GLP-1s: A treatment for obesity or an unmasker of inequality

by Jasmine Ilesanmi

King's Policy Journal

KCL Policy Research Centre

Centre for Public Health

Word Count: 2464

May 2026

Introduction

Since 1980, the prevalence of obesity has risen globally. The National Health Service (NHS) classifies BMI into categories; a healthy weight is a BMI of 18.5 to less than 25, and overweight but not obese is a BMI of 25 to less than 30 (NHS England, 2026). Obesity is defined globally for adults as a BMI of 30 kg/m^2 or above (NHS England, 2026; World Health Organisation, 2025). In 2024, NHS England (2026) reported that 30% of adults were living with obesity and that 66% were either overweight or living with obesity. The World Obesity Federation estimated that in 2020, 800 million people were living with obesity (Masood & Moorthy, 2023).

Recently, GLP-1 medicines have been introduced in the UK to manage obesity. However, their privatised and individualised delivery has increasingly become associated with inequality and discrimination affecting lower socioeconomic status (SES) communities. This article will explore these challenges in the management of obesity before offering alternative recommendations.

GLP-1 medicines: mechanism, rationale and target users

Originally developed for the management of type 2 diabetes mellitus, glucagon-like-peptide 1 (GLP-1) agonists are a class of medications that are now used in the treatment of obesity (Collins & Costello, 2024). GLP-1s were first used as a treatment for obesity in 2014 and have proven to be highly effective in promoting weight loss during treatment, sparking widespread public interest (Drucker et al., 2017; Jackson et al., 2026). GLP-1 treatments work by making people feel fuller by mimicking a natural hormone released after eating and therefore are highly effective in weight-loss management (Medicines and Healthcare products Regulatory Agency, 2026).

In the UK, GLP-1 medicines must be prescribed by a medical professional, however, routes to prescription vary from prescriptions via the NHS to being available for private purchase, where a consultation with a healthcare professional is required, to ensure that the relevant checks can be carried out, including the sharing of the risks and benefits, alongside other necessary information (Medicines and Healthcare products Regulatory Agency, 2025). According to National Institute for Health and Care Excellence (NICE) guidelines, GLP-1 medications may only be prescribed to individuals with an initial Body Mass Index (BMI) of at least 30 kg/m^2 or 35 kg/m^2 or more, depending on the specific type of GLP-1 medication and individual eligibility criteria (NICE, 2025). This directly corresponds to the global definition of obesity, and therefore, GLP-1 medicines are used to manage and treat obesity.

The challenge with obesity is that it can have a significant impact on the quality of life of individuals and is associated with a range of physical, mental and economic consequences (Stephenson et al., 2021). In a study exploring the relationship between obesity and health-related Quality of Life (QoL) in the UK, Stephenson et al., (2021) found a clear correlation between weight and lower levels of QoL because of increasing risks of cancer, myocardial infarction and diabetes, heart failure and kidney failure. Due to the increasing obesity rates in the UK and the risks associated with it, a variety of treatments have been made available, and some of these are GLP-1 medicines. A total of 3.4 million people could be eligible for GLP-1s, and thus the NHS plans to have a phased rollout of the treatment to 220,000 people between 2025 and 2028 (NHS England, 2025).

Challenges with GLP-1 intervention

When creating public health interventions, many challenges arise. This article will now explore two challenges associated with the use of GLP-1 medicines in the UK before proposing recommendations to mitigate them. These challenges that will be discussed are the impact of privatisation and how GLP-1 treatments fail to tackle the social determinants of health (SDoH) that can cause obesity, and instead act as an individualised approach, reacting to obesity, without preventing it.

The impact of privatisation

The inverse care law, first articulated by Hart (1971), describes how the availability of good medical care generally varies inversely with the level of need within target populations, and people who most need the care are often the least likely to receive it. This is becoming increasingly evident in GLP-1 distribution. Hart argues that areas with higher levels of SES have more illnesses, increasing the strain placed on healthcare practitioners who are often operating with fewer resources, support and weaker infrastructure, thereby limiting clinical effectiveness. He then expands on this and warns that when healthcare is shaped by free market forces, including privatisation or fee-for-service models, this inequality is exacerbated – reflecting the dynamics now emerging with GLP-1 distribution. Over the past 40 years, many healthcare systems within the UK have switched from being publicly owned and financed to being outsourced by the private sector. The rationale behind this was that by utilising both mixed markets and private sector interests, public sector costs could decrease, simultaneously improving service quality while reducing the economic strain (Walters et al., 2022).

