strategy&
Part of the PwC network

The GLP-1 shock: A new disruptor in the food aisle

Perspective

Contacts

Strategy& Australia

Birger Maekelburger
Partner, Strategy& Australia
b.maekelburger@au.pwc.com

Dr. Steven Wibowo
Senior Manager, Strategy& Australia
steven.wibowo@au.pwc.com

PwC Australia

Tom Sorrell
Partner, PwC Australia
Tom.i.sorrell@au.pwc.com

Nicola Lynch
Partner, PwC Australia
Nicola.p.lynch@au.pwc.com

Brian Man
Partner, PwC Australia
Brian.man@au.pwc.com

Donna Watt
Partner, PwC Australia
Donna.watt@au.pwc.com

About the authors

Birger Maekelburger is a Partner in PwC's Strategy& team with 20 years' of Strategy Consulting and Deals Strategy experience. He leads the Strategy& Retail & Consumer team as well as the Deals Strategy team in Australia.

Dr. Steven Wibowo is a Senior Manager in PwC's Strategy& Australia, specialising in growth, commercial, and market strategy in the retail, consumer, and health sectors. Steven holds a PhD in Chemical and Biomolecular engineering with prior experience building a pharma/biotech venture.

Tom Sorrell leads PwC Australia's Pharmaceuticals & Life Sciences team, advising clients on their most complex deals, strategy & operations programs. He was previously part of PwC's US Life Sciences centre of excellence.

Nicola Lynch leads PwC's Health and Education Industry in Australia and also serves as PwC's Global Health Industry lead for Risk Services. Her expertise spans clinical, financial, and operational domains, supporting healthcare providers with innovative solutions.

Brian Man leads PwC Australia's Retail and Consumer practice. Brian is a recognised retail sales and marketing specialist with over 20 years of retail experience spanning management consulting, executive-level roles in strategy, operations, sales, and marketing.

Donna Watt is the lead Partner of the Retail and Consumer practice in PwC Australia, with over 25 years' experience in large-scale transformations/ deals. She has held executive roles at Foster's which included leading several global functions and the demerger of the wine business.

What happens to a food business when customers no longer want – or need – as much?

The most disruptive new player in the food industry is a prescription.

Walk into any big supermarket right now and you can feel the change.

GLP-1 receptor agonists – the drug class behind Ozempic, Wegovy, and Mounjaro – have moved from specialist diabetes therapy to a mainstream weight-management tool faster than almost any therapeutic class in pharmaceutical history. They are already reshaping what millions of consumers eat, how much they spend, and what they reach for in the aisle. And the drugs available today are not the end of the story: They are the beginning.

For grocery retailers, consumer packaged goods companies, and agricultural producers, the question is no longer whether GLP-1 therapies will affect your business. The evidence on that is settled. The question is whether your strategy reflects the reality that is already forming – and whether you are positioned to lead the response or be forced into it.

This paper sets out what the evidence tells us, four scenarios for how GLP-1 will reshape the food industry over the next five years, and the concrete decisions that food businesses need to make now.

The disruption in numbers

The scale of what is underway becomes clear quickly when you look at the data.

The global market for GLP-1 and anti-obesity medications is projected to reach US$130–150 billion annually by 2030, up from approximately US$6 billion in 2021. That represents one of the fastest demand curves in modern pharmaceutical history.[1] Goldman Sachs estimates that GLP-1 drugs could be used by as many as 70 million Americans by 2035 under an optimistic adoption scenario – roughly one in five adults.[2] Our US research found that 8–10% of Americans are currently taking GLP-1 medications, and that interest runs well ahead of current use, with 30–35% expressing intent to use them.[3]

The food industry is already feeling the early tremors. Walmart's CEO noted in 2023 that customers using GLP-1 medications were purchasing "a little less food" and that the company was tracking the trend closely.[4] Kroger reported similar observations in earnings calls, with early softening in snack and confectionery volumes in higher-adoption geographies.[5]

The consumer behaviour data is consistent and directional:

