



Obesity

From Lifestyle Blame to a
Chronic Disease Approach

October 2025

alkemihealth.com

Obesity reflects an effort by Alkemi to highlight an emerging disease state. The information presented is a synthesis of the views of Alkemi and is intended for research purposes only.

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The Escalating Obesity Epidemic

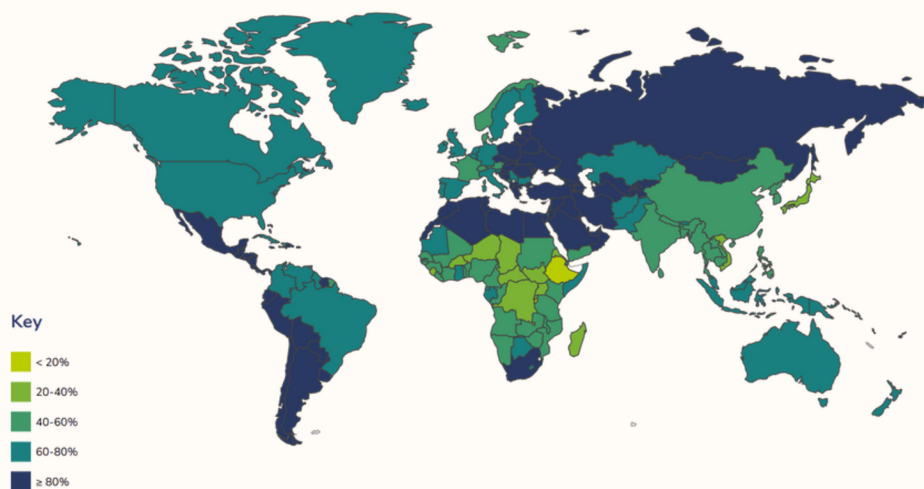


Obesity continues to reach record levels in 2025, posing urgent challenges for health systems. More than 2 in 5 U.S. adults are now living with obesity, and in 23 states the adult obesity rate exceeds 35% (up from zero states at that level in 2012)^{1,2}. Certain populations are disproportionately affected: for example, obesity rates are highest among Black and Latino communities and in rural areas, driven in part by structural barriers to healthy food and exercise². Youth obesity is also on the rise – nearly 20% of U.S. children and adolescents have obesity, a rate tripled since the 1970s³. Globally, the World Health Organization reports over 1 billion people with obesity as of 2022 (about one in eight people), more than double the prevalence in 1990.

The economic burden of this epidemic is staggering. Obesity is linked to higher risks of diabetes, heart disease, stroke, certain cancers, and more, which translate into hefty healthcare expenditures. In the U.S. alone, obesity-related medical costs were recently estimated at \$173 billion per year (2019 dollars)^{4,5,6}. When factoring in lost productivity and other indirect costs, the total annual economic impact may exceed \$1.4 trillion⁷. In practical terms, an individual with obesity incurs on average ~\$1,800 more in healthcare expenses per year than someone at a healthy weight⁶. For employers and payers, obesity contributes to higher rates of disability and absenteeism as well. Addressing obesity is not only a medical priority but a financial imperative for the healthcare industry.

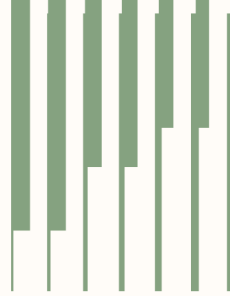
Estimated lifetime risk of high BMI during adulthood

Maximum prevalence (%) of BMI 25kg/m² or more during adulthood



Source: World Obesity Federation analyses of NCD-RisC (2024) data for 2022

The risk of developing obesity over the course of adulthood has reached epidemic levels with all countries facing an elevated risk.



Obesity as a Disease, Not a Personal Failure

Modern science has changed how we think about obesity, for decades it was viewed as a **personal lifestyle choice**.

With guidance from the **AMA** and **OMA**, we now understand that obesity is a **chronic disease** affecting all aspects of a patient's life.

