Future of Food

The other half of the prescription

How GLP-1 drugs are creating a market NZ could own

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How GLP-1 drugs are creating a market New Zealand could own

Weight loss drugs are radically altering global diets. People are eating less, shedding snacks and dropping the drink. But the drugs solve for weight, not for nutrition, and they leave behind deficits that food has to fill. For a nation built on selling volume, the opening is not smaller portions. It is the nutrition protocol nobody has written yet.

Threats

- GLP-1s weaken the assumption that global food demand will keep growing.
- Meat and dairy producers are exposed wherever they rely on large portions and undifferentiated commodity markets.
- Food is shifting from meals to dosing, a format New Zealand does not currently make.
- Pharma, clinical nutrition and ingredient companies are already defining the GLP-1 diet protocol. Food producers risk arriving after the standards are set.
- The signal is early and hard to measure, which makes it easy for boards to defer.
- Under-investment in protein formats, nutritional science and clinical evidence will hand the opportunity to overseas food-pharma specialists.

Opportunities

- The drugs create nutritional gaps they do not close: protein, leucine, fibre, calcium, iron and vitamin D.
- Value shifts from volume to nutrition per bite, function per serve and proof per claim.
- Dairy protein, whey, red meat, seafood, eggs and legumes gain a specific clinical job to do.
- Small, complete meals become the premium format rather than the compromise.
- Gut-comfort products serve a daily compliance problem, not a wellness preference.
- Evidence-backed foods can fill the gap left by the absence of clinical guidance.
- New Zealand can move from commodity calories to differentiated, provable protein.

One year on from Wegovy's arrival in New Zealand, the GLP-1 revolution still sounds a little like science fiction. Take the shot. Drop the kilos. Bingo, you are Kim Kardashian.

Or something like that.

Medsafe approved Wegovy for weight management in 2025 and it has been available on private prescription since 1 July, at an estimated NZ$450 to $600 a month.[1] It is not publicly funded, though Pharmac's Obesity Treatment Advisory Group recommended funding it with high priority in December 2025.[2]

Technically a GLP-1 agonist, Wegovy is one of a growing family of drugs that suppress appetite by mimicking glucagon-like peptide-1, the naturally occurring hormone that regulates blood sugar, digestion and hunger. The pipeline behind it is filling fast with pills, dual agonists, off-patent copies and natural alternatives, including Calocurb, a New Zealand capsule built on Amarasate, a bitter-hops extract developed by Plant and Food Research and marketed as a natural GLP-1 activator.[3]

The bigger accelerant is the pill. In December 2025 the FDA approved the first oral GLP-1 for weight management, a once-daily 25mg semaglutide tablet. Adherent patients in the OASIS 4 trial lost 16.6 percent of their body weight.[4] Removing the needle removes the last real barrier between obesity medicine and lifestyle purchase.

The results are genuinely dramatic. In the STEP 1 trial, semaglutide produced a mean 14.9 percent body-weight reduction at 68 weeks against 2.4 percent on placebo.[5] Tirzepatide has reached 15 to 21 percent.[6] For many people this is transformative, cutting the risk of diabetes and cardiovascular disease. Users report more energy and fewer cravings, and a randomised trial has now shown low-dose semaglutide reducing drinking quantity, craving and heavy-drinking days.[7] A Swedish cohort of about 95,000 people found semaglutide use associated with a 42 percent lower risk of mental health deterioration.[8]

It is showing up at national scale. Gallup found US adult obesity peaked at a record 39.9 percent in 2022 and fell to 37.0 percent by 2025, about 7.6 million fewer obese adults.[9] That is a rare change of direction for a condition that cost an estimated US$260 billion in American adult medical spending in 2016 alone.[10]

Adoption is broad and getting broader. Roughly one in five US households now includes a current GLP-1 user, up from 9 percent in January 2025.[11] Australian sales rose tenfold in five years.[12] UK adult users nearly tripled in two years to 1.9 million.[13] JPMorgan expects about 25 million US users by 2030, and up to 30 million at the top end.[14] Globally, Eli Lilly's chief executive put current users at 20 to 25 million.[15]

Then comes the patent cliff. Semaglutide protection began expiring in 2026 across markets including India, Canada, China, Brazil and Turkey, together about 40 percent of the world's population.[16] When India's patent lapsed in March, Natco launched an injection at about US$14 a month.[17] The growth market for medicated nutrition is not only American. It is Asian, and it is cheap.