The privatisation of GLP-1 medicines has also benefited individual consumers by decreasing waiting times before treatment initiation. Long wait times have remained a persistent challenge in the

NHS, resulting in poorer outcomes, despite efforts to address the issue (Limiri, 2025). Furthermore, the COVID-19 pandemic resulted in systemic backlogs in care due to the routine underinvestment in the NHS before the pandemic, exposing systemic weaknesses, increasing wait times and reducing healthcare quality (British Medical Association, 2024). Therefore, in making GLP-1 medicines available for purchase, the policy arguably reduces the strain on the NHS and provides treatment earlier for those who can afford it. However, despite these benefits, the privatisation of GLP-1 treatments has led to the inequality predicted by Hart (1971), as those with lower SES, who are most at risk of obesity, are unable to afford it, proving the proposed benefits of privatisation to be idealistic yet ineffective (Anekwwe et al., 2020).

Low SES can influence health in multiple ways, including health behaviours, access to care, environmental exposures, physiological experiences, cultural definitions of health, and psychological factors (Autret & Bekelman, 2024). According to the National Centre for Health Statistics, the highest prevalence of obesity from 2017-18 was seen in black women in the US, and groups from different racial minority groups followed a similar trend in obesity rates (Hales et al., 2020). Additionally, according to UK statistics measured in 2022, 70.8% of black adults were overweight, and from 2022 to 2023, the prevalence of those living as overweight (including obesity) was highest in those living in the most deprived areas (UK Government, 2024; Office for Health Improvement and Disparities, 2024). With these statistics in mind, the main targets for GLP-1 treatment should be those from racial and economic minority backgrounds who archetypally are the population of low SES. However, under the current privatisation system, this is the population least able to access treatment due to the backlogs and waiting times discussed previously, and the economic constraints they are under.

Another possible risk associated with this privatisation is that, as access to GLP-1 medicines becomes concentrated amongst those with higher SES, existing stigma surrounding obesity may intensify and take on more pronounced class and racial dimensions. Hughes and McArthur (2023) state that stigmatisation around weight is largely understood in two categories: weight-related discrimination (experienced) and internalised weight stigma. In a study exploring this in British Adults, Hughes and McArthur (2023) found that weight-stigmatising attitudes were displayed most amongst lower-income populations, and least amongst those with a degree. This suggests that while those who are educated and of higher SES may not display stigmatisation towards someone with obesity, those most at risk of obesity may experience increasing internalised stigmatisation and discrimination from the lower SES communities they exist in. Hughes and McArthur (2023) also posit that those of lower SES generally believe that obesity is a result of factors within the individual's control, whereas populations in higher SES understand that obesity is caused by a variety of factors, such as genetics, limited time and limited

finances. Therefore, with the rise of GLP-1 use in the higher SES populations, those in lower SES may misunderstand the cause of their obesity and the lack of this in higher SES communities and experience greater internalised and experienced stigma.

Finally, due to the high demand and multiple uses of GLP-1 treatments, GLP-1 medicines have experienced shortages and populations who are eligible for treatment wait on average from several months to over 2 years for GLP-1 treatment (Brennan-Davies & Lakey; Oviva, 2025). Furthermore, different NHS trusts have varying waiting lists and availability, and some areas do not have a recognised weight-loss pathway at all, increasing the class divides even further (Happy Pharmacy, 2025).

GLP-1 treatment as an individualised response, not a social prevention

The second problem with GLP-1 treatment is its inability to address the systemic issues that have led to increasing obesity amongst socioeconomic minorities, to begin with. As stated by Breilh (2023), health should not be considered in isolation but rather as the subsumption of historical and social processes that have resulted in its presentation in society. Breilh (2023) posits the idea of Social Determination, where diseases are explored by their causes and how they have become what they are throughout the organisation of society.