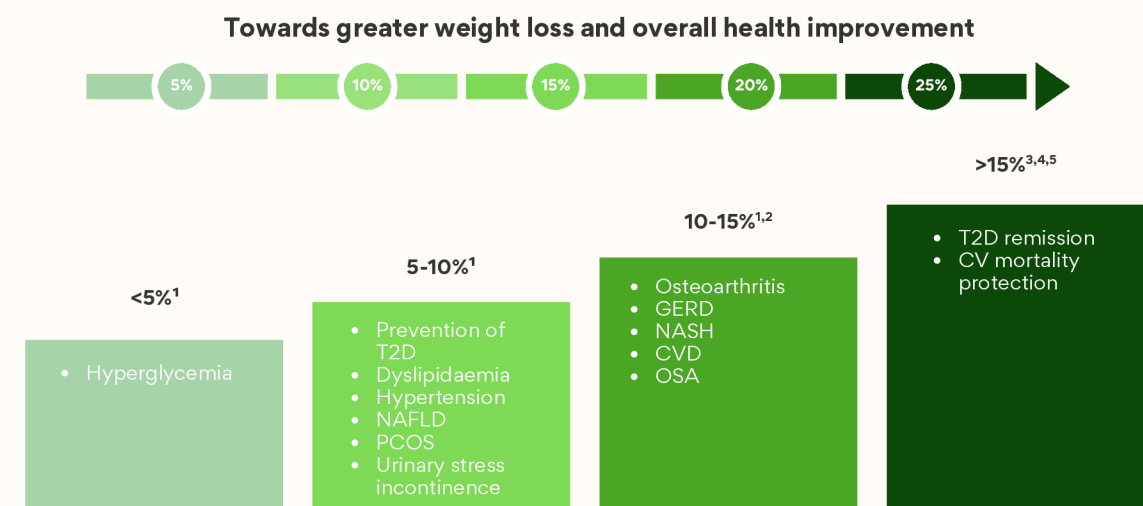
For decades, obesity was viewed as a result of lifestyle choices, a failure of willpower or discipline. Patients were frequently told that if they simply ate less and exercised more, their weight issues would resolve. While lifestyle factors are important, this perspective overlooked the complex biological and environmental drivers of obesity. In 2013, the American Medical Association (AMA) officially recognized obesity as a chronic disease, helping to shift the narrative away from lifestyle choices⁸. The Obesity Medicine Association (OMA) defines obesity as a “chronic, relapsing, multi-factorial, neurobehavioral disease” in which excess body fat leads to metabolic, biomechanical, and psychosocial health consequences⁹. This frames obesity as a multifaceted medical condition that is influenced by genetics, hormones, neural pathways, and environment rather than a simple lack of self-control.

Scientific research has illuminated how the bodies of people with obesity often actively resist weight loss. Many individuals have impaired metabolic and hormonal signals related to hunger and satiety¹⁰. For example, their brain may not register fullness appropriately, or their metabolism slows down significantly when they cut calories. These biological factors help explain why traditional diet-and-exercise approaches have such modest long-term success. Studies show even the most motivated patients often achieve only about 5–10% weight loss through intensive lifestyle changes, and the vast majority (80–90%) regain that weight over time^{11,12}. This isn't to say lifestyle changes aren't a factor but rather that obesity triggers the body to defend a higher weight, much like other chronic diseases that tend to relapse.

Treating obesity as a chronic disease can unlock huge health benefits. Clinicians increasingly recognize that intentional weight loss of even 5–10% can lead to meaningful improvements in blood pressure, blood sugar, and blood lipids. These improvements can help prevent progression to diseases like type 2 diabetes, hypertension, and high cholesterol¹³. Greater weight loss (15% or more of body weight) has been associated with putting type 2 diabetes into remission and significantly reducing cardiovascular risks¹³. This reframes obesity treatment as preventative medicine for a host of serious conditions.

With such evidence in hand, healthcare stakeholders are increasingly asking: rather than treating diabetes, heart disease, and other complications caused in part by obesity, what if we addressed the root cause of obesity itself earlier? This question is driving a paradigm shift in medicine and health policy. It is causing traditional attitudes about the causes of obesity (internal and externalized weight biases), that often result in patients not engaging in preventive healthcare, to change. Physicians, employers, and insurers are beginning to view obesity treatment as an upstream investment that can yield downstream savings (in lives and dollars)^{14,15}. In short, tackling obesity as a disease may be one of the most impactful ways to improve population health in the 21st century.