Most importantly, eating less does not mean eating well.

But like all good science fiction, the rise of GLP-1s prompts the question: what does it all mean?

These drugs are miraculous and they are also messy. Public health experts are arguing over who should pay for what many people are using as a lifestyle choice. Physicians are tracking side effects from nausea to pancreatic and kidney injury. Clinicians are reporting unplanned pregnancies, so-called Ozempic babies, as weight loss restores ovulation.[18] Brides are doubling down before the wedding, with 10 percent of engaged people using semaglutide and dressmakers rewriting their alteration policies.[19] Even cats are in it. In December 2025 China's agriculture ministry accepted for review a weekly dual-agonist injection for obese cats, which produced average body-weight loss of 9.3 percent in six weeks.[20] Pet food is next.

Scott Galloway argues the economic consequences outrun the ones we spend all our time discussing. "If we want to transform the economy, and the well-being of Americans, we should focus on GLP-1, not GPT-5."[21]

For the food sector there is a narrower question. What happens when people lose their appetite?

Eating less, needing more

The first effect is the obvious one. GLP-1s reduce hunger, increase satiety and quieten what users call food noise. Portions shrink. Grazing falls. Drinking drops.

Cornell researchers tracking about 150,000 households found grocery spending fell 5.3 percent on average within six months of starting a GLP-1, and by more than 8 percent in higher-income households, with savoury snacks down about 10 percent.[22] Numerator now puts grocery spend nearly 4 percent lower after a year on the drugs.[23] JPMorgan estimates GLP-1s could remove US$30 billion to US$55 billion of annual food and beverage sales as soon as 2030.[24]

That is good news for public health. Excessive intake and ultra-processed food are linked to a long list of lifestyle diseases and cost health systems billions.

Scratch deeper and the picture gets more interesting, because eating less does not automatically mean spending less. Circana found that after a year on the drugs, users' restaurant spending was actually up 0.9 percent, with casual dining up 4.1 percent, while their retail food spending fell 1.6 percent and alcohol fell steeply.[25] Some categories gain. Households using GLP-1s consume yoghurt at nearly three times the average rate.[26] Almost 90 percent still buy ice cream, though in smaller portions and higher-protein formats.[27] Circana projects GLP-1 users will account for 35 percent of US food and beverage sales by 2030.[28] Not because they eat more, but because they are the shoppers who will decide what a premium product has to prove.

Nor does everyone stay on the drugs. For occasional users, the bride being the obvious case, the wedding ends and so does the prescription. Spending patterns often revert, and sometimes overshoot.

Most importantly, eating less does not mean eating well.

What the drug does not do

When appetite falls sharply, people lose weight. They also lose muscle, miss protein and fibre targets, and fall short on micronutrients. GLP-1s are very good at shedding kilos. They do not design a nutritionally complete diet.

The Mayo Clinic notes that approximately 25 to 40 percent of the weight lost on GLP-1 therapy can

Tens of millions of people are on a medical intervention whose dietary half has not been written.

come from lean mass, which includes muscle, water, connective tissue and organ tissue.[29] Trial data are kinder: in the SURMOUNT-1 body-composition substudy, patients losing 21.3 percent of body weight lost 33.9 percent of fat mass and 10.9 percent of lean mass, roughly three to one.[30] Either way, the muscle question is real. Lose weight fast on too little protein and too little resistance exercise and you get weaker. That matters for ageing, mobility, metabolic health and, ironically, for keeping the weight off.

