

Who Gets the Drug? Reimbursement, the Market and the Allocation of GLP-1 Agonists in Japan and China

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Abstract

Obesity is recognised as a disease by the professional society that governs its treatment in Japan and by the health ministry in China, and semaglutide and tirzepatide are licensed for weight management in both. Who receives them is decided elsewhere. In Japan, where insurance pays for the obesity products on its own conditions, fewer than one in a hundred of the six million people the rule declares eligible are treated, through some 1,200 accredited institutions, while a diabetes product prescribed at full cost for slimming has become the country's fourth best-selling medicine. In China, where the payer excludes weight loss as a purpose, the same drugs reach young, urban, well-paid women through hospital weight clinics, pharmacies and delivery platforms at prices competition has driven down. Reading the documents of regulators, payers, professions, manufacturers and markets from 2019 to 2026, the article argues that a drug is allocated at a series of gates—trial, licence, reimbursement rule, prescribing site, price—each held by a different party on a different principle, and that the payer's rule decides not who gets the drug but who gets it at collective expense, fixing the size and character of the market that answers for everyone else.

Introduction

In the fiscal year that ended in March 2026, the fourth best-selling prescription medicine in Japan was Mounjaro, a once-weekly injection of tirzepatide licensed for type 2 diabetes, with sales of about 130 billion yen in its third year on the market (Mix Online, 2026; Maeda, 2026). In June of that year the Ministry of Health, Labour and Welfare wrote to every prefecture, and to the two manufacturers concerned, that the drug and its relatives were being used “in some medical institutions for cosmetic or slimming purposes other than the treatment of type 2 diabetes and obesity disease”, and that adverse-event reports should henceforth record “off-label use (cosmetic purpose)” as the reason for administration (MHLW, 2026c; 2026d). The same ministry had, since February 2024, paid for a second product of the same class, Wegovy, for obesity disease, on condition that the patient had one of three named comorbidities, had completed six months of documented dietary and exercise therapy at the prescribing institution, and would stop within 68 weeks (MHLW, 2023; 2026a). About 1,200 institutions satisfied the conditions under which the insured drug could be prescribed; of the roughly six million people whom the manufacturer's own reading of the rule made eligible, fewer than one in a hundred were being treated (Mix Online, 2025; Maeda, 2026).

In China no public insurer pays for weight loss at all. The National Healthcare Security Administration had said so in April 2024, in answer to a public already asking whether the “miracle weight-loss drug” could be reimbursed, and the reimbursement lists of 2024 and 2025 admitted no weight-management indication (NHSA, 2024a; 2024b; STCN, 2024; Yicai, 2025). Yet in 2025 semaglutide products sold about 1.08 billion dollars in Greater China (NBD, 2026); the weight-management product Nuohe Ying, launched in November 2024 at about 1,400 yuan a pen, was within fourteen months being sold on delivery platforms, alongside tirzepatide and a domestic rival, at prices that had fallen by half and more (Yicai, 2024; CLS, 2026); and a platform described its GLP-1 customers as “mainly female office workers, women accounting for over seventy per cent, aged mainly thirty to thirty-five, of middle to high income, principally from first-tier and super-first-tier cities” (Time Weekly, 2025). Whoever gets the drug in China, the disease classification of the health ministry, the licence of the drug regulator and the exclusion of the payer do not, between them, say who.

This article asks how the question in its title is answered. It takes the answer to be produced not by any single decision but by a sequence of gates, each held by a different party and opened on a different proof: the trial, which fixes which bodies the evidence covers; the licence, which fixes an indication; the reimbursement rule, which fixes an entitlement; the prescribing site, which fixes who may prescribe and where; and the price and the sales channel, which fix who can buy what the payer declines to buy. The sociology of medicalisation has followed the first of these closely, the science studies of standards the conventions on which the second and third rest, and the study of coverage decisions the deliberation behind the third; none has followed the drug through all of them to the person who receives the pen, and the policy literature on GLP-1 agonists, which asks how many people are eligible and which systems reimburse (Dellgren et al, 2024; Yoo et al, 2026), assumes that the second question settles the first.

Japan and China are the cases for reasons the third section sets out: they hold steady what a comparison would want to hold steady, each had a disease classification for obesity before the drugs arrived, and they occupy the poles of a six-system inventory in how the classification is coupled to entitlement and in what the coupling leaves to the market. In Japan the state's channel is narrow and exacting, and the market channel beside it wide, lightly governed and inverted in its clientele; in China there is no state channel for obesity, and the state's allocative work consists in policing the border with the diabetes channel it does pay for and in adjusting, through patents, data protection and the essential medicines list, the terms on which the market answers.

The argument can be stated in advance. Recognition of a disease does not produce entitlement, and entitlement does not produce access. Between them stand the gates, and at each the party that holds it applies a principle of its own—effort documented in a file, an indication coded on a claim, a rank in a queue, a price met at a counter—so that the allocation of the drug has the structure Elster (1992) called local justice, a composition of institution-specific allocations rather than the application of one. The reimbursement rule, in that composition, decides not who receives the drug but who receives it at collective expense, and so fixes the share of the demand the market will serve; the figure of the recipient is produced twice, by the payer's proofs and by the market's price, and in both countries the two are inverses. What follows describes how they are made, by whom, and with what instruments each institution addresses the one it did not intend.

Who gets what

The question of who gets a drug has been asked in several literatures, and each has answered for one gate. The sociology of medicalisation established that the boundary of disease is contingent and that payers help to move it. Conrad described medicalisation as “a form of collective action” whose engines had shifted by the 1980s, when “health policy shifted from concerns of access to cost control, and managed care became central” (Conrad, 2007, pp. 9, 14); Greene showed how thresholds set by “expert committees that define standards, thresholds, and guidelines” turned hypertension, diabetes and cholesterol into symptomless conditions shaped around the drugs that treated them (Greene, 2007, p. 8; Dumit, 2012). Obesity has been the paradigm of the argument (Saguy, 2013), and for two decades the question whether it is a disease has been argued as though a white paper or a commission could settle it (Allison et al, 2008; Rubino et al, 2025); and the pharmaceuticalisation literature added that conditions are translated “into opportunities for pharmaceutical intervention” beyond the medicalised, into “the creation of new consumer markets” (Williams et al, 2011, pp. 710–711; Bell and Figert, 2012). What this lineage tracks is the label. It has seldom followed a labelled condition and a licensed drug into the office where a payer decides which uses are its business, or asked what the consumer market it names does when the payer declines.

