

The Ozempic Era Could Shift Blame for Obesity From Individuals to Commercial Food Systems

The obesity rate in the United States has more than tripled since the early 1970s, spurred by the arrival of ultra-processed foods in the 1980s. The US rate is now nearly twice the average of other high-income countries. Some 60% of adult Americans have at least one chronic health condition (mainly hypertension and lipid disorders) and almost three-quarters are overweight or obese. Meanwhile, America leads the world in the fraction of ultra-processed foods in adults' diets. Almost 60% of the calories consumed by Americans come from such foods, compared to about 30% for France and less than 20% for Italy. It's hard to ignore the role of abundant ultra-processed foods in America's worsening obesity and metabolic health crisis.

In our work as public health researchers, we've done a system-mapping analysis demonstrating that a central roadblock to mitigating this health crisis is the persistent, widespread cultural assumption that obesity is a problem of individuals rather than a societal problem of the food system. Until this deeply rooted assumption changes, the United States is likely to stay on this trajectory of overwhelming rates of obesity- and nutrition-related chronic diseases.

There is, however, one medical innovation that could set the country on a different path: a fast-growing class of drugs, called GLP-1 agonists, that includes Ozempic (in which semaglutide is the active ingredient), Mounjaro (tirzepatide), and Wegovy (also semaglutide). One in eight American adults reported in May 2024 that they have taken a

GLP-1 agonist, and new research data come out almost daily reporting these drugs' effects on weight loss and a seemingly ever-expanding range of health conditions. Trials suggest patients taking these medicines lose around 10–20% of their body weight, though numbers vary considerably across trials and individuals. The jury is still out as to which GLP-1 works best in what circumstances, but with more than 100 potential anti-obesity drugs in development pipelines, it is clear that weight loss drugs are poised to disrupt medicine, human behavior, economies, and more.

Even though scientists do not know exactly how these new weight loss drugs work, many GLP-1 users report reduced cravings for ultra-processed foods. Recognizing that fact could be a key to reframing obesity as a societal problem driven by hazardous commercial goods.

Lessons from tobacco and alcohol

A similar framing around alcohol and tobacco led to effective regulation that reduced consumption of these harmful substances, producing a suite of policy tools that have been honed and tested over decades. Alcohol taxes have been in place around the world for more than a century, and most countries also use warning labels and age requirements to limit purchasing.

The number of countries adopting tobacco regulations reached critical mass in the late-twentieth century and led to the 2003 World Health Organization Framework

Convention on Tobacco Control, the only international treaty to explicitly protect public health from a hazardous commercial product. As a result of such established regulatory regimes, most people take for granted that governments can and should protect children and public health by regulating sales and consumption of products that inspire cravings and are harmful.

Many other nations actively apply this well-studied public health toolkit to ultra-processed or commercial foods to prevent obesity and related chronic diseases. Today, 117 countries and territories tax soda; some also tax other ultra-processed foods. Many countries place warning labels on the packaging of ultra-processed foods to alert consumers to their health harms. Countries throughout Europe regulate child-focused marketing and the color and flavor additives companies use to make products more enticing to children. Chile is a global front-runner in this regard, with its 2016 food labeling, marketing, and school sales policies leading to reduced purchases of foods high in calories, sodium, sugar, and saturated fat.

As ultra-processed products saturated the food supply after 1980, corporate marketing promoted the idea that obesity and metabolic disease are problems under individual control, focusing attention away from consumption and toward physical activity. By 2001, US obesity rates were over 30%; as concerns grew, sugary-beverage companies began deploying messaging strategies that promoted “an active lifestyle” and supporting academics who emphasized exercise, effectively diverting the narrative away from the impacts of sugary beverages.

As obesity rates grew, so did a multibillion-dollar market for weight loss programs, including commercial weight loss chains such as Weight Watchers and Jenny Craig (acquired by Heinz and Nestle, respectively), meal replacements and appetite suppressants, bariatric surgery, weight loss advertising, and weight loss coaches—not to mention gym memberships and diet foods. Food industry messaging combined with the growing diet industry promoted a mindset favoring individual solutions to obesity. Together they normalized the idea that individuals

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However, the United States is not among countries adopting policies such as warning labels and taxes to limit the impact of ultra-processed foods. A few American cities have tried to tax soda and apply warning labels, only to have these policies legally preempted—prevented by a higher level of government—due to pressure from food industry trade organizations.

Who owns obesity?

In 1998, the attorneys general of 46 US states reached a \$206 billion settlement with the tobacco industry that led to federal and state regulations around advertising and smoking. So what keeps US policymakers from implementing integrated, multipronged policies to discourage unhealthy diets? In our 2024 study, conducted shortly before the widespread prescription of GLP-1 agonists for obesity, we unpacked systemic drivers and feedback mechanisms using a complex systems analysis. We identified several self-reinforcing feedback loops that entrench food policy inertia—as well as the absence of countering loops that could destabilize it. Our analysis suggests that food policy became stuck because of an ill-founded assumption that obesity is a personal failing, not something society should tackle.

and the medical weight loss industry—not policymakers—“own” the obesity problem. By keeping the social and policy focus on individual responsibility, these arguments have created an atmosphere where policymakers have failed to implement even basic evidence-based obesity-prevention policies used by other countries.