So protein, oversold for a decade, has finally found a genuine use case. The adult recommendation is 0.8g per kilogram of body weight. During active weight loss, clinicians suggest 1.2 to 1.6g.[31] Yet in one small study of 60 users, only 43 percent reached even 1.2g per kilogram and just 10 percent reached 1.6g.[32] That gap is the entire commercial story. The drug removes the appetite that would have carried three full meals, so the protein has to arrive in less food.

Which means protein quality and structure matter more than protein volume. Muscle protein synthesis responds when each meal crosses a threshold, and leucine is the trigger. The evidence in older adults points to around 3g of leucine alongside 25 to 30g of protein per main meal.[33] Leucine is densest in dairy, whey, eggs, meat and fish. Small portions of ordinary meals do not get there.

Micronutrients follow the same logic. In three-day food records from 69 GLP-1 users, 72 percent fell below recommended calcium intake, 64 percent below iron, and only 1.4 percent met vitamin D recommendations.[34]

Here is the part that should interest every food exporter. After bariatric surgery, clinicians work to settled supplementation protocols, because deficiency is expected and monitored. For GLP-1s there is nothing equivalent. As a November 2025 review in the International Journal of Obesity put it, no formal consensus recommendations exist for people starting these drugs, and there is no global framework for dietary screening, intervention or supplementation.[35]

Tens of millions of people are on a medical intervention whose dietary half has not been written.

Who fills that gap? Why not New Zealand?

The iatrogenic gap

Cast your mind to 2035. The drugs and their variants are cheap, oral and widely available, some of them publicly funded. Weight management is a daily dose. Obesity is treated as a choice. Fat is a fashion faux pas.

That world is not hard to imagine, because fringe interventions have a habit of becoming ordinary.

In that world, diet moves from eating to dosing, and food becomes the missing half of a medical protocol. It fills an iatrogenic gap. Iatrogenic means a health problem caused by a medical treatment. That is precisely what the nutritional shortfalls of GLP-1s are.

The drug is one half of an obesity intervention. Diet is the other.

Clinicians, ingredient suppliers, dietitians, food companies, pharmacies and app platforms are all in the process of defining what best practice looks like. It is likely to include high-protein small meals, whey and dairy protein formats, leucine-dense products, protein-plus-fibre combinations, calcium, iron and vitamin D delivery, gut-comfort products, tracking and clinical support, and food designed for muscle maintenance rather than calorie reduction.

Who fills that gap? Why not New Zealand?

Why should New Zealand not be in the room when those protocols are decided?

This is more specific than premium food or generic wellness. It points to functional ingredients, fortified formats, and small complete meals with clinical evidence behind them. Lactoferrin and leucine-fortified yoghurt. Omega-3-enhanced meat. Fibre that solves a tolerance problem rather than ticking a label.

Some of the market is already visible. Fonterra's nutrition team named GLP-1-driven protein demand the biggest opportunity for dairy food and beverage innovation in 2026, and found GLP-1 users consume almost three times more high-protein dairy than others, preferring dairy to plant protein for its complete amino acid profile.[36] Meanwhile US exports of high-protein whey to China fell 47 percent in the first four months of 2026 as domestic demand absorbed the supply.[37] Tariffs are part of that story, but so is a genuine global scramble for assayable, high-leucine protein. So much for peak protein.

It also reframes the competitive set. By the late 2030s Fonterra's competition may not be Ireland. It may be Abbott, Nestlé Health Science and Novo Nordisk itself. Or, better, Fonterra may be their supplier and partner: the drug for weight loss, the dairy fraction for muscle retention.

Lamb is back

Is a leg of lamb compatible with that future? Yes, though not in the format we know.

At E Tipu this year, food entrepreneur Nicola O'Rourke described a new era of intentional eating, with consumers microdosing food according to moods, desires and medicinal needs.[38] Future consumers will care less about volume and more about effect: concentrated protein, leucine, fibre and minerals, with satiety, metabolic benefit and gut health that can be demonstrated rather than asserted.

Which makes "is a leg of lamb compatible?" the wrong question. A medicated, ageing, sarcopenia-prone population is precisely the market for dense complete protein with a high leucine load. What becomes irrelevant is the format and the undifferentiated claim, not the lamb.

