The Rise of Out-Of-Pocket Payment for GLP-1 Therapies: Implications for Traditional Pharmaceutical Reimbursement and Market Access in Europe

HPR118

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Objective

European pharmaceutical pricing, reimbursement and market access (PRMA) systems rely on payer-funded access supported by health technology assessment (HTA) and cost-effectiveness evaluation. Increasing demand for glucagon-like peptide-1 (GLP-1) therapies for obesity has been accompanied by growing patient willingness to self-fund treatment.

This study explored whether rising out-of-pocket (OOP) payments represent a shift away from payer-mediated access models.

Methods

A targeted, structured literature and policy review was conducted across the EU4 + UK markets (France, Germany, Italy, Spain and the United Kingdom), covering the period 2018–2026, to characterise OOP payment for GLP-1/GIP-based therapies (semaglutide and tirzepatide) in obesity. The targeted search drew on peer-reviewed literature, national HTA appraisals and reimbursement decisions, payer and policy documentation, and commercial pricing/prescribing datasets. Evidence was extracted and synthesised across four domains: patterns of OOP utilisation, drivers of self-pay demand, payer-imposed access restrictions, and their combined implications for PRMA strategy

Scope definition
- EU4 + UK markets
- Semaglutide & tirzepatide
- 2018-2026

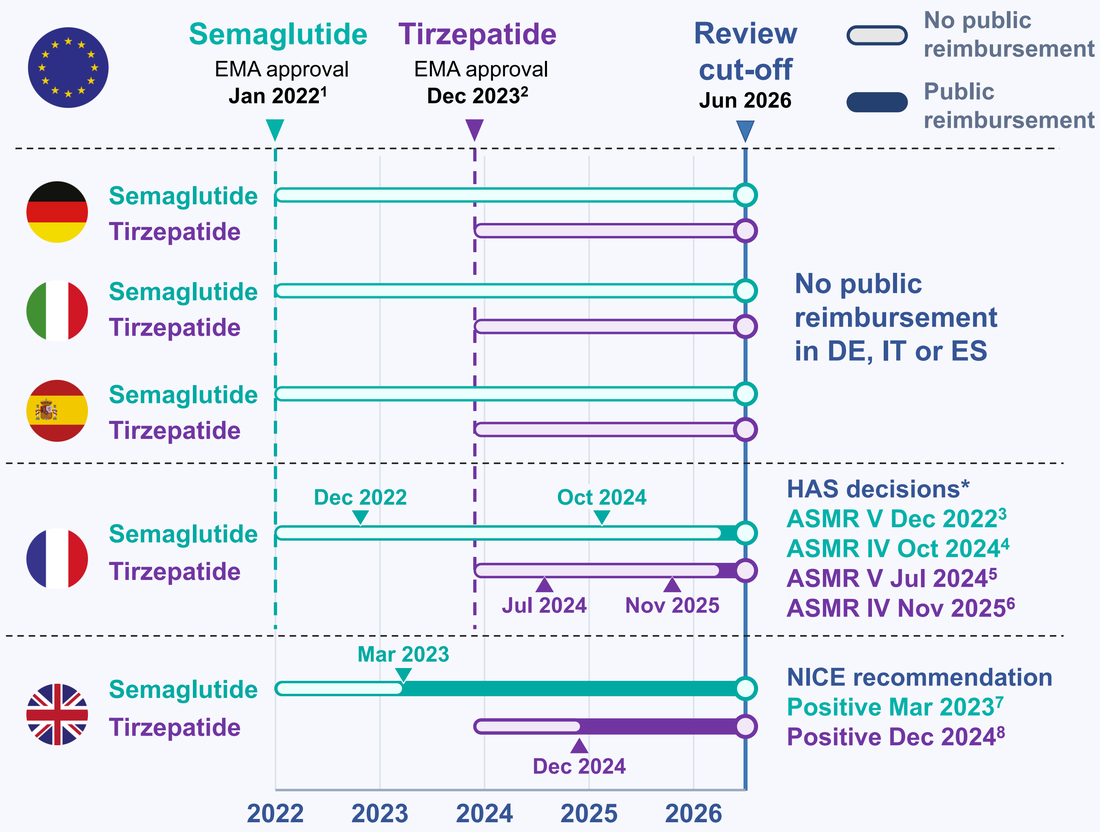
Source identification
- Peer-reviewed literature
- HTA reports & appraisals
- Reimbursement policies
- Pricing & prescribing data

Evidence synthesis
- Categorisation
- Consistency checks

Evaluation
- OOP utilisation trends
- Payer access restrictions
- Self-pay drivers
- PRMA implications

Results

Fig 1: EMA approval and national reimbursement timelines (EU4 + UK) for semaglutide and tirzepatide in obesity



*New evidence demonstrating clinically meaningful benefits beyond weight loss supported increased ASMR ratings at reassessment for both AOMs, strengthening their reimbursement propositions. Reimbursement was ultimately implemented in Jun 2026[9], with eligibility more restrictive than HAS recommendations.