Shift from individuals

But even entrenched social systems can be disrupted by chance events that push societies to reframe current realities. GLP-1s could deliver precisely this sort of shock to the system. According to a leading hypothesis, GLP-1s slow digestion and trigger satiety, making people want to eat less. People who take GLP-1s often report a distaste for ultra-processed foods and a preference for fresh fruits and vegetables. And early evidence suggests that GLP-1s aren't just effective for obesity, but also for chronic diseases linked to obesity, including fatty liver disease, diabetes, cancers, dementia, and heart disease. Long-term prescriptions for GLP-1s will undoubtedly strain health system budgets, and the drugs carry potential risks for yet-to-be-understood side effects, but their effects at the societal level could be beneficial.

First, the widespread use of GLP-1s could drive down demand for ultra-processed foods, eventually causing food companies to reformulate products. There are some indications that this is already happening. Food and beverage industry market research shows a 700% increase in GLP-1 prescriptions for nondiabetic patients from 2019 to 2023. Some market research finds that households with at least one GLP-1 user cut grocery spending by 6%, with sales of calorie-dense, ultra-processed items such as chips, baked goods, and cookies the most adversely affected. The soda industry seems particularly hard hit: An estimated one-third of GLP-1 users quit sugary beverages altogether, and another third cut back. Industry trade publications blame GLP-1s for a slump in share prices at PepsiCo, Coca-Cola, and McDonald's. Coca-Cola is now reassuring investors that the company "can adapt to anything that comes at us." Some ultra-processed food companies are already floating new "companion products" and "Ozempic-era foods and beverages" such as high-protein snacks and meal replacements targeted to specific niches of GLP-1 users.

Second, GLP-1 agonist medications could fundamentally

was their own responsibility. By helping ordinary people understand that craving, compulsion, and food noise are key obstacles to weight loss, GLP-1s could help shift the blame for obesity away from individuals and toward the ultra-processed, hyper-palatable commercial food products that dominate the American diet.

Some online influencers and weight stigma activists have already begun to amplify this narrative, with Reddit communities of GLP-1 users discussing the medications in the context of addiction, binge-eating, and drinking. Speaking of her own weight loss journey on a GLP-1, Oprah Winfrey described an "aha" moment when she realized, "I'd been blaming myself all these years for being overweight," when in fact, "it's not about willpower—it's about the brain."

The discovery of GLP-1 agonist medications was spurred by a medicalized understanding of obesity as a problem of individuals. It is therefore ironic that GLP-1s could help redirect blame for obesity on the broader food system and ineffective food policies. Of course, there are no guarantees that a new reality will make society rethink its long-held

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shift the scientific paradigm for obesity to more closely align with models of tobacco and alcohol addiction. For example, GLP-1 user experiences of muted "food noise" have led researchers to explore how these drugs could be affecting dopamine transport in the brain, following models from addiction science. Initially, GLP-1 users treated for diabetes and obesity reported spontaneous declines in alcohol consumption as a side effect. This led researchers to study the potential for treating alcohol use disorder; the first published clinical trial indicated that semaglutide may be effective in reducing alcohol consumption. Evolving alongside GLP-1 research is a growing field of research on food addiction and brain science focused on how ultra-processed, hyper-palatable foods maximize craving and consumption. All this bolsters the idea that obesity could be a manifestation of addiction—craving, compulsion, and loss of control—leading to a closer identification of ultra-processed foods with alcohol and tobacco.

Finally, by changing the lived experience of people who struggle with weight loss, GLP-1s could bring about a shift in the broader public discourse on obesity. A pre-Ozempic study found that the top reason people gave for not consulting their doctors for help with obesity was a belief that managing weight

cultural assumptions. The "technofix" promise of GLP-1s could even serve to further entrench the current medicalized, individualistic paradigm. Indeed, a recent *Lancet* commission of experts (many who declare ties to the pharmaceutical industry) controversially proposed redefining obesity into two distinct medical diagnoses: "clinical obesity," a chronic disease, and "preclinical obesity," a state of increased risk for clinical obesity and related diseases. In our view, this would further medicalize obesity, positioning doctors as the "owners," and worsen its stigma.

Still, we believe that the current moment holds the possibility for our society to update old assumptions about obesity being the sole responsibility of individuals. And if this path is taken, it will allow us to finally acknowledge that the obesity epidemic touches all of us one way or another, and it is therefore our collective responsibility. That would generate policy momentum in healthier directions.

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