GLP-1 Agonists and the Medicalization of Obesity in Canada: Promise and Pitfalls

Photo by Haberdoedas on Unsplash

Jordan Pham[1]

[1] University of Ottawa, Ottawa, ON, Canada

Correspondence: jpham060@uottawa.ca

Date Submitted: September 29, 2025
Date Accepted: November 11, 2025
Date Published: July 31, 2026

DOI: https://doi.org/10.18192/UOJM.V16i1.7628

Keywords: *Obesity, GLP-1 receptor agonists, chronic disease management, pharmacotherapy, health equity*

ABSTRACT

Obesity is increasingly recognized as a complex, chronic disease requiring comprehensive management. The rise of pharmacologic interventions, particularly glucagon-like peptide-1 receptor agonists, has transformed obesity treatment by enabling clinically significant weight loss and reducing obesity-related comorbidities. However, these therapies also raise critical concerns regarding affordability, equitable access, long-term reliance, and the potential to overshadow systemic prevention strategies. This commentary examines the benefits and limitations of medicalizing obesity, and highlights the need to balance pharmacologic innovation with lifestyle, behavioral, and public health interventions. A multifaceted approach is essential to ensure sustainable outcomes, reduce inequities, and address the societal and structural drivers of obesity.

RÉSUMÉ

L'obésité est de plus en plus reconnue comme une maladie complexe et chronique nécessitant une prise en charge globale. L'essor des interventions pharmacologiques, en particulier des agonistes des récepteurs du glucagon-like peptide-1 (GLP-1), a transformé le traitement de l'obésité en permettant une perte de poids cliniquement significative et en réduisant les comorbidités associées à l'obésité. Toutefois, ces thérapies soulèvent également des préoccupations importantes concernant l'abordabilité, l'équité d'accès, la dépendance à long terme et le risque d'éclipser les stratégies systémiques de prévention. Ce commentaire examine les avantages et les limites de la médicalisation de l'obésité et met en lumière la nécessité d'équilibrer l'innovation pharmacologique avec des interventions axées sur les habitudes de vie, les comportements et la santé publique. Une approche multidimensionnelle est essentielle afin d'assurer des résultats durables, de réduire les inégalités et de s'attaquer aux facteurs sociétaux et structurels contribuant à l'obésité.

INTRODUCTION

Obesity remains one of the most pressing public health challenges in Canada, with nearly 30% of Canadians classified as obese.[1] This growing burden has placed significant strain on the healthcare system and reshaped how obesity is addressed, with growing reliance on pharmaceutical interventions. Obesity contributes to numerous comorbidities, including cardiovascular disease, diabetes, certain cancers, and musculoskeletal conditions, and is associated with reduced quality of life.[2]

In response, pharmaceutical therapies have emerged as a central component of modern obesity management. Among the most notable developments is the introduction of glucagon-like peptide-1 (GLP-1) receptor agonists, such as semaglutide (Ozempic, Wegovy), which have gained widespread attention in recent years.[3] GLP-1 receptor agonists exert their effects by enhancing insulin secretion, delaying gastric emptying, and reducing appetite—mechanisms that improve glycemic control and weight loss.[4] While initially developed for the management of type 2 diabetes, several GLP-1 receptor agonists are now approved specifically for weight management (e.g., Wegovy, Zepbound), reflecting a significant shift in their clinical use.[3]

Other pharmacological options also play a role. For example, Contrave, a combination of bupropion and naltrexone, has been utilized to target food cravings and assist with long-term weight control.[5] The increasing availability of such medications reflects an important evolution in the clinical approach to obesity, moving away from lifestyle-only interventions toward more integrated pharmacologic strategies.

This shift also aligns with principles of lifestyle medicine, which emphasize nutrition, physical activity, sleep, and stress management as core components of chronic disease prevention.[6] Framing obesity care within this broader, evidence-based context reinforces that pharmacologic therapies should complement, rather than replace, behavioral and environmental interventions that support long-term health.