Fig 2: Reimbursement status for semaglutide and tirzepatide across the EU4 + UK

Asset	Weight Management Reimbursement Status				
	Germany	Italy	Spain	France	UK
Semaglutide	**Not reimbursed** under SGB V § 34(1)*[10]	**Not reimbursed** Class C[11]	**Not reimbursed**** Article 92.1(d), RDL 1/2015[12,13]	**Restricted**[9]	**Restricted**[7]
Tirzepatide				**Restricted**[9]	**Restricted**[8]

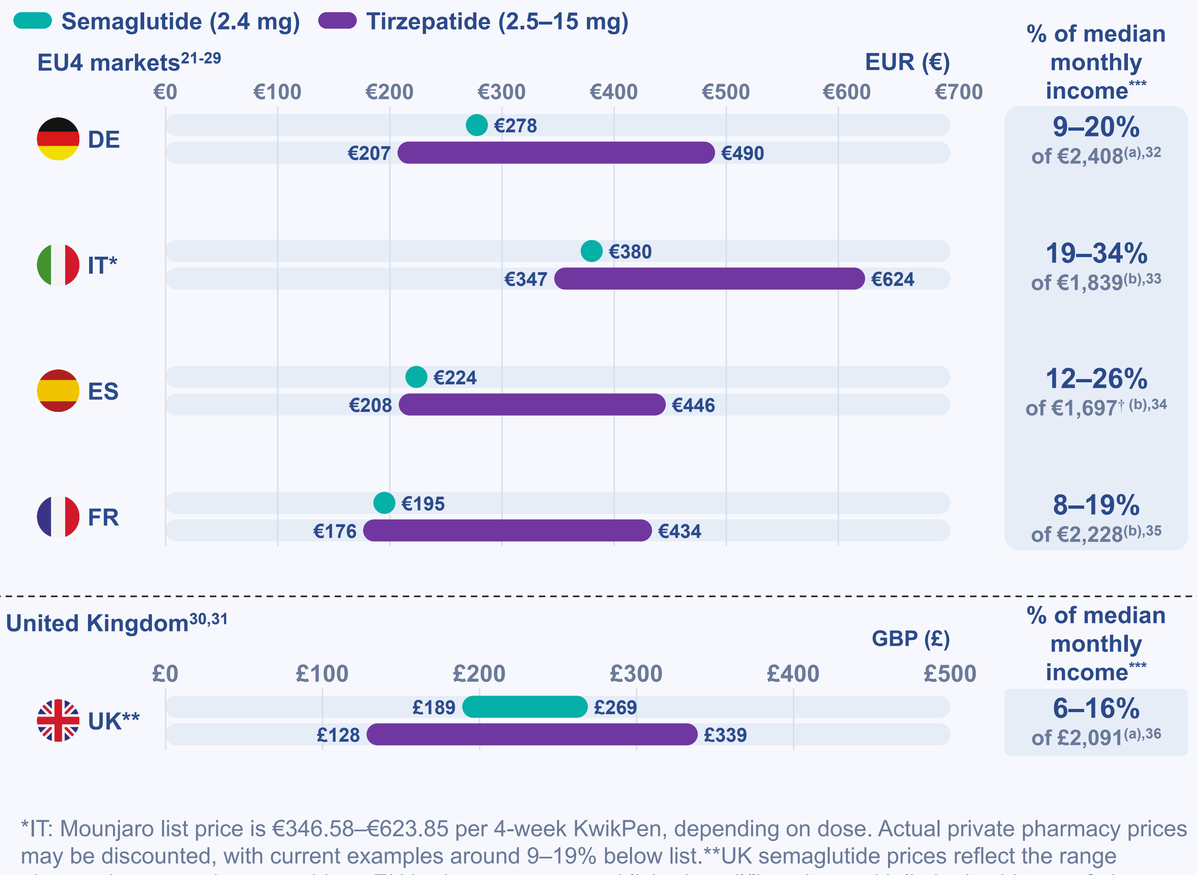
*Under § 34(1) of SGB V, medicinal products predominantly used for weight loss, appetite suppression or weight regulation are explicitly excluded from GKV reimbursement in DE, as they fall within the legislative category of medicines primarily intended to improve QoL[10]. **Not reimbursed due to budget impact concerns. French reimbursement is limited to adults with BMI ≥40 kg/m² or BMI ≥35 kg/m² with qualifying comorbidities, following unsuccessful nutritional management. NHS access is constrained by specialist service capacity and phased implementation. In England, tirzepatide reimbursement through primary care is initially prioritised for patients with severe obesity and multiple qualifying comorbidities.

