

# 从健康体重到健康经济：升级体重管理体系并提升可负担性，促进长期社会经济韧性

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## 摘要

肥胖已经被公认为一种慢性疾病，也是 200 多种慢性疾病的危险因素，与糖尿病、高血压、血脂异常、心血管及呼吸系统疾病、生育健康等密切相关，并显著增加死亡风险。研究显示，身体质量指数（BMI）每增加 1 个单位，肥胖患者的死亡风险平均上升 9%。肥胖已成为中国第六大致死致残的主要危险因素，正对中国未来疾病结构及健康预期寿命构成深远影响。

中国超重、肥胖流行呈持续上升、年轻化与城乡差异扩大的趋势，已成为亟需应对的重要公共卫生挑战。目前中国成人超重/肥胖症患病率达 **50.7%**（**5.32 亿人**），人数总数居全球首位，预计 2030 年升至 **70.5%**（约 **8.11 亿人**）；同期，青少年肥胖症患病率或由 **19.8%** 上升至 **31.8%**。农村增速持续高于城市，2030 年农村成人超重/肥胖症患病率或达 **73%**。

高患病率与庞大的患者规模正带来沉重的医疗负担，且因超重肥胖的劳动力下降损失造成巨大的经济影响。一项由跨国商业资讯机构 GlobalData 基于官方公开数据库及多重回归模型开展的多国测算显示，2025 年中国肥胖相关经济总成本约 **1 万亿元**（当年 **GDP 占比 0.7%**，接近 2025 年温州或大连等地级市一年的全部 **GDP**），十年后或至 **1.3 万亿元**，其中直接医疗费用约占 **40%**，间接成本约占 **60%**（包括生产力损失、劳动参与度下降与过早

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<sup>1</sup> 本报告仅代表企业相关研究观点，不代表论坛主办单位和承办单位立场和观点。

死亡等)。随着劳动力质量与供给的逐步削弱，可能对经济增长潜力造成持续压力，并在中长期带来可持续发展的风险。

国际上，权威期刊建议将肥胖区分为临床前肥胖与临床肥胖，对临床肥胖患者开展系统的医学治疗；2025年12月世界卫生组织（WHO）<sup>2</sup>发布的关于使用胰高血糖素样肽1（GLP-1）疗法治疗肥胖症的指南亦指出，药物治疗是肥胖综合干预的重要组成部分。由此可见，**将肥胖纳入医学干预体系已成为全球治理肥胖的关键路径**。研究进一步表明，及时运用创新药物开展治疗不仅能带来显著、持续的健康获益，还能在减少共病负担、延缓劳动力衰减和提升劳动参与度等方面产生显著的长期经济回报，具有“提高健康、改善生产力、减少早亡，促进经济增长”的多重效益。

可喜的是，在《健康中国2030》《“体重管理年”活动实施方案》等一系列文件中，中国已在政策能级和维度上将体重管理的重要性不断提升。但在具体执行上仍面临一定不确定性，尤其是在广大基层地区，诊疗能力建设、规范化管理和药物可及性仍需显著加强。此外，尽管肥胖已在医学界广泛被视为慢性病，但目前尚未纳入国家基本医疗保障体系；医保层面对“医学体重管理”与“医美减肥”尚未实现科学区分，导致具有明确临床价值的创新治疗手段难以进入保障路径。保障缺位使得体重管理难以形成完整的闭环，影响综合治理效果。

鉴于以上分析，我们认为，当前正处于遏制肥胖高发态势的关键政策窗口期，有必要在以下几方面进行积极、科学、系统的完善与优化：

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<sup>2</sup> WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults. World Health Organization. Accessed on Feb 10, 2026. <https://app.magicapp.org/#/guideline/LrRxrL>

### **1. 将体重管理和肥胖防治纳入“十五五”国民健康规划，强化战略设计与考核机制，推进健康促进与经济增长的紧密协同**

将体重管理纳入“十五五”国民健康规划，设立“健康体重”专项行动，明确国家控肥目标；建立跨部门协同体系与全链条考核机制（比如借鉴高血压、糖尿病的考核指标等），并将 BMI、腰围等体重管理服务纳入基本公共卫生服务体系，推动资源投入和政策保障体系化。

### **2. 将体重管理服务延伸到基层，建立正确药物认知，并推动创新药物纳入国家基本药物目录，实现广泛可及**

依托世界卫生组织（WHO）《指南》，确立“生活方式 + 药物 + 随访”的一体化模式，加强基层医务人员在体重管理与药物干预方面的培训；将新型减重药物纳入国家基本药物目录，以提升基层与农村地区的药物可及性，改善规范化诊疗能力。

### **3. 科学区分医学体重管理和医美减肥，并基于卫生技术评估和成本效益分析，逐步将医学体重管理药物纳入医保支付范围，构建可持续医疗筹资体系**

从医疗保障政策层面明确肥胖的慢病属性，与医美减肥进行科学区分；以卫生技术评估（HTA）和真实世界证据为准入依据，分级分类将高风险人群（如中重度肥胖症患者）等逐步纳入医保保障；参考国际经验，建立可持续支付机制，并同步推动雇主保险、税优健康险等多层次保障体系，形成“医保 + 商保 + 雇主”协同分担模式。

总体而言，通过战略升级、体系化执行、诊疗认知升级，基层能力强化、合理保障与多元筹资机制协同，中国可在控制基金风险的前提下提升体重管理的可及性与可负担性，建立覆盖预防、诊断、治疗、保障等的长期管理闭环，系统减少肥胖带来的慢病负担与长期经济损耗，为中国人口健康水平提升与经济社会可持续发展提供长期支撑。

## 一、 肥胖：不可负担之重

### (一) 肥胖高发且年轻化趋势越发明显，农村患病率与趋势预计将超过城市，成为重大公共卫生挑战

肥胖问题日益严重并呈蔓延趋势，已成为 21 世纪全球最严重的公共卫生问题之一，引发日趋严峻的公共卫生与经济双重挑战。

近年来，中国人群中超重和肥胖症的患病率呈持续快速上升趋势。数据显示，中国成人超重肥胖率从 1990 年的 13.2%<sup>3</sup> 攀升至 2024 年的 50.7%（依据中国的《肥胖症诊疗指南》标准<sup>4</sup>，超重率 34.3%，肥胖患病率 16.4%）<sup>5</sup>，相当于每两名成人中就有一人受体重问题困扰。按此标准计算，中国成年超重肥胖人群总数已达 5.32 亿<sup>6</sup>，总人数位列全球第一<sup>7</sup>。若不加以控制，2030 年成人超重肥胖症患病率预计将达到 70.5%<sup>8</sup>，约 8.11 亿人，构成重大公共卫生挑战。

与此同时，肥胖症患病群体呈现出年轻化趋势。研究显示，推动成人人群中肥胖率迅速增长的主要原因是青年患者，2010 至 2018 年间，18~29

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<sup>3</sup> Helble, M. and Francisco, K. The Imminent Obesity Crisis in Asia and The Pacific: First Cost Estimates. ADBI Working Paper 743. 2017, Tokyo: Asian Development Bank Institute.

<sup>4</sup> 按照中国临床指南标准，BMI 达到 24kg/m<sup>2</sup> 且低于 28kg/m<sup>2</sup> 为超重，达到或超过 28kg/m<sup>2</sup> 为肥胖症

<sup>5</sup> 《肥胖症诊疗指南（2024 年版）》（国卫办医政函〔2024〕382 号）。国家卫生健康委办公厅。

[https://www.gov.cn/zhengce/zhengceku/202410/content\\_6981734.htm](https://www.gov.cn/zhengce/zhengceku/202410/content_6981734.htm)

<sup>6</sup> *ibid.*

Jing An, Qingyi Jia, Yan Huang, Yuzi Cao, Yaqian Duan, Huijie Zhang, Sheyu Li, Obesity care in Chinese adults: from evidence to clinical practice, *Precision Clinical Medicine*, Volume 8, Issue 4, December 2025, pbaf036, <https://doi.org/10.1093/pcmedi/pbaf036>

中国成年人（18 岁及以上）人口规模近似估计为 10.5 亿人。该估算基于人口年龄结构推算：在中国总人口约 14 亿、18 岁以下人口约占 23~25% 的情况下，成年人群规模取整为约 10.5 亿人。

<sup>7</sup> GBD 2021 Lower Respiratory Infections and Antimicrobial Resistance Collaborators (2024). Global, regional, and national incidence and mortality burden of non-COVID-19 lower respiratory infections and aetiologies, 1990-2021: a systematic analysis from the Global Burden of Disease Study 2021. *The Lancet. Infectious diseases*, 24(9), 974-1002. [https://doi.org/10.1016/S1473-3099\(24\)00176-2](https://doi.org/10.1016/S1473-3099(24)00176-2)

该论文指出中国以 4.2 亿居超重肥胖人数全球第一，这里的超重肥胖定义遵从国际标准。

<sup>8</sup> 《体重管理指导原则（2024 年版）》，中华人民共和国国家卫生健康委员会，

[https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000\\_59785.pdf](https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000_59785.pdf)

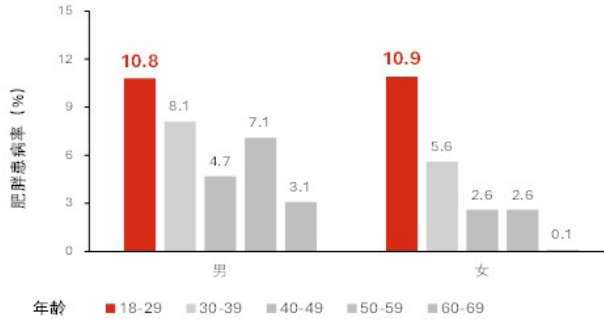


图 1：2010～2018 年 18～69 岁人群肥胖症患病率年度增长

岁的肥胖症患病率年度增长率高达约 11%<sup>9</sup>（见图 1）。肥胖高发不仅出现在成年人群体中，青少年更是逐渐成为我国肥胖迅猛增加的主力军，超重肥胖率呈明显上升趋势。目前青少年超重肥胖率约 19.0%<sup>10</sup>，已成为重大公共卫生问题，若得不到有效遏制，到 2030 年中国青少年超重肥胖率将达 31.8%<sup>11</sup>。

此外，超重和肥胖问题在男性群体中更为突出。从超重情况来看，男性超重率高达 40.2%；女性超重率为 27.4%。在肥胖层面，男性肥胖率达 17.6%；女性肥胖率为 9.6%<sup>12</sup>。整体而言，男性超重率是女性的 1.5 倍，肥胖率更是达到女性的 1.8 倍。

此外，农村肥胖患病率持续上升，将超过城市地区。流行病学研究显示，预估 2030 年，农村地区成人超重肥胖率（73.0%）将超过城市地区（66.6%），危及基层公共卫生系统的可持续和公平发展<sup>13</sup>，广大的农村地区

<sup>9</sup> Wang L., Zhou B., Zhao Z., et al. Body-mass index and obesity in urban and rural China: findings from consecutive nationally representative surveys during 2004-18. *Lancet*. 2021 Jul 3; 398(10294): 53-63.

<sup>10</sup> 《肥胖症诊疗指南（2024 年版）》（国卫办医政函〔2024〕382 号）。国家卫生健康委办公厅。  
[https://www.gov.cn/zhengce/zhengceku/202410/content\\_6981734.htm](https://www.gov.cn/zhengce/zhengceku/202410/content_6981734.htm)

<sup>11</sup> 《体重管理指导原则（2024 年版）》，中华人民共和国国家卫生健康委员会，  
[https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000\\_59785.pdf](https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000_59785.pdf)

<sup>12</sup> Chen K, Shen Z, Gu W, et al. Prevalence of obesity and associated complications in China: A cross-sectional, real-world study in 15.8 million adults. *Diabetes Obes Metab*. 2023;25(11):3390-3399. doi:10.1111/dom.15238

<sup>13</sup> Sun X., Yan A.F., Shi Z., et al. Health consequences of obesity and projected future obesity health burden in China. *Obesity (Silver Spring)*. 2022 Sep;30(9): 1724-1751.

正成为肥胖防控的重点关注区域（见图 2）。

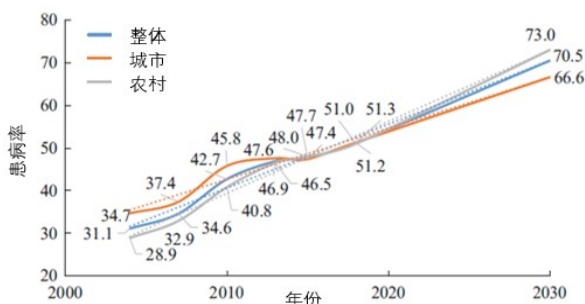


图 2：2000 年～2030 年中国城市和农村地区超重和肥胖患病率趋势

农村地区的肥胖增长趋势已持续多年。全国长周期调查显示，2010 年前成人超重和肥胖快速上升，增速在城市更为明显<sup>14</sup>；但自 2010～2018 年起，城市增速放缓，而农村反而加速。早在 2013 年，农村女性的标化患病率已全面超过城市女性（超重：46.0% vs. 43.6%；肥胖：14.4% vs. 13.3%）<sup>15</sup>。

青少年群体也呈现类似分化趋势。城市儿童的超重肥胖增速已明显放缓，而农村儿童仍持续线性上升。预测显示，到 2030 年，农村青少年超重肥胖率将达 40.82%（城市为 38.43%），女孩为 26.76%（城市 24.61%）<sup>16</sup>。

## （二）肥胖是众多高负担慢性疾病的危险因素

肥胖与 200 余种慢性病相关，肥胖人群的合并症发生率显著高于体重正常人群。其中，糖尿病、高血压、血脂异常及心血管疾病是最常见的肥胖相关合并症，肥胖人群中这四类疾病的发生率分别高达 57%、72%、65% 和 23%。以糖尿病为例，研究显示超重和肥胖人群对比正常体重人群 2

<sup>14</sup> Wang L., Zhou B., Zhao Z., et al. Body-mass index and obesity in urban and rural China: findings from consecutive nationally representative surveys during 2004–18. *The Lancet*. 2021; 398(10294): 53-63.