Yet, these developments also raise critical questions. To what extent do pharmacological treatments address the underlying drivers of obesity, which include not only biological but also social, economic, and environmental determinants? While medications may help individuals achieve clinically meaningful weight loss, concerns remain about their long-term efficacy, accessibility, and potential to oversimplify what is, at its core, a complex societal issue.

Accordingly, the central purpose of this commentary is to critically evaluate whether the medicalization of obesity, through pharmaceutical innovation, represents genuine progress in patient care or whether it risks narrowing our focus to individual-level treatment at the expense of addressing the broader structural determinants of health.

DISCUSSION

The Case for Medicalization

New pharmacologic therapies for obesity are transforming the treatment landscape, enabling patients to achieve clinically meaningful weight reduction while simultaneously reducing obesity-related health complications. Clinical trials demonstrate that individuals who take glucagon-like peptide-1 receptor agonists in combination with lifestyle modifications can lose between 6.1% and 17.4% of their baseline body weight.[7] This degree of weight loss meaningfully reduces the risk for diabetes, hypertension, and cardiovascular disease, while improving physical and psychosocial well-being.[8]

The clinical importance of such therapies is especially evident in populations for whom weight loss is particularly difficult. Patients with endocrine or metabolic disorders, such as Cushing syndrome or PCOS, often struggle to lose weight through lifestyle changes alone.[9,10] Studies estimate that approximately 80–85% of individuals regain weight following initial loss, underscoring the chronic and relapsing nature of obesity.[11] Pharmacologic interventions, particularly long-term GLP-1 receptor agonist use, not only facilitate initial weight reduction but also help patients maintain that loss, reducing the cycle of repeated weight gain and loss that can worsen metabolic health.

This shift has also changed how obesity is perceived in healthcare. Historically, obesity has often been framed as the result of individual lifestyle choices, such as overeating or inactivity. However, the rise of effective pharmacotherapies has contributed to reframing obesity as a chronic disease with biological underpinnings that can and should be managed through medical treatment.[12] In fact, obesity is now formally recognized as a chronic disease by numerous Canadian health associations.[13]

This recognition, coupled with the growing accessibility of pharmacologic treatment, is helping to reduce stigma and change the societal narrative—positioning obesity not as a matter of personal responsibility, but as a legitimate medical condition that warrants structured, evidence-based care.

Critiques and Limitations

While novel pharmacologic options for obesity represent an important advancement, they also raise difficult questions about fairness, affordability, and sustainability. The cost of treatment is a primary concern: a month's supply of semaglutide prescribed for weight loss may range from $200–$300 CAD, with other formulations reaching as high as $400–$500 CAD per month. Such prices place these therapies out of reach for uninsured Canadians. The result is an inequitable distribution of care, in which wealthier patients may benefit from effective pharmaceutical treatment while those with fewer resources are excluded. If medications are to become a central component of obesity care, strategies to address cost and access will be essential to prevent widening health disparities.

Long-term reliance further complicates the issue. Obesity is a relapsing condition, and evidence suggests that discontinuing pharmacotherapy often leads to substantial weight regain. In one study, after 12 months off semaglutide, 44% of participants regained at least one-quarter of their lost weight, and 18% regained all of it.[15] These findings raise concerns about the necessity of indefinite treatment. Prolonged use not only amplifies financial barriers but also increases the potential burden of side effects and ongoing monitoring. Unlike one-time interventions, these therapies may commit patients to years, if not decades, of continuous use, intensifying questions about sustainability at both the individual and system levels.[16]

Cultural perceptions of obesity treatment are also shifting in ways that merit caution. Popular media and celebrity endorsements have increasingly framed pharmacotherapy as an effortless solution, a "shortcut" to weight loss that bypasses lifestyle changes.[17] This narrative risks overshadowing the broader context of obesity as a condition influenced by behavioural, environmental, and social determinants. By presenting medication as a stand-alone solution, there is a danger of reducing a complex disease to a matter of prescription management, sidelining the importance of prevention and long-term health promotion.[18] As these therapies gain prominence, careful messaging will be required to balance their promise with the reality of their limitations, ensuring that obesity continues to be approached as a multidimensional condition requiring comprehensive strategies.