Weight loss is associated with clinical improvements in obesity-related complications



CV, cardiovascular; CVD, cardiovascular disease; GERD, gastro-oesophageal reflux disease; HFpEF, heart failure with preserved ejection fraction; NAFLD, non-alcoholic fatty liver disease; NASH, non-alcoholic steatohepatitis; OSA, obstructive sleep apnoea; PCOS, polycystic ovary syndrome; T2D, type 2 diabetes. 1. Garvey et al. Endocr Pract 2016;22(Suppl. 3):1; 2. Look AHEAD Research Group, Gregg. Lancet Diabetes Endocrinol 2016;4:913; 3. Lingvay et al. Lancet 2022;399:394; 4. Benraoune, Litwin. Curr Opin Cardiol 2011;26:555; 5. Sundstrom et al. Circulation 2017;135:1577.

For decades, the go-to metric has been the body mass index (BMI) which is a simple calculation of weight relative to height. BMI is easy to measure, but it has well-known limitations. It doesn't distinguish fat from muscle (so a very muscular person can be "obese" by BMI despite low body fat), nor does it account for fat distribution or individual differences in build¹⁶. As a result, BMI-based definitions can misclassify some individuals and may not capture health risks in others until weight has already had serious effects. It is clear that a new approach to how we diagnose obesity is needed.

		WEIGHT																											
		lbs																											
		90	100	110	120	130	140	150	160	170	180	190	200	210	220	230	240	250	260	270	280	290							
		kgs	41	45	50	54	59	64	68	73	77	82	86	91	95	100	104	109	113	118	122	127	131						
HEIGHT	5'0"	ft/in	4'8"	142"	22	25	27	29	31	34	36	38	40	43	45	47	49	52	54	56	58	61	63	64					
	4'9"	cm	119	22	24	26	28	30	32	35	37	39	41	43	45	48	50	52	54	56	58	61	61						
	4'10"	147.3	119	21	23	25	27	29	31	33	36	38	40	42	44	46	48	50	52	54	56	59	61						
	4'11"	149.8	118	20	22	24	26	28	30	32	34	36	38	40	42	44	46	48	51	53	55	57	59						
	5'0"	152.4	118	20	21	23	25	27	29	31	33	35	37	39	41	43	45	47	49	51	53	55	57						
	5'1"	154.9	117	19	21	22	25	26	28	30	32	34	36	39	40	43	45	47	49	51	53	55	57						
	5'2"	157.4	116	18	20	22	24	26	27	29	31	33	35	37	39	42	44	46	48	49	51	53	55						
	5'3"	160.0	116	18	19	21	23	25	27	28	30	32	34	35	37	39	41	43	44	46	48	50	51						
	5'4"	162.5	115	17	19	21	22	24	26	27	29	31	33	34	36	37	39	41	43	45	46	48	50						
	5'5"	165.1	115	17	18	20	22	23	25	27	28	30	32	33	35	36	37	39	40	42	43	45	47	48					
5'6"	5'6"	167.6	115	16	18	19	21	23	24	26	27	29	31	32	34	36	37	39	40	42	44	45	47						
	5'7"	170.1	114	16	17	19	20	22	24	26	27	29	30	31	33	35	36	38	39	41	42	44	45						
	5'8"	172.6	114	15	16	18	20	21	23	25	27	29	30	31	33	34	36	37	39	40	42	43	45						
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	5'11"	180.3	113	14	15	16	18	20	21	22	24	25	27	28	29	32	33	35	36	38	39	40	42						
	6'0"	182.8	112	14	15	16	18	19	20	22	23	24	26	27	28	30	31	33	34	35	37	38	39						
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6'10"	208.2	9	10	12	13	14	14	15	16	17	18	19	20	21	22	18	24	25	26	27	28	29							
6'11"	210.8	9	10	11	12	13	14	15	16	17	18	19	20	21	19	23	23	25	27	28	29	30							

Traditional adult BMI chart only factors in height and weight calculations, leading to misqualifications

In recognition of these issues, the AMA in 2023 adopted a new policy discouraging the use of BMI as a standalone diagnostic tool. The AMA emphasized that BMI is an “imperfect” measure that should be used in conjunction with other assessments, such as waist circumference, body composition, and clinical indicators of health, especially given BMI’s historical biases across different ethnic groups and sexes^{17,18}. The AMA went so far as to state that BMI should not be used as the sole criterion to deny insurance reimbursement for obesity treatment¹⁹. This is a significant shift from the decades old thinking around BMI, as the AMA is putting patients first and recognizing that their BMI number alone doesn’t tell the whole story.