<sup>15</sup> *ibid.*

<sup>16</sup> Dang J, Liu Y, Cai S, Zhong P, Shi D, Chen Z, Zhang Y, Dong Y, Ma J, Song Y. Secular trend and projection of overweight and obesity among Chinese children and adolescents aged 7-18 years from 1985 to 2019: Rural areas are becoming the focus of investment. *Chin Med J (Engl)*. 2025 Feb 5;138(3):311-317.

型糖尿病发病风险分别升高 51%、149%，新发合并症发生率分别增加 21%、22%<sup>17</sup>。除此之外，肥胖也与呼吸疾病息息相关。大约 70%的阻塞性睡眠呼吸暂停患者合并肥胖<sup>18</sup>。因此提前实施体重管理，可大幅降低肥胖向其他慢性病进展的风险。肥胖作为一种复杂性慢性疾病，需从临床评估与早期诊断着手，实施全生命周期管理。

除了高度关注的基础慢病外，肥胖也会加剧对女性生殖健康的影响，对中国人口健康可持续发展构成重大威胁。对于育龄女性而言，多囊卵巢综合征（PCOS）是女性排卵障碍性不孕的主要原因之一，在中国影响约 2400 万的育龄女性。PCOS 患者多数合并超重/肥胖，且超重/肥胖会加重 PCOS 的症状。在普通女性中 PCOS 发病率约为 7.8%，而在超重/肥胖女性中可高达 28.3%<sup>19</sup>，并且超重/肥胖与 PCOS 之间相互促进，形成恶性循环，PCOS 患者中合并超重、肥胖或腹型肥胖的比例呈现逐年扩大趋势。

肥胖还是导致死亡的重要危险因素。根据 2019 年全球疾病负担研究，全球肥胖相关总死亡人数达 502 万人<sup>20</sup>，是全球第五大导致死亡的危险因素，也是中国第六大致死致残主要危险因素<sup>21</sup>。且超重肥胖者死亡风险随 BMI 增加而增加，BMI 每增加一个单位，超重者死亡风险增加 5%，肥胖者增加 9%<sup>22</sup>。《美国医学杂志》子刊一项由英格拉姆中心与上海研究所针对近 10 万中国成年人的联合研究指出：从成年早期到中年，体重指数超过 23 的成年

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<sup>17</sup> Yu C, et al. Influence of Overweight and Obesity on Disease Progression, Healthcare Utilization and Costs Among People with Prediabetes: A Cohort Study in China. *Value Health*. 2025; 28(6): S175-S176.

<sup>18</sup> Wolk R., Shamsuzzaman A.S., Somers V.K. Obesity, sleep apnea, and hypertension. *Hypertension*. 2003 Dec; 42(6): 1067-74.

<sup>19</sup> Wang W., Wang L. Endocrinologist consensus on weight management in overweight/obese patients with PCOS. *Chinese Soc Endocrinol*. 2025 Jan 25.

<sup>20</sup> Chong B., Jayabaskaran J., Kong G., et al. Trends and predictions of malnutrition and obesity in 204 countries and territories: an analysis of the Global Burden of Disease Study 2019. *EClinicalMedicine*. 2023 Feb 16;57: 101850.

<sup>21</sup> Yang X., et al. *Acta Nutrimenta Sinica* 2014,36: 212-17 (in Chinese)

<sup>22</sup> Sun Y.Q., Burgess S., Staley J.R., et al. Body mass index and all cause mortality in HUNT and UK Biobank studies: linear and non-linear mendelian randomisation analyses. *BMJ*. 2019 Mar 26;364:11042.

人，体重每多增加 10 斤，男性和女性晚年的全因死亡风险将升高 9%和 14%，还伴随着糖尿病、心血管疾病、抑郁症、阿尔茨海默症等疾病风险的增加<sup>23</sup>。这些数据表明，肥胖与死亡率高度相关。

### （三）肥胖成为社会经济可持续发展的阻碍

肥胖对中国医疗体系和社会经济发展造成持续加重的负担。一项由跨国商业资讯机构 GlobalData 2025 年开展的多国超重与肥胖经济负担研究中，结合公开发布数据并通过统计模型分别量化了加拿大（2023 年）<sup>24</sup>、美国（2024 年）<sup>25</sup>、中国（2025 年）等国家（见表 1）当年及未来十年超重肥胖及其合并症带来的直接医疗负担，以及对社会生产力与劳动力参与造成的间接经济损失，超重与肥胖在上述国家均造成了沉重的疾病与经济负担。中国具体数据见下文。

表 1：加拿大、美国和中国的超重与肥胖总经济负担

单位：亿美金	加拿大（2023） <sup>26</sup>	美国（2024）	中国（2025）
总经济负担	204	9330	1420
GDP 占比	0.95%	3.2%	0.7%

从中国的数据来看<sup>27</sup>：2025 年，成人及 12 - 17 岁青少年超重与肥胖的总经济成本已达 1 万亿元，约占当年 GDP 总量的 0.7%。预计十年后，总经济

<sup>23</sup> Jia G, Shu X, Liu Y, et al. Association of Adult Weight Gain With Major Health Outcomes Among Middle-aged Chinese Persons With Low Body Weight in Early Adulthood. *JAMA Netw Open*. 2019;2(12):e1917371. doi:10.1001/jamanetworkopen.2019.17371

<sup>24</sup> Chen, F., Sapra, T., Natale, Z. *et al.* Modeling the cost of inaction in treating obesity in Canada. *BMC Public Health* 25, 865 (2025). <https://doi.org/10.1186/s12889-025-21905-2>

<sup>25</sup> GlobalData. Health Disparity Implications of Obesity by Race and Ethnicity: Pathway to Improving Health through Obesity Treatment. <https://www.globaldata.com/health-economics/US/HealthEquity/HealthEquity.pdf>

<sup>26</sup> 基于 1 USD=0.74 CAD 的汇率

<sup>27</sup> 以下 1.3 节相关数据均来源于礼来公司与跨国商业资讯机构 GlobalData 联合开展的超重与肥胖相关经济负担研究，该研究成果拟于本年度进行国际学术期刊投稿发表。

成本将达 1.3 万亿元，增长约 30%。超重和肥胖人群的整体负担相当，超重相关成本约为 4900 亿元，肥胖相关成本约为 5260 亿元。

**肥胖及其合并症带来高额直接医疗负担。**根据上述 GlobalData 开展的超重与肥胖经济负担研究，当前中国成年人因超重和肥胖本身及由此引发的慢性病产生的直接医疗费用合计高达约 4154 亿元。若未来十年对超重与肥胖问题仍缺乏更加系统性的干预和管理，相关直接医疗成本还将进一步增加 36%，达到 5662 亿元，给国家医疗资源与财政带来更为沉重的压力。在 12 - 17 岁青少年超重人群中，发病率与直接医疗负担已呈现出显著的城乡差异。未来十年，农村青少年超重率将快速上升（男性 18.2%，女性 9.6%），且整体患病水平持续走高（见图 3）。

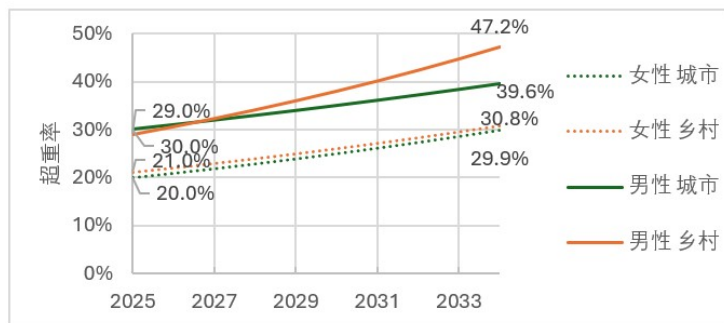


图 3：2025 年 ~ 2035 年 12 ~ 17 岁青少年超重人群医疗支出增长情况

从医疗支出趋势看，这一差异更加明显：农村 12 - 17 岁青少年直接医疗支出将增长 5%，而城市则下降 6%；尤其在男性青少年中，农村医疗支出增幅达 11%，城市则大幅下降 10%（见表 2）。亟需将更多优质医疗资源下沉至农村基层，以遏制相关疾病及医疗需求的过快增长。

表 2：中国 12~17 岁青少年未来十年超重人群医疗支出增长率

	女性	男性	青少年全人群
城市	4%	-10%	-6%
农村	3%	11%	5%

其次，肥胖带来的间接经济损失更为突出。上述测算显示，中国因超重和肥胖造成的间接损失总额高达 5956 亿元，在总经济成本中占比达到六成，规模远超直接医疗支出，成为制约经济高质量发展的重要因素。其中，超重与肥胖导致的有效劳动力生产力损失占到全部间接成本的六成，包括带病出勤与缺勤，约一半的间接损失来自于因带病出勤引发的在岗低效与隐性生产力损耗。

此外，超重与肥胖还导致劳动年龄人口退出劳动力市场或放弃求职，造成近三成的间接经济损失。肥胖相关的过早死亡损失也超 700 亿元，造成劳动力永久性流失，形成不可逆的社会资源损耗。

表 3：2025 年中国超重与肥胖带来间接经济损失的构成情况

原因构成	经济损失（亿元）	占比
有效劳动力效率下降：带病出勤与缺勤	3637	61%
退出劳动市场	1604	27%
过早死亡	715	12%
合计	5956	100%

在中国生育率偏低、人口老龄化加速的背景下，劳动力资源日趋紧张，肥胖相关疾病负担将进一步压缩有效劳动力存量，降低社会经济创造能力。

## 二、遏制肥胖高发态势刻不容缓

近年来，随着各类研究的深入，肥胖作为一种复杂可复发的慢性疾病的共识已在医学界逐步建立。政府也已充分意识到肥胖已经对公共卫生和经济社会可持续发展构成威胁，在过去三年形成了从倡导、行动、规范到战略化的跃迁，形成“预防为主、全人群覆盖、全生命周期管理”的政策框架。

2024年6月，国家卫健委联合多部门启动并持续推进“体重管理年”行动<sup>28</sup>，健康体重管理行动已于2025年纳入“健康中国行动”<sup>29</sup>。这是中国首次将体重管理写入政府主导的行动方案，标志着体重管理和肥胖防控的政策能级进一步提升。一方面，发布《体重管理指导原则（2024年版）》为医疗机构和专业人员提供了统一规范，强调慢性病防控前移，强化医疗、家庭、社区三方协同<sup>30</sup>。另一方面，针对三级医院设置健康体重管理门诊，优化医院健康体重管理服务模式<sup>31</sup>，将三级公立医院均提供健康体重管理门诊服务事项纳入2026年为民服务十件实事之一，要求2026年实现三级公立医院健康体重管理门诊全覆盖。目前，全国已在5500多所二级以上公立医院设立健康体重管理门诊<sup>32</sup>。

一系列高规格、系统性的体重管理政策文件和行动计划的出台体现了国家对于遏制肥胖高发态势的决心。然而，考虑到超重和肥胖对于广大人民群众

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<sup>28</sup> 《关于印发“体重管理年”活动实施方案的通知》（国卫医急发〔2024〕21号）. 国家卫健委等十六部门. [https://www.gov.cn/zhengce/zhengceku/202406/content\\_6959543.htm](https://www.gov.cn/zhengce/zhengceku/202406/content_6959543.htm)

<sup>29</sup> 《全国爱卫会关于将健康体重管理行动等3个行动纳入健康中国行动的通知》全爱卫发〔2025〕2号. 全国爱国卫生运动委员会. [https://www.gov.cn/zhengce/zhengceku/202504/content\\_7018518.htm](https://www.gov.cn/zhengce/zhengceku/202504/content_7018518.htm)

<sup>30</sup> 《国家卫生健康委办公厅关于印发体重管理指导原则（2024年版）的通知》（国卫办医急函〔2024〕469号）. 国家卫健委.

<https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7.shtml>

<sup>31</sup> 《关于做好健康体重管理门诊设置与管理工作的通知》（国卫办医政函〔2025〕113号）. 国家卫健委. <https://www.nhc.gov.cn/yzygj/c100068/202504/52bcc453524149b884ddf6e2969d24d9.shtml>

<sup>32</sup> 国家卫生健康委员会2026年2月12日新闻发布会文字实录. 国家卫健委.