These tensions also reflect a broader discussion within the medical literature regarding the evolving role of pharmacotherapy in obesity care. Chakhtoura et al. (2023) emphasize that while GLP-1 receptor agonists represent one of the most effective classes of anti-obesity medications to date, their rapid expansion must be accompanied by careful evaluation of long-term sustainability, safety, and equitable access.[19] Similarly, Steenackers et al. (2025) argue that pharmacologic treatments alone cannot adequately address the behavioral and environmental determinants of obesity, warning that without structural reform, such therapies risk becoming isolated interventions rather than components of a coordinated care strategy.[20] Together, these perspectives highlight that the central challenge is not whether obesity should be treated medically, but how pharmacologic innovation can be integrated with preventive, lifestyle, and policy-based approaches to achieve lasting population health benefits. Together, these perspectives highlight that addressing this challenge requires a broader framework for obesity care.

Toward a Comprehensive Approach to Obesity Care

The social understanding of obesity and its treatment is undergoing a profound transformation. Increasingly, obesity is being reframed as a chronic medical condition rather than a moralized issue of self-control, requiring clinical attention and ongoing support. While this medicalization has helped to reduce stigma and encourage treatment-seeking, it also underscores the impact of socioeconomic status on access. Individuals with comprehensive insurance or disposable income are positioned to benefit from new pharmaceutical therapies, while those without financial resources remain limited to conventional strategies that are often more demanding and less effective in the short term. This divide illustrates how socioeconomic status continues to shape treatment opportunities and outcomes, raising concerns about fairness within the evolving landscape of care.

Relying too heavily on pharmacologic interventions also risks shifting attention away from the structural and environmental drivers of obesity. While these medications facilitate weight loss, they do not address upstream contributors such as food insecurity, widespread availability of ultra-processed foods, often energy-dense and nutrient-

poor, or limited community health investment.[21] If these factors remain unaddressed, society risks perpetuating a cycle in which obesity is managed primarily through costly pharmaceutical options rather than prevented through long-term systemic change. Medications, therefore, should be understood as a supportive tool—particularly valuable for those with physiologic or metabolic barriers to weight loss—but not as a replacement for broader public health strategies.

To ensure a sustainable approach, treatment must be integrated into a wider framework that prioritizes prevention and holistic care. Policies that improve access to nutritious foods, such as subsidies for fresh produce and restrictions on marketing unhealthy products to children, can help shift population-level behaviours.[22] Similarly, designing cities that encourage walking, cycling, and active commuting can embed physical activity into daily routines.[23] Expanding community-based fitness initiatives and subsidized recreation opportunities can further reduce barriers to movement.[24] Still, implementing these initiatives is not without challenges. Many communities face limited funding, uneven infrastructure, and competing policy priorities that make programs difficult to sustain. Access to safe recreational spaces varies widely, especially in rural or low-income areas. To ensure that these efforts have a lasting impact, governments and local organizations must commit to long-term support and collaboration.[25] Equally importantly, mental health resources, including stress management programs, counseling, and peer support networks, are essential, given the well-documented links between psychological well-being and obesity risk.[26]

By weaving together pharmaceutical therapies with these non-pharmacological strategies, a more balanced and equitable framework for addressing obesity can be achieved. Medications should be viewed as one tool within a larger toolkit, reserved for those who face the greatest barriers or highest risks, while the cornerstone of care remains rooted in prevention, lifestyle modification, and systemic reform. Such an integrated approach respects the complexity of obesity, promotes long-term sustainability, and ensures that interventions extend beyond the privileged few to benefit individuals across all socioeconomic groups. This broader perspective best supports disease reduction and promotes equity in population health.