The science studies of standards established how contingent categories are made to hold. Bowker and Star (1999) showed that classifications have consequences that are invisible because they are infrastructural; Timmermans and Epstein observed that “every standard is simultaneously overdetermined and incomplete” and delegates “residual work” to those who must live with it (2010, p. 81); and Cambrosio and colleagues named the “regulatory objectivity” of post-war biomedicine, which “consistently results in the production of conventions” treated as facts far from the encounter in which they apply (2006, p. 189). The WHO’s 2004 consultation on Asian populations, which “made no attempt to redefine BMI cut-off points for each population separately” and remarked that “cut-off points are merely a convenience for public health action” (WHO Expert Consultation, 2004, p. 157), is a textbook instance. This lineage supplies the vocabulary in which a comorbidity count or a 68-week limit can be read as a convention with a maintenance cost; it has rarely followed a convention into a reimbursement file, where its status changes from a convenience into a condition of payment, or to the counter where the same convention, unpaid, becomes a price.

The study of coverage decisions and of allocation established that limits are set in deliberation and that scarce goods are distributed by principles that vary with the institution. Daniels and Sabin required that limit-setting be public, rest on grounds “fair-minded people can agree are relevant”, be revisable and be enforced (2002, pp. 11–12), and Kleinhout-Vliek and colleagues, observing appraisal committees across Western Europe, showed that “contextual factors are established ‘around the table’, ie, in deliberation” (2020, p. 390) and that a committee “constructs necessity” in phases (2021, p. 457). The bioethics of the new drugs has proposed tiers of priority for a supply that in the United States has been allocated “largely on a first-come, first-served basis” and by “ability to pay”, a framework addressed to “governments, professional societies, and physicians” as its executors (Emanuel et al, 2024, p. 1839). Behind this work stand older accounts of allocation. Calabresi and Bobbitt (1978) separated the first-order determination of how much of a scarce good a society will produce or buy from the second-order determination of who receives it, and observed that societies mix markets, political process, lotteries and custom in making the second. Elster (1992) named local justice the practice by which institutions allocate goods and burdens by principles of their own, need here, merit there, a queue or a lottery elsewhere, so that a person’s share falls out of an uncoordinated composition. Stone (1984) showed for disability that a category can serve as the boundary between two systems of distribution, one based on work and one on need, and that the state’s problem is then to define, certify and police who belongs on the need side. Each of these accounts describes a gate; none, because none was written about pharmaceuticals, describes what happens when the good excluded at one gate remains for sale at another. Pharmaceutical anthropology has approached that question from the other direction: Ecks (2005) called pharmaceutical citizenship the promise, made in the marketing of antidepressants in India, that taking a drug would bring the marginal back into the fold, a promise addressed to people as buyers before it reaches them as patients.

Two further concepts carry the analysis of the proofs at the gates. Deservingness, as van Oorschot’s study of public opinion resolved it, names the criteria by which people judge who merits collective support—control over one’s neediness, attitude, reciprocity, identity and need (van Oorschot, 2000)—and later work has found it travelling with weight stigma (Hughes and McArthur, 2023); experimental studies report that weight lost with semaglutide is judged less praiseworthy than weight lost by effort even when diet and exercise accompany the drug (Bachmakova et al, 2025), and that effort is moralised independently of its results (Celniker et al, 2023). The eligibility rules examined below have a form that resembles these judgements; they do not record whether the judgements shaped them, and the form, as will appear, is more specific than a preference for effort. From Mol comes the vocabulary in which the form can be described. In *The Body Multiple* the multiplicity of a disease is held together by coordination and kept from clashing by distribution, incompatible enactments being assigned to different sites (Mol, 2002). A reimbursement rule also distributes, but conditionally, since a use is assigned to the reimbursed side only when specified proofs are supplied, and with sanction, since crossing is audited and penalised. The result may be called the *drug partitioned*: a pharmaceutical use already constituted by classification, trial, licence and product, further divided by the organisation of eligibility, held in its divisions by proofs that particular parties must produce, and sold, on the far side of the division, to whoever can pay.

Why Japan and China: the design of the comparison

The comparison is built in two layers, and its unit is the technique rather than the country. The first layer is an inventory of the ways in which six systems draw the boundary between the reimbursed and the unreimbursed use of the same drugs, recorded in Table 1 under the same seven heads for each, from the legal basis of the boundary to the instrument that reaches its outside. The inventory does not aim at representativeness; it establishes the range of variation and shows, before any case is opened, that the range does not sort by the usual categories of health-system comparison. Typologies built on financing and provision (Wendt, 2009; Böhm et al, 2013) would place Japan, Germany and China together among the systems financed by social insurance and England among those financed by taxation; on the boundary drawn around these drugs, Germany and China stand together, Japan stands alone, and England's queue most resembles the American programme that pierces a statute. The second layer opens the two systems that bound the range: Japan, where the proof of eligibility falls most heavily on the clinic, and China, where it falls on the claimant. Taking the technique as the unit keeps the comparison from the methodological nationalism that reads every difference as one of national culture (Wimmer and Glick Schiller, 2002), while acknowledging that licences, funds and professions remain national, so that the nation is still where techniques are assembled.

Table 1

The gates and the counter: elements of the allocation of GLP-1 agonists for obesity in six systems (analytic present: September 2026)

