Written Evidence Submitted by Coalition for Responsible Digital Health (FWM0189)

Health and Social Care Committee

Written evidence submitted by the Coalition for Responsible Digital Health (CoRDH)

About CoRDH

1. The Coalition for Responsible Digital Health (CoRDH) is a member coalition for regulated, digital first healthcare providers, including Numan, Voy, Juniper, SheMed and Simple Online Pharmacy. Our members deliver safe, patient centred online and remote care, supported by clinical governance, responsible prescribing and ongoing programme support.

2. Across our membership, CoRDH members currently treat approximately 300,000 patients per month and we estimate that we account for around 15% of people actively on GLP-1 treatment in the UK.

3. CoRDH exists to ensure policy and regulation keep pace with changes in how care is delivered, so that digital healthcare models can contribute effectively to safe, high quality prevention, system efficiency, and economic growth. At a time when regulatory uncertainty, gaps in access, and pressure on NHS services risk slowing the adoption of proven digital models, CoRDH provides a collective voice for responsible providers.

4. We work with Government, regulators, and the health system to shape patient centred care and protect patient safety, as well as to improve access, outcomes and efficiency across UK healthcare.

Context and purpose of this submission

5. CoRDH was pleased to appear as an oral witness at the **House of Commons Health and Social Care Committee Food and Weight Management inquiry session on 25 March 2026**. During that session, Members asked CoRDH to provide additional quantitative data and case material from across our membership.

6. This written submission provides narrative context for that evidence, in response to **Questions 5 and 6** of the Committee's call for evidence.

7. The annexes include:
    a. Outcomes and engagement patterns in digital-first weight management programmes.
    b. Safety and escalation data, including referral rates from digital providers back to NHS services and the most common referral reasons.
    c. Evidence on behavioural change and programme engagement from member

services, including qualitative patient experiences.

d. Scenario-based estimates of the potential capacity of digital providers to support NHS weight management objectives.
e. Information on the Summary Care Record (SCR) pilot involving private providers.
f. Relevant economic modelling on obesity, prevention and productivity and NHS workforce capacity.

8. This document sets out CoRDH's view on the opportunities and risks associated with GLP-1 medicines, describes the contribution that regulated, digital-first providers make to obesity care, and sets out policy and regulatory changes that would allow these models to operate safely and at greater scale.

GLP-1 medications: opportunities, challenges and the role of digital-first wraparound care

Patient benefits of GLP-1s and demand

9. Independent economic modelling has highlighted the large economic burden associated with obesity in the UK, and the potential for prevention and effective treatment to deliver substantial long-term productivity and fiscal gains.

10. NICE has concluded that GLP-1 medicines are cost-effective for the NHS when used within defined eligibility criteria, and their cost-effectiveness can be enhanced when combined with lifestyle support. Recent draft NICE guidance extending semaglutide to high-risk cardiovascular patients underlines the growing role of GLP-1's in prevention, but also increases pressure for these programmes to be delivered efficiently. A key challenge is how to deliver effective programmes while making the best use of limited clinical capacity.

11. CoRDH members currently treat approximately 300,000 patients per month, and we estimate that we account for around 15 percent of all patients actively on GLP-1 treatment in the UK through private digital services. For many of these patients, digital provision has been the first opportunity to access structured, medically supervised weight management support.

12. Across member services, clinicians report a large proportion of patients have previously tried to access NHS weight management services but encountered long waits, strict eligibility thresholds, or limited local provision. Many patients also report feeling stigmatised because of their weight, which can also deter them from seeking further care for their condition via their usual healthcare provider.

13. Digital services can help address this by:
    a. Allowing clinician-led assessments that are not constrained by geography or appointment availability.
    b. Providing regular contact through digital tools, messaging and scheduled reviews.

c. Allowing clinicians to focus their time on patients who require closer monitoring or complex care.
d. Offering discreet, convenient access to care that many patients find more acceptable than in-person settings.

14. Evidence from CoRDH member services on engagement, outcomes and escalation rates indicates that well-designed digital delivery models can optimise clinician time while maintaining appropriate oversight.

15. CoRDH's view is that regulated digital weight management services can contribute to these wider benefits while helping to relieve pressure on NHS clinicians by supporting patients safely in parallel to core services.

16. The modelling illustrates that expanding regulated digital weight management services could reduce pressure on NHS clinicians, allowing them to focus on patients with complex needs while achieving broader system-wide economic and productivity gains.