Lumina Lamb may have just found its global relevance. Grown out of the Omega Lamb programme, a nine-year Primary Growth Partnership worth $14.35 million of Crown funding matched by industry, this high-country lamb is specified on intramuscular fat of 3 to 4.5 percent and a minimum 35 days finishing on chicory and clover, and sold on tenderness, marbling and a distinctive nutritional profile.[39] It goes to high-end restaurants at a premium, where scarcity is part of the value. Worth noting: the company's claim of significantly higher omega-3 and polyunsaturated fats than other lamb is not quantified.[40] In the market this article describes, that is no longer a detail. It is the whole asset.

A smaller-eating world is not a threat to that. It is the reason it exists.

What else could New Zealand deliver

Here is the uncomfortable part. New Zealand Trade and Enterprise has already told exporters what is coming. Its guidance says GLP-1 medicines are changing what and how much people eat worldwide, and that "the winners won't be the biggest portions; they'll be the products that deliver the most nutritional value per bite".[41] The advice is specific and disciplined: lead with approved protein or fibre claims in regulated markets, and avoid

"the winners (will) be the products that deliver the most nutritional value per bite"

weight-loss or medical-style messaging.[42] The signal has been sent. The question is who acts on it.

Three New Zealand assets stand up to that test.

Dairy protein, and specifically leucine density. This is the only place where the mechanism, the numbers, the manufacturing scale and the customer channel all line up. Leucine makes up 11.0 percent of the amino acids in whey protein against 5.1 percent in hemp, and 25g of whey protein delivers the same 2.7g of leucine as 54g of hemp.[43] Massey's work puts whey protein isolate's leucine ratio at 2.57 times requirement.[44] Translated: the same anabolic signal in less than half the food. That is not a wellness claim, it is arithmetic, and it is exactly the GLP-1 user's problem. Fonterra already sells clear whey isolates into medical and healthy-ageing applications, Westland has put AU$65 million into lactoferrin capacity at Hokitika, and Miraka makes fortified high-protein A2 UHT.[45] The capability is not one company deep.

Green kiwifruit, because the claim is already authorised. New Zealand holds something almost no one else does: the European Union has approved the claim that consumption of green kiwifruit contributes to normal bowel function by increasing stool frequency, at two fruit or 200g of flesh, on a dossier of 18 human trials.[46] The pivotal study ran 184 participants across three gut phenotypes at four sites in New Zealand, Italy and Japan over 16 weeks, tested head to head against psyllium.[47] Two kiwifruit is a genuinely small portion. And there is a second mechanism sitting underneath: actinidin, unique to kiwifruit, measurably accelerates gastric protein digestion and stomach emptying.[48] For a user with delayed gastric emptying who cannot fit their protein in, that is a mechanistically interesting pairing rather than a marketing one. Nobody appears to have tested it in GLP-1 users. Somebody should.

Lean red meat, as nutrient per bite, with Mīti as the format proof. Protein shakes are poor at the micronutrient half of the problem. Lean red meat delivers 20 to 24g of protein per 100g with all nine essential amino acids plus bioavailable iron, zinc and B12,[49] and AgResearch has measured a significantly better amino acid response from New Zealand red meat than from a processed alternative.[50] Mīti shows what the format looks like: 10.8g of protein in a 42g serve, nine ingredients, made from dairy beef.[51] Small, complete, portable, provable.

Behind all three sits the asset that matters most and gets talked about least. The Riddet Institute's Proteos programme has assessed 97 foods for digestible protein quality measured in the small intestine, building toward an open database of 100 protein sources with Wageningen and the University of Illinois.[52] If the world is about to start paying for protein quality rather than protein tonnage, New Zealand hosts the measuring instrument.

Then there is Calocurb, which sits in a different category altogether. Built on Amarasate, a hops extract from a $20 million Plant and Food Research programme that screened more than 900 compounds, it raises the body's own GLP-1 and CCK to as much as six times baseline within an hour.[53] It is a New Zealand-grown appetite intervention, not a companion food, and it competes with the drug rather than supporting it. Worth watching for exactly that reason.

