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Pop a pill to lose weight? The GLP-I ