that markers such as blood pressure, glycaemic control and lipid profiles return towards baseline, often within 1 to 1.5 years of treatment cessation. Without the behavioural, nutritional and clinical support that helps sustain healthy habits, weight loss may prove difficult to maintain over the longer term.

SOURCE: BUDINI ET AL., 2026; WEST ET AL., 2026



SECTION 03

Healthier weight does not always mean healthier habits

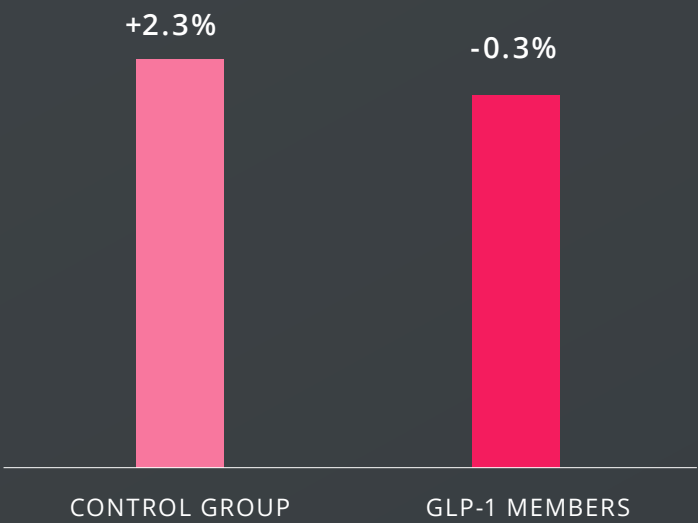
Discovery's grocery data illustrate this challenge. Among members using GLP-1 medication without coaching or structured support, overall grocery spending remained largely unchanged, but purchasing patterns shifted in less favourable directions. Spending on convenience meals and protein products increased, while spending on fruit, vegetables, legumes and other nutrient-dense foods declined. The finding highlights an important distinction. Medication can reduce appetite and facilitate weight loss, but it does not automatically establish the behaviours associated with long-term health. Improving the quality of the diet requires a different intervention: structured behavioural and nutritional support.

Grocery basket on medication alone (no coaching)

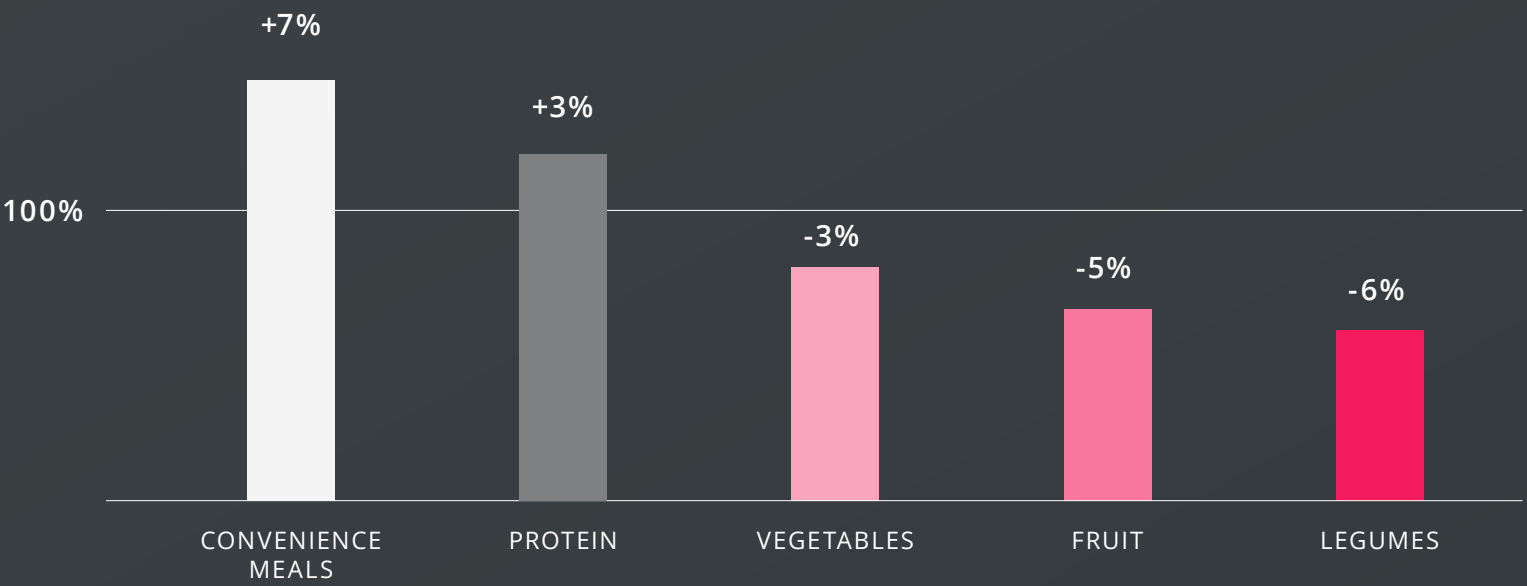
Total grocery spend remains broadly unchanged, but the composition of the basket shifts:

- ↑ CONVENIENCE MEALS, PROTEIN
- ↓ FRUIT, VEGETABLES, LEGUMES

TOTAL FOOD SPEND
Indexed change in average monthly spend per member, six months before and six months after GLP-1 treatment



LIMITED CATEGORIES
Indexed food spend 6 months pre vs. 6 months post GLP-1 treatment