Healthcare organizations are moving toward a more nuanced staging of obesity severity. For example, the Obesity Medicine Association (OMA) and the American Association of Clinical Endocrinologists (AACE) recommend classifying obesity not just by BMI, but also by the presence of weight-related comorbidities. A patient with a lower BMI but multiple obesity-related health issues (think prediabetes or sleep apnea) may warrant more aggressive treatment than someone with a higher BMI but no complications. These frameworks (referred to as the complications-centric model) effectively stage obesity from 0 to 2: Stage 0 indicating no apparent obesity-related complications, Stage 1 indicating mild to moderate complications, and Stage 2 indicating severe complications. Treatment intensity is guided by this staging, escalating from lifestyle changes alone to medications or surgery as the severity increases^{20,21}.

➔ **BMI-based definitions can misclassify some individuals** and may not capture health risks in others until weight has already had serious effects.

BMI kg/m2	Disease Stage	Suggested Therapy
< 25 <23 in certain ethnic groups	Normal weight (no obesity)	Healthy lifestyle
25-29.9 23-24.9 in certain ethnicities	Overweight stage 0 (no complications)	Lifestyle therapy
≥30 ≥25 in patients of certain ethnicities	Overweight stage 0 (no complications)	• Lifestyle therapy • Anti-obesity medication
≥25 ≥23 in patients of certain ethnicities	Obesity stage 1 (1 or more mild-moderate complications)	• Lifestyle therapy • Anti-obesity medication
≥25 ≥23 in patients of certain ethnicities	Obesity stage 2 (at least 1 severe complication)	• Lifestyle therapy • Anti-obesity medication

Clinical guidelines from AACE now factor in both BMI and health complications to assess obesity severity. Patients with obesity-related conditions (even at modest BMI levels) are classified at a higher disease stage, prompting earlier intervention with anti-obesity medications or other therapies. Conversely, an individual with a high BMI but no complications may start with lifestyle therapy. This complications-centric staging ensures that treatment is tailored to a patient's true health risk.

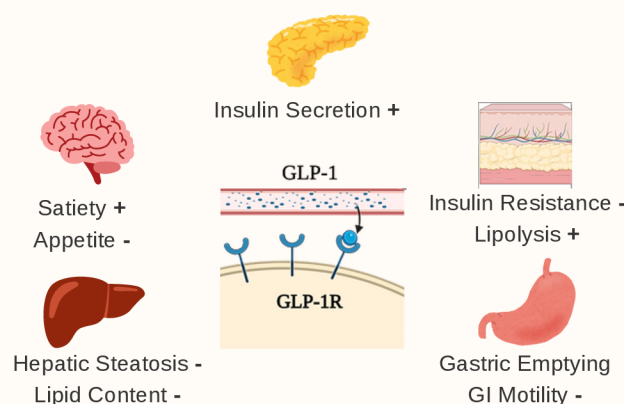
The move beyond a one-size-fits-all BMI approach means providers should conduct a more comprehensive evaluation. This might include measuring waist circumference (to gauge visceral fat), checking for metabolic syndrome markers, and assessing obesity's impact on quality of life. In consultations, clinicians should thoroughly assess the root causes of a patient's weight gain, as well as aim to understand perceived barriers to them feeling capable of taking action to improve their health³⁶. By identifying patients who have obesity-related health risks sooner, clinicians can initiate appropriate treatments sooner and potentially prevent those "mild" issues from progressing to serious disease. Overall, these evolving diagnostic guidelines align with the view of obesity as a chronic disease: one that requires continuous monitoring and a personalized management plan, rather than a simplistic threshold on a chart.

New Treatments Transforming Obesity Care

Perhaps the most exciting development in obesity management is the emergence of highly effective medications that induce substantial weight loss. Until recently, treatment options were quite limited. Standard advice revolved around diet, exercise, and behavioral counseling. A few prescription weight-loss drugs have been available (such as phentermine, orlistat, or combination drugs like phentermine/topiramate and naltrexone/bupropion), but these typically produce only single-digit percentage weight loss and often have tolerability issues. Bariatric surgery has been the most effective intervention (often leading to 20–30% weight loss or more), but surgery is invasive, expensive, and reserved for severe cases. This left a huge gap for the millions of patients in between, those finding lifestyle changes alone were insufficient, but who weren't candidates for or did not want surgery.