Fig 3: Private GLP-1/GIP agonist use for weight management is substantial across the EU4 + UK, with rapid growth in IT and FR

DE	IT	ES	FR	UK
100k privately using anti-obesity medicines by end-2024[14]; with Wegovy launching in Jul 2023[15]	**143%** increase in privately purchased weight-management medicines, 2024 vs 2023[11]	**43%** of Ozempic use in Spain was dispensed through private prescriptions in 2023*[16]	**128k**** GLP-1 packs dispensed in May 2025, around double that of Sep 2024[17]	**~1.5m** people using GLP-1 drugs for weight management by 2025; >90% accessing privately[18,19]

*Ozempic is has received public reimbursement for T2D since Jun 2019; private prescriptions largely driven by demand as an AOM[16,20]. **GERS data, reported by Le Monde: 51,380 semaglutide, 76,480 tirzepatide[17]

Fig 4: Monthly OOP costs ranged from £128–£339 in the UK & €176–€624 across EU4, representing 6–34% of median monthly disposable income



*IT: Mounjaro list price is €346.58–€623.85 per 4-week KwikPen, depending on dose. Actual private pharmacy prices may be discounted, with current examples around 9–19% below list.**UK semaglutide prices reflect the range observed across private providers; EU4 prices represent published retail/list prices, with limited evidence of pharmacy-level variation, hence the range only observed in the UK graph.***Median monthly disposable income, based on (a) 2025 and (b) 2024 estimates. †Calculated based on at risk of poverty threshold of 60% of median income; with the value of the poverty risk threshold for a single-person household in Spain standing at €12,220.40 per year[34].

Conclusion

Growing reliance on OOP payments for GLP-1-based therapies across the EU4 + UK suggests a shift towards hybrid access models, combining selective public reimbursement with privately funded treatment.

Despite no public reimbursement for obesity in DE, IT or ES and restricted access in FR and the UK, private use is substantial across all markets reviewed, with evidence of rapid growth in IT and FR. This reflects more than affordability pressure on healthcare systems: patients are now funding treatment directly, at an estimated 6–34% of median monthly disposable income).

Limitations

OOP utilisation data came from heterogeneous sources (dispensing data, surveys, policy and media reports) that differ in definitions, time periods and coverage, limiting direct comparison across markets.

Private channels (online pharmacies and telehealth providers) are not consistently captured, self-funded use is likely underestimated. Findings reflect the policy position at the Jun 2026 review cut-off. This study was a targeted as opposed to a systematic literature review, with no quality appraisal.

Future Directions

As patients increasingly act as co-purchasers, future market access strategies will need to account for differing value drivers across public and private markets, including payer priorities, consumer decision-making and willingness to pay.

These evolving pathways blur the boundaries between public and private value, highlighting the limitations of traditional payer-focused pricing and value frameworks.

Sources: 1. Wegovy® EMA EPAR; 2. Mounjaro® EMA EPAR; 3. Wegovy® HAS Reimbursement Assessment (2022); 4. Wegovy® HAS Reassessment (2024); 5. Mounjaro® HAS Reimbursement Assessment (2024); 6. Mounjaro® HAS Reassessment (2025); 7. Wegovy® NICE Guidance TA875 (2023); 8. Mounjaro® NICE Guidance TA1026 (2024); 9. Service Public, Anti-obesity Medicine Reimbursement (2026); 10. German Social Code V, §34; 11. AIFA, Diabetes and Obesity Medicines Guidance (2026); 12. Spanish Royal Legislative Decree 1/2015; 13. Good Fiber Company, Wegovy® and Mounjaro® Access in Spain (2026); 14. IQVIA, Outlook for Obesity (2025); 15. Deutsches Ärzteblatt, Semaglutide Uptake in Germany; 16. El País, Ozempic® Access in Spain (2024); 17. Le Monde, Anti-obesity Medicine Misuse (2026); 18. UK Government, 10 Year Health Plan (2025); 19. BMJ, Affordability of Weight-loss Medicines (2026); 20. Ozempic® AEMPS Therapeutic Positioning Report (2019); 21. Wegovy® ApoDiscounter German Prices; 22. Mounjaro® Shop Apotheke German Prices; 23. Wegovy® Italian Summary of Product Characteristics; 24. Mounjaro® Farmacia Murtas Italian Prices; 25. Mounjaro® Pharmercure Italian Prices; 26. Wegovy® ZAVA Spanish Prices; 27. Mounjaro® Farmacéuticos, Issue 505, pp. 34–35; 28. Wegovy® French Public Medicines Database; 29. French Public Medicines Database; 30. Wegovy® Quick Meds UK Prices; 31. Mounjaro® Quick Meds UK Prices; 32. Destatis, German Poverty Thresholds (2026); 33. ISTAT, Italian Household Income and Living Conditions (2026); 34. INE, Spanish Poverty Statistics (2026); 35. INSEE, French Living Standards and Poverty (2026); 36. UK DWP, Households Below Average Income (2026).