<https://www.nhc.gov.cn/xcs/c100122/202602/07e794cb75d946989950f5adb629ac65.shtml>

众健康和国家长远社会经济发展的危害性和高发态势的紧迫性，我们认为目前政策在以下几个方面亟待提升。

**首先，与其他重点慢性病相比，超重和肥胖的政策定位、落地实施以及考核方面不够清晰，资源配置和投入尚显不足。**

从政策定位来看，以糖尿病防治为例，国家卫健委在国家规划文件的基础上进一步发布《健康中国行动——糖尿病防治行动实施方案（2024—2030年）》、《高血糖症营养和运动指导原则（2024年版）》等文件，对糖尿病的预防、筛查、诊断、治疗和管理等各个环节进行了全流程部署。反观肥胖，虽然已经被认为是独立慢病，但在国家规划以及慢病专项行动中对于肥胖的部署不足。慢病相关规划中仅将超重肥胖人群视为慢性病高危人群，肥胖仅在部分行动中作为需要干预的因素。

从考核指标来看，高血压、糖尿病拥有明确且量化的考核体系，而肥胖的考核指标严重不完善。高血压、糖尿病的30岁以上居民高血压知晓率、患者规范管理率、治疗率、控制率均作为政府工作指标，纳入地方政府和基层医疗机构绩效评价，强制工作落地。而肥胖尚未设定明确的防控成效考核目标。

从资源配置来看，重点慢病享有明确的政策倾斜与资源保障。慢性病患者属于优先纳入家庭医生签约服务的范围，需健全治疗康复长期护理服务链。比如高血压和2型糖尿病患者均被纳入国家基本公共卫生服务项目、属于家庭医生签约服务的重点人群，需提供免费筛查、定期随访、用药指导、健康评估等全周期服务。而肥胖自身作为一种独立慢病、且作为其他多种慢病的重要关键危险因素，尚未被纳入同等政策保障范畴与规范化管理体系。

可见，尽管肥胖已经被定义成一种复杂可复发的慢病，其管理在政策体系中仍主要依附于其他健康领域，尚未作为一个独立且需要体系化治理的公

共卫生问题予以统筹安排。目前政策定位不够清晰，资源投入呈现碎片化特征，这与肥胖作为 200 余种慢性病源头的重大公共卫生价值不匹配，也无法应对农村地区肥胖率即将超过城市的防控挑战。上述趋势凸显建立独立、体系化肥胖管理政策的迫切性，亟需在国家层面引入更为综合、多维度和体系化的政策支持和资源投入。

此外，目前政策在全民体重管理方面主要聚焦在锻炼、饮食等生活方式改变，而药物干预作为有效管理超重和肥胖的重要一环，对其重视程度尚显不足。

肥胖作为一种可治疗且致病因素复杂的疾病，需要长期医学管理以实现个体化最佳体重并长期维持，并达到提高整体生活质量和健康状况的目标<sup>33</sup>。目前，肥胖的治疗有三大主要手段，包括生活方式和行为干预、药物治疗及代谢外科手术等。

虽然生活方式改变是肥胖管理的基石，但许多患者由于难以长期坚持生活方式，或因减重后身体的生理和神经激素适应性调整而无法长期维持减重效果<sup>34</sup>。中华医学会内分泌学会发布的《肥胖患者的长期体重管理及药物临床应用指南（2024 版）》指出，“生活方式干预需贯穿长期体重管理的始终，但单纯的生活方式干预往往效果欠佳或者出现反弹。因此在强化治疗期，建议对于所有达到肥胖或腹型肥胖标准的患者，或者存在肥胖相关合并症的患者，可联合减重药物起始治疗”<sup>35</sup>。

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<sup>33</sup> Chinese Society of Endocrinology. Guideline for Chronic Weight Management and Clinical Practice of Anti-obesity Medications (2024 Version). Chinese Journal of Endocrinal Metabolism. 2024, (40) 7: 545-564.

<sup>34</sup> Gadde, K.M., Martin, C.K., Berthoud, H., et al. Obesity: Pathophysiology and Management. *J Am Coll Cardiol*. 2018 Jan 2;71(1):69-84.

<sup>35</sup> Chinese Society of Endocrinology. Guideline for Chronic Weight Management and Clinical Practice of Anti-obesity Medications (2024 Version). Chinese Journal of Endocrinal Metabolism. 2024, (40) 7: 545-564.

《肥胖症诊疗指南（2024）》为超重和肥胖症患者提供了详细的规范化诊疗路径，针对不同人群制定了清晰的生活方式干预或治疗介入方案<sup>36</sup>：对于超重且未合并肥胖相关疾病的人群，推荐采取生活方式干预；对于合并肥胖相关疾病的超重人群、轻度及中度肥胖症患者，考虑或推荐药物治疗；重度肥胖患者可通过手术治疗改善病情。此外，2025年《柳叶刀糖尿病与内分泌学》委员会重新定义了肥胖，将其划分为临床前肥胖和临床肥胖<sup>37</sup>，为肥胖的规范化诊疗提供了科学依据与指导。临床前肥胖表现为体脂过量但尚未造成器官损害，主要通过健康管理和生活方式干预来控制风险；临床肥胖则指过量体脂已引发器官功能受损或出现相关合并症，需要接受系统的医学治疗，以减轻症状并防止进一步损伤。

因此，在生活方式干预的基础上，对于临床肥胖患者，使用药物等手段来对抗生理反弹机制及共病带来的健康隐患，对于长期体重管理来说至关重要。新型减重药物，如肠促胰岛素类药物（GLP-1 RA 和 GLP-1/GIP RA）已经展现明显的疗效和较好的安全性，以及减重以外的代谢和心肾获益。已在疗效、安全性以及代谢和心肾等方面显示出显著优势。然而，当前临床体重管理仍以“失败后再治疗模式”（Treat-to-Failure）为主，即在生活方式干预多次失败后才启动药物治疗。对于存在生理性抵抗机制的患者，这一模式往往难以实现有效且持续的减重，易导致反弹。同时，医生和患者对减重药物治疗的认知仍较为保守<sup>38</sup>。一项美国的调查显示：虽然近一半患者表达尝试

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<sup>36</sup> 《肥胖症诊疗指南（2024年版）》(国卫办医政函〔2024〕382号). 国家卫生健康委办公厅.  
[https://www.gov.cn/zhengce/zhengceku/202410/content\\_6981734.htm](https://www.gov.cn/zhengce/zhengceku/202410/content_6981734.htm)

<sup>37</sup> Rubino F et al. Definition and diagnostic criteria of clinical obesity. *Lancet Diabetes Endocrinol.* 2025 Mar;13(3):221-262. doi: 10.1016/S2213-8587(24)00316-4. ISSN: 2213-8587.

<sup>38</sup> Granara, B. and Laurent, J. Provider attitudes and practice patterns of obesity management with pharmacotherapy. *Journal of the American Association of Nurse Practitioners.* 2017, 29(9): 543-550.

处方类减重药物的意愿，但仅有约 1/5 曾在医生建议下接受正规治疗，真正持续使用者仅 4.2%<sup>39</sup>。

因此，亟需推动体重管理从“失败后再治疗”（Treat-to-Failure）向“成功综合干预模式”（Treat-to-Success）转变，基于对生理性反弹机制的科学认识，更早、更系统地将生活方式与药物干预相结合，建立面向肥胖患者的长期、规范的体重管理模式。

最后，医疗保障层面尚未充分确立肥胖作为慢性疾病的定位，其治疗的可负担性和公平性有待提升。

《全球肥胖应对指数》<sup>40</sup>（由《经济学人》智库发布）对包括中国、英国、法国、德国、芬兰、澳大利亚、日本、韩国在内的 20 个国家的肥胖防控政策进行评估，从政策与治理框架、体重管理体系、食品质量与安全、运动锻炼四个维度进行排名，中国位列第八。中国在多个方面表现突出：开展“中国全民健康体重管理年”等全国性行动提升公众认知；建立完善的临床指南体系，将肥胖明确为慢性疾病；在青少年领域制定统一的膳食营养标准、强制营养教育和每天两小时体育活动要求。特别是在青少年运动锻炼维度，中国是唯一超出世界卫生组织推荐标准的国家。然而，中国在肥胖治疗的医疗保障方面仍欠缺，使管理体系维度整体低于平均水平。医疗保障政策的支持不足，以及相关治疗手段的卫生技术评估和成本效益研究仍显薄弱，导致体重管理体系得分较低、亟待完善。

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<sup>39</sup> Kaplan, L., Gudzone, K., Ard, J., et al. Perceptions of anti-obesity medications among people with obesity and healthcare providers in the US: Findings from the OBSERVE study. *Obesity (Silver Spring, Md.)*. 2025, 33 (6): 1076-1086

<sup>40</sup> Economist Impact. An epidemic of inaction: assessing national responses to obesity - Findings from the Obesity Response Index.  
[https://assets.ctfassets.net/9crgcb5vlu43/2PTzc84YiThZYRVdq7hkHo/c8b32b5765d9ace54a4a9ed310c5947d/EI\\_x\\_Eli\\_Lilly\\_Global\\_Obesity\\_Response\\_Index\\_Report.pdf](https://assets.ctfassets.net/9crgcb5vlu43/2PTzc84YiThZYRVdq7hkHo/c8b32b5765d9ace54a4a9ed310c5947d/EI_x_Eli_Lilly_Global_Obesity_Response_Index_Report.pdf)  
Original Research: <https://impact.economist.com/health/obesity-response-index/global>

根据 2020 年颁布的《基本医疗保险用药管理暂行办法》规定，减肥的药物不能纳入《基本医疗保险药品目录》<sup>41</sup>。然而，医学界已形成“肥胖作为慢性疾病需长期医学管理”的共识，且近年来大量研究证据进一步证实，以 GLP-1 RA 为代表的新型减重药物在超重与肥胖及其相关代谢、心肾疾病中具有明确的疗效和良好的安全性，能够带来实质性的临床获益，相应的肥胖症临床诊疗指南也随之不断完善。在此背景下，从政策层面对医学体重管理与医美减肥进行科学区分已具备较为充分的依据，也有助于推动肥胖防治规范化与体系化发展。

从医保基金可持续性和经济性角度来看，部分地区的经验提示新型减重药物也展现出显著的健康与经济回报。根据 GlobalData 公开发布的文献综述，以新型减重药物（如 GLP-1）为例，其可带来平均约 20% 的体重降低，每年可为个体医疗支出节省大约 760–4,720 美元<sup>42</sup>。另一项基于中国成人超重和肥胖人群的 Population Model 测算显示，使用肠促胰岛素类药物可使人均费用节约约 1261 元；放大到长达数十年的整个治疗人群的生命周期，总节约金额预计可高达 70 万亿元<sup>43</sup>。其中约一半来自合并症减少带来的直接医疗费用节省，另一半则源自相关间接费用负担的有效降低。因此，尽早针对超重和肥胖进行药物干预不仅可以减少远期合并症所带来的直接医疗支出，还能通过改善健康状况、减少残疾过早死亡，降低社会生产力损失及长期照护需求，从更宏观的社会经济层面缓解医疗体系压力。

然而，目前医疗保障政策尚未在制度上区分医学体重管理和医美减肥，肥胖的慢病属性及其长期管理需求尚未在医保政策中得到体现，针对体重管

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<sup>41</sup> 《基本医疗保险用药管理暂行办法》（国家医疗保障局令第 1 号）。国家医疗保障局。

[https://www.gov.cn/gongbao/content/2020/content\\_5547646.htm](https://www.gov.cn/gongbao/content/2020/content_5547646.htm)

<sup>42</sup> GlobalData. Economic Benefits of Obesity Treatment: Review of the Current Literature. Oct 2025,

<https://www.globaldata.com/health-economics/us/>

<sup>43</sup> 相关数据均来源于礼来公司开展的肠促胰岛素类药物对适用人群医疗费用节约影响研究，该研究成果拟于本年度向国际学术期刊投稿发表。

理药物的医疗保障仍处空白。这导致了相当一部分有明确医学治疗需求的超重和肥胖患者面临“有药可治但难以负担”的困境，即便在医生的建议下启动药物干预，也有可能面临因费用问题中断治疗，进而可能导致体重反弹、代谢指标恶化并加剧合并症风险，从长期看反而加重社会医疗负担。

因此，作为肥胖防治体系中的关键环节，建议医疗保障政策能与防治有效衔接，建立起体重管理全流程的闭环，提升肥胖治疗的连续性、效果以及服务的可负担性与公平性。

### 三、 政策建议

鉴于以上分析，我们认为当前阶段是遏制肥胖高发态势的重要政策窗口期。相关政策体系亟需在若干关键方面进行更加积极、科学且具有针对性的调整与优化，以更好地支持体重管理的规范化发展并提升肥胖防控的整体效能。

#### **（一） 将体重管理和肥胖防治纳入“十五五”国民健康规划，在现有政策基础上加大落地执行力度并进行持续的政策保障，将健康促进与经济增长形成更紧密的协同**

将体重管理与肥胖防治提升至国家战略高度，是应对中国日益突出的慢性病负担、提升全民健康素质的关键举措。在宏观层面，健康体重的改善可以显著减少医疗开支，提高劳动年龄人口的健康寿命（Health-Adjusted Life Expectancy），提升有效劳动供给，降低缺勤率、失能率，并通过提升人力资本储备促进经济增长。当前相关政策已初步构建了“防、治、管”结合的框架，但为取得突破性成效，亟需在战略层级、执行强化与系统支撑上实现全面升级。

首先，建议以“十五五”开局之年为契机，强化顶层设计，将体重管理和肥胖防治纳入“十五五”国民健康规划。建议在规划中设立“健康体

重”专项行动，明确国家层面的中长期减重与肥胖率控制目标，并将其作为“健康中国”建设的核心考核指标之一。此外，还应建立跨部门协调机制和配套政策体系。这不仅能凸显其战略优先级，更能推动其融入各项相关国策（如教育、体育、社会保障、城市建设、经济政策等），实现“将健康融入所有政策”，从源头上构建抑制肥胖的社会环境与支持性生态系统。

