

Q&A: Weighing the social costs of weight-loss drugs

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A wildly popular class of drugs called GLP-1 agonists—which includes Ozempic, Wegovy, Mounjaro, and Zepbound—are revolutionizing the treatment of obesity.

[One in eight adults](#) has tried a GLP-1 drug for weight loss or to manage their diabetes, and a tidal wave of research is revealing that these medications may also help with a range of health issues, from lowering the risk of heart disease and certain cancers to treating sleep apnea and substance use disorders.

"These drugs are making a big difference because of how effective they are," says Angela Godwin Beoku-Betts, a clinical assistant professor at the NYU Rory Meyers College of Nursing and board-certified family nurse practitioner who runs a private clinic in the Bronx focused on obesity and weight loss.

While millions have readily embraced these medications, they're new, and there's not a lot of data on how they'll affect patients—and society—over the long term. The high demand and costs for GLP-1s have driven patients to telehealth prescribers and less-regulated compounded versions, and gaps have emerged in who can access them.

"What does it mean to be medicating a population instead of addressing the social and structural issues that contribute to obesity?" asks Virginia Chang, a physician, sociologist, and associate professor of social and [behavioral science](#) at the NYU School of Global Public Health who studies obesity and health disparities.

NYU News spoke with Chang and Godwin about how this new generation of weight-loss drugs is both raising questions while offering some unexpected answers.

Are these drugs addressing the root causes of obesity?

Chang: Obesity has always been a tug of war between individual behaviors and the culture and society that structures those behaviors. What you eat and how much you exercise is a matter of individual

choice—but we also have a [food environment](#) that has changed tremendously in the last several decades.

Food has become much less expensive, and we now contend with ultraprocessed foods and food deserts where people can't get healthy foods.

The built environment has also changed. We now live in an economy where more people have desk jobs and are not doing manual labor. Labor-saving devices, suburbanization—all of those things have changed to create the increase in obesity that we've seen. It's not a genetic change; the human gene pool is the same as it was in the eighties, when the prevalence of obesity started to go up.

Applying a medication disrupts that equation, because suddenly, we have a highly effective drug that can intervene on the entire process. But it takes our attention away from the broader environment and all of the upstream factors that contributed to the epidemic of obesity we currently see.

We're applying a medical solution to social problems. But these are also social problems that have proven to be very intractable for the last several decades.

Godwin: These medications don't make changes to eliminate food deserts. They don't change how we make decisions day to day. If we don't fix those societal issues, my concern is what will happen long-term.

Are weight loss drugs reaching those who most need them?

Godwin: My research focuses on minority individuals, mostly women.

Many have Medicare or Medicaid, which generally are not paying for weight-loss drugs. For these patients, paying out of pocket isn't an option. There's still a lot of work to be done as to who is able to get these medications.

Chang: In addition to [weight loss](#), these drugs have also been shown to reduce cardiovascular risk, which expanded their domain of clinical application. It will be interesting to see if there's more pressure on insurance, both public and private, to cover these drugs, given their added benefits.

There are already social gradients in obesity and cardiovascular disease. We now know that there are social gradients in access to these drugs, which will only exacerbate those other gradients.

Many people are learning about GLP-1 drugs on social media and are using telehealth services to get them. Where does that leave the role of the traditional health care provider?

Chang: I'm a general internist. When people go to a telehealth provider, they're not evaluated in a traditional, holistic medical setting where a provider sees someone in person—where they give them a physical exam and then weigh their entire medical history and make a global assessment of whether they should be on a drug.

In the current environment, some people are going to the internet in pursuit of one drug—they might answer five questions online and get the drug in the mail, and there's huge variation in whether there's any follow-up. I don't think we've really seen that kind of thing with other drugs, so it's a very different situation.

Godwin: A lot is missing in these types of virtual interactions. In my clinic, I like seeing patients face to face. I have a million questions for them: Do you have a history of pancreatitis or thyroid cancer?

Are you skipping meals or eating late at night? Are you eating meals high in protein? Are you having GERD? Are you on the right dose? These questions lead to conversations about the future—if you don't change your habits now, what does your life look like in five, 10, or 15 years?

Also, when people come to see me, there's often something else that needs to be addressed. For instance, some men have low testosterone, or women have perimenopausal factors.

While these drugs are really effective, there are some people on them who never lose weight. Why not? Often they're not talking with a provider about it—how to actually eat on Ozempic.

My concern in general is that there's a lack of education and guidance as to what your life should look like aside from these medications. It's just, "I want the medication," and not a whole discussion of lifestyle and eating and cooking and exercising.

What will you be keeping an eye on when it comes to the long-term impact of these drugs?

Chang: There's not been a lot of talk around these drugs making people not want to eat as much. What does this mean from a sociological standpoint? What if we're not spending as much time at dinner? Eating—sitting together at a table—is a major form of human interaction in all societies. And if we spend less time at the table, do we find other ways to socialize in the long-term? We just don't know right

now.

But I would particularly like to see where social disparities go with obesity, cardiovascular disease, and diabetes. Clinical trials, by definition, don't have long-term data in the beginning. I would like to know what the long-term health effects are.

Godwin: I would also like to see an improvement in chronic health conditions—a decrease in the gap between those with diabetes and cardiovascular diseases and everyone else. My concern is, if people think this is a "fix," then we won't address the issues that lead to [obesity](#) anymore. But my hope is that we don't ignore improvements that still need to be made.

Provided by New York University

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