- GLP-1 users typically reduce caloric intake by 20–30% while on therapy, according to clinical trial data for semaglutide and tirzepatide.[6]

[1] Goldman Sachs Global Investment Research, *Obesity: The Next Frontier, 2023.*
[2] Goldman Sachs, *The GLP-1 Obesity Treatment Boom, 2023.*
[3] PwC US, *From molecules to milestones: Reinventing for the future of weight loss drugs, 2024.*
[4] Walmart Q2 FY2024 Earnings Call, CEO Doug McMillon, August 2023.
[5] Kroger Q3 FY2023 Earnings Call, 2023.
[6] Wilding JPH et al., *New England Journal of Medicine, 2021;* Jastreboff AM et al., *New England Journal of Medicine, 2022.*

- Consumer panel analysis suggests GLP-1 households reduce monthly food and beverage spend by an estimated 6-9%, with the sharpest declines in snacks, confectionery, sugary drinks, and discretionary ready meals.[7,8]

- Critically, a significant proportion of users report persistent changes in food preferences and portion norms even after discontinuing therapy, suggesting the impact is not purely pharmacological but also behavioural and cultural.[8,9,10]

Put this in portfolio terms: If GLP-1 adoption reaches even 10-15% of adults in a major developed market– a mid-range estimate, not an aggressive one –the aggregate reduction in caloric demand reduction across a large grocery network could be equivalent to losing the annual food volume of several large-format stores. That is not a rounding error. It is a structural demand shift that will show up in the P&L before it shows up in most strategy documents.

The Australian context makes this tangible. Approximately 67% of Australian adults are overweight or obese – more than 13 million people who are clinically eligible candidates for weight-management intervention.[11] Type 2 diabetes, the currently PBS-reimbursed indication for semaglutide, affects ~1.3 million Australians.[12] The addressable population is not a rounding error either. A PBS listing decision for obesity, which the cardiovascular outcomes data increasingly supports, would be the single biggest accelerant of GLP-1 adoption in this market, and the single biggest trigger for food industry exposure.

The hottest new disruptor in food and beverage isn't a brand, a platform, or a retail format. It's an appetite-suppressing drug – and it’s already in your customers' fridges.

Why this is different from previous health trends

Every decade has its food and health disruption: Fat-free in the 1990s, low-carb in the 2000s, clean label in the 2010s. It is reasonable to ask whether GLP-1 is simply the latest cycle.

It’s not – for three structural reasons:

First, this is a biological intervention, not a lifestyle choice.

Previous health trends required conscious, sustained consumer effort to maintain. GLP-1 therapies pharmacologically alter appetite and satiety signalling. The behavioural change is not dependent on willpower – it is, to a significant degree, engineered. That makes it more durable and more scalable than any diet trend in history.

Second, the drugs are getting dramatically better.

Next-generation multi-hormone agonists, including tirzepatide (already approved), retatrutide and oral semaglutide (in late-stage development or early approval), are delivering weight-loss outcomes of 20–25% of body weight in clinical trials, with improving tolerability and retention.[13] Oral formulations, once considered years away, are now approaching commercialisation at

[7] Morgan Stanley Research, *GLP-1s and the Future of Food, 2023.*
[8] Numerator/NielsenIQ consumer panel analysis, 2023–2024.
[9] Aronne LJ et al., "Continued Treatment With Tirzepatide for Maintenance of Weight Reduction in Adults With Obesity: The SURMOUNT-4 Randomized Clinical Trial," JAMA, 2024.
[10] Rubino DM et al., JAMA, 2021 – STEP 4 trial.
[11] Australian Institute of Health and Welfare (AIHW), *Overweight and Obesity, 2023.*
[12] Diabetes Australia, *Diabetes in Australia, 2024.*
[13] Jastreboff AM et al., *New England Journal of Medicine, 2023.*

scale. Every improvement in efficacy, tolerability, and convenience expands the addressable population.

Third, the economics are moving towards mass-market access.