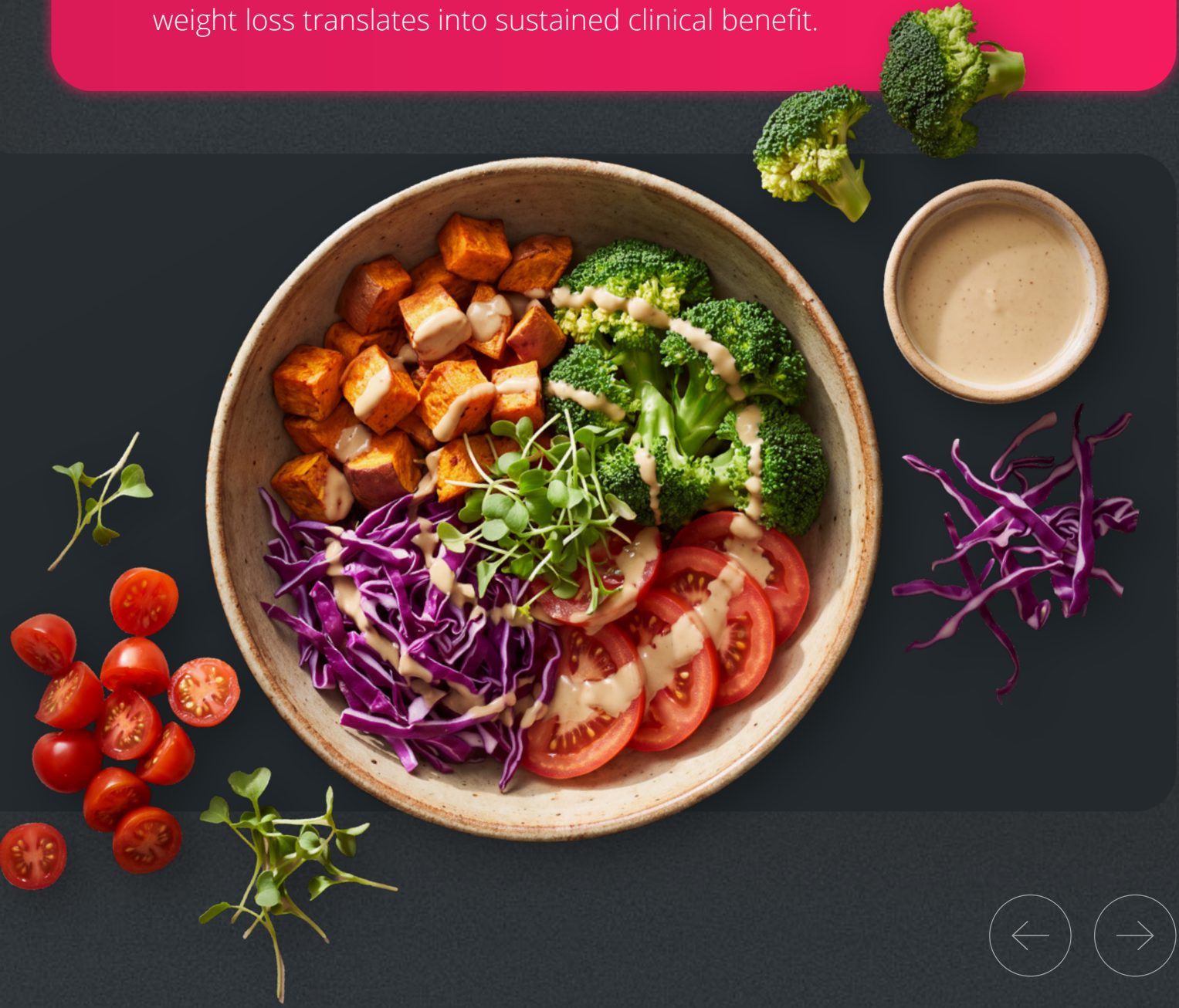


SOURCE: DISCOVERY HEALTH MEDICAL SCHEME AND DISCOVERY VITALITY, 2025: APPENDIX A5

Why this matters in clinical practice

Clinical guidance is converging on a common principle: anti-obesity medicines are most appropriately used as part of a structured model of obesity care, not as standalone prescriptions. The medicine addresses important biological drivers of obesity, but it does not, on its own, provide the practical support many people need to improve diet quality, increase physical activity, preserve lean muscle mass, manage side effects, remain engaged with treatment, and plan for maintenance over time.

This is the role of wraparound care. The objective is not to imply that meaningful weight loss alone will automatically translate into durable health outcomes, but rather to create the conditions that make those outcomes more likely: clinical oversight, nutrition guidance, behaviour change support, physical activity reinforcement, and longitudinal follow-up. In this model, medication creates the opportunity for meaningful weight loss, while integrated care helps members use that opportunity to improve dietary quality, increase physical activity, sustain health-enhancing behaviours, and maximise the likelihood that weight loss translates into sustained clinical benefit.

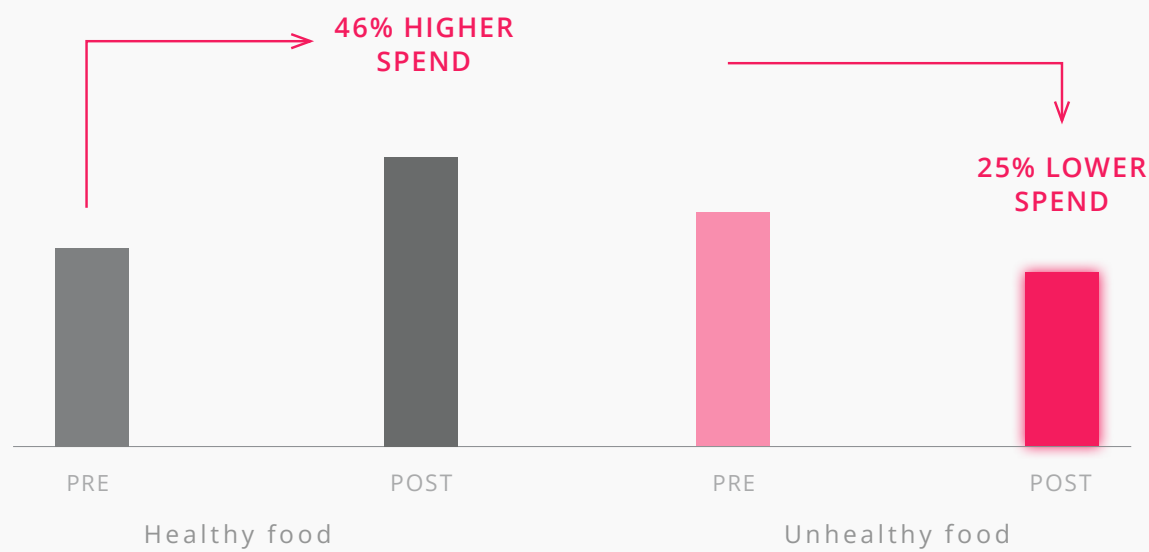


SECTION 04

Early real-world results: behaviour changes within weeks

To test this integrated model in practice, Vitality launched an early pilot of the HealthyWeight Medicated Programme. The pilot extended the existing HealthyWeight offering by introducing a multidisciplinary model of care that combined medical assessment, dietitian-led nutrition support and ongoing behavioural coaching. Members underwent a structured clinical assessment, including baseline pathology testing and a doctor’s consultation, to determine the most appropriate treatment plan and, where clinically appropriate, eligibility for anti-obesity medication. The programme combined clinical care, nutrition guidance, physical-activity reinforcement and behaviour-change support within a single care pathway designed to help translate the clinical potential of anti-obesity medication into more durable health outcomes.

FOOD SPEND 3 MONTHS PRE VS. 3 MONTHS POST PILOT

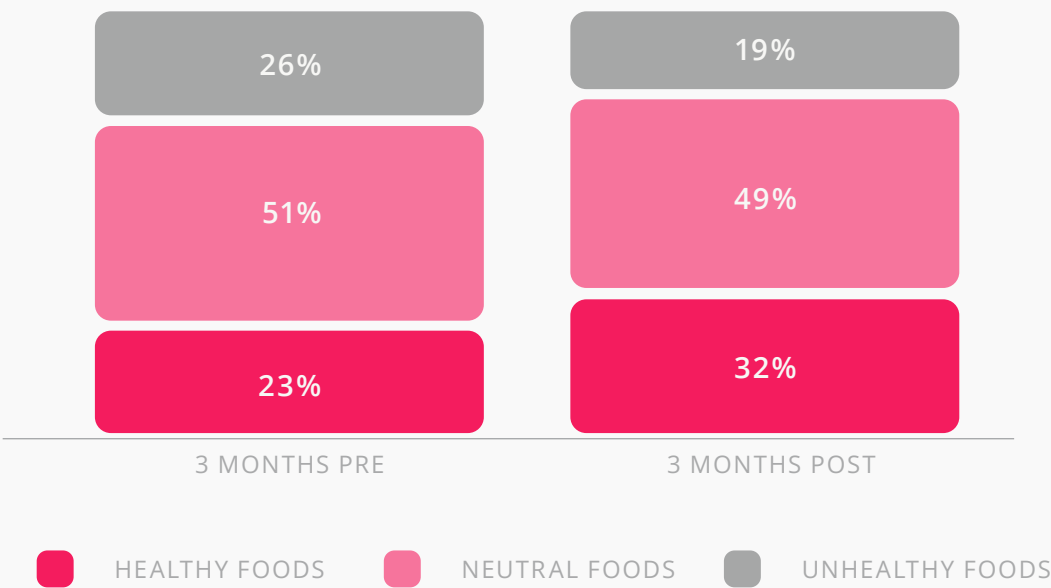


SOURCE: DISCOVERY VITALITY, 2026: APPENDIX A6

In the Vitality HealthyWeight pilot, structured support was associated with early improvements in diet quality. Compared with the three months before enrolment, members’ food choices in the first three months of the pilot shifted towards more nutritious options: purchases of healthy foods increased by 46%, while purchases of unhealthy foods decreased by 25%.



BASKET COMPOSITION 3 MONTHS PRE VS. 3 MONTHS POST PILOT



SOURCE: DISCOVERY VITALITY, 2026: APPENDIX A6

The overall grocery basket size remained broadly stable, but its nutritional profile improved, with healthy foods increasing from 23% to 32% of the basket and unhealthy foods falling from 26% to 19%. These emerging one-month results, drawn from an initial cohort of 55 members, suggest that appetite suppression can be directed towards better nutrition quality when medication is delivered with structured behavioural and nutritional support.