**其次，建议参考现行国家及地方慢病防治考核指标，设立全面的、切实可行的政府和医疗机构绩效评价考核体系，推动体重管理有效落地。**在政府层面，可设计包括成人肥胖患病率、学生超重肥胖率、肥胖相关早死风险并参考高血压、糖尿病等的知晓率、治疗率、规范化管理率与控制率等指标，引导地方政府将降低肥胖患病率作为提升区域劳动供给、改善人口健康结构的重要抓手。在医疗机构层面，建议从筛查与诊断规范（如成人体重指数（BMI）录入率、肥胖相关合并症筛查率等）、干预与管理质量（如减重达标率、药物干预规范率等）、基层管理绩效（如社区体重筛查率、肥胖合并症转诊率等）等方面按临床规范、分级进行设计和考核。

**最后，建议在现有政策基础上，参考目前重点慢病管理的先进经验，建立多层次的政策保障与资源投入机制。**一方面，考虑将体重管理相关筛查服务（如 BMI 计算，腰围，腰高比等）纳入国家基本公共卫生服务项目，建立统一的服务规范并配套经费支持，特别是在基层医疗机构逐步建立明确的肥胖规范化管理的职责和操作依据，并加强培训。另一方面，需突破卫生系统边界，推动跨部门协同立法与规制。例如，制定更严格的食品营养标签与广告法规，推动“减盐、减油、减糖”的食品产业改革，将体育设施与活跃通勤模式强制性纳入城乡规划，并对相关科研、技术开发给予稳定资金支持。

综上所述，通过战略升级、执行强化与系统保障三管齐下，将体重管理

从一项公共卫生倡议，全面提升为一项全社会共同行动、具有刚性约束与持续动力的国家健康工程，方能有效遏制肥胖及其相关疾病负担的上升趋势，为全民健康奠定坚实基础。

**(二) 借鉴世界卫生组织相关指南和专家意见，将体重管理服务向基层延申并建立正确的药物临床应用认知，将肥胖治疗创新药物纳入国家基药目录，实现更广泛、更公平的可及**

2025 年 12 月，世界卫生组织推出了《成人肥胖症治疗中使用胰高糖素样肽-1 (GLP-1 RA) 疗法的指南》(以下简称“《指南》”)。该《指南》基于肥胖是一种复杂可复发的慢性疾病的认识，提出有效的肥胖管理不仅仅是单纯的减重，而需要建立整合了行为和生活方式改变、药物治疗、长期随访、社会保障和支持性环境的综合管理模式<sup>44</sup>。

《指南》特别强调，GLP-1 RA 等创新疗法的出现使得有效的药物治疗作为肥胖综合干预的一个重要组成部分成为可能，然而目前各国对于肥胖的药物治疗并未形成统一、科学的认识，往往造成治疗的延误和不充分。因此，世界卫生组织认为有必要出台一个基于临床证据、尊重各国卫生系统发展现状、以公共卫生优先事项和公平原则为指导的指南，帮助各国更好地将 GLP-1 RA 等创新药物安全、公平且适当地纳入医疗服务，包括基层医疗体系、非传染性疾病预防计划、基本药物清单和健康服务包等<sup>45</sup>。

世界卫生组织的《指南》对于中国提升基层肥胖诊疗能力，在基层医疗卫生人员中建立正确体重管理和药物临床应用认知，具有借鉴价值。2025 年一项针对中国西南地区 240 名基层医师的调查显示，尽管 80%的受访者认可肥胖属于慢性疾病，75%了解其健康危害，但在体重管理的临床实践，尤

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<sup>44</sup> WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults. World Health Organization. Accessed on Feb 10, 2026.

<https://app.magicapp.org/#/guideline/LrRxrL>

<sup>45</sup> *ibid.*

其是药物干预方面的认知仍然不足。调查中，55%和60%的医师对饮食与行为干预的作用具有较高认知，但仅30%对减重药物具备正确知识。相比之下，接受过相关正规培训的医师在知识（3.95 vs 2.32）、态度（4.59 vs 3.96）和临床实践（1.76 vs 1.25）方面得分均显著更高，提示系统性培训对提升基层肥胖规范化诊疗能力具有重要作用<sup>46</sup>。

该调查表明，目前中国基层医务工作者对于体重管理相关的知识水平和临床能力仍需要加强，基层肥胖诊疗水平有待提升。通过系统性的学习与培训，强化基层医护人员对肥胖诊疗的专业能力与知识储备，进而建立起对肥胖症治疗方案及药物的正确认知，推动药物的规范化和常规化的临床应用至关重要。

前文指出，农村人口肥胖患病率近年来持续上升，已呈现出超越城市人口的高发趋势。二三级医院内分泌专科医生对肥胖合并症有着更为深刻的理解，在减重药物使用方面也有着更为丰富的专业知识，能够更好地指导患者进行体重管理，而服务广大农村地区的医务工作者往往因为缺少体重管理和肥胖诊疗相关知识的培训，也苦于接触不到新型减重药物而无法积累相关药物使用的临床经验，因此，提升GLP-1 RA等创新药物可及性或有助于遏制农村地区肥胖高发。

**我们建议参考世界卫生组织专家建议，将相关新型减重药物纳入国家基本药物目录，实现更广泛、更公平的药物可及。**基于肥胖的疾病特性和长期管理的需要，将相关药物纳入国家基本药物目录不仅对于广大的肥胖症及合并症患者长期体重管理和相关疾病的治疗有着重大意义，同时也可以推动各级医疗机构，特别是基层医疗机构的日常配备，帮助基层医务工作者建

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<sup>46</sup> Tang J., Chen H. and Pi L. Obesity-related knowledge, attitude, and practices among primary care physicians in China: a cross-sectional study. *Front. Med.* 2025 (12):1668886.

立科学的药物认知、积累临床应用经验，在广大农村地区实现药物的公平可及。

**（三）借鉴国际经验，基于卫生技术评估、成本效益和长期体重管理获益，科学区分医学体重管理和医美减肥，将医学体重管理药物纳入医保支付范围，建立可持续性的医疗保障筹资体系**

随着社会对肥胖慢病属性认知的不断加深，医学体重管理已与以外形改善为目的的医美减肥形成明晰区分。国内外指南均将肥胖界定为需要长期管理的慢性疾病，新型减重药物凭借确切的疗效和良好安全性，为超重肥胖及其相关代谢和心肾合并症患者带来实质性临床获益，为政策上区分医学体重管理与医美减肥提供了充分依据。构建覆盖全流程与全生命周期的体重管理政策闭环，医疗保障体系的完善尤为关键。

首先，建议明确肥胖的慢病定义，与医美减肥进行科学区分，更精准地将具有明确临床诊疗标准的体重管理药物逐步纳入基本医疗保障范围。依据《肥胖症诊疗指南（2024年版）》的定义和分型分期，需建立统一疾病界定，将治疗性体重管理药物与医美减肥产品严格区隔，建议在科学界定的前提下对现行减肥类药物“不纳入医保”的相关规定进行重新评估与优化调整，以更好满足临床治疗需求。国际实践已提供可借鉴经验，包括英国、阿联酋、日本等国家均将体重管理药物纳入医保支付体系。

其次，结合真实世界数据与科学技术评估手段，从高风险人群起步，稳妥推进医保覆盖。结合国际经验并立足中国国情，建议基于真实世界证据开展卫生技术评估和成本效益分析，优先将中重度肥胖患者等高风险人群逐步纳入医疗保障范围。

英国 NHS 自 2024 年起将 GLP-1 RA 类药物纳入报销，用于减重和体重维持，并以健康相关生活质量、成本效果和风险等级为核心准入标准，利用

质量调整生命年（QALY）、增量成本效果比（ICER）等指标建立分级分类的报销规则，以平衡临床需求与医保基金的可持续性<sup>47</sup>。国际研究亦证实体重管理药物的医保覆盖具有长期经济性。例如，美国 Medicare 若纳入相关药物并强化行为治疗，预计十年内可节省 200 - 230 亿美元医疗保险支出<sup>48</sup>。

与此同时，鉴于超重与肥胖对劳动力的长期影响，建议同步探索创新支付方式，尝试引入雇主参与的商业保险，构建多层次体重管理医疗保障体系。建议鼓励雇主通过商业保险为员工提供体重管理相关保障，以分担超重肥胖导致的在岗低效和劳动力损耗，并推动税优保险等政策落地，逐步构建多层次体重管理保障体系。

综上所述，通过借鉴国际经验、完善卫生技术评估与成本效益分析，逐步放开对减重药物“一刀切”式的报销限制，并同步推进多元支付机制建设，可在确保基金可持续性的前提下，提高高风险人群的治疗可及性，系统降低超重和肥胖带来的医疗与经济负担。

## 四、 总结

近年来，肥胖在中国呈现持续攀升和显著年轻化趋势，已成为不容忽视的重大公共卫生挑战。作为 200 余种慢性疾病的共同源头，肥胖不仅增加医疗系统负担，也对人口健康、劳动力供给与经济社会的长期可持续发展构成深远影响，尽快遏制其高发态势已刻不容缓。

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<sup>47</sup> Interim commissioning guidance. National Health Service. Accessed Feb 10, 2026. <https://scottishmedicines.org.uk/media/9388/tirzepatide-mounjaro-final-may-2024-amended-050624-140825-for-website.pdf>.

<sup>48</sup> Chen F, Su W, Ramasamy A, Zvenyach T, Kahan S, Kyle T, Ganguly R. Ten-year Medicare budget impact of increased coverage for anti-obesity intervention. *J Med Econ.* 2019 Oct;22(10):1096-1104. doi: 10.1080/13696998.2019.1652185. Epub 2019 Aug 19. PMID: 31378108.

国家已将体重管理的政策能级进一步提升，初步形成“预防为主、全人群覆盖、全生命周期管理”的政策框架<sup>49</sup>，并在跨学科诊疗能力方面取得进展，但现有政策仍偏宏观，执行落地、考核体系和资源配置不足，对药物干预的重视亦不够。当前医疗保障政策对医学体重管理与医美减重的边界界定尚需进一步细化，具有明确临床价值的新型体重管理药物尚未纳入医保目录，在可及性和可负担性方面仍存在一定不足，也在一定程度上限制了体重管理闭环的构建。“十五五”时期将是推动相关政策完善和体系建设的重要窗口。通过加强顶层设计、完善考核机制、优化资源配置，并推进创新型体重管理药物的规范化保障安排，有望进一步提升政策落实成效，加快构建系统化、可持续的肥胖防控体系。由此可持续降低中长期疾病风险，提升人群健康水平，并通过扩大有效劳动力、提升劳动生产率，进一步促进经济稳健增长。

礼来作为一家拥有 150 年历史的全球创新型医药企业，重新定义糖尿病与肥胖疗法，减少肥胖对人体的长期影响，致力于解决全球多重挑战的创新临床试验，同时确保药物的可及性和可负担性。同时，我们通过企业实践推动体重管理关口前移，将肥胖处方药报销纳入员工福利体系，以企业标准示范推动规范化、可持续的肥胖管理模式。未来，我们愿与政策制定者、医疗机构和产业伙伴保持紧密合作，共同构建更加完善的体重管理与肥胖防控体系，助力实现健康中国战略目标。

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<sup>49</sup> 《关于印发“体重管理年”活动实施方案的通知》（国卫医急发〔2024〕21号），国家卫健委等十六部门。[https://www.gov.cn/zhengce/zhengceku/202406/content\\_6959543.htm](https://www.gov.cn/zhengce/zhengceku/202406/content_6959543.htm)

# **From Healthy Weight to Healthy Economy: Upgrading Weight Management and Affordability for Long-term Socio-economic Resilience**

*Eli Lilly and Company*<sup>1</sup>

## **Executive Summary**

**Obesity represents a critical public health challenge in China, contributing to a wide range of chronic conditions, elevated mortality risk, and a growing national health and social burden.** Widely recognized as a chronic disease, obesity is an important risk factor for more than 200 other conditions, including diabetes, hypertension, dyslipidemia, cardiovascular diseases, respiratory diseases, and reproductive disorders. Obesity also significantly increases mortality risk. Studies show that each one-unit increase in Body Mass Index (BMI) is associated with on average 9% higher risk of mortality among individuals with obesity. At present, obesity has become the sixth leading risk factor for death and disability in China, exerting a profound impact on the country's future disease burden and healthy life expectancy.

**China has the world's largest population who suffer from overweight or obesity, and the prevalence continues to rise with earlier onset and widening urban–rural disparities.** According to the latest statistics, China's prevalence of overweight and obesity among adults stood at **50.7% in 2024, affecting approximately 532 million people and ranking first globally.** If the trend continues, **by 2030, this figure will reach 70.5% (approximately 811 million adults).** Among adolescents, the prevalence is projected to rise from **19.8% to 31.8%**, while that of rural adults would reach **73% by 2030.** There is a pressing

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<sup>1</sup> The views expressed in this report are those of the enterprise research and do not represent the official stance or opinions of the forum host and organiser.

need to prioritize resources to address the rising trends, particularly in primary care settings.