In the past few years, a new class of medications has changed the landscape. Glucagon-like peptide-1 (GLP-1) receptor agonists, originally developed for diabetes, have been repurposed for obesity treatment with impressive results. These drugs work by mimicking gut hormones that regulate appetite and blood sugar, helping patients feel full sooner and eat less. The first of these, liraglutide (Saxenda), offered proof of concept by producing around 5–7% weight loss on average. But the real game-changer was semaglutide.

In 2021, the FDA approved a high-dose injectable form of semaglutide (brand name Wegovy by Novo Nordisk) specifically for obesity, after clinical trials showed unprecedented efficacy; patients lost around 15% of their body weight on average over 68 weeks^{22,23}. Many participants achieved far greater losses (20% or more), approaching the results typically only seen with surgery. Providers now had a medical therapy that could rival bariatric surgery in effectiveness.



Source: [Frontiersin](#)

Visualization of the effects that GLP-1s have throughout the body. They act on many central organs to limit appetite and reduce the urge to eat.

Hot on the heels of semaglutide, a new drug called tirzepatide has raised the bar even further. Tirzepatide (brand name Zepbound for obesity, by Eli Lilly) is a dual-action injectable that activates both the GLP-1 and GIP receptors, essentially combining two hormones in one. Approved in late 2023, tirzepatide has shown the strongest efficacy to date, with clinical trial patients losing over 20% of their weight on the highest dose, an unprecedented result for a medication^{22,23}. These therapies are allowing patients with obesity to achieve weight loss that was virtually impossible through prior nonsurgical means. The downstream effects of such significant weight loss have yet to be realized, but early outcomes indicate these levels of weight loss could drive significant outcomes for patients.

The impact of these medications is already being felt across the healthcare industry. Demand for Wegovy and similar GLP-1 drugs has skyrocketed leading to supply shortages at times. Insurance coverage is a work in progress (many payers initially excluded weight-loss drugs, though this is changing as the evidence of benefit mounts). Despite coverage gaps, Wegovy's sales surpassed \$12 billion in the third quarter of 2024 alone, reflecting appetite for effective obesity treatments even if patients have to pay out of pocket for treatment³⁴. Furthermore, beyond weight loss itself, these drugs are demonstrating broader health benefits.

A landmark outcomes trial (SELECT) found that semaglutide reduced the risk of major cardiovascular events (heart attack, stroke, etc.) by 20% in overweight/obese patients with heart disease. Other studies show that patients on GLP-1 therapy often see improvements in blood pressure, cholesterol, and liver fat. Notably, in people with prediabetes, substantial weight loss with these medications may help prevent progression to full diabetes, and in some with type 2 diabetes, induce remission^{24,25}.

With these powerful tools, providers now have a full spectrum of interventions for obesity: from lifestyle programs and coaching, to medications, and still including bariatric surgery for those who need it.

In practice, the best outcomes often come from a combination approach – medications paired with nutritional and behavioral support – to maximize weight loss and help patients sustain it. It's important to note that obesity medications are generally intended for long-term use. Once stopped, patients tend to experience a resurgence in appetite and gradual weight regain (since the underlying biology is still there)^{26,27}. This reinforces the view of obesity as a chronic condition: much like a person with hypertension might need to stay on blood pressure pills, a person with obesity may need ongoing pharmacotherapy to manage their weight in the long run.

As of 2025, research and development in this field is white-hot. Pharmaceutical innovators are working on next-generation therapeutics (such as triple-hormone agonists and oral versions of these drugs) that could push weight loss even further. The pipeline includes agents targeting entirely new pathways as well. It's an exciting time, but also one that will require navigating questions of access and affordability: these new drugs are expensive, and ensuring that the people who need them can get them (while managing the cost for payers) is a key challenge ahead.

