Are Anti-Obesity Drugs Life-Saving or Lifestyle Medicines? Reframing the Policy and Economic Debate

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Anti-obesity pharmacotherapies are not lifestyle aids but disease-modifying, life-saving treatments, that demand policy and reimbursement alignment.

Robust clinical evidence demonstrates sustained weight loss, reduction of cardiometabolic risks, and improved survival, while economic analyses confirm cost-effectiveness.

Background and Objective

To assess whether anti-obesity pharmacotherapies should be reclassified and reimbursed as life-saving interventions rather than lifestyle aids, based on emerging clinical and economic evidence, with a focus on the Central and Eastern European (CEE) context.

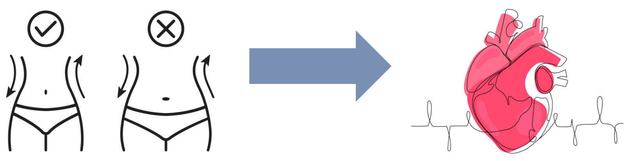

Figure 1. From Lifestyle Aid to Life-Saving Therapy.
Current perception of anti-obesity medicines as lifestyle support creates barriers to access, while emerging clinical and economic evidence demonstrates their role as life-saving, disease-modifying therapies.

Methods

A targeted literature and policy review was conducted using data from clinical trials (SCALE, SELECT, SURMOUNT), cost-effectiveness studies, and reimbursement frameworks across European countries. The analysis focused on the clinical impact of GLP-1/GIP receptor agonists and SGLT2 inhibitors, their cost-effectiveness profiles, and alignment between clinical guidelines and payer criteria.

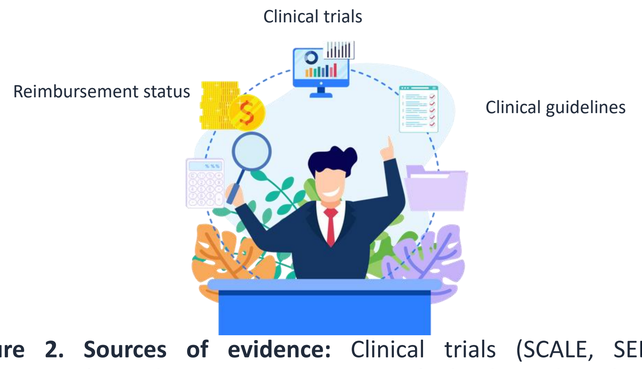

Figure 2. Sources of evidence: Clinical trials (SCALE, SELECT, SURMOUNT), reimbursement status in CEE (Poland, Czechia, Slovakia, Lithuania and Estonia), EU4, Sweden and Norway, clinical guidelines.

Results

Obesity is now recognized as a chronic, relapsing condition with metabolic, genetic, and hormonal underpinnings. Recent pharmacotherapies (e.g., semaglutide, tirzepatide) have shown significant reductions in cardiovascular events, renal complications, and mortality—even in non-diabetic populations. Economic models consistently demonstrate favorable cost-effectiveness, particularly in high-risk groups, with potential long-term savings from avoided complications. [1,2,3] Despite this, anti-obesity drugs remain unreimbursed or highly restricted in many health systems. Reimbursement criteria often rely on outdated indicators (e.g., BMI, HbA1c), which fail to capture cardiometabolic risk. The lack of funding for pharmacologic, behavioral, and supportive care delays intervention and increases long-term healthcare costs.

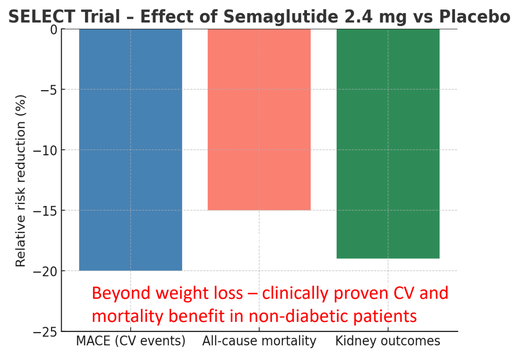

Figure 3. Main results of SELECT trial [5]: *semaglutide 2.4 mg significantly reduced major adverse cardiovascular events (–20%), all-cause mortality (–15%), and kidney outcomes (–19%) compared with placebo in overweight or obese adults without diabetes (NEJM 2023).*

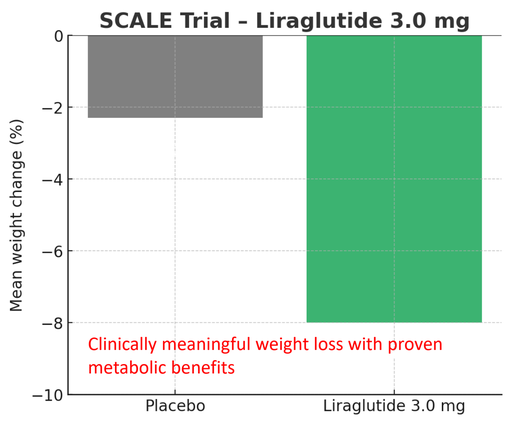

Figure 5. Main results of SCALE trial [4]: *liraglutide 3.0 mg resulted in a mean weight reduction of –8.0% compared with –2.3% in the placebo group, confirming clinically meaningful efficacy in obesity management (NEJM 2015).*