**Overweight and obesity have inevitably become a major healthcare and economic burden due to high medical costs and reduced labor productivity. A study conducted by multinational business intelligence firm GlobalData based on official public databases and multivariable regression models shows that, the total economic costs related to overweight and obesity in China reached approximately CNY 1 trillion in 2025, accounting for 0.7% of China’s national GDP, roughly equivalent to the 2025 GDP of Chinese cities like Wenzhou or Dalian. Of these costs, 40% came from the direct medical costs of obesity and its comorbidities and 60% from the incurred productivity losses. If no action is taken, the figure will rise by 30% to about CNY 1.3 trillion within a decade. As labor quality and supply gradually weaken, such trend will exert sustained pressure on China’s economic growth potential and pose risks to development resilience over the medium and long term.**

**From international perspective, clinical intervention and evidence-based treatment have become widely recognized as cornerstones of effective obesity management, bringing both health benefits and long-term economic value.** An international leading journal has suggested a clear distinction between pre-clinical obesity and clinical obesity, and proposed systematic medical treatment for patients with clinical obesity. The World Health Organization (WHO) guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults published in December 2025<sup>2</sup> also note that pharmacotherapy is an important component of comprehensive interventions for obesity. It is therefore evident that integrating obesity into the clinical care system has become a key global approach to obesity management. Studies further show that timely treatment with innovative drugs can not only deliver significant and sustained health benefits, but also generate substantial long-term economic returns by reducing the burden of

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<sup>2</sup> WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults. World Health Organization. Accessed on Feb 10, 2026. <https://app.magicapp.org/#/guideline/LrRxrL>

comorbidities, slowing labor force decline, and increasing labor force participation. This yields multiple benefits: improving health, enhancing productivity, reducing premature deaths, and boosting economic growth.

**It is encouraging to note that, through a series of policy documents such as *Healthy China 2030* and the *Implementation Plan for the Year of Weight Management Initiative*, China has been progressively elevating the importance of weight management in terms of both policy level and dimension. However, implementation still faces uncertainties, particularly in primary care and rural settings and at the healthcare security level.** In primary care institutions and rural areas, practical challenges remain prominent: significant improvements are needed in clinical capacity, standardized management, and equitable access to medications. Furthermore, although obesity is widely recognized as a chronic disease within the medical community, it has not yet been incorporated into the healthcare security system. A clear scientific distinction between clinical weight management and cosmetic weight loss has yet to be established at the policy level, which limits insurance coverage for innovative therapies with proven clinical value. These gaps in healthcare security and service delivery hinder the development of a fully integrated, closed-loop management system for obesity, and ultimately restrict the overall effectiveness of national obesity governance.

China is now at a critical turning point, and immediate action is needed. While China has prioritized weight management on the national agenda, more proactive, scientific and systematic efforts should be made to effectively curb the rising prevalence of obesity:

- 1. Elevate weight management in the 15th Five-Year Plan for National Health with long-term implementation plans and sustained investment, creating synergy between health promotion and economic growth.**

Weight management shall be integrated into the National Health Plan for the 15<sup>th</sup> Five-Year Plan period, with a Healthy Weight campaign and clear national obesity control targets. A cross-departmental collaboration mechanism and a holistic assessment mechanism (for instance, by drawing on assessment indicators for

conditions like hypertension and diabetes) shall be established. We should also incorporate weight management services such as BMI and waist circumference measurements into the basic public health service system, thereby promoting the systematization of resource investment and policy support.

**2. Recognize the value of pharmacotherapy for obesity and expand access to evidence-based solutions, including evaluating the inclusion of innovative obesity management medications (OMMs) on the National Essential Drug List to achieve broader access.**

Current interventions focus primarily on lifestyle change, underestimating the value of pharmacotherapy for weight management. The newly released WHO Guidelines provide a holistic and standardized model for weight management, with focus on pharmacotherapy. By aligning with the WHO Guidelines and Lancet’s definition of clinical obesity, weight management and obesity treatment capacity should be strengthened at primary care level and innovative OMMs should be scientifically evaluated to be included on the National Essential Drug List (NEDL) to expand access, particularly in rural areas.

**3. Comprehensively reduce the disease burden by gradually covering clinical obesity treatment in the basic medical insurance and exploring innovative payment schemes.**

Clinical obesity treatments remain excluded from reimbursement due to being grouped with cosmetic weight-loss products. With the consensus of obesity as a complex, relapsing, chronic disease, weight management for clinical purposes should be clearly differentiated from lifestyle-related treatments such as cosmetic weight loss. By adopting health technology assessment and cost-effectiveness analysis, medium-to high-risk populations (e.g., patients with moderate to severe obesity) should be gradually covered by basic medical insurance, supplemented by innovative payment schemes and a sustainable and equitable healthcare financing system to comprehensively reduce the economic burden of obesity.

# 1. Obesity: An Unaffordable Burden

## 1.1 Obesity is growing rapidly and affecting younger populations, with rural prevalence projected to surpass urban levels, presenting a major public health challenge

As one of the most critical global public health crises of the 21<sup>st</sup> century, obesity poses mounting challenges to both public health and national economic development.

**In recent years, the prevalence of overweight and obesity among China's population has continued to rise rapidly.** Data show that the overweight and obesity rate among Chinese adults increased from 13.2% in 1990 to **50.7%** in 2024 (overweight 34.3%, obesity 16.4% according to the *Chinese Guidelines for the Clinical Management of Obesity (2024 Edition)*)<sup>345</sup>. This means that approximately one in every two adults is affected by weight-related disorders. The total affected population reached **532 million people in 2024**<sup>6</sup>, ranking first in the world<sup>7</sup>. If left uncontrolled, the overweight and obesity rate among adults is projected to reach **70.5% by 2030**, affecting approximately **811 million people** and posing a major public health challenge<sup>8</sup>.

**Obesity is becoming increasingly prevalent among younger populations.**

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<sup>3</sup> Helble, M. and Francisco, K. The Imminent Obesity Crisis in Asia and The Pacific: First Cost Estimates. ADBI Working Paper 743. 2017, Tokyo: Asian Development Bank Institute.

<sup>4</sup> According to the Chinese clinical guidelines, a BMI of 24 kg/m<sup>2</sup> to less than 28 kg/m<sup>2</sup> is defined as overweight, and a BMI of 28 kg/m<sup>2</sup> or above is defined as obesity.

<sup>5</sup> Chinese Guidelines for the Clinical Management of Obesity (2024 Edition). General Office of Chinese National Health Commission. [https://www.gov.cn/zhengce/zhengceku/202410/content\\_6981734.htm](https://www.gov.cn/zhengce/zhengceku/202410/content_6981734.htm)

<sup>6</sup> *ibid.*

Jing An, Qingyi Jia, Yan Huang, Yuzi Cao, Yaqian Duan, Huijie Zhang, Sheyu Li, Obesity care in Chinese adults: from evidence to clinical practice, *Precision Clinical Medicine*, Volume 8, Issue 4, December 2025, pbaf036, <https://doi.org/10.1093/pcmedi/pbaf036>

The adult population of China (aged 18 and above) is approximated at 1.05 billion. This estimate is based on population age structure: given a total population of approximately 1.4 billion and about 23–25% of the population under 18, the adult population is rounded to 1.05 billion.

<sup>7</sup> GBD 2021 Lower Respiratory Infections and Antimicrobial Resistance Collaborators (2024). Global, regional, and national incidence and mortality burden of non-COVID-19 lower respiratory infections and aetiologies, 1990-2021: a systematic analysis from the Global Burden of Disease Study 2021. *The Lancet. Infectious diseases*, 24(9), 974–1002. [https://doi.org/10.1016/S1473-3099\(24\)00176-2](https://doi.org/10.1016/S1473-3099(24)00176-2).

<sup>8</sup> Guidelines for Weight Management (2024 Edition). National Health Commission, [https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000\\_59785.pdf](https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000_59785.pdf)

Studies indicate that young adults aged 18–29 years are the main driver of the rapid growth in obesity among the general adult population, with an annual prevalence growth rate of approximately **11%** (Figure 1)<sup>9</sup> from 2010 to 2018. High obesity levels are not limited to specific adult groups. A sharp upward trend in overweight and obesity rates is also observed among adolescents. Currently, the overweight and obesity rate among adolescents stands at **19.0%**, raising a major public health concern<sup>10</sup>. Without effective intervention, this figure is projected to rise to 31.8% by 2030<sup>11</sup>.

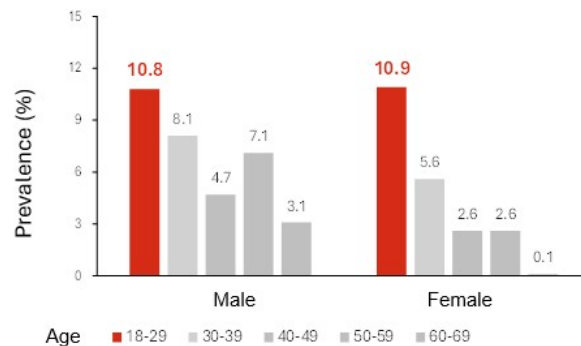


Figure 1: Annual Growth Rate of Obesity Prevalence among Adults Aged 18-69, 2010-2018

**Overweight and obesity are more pronounced among males.** The prevalence of overweight was 40.2% among men and 27.4% among women. The prevalence of obesity was 17.6% among men and 9.6% among women<sup>12</sup>. Overall, the prevalence of overweight among men is 1.5 times that among women, and the prevalence of obesity among men is 1.8 times that among women.

**Furthermore, the prevalence of obesity in rural areas continues to rise and is**

<sup>9</sup> Wang L., Zhou B., Zhao Z., et al. Body-mass index and obesity in urban and rural China: findings from consecutive nationally representative surveys during 2004-18. *Lancet*. 2021 Jul 3; 398(10294): 53-63.

<sup>10</sup> Chinese Guidelines for the Clinical Management of Obesity (2024 Edition). General Office of Chinese National Health Commission. [https://www.gov.cn/zhengce/zhengceku/202410/content\\_6981734.htm](https://www.gov.cn/zhengce/zhengceku/202410/content_6981734.htm)

<sup>11</sup> Guidelines for Weight Management (2024 Edition). National Health Commission, [https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000\\_59785.pdf](https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7/files/1736390749000_59785.pdf)

<sup>12</sup> Chen K, Shen Z, Gu W, et al. Prevalence of obesity and associated complications in China: A cross-sectional, real-world study in 15.8 million adults. *Diabetes Obes Metab*. 2023;25(11):3390-3399. doi:10.1111/dom.15238

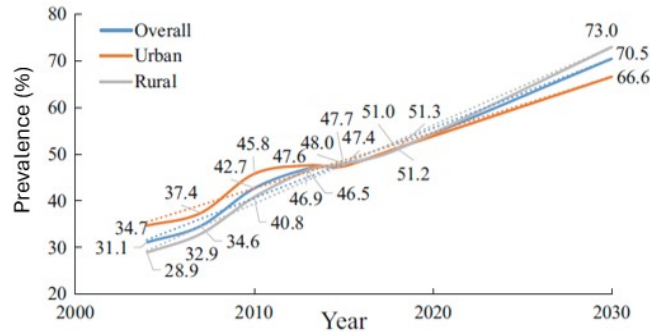


Figure 2: Trends in Overweight and Obesity in Urban and Rural China, 2000–2030

**expected to surpass that in urban areas.** An epidemiology study projects that by 2030, the overweight and obesity prevalence rate among rural adults (73.0%) will surpass that in urban areas (66.6%), undermining the sustainable and equitable development of the primary public health system (Figure 2)<sup>13</sup>. Rural areas across the country are becoming a key focus for obesity prevention and control.

In retrospect, the upward trend of obesity in rural areas has persisted for many years. National surveys show that before 2010, overweight and obesity among adults rose rapidly, with a more pronounced increase in urban areas. However, from 2010 to 2018, the growth rate slowed in cities but accelerated in rural areas<sup>14</sup>. As early as 2013, the age-standardized prevalence of overweight and obesity among rural women had already exceeded that among urban women (overweight: 46.0% vs. 43.6%; obesity: 14.4% vs. 13.3%)<sup>15</sup>.

**1.2 A similar diverging trend is observed among adolescents. The growth rate of overweight and obesity among urban children has slowed significantly, while that among rural children continues to rise linearly. Projections indicate that by 2030, the overweight and obesity rate among rural adolescents will reach 40.82% (urban: 38.43%), and 26.76% among rural**

<sup>13</sup> Sun X., Yan A.F., Shi Z., et al. Health consequences of obesity and projected future obesity health burden in China. *Obesity (Silver Spring)*. 2022 Sep;30(9): 1724-1751.

<sup>14</sup> Wang L., Zhou B., Zhao Z., et al. Body-mass index and obesity in urban and rural China: findings from consecutive nationally representative surveys during 2004–18. *The Lancet*. 2021; 398(10294): 53-63.

<sup>15</sup> *ibid.*

**girls (urban: 24.61%)<sup>16</sup>. Obesity is a major risk factor for numerous high-burden chronic diseases**

**Obesity is a major causal factor in chronic disease development and is associated with more than 200 chronic diseases, and the incidence of complications in people living with obesity is significantly higher than that in people with healthy weight.** Diabetes, hypertension, dyslipidemia, and cardiovascular diseases are the most common obesity-related complications, with the incidence reaching as high as 57%, 72%, 65% and 23% respectively among people living with obesity. Taking diabetes as an example, studies show that the risk of developing type 2 diabetes increases by 51% and 149% in people living with overweight and obesity respectively compared with healthy people, and the incidence of newly developed comorbidities increases by 21% and 22% respectively<sup>17</sup>. In addition, obesity is closely linked to respiratory diseases. Approximately 70% of patients with obstructive sleep apnea are complicated with obesity<sup>18</sup>. Therefore, managing weight at an early stage can significantly reduce the risk of obesity progressing to other chronic diseases, as obesity is a chronic complex disease that requires lifelong care beginning with clinical assessment and early diagnosis.