A similar pattern emerged for physical activity, with structured support associated with early increases in movement and goal completion. The number of individuals who reached their weekly Vitality Active Rewards physical-activity goal rose from **50% to 67%**, while weekly

physical-activity points increased by 38% - **equivalent to an additional 5,000 or more steps three times a week**. These changes suggest that healthier behaviours can begin to strengthen within weeks of programme initiation, even as members adjust to medication, side

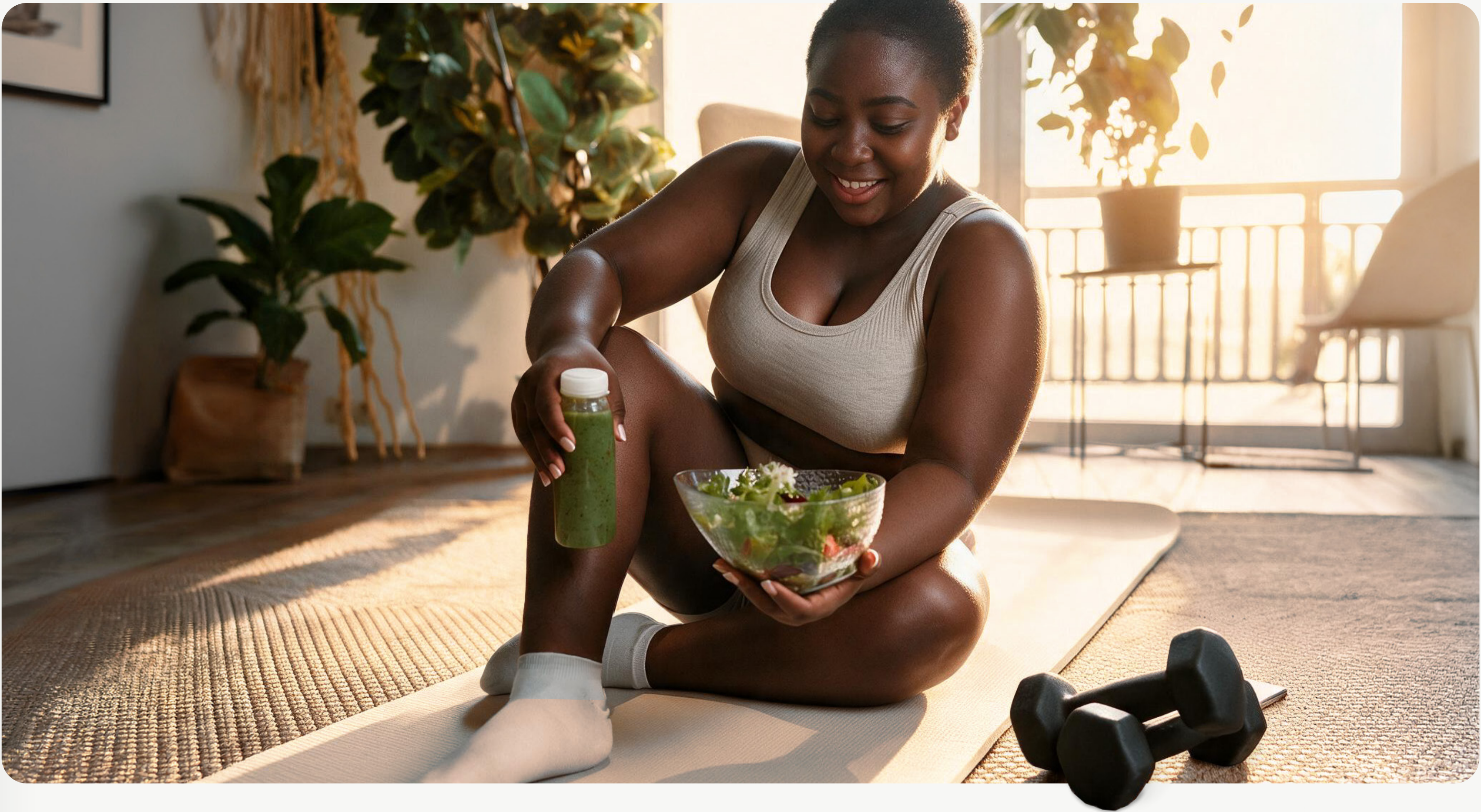
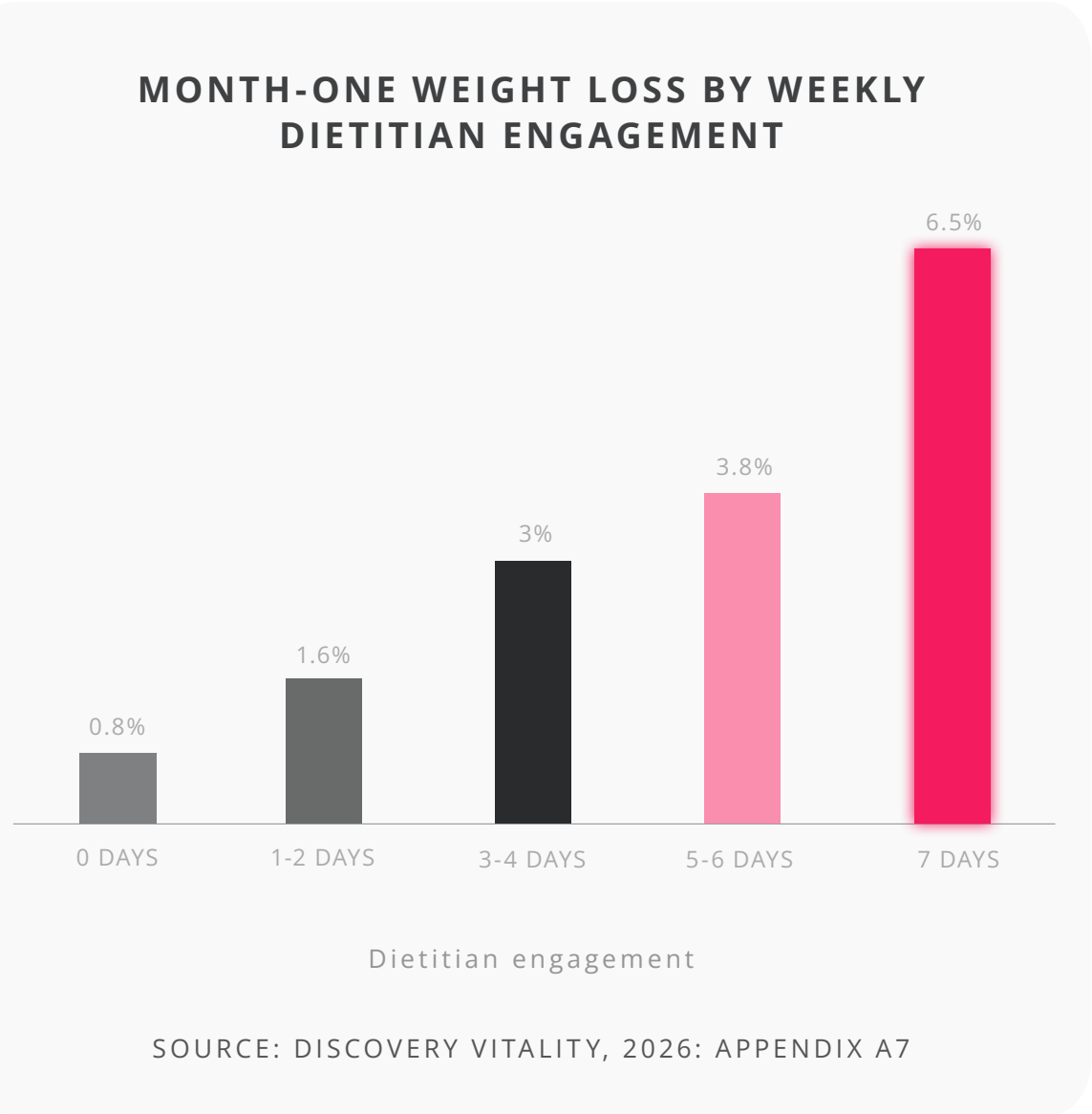
effects and new eating patterns. The strongest early clinical signal, however, was seen in the relationship between dietitian engagement and first-month weight loss.

SOURCE: DISCOVERY VITALITY, 2026: APPENDIX A6

SECTION 04

Month-one weight loss increased progressively with dietitian engagement.

Members who engaged daily lost 6.5% of body weight in the first month, compared with 0.8% among members with no dietitian engagement. Although preliminary, the dose-response pattern is consistent: greater engagement with structured nutritional support was associated with greater early weight loss.