System	Legal basis of the payer's boundary	What the payer classifies	Proof required for a claim	Temporal condition	Who is admitted at collective expense	The counter: who buys, at what price	Instrument reaching the outside
Japan	Optimal use promotion guideline tied to NHI listing; Insurance Bureau notice on claim content	Diagnosis (obesity disease with named comorbidity), facility, patient's regimen	Facility accreditation; dietitian's licence number; dated six months of guidance; plan dates; monthly attestation of improvement	68-week maximum (72 for tirzepatide); restart after six months in principle	Manufacturer's peak forecast 100,000; about 1,200 institutions; 'one per cent or less' of about six million eligible	Self-pay clinics, often online; diabetes products off-label; subscriptions from 20,000 yen a month; consumer complaints 49/205/169 (FY2021–23)	Ministerial notices to prefectures and manufacturers; advertising rules; professional statements; syndrome named for the underweight
China	Interim Measures (2020) excluding 'improvement of living state' drugs; payment scope on the reimbursement list	Purpose/indication (diabetes versus weight loss); product (Nuohe Tai versus Nuohe Ying)	Indication code on the claim	None stated	Diabetes indication only (semaglutide 2021; tirzepatide 2026); essential medicines list 2026 for diabetes	Hospital weight clinics, pharmacies, delivery platforms; about 1,400 yuan a pen at launch, a few hundred by January 2026; buyers 'over seventy per cent women, aged thirty to thirty-five, middle to high income'	Penalties for fraudulent claims; appeal to the insured as guardian; patent and data-protection timing; no price instrument
England	NICE recommendation converted into NHS England phased introduction	Rank by comorbidity count and BMI, with ethnicity-adjusted thresholds	Qualifying comorbidities; wrap-around support	Three-year cohorts within up to twelve years	About 220,000 in three years of about 3.4 million eligible	About 1.6 million users in the previous year, mostly private; twice as often women	Commissioning guidance; no instrument on private supply cited
United States (Medicare)	Statutory exclusion (Part D, 2003); GLP-1 Bridge from July 2026	Drug class; then BMI with named conditions	Provider attestation; prior authorisation	Bridge to end of 2027; BALANCE for Medicare delayed	Beneficiaries meeting Bridge criteria at \$50 a month	Cash and commercial channels; negotiated \$245 model price for a benefit not yet in force	Programme rules
Germany	Social Code Book V clause; G-BA annex (2024)	Purpose (quality of life; weight regulation)	None (excluded)	None	None for weight	Private purchase	Statute
South Korea	Positive list; not listed	—	—	—	None	Private purchase from October 2024; telemedicine prescription barred from December 2024	Pilot-scheme guideline on telemedicine

Within the second layer the pair is chosen on the logic of most similar systems (Przeworski and Teune, 1970): as much as possible is held steady so that the divergence can be attributed to what remains. Both provide statutory coverage their governments describe as universal, and in both a single national body fixes the terms on which a drug enters public payment—the Central Social Insurance Medical Council in Japan, the reimbursement-list negotiation in China. Both had domestic obesity classifications with thresholds below the Western 30 before the drugs arrived, 25 in Japan from 2000 and 24 and 28 in China from 2003, and both licensed the drugs on trials in their own populations. The same two

multinational manufacturers supply both markets and obtained obesity indications in the two countries within sixteen months of each other; both states police prescribing and claims; both funds are under fiscal strain; and both societies have lawful self-pay medicine and an online pharmacy trade through which a drug can reach a buyer without a payer. What differs is confined to the coupling. In Japan the classification belongs to a professional society, is enforced through a specialist system and is written into the conditions of reimbursement; in China it belongs to the health ministry, and the payer applies a category of its own, a genus of purpose written in 2019, that predates the guideline and never meets it. The divergence in entitlement, and in what each system leaves to the market, can therefore be attributed neither to financing, nor to the absence of a disease concept, nor to the manufacturers, but to who owns the classification and whether the payer's category is nosological or purposive.

The two are poles, not a sample. The other systems in the inventory either combine the Japanese and Chinese techniques—the American programme admits by diagnosis and attestation inside a statutory exclusion of purpose—or govern by an instrument neither uses, the queue; and South Korea, which shares Japan's trials and thresholds, leaves Wegovy, launched there in October 2024, off the list of covered items without any category that can be read (Ahn, 2024), so that it serves as a control for non-reimbursement rather than a second case of exclusion. A pair chosen in this way cannot establish how often a coupling produces an outcome, but it can establish how, by tracing the same act—recognition, licensing, the payer's rule, the sale—in the same order in both systems. Two limits follow. National rules are applied unevenly, by some 1,200 institutions in Japan and by provinces and platforms in China, and the analysis reads the rules and their stated application, not local practice; and the materials on the two markets are asymmetric, so that the markets are compared in direction and clientele, never in size.

Materials and reading

The analysis rests on public documents issued between April 2019 and September 2026. Administrative instruments—Japan's optimal use promotion guidelines, the Insurance Bureau's notices on what a claim must record, China's Interim Measures on the Administration of Medicines under Basic Medical Insurance and the payment scopes attached to its reimbursement lists—state what a claim must satisfy. Regulatory review reports and approvals state which products exist, for which indications, and on what evidence. Professional statements and ministerial notices state what a profession or a ministry has chosen to problematise, and a payer's communications to the public state how it describes the outside of coverage to those who might enter it. A second set of materials describes that outside: manufacturers' forecasts of patient numbers and sales submitted at listing, and their press releases; the records of consumer-protection bodies; industry sales rankings; the trade and financial press of both countries, including investigative test-purchases on delivery platforms; and platforms' own descriptions of their customers. These are used for what they can bear: a manufacturer's forecast is evidence of what the company expected the insured channel to carry, not of what it carried; a platform's profile of its buyers is a statement by an interested party; a journalist's test-purchase shows that a prescription could be obtained in a given way on a given day. No claim depends on the precision of a number that only its producer could verify.

Each document was read with the same questions in mind: what it represents the problem to be (Bacchi, 2009); on which entity it acts, whether the disease, the product, the indication, the patient, the fund or the price; through which requirement it draws the line between claimable and unclaimable use; to whom it assigns the work of showing that the requirement has been met; and, for the materials describing the market, through which channel and at what price the drug reaches those the requirement excludes. The eligible patient is throughout an administrative figure and the buyer a commercial one; neither is a patient's experience, which these documents do not contain. The market that answers for what the payer excludes is examined under the three heads the Chinese payer's own communication distinguishes—self-pay use within an approved indication, self-pay use outside one, and claims made under a covered indication for an uncovered purpose—together with a fourth that neither payer names, the price. Translations from Japanese and Chinese are mine, with the original term given where the translation carries weight. The analytic present is September 2026; the boundaries and the prices moved throughout, and that movement is treated as part of the record.

Japan: a narrow gate and a wide market

A disease owned by a profession

The Japanese classification began with a measurement rather than a drug. Matsuzawa's group in Osaka "established the concept of visceral fat obesity" in the 1980s (Matsuzawa, 2010, p. 131); the Japan Society for the Study of Obesity set its threshold in a guideline of 2000 (Ogawa et al, 2024, p. 224), and the criteria for "obesity disease" that it published in 2002 were derived from 1,193 subjects, in whom the number of complications rose with BMI until "the average value was greater than 1.0 at a BMI of 25" (JASSO, 2002, p. 987). The society's purpose, as its 2022 guideline restates it, is "to identify those who might benefit from weight reduction within a large population of obese individuals": obesity is a BMI of 25 or more, and it becomes obesity disease "if accompanied by any of the 11 specific obesity-related health disorders that weight reduction can prevent or alleviate", or by visceral fat obesity (Ogawa et al, 2024, p. 223). The classification was built to select, and a specialist system introduced in 2013 and an alignment "between diagnostic criteria, physician training, and insurance coverage" that the society's leadership describes as "uncommon internationally" have grown around it (Ogawa et al, 2026, p. 6). The Lancet Commission, whose distinction between clinical and preclinical obesity the same authors claim to have anticipated by a quarter of a century (Ogawa et al, 2026, p. 5),

condemned “obesity plus criteria”—requiring “the presence of another disease” for “indication to and coverage of obesity treatment”—as practices that “can effectively, and unfairly, deny access to care” (Rubino et al, 2025, pp. 222, 224). The Japanese rule is an obesity-plus rule, and it is nowhere more tightly coupled to a disease classification than here; even here the two are not the same.