GLP-1 medications remain expensive today – semaglutide costs approximately AU$300-600 per month in Australia (private prescription/ non-PBS) and US$900–1,000 per month in the US without insurance.[14] But biosimilar competition is emerging, oral formulations will carry lower cost structures, and payers are rapidly expanding coverage as the long-term cardiometabolic savings become undeniable. The FDA and TGA approval of semaglutide for cardiovascular risk reduction in 2024 was a landmark moment: It shifted GLP-1 from a weight-loss drug to a mainstream chronic disease management tool with all the coverage implications that carries.[15] Australia's PBAC is actively evaluating a similar case for obesity reimbursement. When that listing comes, the economics of access in this market change overnight.

The combination of biological efficacy, accelerating drug innovation, and improving economics means the trajectory is clear, even if the exact pace remains uncertain. This isn't a fad – it's a platform shift.

The forces shaping how it plays out

GLP-1's ultimate impact on the food industry will not be determined by the drug alone. It will be shaped by the system response around it. Three forces are decisive:

Access and affordability

Do GLP-1 therapies remain expensive and prescription-limited, serving primarily affluent and high-risk populations? Or does a combination of oral formulations, biosimilar competition, and expanding payer coverage push them into genuine mass-market territory? The trajectory today points towards the latter, but the speed matters for planning horizons. In Australia, the answer hinges on one key decision: PBS listing for obesity. Demand is already running ahead of supply. The TGA issued repeated shortage notifications for semaglutide between 2022 and 2024, driven in part by off-label use for weight loss[16] That isn't a market waiting passively. It's a market straining against an access constraint.

Behavioural change

When people use GLP-1s, do they simply eat less while on-drug and revert to previous patterns when they stop? Or do they develop lasting new habits – smaller portions, reduced ultra-processed food consumption, greater sensitivity to protein and fibre – that persist over time and diffuse culturally to non-users through social norms, clinical advice, and the broader food environment? Early evidence increasingly supports the deep and durable change thesis, but the long-term picture is still forming[10]

Food industry and government response

The food environment is not passive. Grocery retailers that redesign ranges, CPG companies that reformulate proactively, and governments that strengthen nutritional regulation can all amplify and sustain behavioural change. If the food industry leans in, GLP-1 becomes a

[14] GoodRx, semaglutide (Wegovy) list price without insurance, 2024; PBS/TGA approved indications and private prescription cost for semaglutide in Australia, 2024.
[15] US FDA and TGA approval of semaglutide for cardiovascular risk reduction, 2024.
[16] Therapeutic Goods Administration (TGA), Medicine Shortage Notifications – semaglutide, 2022–2024.

catalyst for a genuinely healthier food system and a source of new value pools. If it resists, the disruption is more painful and less productive for everyone, including the industry itself.

How these three forces combine will determine two things above all else:

- **The scale of adoption**: How many consumers are meaningfully on GLP-1 therapy, for how long, and at what cost.
- **The depth of change:** Whether the food behaviours GLP-1 unlocks become lasting or fade when the prescription does.

Mapping these two dimensions against each other produces four scenarios that every food business needs to plan for.

Four scenarios for the GLP-1 food future

No one can forecast with precision which of these futures will materialise. But every one of them has strategic implications – and a food business may be implicitly betting on one without having made that choice explicitly. The purpose of these scenarios is to make that bet visible, stress-test it, and decide whether it is the right one.

Scenario 1: Eroding baseline

Low to medium adoption · Shallow behavioural change

GLP-1 adoption grows meaningfully beyond today's levels, but it doesn't go fully mass-market. The drugs work well for those who take them – but many discontinue due to cost, side effects, or access barriers, and when they stop, dietary habits broadly revert. There is no decisive cultural shift, just a slow, steady erosion of caloric demand in the most exposed categories.

Governments introduce modest nutritional labelling updates. Retailers and CPGs launch "GLP-1 friendly" ranges without fundamentally rethinking their portfolios. The food environment looks largely unchanged on the surface.