Recommendation 1: The Committee should recommend that DHSC and NHS England explicitly incorporate regulated private sector GLP-1 programmes delivered with digital-first wraparound care into national obesity and prevention strategies, and use evidence from these services when assessing the long term cost effectiveness and workforce impact of GLP-1 based weight management.

The importance of wraparound care (including the role of digital services)

17. GLP-1 medicines are most effective and safest when prescribed within structured programmes that support behaviour change and long-term weight management.

18. Across CoRDH members, digital programmes typically support behaviour change and long-term weight management through structured clinical assessments aligned with relevant guidance.

19. These programmes provide access to multidisciplinary teams including doctors, pharmacists, nurses, nutrition specialists and health coaches, alongside digital tools that support education, self-monitoring and long-term behaviour change. Patients also receive regular clinical check-ins and support for dose titration, side-effect management and safeguarding.

20. Aggregated data from CoRDH members show that patient engagement with wraparound care is strongly associated with programme outcomes. In particular:

a. Patients with higher levels of engagement achieve greater average weight loss than those who engage less.
b. Higher engagement is associated with better medication adherence and earlier reporting of side effects.

c. Patients are more likely to maintain benefits when programmes include a planned maintenance phase, with reduced or discontinued medication alongside continued lifestyle support.

21. Experience from member services and feedback from patient communities and support groups further illustrate how behavioural support, coaching and peer communities contribute to sustained lifestyle change.

Recommendation 2: The Committee should recognise that the benefits of GLP-1 medicines can be more sustainable when patients have access to multidisciplinary wraparound care, and that digital delivery models are often the most practical way to provide this support consistently at scale.

Barriers to digital services and regulation

Equity of and access to current weight management services

22. Evidence from clinicians and patients indicate that access to NHS weight management services varies across England.

23. Patients entering digital programmes frequently report that:
    a. Local Tier 2 or Tier 3 services are unavailable or commissioned at a limited scale.
    b. Waiting times for structured weight management programmes can be long.
    c. Eligibility thresholds exclude many people with clinically significant obesity related risks.

24. Clinicians working alongside the NHS also report concerns about the capacity of primary care services to provide ongoing monitoring and behavioural support for large numbers of patients using GLP-1 medicines.

25. Without changes to delivery models, there is a risk that many eligible patients will not be able to access effective treatment, that inequalities in access to care will widen, and that some patients will turn to unregulated sources of medication.

Recommendation 3: The Committee should recognise that access to weight management services currently varies across England and ask DHSC and NHS England how digital delivery models will be used to improve access and reduce inequity.

Recommendation 4: The Committee should recommend that the Government supports Integrated Care Boards in expanding commissioning of regulated digital providers for Tier 2 and relevant Tier 3 weight management services within clear contracts and outcome measures.

Regulation and digital clinical pathways

26. Digital-first services are not always well-understood within regulatory and inspection frameworks that have been built around traditional in-person care. This can result in

responsible, well-governed digital providers being treated more cautiously than equivalent bricks-and-mortar services, and make it harder for patients and professionals to distinguish them from unsafe or illegal operators.

27. For example, some CoRDH members use clinician supervised decision support tools within digital care pathways to structure patient assessments or highlight potential clinical risks.

28. Evidence from CoRDH member services indicates that:

    a. Decision support tools should operate transparently and under clinical supervision.
    b. Final prescribing decisions must always rest with qualified clinicians.
    c. Regulatory guidance should reflect the practical risks associated with digital pathways.

29. Clear guidance would help responsible providers develop safe, digital services while maintaining strong clinical oversight. It would also support regulators by clarifying how existing frameworks apply to digital care pathways, promoting consistent interpretation across the sector, and making it easier to distinguish between well-governed regulated providers and unsafe or non-compliant services.

Recommendation 5: The Committee should ask MHRA, CQC, GPhC and NHS England to publish joint guidance on digital weight management pathways developed from engaging with regulated digital-first providers, including the appropriate use of clinician supervised decision support tools in patient assessment and follow-up.

Black market and illegal supply

30. Members recognise that patients may consider black market options when they cannot access regulated services. Marketing by illegal sellers can be misleading or aggressive, and patients often turn to these sources when regulated pathways are inaccessible, highlighting the system-wide value of regulated digital programmes.