The licence: a trial written into an indication

In Japan approval is very nearly listing. Of the new molecular entities approved between October 2004 and December 2014, 97.4 per cent—304 products—were entered in the national price list, on average 66 days after authorisation (Takayama and Narukawa, 2016, p. 361), so that the work of deciding who will get a drug at public expense is done not at the price list but in the indication and in the guideline attached to it. The indication for Wegovy was drawn from a trial designed to the classification. The regulator’s review report records the applicant’s reasoning: the society’s guideline defines obesity as BMI 25 and obesity disease by health disorders; the number of complications and mortality “tend to increase when BMI exceeds 27”; and “in the light of these domestic realities” the applicant designed trial 4382, in Japan and South Korea, for patients with hypertension, dyslipidaemia or type 2 diabetes and a BMI of 27 with two or more disorders or 35 with one (PMDA, 2023, pp. 46–47). The agency saw “no problem” in setting the indication on the trial’s selection criteria (PMDA, 2023, p. 47), and the licence reads accordingly: obesity disease, “limited, however, to cases having hypertension, dyslipidaemia or type 2 diabetes, in which sufficient effect is not obtained from dietary and exercise therapy”, with a BMI of 27 and two disorders or a BMI of 35 (PMDA, 2023, p. 58). A patient with a BMI of 30 and one disorder, whom the society’s criteria diagnose with the disease and whom the American and European labels reproduced in the same report would treat, is outside the Japanese licence: the trial carried the society’s classification into the licence, and narrowed it on the way. Wegovy became reimbursable on 22 February 2024 and Zepbound, tirzepatide’s obesity product, was listed on 19 March 2025 (JASSO, 2025, p. 1; Hakariya et al, 2024, p. 3006).

The payer’s scope: a claim made of dates

The optimal use promotion guideline that accompanies the listing was issued under a cabinet policy of 2016 whose purpose is to provide innovative medicines “to patients who truly need them” (MHLW, 2026a, p. 2), and compliance with it is a condition of reimbursement. It adds three requirements that the licence does not contain. Where is settled by the facility: an insured institution accredited as a training facility by a named society, with a full-time specialist and “a system in place for appropriate nutritional guidance by a full-time registered dietitian”, the same section stating that “the drug must not be administered for purposes of slimming, dieting or the like outside the obesity disease that is the object of treatment” (MHLW, 2026a, pp. 17–18). What must precede the drug is settled by the prerequisite: at least six months of treatment under a dietary and exercise plan “at the institution that will administer the drug”, “without sufficient effect”, including “nutritional guidance from a registered dietitian at a frequency of at least once every two months”, which the institution must confirm, “for example by checking the patient’s own records”, and record (MHLW, 2026a, p. 19). How long the drug may continue is settled by the calendar: “since there is no experience of use exceeding 68 weeks in clinical trials in Japanese subjects, administration of the drug shall be a maximum of 68 weeks”, with discontinuation to be considered after three or four months without improvement and resumption after relapse permitted only after “in principle, six months or more” of renewed lifestyle therapy (MHLW, 2026a, pp. 19–20). The tirzepatide guideline repeats the structure with 72 weeks (MHLW, 2025).

The Insurance Bureau then converted the guideline into the content of the claim. Its notice of 21 November 2023 requires the claim on which the first dose is billed to state, in the remarks field, the institution’s society certification, the dietitian’s licence number, the physician’s qualification, the comorbidities and the BMI band, “the date on which the treatment plan for dietary and exercise therapy was drawn up”, “all the dates on which nutritional guidance by a registered dietitian was received, showing at least six months”, and “the date on which the treatment plan for this product (a plan to discontinue within 68 weeks) was drawn up”; every subsequent claim must state the latest date of dietitian guidance, the number of weeks since the first dose, and the latest values of weight, glucose, blood pressure and lipids “together with the fact that an improving trend has been observed” (MHLW, 2023). A claim for Wegovy is a dated account of a relationship between a patient and an institution, renewed monthly, and it must assert improvement each time it is renewed.

These requirements have clinical readings, and the regulator’s review supplies them: the society’s guideline places pharmacotherapy after three to six months of lifestyle therapy, and the agency asked that the drug be considered “only for patients who medically need weight reduction and, among them, are thought to need drug treatment” (PMDA, 2023, p. 50). None accounts for the form the prerequisite took. The trials required a history of unsuccessful dieting; the rule requires six months at this institution, under its plan, with its dietitian, verified from the patient’s own records and copied, date by date, into the claim. It requires two things at once: the patient must be shown to have carried out the therapy and shown not to have benefited sufficiently from it, both proofs the institution’s, and the institution that produces them the one that will prescribe. This double proof is the form that deservingness takes here: van Oorschot’s reciprocity, a contribution made before the collective pays, except that the contribution is made to a regimen rather than to the fund, and it is its recorded insufficiency that converts it into a claim.

Whom does the gate admit? The manufacturer’s forecast, accepted by the Central Social Insurance Medical Council on 15 November 2023, put the number of patients at peak, in the fifth year, at 100,000, with sales of 32.8 billion yen (Chuiyko News, 2025). The company’s president said in April 2025 that about six million people met the guideline’s criteria, and a later release put the number with obesity disease at 16 million, of whom

“only a very small fraction” were treated (Mix Online, 2025; Novo Nordisk Pharma, 2025). By September 2026 an industry editor could report that about 1,200 institutions met the facility requirements and that patients treated with either insured product remained “one per cent or less” of the eligible six million (Maeda, 2026). A payer-side member of the Council asked in March 2025 that use be monitored so that there was none “deviating from the guideline, including in self-pay practice” (Chuiyko News, 2025). The numbers describe a channel built to carry one or two of every hundred people whom the rule declares eligible, before price is considered: at list, a month of the full dose costs 42,960 yen, of which a working-age patient pays three tenths (Japan Medical Journal, 2023).