Taken together, the pilot findings are directionally consistent with the broader evidence in this report. Anti-obesity medicines create the conditions for clinically meaningful weight loss, but the quality and durability of that weight loss depend on the behaviours and clinical support that accompany treatment.

Improvements in diet quality and physical activity, together with sustained engagement in behavioural coaching, are therefore not ancillary to pharmacotherapy; they are part of how its health benefits are realised. This clinical logic informs the Vitality HealthyWeight model described in the next section.

SECTION 05

Vitality HealthyWeight: translating evidence into an integrated model of obesity care

A clinically led model for turning weight-loss into sustainable health outcomes.

Vitality HealthyWeight is Discovery Vitality's integrated obesity-management programme, designed from the principles set out in this report. It is clinically led, behaviourally informed and built to support sustainable weight loss and metabolic health, rather than short-term weight reduction. The programme combines dietitian-led nutrition coaching, structured digital support, practical meal planning, rewards, physical-activity reinforcement and medical oversight where clinically appropriate. Its defining feature is that it is care led, not medication led.

Pharmacotherapy, when used, is adjunctive to the broader intervention. HealthyWeight has two pathways. The non-medicated pathway provides intensive dietitian coaching, behaviour-change support, personalised meal plans, recipes and lifestyle support for members who want structured weight-management support without medication, or for whom anti-obesity medication is not clinically appropriate. The medicated pathway builds on the same behavioural and nutrition foundation, adding medical assessment and ongoing monitoring where clinically appropriate, including for members who enter the programme with an existing prescription.

The HealthyWeight Medicated Programme

The medicated HealthyWeight pathway starts with clinical eligibility and moves through a structured activation sequence before longitudinal care begins. The aim is to ensure that

medication, where used, is introduced only after appropriate assessment and within the same behavioural and nutritional model that supports durability of weight loss.

01

Eligibility screening

Validated BMI values of 27 and above, unlock access to the medicated journey

02

Introductory dietitian call

Programme orientation, clinical and lifestyle context, and discussion of whether medication assessment should proceed

03

Pathology testing

Baseline testing to inform clinical review and identify contraindications or risks requiring medical input

04

Virtual clinical assessment with a doctor

Review of medical history, comorbidities, medication history, pathology and clinical appropriateness of medical therapy or anti-obesity medication

05

HealthyWeight onboarding

Activation of the longitudinal care journey, with nutrition coaching, behavioural support and ongoing monitoring

HealthyWeight delivers a structured model of obesity care that combines clinical assessment, nutrition support, behaviour change and longitudinal follow up. Where appropriate, pharmacotherapy is incorporated as one component of a comprehensive care pathway.



SECTION 05

Expert perspective: telemedicine can extend obesity-care expertise without replacing primary care

Dr Fatima Cody
Stanford, Associate
Professor of Medicine
and Pediatrics, Harvard
Medical School



or to make time for frequent in-person visits while managing work, family and other clinical appointments. Telemedicine is one practical way to close that distance, connecting patients to evidence-based counselling and, where appropriate, enabling pharmacotherapy to be initiated and monitored while patients remain connected to their usual care team.

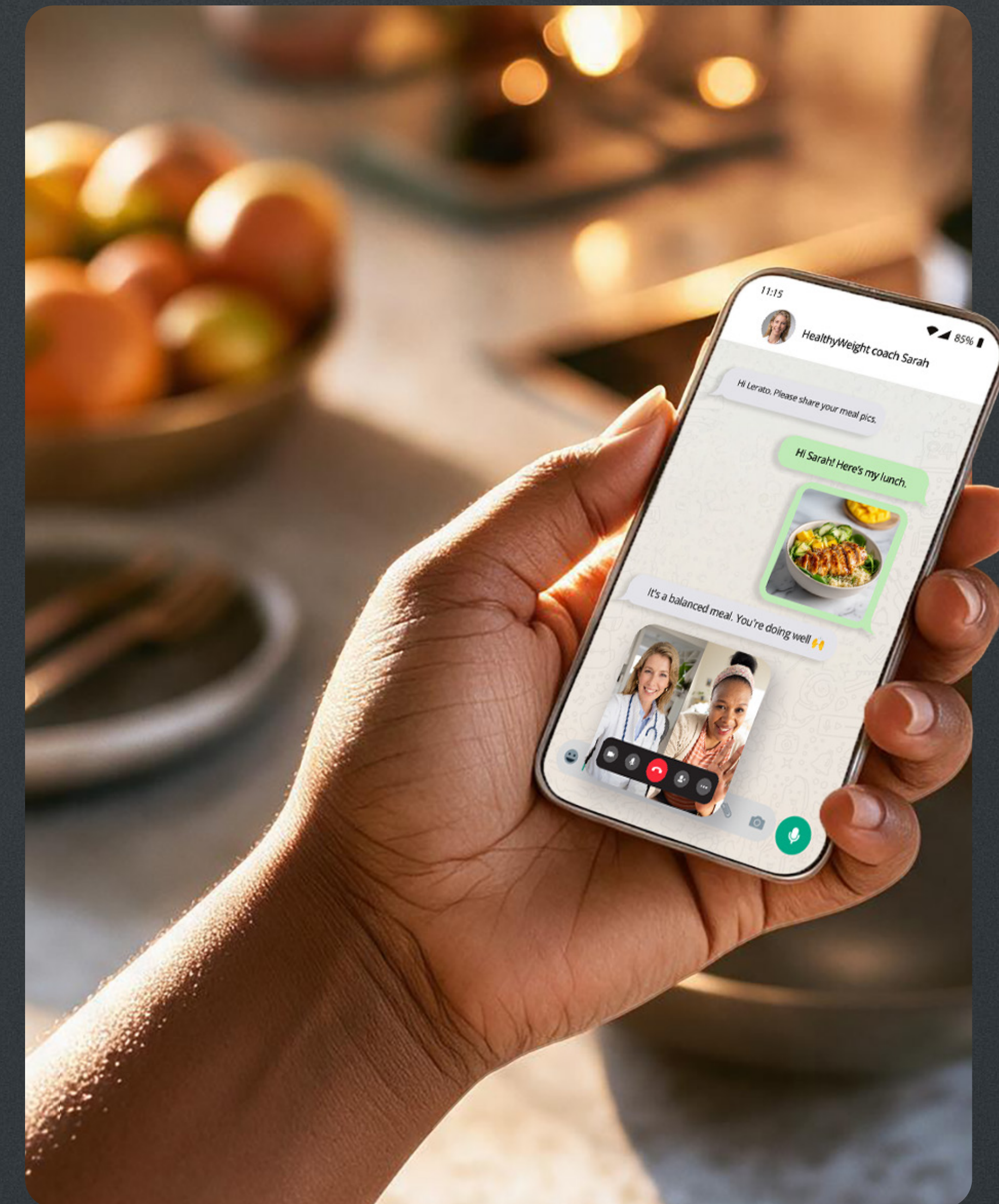
South Africa's HPCSA Telehealth Guidelines were built on a similar logic: delivering care at a distance to underserved communities, alleviating the human-resource crisis and improving links between developed facilities and underdeveloped, often rural, areas. The guidelines are equally clear that telehealth is best practised where an existing practitioner relationship already exists, rather than as a substitute for one, and that treatment based solely on an online questionnaire does not meet the standard of care. That distinction matters in obesity care. Virtual services should extend expertise without displacing the primary

care provider, who remains central to continuity, comorbidity management and overall coordination of care.

Three practical lessons follow. First, virtual obesity programmes require governance: South Africa's first national clinical guideline for adult obesity recommends GLP-1 agonists only as part of a comprehensive plan that includes behavioural therapy, nutrition support and long-term follow-up. Their value depends on virtual programmes delivering that model, not medication alone. Second, patient selection should account for more than BMI. Obesity is not currently included among the conditions covered as Prescribed Minimum Benefits, so selection should match patients to treatments they can realistically sustain. Third, continuity must be planned deliberately. A responsible programme needs a plan for continued support and clear hand-back to primary care if medication access changes, so patients are not pushed toward falsified products marketed outside the regulated supply chain.

As lower-cost options arrive, the access gap should narrow. Until then, telemedicine built around the primary care relationship is one of the clearest ways to extend equitable obesity care now.

