Since 1993, the number of people living in the UK with obesity (BMI ≥ 30 kg/m²) has doubled, from 14.9% to 28%, and that number continues to rise. The health risks of obesity are staggering: diabetes, heart attack, stroke, sleep apnoea, and arthritis: all-cause mortality is far higher in those living with obesity, with associated comorbidities piling enormous strain onto an increasingly haggard NHS. Public health initiatives thus far have done little to tackle the root cause of obesity. With clinicians guided to take a very cautious approach to raising the issue of weight for fear of causing offence, or being accused of ‘body shaming’, without a meaningful top-down approach to address the underlying issues contributing to the increasing size of the problem it will, alongside our patients, simply continue to grow.

Glucagon-like peptide 1 receptor (GLP-1) agonists offer an intriguing solution. GLP-1 is an enzyme produced by the small intestine following a meal. It works on the pancreas to increase production of insulin and decrease the production of glucagon. It is this which makes GLP-1 an effective treatment for type 2 diabetes. A secondary effect of GLP-1 agonists is to slow gastric emptying, thus prolonging the feeling of fullness and reducing the appetite, reducing overall caloric intake. Semaglutide, (sold under brand names Ozempic, Wegovy, and Rybelsus), have been recommended by NICE since 2022 and promise to reduce your weight by 2%.

**DOES IT WORK?**

But for how long will they work? Current guidance in the UK states that they can only be used for 2 years after which point they must be discontinued. So how does the body react to the sudden removal of GLP-1 receptor stimulation? Not well, it seems. Recent research highlights that most patients regain their weight back after their medication is stopped. And how can we assess the benefits of this short-term weight loss with the potential risks of pancreatitis, and cancer, not to mention the lack of the real mental health benefits of exercise? With over 67 million people living in the UK, and GLP-1 agonists costing up to £1500 per patient per annum, the NHS would be looking at a bill of around £45 billion over two years should they be made available to all classified as obese (54 million adults in the UK, 28% of them are obese = 15 million. At a cost of £3000 that should equate to approx £45 billion). Another exceptionally important consideration is that GLP-1 agonists are now in short supply worldwide, patients with diabetes and established on GLP-1 agonists who rely on them for adequate glycaemic control and vascular protection are now facing uncertainty. Introducing a temporary weight loss fix using GLP-1 agonists without consideration of the wider implications and long-term plan is quite frankly, an absurdly short-sighted idea. Obesity strategies such as this feel somewhat like sprinkling teaspoons of water onto an increasing blaze: it will never work. I’m all for collaborative working alongside industry when appropriate and carefully thought through, however, government policy really needs to step it up. It shouldn’t take the (now somewhat controversially disgraced and replaced) PM to end up in hospital with COVID-19 for him and his political comrades to take note of the importance of the health implications of living with obesity. Clinicians have been trying to highlight this for decades; introducing a sugar tax was merely scratching the surface. It is time for all agencies to work cohesively and proactively to create an effective bottom-up approach to prevent obesity from conception. Introducing another medication feels like yet another reactive, knee-jerk sticking plaster onto the gaping wound of a complex and multifaceted problem. What it really needs is to be taken into theatre, washed out, debrided, and sutured carefully back together from the inside out.

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“Introducing another medication [for obesity] feels like yet another reactive, knee-jerk sticking plaster onto the gaping wound of a complex and multifaceted problem.”

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