The same pen acquired a second gate in June 2026, when Wegovy was approved for metabolic dysfunction-associated steatohepatitis with moderate or advanced fibrosis and received a guideline of its own. For that indication the patient is selected by biopsy or non-invasive measures of fibrosis and is “in principle” to have a BMI of 23 or more, the trial having enrolled few patients below 23; there is no six-month prerequisite, no 68-week limit, and continuation is judged at twelve months by the state of the liver (MHLW, 2026b, pp. 8–9; MHLW, 2026e). A person with a BMI of 24 and a fibrotic liver may now receive at public expense what a person with a BMI of 30 and one disorder may not, the proof demanded of the first being a stage of tissue and of the second a record of conduct. Who gets the drug depends, within one product and one payer, on which disease the fat is attributed to.

The market that answers

The outside of the insured channel has three parts, and price runs through all of them. Self-pay use within the licensed indication is lawful, since the guideline governs insured use rather than prescribing and Japanese law permits care outside the insurance schedule (*jiyū shinryō*). Self-pay use outside the indication is the part that has grown. Before Wegovy was listed, the diabetes products were being prescribed for weight loss in private clinics, often online (Hakariya et al, 2024, p. 3006). The National Consumer Affairs Center recorded 49 consultations about online slimming treatment in fiscal 2021, 205 in 2022 and 169 in the first seven months of 2023, the typical case being a woman prescribed months of a diabetes drug by video consultation, on a subscription costing more than 20,000 yen a month that she could not cancel (NCAC, 2023). Kinoshita describes a “medical diet” (*iryō daietto*) market in which “some physicians’ morals have declined seriously with the expansion of the self-pay market” (Kinoshita, 2026, p. 157). Mounjaro’s rise to fourth place in the national market within three years of launch belongs to the same expansion (Mix Online, 2026; Maeda, 2026).

The instruments turned on this part of the outside are those a ministry and a profession use on doctors. The ministry’s notices of 16 June 2026 rehearse the licensed indications and the guideline, remind institutions that advertising self-pay treatment with off-label medicines is “in principle prohibited” beyond websites that disclose contents, cost and risks, ask that adverse-event reports name cosmetic off-label use, and instruct the two manufacturers to work with wholesalers so that warnings reach institutions and pharmacies (MHLW, 2026c; 2026d). The notice to prefectures frames the problem as one of supply, asking for appropriate use “so that supply to patients who truly need it is not obstructed”, while adding that all the products were “on normal shipment” (MHLW, 2026c). The society’s statement had already declared the drugs “not drugs to be used for cosmetic, slimming, dieting or similar purposes” (JASSO, 2025, p. 1). The third part of the outside, claims made under the insured indication for excluded uses, is addressed by the compliance condition and the Council’s call for monitoring; the corpus records no audit.

What is distinctive about this outside is not that it is lawful, for China’s largely is too, but that it has inverted the payer’s figure of the recipient, and that the profession has responded to the inversion with a further classification. In 2025 the society, with four other societies, proposed a “Female Underweight/Undernutrition Syndrome”, observing that about a fifth of Japanese women in their twenties have a BMI under 18.5 and that “the off-label use of GLP-1 receptor agonists, which are drugs for diabetes and obesity disease, has recently been introduced as an ‘easy method of slimming’ and has become a social problem”; it names social networks, fashion media and “poverty” among the causes, and remarks that “no disease concept exists that expresses the relationship between low weight or undernutrition and illness” (JASSO Working Group, 2025, pp. 55–56). The document does not attribute the syndrome to the drugs. What it shows is a single professional body extending the technique with which it selects patients to the other end of the scale, to name a population that the market, rather than the payer, has supplied.

China: an excluded purpose and a market that answers

A disease recognised by one agency

China’s obesity classification also predates the drugs, and its origins are documented: the Working Group on Obesity in China was created in 2000 under the Chinese branch of the International Life Sciences Institute, Roche “supported the meta-analysis that defined the BMI (body mass index) cutoffs for obesity and overweight (2000–2001)”, and drug-company support “was critically important to the development of the science of obesity and the transformation of obesity into a disease entity in China” (Greenhalgh, 2016, pp. 496–497). The thresholds that emerged, 24 for overweight and 28 for obesity, are the entry points of every Chinese document analysed here. In October 2024 the National Health Commission issued a guideline that describes obesity as “an independent disease among chronic diseases and an important cause of many chronic diseases”, grades it above 28, provides for drug treatment “in combination on the basis of lifestyle intervention” where lifestyle intervention fails,

and names five approved drugs (NHC, 2024). Four months earlier sixteen ministries had launched a three-year “Year of Weight Management” that mentions neither drugs nor insurance (NHC *et al*, 2024), and in March 2025 the Commission and the administration for Chinese medicine instructed the general hospitals under national and provincial authority to “basically achieve full coverage” of weight-management clinics by the end of June, using “relevant drugs reasonably” and “selecting appropriate treatment strictly according to the indication” (NHC and NATCM, 2025). Recognition in China is thus complete on its own terms, a disease with a pharmacological indication, a population target and a clinic in every major public hospital; none of these documents mentions the payer.

The licence: three products, two thresholds

Semaglutide exists in China, as in Japan, as two products: Nuohe Tai (Ozempic), licensed in 2021 for type 2 diabetes, and Nuohe Ying (Wegovy), approved on 25 June 2024 for weight management in adults with a BMI of 30, or of 27 with a comorbidity, two products that the manufacturer says “cannot be substituted for each other” (Novo Nordisk, 2024). Tirzepatide exists as one product, Mufengda (Mounjaro), approved in May 2024 for diabetes and in July 2024 for weight management “covering both indications” under a single brand (Xinhua, 2025), and a domestic dual agonist, mazdutide, was approved for weight management in June 2025 under the brand Xin’ermei (Time Weekly, 2025). The thresholds are not the same across the three: the imported semaglutide product carries the global 30 and 27, while tirzepatide and mazdutide carry the Chinese 28 and 24, so that a person with a BMI of 29 and no comorbidity is inside the licence of two products and outside the third. China thus runs several classifications at once, and none of them reaches payment.