**In addition to common chronic diseases, obesity also exacerbates adverse effects on women's reproductive health, posing a major threat to the sustainable development of China's population health.** For women of reproductive age, polycystic ovary syndrome (PCOS) is one of the main causes of anovulatory infertility, affecting approximately 24 million women of reproductive age in China. Most PCOS patients are complicated with overweight/obesity, and overweight/obesity worsens the symptoms of PCOS: the incidence of PCOS is about 7.8% in the general female population but can be as high as 28.3% in women

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<sup>16</sup> Dang J, Liu Y, Cai S, Zhong P, Shi D, Chen Z, Zhang Y, Dong Y, Ma J, Song Y. Secular trend and projection of overweight and obesity among Chinese children and adolescents aged 7-18 years from 1985 to 2019: Rural areas are becoming the focus of investment. *Chin Med J (Engl)*. 2025 Feb 5;138(3):311-317.

<sup>17</sup> Yu C, et al. Influence of Overweight and Obesity on Disease Progression, Healthcare Utilization and Costs Among People with Prediabetes: A Cohort Study in China. *Value Health*. 2025; 28(6): S175-S176.

<sup>18</sup> Wolk R., Shamsuzzaman A.S., Somers V.K. Obesity, sleep apnea, and hypertension. *Hypertension*. 2003 Dec; 42(6): 1067-74.

living with overweight or obesity<sup>19</sup>. Moreover, overweight/obesity and PCOS mutually aggravate one another, and the proportion of PCOS patients complicated with overweight, obesity, or abdominal obesity is showing an expanding trend year by year.

**Obesity is also a major risk factor for death.** According to the 2019 Global Burden of Disease Study, the total number of obesity-related deaths reached 5.02 million worldwide, making obesity the fifth leading risk factor for death globally and the sixth leading cause of death and disability in China<sup>20 21</sup>. In addition, the risk of death in people living with overweight and obesity increases with the rise of BMI—for each unit increase in BMI, the risk of death increases by 5% in overweight people and 9% in people living with obesity<sup>22</sup>. A joint study by the Vanderbilt Epidemiology Center and the Department of Epidemiology at Shanghai Cancer Institute found that among those with BMI over 23 kg/m<sup>2</sup>, every 5 kg weight gain from early to middle adulthood was linked to a 9% higher risk of all-cause mortality in men and 14% in women, as well as increased risks of diabetes, cardiovascular disease, depression, and Alzheimer’s disease<sup>23</sup>. Obesity contributed to 5,473 cardiovascular deaths (21.1% of total cardiovascular deaths), 979 diabetes deaths (10.7%), and 846 cancer deaths (2.6%), showing a strong correlation between obesity and mortality.

### **1.3 Obesity is a barrier to sustainable socioeconomic development.**

**Obesity imposes a growing burden on China’s healthcare system and socioeconomic development.** A multinational study titled *Cost of Inaction in*

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<sup>19</sup> Wang W., Wang L. Endocrinologist consensus on weight management in overweight/obese patients with PCOS. *Chinese Soc Endocrinol.* 2025 Jan 25.

<sup>20</sup> Chong B., Jayabaskaran J., Kong G., et al. Trends and predictions of malnutrition and obesity in 204 countries and territories: an analysis of the Global Burden of Disease Study 2019. *EClinicalMedicine.* 2023 Feb 16;57: 101850.

<sup>21</sup> Yang X., et al. *Acta Nutrimenta Sinica* 2014,36: 212–17 (in Chinese)

<sup>22</sup> Sun Y.Q., Burgess S., Staley J.R., et al. Body mass index and all cause mortality in HUNT and UK Biobank studies: linear and non-linear mendelian randomisation analyses. *BMJ.* 2019 Mar 26;364:11042.

<sup>23</sup> Jia G, Shu X, Liu Y, et al. Association of Adult Weight Gain With Major Health Outcomes Among Middle-aged Chinese Persons With Low Body Weight in Early Adulthood. *JAMA Netw Open.* 2019;2(12):e1917371. doi:10.1001/jamanetworkopen.2019.17371

*Treating Obesity*, conducted by multinational business intelligence firm GlobalData in 2025, used publicly available data and statistical models to analyze obesity’s economic burden. The study quantified the direct medical costs of overweight, obesity and their comorbidities, as well as the indirect economic losses related to social productivity and labor force participation in Canada (2023), the United States (2024), China (2025) and other countries for the reference year and the subsequent decade (Table 1)<sup>24,25</sup>. Overweight and obesity impose a substantial health and economic burden in all countries included in the study (China-specific data are presented below).

Table 1: Total Economic Burden of Overweight and Obesity in Canada, the United States, and China

(\$ billion)	Canada (2023) <sup>26</sup>	USA (2024)	China (2025)
Total economic burden	20.4	933	142
GDP%	0.95%	3.2%	0.7%

The China study data shows that in 2025, the total economic cost of overweight and obesity among Chinese adults and adolescents aged 12–17 years reached **CNY 1 trillion (approximately USD 142 billion)**, accounting for approximately **0.7% of GDP** for the year<sup>27</sup>. This total cost is projected to rise to **CNY 1.3 trillion** in a decade, an increase of approximately 30%. The overall burden attributable to being overweight and obesity is comparable: overweight-related costs amount to about **CNY 490 billion**, while obesity-related costs total **CNY 526 billion** approximately.

**Obesity and its comorbidities entail substantial direct medical costs.** In light of

<sup>24</sup> Chen, F., Sapra, T., Natale, Z. et al. Modeling the cost of inaction in treating obesity in Canada. *BMC Public Health* 25, 865 (2025). <https://doi.org/10.1186/s12889-025-21905-2>

<sup>25</sup> GlobalData. Health Disparity Implications of Obesity by Race and Ethnicity: Pathway to Improving Health through Obesity Treatment. <https://www.globaldata.com/health-economics/US/HealthEquity/HealthEquity.pdf>

<sup>26</sup> Based on exchange rate 1 USD=0.74 CAD

<sup>27</sup> All below data presented in Section 1.3 are derived from a study on the economic burden of overweight and obesity jointly conducted by Eli Lilly and the multinational business intelligence firm GlobalData. The study is planned for submission to an international academic journal within this year.

the above study, the direct medical costs attributable to overweight and obesity and associated chronic diseases among Chinese adults amount to approximately CNY 415.4 billion. Without systematic intervention and management of overweight and obesity over the next decade, related direct medical costs are expected to increase by 36% and reach approximately CNY 566.2 billion, placing heavier pressure on national healthcare resources and public finance.

Among overweight adolescents aged 12–17 years, significant urban-rural differences have emerged in both incidence and direct medical costs. Over the next decade, the overweight rate among rural adolescents will increase rapidly (18.2% for males and 9.6% for females), with the overall prevalence continuing to rise (Figure 3).

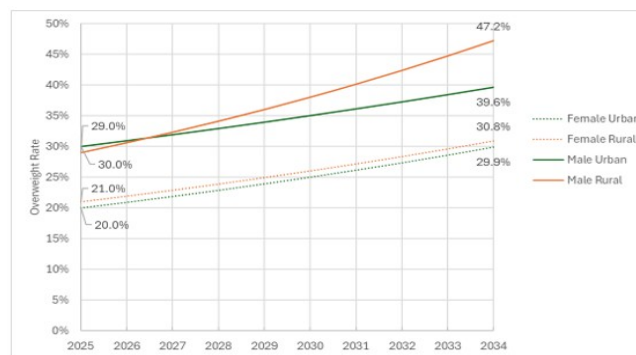


Figure 3: Growth in Medical Expenditure for Overweight Adolescents Aged 12-17, 2025-2035

In terms of the medical cost trend, the urban-rural gap is equally prominent: over the next decade, direct medical cost for rural adolescents aged 12–17 will increase by 5%, while that in urban areas will decrease by 6%. Particularly among male adolescents, medical cost in rural areas will rise by as much as 11%, compared with a sharp decrease of 10% in urban areas (Table 2). This contrasting urban–rural trend underscores the urgent need to channel more high-quality medical resources to rural primary care settings, in order to curb the rapid growth of related diseases and surging healthcare demand.

Table 2: Growth in Medical Costs for Overweight Adolescents (12–17) Over the Next 10 Years

	Female	Male	All
Urban	4%	-10%	-6%
Rural	3%	11%	5%

**Furthermore, the indirect economic losses attributable to obesity are even more substantial.** Estimates indicate that total indirect losses caused by overweight and obesity in China have reached **CNY 595.6 billion**, accounting for **60% of the overall economic cost**. This figure far exceeds direct medical cost and has become a major constraint on robust economic development. Among these, the loss of effective labor productivity caused by overweight and obesity accounts for 60% of all indirect costs, including presenteeism and absenteeism. Approximately half of the indirect losses stem from on-the-job inefficiencies and hidden productivity drains resulting from presenteeism.

In addition to that, overweight and obesity compel working-age individuals to withdraw from the labor force or discontinue job-seeking activities, contributing to approximately 30% of indirect costs. Premature deaths related to obesity incur losses exceeding CNY 70 billion, resulting in the permanent depletion of human capital and irreversible loss of social welfare resources.

Table 3: Indirect Economic Losses Caused by Overweight and Obesity in China (2025)

Cause	Economic Loss (Billion CNY)	Percentage
Decline in Effective Labor Efficiency: Presenteeism and Absenteeism	3637	61%
Withdrawal from the Labor Market	1604	27%
Premature Death	715	12%
Total	5956	100%

Against the backdrop of persistently low fertility rates and accelerating population

aging in China, labor resources are becoming increasingly scarce. The obesity-related disease burden is further compressing the size of the effective labor force and undermining the nation's capacity for socioeconomic value creation.

## **2. Urgent Action Is Needed to Curb the High Prevalence of Obesity**

With the advancement of research, consensus has gradually emerged in the medical community that obesity constitutes a complex, relapsing, chronic disease. The government has also fully recognized that obesity poses a threat to public health and sustainable socioeconomic development. Over the past three years, China's policy response has evolved from advocacy and targeted initiatives to standardized governance and strategic prioritization, forming a policy framework centered on "prevention first, full population coverage, and whole-life cycle management."

In June 2024, the National Health Commission (NHC), together with multiple departments, launched and continued to advance the *Weight Management Year* campaign<sup>28</sup>. Additionally, the *Healthy Weight Management Initiative* has been incorporated into the *Healthy China Action in 2025*<sup>29</sup>. As the first national-level systematic initiative in China to incorporate weight management, it marks a further elevation of the policy level for weight management and obesity prevention and control in government-led action plans.

On one hand, the issuance of the *Guiding Principles for Weight Management (2024 Edition)* has provided unified standards for medical institutions and professionals, emphasizing early prevention of chronic disease control and strengthening collaboration among medical institutions, families, and communities<sup>30</sup>.

On the other hand, health weight management clinics have been established in

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<sup>28</sup> Notice on the Action Plan of Weight Management Year Campaign. Chinese National Health Commission and other 16 ministries. [https://www.gov.cn/zhengce/zhengceku/202406/content\\_6959543.htm](https://www.gov.cn/zhengce/zhengceku/202406/content_6959543.htm)

<sup>29</sup> Notice of the National Patriotic Health Campaign Committee on Incorporating Three Actions Including the Healthy Weight Management Initiative into the Healthy China Action. [https://www.gov.cn/zhengce/zhengceku/202504/content\\_7018518.htm](https://www.gov.cn/zhengce/zhengceku/202504/content_7018518.htm)

<sup>30</sup> Guiding Principles for Weight Management (2024 Edition). General Office of Chinese National Health Commission. <https://www.nhc.gov.cn/ylyjs/zcwj/202412/75cb79c171c94def9e768193e65484f7.shtml>

tertiary hospitals to optimize service models<sup>31</sup>. The provision of such clinics in all tertiary public hospitals has been included as one of the ten key public services for 2026, with full coverage targeted for completion by 2026. At present, China has set up health weight management clinics in over 5,500 secondary and tertiary hospitals<sup>32</sup>.

The introduction of a series of national-level policy documents and action plans for weight management demonstrates China's determination to curb the high prevalence of obesity. Nevertheless, considering the imminent threat of overweight and obesity posed to the health of the people and the long-term socioeconomic development, we believe that the current policies urgently need to be enhanced in the following aspects.

**Firstly, compared with other key chronic diseases, the policy positioning, implementation, and assessment of overweight and obesity remain relatively unclear, while the allocation and investment of related resources are still inadequate.**

From the perspective of policy positioning, taking diabetes prevention and control as an example, in addition to national planning documents, the National Health Commission has further issued documents such as the *Implementation Plan for the Healthy China Initiative — Diabetes Prevention and Control Action (2024—2030)* and the *Guiding Principles for Nutrition and Exercise in Hyperglycemia (2024 Edition)*, which have made full-process arrangements for all links of diabetes prevention, screening, diagnosis, treatment and management. In contrast, although obesity has been recognized as an independent chronic disease, the deployment of policies for obesity in national plans and special chronic disease initiatives remains inadequate. In chronic disease-related plans, people living with overweight and obesity are only regarded as high-risk groups for chronic diseases, and obesity is

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<sup>31</sup> Notice on the Establishment and Administration of Health Weight Management Clinics. Chinese National Health Commission.