- **Grocery**: Smaller baskets and weaker snack volumes where uptake is highest, but category structures broadly hold.
- **CPG**: GLP-1 earns a page in the strategy deck. Some high-protein options and smaller packs are added. Legacy brands still carry the P&L.
- **Farmers**: More talk of nutrition, but no dramatic shifts in crop or livestock demand.

In Australia, this scenario describes the current state and the near-term trajectory if PBS listing for obesity is delayed or limited in scope. Access constraints keep adoption concentrated among higher-income, higher-motivation consumers. The food environment shifts slowly and unevenly.

The risk: This scenario feels familiar – and that's precisely its danger. Slow erosion is the easiest disruption to rationalise away, until the cumulative effect becomes undeniable. If assumptions about adoption and depth of change prove wrong, the cost is stranded store formats, portfolios built around declining categories and farm systems misaligned with nutritional demand.

Scenario 2: Lifestyle ripple

Low to medium adoption · Deep behavioural change

GLP-1 never goes truly mass-market – perhaps 8–12% of adults use it for weight management. But the cultural ripple is disproportionate to its clinical reach. Users discover what it feels like to live on fewer, better calories and don't fully go back. Clinicians, wellness platforms and social media amplify the message. Regulators sharpen standards.

The drug is the spark. The fire is behavioural and social.

- **Grocery:** Over three to five years, the "normal basket" shifts to more protein, more fresh produce, less bulk sugar and refined carbohydrates. "Smart indulgence" and "gut-healthy" ranges move from niche to centre stage.
- **CPG:** Challenger brands with credible metabolic-health stories take real share. Early movers that reformulated for satiety and repositioned around "value per bite" build durable advantage. Late movers play catch-up.
- **Farmers:** Contract discussions begin to reflect nutritional value. Plant proteins, pulses, and lean animal proteins become structurally more attractive.

In Australia, this scenario is plausible even without a PBS obesity listing – if off-label use continues to grow among early adopters and the cultural conversation accelerates through media, clinicians, and wellness platforms. The concentrated grocery market amplifies the effect: If either of Australia's two major retailers moves decisively toward a metabolic health proposition, the category ripple is felt immediately across approximately 65% of the market.[17]

The risk: The Lifestyle Ripple is arguably the most underweighted scenario in industry planning – precisely because it doesn't feel dramatic enough to force urgent action. But a GLP-1 boom is not required to reshape value pools. By the time the trend is obvious to everyone, the early movers will have locked in their advantage.

Scenario 3: Pharma ‘autopilot’

High adoption Shallow behavioural change

GLP-1 goes genuinely mass-market. Orals are available, biosimilars drive prices down, and payers fund long-term use. But behavioural change remains shallow – the drug is treated as an on/off switch or as a substitute for healthier lifestyle choices. Food systems and regulators rely on GLP-1 as the primary lever against obesity without redesigning the food environment.

- **Grocery:** Basket contraction in high-adoption geographies is impossible to ignore. Snacks, confectionery, and sugary drinks shrink first. Pharmacy and health services partially offset the loss, but food margins face structural pressure, and demand is volatile as consumers cycle on and off therapy.
- **CPG:** Structural demand drags in high-calorie categories alongside rapid growth in companion ranges like protein shakes, nutrient-dense micro-meals, muscle-preservation products. But because behavioural change does not run deep, legacy indulgent brands still matter for off-therapy consumers. The portfolio carries a structural fault line.

[17] Australian Competition and Consumer Commission (ACCC), Supermarkets Inquiry Final Report, 2024.

- **Farmers:** Calories per capita plateau or fall. Sugar and feed-intensive livestock feel the squeeze. The challenge is not just direction, but also the volatility.

In Australia, this scenario is most likely triggered by a PBS obesity listing combined with limited government or industry action to reshape the food environment. The sugar industry and the feedlot beef sector face the most direct structural questions. Conversely, Australia's strong protein export position in beef, seafood, and dairy could be a relative beneficiary as global protein demand rises.