The payer’s scope: a genus of purpose

Nuohe Tai entered the National Reimbursement Drug List, “the main route for drug reimbursement” (Macabeo *et al*, 2023), in the 2021 adjustment, whose negotiations cut admitted drugs’ prices steeply (Zhu *et al*, 2025). The exclusion of weight loss is older than the drugs. The administration’s explanation of its 2019 adjustment listed the kinds of drug that “cannot be included”, among them “drugs used for weight loss, cosmetic purposes, smoking cessation and the like”, adding that “some of these improve quality of life (*gaishan shenghuo pinzhi*), some are preventive, some fall within public-health provision, and none are within the scope of the adjustment” (NHSA, 2019). The Interim Measures of 2020 then fixed the genus in a regulation, without the reason: among eight kinds of drug that cannot enter the list are those “mainly for enhancing sexual function, treating hair loss, weight loss, cosmetic purposes, smoking cessation, alcohol cessation and other ‘improvement of living state’” (*gaishan shenghuo zhuangtai*) (NHSA, 2024b).¹ The category names purposes, in the company of hair, cosmetics and tobacco, rather than pathologies, and it is the counterpart of the German statutory clause that excludes medicines primarily serving “an increase in the quality of life” (G-BA, 2024).²

The rule met the drugs in April 2024. Asked, in the title of its own post, whether the “miracle weight-loss drug” had entered medical insurance, the administration answered that the payment scope of semaglutide “is limited to two situations related to adult type 2 diabetes”, that “a weight-loss drug, however ‘miraculous’, cannot enter medical insurance”, and that use for obesity, not yet licensed, “remains off-label” (NHSA, 2024a; 2024b). The reason given was the fund, whose “every cent is hard-earned and must be spent on the blade’s edge of treating illness and saving lives” (NHSA, 2024b; Workers’ Daily, 2024). The rule held as the products changed. The 2024 adjustment did not admit Nuohe Ying (STCN, 2024). The 2025 adjustment admitted tirzepatide “less than a year after launch”, but “the scope of insurance coverage applies only to glycaemic control in adult patients with type 2 diabetes” (Yicai, 2025), and the first “commercial health insurance innovative drug list”, published the same day for drugs “beyond the basic function” of the fund, contained no drug for weight (NHSA, 2025; 2026a). By the 2026 round the exclusion had become a fact about applications rather than decisions: no weight-management indication of any GLP-1 agonist appears among the products passing formal review in June 2026, and the domestic maker of mazdutide applied with the label of its diabetes product (NHSA, 2026b; Innovent, 2026). In July 2026 semaglutide and liraglutide entered the National Essential Medicines List, which obliges hospitals to stock listed products, again “for the treatment of type 2 diabetes” and not, as a financial daily noted, as the “weight-loss injection” most people knew (EEO, 2026). A drug the health ministry had named as a treatment for a chronic disease was admitted by the payer, twice, as a treatment for a different one, and the manufacturers had learned to ask for nothing else.

The market that answers

Nuohe Ying was launched on 17 November 2024. Its maker said that it was not sold “through any online platform” and “for the present does not belong to the drugs reimbursed by national basic medical insurance”; the price through private hospitals was about 1,400 yuan a pen, against less than 800 for the diabetes product (Yicai, 2024). Public hospitals were slow to stock it, tertiary hospitals still carrying only the diabetes product in December 2024 (Jiemian, 2025), and retail pharmacies were not: a pharmacy beside a tertiary hospital in Guangzhou posted “Nuohe Ying has arrived” on its door, sold it at 1,200 to 1,800 yuan, and, being a “dual-channel” pharmacy, also dispensed the diabetes product with reimbursement (Time Weekly, 2025). Manufacturers turned to retail because, in the words of an executive of a domestic GLP-1 firm, “the state has stated clearly that weight-loss drugs will not be included in medical insurance”, so that “the broader market for the GLP-1 track may be outside the hospital, in retail” (Time Weekly, 2025). Tirzepatide went on sale on Meituan and JD Health in January 2025 from the same batches supplied to hospitals (Jiemian, 2025), and mazdutide followed in July (Time Weekly, 2025). JD Health reported that its GLP-1 sales in the June 2025 shopping festival had more than tripled year on year, and Meituan described the buyers quoted in the introduction (Time Weekly, 2025).

Price then did what the payer had declined to do. In December 2025 the financial press recorded that semaglutide and tirzepatide had been “cut by half” and “to a fifth” on several platforms and in some public procurement; by January 2026 a 10 mg pen of Mufengda sold on Meituan for 559 yuan, semaglutide for 300 to 400, and mazdutide, which had “held back”, for 489 yuan a box (CLS, 2026). The timing of the entrants for whom the originators were, in the industry’s reading, “making room in advance” (CLS, 2026) is itself an allocative decision taken elsewhere. Semaglutide’s compound patent expired in China on 20 March 2026, and some ten domestic firms had filed; none was approved, because the marketing authorisation had been registered to a Swiss subsidiary and the China–Switzerland Free Trade Agreement grants “at least six years” of protection to undisclosed trial data from approval, which runs to April 2027 (NBD, 2026). Who gets the drug in 2026, and at what price, is thus decided in part by a trade agreement and a corporate registration.

The claim’s proof at this market gate is thin. In June 2026 reporters obtained prescriptions for tirzepatide and semaglutide on four delivery platforms by ticking, without verification, options such as “diabetes combined with obesity”, and found merchants advertising a “no weight loss, guaranteed compensation” service worth up to 5,000 yuan (The Paper, 2026; CLS, 2026). The administration, for its part, polices the other side of the counter. Its post of April 2024 distinguishes the parts of the outside: prescription drugs “may be dispensed, purchased and used only on the prescription of a licensed or licensed-assistant physician”, so that self-pay purchase is lawful on prescription and off-label use a risk rather than an offence; what is prohibited is the claim, since “obtaining medical-insurance funds by deception may be punished and may even be illegal” and “every insured person is a guardian of the medical-insurance fund” who should not “harm the ‘life-saving money’ for a small immediate gain” (NHSA, 2024b). The same post “hopes that medical institutions will strengthen prescription management and use good drugs on patients who truly need them” and advises that “through disciplined exercise and reasonable diet, weight management can in most cases be done well” (NHSA, 2024b). The Chinese payer polices the claim and exhorts the conduct; the Japanese payer makes the conduct the claim; and in both, the person who gets the drug without either is the person who pays.

What the comparison shows

Set side by side, the two systems no longer sort into a country that pays and a country that does not: both recognise the disease and license the same ingredients, in both the person the classification describes and the person the payer admits are different people, and in both the difference is made up by a market whose clientele is the inverse of the payer’s figure. They differ in the object on which the payer’s requirement bears, in the party to whom proof is assigned, and in how much of the demand each leaves to the market.