Healthcare system and Policy Implication

The widespread adoption of pharmacologic therapies for obesity also carries significant implications for healthcare systems. The rapid increase in demand for GLP-1 receptor agonists has already contributed to supply shortages, limiting availability for patients with type 2 diabetes, a population for whom these medications were initially intended.[13] Such shortages highlight the risks of expanding indications without robust planning for manufacturing, distribution, and equitable allocation. To keep pharmacotherapy reliable for obesity, health systems must anticipate these pressures and safeguard continuity of care.

In addition, questions of regulation, reimbursement, and prescribing practices are becoming increasingly urgent. Public coverage for obesity medications remains inconsistent across Canada, leaving many patients dependent on private insurance or out-of-pocket payment.[27] Without coordinated national frameworks, prescribing patterns may become fragmented, and resource allocation may disproportionately favor those with better access to healthcare providers and benefits. These challenges emphasize the need for coordinated policy responses that integrate pharmacotherapy into chronic disease management programs while ensuring affordability, transparency, and equitable access. Addressing these structural considerations is essential if the promise of obesity medications is to translate into sustainable public health gains.

CONCLUSION

The medicalization of obesity marks a profound shift in how healthcare conceptualizes and addresses this complex condition. No longer dismissed as a matter of limited willpower, obesity is now increasingly recognized as a chronic disease shaped by genetic, psychological, environmental, and social determinants. This reframing has spurred the development of new therapeutic options, including pharmacologic agents such as GLP-1 receptor agonists, which provide meaningful weight loss and relief from associated health complications. Yet, these medications are not a cure-all. Sustainable progress demands that they be integrated into a broader framework—one that prioritizes healthy food access, opportunities for physical activity, robust mental health supports, and population-level prevention strategies.

An exclusive focus on pharmaceuticals risks entrenching

inequities, fostering long-term dependence, and diverting attention from systemic reforms. By contrast, a balanced approach—where medical treatments are used alongside lifestyle, behavioral, and structural interventions—ensures more equitable and durable outcomes. Such a model acknowledges the diverse roots of obesity, tailors care to individual needs, and supports population health in the long term.

Ultimately, effective and equitable obesity care depends on combining medical innovation with sustained investment in prevention and social supports, so that the benefits of pharmacologic advances can be realized without reinforcing existing social and health disparities.