Discipline matters here, though, because the temptation is to reach for the whole cupboard. Several of our favourite stories do not survive the evidence test for

A meal-kit company beat the entire export sector to the positioning.

this market. Marine collagen is the clearest example: Fonterra's own head-to-head research reports that collagen is lower in leucine, is an incomplete protein without added tryptophan, and produced significantly less muscle growth over five days than whey.[54] It is our fastest-moving marine protein investment and the wrong hero for a muscle-retention argument. Greenshell mussel extract carries EPA at 5.2 percent and DHA at 3.4 percent of fatty acids against 18 and 12 percent in fish oil, and the gut evidence rests on a small non-blinded trial where the microbiota shifts were tendencies rather than significant findings.[55] Manuka honey as a gut-comfort product is supported mainly by a 28-day mouse study in which nearly every organic acid was unchanged, and it is still sugar.[56] Hemp protein is 5.1 percent leucine, below the WHO requirement, and needs 105g of raw material to match 25g of whey. [57] Blackcurrant anthocyanin research is real but aimed at exercise recovery and oxidative stress in samples of ten to thirty people.[58] Even Lumina's omega-3 advantage, which is probably true, is unquantified in the company's own materials.[59]

That is not a reason to drop any of them. It is a reason to fund the trials, because in this market the claim is the product.

Who is already in the room

The finished-product shelf is filling fast, and not with New Zealand names.

Abbott launched Protality in January 2024, explicitly for adults on GLP-1s: 30g of protein, 4g of what it calls comfort fibre, 150 calories, and 25 vitamins and minerals in an 11-ounce bottle.[60] Read that formulation again. It is dairy protein plus fibre plus micronutrients, which is to say it is a New Zealand shopping list assembled by someone else. Nestlé created Vital Pursuit as its first brand built for GLP-1 users, now national in Walmart, Target and Kroger with 14 frozen meals portion-aligned to a medicated appetite, and is pushing formats to 33g of protein and 17g of fibre.[61] Danone built Oikos Fusion for the same consumer at 23g of protein and 5g of prebiotic fibre in a seven-ounce pot, and publishes a recommendation of 80 to 120g of protein a day for GLP-1 users, which is a useful measure of the size of the ingredient prize.[62] Herbalife sells a GLP-1 Nutrition Companion.[63] Maeva launched in January 2026 as a direct-to-consumer line sold exclusively to GLP-1 users.[64] And Novo Nordisk itself is moving into food adjacencies, partnering with Novonesis on synbiotic supplements through its Transformational Prevention Unit in Obesity.[65]

Two things follow. First, none of these companies farm. They buy protein, fibre and bioactives from someone, and that someone can be us. New Zealand's realistic position is upstream, in quantified ingredients with clinical backing, not in a frozen meal competing with Nestlé at $4.99.

Second, and more awkwardly, the only New Zealand business found selling an explicit GLP-1 product to consumers is My Food Bag, whose Fresh Start GLP-1 Support Meal Plan offers 25 to 40g of protein at 250 to 450 calories a plate.[66] A meal-kit company beat the entire export sector to the positioning. That should tell us something about where the sector's attention has been.

Two futures

It would be easy to read all this as settled. It is not, and the honest version of this argument has two branches.

In the first, the protocol gets codified overseas. Clinical nutrition companies and pharma partners define what a GLP-1 diet looks like, own the evidence, own the

GLP-1s point to a future that is not here yet: weaker appetite, more selective choice, higher standards of proof.

formats and own the clinician relationship. New Zealand supplies the raw protein fraction into someone else's branded product, at someone else's margin. This is the familiar outcome. It is what happened with infant formula ingredients for years before anyone here built brands.

In the second, New Zealand shows up early with the science, the assays and the clinical partnerships, and sells nutrition per bite rather than tonnes of protein. That requires spending money on evidence before the market proves itself.

The uncomfortable part is that the same physical products serve both futures. What separates them is not what we grow. It is whether we can prove what it does.