In the Marmot Report, it was stated that obesity is associated with social and economic deprivation across all life stages and is becoming increasingly more common (Marmot et al., 2020). This concept is known as the Social Determinants of Health (SDoH), which the World Health Organisation (n.d.) defines as the social conditions in which people live that influence health and inequality. Some of the SDoHs that impact obesity rates are poverty, unemployment and inadequate food and nutrition. In Hughes and McArthur (2023), participants' responses were analysed to summarise beliefs about the ability to maintain a healthy weight. These highlighted that the healthy food prices and time to keep active, two factors significantly impacted by poverty and employment type, were the primary reasons people struggled to maintain a healthy weight. In an independent UK government review, McGregor-Smith (2017) highlighted that ethnic minorities, women and those with disabilities face disadvantages in the labour market due to structural and historical biases that disfavour them. They posit that there is discrimination at every stage of an individual's career, including before it even starts. There is a 15.3% unemployment rate for black and ethnic minority workers compared to the 11.5% rate for white workers (McGregor-Smith, 2017). Joblessness is a significant predictor of poverty and, by extension, the ability to afford nutritious meals and prevent obesity (Clark & Shankley, 2020).

In a longitudinal study from 2013 to 2023 exploring food prices in the UK, Hoenink et al.(2024) found that there was an overall increase in the price of all foods within their sample and a 22% price increase from 2021 to 2023. Additionally, they also discovered that the relative price of healthier foods was more than the price of less healthy foods throughout the study, highlighting the differences in nutritious food available to those from low SES backgrounds. It is no surprise, then, that minority populations struggling with poverty and unemployment would not have the resources, whether time or money, to maintain a healthy weight and obesity, let alone private GLP-1 treatment.

This section has explored the many ways in which obesity is a cause of complex social and economic structures, not individual choice. However, the introduction of GLP-1 use for obesity treatment focuses on individualised treatments that are not meant to prevent obesity but rather treat it. The Social Determination of health is understood across three domains: the general domain- the structural forces of hegemonic politics and culture, the particular domain of collective modes of living, e.g. class, race and gender and the individual domain that highlights the styles of living by which individuals and families exist and make health choices (Breilh, 2023). Although effective in the management of obesity, GLP-1 treatments fail to address and mitigate the systemic flaws, general domains and SDoHs that have led to healthcare and nutrition inequality across the UK. Instead, obesity is cared for as an individualised approach, focusing solely on people's individual choices without paying attention to the contexts outside of individuals' control and in doing this, treatment is used as a response to obesity without the creation of tools to prevent it.

Policy Recommendations

This next section will explore two recommendations to tackle the two significant reasons that Hughes and McArthur (2023) identified as obstructing low SES communities from maintaining a healthy weight: healthy food access and physical inactivity.

Making healthy foods accessible with Food Buses

To address food access inequalities across the UK, various charities have set up food buses as a strategy of providing healthy food to food deserts – areas with limited access to affordable and nutritious food. One example of this is The Food Bus Project by *Be Enriched*, launched in response to food insecurity in areas like Wandsworth and Lambeth (Be Enriched, n.d.). By going into food deserts around South London, this initiative can provide low SES areas with healthier foods at more affordable prices (approximately 25% cheaper than traditional shops in South London). It also stops in areas where

supermarkets are scarce, creating a healthier food environment necessary for improving health and nutrition (Nuffield Council on Bioethics, 2007; Yap et al., 2025). Government public health teams should collaborate with these existing charities and initiatives and create similar projects in different boroughs to increase healthy food accessibility. Additionally, due to the evidence that the media has a significant impact on policy and public perception, media campaigns should be utilised to spread awareness about these projects and should be used to gain donations and governmental support.

Tackling Physical Inactivity

In a literature review exploring ways to reduce physical inactivity in SES communities, Rawal et al. (2020) found that factors across multiple ecological systems significantly affect people's ability to exercise. At the macrosystem level, urban planning and the affordability of sports opportunities were important barriers. At the exosystem level, inflexible work hours and family responsibilities contributed to exhaustion and a lack of time for physical activity. At the mesosystem level, a lack of culturally diverse exercise opportunities also reduced participation in physical activity. To tackle this, public health teams should create free exercise opportunities such as the Healthy Habits Programme for the Latin American community in Lambeth, for various cultural backgrounds (including resources in different languages) to create a safe time and space for physical activity (Lambeth Council, n.d.).

Conclusion

This paper has explored how the privatisation and individualisation of GLP-1 treatment have led to a system wherein the populations most in need of GLP-1 treatment are unable to access it and, therefore are more likely to struggle with obesity and the comorbidities associated with it. To tackle these problems, this article has emphasised how focusing on the SDoH could evolve the current health landscape from an individualised approach to a collective one that can prevent obesity altogether.