The risk: Pharma autopilot is disruptive without being transformative. It compresses margins and adds volatility without automatically generating the new value pools that come with genuine behavioural change. Food businesses that haven't adapted their portfolios before this scenario arrives are simply caught in the crossfire between pharma economics and shifting payer priorities.

Scenario 4: Managed metabolic reset

High adoption Deep behavioural change

This is the scenario where GLP-1 becomes a genuine turning point for the food system.

Next-generation agonists deliver 25–30% weight loss with significantly improved tolerability and long-term retention. Oral therapies are commonplace. Patent expiries and competition have driven prices to levels accessible across income groups in most developed markets. Payers treat GLP-1-class drugs as standard cardiometabolic care – as routine as statins.

Crucially, the drug is not the whole story. People don't just lose weight – they learn to live differently. Smaller portions become normal. Ultra-processed mindless eating declines. Protein and fresh produce become the dominant basket drivers. And the food industry, rather than resisting this shift, actively designs for it.

Retailers/grocers redesign store formats and digital journeys around health missions. CPG companies treat metabolic health as a primary innovation platform. Governments use regulation, incentives and public education to reinforce the shift. The food system and the health system, for the first time, begin to point in the same direction.

- **Grocery:** Less space for old-school centre-store indulgence; more for fresh, high-protein ready meals, clinical nutrition and in-store health services. Loyalty programmes are built around health outcomes, not just spend.

- **CPG:** The concept of "selling as many calories as possible" looks archaic. Winning positions are in clinically aligned nutrition, companion products and personalised nutrition platforms. Large empty-calorie brands are managed down, not defended.

- **Farmers:** A full crop and herd rethink. Land and capital shift toward plant proteins, pulses, nuts and lean (or premium) livestock. Long-term contracts bundle nutritional, carbon and biodiversity outcomes.

In Australia, this scenario represents the most significant structural opportunity – and the most significant risk for businesses that don't move. With 67% of the adult population overweight or obese[11], the health system has a compelling incentive to lean in. The concentrated grocery market means that a strategic pivot by either major retailer towards integrated metabolic health – where food, pharmacy, and digital health services work together – could redefine the competitive landscape rapidly and durably

The opportunity: This is the world where GLP-1 becomes a catalyst for a healthier food system and genuinely new growth pools. It is also the world where standing still is not a viable option for any significant player in the food value chain.

Where the evidence is pointing

Our read of the evidence is most consistent with a path towards Scenario 2 (Lifestyle Ripple) in the near term, with a meaningful and growing probability of Scenario 3 or 4 by the late 2020s, contingent on the pace of oral formulation approvals and adoption, biosimilar entry, and payer coverage expansion.

Four leading indicators support this view:

- Oral GLP-1 formulations are no longer a pipeline story – they are a market reality. Wegovy's oral format reached one million US prescriptions in 12 weeks and three million by month five. That is a faster adoption curve than the injectable launch[18]. Eli Lilly's oral candidate orforglipron showed approximately 9% weight loss versus placebo in Phase 2 trials. Together, these signals confirm that the access barrier of weekly injections is being dismantled faster than most food industry planning assumptions reflect.[19,17]

- The FDA and TGA approval of semaglutide signals a transition from a lifestyle drug to standard chronic disease management[15]. Coverage follows clinical indications, and this approval materially expands the reimbursable population.

- A growing body of consumer research shows that GLP-1 users with the most significant weight loss demonstrate deep and durable changes in eating behaviour, taste preferences, and portion norms.[7,8,13] They are a preview of potential mainstream behaviour.

- Payer and government decisions will be the single biggest accelerant of mass adoption – and the direction of travel is clear. France's move to reimburse obesity GLP-1s through Assurance Maladie from 15 June 2026 marks a significant signal that major developed-market governments are shifting these therapies from private-pay treatments towards public health system coverage[20]. Each new national reimbursement decision adds millions of eligible users overnight and shifts GLP-1 from a drug for the affluent to a standard public health tool. In Australia, the PBAC faces the same evidence and the same logic — the question is timing, not direction.