This shared-care framing is directly relevant to South Africa, where obesity-medicine expertise is still developing and virtual care can extend access without displacing the clinician who remains responsible for continuity of care.



Implications for practice

Realising the value of the new anti-obesity medicines requires coordinated action across clinical practice, care delivery and member support. The evidence in this report points to a clear implication: obesity treatment should be designed around durability, not initial weight loss alone.



For clinicians

1

Invest in continued professional development and upskilling in obesity management, including clinical assessment, appropriate use of anti-obesity medicines, nutrition, behaviour change and the management of obesity-related comorbidities.

2

Prescribe anti-obesity medicines within a broader model of care, not as standalone scripts, with nutrition, physical activity, behavioural support and follow-up built in from the start.

3

Be open to shared-care models, including virtual care where appropriate, that extend access to obesity-medicine expertise without displacing the patient's primary care provider or treating doctor. This clinician remains central to continuity, comorbidity management and escalation when clinical complexity falls outside the obesity-care pathway.

For members and individuals

1

Approach obesity care as the management of a chronic health condition, rather than a short-term weight-loss effort. As with many chronic conditions, effective treatment and support often need to be sustained over time.

2

Seek care from experienced professionals with expertise in obesity medicine, who can provide comprehensive support that includes clinical assessment, nutrition guidance, physical activity, behavioural coaching and ongoing follow-up.

3

Stay engaged with structured support over time. The early HealthyWeight findings suggest that greater engagement with coaching and follow-up is associated with stronger early outcomes.

For employers and the broader system

1

Recognise obesity as a chronic health condition that affects workforce health, productivity and long-term wellbeing, rather than a short-term lifestyle issue.

2

Connect employees with credible programmes that manage obesity holistically, combining clinical oversight, nutrition, physical activity, behavioural coaching and ongoing follow-up, including virtual care where appropriate.

3

Raise awareness of, and where feasible support access to, behavioural programmes that help sustain results. This can include education, navigation, coaching and outcome tracking alongside clinical care.

Anti-obesity medicines can help people lose weight. Integrated care is what helps turn that weight loss into durable health outcomes.

APPENDIX A

Data sources, methodology, and analytical notes

This appendix sets out the analytical methodology, data sources, and relevant caveats for each quantitative finding reported in the white paper. Entries are organised by chapter and cross-referenced to the location in the main text where the finding appears. Where data represents preliminary pilot findings, this is stated explicitly.

All Discovery data presented in this white paper has been anonymised and aggregated. No individually identifiable member information is included. Where analyses compare groups, standard confounding adjustments are noted in the relevant entry.

SECTION 1: OBESITY IS COMMON, COSTLY, AND DIFFICULT TO REVERSE

A1

Healthcare cost of care for obesity

DATA SOURCE

Discovery Health Medical Scheme (DHMS) claims data for 2024 using a subset of DHMS members with BMI data.

METHODOLOGY

Total healthcare costs were analysed on a per life per month (PLPM) basis and segmented according to waist-adjusted BMI categories. To enable meaningful comparisons between BMI groups, costs were standardised for differences in age, gender, and plan composition and are reported as risk-adjusted costs.

The risk-adjusted PLPM costs were derived using the following methodology:

- 1. Baseline cost determination:** Average healthcare costs per life per month were calculated for each combination of age band, gender, and plan across the overall population.
- 2. Risk weighting:** Relative cost weights were calculated by comparing the PLPM cost for each age-gender-plan subgroup against the corresponding average cost for the overall population.
- 3. Population standardisation:** The distribution of individuals within each waist-adjusted BMI category (healthy, overweight, and obese) across age, gender, and plan subgroups was applied to the corresponding population weights.
- 4. Cost adjustment:** A weighted adjustment index was calculated for each BMI category and applied to the observed (unadjusted) BMI-specific PLPM costs to produce age-, gender-, and plan-standardised healthcare cost estimates.

The resulting costs represent the risk-adjusted healthcare expenditure per life per month for each waist-adjusted BMI category after accounting for differences in demographic and benefit-structure profiles, thereby enabling a more meaningful comparison of healthcare costs across BMI groups.

REPORTED FINDING

Healthcare costs increase with increasing adiposity. An obese life has between an 11% and 27% higher cost per life per month than a healthy life.

CAVEATS

The analysis was conducted using the subset of DHMS members with available BMI data, representing approximately one-fifth of the total population.

APPENDIX A

SECTION 1: OBESITY IS COMMON, COSTLY, AND DIFFICULT TO REVERSE

A2 Longitudinal weight status trajectories

DATA SOURCE

Discovery Vitality data for Vitality members who completed a Vitality Health Check (VHC) in both 2010 and 2025.

METHODOLOGY

Weight status at 2010 and 2025 was classified using waist-adjusted BMI. Members were categorised into three groups at baseline (2010): healthy weight (in range), overweight (at risk), and obese (high risk).

A healthy weight is defined as a BMI between 18.5-24.9 kg/m² or a BMI between 25-29.9 kg/m² with gender and age-specific waist circumference thresholds (for those aged below 65 years: <94 cm for men and <80 cm for women; for those aged 65 years or older: <102 cm for men and <88 cm for women); overweight is defined as a BMI ≥25 kg/m² with gender and age-specific waist circumference thresholds (for those aged below 65 years: ≥94 cm for men and ≥80 cm for women; for those aged 65 years or older: ≥102 cm for men and ≥88 cm for women); obese is defined as a BMI ≥30 kg/m².

Transition proportions represent the percentage of members in each baseline category who moved to each weight status category by 2025.

REPORTED FINDING

70% of members classified as obese (high risk) in 2010 remained obese in 2025. 48% of members classified as overweight (at risk) in 2010 moved to a healthy weight range by 2025.

CAVEATS

This analysis tracked the same members across two time points 15 years apart, providing a uniquely longitudinal view of weight status change within the Discovery membership. The cohort comprises members who engaged with the VHC at both points, which reflects sustained health engagement. The analysis is cross-sectional at two time points; it does not account for weight status changes occurring between 2010 and 2025. Findings describe observed trajectories in this cohort; causal attribution requires further modelling, and results should not be extrapolated as population projections.

SECTION 2: NEW ANTI-OBESITY MEDICINES HAVE CHANGED WHAT IS POSSIBLE

A3 Anti-obesity medicine claimants trend

DATA SOURCE

Discovery Health Medical Scheme pharmacy claims data for 2022–2025.

METHODOLOGY

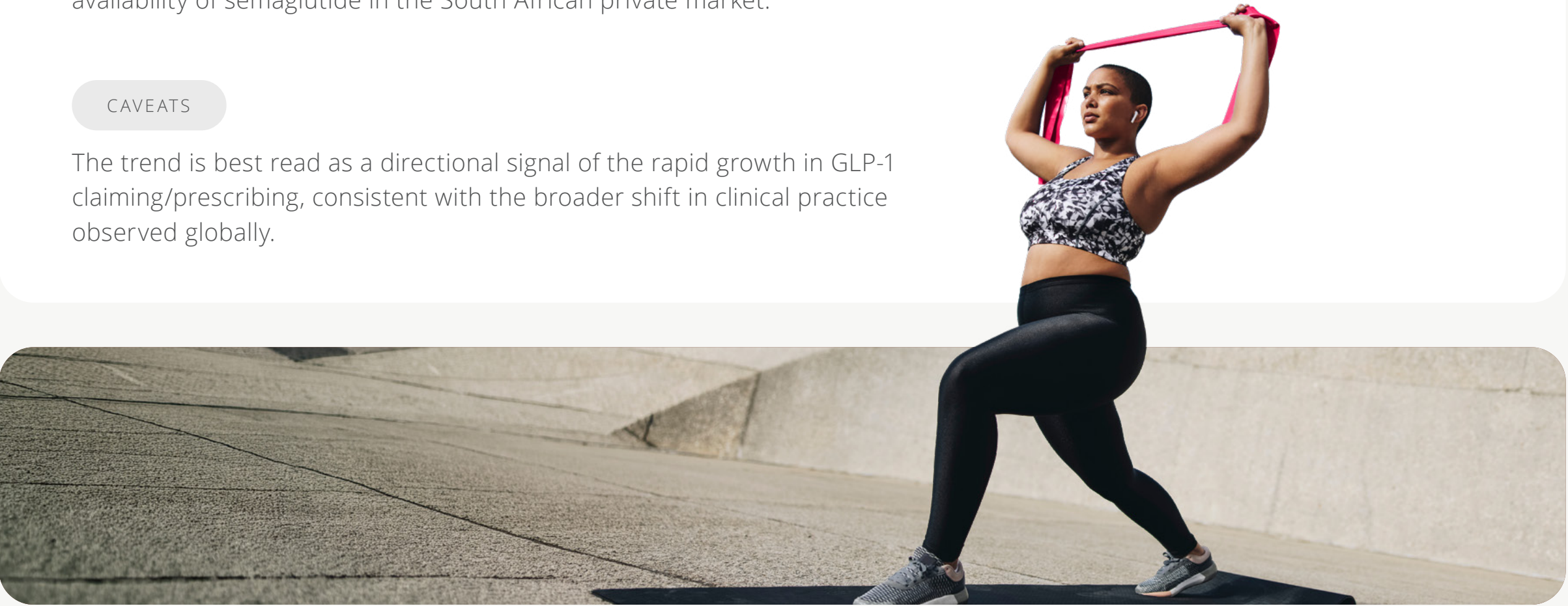
Claimants are defined as DHMS members who made at least one pharmacy claim for a GLP-1 receptor agonist (ATC codes: ‘A10BJ06’, ‘A10BJ05’, ‘A10BJ02’, ‘A10BX16’) in the relevant calendar year (2022-2025). Annual claimant counts are indexed to 2022 as baseline.