<https://www.nhc.gov.cn/yzygj/c100068/202504/52bcc453524149b884ddf6e2969d24d9.shtml>

<sup>32</sup> National Health Commission Press Release. Feb 12, 2026.

<https://www.nhc.gov.cn/xcs/c100122/202602/07e794cb75d946989950f5adb629ac65.shtml>

merely identified as a factor requiring intervention in some initiatives.

In terms of key performance indicators, hypertension and diabetes have well-established, quantifiable performance assessment systems, whereas such systems for obesity remain significantly inadequate. A range of indicators are employed for performance evaluation, including the awareness rate of hypertension among residents aged 30 years and above, as well as the standardized management rate, treatment rate, and control rate for patients with hypertension and diabetes. These indicators are incorporated into the performance appraisal systems of local governments and primary medical institutions to ensure policy implementation. However, no specific performance assessment targets have been established for the prevention and control of obesity.

In terms of resource allocation, key chronic diseases benefit from clear policy prioritization and resource guarantees. Individuals with chronic conditions are prioritized for inclusion in family doctor contract services, requiring a comprehensive long-term care service chain covering treatment and rehabilitation. For example, patients with hypertension and type 2 diabetes are both included in the National Basic Public Health Service Program and identified as key target groups for family doctor contract services, for whom full-cycle services such as free screening, regular follow-up, medication guidance, and health assessment are provided. However, obesity itself, as an independent chronic disease and a critical risk factor for many other chronic conditions, has yet to be included in equivalent policy protection frameworks and standardized management system.

Nevertheless, although obesity has been recognized as a complex, relapsing, chronic disease, its management within the policy framework remains largely embedded in other health domains. It has not yet been strategically coordinated as an independent public health issue requiring systematic governance. Currently, obesity's policy positioning remains unclear, and resource allocation is fragmented. This is inconsistent with the significant public health importance of obesity as the major risk factors of more than 200 chronic diseases. Such a circumstance is also inadequate to address the mounting challenge posed by the impending crossover in

obesity rates, where rural rates are set to exceed urban rates. These trends underscore the urgency of establishing an independent and systematic obesity management policy. There is an imperative need to introduce more comprehensive, multi-dimensional, and integrated policy support and resource investment at the national level.

**Secondly, the current national weight management policies mainly focus on lifestyle changes such as physical activities and diet, while pharmacotherapeutic intervention, as an important part of effective weight management for overweight and obesity, has not received sufficient attention.**

As a treatable condition with complex pathogenic factors, obesity requires long-term medical management to achieve and sustain optimal individualized weight, with the goal of improving overall quality of life and health outcomes<sup>33</sup>. Currently, there are three major approaches to obesity treatment, namely lifestyle and behavioral interventions, pharmacotherapy, and metabolic surgery.

Lifestyle modification is recommended as the cornerstone of obesity management, but many patients do not achieve long-lasting benefits due to difficulty with adherence as well as physiological and neurohormonal adaptation of the body in response to weight loss<sup>34</sup>. According to the *Guideline for Chronic Weight Management and Clinical Practice of Anti-obesity Medications (2024 Version)* published by Chinese Society of Endocrinology, lifestyle interventions need to be integrated throughout long-term weight management, but lifestyle interventions alone often lead to poor results or even weight rebound. Therefore, during the intensive treatment period, it is recommended that for all patients who meet the criteria for obesity or with abdominal obesity, or those with obesity related

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<sup>33</sup> Chinese Society of Endocrinology. Guideline for Chronic Weight Management and Clinical Practice of Anti-obesity Medications (2024 Version). *Chinese Journal of Endocrinal Metabolism*. 2024, (40) 7: 545-564.

<sup>34</sup> Gadde, K.M., Martin, C.K., Berthoud, H., et al. Obesity: Pathophysiology and Management. *J Am Coll Cardiol*. 2018 Jan 2;71(1):69–84.

comorbidities, medications can be introduced to initiate treatment<sup>35</sup>.

*Chinese Guidelines for the Clinical Management of Obesity (2024 Edition)* provide detailed and standardized clinical pathways for people living with overweight and obesity, and establishes clear recommendations for lifestyle intervention or medical treatment across different populations: For overweight individuals without obesity-related comorbidities, lifestyle intervention is recommended. For overweight individuals with obesity-related comorbidities, as well as patients with mild or moderate obesity, pharmacotherapy may be considered or recommended. For patients with severe obesity, surgical treatment may be used to improve clinical outcomes<sup>36</sup>.

In addition, the 2025 Lancet Diabetes and Endocrinology Commission has proposed a revised definition of obesity, classifying the condition into pre-clinical obesity and clinical obesity<sup>37</sup>. Pre-clinical obesity is characterized by excess adiposity in the absence of organ damage, with associated risks managed primarily through health monitoring and lifestyle interventions. Clinical obesity, by contrast, refers to excess adiposity that has already resulted in organ dysfunction or related comorbidities, requiring systematic medical treatment to alleviate symptoms and prevent further health deterioration.

The redefinition provides a scientific basis and guidance for the standardized diagnosis and treatment of obesity. Therefore, on the basis of lifestyle intervention, the use of medications and other approaches to counteract the physiological rebound mechanism and health risks caused by comorbidities is crucial for long-term weight management among patients with clinical obesity. Novel weight-loss medications, such as incretin-based therapies (e.g., GLP-1 RA, GLP-1/GIP RAs),

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<sup>35</sup> Chinese Society of Endocrinology. Guideline for Chronic Weight Management and Clinical Practice of Anti-obesity Medications (2024 Version). *Chinese Journal of Endocrinal Metabolism*. 2024, (40) 7: 545-564.

<sup>36</sup> Chinese Guidelines for the Clinical Management of Obesity (2024 Edition). General Office of Chinese National Health Commission. [https://www.gov.cn/zhengce/zhengceku/202410/content\\_6981734.htm](https://www.gov.cn/zhengce/zhengceku/202410/content_6981734.htm)

<sup>37</sup> Rubino F et al. Definition and diagnostic criteria of clinical obesity. *Lancet Diabetes Endocrinol*. 2025 Mar;13(3):221-262. doi: 10.1016/S2213-8587(24)00316-4. ISSN: 2213-8587.

have demonstrated significant efficacy and favorable safety, as well as metabolic, cardiac and renal benefits beyond weight reduction.

However, current clinical weight management still relies predominantly on a treat-to-failure model, in which pharmacotherapy is initiated only after repeated failures of lifestyle intervention. For patients with physiological resistance mechanisms, this model often fails to deliver effective and sustainable weight loss and readily leads to weight regain.

Meanwhile, attitudes toward weight-management pharmacotherapy remain conservative among both physicians and patients<sup>38</sup>. Surveys indicate that physicians commonly express concerns regarding safety, drug-drug interactions (DDI), and cost when considering pharmacotherapy initiation. A study in the United States shows that although nearly half of patients report willingness to try prescription weight-loss medications, only approximately one-fifth have received formal treatment based on a physician's recommendation, and only 4.2% have maintained ongoing treatment<sup>39</sup>.

Thus, there is an urgent need to shift weight management from the “treat-to-failure” model to a “treat-to-success” integrated intervention model. Building on scientific insights into physiological rebound mechanisms, lifestyle and pharmacotherapy interventions should be combined earlier and more systematically to establish a long-term, standardized weight management framework for patients with obesity.

**Lastly, the recognition of obesity as a chronic disease has not been fully institutionalized in medical insurance policies, and the affordability and equity of obesity treatment require further improvement.**

The Global Obesity Response Index (published by *The Economist*) assesses obesity prevention and control policies in 20 countries, including China, the United

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<sup>38</sup> Granara, B. and Laurent, J. Provider attitudes and practice patterns of obesity management with pharmacotherapy. *Journal of the American Association of Nurse Practitioners*. 2017, 29(9): 543-550.

<sup>39</sup> Kaplan, L., Gudzone, K., Ard, J., et al. Perceptions of anti-obesity medications among people with obesity and healthcare providers in the US: Findings from the OBSERVE study. *Obesity (Silver Spring, Md.)*. 2025, 33 (6): 1076-1086

Kingdom, France, Germany, Finland, Australia, Japan, and the Republic of Korea<sup>40</sup>. It conducts a comprehensive ranking across four dimensions: policy and governance, obesity management system, food quality and safety, and physical activity, with China ranking eighth overall.

China demonstrates outstanding performance in several areas: it has effectively raised public health awareness through the launch of national initiatives such as the “China National Year of Healthy Weight Management”; established a relatively sound system of clinical guidelines, clearly defining obesity as a chronic disease; and for children and adolescents, formulated unified dietary and nutrition standards, implemented mandatory nutrition education, and enforced a requirement of two hours of physical activity per day. Notably, in the dimension of adolescent physical activity, China is the only country that meets and exceeds the standards recommended by the World Health Organization.

However, China remains deficient in medical insurance coverage for obesity treatment, bringing its overall score in the obesity management dimension below average. Insufficient support from medical insurance policies, along with weak health technology assessment and cost-effectiveness research on related treatments, has resulted in a relatively low score regarding obesity management that urgently needs improvement.

Under the *Interim Measures for the Administration of Drugs for Basic Medical Insurance* issued in 2020, weight-loss drugs for cosmetic purposes are ineligible for inclusion in the Catalog of Drugs for Basic Medical Insurance<sup>41</sup>. Nevertheless, the medical community has reached a consensus that obesity as a chronic complex disease requires lifelong care beginning with clinical assessment and early diagnosis. In recent years, extensive research evidence has further confirmed that

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<sup>40</sup> Economist Impact. An epidemic of inaction: assessing national responses to obesity Findings from the Obesity Response Index.  
[https://assets.ctfassets.net/9crgcb5vlu43/2PTzc84YiThZYRVdq7hkHo/c8b32b5765d9ace54a4a9ed310c5947d/EI\\_x\\_Eli\\_Lilly\\_Global\\_Obesity\\_Response\\_Index\\_Report.pdf](https://assets.ctfassets.net/9crgcb5vlu43/2PTzc84YiThZYRVdq7hkHo/c8b32b5765d9ace54a4a9ed310c5947d/EI_x_Eli_Lilly_Global_Obesity_Response_Index_Report.pdf)

Original Research: <https://impact.economist.com/health/obesity-response-index/global>

<sup>41</sup> Interim Measures for the Administration of Drugs for Basic Medical Insurance. Chinese National Healthcare Security Administration. [https://www.gov.cn/gongbao/content/2020/content\\_5547646.htm](https://www.gov.cn/gongbao/content/2020/content_5547646.htm)

novel weight-loss medications represented by GLP-1 RAs exhibit clear efficacy and favorable safety profiles in the management of overweight, obesity, and associated metabolic, cardiovascular, and renal diseases, delivering substantial clinical value. Corresponding clinical guidelines for obesity have also been continuously refined. Against this backdrop, there is a fairly solid scientific basis for distinguishing between medical weight management and weight loss for cosmetic purposes at the policy level, which contributes to promoting the standardized and systematic development of obesity prevention and treatment.

From the perspective of medical insurance fund sustainability and economic efficiency, novel weight-loss medications also demonstrate significant health and economic returns as suggested by regional experiences. Taking GLP-1-based agents as an example, the published study conducted by GlobalData shows that they can achieve an average weight reduction of approximately 20%, translating to an estimated annual savings of 760–4,720 US dollars per individual in medical expenses<sup>42</sup>.

Another population model-based analysis among Chinese adults who are overweight or living with obesity shows that the use of incretin-based therapies could save approximately CNY 1,261 per person. Extrapolated over the multi-decade lifetime of the entire treated population, the total cost savings are projected to reach up to CNY 70 trillion<sup>43</sup>. About half of these savings stem from direct medical cost reductions due to fewer complications, while the other half comes from the effective mitigation of related indirect cost burdens.

Therefore, early pharmacotherapeutic intervention for overweight and obesity can not only reduce direct medical expenditures associated with long-term complications, but also mitigate losses in social productivity and demand for long-term care by improving health outcomes, reducing disability, and lowering

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<sup>42</sup> GlobalData. Economic Benefits of Obesity Treatment: Review of the Current Literature. Oct 2025, <https://www.globaldata.com/health-economics/us/>

<sup>43</sup> Data are derived from a study conducted by Eli Lilly on the impact of incretin-based therapies on healthcare cost savings in eligible population. The study is planned for submission to an international academic journal within this year.

premature mortality. This, in turn, alleviates pressure on the healthcare system at a broader socioeconomic level.

China still has obvious shortcomings in medical insurance support for obesity treatment, resulting in an overall score below the average in the obesity management. Insufficient support from healthcare security policies, coupled with relative weaknesses in health technology assessment and cost-effectiveness research on related treatment modalities, has led to relatively low overall performance of China's obesity management system, one that urgently requires further efforts to address gaps and achieve systematic improvement.

However, current medical insurance policies have not institutionally differentiated medical weight management from cosmetic weight loss. The chronic disease nature of obesity and its need for long-term management have not been reflected in medical insurance policies, and medical insurance coverage for weight-management medications remains absent. This leaves a considerable number of people living with overweight and obesity with clear medical needs facing the barrier that effective drugs are available but unaffordable. Even when patients commence pharmacotherapy as advised by a physician, cost pressures often lead to treatment discontinuation, which can lead to weight regain, worsening metabolic parameters, and exacerbating complication risks, ultimately increasing the social medical burden in the long run.