Scenario 1 (the Eroding Baseline) may feel like the safe planning assumption. It should not be. The evidence today already points beyond it. The Lifestyle Ripple is quietly underway, and the trajectory of drug innovation, payer coverage, and consumer behaviour all point toward a more disruptive outcome by the late 2020s. In Australia specifically, the PBS listing decision is not a matter of if – it is a matter of when. Food businesses planning for the Eroding Baseline as their central case are, in our view, systematically underestimating the speed of change.

The strategic challenge is to position for that reality before it becomes obvious, as well as build the optionality to scale if the trajectory moves further still.

[18] Fierce Pharma market research, The Oral GLP-1 Tracker: Novo's Wegovy keeps gaining ground in obesity market, June 2026.
[19] Rosenstock J et al., New England Journal of Medicine, 2023.
[20] Service Public, Deux médicaments contre l'obésité remboursés depuis le 15 juin, June 2026.

What this means to Grocery, CPG and farmers

Three strategic imperatives hold across all four scenarios. They create value regardless of which future materialises,

1. Shift from "more volume" to "better calories"

GLP-1 accelerates an underlying reality: Consumers can and will get by on fewer calories. That places a structural ceiling on volume-driven growth.

The question is no longer *"How do we sell more?"* It is: "How do we help people get more value (i.e. health, enjoyment, performance) from fewer, better calories?"

For **grocery retailers**: Reframe category roles around "metabolic health," "smart indulgence", and "performance nutrition." Design loyalty programmes around the quality of what customers buy, not just frequency and volume. In Australia, the data advantage available to an early mover on metabolic health is significant.

For **CPG companies**: Reformulate aggressively for satiety, protein, and fibre. Reposition indulgent brands as smaller, more intentional moments rather than bulk consumption occasions.

For **farmers and producers**: Align land use and capital with the rising premium on protein and fibre sources. Build the traceability and sustainability credentials that command margin in a nutrition-focused food system.

2. Treat GLP-1 users as a strategic segment today

An estimated 15 million US adults were using GLP-1 medications as of early 2025 – and growing[21]. In Australia, the current user base is smaller – constrained by out-of-pocket costs and PBS access limitations – but the off-label demand evidenced by repeated TGA shortage notifications confirms that motivated, health-engaged consumers are already seeking access[16]. They don't behave like average shoppers. They spend less on food, rebalance decisively toward protein and fresh produce, and a significant proportion report lasting changes in their relationship with food.

Every food business should be able to answer three questions right now:

1. What does a GLP-1 user's basket look like in this network and how does it differ from a matched non-user?

2. Which categories and brands are most exposed if this segment doubles in 18 months?

3. Where are the genuine opportunities (e.g., protein, gut health, satiety, muscle preservation) where serving this segment is accretive to both health and margin?

This isn’t a segmentation exercise. It’s a way of seeing tomorrow's mainstream consumer today.

[21] IQVIA Institute for Human Data Science, The Use of Medicines in the U.S., 2024.

3. Build and join metabolic-health ecosystems

The most strategically interesting moves emerging globally involve ecosystems, not solo players:

- Retailers/Groceries are bundling pharmacy services, nutrition consultations, and curated health ranges into an integrated proposition.
- CPG companies are co-developing ranges with clinicians or digital health platforms, building clinical credibility that marketing alone cannot provide.
- Producers are entering nutritionally specified supply contracts that enable credible health and sustainability claims, and the premiums that come with them.

In Australia, the ecosystem opportunity is acute. The combination of a concentrated grocery market, an expanding retail pharmacy footprint, and a health system under pressure to reduce the long-term costs of obesity creates the conditions for integrated metabolic health propositions that bundle food, pharmacy, and digital health services in ways that are genuinely differentiated.

The question for every player in the food value chain is: **What role do you want to play in a consumer's metabolic-health journey – and who do you need alongside you to make that credible?**

Four decisions leaders need to make now

Regardless of which scenario feels most likely, there are four decisions you can’t sensibly postpone.