REPORTED FINDING

Anti-obesity medicine use was relatively flat in the pre-incretin era, rising sharply from 2022 onwards following broader availability of semaglutide in the South African private market.

CAVEATS

The trend is best read as a directional signal of the rapid growth in GLP-1 claiming/prescribing, consistent with the broader shift in clinical practice observed globally.



APPENDIX A

SECTION 3: THE SUSTAINABILITY GAP: WHY MEDICATION ALONE IS NOT ENOUGH

A4 Physical activity before and after GLP-1 initiation

DATA SOURCE

Vitality Active Rewards data for Discovery Vitality members who initiated GLP-1 therapy between 2019 and 2025.

METHODOLOGY

Physical activity patterns were assessed before and after GLP-1 initiation using Vitality active engagement measures. Members were classified into two groups:

- GLP-1 treatment only
- GLP-1 treatment combined with existing physical activity engagement.

Members were grouped according to their baseline activity level and transitions between activity categories following treatment initiation were evaluated.

REPORTED FINDING

Physical activity declines were substantially more common among members using GLP-1 therapy without an established exercise habit.

Approximately 13% of previously active Vitality members stopped regular exercise in the months following GLP-1 initiation. This finding excludes members who simply moved to a lower exercise category. This pattern is consistent with appetite suppression reducing the perceived urgency of physical activity.

Overall, the findings suggest that GLP-1 therapy alone is associated with a greater likelihood of reductions in physical activity, while members who combine GLP-1 treatment with established exercise habits are more likely to maintain activity levels after treatment initiation.

CAVEATS

Activity data is drawn from Vitality platform engagement metrics including step counts, gym visits, and Vitality Active Rewards goal completions, which represent a well-validated and consistently measured proxy for physical activity in this population. Changes in activity categories reflect observed engagement patterns, rather than direct measurement of all physical activity undertaken by the members. The analysis describes behavioural transitions following GLP-1 treatment and should not be interpreted as establishing a causal relationship between GLP-1 treatment and changes in exercise behaviour.

A5 Grocery purchasing behaviour: GLP-1 users without structured support

DATA SOURCE

Discovery Vitality grocery scanner data from partner retailers for Discovery Vitality members on the HealthyFood benefit who initiated GLP-1 therapy in 2025, 6 months pre-initiation versus 6 months post-initiation.

METHODOLOGY

The analysis considered a group of 10,000 individuals on DHMS taking GLP-1 medication, who were activated on the HealthyFood benefit at least 6 months prior to taking GLP-1 medication. The analysis looked at members who started taking GLP-1 medication in the months between January and August 2025, to adjust for seasonality, with their spend change indexed against a control group's change in spend over the same period. Food spend was assessed by category as per the HealthyFood catalogue (classified as healthy, neutral and unhealthy items).

REPORTED FINDING

Members initiating GLP-1 therapy without structured dietary support showed changes in basket composition. Basket size decreased (consistent with appetite suppression) without a corresponding increase in the proportion of nutritionally superior items, suggesting that reduced intake is not accompanied by improved dietary quality without coaching support. The food spend on convenience meals (including ready meals) and protein foods (including fattier meats such as red meat and chicken with skin) increased (by 7% and 3% respectively), while the spend on fruit, vegetables, and legumes decreased.

CAVEATS

This analysis draws on grocery scanner data from Discovery's partner retail network, which accounts for a substantial proportion of members' food purchasing. Purchasing at non-affiliated retailers is not captured, which is relevant context; however, the directional findings, namely reduced basket size without improved dietary quality, are clinically consistent and coherent.

APPENDIX A

SECTION 4: THE GREATEST VALUE COMES FROM COMBINING MEDICINE WITH BEHAVIOUR CHANGE

A6 HealthyWeight medicated programme pilot: basket composition shift and physical activity engagement

DATA SOURCE

Discovery Vitality HealthyFood benefit scanner data for a cohort of 55 Discovery Vitality members enrolled in the HealthyWeight medicated programme pilot in 2026 and actively using the HealthyFood benefit.

METHODOLOGY

Grocery spend was assessed by HealthyFood-qualifying versus non-qualifying items (classified as healthy, neutral or unhealthy) three months before enrolment versus three months after programme participation. The primary outcomes were: (1) change in grocery spend on healthy, neutral and unhealthy items; and (2) change in proportion of healthy, neutral and unhealthy food items in monthly basket. Active Rewards goal completion and Vitality fitness points data were used to assess physical activity engagement during the programme period.

REPORTED FINDING

Healthy food spend increased by 46%, while unhealthy food spend decreased by 25%. The basket proportion of healthy foods increased from 23% to 32%, while the proportion of unhealthy foods decreased from 26% to 19%. Vitality Active Rewards physical-activity goal completion rose from 50% to 67%, while weekly physical-activity points increased by 38% following programme enrolment.

CAVEATS

A cohort of 55 members is sufficient to detect the magnitude of changes observed here, and the findings are statistically meaningful. Published clinical research frequently draws on cohorts of comparable or smaller size, particularly in early-phase and pilot studies. The cohort specifically comprises members actively using the HealthyFood benefit, which makes it a well-defined and internally consistent group for assessing the food environment intervention. As the programme scales, these findings will be validated in a larger population.

A7 HealthyWeight medicated programme pilot: coaching engagement

DATA SOURCE

Discovery Vitality HealthyWeight medicated programme participant data for 2026. The pilot enrolled 55 Discovery Vitality members.

METHODOLOGY

Coaching engagement was assessed by the number of days that a member had a dietitian coaching interaction per week during the first month of programme participation. Weight loss is reported as the mean percentage reduction from starting body weight within the first month.

REPORTED FINDING

Month-one weight loss increased progressively with dietitian engagement. Members who engaged daily lost 6.5% of body weight in the first month, compared with 0.8% among members with no dietitian engagement.

CAVEATS

These findings represent early evidence from the first cohort to receive the full integrated HealthyWeight medicated pathway. Longer-term follow-up is underway.



Glossary

Anti-obesity medicine: Medicine used to support weight loss and long-term weight management in people living with overweight or obesity.

Appetite suppression: A reduction in hunger, appetite or food-related thoughts which may lead people to lower their energy intake.

Bariatric surgery: Surgery that leads to significant weight loss by changing the digestive system.

Behaviour change: Changes in daily habits that support better health, such as healthier eating, regular movement and treatment adherence.

Behavioural coaching: Structured support that helps people build and maintain healthier habits over time.

Body composition: The mix of fat, muscle, bone and water that makes up a person's body weight.

Body mass index (BMI): A measure based on height and weight, commonly used as an indicator of weight related health risk.