REFERENCES

1. Public Health Agency of Canada. Obesity Statistics in Canada: Report. Ottawa: Public Health Agency of Canada; 2025 Jun 5. Available from: https://www.canada.ca/en/public-health/services/publications/healthy-living/obesity-statistics-canada.html
2. World Health Organization. Obesity: Health consequences of being overweight. Geneva: World Health Organization; 2024 Mar 1. Available from: https://www.who.int/news-room/questions-and-answers/item/obesity-health-consequences-of-being-overweight
3. Watanabe JH, Kwon J, Nan B, Reikes A. Trends in glucagon-like peptide 1 receptor agonist use, 2014 to 2022. J Am Pharm Assoc (2003). 2024 Jan-Feb;64(1):133-138. doi: 10.1016/j.japh.2023.10.002. Epub 2023 Oct 10. PMID: 37821008.
4. Cleveland Clinic. GLP-1 Agonists: What They Are, How They Work & Side Effects. Cleveland: Cleveland Clinic; [cited 2025 Sep 16]. Available from: https://my.clevelandclinic.org/health/treatments/13901-glp-1-agonists
5. Obesity Medicine Association. Weight Loss Medications. cited 2025 Sep 16]. Available from: https://obesitymedicine.org/blog/weight-loss-medications/
6. Katz DL, Frates EP, Bonnet JP, Gupta SK, Vartiainen E, Carmona RH. Lifestyle as Medicine: The Case for a True Health Initiative. Am J Health Promot. 2018 Jul;32(6):1452-1458. doi: 10.1177/0890117117705949. Epub 2017 May 19. PMID: 28523941.
7. Jensterle M, Rizzo M, Haluzík M, Janež A. Efficacy of GLP-1 RA Approved for Weight Management in Patients With or Without Diabetes: A Narrative Review. Adv Ther. 2022 Jun;39(6):2452-2467. doi: 10.1007/s12325-022-02153-x. Epub 2022 May 3. PMID: 35503498; PMCID: PMC9063254.
8. Wing RR, Lang W, Wadden TA, Safford M, Knowler WC, Bertoni AG, Hill JO, Brancati FL, Peters A, Wagenknecht L; Look AHEAD Research Group. Benefits of modest weight loss in improving cardiovascular risk factors in overweight and obese individuals with type 2 diabetes. Diabetes Care. 2011 Jul;34(7):1481-6. doi: 10.2337/dc10-2415. Epub 2011 May 18. PMID: 21593294; PMCID: PMC3120182.
9. Sasson L, Dery L, Stern J, Shimon I, Rudman Y, Dotan I, Kushnir S, Shochat T, Fleseriu M, Akirov A. Weight gain reversibility and BMI following treatment for Cushing's syndrome: long-term outcomes and potential predictors. Pituitary. 2025 Jun 26;28(4):78. doi: 10.1007/s11102-025-01550-z. PMID: 40569537.
10. Moran LJ, Lombard CB, Lim S, Noakes M, Teede HJ. Polycystic ovary syndrome and weight management. Womens Health (Lond). 2010 Mar;6(2):271-83. doi: 10.2217/whe.09.89. PMID: 20187731.
11. Stanford Health Care. Weight Loss Maintenance. [cited 2025 Sep 16]. Available from: https://stanfordhealthcare.org/medical-conditions/healthy-living/obesity/weight-loss-maintenance.html (10)
12. Haslam D. Weight management in obesity – past and present [Internet]. International Journal of Clinical Practice; 2016 [cited 2025 Sept 16]. Available from: https://onlinelibrary.wiley.com/doi/10.1111/ijcp.12771
13. Obesity Canada. Obesity: A Recognized Chronic Disease. [cited 2025 Sep 16]. Available from: https://obesitycanada.ca/understanding-obesity/obesity-recognized-chronic-disease/
14. Hub International. GLP-1 Weight Loss Drugs: What Employers Need to Know. [cited 2025 Sep 16]. Available from: https://www.hubinternational.com/en-CA/blog/2024/08/glp-1-weight-loss-drugs/
15. Bartelt K, Mast C, Deckert J, Gracianette M, Joyce B. Many Patients Maintain Weight Loss a Year After Stopping Semaglutide and Liraglutide. EPIC Research. [cited 2025 Sep 16]. Available from: https://www.epicresearch.org/articles/many-patients-maintain-weight-loss-a-year-after-stopping-semaglutide-and-liraglutide
16. Klein S. Long-term pharmacotherapy for obesity [Internet]. The Obesity Society; 2012 [cited 2025 Sept 16]. Available from: https://onlinelibrary.wiley.com/doi/full/10.1038/oby.2004.283
17. Rad J, Melendez-Torres GJ. Critical discourse analysis of social media advertisements for GLP-1 receptor agonist weight loss drugs: implications for public perceptions and health communication. BMC Public Health. 2025 Sep 1;25(1):2996. doi: 10.1186/s12889-025-24197-8. PMID: 40890660; PMCID: PMC12400570.
18. Gómez-Martín M, Canfell OJ, Chai LK, Jansson AK, Littlewood R, Sullivan C, Power D, Clarke ED, Ells L, De Vlieger N, Burrows TL, Collins CE. What is the Role of Primary Prevention of Obesity in an Age of Effective Pharmaceuticals? Curr Obes Rep. 2025 May 7;14(1):39. doi: 10.1007/s13679-025-00632-0. PMID: 40332727; PMCID: PMC12058953.
19. Chakhtoura M, Haber R, Ghezzawi M, Rhayem C, Tcheroyan R, Mantzoros CS. Pharmacotherapy of obesity: an update on the available medications and drugs under investigation. EClinicalMedicine. 2023 Mar 20;58:101882. doi: 10.1016/j.eclinm.2023.101882. PMID: 36992862; PMCID: PMC10041469.
20. Steenackers N, Toumazia J, Deleus E, Mertens A, Lannoo M, Pazmino S, van Laar ADE, Van der Schueren B, Vangoitsenhoven R. Pharmacotherapy for obesity: are we ready to select, tailor and combine pharmacotherapy to achieve more ambitious goals? Front Endocrinol (Lausanne). 2025 Jun 18;16:1569468. doi: 10.3389/fendo.2025.1569468. Erratum in: Front Endocrinol (Lausanne). 2025 Oct 02;16:1656611. doi: 10.3389/fendo.2025.1656611. PMID: 40607226; PMCID: PMC12214899.
21. Lakerveld J, Mackenbach J. The Upstream Determinants of Adult Obesity. Obes Facts. 2017;10(3):216-222. doi: 10.1159/000471489. Epub 2017 Jun 1. PMID: 28564658; PMCID: PMC5644962.
22. Boyland E, McGale L, Maden M, Hounsome J, Boland A, Jones A. Systematic review of the effect of policies to restrict the marketing of foods and non-alcoholic beverages to which children are exposed. Obes Rev. 2022 Aug;23(8):e13447. doi: 10.1111/obr.13447. Epub 2022 Apr 5. PMID: 35384238; PMCID: PMC9541016.
23. CDC. Designing activity-friendly communities [Internet]. Centers for Disease Control and Prevention; 2024 [cited 2025 Sept 16]. Available from: https://www.cdc.gov/physical-activity/features/designing-activity-friendly-communities.html
24. Ostermeier E, Gilliland J, Irwin JD, Seabrook JA, Tucker P. Developing community-based physical activity interventions and recreational programming for children in rural and smaller urban centres: A qualitative exploration of service provider and parent experiences - BMC Health Services Research [Internet]. BioMed Central; 2024 [cited 2025 Sept 16]. Available from: https://bmchealthservres.biomedcentral.