1

Put a number on your exposure

Build a **simple GLP-1 P&L stress-test:**

- Apply conservative (5–8% of adults), base (10–15%) and accelerated (18–25%) adoption scenarios to your category mix.
- Quantify downside in exposed categories (snacks, confectionery, sugary drinks, “empty calorie” staples).
- Quantify upside in proteins, fresh, clinical nutrition, companion and recovery products.
- Farmers and producers should do the same for their crop and herd portfolios, feeding that into land-use and capex decisions. For Australian agricultural producers, apply the same lens to commodity portfolios – sugar, feedlot beef and refined carbohydrate crops carry the most direct downside exposure; protein commodities carry the most direct upside.

If you can’t see the impact, you can’t manage it.

2

Decide your stance: Wait, follow, or lead?

Using the scenarios, make an explicit choice:

- Are you going to **wait and see**, making only incremental changes?
- Are you planning to **fast-follow** once the direction is clearer? Build fast-follow capability and monitor leading indicators closely.
- Or do you intend to **lead?** Invest ahead of certainty to shape the Managed Metabolic Reset rather than be shaped by it.

If you can’t articulate your stance on GLP-1 and metabolic health, the default is “wait and hope” – which is not a strategy. In Australia, where a single PBS listing decision could accelerate the market overnight, the cost of being caught without a declared stance is higher than in markets where adoption is already gradual and visible.

3

Launch two to three GLP-1 / metabolic pilots in the next 12 months

Move from theory to controlled experiments:

- Retailers/Groceries: Pilot a **GLP-1-friendly journey** in one banner or region – with curated ranges, labels, bundles, digital journeys, and health services. Generate data on basket composition, loyalty and health engagement, not just revenue.
- CPGs: Launch or partner on **one serious metabolic-health platform** – for example, a range co-developed with a clinic or health-tech player, not just a new claim on pack.
- Farmers: Design at least one **end-to-end value chain pilot** where you supply traceable, nutritionally-specified products into a health-aligned retail or CPG program.

Design these pilots to produce data on **basket changes, loyalty, willingness to pay and health.**

4

Build a GLP-1 "radar" into strategic governance

Finally, embed GLP-1 and metabolic health into your **strategy governance**:

- Track a small set of indicators quarterly: Prescription volumes, payer coverage, pricing and generic trends, regulatory moves, and volume trends in key food categories. In Australia, add one indicator to this list: PBAC review progress and any signals on PBS obesity listing timing. That single policy decision is the most consequential near-term trigger for this market and deserves dedicated monitoring.
- Use these to **refresh your scenarios annually** and adjust category, portfolio and capex decisions – especially for long-lived assets like stores, plants and land.
- Assign clear organisational ownership. This isn't a marketing question or a regulatory affairs question. It's a question for the most senior leadership in every food business.

In other words: Treat GLP-1 not as a one-off headwind but as a **structural signal** about where consumer health – and your future profit pools – are heading.

Is your strategy keeping up?

GLP-1 therapies have turned the human appetite into a programmable variable.

For the retail and consumer ecosystem, that's as profound as e-commerce or the smartphone was a decade ago.

You can ride that wave, help shape a healthier food system, and unlock new growth around better calories. Or you can assume it's just another fad and hope your current playbook holds.

The drugs are already in your customers' fridges. The basket data is already shifting. The early movers are already building the positions that will matter.

The only real question is whether your strategy is keeping up.

How Strategy& can help

Strategy& works with grocery retailers, CPG companies, and agricultural businesses globally to navigate structural disruptions, from scenario development and portfolio stress-testing to growth strategy, commercial transformation, and ecosystem partnerships.

To explore what GLP-1 means specifically for your business - including a tailored scenario analysis, portfolio exposure assessment or metabolic-health and commercial strategy -we would welcome the conversation.

strategy&

Part of the PwC network

www.strategyand.pwc.com

PWC201259319