31. CoRDH members are committed to complying with MHRA and ASA rules on medicines advertising and patient-facing content in response to evolving regulatory expectations. Stakeholders have expressed concern that in the absence of sufficiently clear, prospective guidance, enforcement can sometimes appear to rely on making examples of individual companies to signal expectations to the wider market. This risks creating uncertainty for responsible providers. In our view, clear and consistently enforced standards for the advertising and online promotion of GLP-1 treatments are essential to protect patients, particularly given the role of social media in driving demand for weight loss drugs. Those standards should make it easier for patients to distinguish regulated health services from unregulated or illegal sellers and should prevent claims that trivialise clinical risks or overstate likely outcomes.

32. Recent parliamentary scrutiny, medical press and national consumer media reporting have highlighted the growth of such illicit supply routes and the health risks associated with unregulated products. These external findings echo what CoRDH members hear from patients and observe in clinical practice: when safe, regulated access is constrained, some individuals will seek alternatives regardless of risk. This underlines that greater access to regulated digital pathways not only improves patient safety and outcomes, but also helps reduce reliance on unsafe markets by providing timely, clinically supervised access.

Recommendation 6: The Committee should support a dual approach that combines strong enforcement against illegal sellers with policies that make it easier for patients to identify and access regulated providers.

Recommendation 7: The Committee should recommend that MHRA and ASA work with regulated providers to clarify how existing rules on advertising and online promotion of GLP-1 weight loss treatments apply in digital channels, so that responsible regulated providers can communicate clearly about safe, regulated routes to treatment and the risks of black-market supply, while misleading or illegal promotion is identified and removed quickly.

Safety, monitoring and escalation

33. CoRDH members do not position themselves as replacements for NHS services. Digital providers instead operate as regulated services that can identify risks early and refer patients into NHS care where appropriate.

34. Across member services, patients are assessed against clear inclusion and exclusion criteria aligned with medicine licences and clinical guidance. Structured assessments identify potential clinical risks that may require further investigation or escalation.

35. Patients are also given clear advice on when to seek NHS care, including urgent services where necessary. CoRDH data suggests that referrals back to NHS GPs from digital obesity management programmes are relatively rare, and reserved for clearly defined scenarios such as significantly abnormal results, or new symptoms that need GP-led follow-up.

36. To support continuity of care, members aim to keep NHS GPs routinely informed about treatment for a large share of patients, and some services do so for all weight-management cases. With patient consent, these notifications provide concise updates on new prescriptions and key findings, designed to complement existing NHS records rather than create unnecessary extra work for NHS teams.

37. Initial analysis of referral patterns across CoRDH member services shows that only a small minority of patients are referred back to NHS GPs or specialist services during programmes. Referrals typically are due to issues outside the scope of a digital obesity management service, such as a new or previously unmanaged health problem that requires GP-led review. CoRDH member services manage most care within their remit,

whilst helping to identify wider health needs early and directing patients to NHS support only when there are clear clinical reasons to do so, such as new symptoms or other concerns that warrant further investigation. These referrals illustrate how digital services can support early detection and escalation when problems arise.

Interoperability and access to Summary Care Record

38. Limited data sharing between NHS systems and regulated digital providers remains a barrier to coordinated care. Most private providers, including CQC-regulated digital services, cannot currently access the NHS Summary Care Record (SCR) under standard arrangements.

39. A small number of providers are participating in a pilot that allows SCR access under strict governance arrangements. This pilot is being overseen within the NHS and is testing how appropriately governed access for regulated providers can support safe prescribing and joined up care.

40. Appropriate SCR access could improve safety by:
    a. Allowing clinicians to check diagnoses, medications, and allergies before prescribing.
    b. Reducing duplication of information gathering.
    c. Improving communication between digital providers and NHS GPs.

Recommendation 8: The Committee should recommend that DHSC and NHS England create a clear and consistent route for regulated digital providers to access relevant NHS data, including the Summary Care Record, under appropriate safeguards.

Conclusion

41. GLP-1 medicines, when used within structured clinical programmes, can significantly improve outcomes for people living with obesity.

42. Digital services already deliver clinically-supervised programmes combining medication with behavioural support and monitoring, expanding access and helping the NHS use limited clinical capacity more effectively.

43. Existing economic modelling suggests that even modest reductions in obesity prevalence could generate substantial annual savings, with larger reductions yielding very significant long-term economic and productivity gains.