The Japanese rule operates inside the obesity indication, on the patient and the facility, and its proofs are the institution’s: accreditation, a dietitian’s licence number, dated records of six months of guidance, a treatment plan, and monthly attestation of improvement. The Chinese rule operates between indications, on the purpose, and its proof is the claim: an indication code and, behind it, the beneficiary’s honesty, which the administration addresses without intermediary. From this difference of object follows a difference in the size of the outside. Japan’s gate is narrow by design, as the forecast of 100,000 patients at peak against six million eligible attests, and the market beside it serves the rest on subscriptions of 20,000 yen a month and more (NCAC, 2023); China’s gate for obesity does not exist, so the market serves everyone, at prices that fell within fourteen months to a few hundred yuan a pen on delivery platforms whose prescription checks the press has shown to be nominal.

The other systems in the inventory test how far this account reaches. England is the clearest case of a queue. NICE recommended tirzepatide in December 2024 for a BMI of 35 with one comorbidity, a population “of around 3.4 million”, and NHS England converted the recommendation into a phased introduction of up to twelve years in which “around 220,000 people are expected to benefit in this initial three year roll out period”, beginning with the highest comorbidity counts, with thresholds “usually reduced by 2.5 kg/m²” for South Asian, Chinese, other Asian, Middle Eastern, Black African and African-Caribbean patients and “wrap-around support” as “a mandatory requirement” (NICE, 2024; NHS England, 2026). A population survey found that 2.9 per cent of adults in Great Britain, about 1.6 million, had used a GLP-1 medicine for weight loss in the previous year, women more than twice as often as men and people in mid-life most (Jackson et al, 2026), seven times the number the health service planned to treat in three years; the market had answered before the queue had moved. The United States excluded weight-loss drugs from the Medicare Part D benefit at its creation in 2003, an exclusion that Hernandez and colleagues trace to “the limited effectiveness and unfavorable safety profile” of the agents then available (2024, p. 306), and only thirteen of fifty-one Medicaid programmes covered antiobesity GLP-1s for adults in 2024 (Klebanoff et al, 2026, p. 2003); from 1 July 2026 a “Medicare GLP-1 Bridge”, separate from the drug benefit, covers three named products for beneficiaries with a BMI of 35, or of 30 or 27 with specified conditions, on a provider’s attestation and a copayment of 50 dollars a month, until the end of 2027, while a model that would have brought the drugs into the benefit at a negotiated 245 dollars a month has been delayed indefinitely for Medicare (CMS, 2026; KFF, 2026). Germany’s statutory clause, under which Wegovy was placed in the lifestyle-drug annex in 2024 (G-BA, 2024), is the Chinese genus written into a statute. South Korea launched Wegovy in October 2024 without reimbursement (Ahn, 2024) and within seven weeks barred its prescription by telemedicine, citing improper prescribing and the risk of misuse (MOHW, 2024); two years later the obesity society’s officers were describing at once a problem of misuse and a “blind spot” in which those “without room in their income” found treatment hard to obtain (Medipharma Today, 2026). The WHO added GLP-1 medicines to the Essential Medicines List “for managing type 2 diabetes in high-risk groups” while issuing only “conditional recommendations” for obesity, and promised a “prioritization framework” so that “those with the highest need are reached first” (WHO, 2025), drawing at the level of global norm the line that China’s list draws in law.

Across these cases the elements of the partition—its legal basis, what it classifies, the proof it demands, the time it allows, who enforces it—vary independently of one another; the counter beside each gate does not.

Discussion

The question with which the article began has an answer in the documents, and it is not the one the disease classification gives. Who gets the drug is decided at a series of gates by parties who do not consult one another—in Japan a society's committee, a manufacturer and a regulator, a ministry with its six months and its 68 weeks, the societies whose accreditations qualify some 1,200 institutions, and a market of clinics and subscriptions; in China a payer's category of 2019, a ministry's guideline and clinics, three licences with two thresholds, and a price decided by delivery platforms, a domestic entrant and a trade agreement with Switzerland. Each applies a principle of its own—need as a fund defines it, evidence as a regulator defines it, effort as a profession records it, ability to pay as a platform measures it—and the person who receives the pen is the residue of their composition. This is Elster's local justice with a pharmaceutical addition: the good refused at one gate is not withheld but sold at the next, so that the composition never leaves anyone empty-handed who can pay, and never asks whether those who can are those who should.

The reimbursement rule occupies a particular place in that composition: in Calabresi and Bobbitt's terms it makes the first-order determination, how much of the drug the collective will buy, from which the second-order allocation of the remainder follows by price. Japan's rule is exacting because the guideline regime exists, in an industry editor's summary, "to restrain casual prescribing" and so "the burden on health-insurance finances" (Maeda, 2026), and its exactness is what makes the market outside it large; China's rule is categorical because it was written before the drugs, for hair and cosmetics and tobacco, and its form is what leaves the whole demand to retail. Neither payer sets a price for the outside: Japan's ministry reaches the self-pay clinic only as a regulator of doctors, and frames the problem as one of supply while affirming that supply is normal; China's administration reaches the buyer only as a guardian of the fund, and the state's effect on the market price runs through instruments—the essential medicines list, patent and data-protection law—that were not designed with the fund in mind. The result, in both, is that the norm the state most insists upon, that the drug is for those who "truly need" it, is applied at the gate and nowhere else.

What Stone found for disability applies here with one alteration. The categories "obesity disease" and "improvement of living state" are, as she would predict, boundaries between two systems of distribution, one based on need and certified by proofs, the other on the market; the profession in Japan and the payer in China are the certifying authorities, and the double proof of effort and failure, or the indication code and the oath of honesty, are the certificates. The alteration is that the good on the market side of the boundary is the same pen, produced by the same firm and often prescribed by the same profession: the specialist who signs the dietitian's dates at the university hospital and the physician who signs the online subscription belong to the same licensed body, and the society's naming of a syndrome at the other end of the scale is a way of reclaiming through classification a population it has lost through the market. Ecks's pharmaceutical citizenship appears here inverted: the promise that a drug will bring the marginal into the fold is made, in these two countries, not to the poor but to those who can subscribe, and inclusion at collective expense is the rationed condition, entered on proof and held on renewal. The drug partitioned names distribution in Mol's sense once it is made conditional on proof, sanctioned at the crossing and, on its far side, turned into a price. What the Japanese rule operationalises is more particular than a preference for effort, a patient shown both to have done the regimen and to have failed at it, so that deservingness becomes a fact about a record; China's rule operationalises need as a genus of purpose and leaves conduct to exhortation. Neither form can be derived from the disease status of obesity; both can be derived from who owns the classification and which instruments they hold; and neither reaches the counter.