Product and Manufacturer	Class and MOA	Date of First FDA Approval	Comments
Zepbound (tirzepatide) Lilly	Dual agonists (GIP and GLP-1)	November 2023	Strongest efficacy to date
Wegovy (semaglutide) Novo Nordisk	GLP-1 analog	June 2021	SELECT landmark trial in 2023
Saxenda (liraglutide) Novo Nordisk	GLP-1 receptor agonist	December 2014	Significantly lower weight loss vs Wegovy and Zepbound
Qsymia (phentermine/ topiramate) Vivus	Sympathomimetic amine	July 2012	Mostly replaced by newer agents
Contrave (naltrexone/ bupropin) Curax	Opiod antagonist	September 2014	Mostly replaced by newer agents

The latest anti-obesity medications are reshaping treatment. GLP-1 based drugs like semaglutide (Wegovy) and the dual-agonisttirzepatide (Zepbound) produce far greater weight loss than older drugs (e.g. Qsymia, Contrave).

Strategic Implications for Payers, Providers and Innovators

The reframing of obesity as a treatable disease and the arrival of effective new therapies carry profound implications across the healthcare industry. Here are some actionable insights for different stakeholders:

Innovators and Life Science Companies

The evolving framework around obesity presents huge opportunities for innovation. Pharma and biotech companies have a green field to develop new therapies targeting obesity and metabolic health. The success of semaglutide and tirzepatide validates obesity as a viable market for therapeutic development (with multi-billion dollar potential) and as an area where clinical impact is demonstrable. The push to find better metrics than BMI could spur new diagnostic tools; perhaps leveraging sensors or advanced imaging to assess body composition and metabolic health in more detail. Innovators who can create holistic solutions (combining tech, behavioral science, and medical treatment) will be well-positioned in this new paradigm. Overall, the shift in thinking around obesity is opening a strategic frontier for healthcare innovation aimed at one of the most prevalent chronic diseases of our time.