44. With appropriate regulation, data sharing, and commissioning frameworks, regulated digital providers can support NHS objectives to improve prevention, reduce health inequalities, and protect patients from unsafe markets.

45. CoRDH and its members would welcome continued engagement with the Committee and Government as policy develops.

Summary of recommendations

1. **Recommendation 1:** The Committee should recommend that DHSC and NHS England explicitly incorporate regulated private sector GLP-1 programmes delivered with digital-first wraparound care into national obesity and prevention strategies, and use evidence from these services when assessing the long term cost effectiveness and workforce impact of GLP-1 based weight management.
2. **Recommendation 2:** The Committee should recognise that the benefits of GLP-1 medicines can be more sustainable when patients have access to multidisciplinary wraparound care, and that digital delivery models are often the most practical way to provide this support consistently at scale.
3. **Recommendation 3:** The Committee should recognise that access to weight management services currently varies across England and ask DHSC and NHS England how digital delivery models will be used to improve access and reduce inequity.
4. **Recommendation 4:** The Committee should recommend that the Government supports Integrated Care Boards in expanding commissioning of regulated digital providers for Tier 2 and relevant Tier 3 weight management services within clear contracts and outcome measures.
5. **Recommendation 5:** The Committee should ask MHRA, CQC, GPhC and NHS England to publish joint guidance on digital weight management pathways developed from engaging with regulated digital-first providers, including the appropriate use of clinician supervised decision support tools in patient assessment and follow-up.
6. **Recommendation 6:** The Committee should support a dual approach that combines strong enforcement against illegal sellers with policies that make it easier for patients to identify and access regulated providers.
7. **Recommendation 7:** The Committee should recommend that MHRA and ASA work with regulated providers to clarify how existing rules on advertising and online promotion of GLP-1 weight loss treatments apply in digital channels, so that responsible regulated providers can communicate clearly about safe, regulated routes to treatment and the risks of black-market supply, while misleading or illegal promotion is identified and removed quickly.
8. **Recommendation 8:** The Committee should recommend that DHSC and NHS England create a clear and consistent route for regulated digital providers to access relevant NHS data, including the Summary Care Record, under appropriate safeguards.

Annex

Appendix 1: Private provider capacity

- CoRDH currently treats approximately 300,000 patients per month, which is estimated to represent around 15% of all private patients actively on GLP-1 treatment in the UK. Due to the scalable nature of digital-first models, CoRDH members' total patient base grew by 150-200% over the last year (with some variation between providers) and similar growth rates are anticipated over the course of 2026.

- Based on IQVIA market insights, CoRDH reports that the private sector can easily double capacity every six months organically; this could be doubled every four months if there were Government incentives/plans in place to support faster roll-out at scale.

- One CoRDH member scaled from 0 to 16,000 patients within a six-month period at launch, in response to demand. Based on current infrastructure, supplier network and clinical workforce model, there is ability to further increase capacity in a phased and controlled manner.

Appendix 2: Behavioural changes following engagement with digital services

- Across member services, CoRDH has reported that:
  - Higher engagement with digital wraparound care (including structured coaching, digital tools and regular clinical reviews) is associated with greater average weight physical loss, better medication adherence, and earlier reporting of side effects.
  - Patients are more likely to maintain benefits when programmes include a planned maintenance phase (reduced or discontinued medication with continued lifestyle support).
- Patients using CoRDH member services have reported:
  - "*I'm happier than I can ever remember being. I eat a much healthier diet and rarely have any cakes or donuts. I can go upstairs without thinking I'm going to have a heart attack. I can even kind of run up them. I go to the gym 5 or 6 times a week. It's become my happy place and I've made new friends during this journey through the gym but also the [member] app. I feel supported in my journey and although I've got still further to go I've lost 8 and a half stone and feel such a different person.*"
  - *"I am happy to share what I have noticed since starting my journey on Wegovy. I go walking every morning which I have always done even before starting this journey. This was one of the reasons when I said enough is enough when I noticed how much my weight was impacting on my health because I was struggling to breath due to the weight I was carrying. I am now on week 5 and staying focused and I already find it easier to breathe when I walk."*
  - *"It's improved not just my physical health but my mental health too. I actually went for a job interview yesterday, after five or six years out of employment and this morning they emailed to offer me the job. So I'm going back into employment after five or six years. It's literally been life-changing for me."*
  - *"Finding out that [member] had clinicians that could help me and support me with my nutrition, my mindset, my movement. That was something that really interests me. Having support that helped me understand what was happening to my body, how this was going to work, how it was going to affect me, and I got really good results from it, steady results. I've got more than anything, the confidence back in believing in myself, moving more, being out of the house more. I just can't believe that this is my life now."*
  - *"I find it so easy to open my fridge door without having to find something to snack on because there is no food noise. I have lost 7lb in my 1st month and know that i need to step up with my water intake, any tips would be gladly appreciated. I'm happy with*