Cardiometabolic health: Health relating to the heart, blood vessels and metabolism, including blood pressure, cholesterol, body weight and blood glucose.

Cardiovascular disease: Conditions affecting the heart and blood vessels, including heart disease and stroke.

Chronic condition: A long term health condition that requires ongoing management.

Clinical assessment: A healthcare professional's review of a person's health, risks, needs and treatment options.

Clinical benefit: A measurable improvement in health after treatment or support.

Clinical evidence: Research evidence used to guide healthcare decisions and treatment recommendations.

Clinical guidance: Recommendations based on clinical evidence and professional expertise that help guide appropriate care or treatment.

Clinical trial: A research study that tests the safety or effectiveness of a treatment in people.

Confounding factors: Factors that may influence study results, such as age, activity levels or baseline health status.

Diet quality: How nutritious and balanced a person's overall eating pattern is.

Dose response relationship: A pattern where greater engagement or exposure is linked to a stronger outcome.

Efficacy: How well a treatment works under controlled study conditions.

Food environment: The food choices, incentives and practical supports that shape what people buy and eat.

GIP: Glucose-dependent insulintropic polypeptide, a naturally occurring hormone involved in appetite, metabolism and blood glucose regulation.

GIP and GLP-1 dual agonist: A medicine that acts on both GIP and GLP-1 pathways to support weight management.

GLP-1: Glucagon-like peptide-1, a naturally occurring gut hormone that helps regulate appetite, digestion and blood glucose.

GLP-1 receptor agonist: A medicine that mimics GLP 1 to reduce appetite, increase fullness and support weight loss.

HealthyFood benefit: A Vitality benefit that rewards healthier food purchases and supports healthier eating.

HealthyWeight: Discovery Vitality's integrated weight management programme, combining nutrition support, behavioural coaching, physical activity support and clinical care where appropriate.

High risk: A higher level of health risk, based on measures such as BMI, waist circumference or other health indicators.

Hypertension: Persistently high blood pressure, which increases the risk of heart disease, stroke and other complications.

Incretin: A gut hormone that helps regulate appetite, insulin secretion, digestion and blood glucose.

Incretin based medicines: Medicines that mimic or enhance incretin hormones to support weight management and metabolic health.

Integrated weight management: A weight management approach that combines medical care, nutrition, physical activity and behavioural support.

Lean mass: Body mass that is not fat, including muscle, bone, organs and water.

Legumes: Plant foods such as beans, lentils, chickpeas and peas.

Liraglutide: A GLP-1 receptor agonist used in the management of type 2 diabetes and obesity.

Longitudinal analysis: Analysis that follows people or groups over time to understand how outcomes change.

Maintenance phase: The period during and after treatment when weight loss and health gains need to be maintained.

Glossary *(continued)*

Metabolic health: How well the body regulates blood glucose, blood pressure, cholesterol and energy use.

Muscle loss: Loss of muscle tissue, which can occur during weight loss if muscle preserving strategies, such as appropriate nutrition and physical activity, are not in place.

Next generation medicine: A newer medicine in development or early use that may offer additional treatment benefit compared with existing treatments.

Nutrition coaching: Practical guidance from a trained professional to help people improve food choices and eating habits.

Obesity: A complex chronic disease in which abnormal or excess body fat (adiposity) impairs health, increases the risk of long-term medical complications, and reduces lifespan.

Obesity care: Healthcare and support aimed at managing obesity and related health risks.

Ongoing management: Continued care and support over time, rather than a one off intervention.

Pharmacological treatment: Treatment that uses medicine.

Pharmacotherapy: Treatment of a health condition using medicine.

Pilot: An early version of a programme used to test, learn and refine before wider rollout.

Pilot cohort: The group of members included in an early stage programme or pilot study.

Pilot findings: Early results from a limited group, which may not yet represent the broader population.

Real world data: Data gathered from everyday settings rather than controlled clinical trial conditions.

Real world persistence: How long people continue treatment in everyday settings outside clinical trials.

Real world use: How a medicine or programme is used in everyday life, outside controlled research conditions.

Retatrutide: A next generation medicine in development for obesity treatment.

Semaglutide: A GLP-1 receptor agonist used in the management of type 2 diabetes and obesity.

Shared value: Discovery's model of improving health outcomes in ways that create value for members, funders and the healthcare system.

Short term intervention: A treatment or support that produces benefits over a limited period.

Telemedicine: Healthcare delivered remotely through digital channels such as video or telephone consultations.

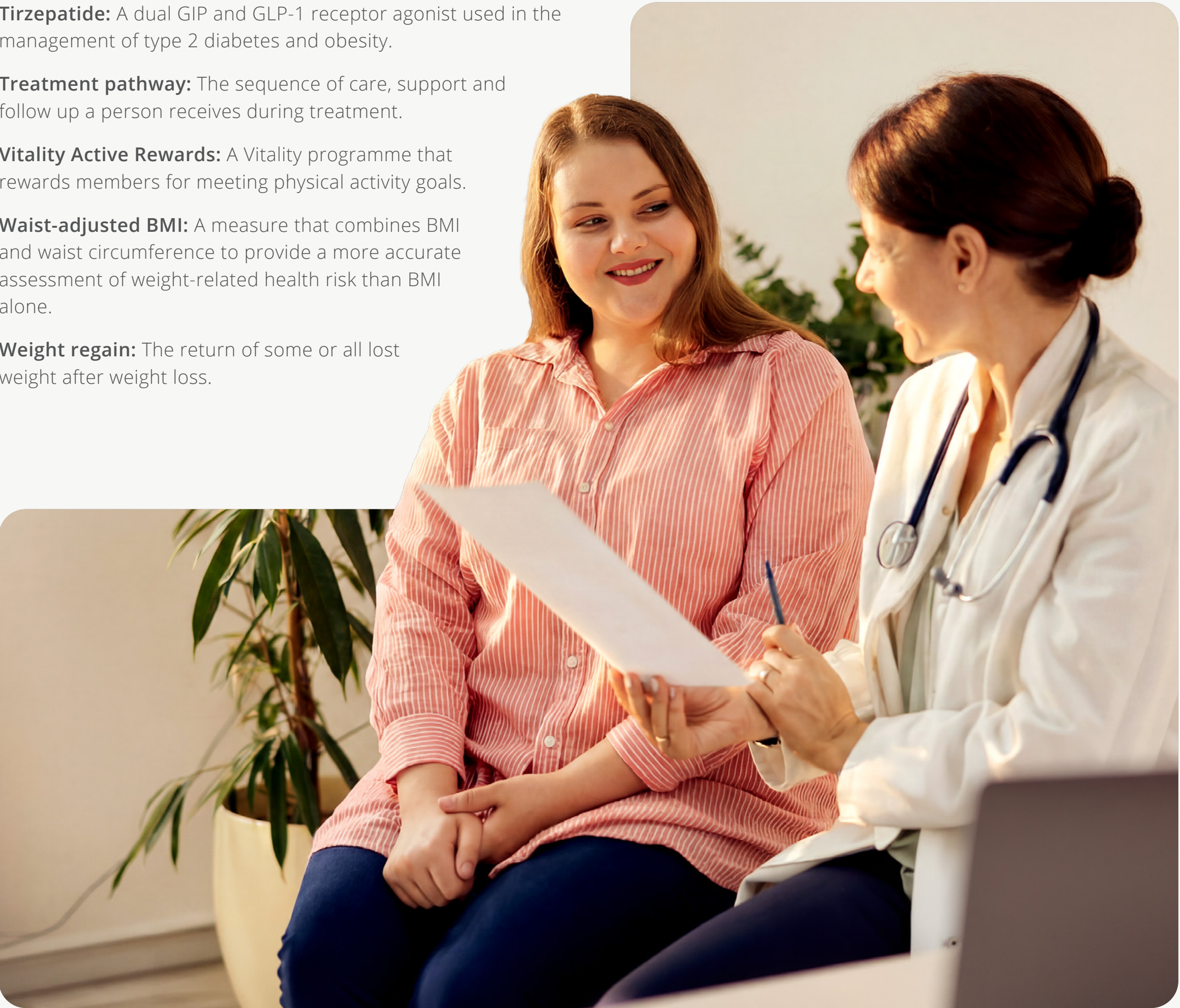
Tirzepatide: A dual GIP and GLP-1 receptor agonist used in the management of type 2 diabetes and obesity.

