Lifestyle with Dr. Z

Obesity: GLP-1s Shortcut to Weight Loss – Blessing or Curse?

Obesity afflicts nearly a billion people around the world and is linked to between 3 and 5 million deaths per year. Efforts to control obesity through exercise, dieting, surgery, and drugs have proven an unmitigated failure. No country has experienced a decline in obesity since the 1970s.

What is obesity?

Simply speaking, obesity is too much fat that presents a risk to health. A body mass index (BMI) over 25 is considered overweight, and over 30 is obese.

Why is the world obese?

We are eating more calories than we use up. For most, it is a simple math problem.
Research also shows that food is cheaper than ever, people are living in cites rather than on the farms, and more women work in sedentary jobs.

What works?

Most have been on a diet at some point. The Atkins low carb diet. The high carb diets. The low protein diets. The high protein diets. The mediterranean diet. It goes on and on. Diets *don't work* over the long term. Thus, we resorted to more drastic measures, such as surgery to shrink the stomach. But now, for the first time in history, there are new medications to deploy against obesity. A miracle cure. Many think a drug is the answer.

Not so. We need to change our thinking. It's not a diet change. It's not the newest drug. It's a lifestyle change. As our country embarks in new ways of thinking, we look to our elected officials to lead and help fund better health.

Take cancer, for example. Like obesity, cancers are caused by many factors. When the U.S. declared war on cancer in 1971, it didn't just go after the pathology. It also opened fronts against behaviors and other drivers of disease—by regulating the tobacco industry, for example, to help reduce lung cancer.

The result was a large-scale shift in how we think about smoking. Every pack of cigarettes now carries a gruesome warning about the risks of smoking. We also invest billions of dollars in screening and treating cancers. We make these investments because we've agreed that cancer's health and social costs are too high to ignore. The 21st Century Cures Act gives $1.8 billion to fund the Cancer Moonshot over a 7-year period.

In contrast, the "Steps to a HealthierUS" gave just $15 million to combat obesity in its first year.

We can apply what we learned about cancer in treating obesity. But we need to invest wisely. Public-private partnerships can serve the public and support our free market economy. As long as our food industries supply cheap, unhealthy food, obesity will persist. Cattle, Poultry, and Dairy have been long-time parts of the US economy. Research shows there may be healthier options. In fact, studies by Dean Ornish, MD, Caldwell Esselstyn Jr., MD, and others have shown that low-fat, plant-based eating habits, combined with regular exercise and a healthy overall lifestyle, can prevent, delay, and even reverse heart disease.

Do medications help? Sure. For the first time in history, we have helpful and safe tools to deploy against obesity: glucagon-like peptide-1 receptor agonists (GLP-1s). These medicines have been shown to help patients shed between 15% and 20% of their body weight.

But while it's some about the drugs, it's not all about the drugs.

Any serious effort to reduce obesity must start by stating that it's a chronic disease and that we must use all tools at our disposal—including coaching, technology, lifestyle changes and safe drugs—to treat it. While most doctors may affirm obesity as a chronic disease, when it comes to creating new journeys for real-life patients, too many clinicians prefer to fall back on outdated beliefs about obesity. They point to patient habits and seek to address this chronic condition with just one tool in the toolbox. That one tool is now a medication – GLP-1s. As with most new drugs, these are not cheap.

But even if every person could get access to GLP-1, we know this medicine only solves a small part of the obesity epidemic. They largely work by reducing appetite and hunger. As with any drug, there are side effects: nausea, vomiting, diarrhea, and low sugars are common. When one

stops the medicine, one usually gains weight again. Further, we do not know the long-term problems that could occur with GLP-1s. (Recall the fen-phen finale that was found to cause valvular heart disease in the 1990s!)

With obesity, we stand at a crossroads: Either we deliver these drugs to the slice of the population that can access and afford them, or we take the road less traveled and make population health our priority.

This means acting to figure out how to deploy today's obesity solutions at scale. This requires real leadership from our elected representatives. And money. Lots of it.

What else can we do?

Let's redefine the journey from weight loss to weight management. Not every person struggling to manage his or her weight should be given drugs before looking at other treatments, and not every patient with obesity needs to be on a drug that yields the largest potential weight loss and profit to the drug company. Pharma, payers, and health systems must work together to come up with guidelines and treatment based on research, health goals and affordability. Importantly, guidelines and therapy can include "drug plus" plans that include beyond-the-pill programs for all. There will be millions of patient journeys and therefore no single "solution." Many of these solutions don't exist today, so it's vital that our leaders and policymakers reward innovation.

Tackling obesity is a marathon, not a sprint. But we must start now.

Of course, this chance wouldn't exist without the new weight-loss drugs, which make success against obesity seem possible.

Let's not squander the opportunity.