my weight loss and how it's starting to make me feel more and more confident every day."

- *"I spent my whole adult life being overweight - I don't know how much money and time I spent on every different programme conceivable. I'd lose a stone and put two back on. Now I've come off the list for a knee replacement, my sleep apnea has been taken off my list of illnesses, and a body composition scan told me I was 15 years younger than my chronological age. It's just the biggest change in my life."*
- *"So if someone had said to me 12 months ago, you'll feel like this, you'll look like this, your confidence will be back, I'd have said no, nothing can do that for me. But weight loss medication, [member] and my own sense of commitment, it's been life changing and just amazing."*

- One CoRDH member carried out a behavioural analysis of Trustpilot reviews using thematic analysis, which indicated that:
  - From 10,566 verified Trustpilot reviews over a one-year period, 860 reviews (8.1%) were identified as substantive weight-loss programme reviews.
  - Within this subset, 277 reviews (32.2%) spontaneously referenced behavioural change.
  - Five recurring behavioural themes were identified within this subset:
    - Coached habit formation and sustainable routines - 147 reviews (17.1%)
    - Reduced "food noise" and a changed relationship with food - 74 reviews (8.6%)
    - Increased physical activity and mobility - 60 reviews (7.0%)
    - Improved confidence and social re-engagement - 54 reviews (6.3%)
    - Emotional wellbeing and mood shift - 37 reviews (4.3%)
- One CoRDH member reported that from a survey of patients using their service:
  - 87% felt that they were more aware of what they eat when using weight care medication.
  - 84% felt they had sustained and improved their physical activity levels.
  - When making healthier buying choices, 68% agreed that more affordable healthy food options would make the biggest difference.
  - Over 50% saw an improvement in sleep, 81% said their overall mental wellbeing improved, and 71% said their self-esteem improved.

Appendix 3: Referrals back to NHS GPs

- CoRDH member services apply clear inclusion and exclusion criteria aligned with medicine licences and clinical guidance, and as a result only a minority of patients are referred back to NHS GPs or specialise services during programmes. Such referrals typically relate to abnormal test results, new or worsening symptoms, or safeguarding concerns. CoRDH also provides patients with clear advice on when to seek NHS care, including urgent care, and that, with consent, GPs are informed of new prescriptions and relevant clinical findings.
- One CoRDH member noted that formal referral activity is not easily captured as they do not generate standard NHS referral letters; instead, they inform all patients' GPs of prescribing decisions.

- Where abnormal blood tests, mental health concerns or other issues are identified, clinicians discuss these directly with patients and advise them when it is appropriate to consult their NHS GP.
- Health coaches also use standardised messages to signpost patients with low-risk mental health needs to appropriate self-care resources.

- One CoRDH member reported that their model is designed to identify and exclude clinically inappropriate patients at the point of assessment. Screening data demonstrates clinical rejection rates of 17-25% with approximately 6-7% of applicants screened out at questionnaire stage before reaching a clinician.
  - For onboarded patients, side-effect-related clinical contact arises in 3.5% of orders. Approximately 70% of such queries are handled through a digital support tool, while 800-1,000 queries per week are escalated to the clinical team for direct review and management.
  - More serious complications are reported to be uncommon (approximately 0.003% of patients) and are in line with known medication risks rather than being specific to the digital model; in these cases, patients are directed to NHS 111 or A&E in line with standard practice.
- One CoRDH member reported that referrals to NHS GPs occur in a small number of cases (approximately 3%) typically in specific clinical scenarios such as significantly abnormal blood test results or where GP-led follow-up is required. It was also reported GPs are informed in a high proportion of weight loss treatment cases (approximately 98%) but that this rate is significantly lower across other services; the overall average is approximately 60%.