Who pays at home

There is a domestic cost to this, and it is worth naming, because the sector conversation tends to treat GLP-1s as an export marketing question.

Processing is the first exposure. Plants optimised for large primal cuts and 200 to 250 gram portions are capital-intensive and slow to reconfigure. If the premium moves to 100 to 150 gram formats with a nutritional specification attached, the constraint is stainless steel, not strategy.

The second is the snack and beverage economy: New Zealand's own confectionery, biscuit, chip and soft drink manufacturing, and the co-manufacturers and packaging businesses behind it. These are the categories falling first in every dataset.

The third is hospitality, already fragile, now facing diners who arrive less hungry. The three-course meal is not dying, but it is getting smaller, and the waste from uneaten food lands on the operator.

The fourth is the co-operative model itself. A structure designed to move maximum volume at an average price is not obviously the structure that captures a premium for proven nutritional function in a small format. That is a governance question, not a marketing one.

None of this argues against the opportunity. It argues for being explicit that the transition has losers here as well as winners, and that pretending otherwise is how sectors get caught.

What needs to change

The danger is not that New Zealand misreads the signal. It is that we read it correctly and move too slowly anyway. Like possums in the headlights, the primary sector finds it hard to move at the speed of the market.

Which is understandable. We have survived on decades of optimisation. Capital-intensive processing, long-established supply chains, the seasonality of farming and the indebtedness of farmers all conspire against fast change. It is harder still when the market signal is speculative. Will GLP-1s have the effect we are suggesting? Is food really turning into medicine?

Speaking at E Tipu, Fonterra director, farmer and nutrition specialist Alison Watters put the governance test bluntly. Asked how much of a company's innovation spend sits in genuine exploration, she said that if the answer is zero, "you don't have an innovation portfolio, you have a project list", and argued that the exploratory 10 percent has to be protected from the quarterly profit and loss discussion.[67]

That is exactly the discipline this market demands. GLP-1s point to a future that is not here yet: weaker appetite, more selective choice, higher standards of proof.

... a world with a smaller appetite is the best market we have ever had.

The stakes are national. New Zealand's export share of GDP has hovered around 26 to 28 percent since the 1970s, against an average near 59 percent for comparable small advanced economies, and economist David Skilling has argued that closing that gap is the core of the country's productivity problem.[68] Food and fibre exports are forecast to reach a record NZ$64.3 billion in the year to June 2026, dairy at NZ$28.6 billion and meat and wool at NZ$14.1 billion.[69] Our three largest goods markets, China at 25 percent, Australia at 13 percent and the United States at 12 percent, are all markets where GLP-1 uptake is rising.[70]