Therefore, as a key component of the obesity prevention system, healthcare securities policies should be coordinated with prevention and treatment initiatives to create a comprehensive, closed-loop weight management framework, improving treatment continuity, effectiveness, affordability, and equity.

### **3. Policy Recommendations**

Based on the above analysis, we believe that the next few years are critical for policy implementation to curb the high prevalence of obesity. The policy system requires more proactive, evidence-based, and focused adjustment and optimization

in the following aspects to better support the standardization of weight management and improve the overall effectiveness of obesity prevention and control.

### **3.1 Integrate weight management and obesity treatment into the 15th Five-Year Plan for National Health and strengthen policy implementation with sustained resource inputs**

In recent years, China has brought weight management and obesity treatment to a national strategic level, as a critical move to address the increasingly prominent chronic disease burden and improve people's wellbeing. Although a policy framework covering obesity prevention, treatment and management has preliminarily taken shape, it is imperative to further upgrade the strategy, strengthen the implementation and pull resources for greater policy effectiveness.

**First, we recommend seizing the policy momentum of the 15th Five-Year Plan and taking a top-down approach by integrating weight management and obesity treatment into the *15th Five-Year Plan for National Health*.** It is important to launch a dedicated weight management initiative in the *Plan*, which specifies the national medium- to long-term targets for weight management and obesity rate and makes these targets as one of the core evaluation indicators for the Healthy China Initiative.

In addition, a cross-departmental coordination mechanism and a supporting policy system should be established to ensure its strategic priority and follow the principle of "Promoting Health in All Policies." Therefore, weight management can be addressed in intersectoral policies, such as education, sports, social security, urban construction, etc., and a social environment in favor of obesity alleviation can take shape.

**Second, we recommend establishing a comprehensive and feasible weight management evaluation system for both governments and medical institutions by referencing the current chronic disease prevention and control evaluation systems at national and local levels.** At the government level, detailed indicators targeting declined obesity prevalence can be designed and introduced to be the lever for more productive labor force and healthier population. These indicators may

include adult obesity prevalence rate, overweight and obesity rate among children and adolescents, obesity-related premature death rate, referencing indicators such as awareness, treatment, standardized management, and control rate for hypertension and diabetes, etc.

At the medical institution level, it is suggested to design and track indicators based on clinical standards, such as screening and diagnosis standards (e.g. adult BMI documentation rate, obesity complications screening rate, etc.), quality of intervention and management (e.g. weight loss rate, standardized medical intervention rate, etc.), and primary care service performance (e.g. community-level weight screening rate, referral rate of obesity comorbidities, etc.).

**Finally, we recommend setting up a multi-level policy support and resource input mechanism based on existing policies and management experiences of other chronic diseases.** On the one hand, it is suggested to consider covering weight management-related screening services (e.g. BMI calculation, waist circumference measurement, waist-to-height ratio etc.) in the National Basic Public Health Service Program, promoting a national standard of service from early diagnosis to treatment with dedicated funding. Particularly in primary care settings, a standardized obesity management and care pathway with clear responsibilities, operational guidance and training programs should be in place.

On the other hand, it is necessary to push weight management directives beyond healthcare system and promote cross-sectoral legislation. For example, the government may consider formulating stricter food nutrition labeling and advertising regulations, reduce salt, oil and sugar in food processing industry, incorporate sports facilities and active commuting modes into urban planning, and provide dedicated funding for relevant scientific research and technological development.

In summary, through strategic upgrading, policy enforcing and systematic support, weight management can be comprehensively elevated from a public health initiative to a national health project with social consensus, mandatory legal

restraints and sustainable momentum, so as to effectively curb the rising trend of obesity and the incurred disease burden.

### **3.2 Informed by the World Health Organization (WHO) guidelines and expert opinions, extend weight management services to the primary care level with scientific understanding of pharmacotherapy for obesity, and include innovative obesity management medications (OMMs) in the National Essential Drug List for broader and more equitable accessibility**

In December 2025, the WHO launched the *Guideline on the Use of Glucagon-like Peptide-1 (GLP-1) Therapies for the Treatment of Obesity in Adults* (hereinafter referred to as the “*WHO Guideline*”). Grounded in the recognition that obesity is a complex, relapsing, and chronic disease, the *WHO Guideline* proposes that effective obesity care goes beyond weight reduction alone, but requires multimodal clinical algorithms integrating behavioral and lifestyle changes, pharmacotherapy, long-term follow-up, social protection and supportive environments<sup>44</sup>.

The *WHO Guideline* emphasizes that the emergence of innovative therapies such as GLP-1 RA and GIP/GLP-1 dual receptor agonists has transformed the obesity treatment landscape. It is the WHO’s first *Guideline* that offers evidence-informed recommendations on the use of GLP-1 RA and GIP/GLP-1 dual receptor agonists, “supporting country-level decision-making to promote the safe, equitable and appropriate integration of these therapies into service delivery models, including primary health care, NCD programs, essential medicines lists and health benefits packages”<sup>45</sup>.

**The *WHO Guideline* presents a valuable reference for China to enhance the capabilities of obesity treatment in the primary care institutions and improve the understanding of pharmacotherapy for among primary care healthcare practitioners (HCPs).** A survey of 240 primary care physicians in southwest China conducted in 2025 shows that, although 80% of the respondents recognized that

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<sup>44</sup> WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults. World Health Organization. Accessed on Feb 10, 2026.  
<https://app.magicapp.org/#/guideline/LrRxrL>

<sup>45</sup> *ibid.*

obesity is a chronic disease and 75% understood its risk for health, their knowledge about clinical practice in weight management, especially pharmacotherapeutic intervention, is rather insufficient. In the survey, 55% and 60% of physicians received high scores on the role of diet and behavioral intervention, but only 30% had correct understanding of OMMs. In contrast, physicians who received formal training scored significantly higher in knowledge (3.95 vs 2.32), attitude (4.59 vs 3.96) and clinical practice (1.76 vs 1.25)<sup>46</sup>, indicating that systematic training plays an important role in improving the capabilities of obesity treatment at the primary level.

This survey suggests that weight management knowledge and clinical capacity of primary care HCPs in China, as well as obesity diagnosis and treatment capabilities in primary care institutions still need to be improved. It is crucial to enhance the professional capabilities and knowledge of HCPs through systematic learning and training on pharmacotherapy and clinical practice for obesity.

As mentioned earlier, the prevalence of obesity in rural areas continues to rise in recent years and is expected to surpass that in urban areas very soon. Endocrinologists in secondary and tertiary hospitals generally have a deeper understanding of obesity comorbidities and more professional knowledge in the use of OMMs, and usually can provide better medical solutions for patients with obesity. However, HCPs serving in the vast rural areas often require more professional training on weight management and struggle to access innovative OMMs, making it harder for them to obtain clinical experience related to such medicines. Therefore, enhancing the accessibility of these OMMs holds significant importance, as it may help curb the high prevalence of obesity in rural areas.

**Therefore, we recommend following the WHO expert opinions and including innovative OMMs on the National Essential Drug List (NEDL) for broader and more equitable drug accessibility.**

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<sup>46</sup> Tang J., Chen H. and Pi L. Obesity-related knowledge, attitude, and practices among primary care physicians in China: a cross-sectional study. *Front. Med.* 2025 (12):1668886.

Based on the features of obesity and the need for long-term care, the inclusion of OMMs on the NEDL will not only support the long-term weight management of the increasing number of patients with obesity and comorbidities, but also facilitate daily provision of these medicines in hospitals at all levels, especially in primary medical institutions. Therefore, primary care HCPs may have better access to these medicines, gain better clinical knowledge and prescription experience, and improve services and drug accessibility in rural areas.

### **3.3 On the basis of health technology assessment and cost-effectiveness analysis, scientifically distinguish medical weight management from cosmetic weight loss, include OMMs in medical insurance coverage and establish a sustainable healthcare financing system**

With the consensus of obesity as a chronic disease, weight management for clinical purposes should be clearly distinguished from cosmetic weight loss. As obesity is clearly defined in both China's and overseas published medical guidelines, and innovative OMMs with proven safety and efficacy have brought substantial clinical benefits to patients with obesity and its related metabolic and cardiorenal complications, there is sufficient evidence to support the differentiation between clinical weight management and weight loss simply for physical appearance in policymaking. The improvement of the medical insurance policy for OMMs constitutes the last puzzle piece for the comprehensive and whole life-cycle policy framework for weight management.

**First, we recommend clearly defining obesity as a complex, relapsing, chronic disease, making a scientific distinction from cosmetic weight loss, and gradually including OMMs with clear and precise clinical evidence in the basic medical insurance coverage.** Based on the definition, classification, and staging of the *Chinese Guidelines for the Clinical Management of Obesity (2024 Edition)*, it is imperative to unify the definition and make a sharp distinction between medicines for clinical weight management and those cosmetic products for weight loss. Under scientifically defined criteria, the current blanket restrictions on excluding OMMs from healthcare coverage ought to be reassessed and optimized to better meet clinical treatment needs. Countries like the United Kingdom, the

United Arab Emirates, Japan have successful cases of the inclusion of OMMs in the medical insurance coverage, which could serve as references for China's policymaking.

**Second, based on real-world evidence and scientific assessment methods, it is suggested to prudently and gradually promote medical insurance coverage starting with high-risk groups.** Based on international practices and China's context, it is recommended to conduct health technology assessment and cost-benefit analysis based on real-world evidence, and begin with high-risk groups such as patients with moderate to severe obesity for drug reimbursement.

The UK's National Health Service (NHS) has covered OMMs for reimbursement since 2024 for weight loss and management. The NHS took into consideration quality of life, cost-effectiveness and risk level as key access criteria, and established tiered reimbursement rules using indicators such as Quality-Adjusted Life Year (QALY) and Incremental Cost-Effectiveness Ratio (ICER) to balance clinical needs and the sustainability of medical insurance funds<sup>47</sup>. International studies have also proven that the medical insurance coverage of OMMs is economically viable in the long term. For example, a US Medicare study shows that if certain OMMs and intensive behavioral therapies are covered, it is estimated to save 20-23 billion US dollars in medical insurance expenditure within a decade<sup>48</sup>.

**At the same time, considering the long-term impact of obesity on labor force productivity, it is also recommended to explore innovative payment methods such as employer-paid commercial health insurance to cover OMM reimbursement and build a multilayer medical insurance system for weight management.** The government should encourage employers to provide weight management-related commercial insurance coverage for employees to mitigate the

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<sup>47</sup> Interim commissioning guidance. National Health Service. Accessed Feb 10, 2026. <https://scottishmedicines.org.uk/media/9388/tirzepatide-mounjaro-final-may-2024-amended-050624-140825-for-website.pdf>.

<sup>48</sup> Chen F, Su W, Ramasamy A, Zvenyach T, Kahan S, Kyle T, Ganguly R. Ten-year Medicare budget impact of increased coverage for anti-obesity intervention. *J Med Econ.* 2019 Oct; 22(10):1096-1104.

low efficiency and productivity loss caused by overweight and obesity and reward the employers with tax-deductible policies and other incentives.

In summary, by referencing international experience, improving health technology assessment and cost-benefit analysis, China should gradually lift the overgeneralizing reimbursement restrictions on OMMs, while promote multi-channel payment schemes. On the premise of fund sustainability, OMMs can be gradually reimbursed for high-risk groups to improve treatment accessibility and systematically reduce the medical and economic burden caused by overweight and obesity.

#### **4. Conclusion**

Over the past years, obesity has become increasingly prevalent in China, with evident trend among younger population. As the key risk factor of over 200 chronic conditions, obesity not only exerts enormous burden on the healthcare system, but also a far-reaching impact on population health, labor productivity and the long-term sustainable development of society and economy. If no action taken, China, with the largest number of people with overweight and obesity and high prevalence, will inevitably be overwhelmed by the problem of obesity.

While China has elevated the policy level of weight management to the national agenda<sup>49</sup>, more efforts are needed to translate the national priority into implementable policies on a full-cycle weight management system, including standardized weight management services in primary care settings, broader and more equitable access to OMMs, and a sustainable, multilayered reimbursement system for OMMs on the basis of health technology assessment, cost-effectiveness analysis and scientific differentiation between clinical weight management and cosmetic weight loss. The 15<sup>th</sup> Five-Year Plan period will be an important time window for the implementation of the weight management system. With better

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<sup>49</sup> Notice on Issuing the Implementation Plan for Weight Management Year. National Health Commission, etc. [https://www.gov.cn/zhengce/zhengceku/202406/content\\_6959543.htm](https://www.gov.cn/zhengce/zhengceku/202406/content_6959543.htm)

institutional design, clear implementation plans and tracking mechanisms, more investment and better insurance coverage of OMMs, the mid- to long-term risks of obesity can be effectively controlled. Therefore, population health, labor force productivity and economic growth could be sustained.

As a global innovation-driven medicines company with a history of 150 years, Lilly redefines diabetes and obesity therapy, reduces the long-term impact of obesity on the human body, and is committed to innovative clinical trials to address multiple global challenges, while ensuring the accessibility and affordability of medicines. At the same time, we are making efforts to promote early intervention for obesity, incorporating OMM reimbursement programs into the employee welfare system, and taking lead in the standardization of obesity management through corporate practice. In the future, we look forward to closely working with policymakers, medical institutions, and industry partners to jointly build a more comprehensive weight management and obesity prevention and control system, and help achieve the strategic goals of a Healthy China.