Beyond the two cases

What the pair contributes to a general account is a way of reading any system in which a drug is at once a treatment and a consumer good, and the inventory in Table 1 suggests how far the reading extends. The six systems resolve into a few couplings between recognition and entitlement, each with a proof and an outside of its own: a professional coupling, Japan's, which writes a nosology into the conditions of payment and locates its proofs in the clinic; a purposive exclusion—China's, and in statutory form Germany's and that of Medicare's drug benefit—which names what the fund is not for and locates its proof in the claim; a queue, England's, which ranks the recognised by severity and proves by a count; a programme, the American bridge, which pierces a statute with a calendar and an attestation; non-inclusion, South Korea's, which leaves nothing to read; and a normative prioritisation, the WHO's, which supplies a vocabulary of "highest need" that the others can borrow. None is predicted by financing, and none is confined to a region; the East Asian pair supplies the two purest forms, but the forms recur. What recurs with them is the counter. Wherever a gate has been set beside a market—England's queue beside the 1.6 million users counted in the months before the roll-out began, Japan's 1,200 institutions beside a diabetes product selling 130 billion yen a year, China's exclusion beside a retail trade in which one platform's GLP-1 sales tripled in a year—the market has answered on a scale the gate does not approach, and its clientele has differed from the gate's in sex and age: women in mid-life in Britain, women in their early thirties in China's largest cities, young women in Japan. The direction of the difference is the same in tax-funded and contributory systems, in systems that pay and systems that refuse, and it suggests a proposition that further cases can test: the collective gate sorts by proof and the counter by desire and means, so that the stricter the gate, the larger the outside and the further its clientele departs from the figure the rule describes.

For the literatures with which the article began, the consequence is a step each has stopped short of. Pharmaceuticalisation, on this reading, is not a spillover from medicalisation into consumption but a partition that produces the two at once: the same licence founds a rationed entitlement and a market, and the “new consumer markets” that Williams and colleagues named are the residue of the payer’s gate rather than an excess beyond it. For the sociology of standards, a convention changes its status at each gate it passes—the WHO’s “convenience” of 2004 becomes a trial’s entry criterion, a licence, a condition of payment and, at the counter, a price—and the “residual work” Timmermans and Epstein described is assigned to a different party at each. For the ethics of allocation, the frameworks offered to “governments, professional societies, and physicians” (Emanuel et al, 2024, p. 1839) presuppose an allocator whom the documents do not contain: allocation is composed across gates that no one holds together, and the counter escapes every framework. For global health, the WHO’s line between diabetes and obesity is already drawn in national law; the techniques for drawing it travel, Japan’s criteria into South Korea and Taiwan by the society’s own account (Ogawa et al, 2026, p. 6) and China’s genus with a German twin; and the expected entry of biosimilars, in China from 2027 and elsewhere as exclusivities lapse, will move the answer further from coverage and towards price, and the instruments deciding who gets the drug will increasingly be those of intellectual property, data exclusivity and platform regulation. The 27 per cent of adults aged 25 to 64 across 99 countries whom trial criteria would make eligible (Yoo et al, 2026, p. 105) will, for the most part, meet a counter before they meet a gate.

Conclusion

Who gets the drug? Not the people the disease classifications describe. In Japan, where obesity disease has been a diagnosis since 2002 and Wegovy a reimbursed drug since 2024, the insured drug reaches fewer than one in a hundred of the six million people the rule declares eligible, through some 1,200 institutions, and only after a facility has documented six months of effort and its failure; the demand the rule refuses is met by diabetes products prescribed at full price, often by video, to women of ordinary weight, more often young than not. In China, where the health ministry calls obesity a disease and orders a weight clinic into every major public hospital, no public insurer pays for weight loss at all, and the same molecules reach young, urban, well-paid women through clinics, pharmacies and delivery platforms at prices that competition has cut by half and more. Two systems that agree on the disease and license the same drugs for it have produced the same result: the payer selects a small population by proof—for obesity in China, none—the market selects a large one by price, and the second population is the inverse of the first, comorbid and documented on one side, young, female and able to pay on the other.

This is the work of the partition, not an accident of its administration. A reimbursement rule does not decide who gets the drug; it decides who gets it at collective expense, and thereby how much of the demand the market will serve and to whom. The stricter the gate, the larger the outside, and no one allocates the outside: the state reaches it only as a regulator of doctors or a guardian of a fund. That is why two decades of argument over whether obesity is a disease have settled nothing about who gets the drug. Recognition did not produce entitlement in China, and entitlement did not produce access in Japan. Access is decided by who owns the classification and whether the payer’s category is nosological or purposive; who is left outside is decided by the price. The six systems in the inventory show the same counter beside every gate, serving more people than the gate admits and a different population, while the patient the allocation frameworks are written for, in greatest need and least able to pay, is refused at the gate for want of proof and at the counter for want of money.

The effects of a therapeutic innovation are therefore read from neither its licence, nor the classifications that greet it, nor the rule of reimbursement, but from the composition of gates and counter, in any system. For the ethics of allocation the consequence is harder: a framework that governs only the gate governs the smaller share of the drug, and a state that declines to price the outside has already decided who gets it. Who gets the drug is decided by the partition of one use into a claimable part and a saleable remainder; and wherever the claimable part is drawn by proof, the answer is the person who can pay.

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Notes

1. The 2019 explanation uses *gaishan shenghuo pinzhi* (improve quality of life); the 2020 regulation and the 2024 answer use *gaishan shenghuo zhuangtai* (improvement of living state). The regulation lists the excluded kinds without a reason; the reason survives only in the explanation that preceded it. The 2024 position was reported on 16 April by state media and restated on 18 April on the administration’s public account

and in *Workers' Daily*, whose title, **“Wegovy”**, is rendered “a weight-loss drug, however ‘miraculous’, cannot enter medical insurance”, the scare quotes being in the original.

2. Germany's Social Code, Book V, excludes from statutory coverage medicines primarily directed at improving quality of life, weight regulation among the named purposes; the Federal Joint Committee listed semaglutide (Wegovy) in the corresponding annex on 21 March 2024 (G-BA, 2024).

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