Appendix 4: Pilot Summary Care Record sharing

- Most CQC-related digital providers cannot currently access the NHS Summary Care Record (SCR) under standard arrangements, and CoRDH reports that this lack of interoperability remains a barrier to fully joined-up care.
- A small number of providers are participating in an NHS-led pilot to enable SCR access for appropriately governed private providers, under strict safeguards. The intention of this pilot is to test how such access can support safe prescribing, reduce duplication of information sharing, and improve communication between digital providers and NHS GPS.
- One CoRDH member indicated an expression of interest to join this pilot, and has indicated willingness to participate in structured SCR sharing arrangements.

Appendix 5: Other providers reported to regulators

- CoRDH reports that they do not hold aggregate statistics on reports made to regulators about other providers, but have indicated that from time to time, they may raise concerns where they consider it to be in the public interest. However, this is not routine and is not currently quantified.
- One CoRDH member reported that where concerns are identified about another provider, the default approach is to engage directly with that provider in the first

instance, with the aim of resolving the issue collaboratively. Immediate escalation to regulators is not considered to be a proportionate or effective first step, instead seeking to avoid unnecessary use of regulatory resources where problems can be addressed directly.

- Another provider would typically only be reported to a regulator where there is a clear and immediate patient safety risk, or where reasonable attempts to resolve concerns directly have been unsuccessful.

Appendix 6: Research on high-engagement patients

- Across member services, CoRDH has reported that higher engagement with digital weight-management programmes is associated with better outcomes, including greater average percentage weight loss, higher rates of achieving clinically meaningful thresholds, improved adherence and earlier reporting of side effects.
- One CoRDH member reported that they have conducted research examining patient outcomes under varying engagement patterns in real-world, lifestyle-supported pharmacological weight-loss therapy. This work analyses how differing levels of engagement with behavioural support and digital tools relate to weight-loss trajectories.
- One CoRDH member reported findings from a large real-world cohort study involving 126,553 participants. Within this cohort, 6,746 (5.3%) met a strict definition of "maximal" digital engagement, which required attending at least one coaching session, tracking weight at least once per week, and logging into the app during the study period.
  - This group differed at baseline: they were on average older, more likely to be female, and had higher baseline BMI and higher prevalence of obesity related comorbidities (e.g. hypertension, hypercholesterolaemia and polycystic ovary syndrome).
  - By 12 months, data from the study found:
    - Engaged patients achieved a mean adjusted weight loss of 22.9% compared with 17.6% among non-engaged patients.
    - Among those who completed 12 months of follow-up, average weight loss exceeded 24%.
    - Differences in outcome emerged early (by around two months) and widened over time.
    - Engaged patients were reported to be nearly three times more likely to achieve at least 20% weight loss than non-engaged patients (16% vs. 5.6%).
- One CoRDH member reported findings from a real-world analysis[1] of 18,390 adults with obesity prescribed tirzepatide and on a digital health programme found that higher engagement, defined by regular app use, messaging with a health coach and/or logging weight weekly) led to significantly greater weight loss.
  - Data from the study found that:
    - Regularly engaged patients achieved 12.0% weight-loss at 3 months, 17.6% at 6 months and 21.0% at 9 months.

[1] Griffiths Z, et al. Impact of Engagement on Weight Loss Outcomes with Tirzepatide and a Digital Health Programme. Poster #608 presented at: ObesityWeek 2025; November 6, 2025

        - Less engaged patients achieved 8.9% weight-loss at 3 months, 13.6% at 6 months, and 16.6% at 9 months.
- One CoRDH member provided real-world evidence from an unsubsidised UK digital weight-loss service that combined lifestyle support with semaglutide treatment[2]. In this study, 7,279 patients initiated treatment between January 2023 and May 2024.
    - Data from the study found that:
        - Patients who adhered strictly to the protocol (regular medication orders and weight tracking) lost an average of 15.67% of their baseline body weight.
        - Patients who tracked their weight fewer than 20 times over the programme recorded a median weight loss of approximately 11.8% whereas those who tracked weight at least 100 times achieved a median loss of approximately 20.2%.

[2] Talay L, et al. (2026) Patient Outcomes Under Varying Engagement Patterns on Real-World Lifestyle-Supported Pharmacological Weight-Loss Therapy. *Obesities*, 6(1), https://doi.org/10.3390/obesities6010002