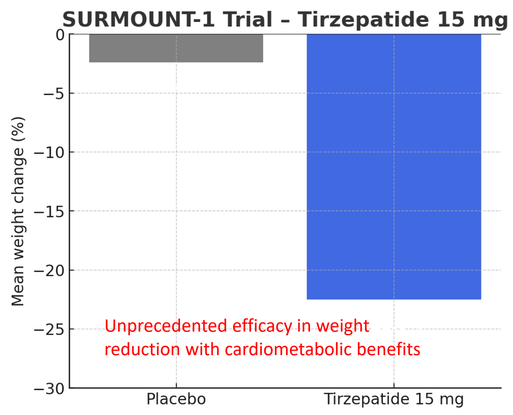

Figure 4. Main results of SURMOUNT-1 trial [6]: *tirzepatide 15 mg achieved unprecedented weight loss of –22.5% compared with –2.4% for placebo, together with improvements in cardiometabolic risk factors (NEJM 2022).*

Table 1. System-Level Barriers and Opportunities for Obesity Pharmacotherapy Reimbursement

Barriers	Opportunities
⚖️ BMI-based access 💰 Budget concerns 🙈 Stigma (“lifestyle aid”)	💗 Risk-based reimbursement 🌍 Regional alignment ⏳ Improved long-term outcomes

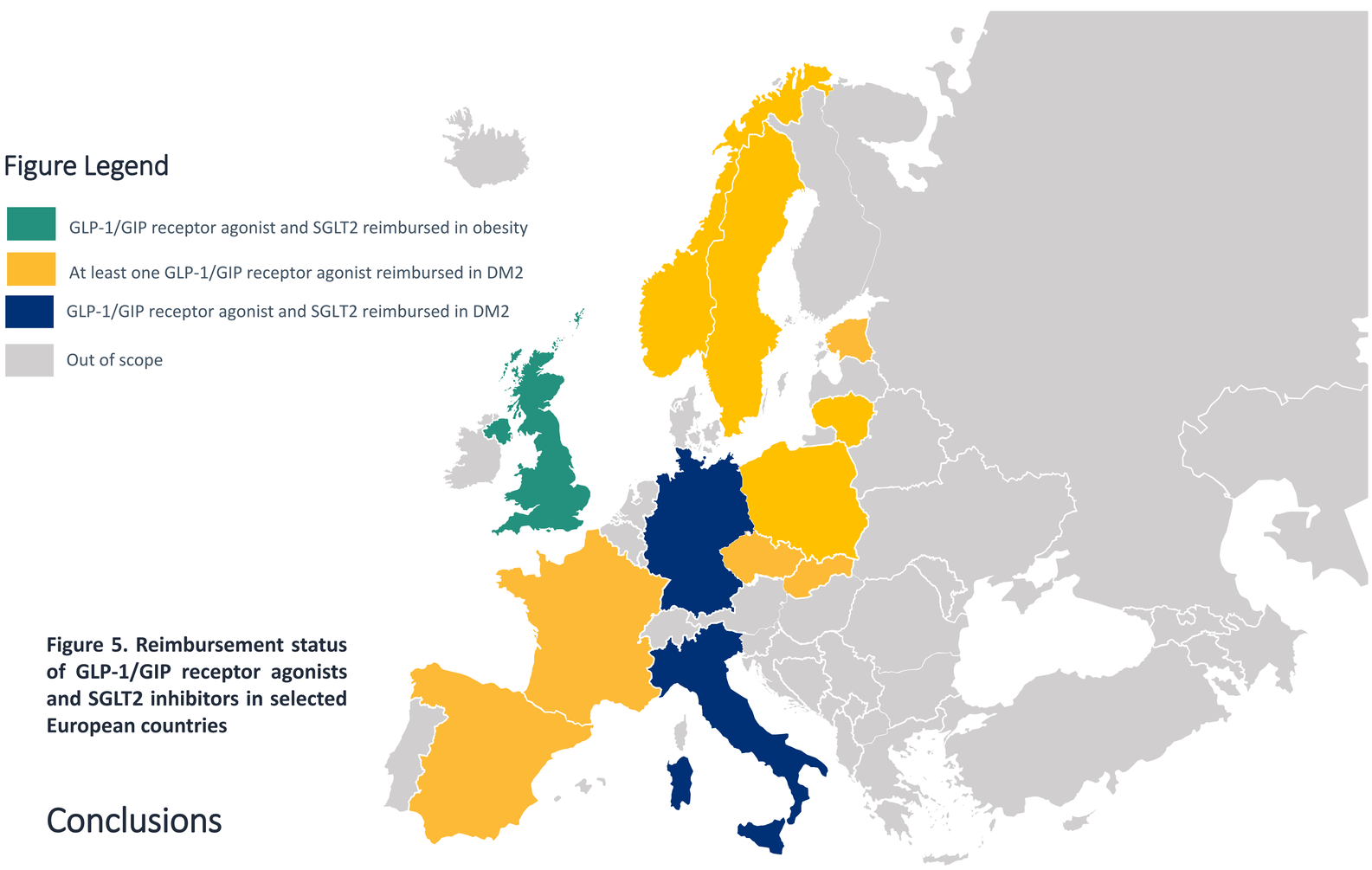

Figure 5. Reimbursement status of GLP-1/GIP receptor agonists and SGLT2 inhibitors in selected European countries

Conclusions

Anti-obesity therapies should be reclassified as life-saving, disease-modifying treatments. Policymakers and payers must align reimbursement criteria with clinical and economic evidence to enable timely, equitable access and unlock the population-level value of proactive obesity management. **Decision-makers face challenges in defining target treatment populations for GLP-1 receptor agonists. Despite favorable cost-effectiveness outcomes, the high budget impact – driven by adverse epidemiological trends and increasing prevalence among younger populations – complicates reimbursement decisions.**

References

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