References

Anekwe, C. V., Jarrell, A. R., Townsend, M. J., Gaudier, G. I., Hiserodt, J. M., & Stanford, F. C. (2020). Socioeconomics of Obesity. *Current Obesity Reports*, *9*(3), 272. https://doi.org/10.1007/s13679-020-00398-7

Asakura, K., & Sasaki, S. (2017). School lunches in Japan: Their contribution to healthier nutrient intake among elementary-school and junior high-school children. *Public Health Nutrition*, *20*(9), 1523. https://doi.org/10.1017/S1368980017000374

Autret, K., & Bekelman, T. A. (2024). Socioeconomic Status and Obesity. *Journal of the Endocrine Society*, *8*(11). https://doi.org/10.1210/jendso/bvae176

Be Enriched. (n.d.). *The Food Bus*. https://www.be-enriched.org/the-food-bus

Breilh, J. (2023). The social determination of health and the transformation of rights and ethics: A meta-critical methodology for responsible and reparative science. *Global Public Health*, *18*(1). https://doi.org/10.1080/17441692.2023.2193830

Brennan-Davies, A. H., & Lakey, S. (2025). Pharmacological Privilege: How Glucagon-Like Peptide-1 (GLP-1) Medications are Widening Health Inequalities. Cureus, 17(11), e97124. https://doi.org/10.7759/cureus.97124

British Medical Association (2024) *BMA COVID Review Report 3: Delivery of healthcare during the pandemic*, 3 September. British Medical Association. Available at: https://www.bma.org.uk/media/aganhcxj/bma-covid-review-report-3-september-2024.pdf

Clark, K., & Shankley, W. (2020). "6: Ethnic minorities in the labour market in Britain". In Ethnicity, Race and Inequality in the UK. Bristol, UK: Policy Press. Retrieved Mar 16, 2026, from https://doi.org/10.51952/9781447351269.ch006

Collins L, Costello RA. Glucagon-Like Peptide-1 Receptor Agonists. [Updated 2024 Feb 29]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2026 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK551568/

Drucker, D. J., Habener, J. F., & Holst, J. J. (2017). Discovery, characterization, and clinical development of the glucagon-like peptides. *The Journal of Clinical Investigation, 127*(12), 4217–4227. https://doi.org/10.1172/JCI97233

Hales, C. M., Carroll, M. D., Fryar, C. D., & Ogden, C. L. (2020). Prevalence of Obesity and Severe Obesity Among Adults: United States, 2017-2018. *NCHS data brief*, (360), 1–8.

Happy Pharmacy. (2025). *Beat the NHS queue: Your fast-track guide to weight loss injections in 2025*. Happy Pharmacy.

https://happypharmacy.co.uk/blogs/wellbeing-and-pharmacy-updates/beat-the-nhs-queue-your-fast-track-guide-to-weight-loss-injections-in-2025

Hart, J. T. (1971). *The inverse care law*. *The Lancet, 297*(7696), 405–412. https://doi.org/10.1016/S0140-6736(71)92410-X

Hoenink, J. C., Garrott, K., Jones, N. R., Conklin, A. I., Monsivais, P., & Adams, J. (2024). Changes in UK price disparities between healthy and less healthy foods over 10 years: An updated analysis with insights in the context of inflationary increases in the cost-of-living from 2021. *Appetite*, *197*, 107290. https://doi.org/10.1016/j.appet.2024.107290

Hughes, A. M., & McArthur, D. (2023). Weight stigma, welfare stigma, and political values: Evidence from a representative British survey. *Social Science & Medicine*, *334*, 116172. https://doi.org/10.1016/j.socscimed.2023.116172

Jackson, S. E., Brown, J., Llewellyn, C., Mytton, O., & Shahab, L. (2026). Prevalence of use and interest in using glucagon-like peptide-1 receptor agonists for weight loss: A population study in Great Britain. *BMC Medicine*, *24*, 1. https://doi.org/10.1186/s12916-025-04528-7

Lambeth Council. (n.d.). *Healthy Habits Programme*. Healthy Habits Programme

Limiri, D. M. (2025). *The impact of long wait times on patient health outcomes: The growing NHS crisis*. *Premier Journal of Public Health, 3*, 100020. https://doi.org/10.70389/PJPH.100020