com/articles/10.1186/s12913-024-11418-w#citeas
25. Swinburn BA, Kraak VI, Allender S, Atkins VJ, Baker PI, Bogard JR, Brinsden H, Calvillo A, De Schutter O, Devarajan R, Ezzati M, Friel S, Goenka S, Hammond RA, Hastings G, Hawkes C, Herrero M, Hovmand PS, Howden M, Jaacks LM, Kapetanaki AB, Kasman M, Kuhnlein HV, Kumanyika SK, Larijani B, Lobstein T, Long MW, Matsudo VKR, Mills SDH, Morgan G, Morshed A, Nece PM, Pan A, Patterson DW, Sacks G, Shekar M, Simmons GL, Smit W, Tootee A, Vandevijvere S, Waterlander WE, Wolfenden L, Dietz WH. The Global Syndemic of Obesity, Undernutrition, and Climate Change: The Lancet Commission report. Lancet. 2019 Feb 23;393(10173):791-846. doi: 10.1016/S0140-6736(18)32822-8. Epub 2019 Jan 27. Erratum in: Lancet. 2019 Feb 23;393(10173):746. doi: 10.1016/S0140-6736(19)30384-8. PMID: 30700377.
26. Jankowska P. The role of stress and Mental Health in Obesity [Internet]. Multidisciplinary Digital Publishing Institute; 2025 [cited 2025 Sept 16]. Available from: https://www.mdpi.com/2673-4168/5/2/20
27. Obesity Canada. Managing your obesity [Internet]. 2025 [cited 2025 Sept 16]. Available from: https://obesitycanada.ca/understanding-obesity/management/

Acknowledgements
I would like to express my sincere gratitude to the editorial team of *UOJM* for their consideration of this commentary. I am thankful for the opportunity to contribute to the ongoing dialogue on obesity care and to engage with the broader academic and clinical community. Scholarly journals such as this are essential for fostering thoughtful discussion, advancing knowledge, and encouraging innovation in medicine and public health.

Conflicts of Interest Disclosure
There are no conflicts of interest to declare.