Treatment pathway: The sequence of care, support and follow up a person receives during treatment.

Vitality Active Rewards: A Vitality programme that rewards members for meeting physical activity goals.

Waist-adjusted BMI: A measure that combines BMI and waist circumference to provide a more accurate assessment of weight-related health risk than BMI alone.

Weight regain: The return of some or all lost weight after weight loss.





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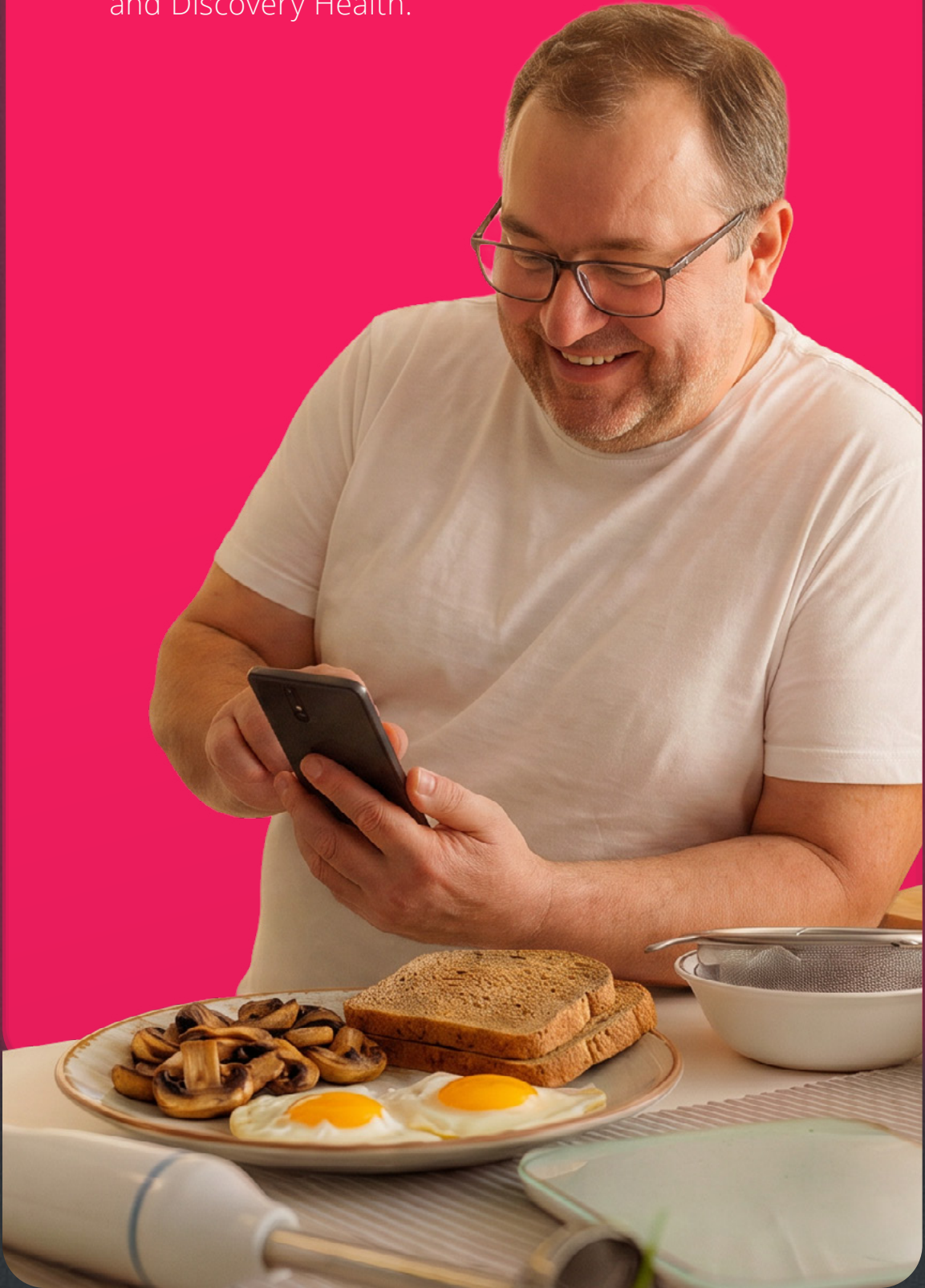
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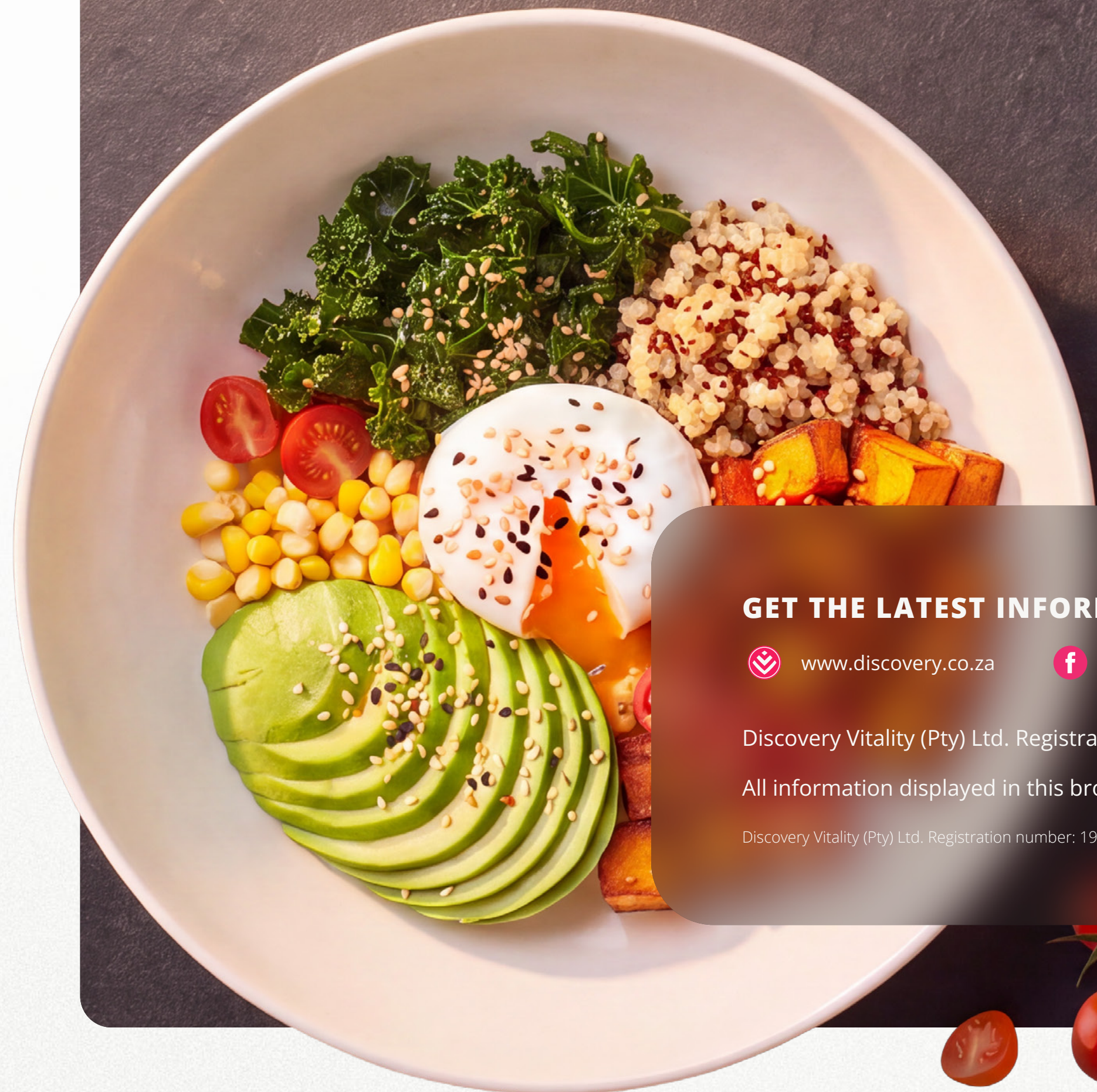
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