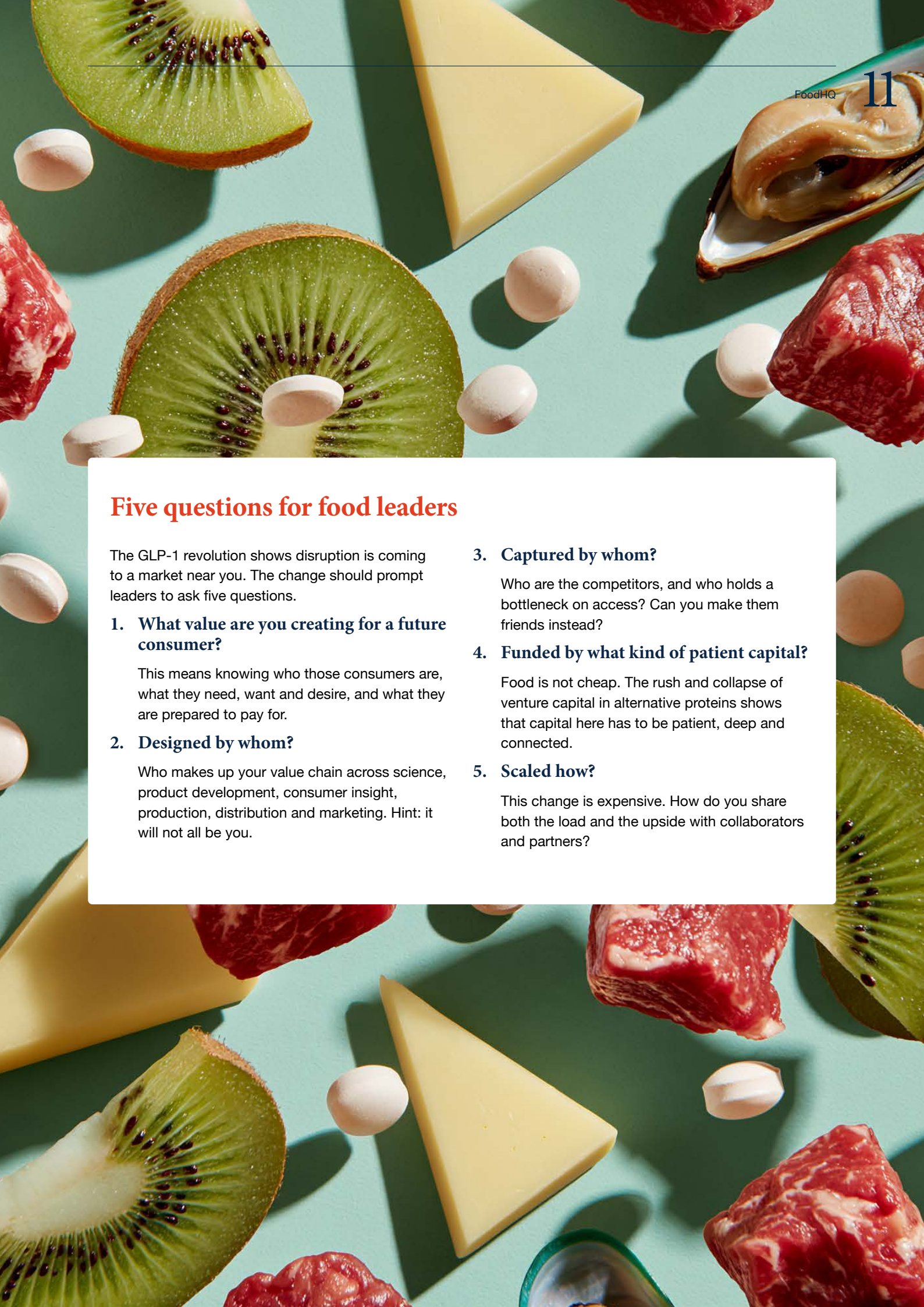
So the question is not whether the world will keep eating. It is whether we can grow export share into markets that are learning to want less of exactly what we currently sell.

Volume was a strategy. Proof is the next one.

The likely winners here are not wellness brands. They are foods and ingredients that can demonstrate nutritional utility in a smaller format: dairy proteins with a clear amino acid story, premium meat with a defined role in muscle maintenance, marine ingredients, prebiotic fibres, bioactives and mini-meals that are credible because they are actually credible.

New Zealand has the raw material, the food safety record, the provenance and some of the science. What it has not yet built is the habit of proving function and getting paid for it.

Nutrition per bite. Function per serve. Proof per claim. If we can sell that, a world with a smaller appetite is the best market we have ever had.



Five questions for food leaders

The GLP-1 revolution shows disruption is coming to a market near you. The change should prompt leaders to ask five questions.

1. **What value are you creating for a future consumer?**

   This means knowing who those consumers are, what they need, want and desire, and what they are prepared to pay for.

2. **Designed by whom?**

   Who makes up your value chain across science, product development, consumer insight, production, distribution and marketing. Hint: it will not all be you.

3. **Captured by whom?**

   Who are the competitors, and who holds a bottleneck on access? Can you make them friends instead?

4. **Funded by what kind of patient capital?**

   Food is not cheap. The rush and collapse of venture capital in alternative proteins shows that capital here has to be patient, deep and connected.

5. **Scaled how?**

   This change is expensive. How do you share both the load and the upside with collaborators and partners?

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