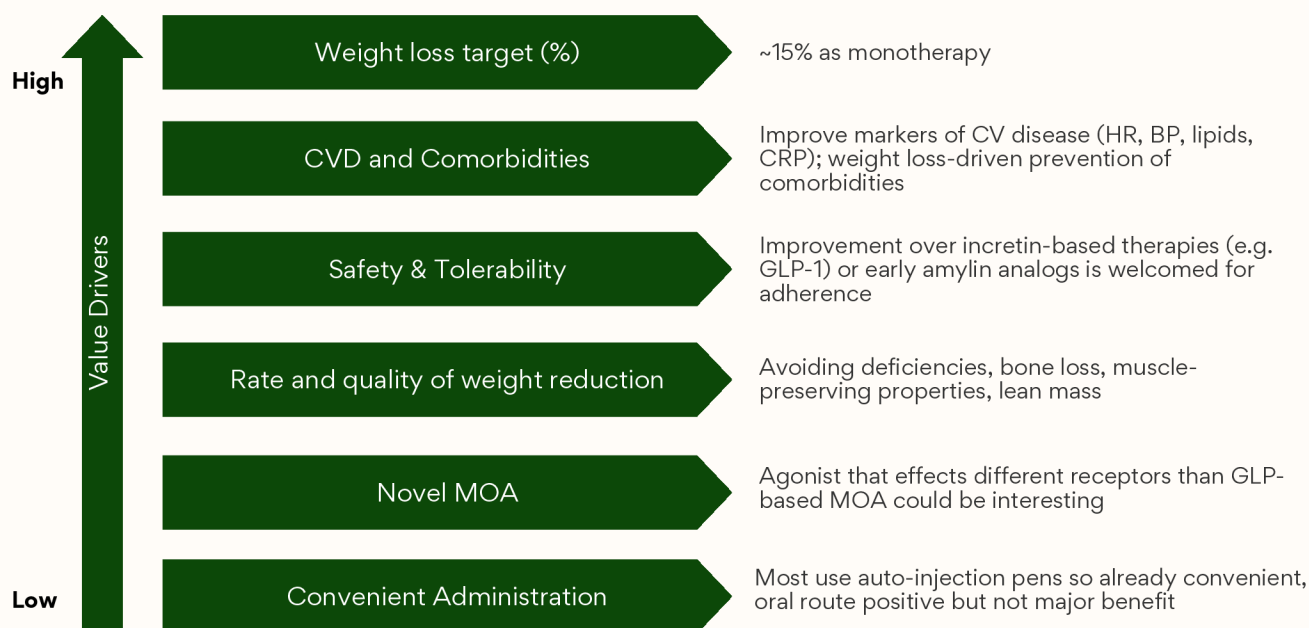
Health Insurers and Payers

Treating obesity proactively can yield significant long-term savings. While the upfront cost of GLP-1 medications is high, payers should weigh it against the downstream costs of untreated obesity including lifelong diabetes, heart disease, kidney failure, and orthopedic surgeries. For example, effective weight loss can put diabetes into remission and reduce cardiovascular events, which means fewer claims in those expensive categories²⁴. Payers are beginning to expand coverage for anti-obesity drugs and weight management programs, especially as guidelines (e.g. AMA and OMA) recognize obesity as a chronic disease requiring chronic treatment. Employers and insurers can also explore incentive programs for healthy weight, similar to wellness programs for smoking cessation. In short, financing obesity care is moving from a “wait-and-see” approach to an investment in prevention, with early adopters may gain an edge in controlling overall healthcare costs.

Providers and Health Systems

It's time to fully integrate obesity management into clinical practice. Providers should approach obesity the same way as other chronic diseases, with regular monitoring, evidence-based treatments, and empathy. This means updating clinical workflows: routinely measuring waist circumference and BMI, screening patients for weight-related comorbidities, and discussing weight in a non-judgmental manner during visits. Current clinical guidelines emphasize that while lifestyle modification remains the foundation, patients with higher risk profiles should be offered adjunctive therapies (medications or surgery) sooner rather than later²⁸. Many primary care providers are partnering with or referring to multidisciplinary clinics for comprehensive care. Health systems are also developing programs for obesity similar to cardiology or oncology service lines, recognizing that treating obesity can improve outcomes across multiple domains (cardiovascular, endocrine, orthopedic). Embracing this disease model and reducing weight stigma in clinical settings will be key to engaging patients. Every encounter is an opportunity to address obesity, rather than avoiding the topic.

Key Value Drivers for Obesity Molecules as Identified by Payers



The value drivers emphasize the importance of overall weight loss when it comes to perceived value amongst payers (primary research). the importance of developing efficacious treatments that reduce comorbidities in a safe manner remain the main target. Quality weight loss is a concept that will be watched closely in coming years as innovators continue to push the bonds of obesity treatments.

Navigating the future with an evidence driven approach

At Alkemi, we specialize in helping healthcare companies and stakeholders make sense of emerging scientific developments and obesity is a prime example of an evolving landscape that demands clarity. Our approach is grounded in rigorous scientific research and data-driven decision-making. We follow the latest clinical trials, guideline updates, and market trends in metabolic health to distill what is credible and actionable for executive strategy. In the case of obesity, Alkemi understands that the framework is shifting: new definitions, new treatments, new expectations. We work with key stakeholders to model the long-term impact of covering obesity interventions on population health and costs. We support providers, innovators and health systems in developing care models that incorporate cutting-edge therapies through evidence, competitive differentiation, and positioning in this fast-moving therapeutic area.

Obesity, perhaps more than any other condition, exemplifies the need for interdisciplinary thinking, blending clinical evidence with economic and social considerations. Alkemi's team prides itself on balancing innovation with practical insight. We help our clients ask the right questions: How do new obesity guidelines affect our product or policy? What does the latest outcomes data mean for insurers' ROI? Where are the unmet needs in obesity care that new solutions can fill?

By approaching obesity not as a static issue but as an evolving disease framework, Alkemi empowers healthcare leaders to craft strategies that improve patient outcomes and organizational performance. In this era of rapidly advancing obesity science, our commitment is to ensure that decisions are anchored in the best available evidence and a forward-looking perspective.

Alkemi Strategy Framework



Conclusions



Summary

Obesity in 2025 is at a tipping point.

The recognition of obesity as a chronic disease and the arrival of effective therapies are transforming how we combat this epidemic.

For healthcare executives, the task now is to translate this scientific and clinical progress into strategy: redesign benefit plans and care pathways, invest in prevention and treatment programs, and innovate new solutions.

The organizations that succeed will be those that view obesity through a modern, and evidence-based lens.

By doing so, we can reduce the enormous human and economic toll of obesity and usher in a healthier future for patients and health systems alike.^{29,30}

Prepared by
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Obesity - October 2025

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