Marmot, M., Allen, J., Boyce, T., Goldblatt, P., & Morrison, J. (2020). *The Marmot Review 10 Years On: Full Report.* Institute of Health Equity. https://www.instituteofhealthequity.org/resources-reports/marmot-review-10-years-on/the-marmot-review-10-years-on-full-report.pdf

Masood, B., & Moorthy, M. (2023). Causes of obesity: A review. *Clinical Medicine*, *23*(4), 284-291. https://doi.org/10.7861/clinmed.2023-0168

McGregor-Smith, R. (2017) Race in the Workplace: The McGregor-Smith Review. London: Department for Business, Energy and Industrial Strategy

Medicines and Healthcare products Regulatory Agency. (2026, February 5). *GLP-1 medicines for weight loss and diabetes: What you need to know*. GOV.UK. https://www.gov.uk/government/publications/glp-1-medicines-for-weight-loss-and-diabetes-what-you-need-to-know/glp-1-medicines-for-weight-loss-and-diabetes-what-you-need-to-know

National Institute for Health and Care Excellence. (2025). *A guide for prescribing medicines to manage overweight and obesity* (NICE Guideline NG246 resource). https://www.nice.org.uk/guidance/ng246/resources/a-guide-for-prescribing-medicines-to-manage-overweight-and-obesity-pdf-19828318651333

NHS England. (2025). *Interim commissioning guidance: Implementation of the NICE technology appraisal TA1026 and the NICE funding variation for tirzepatide (Mounjaro®) for the management of obesity*. https://www.england.nhs.uk/publication/interim-commissioning-guidance-implementation-of-the-nice-technology-appraisal-ta1026-and-the-nice-funding-variation-for-tirzepatide-mounjaro-for-the-management-of-obesity/

NHS England. (2026). *Health Survey for England 2024: Adults' overweight and obesity*. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2024/adults-overweight-and-obesity

Nuffield Council on Bioethics. *Public health: ethical issues.* London: Nuffield Council on Bioethics, 2007: 60. https://www.nuffieldbioethics.org/publication/public-health-ethical-issues/

Office for Health Improvement and Disparities. (2024, May 8). *Obesity profile: Short statistical commentary May 2024*. GOV.UK. https://www.gov.uk/government/statistics/update-to-the-obesity-profile-on-fingertips/obesity-profile-short-statistical-commentary-may-2024

Oviva. (2025, September 1). *Tackling tier 3 weight management waiting lists*. Oviva. https://oviva.com/uk/en/tier-3-weight-management-waiting-lists/

Rawal, L. B., Smith, B. J., Quach, H., & N Renzaho, A. M. (2020). Physical Activity among Adults with Low Socioeconomic Status Living in Industrialized Countries: A Meta-Ethnographic Approach to Understanding Socioecological Complexities. *Journal of Environmental and Public Health*, *2020*, 4283027. https://doi.org/10.1155/2020/4283027

School Food Matters. (2023, October 16). *What lessons can we learn from Japan's acclaimed school food programme?* School Food Matters. https://www.schoolfoodmatters.org/news-views/blog/what-lessons-can-we-learn-japans-acclaimed-school-food-programme

Stephenson, J., Smith, C. M., Kearns, B., Haywood, A., & Bissell, P. (2021). The association between obesity and quality of life: A retrospective analysis of a large-scale population-based cohort study. *BMC Public Health*, *21*, 1990. https://doi.org/10.1186/s12889-021-12009-8

UK Government. (2024, April 10). *Overweight adults*. Ethnicity Facts and Figures. https://www.ethnicity-facts-figures.service.gov.uk/health/diet-and-exercise/overweight-adults/latest/

Walters, J. K., Sharma, A., Malica, E., et al. (2022). Supporting efficiency improvement in public health systems: A rapid evidence synthesis. *BMC Health Services Research, 22*, 293. https://doi.org/10.1186/s12913-022-07694-z

World Health Organisation, 2025
https://www.who.int/en/news-room/fact-sheets/detail/obesity-and-overweight

World Health Organization. (n.d.). *Social determinants of health*. World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Yap, C., Tiwari, C., & Vogel, C. (2025). Informing a People-Centred Food Strategy for the London Borough of Hounslow (Version 2). City, University of London. https://doi.org/10.25383/city.30833849.v2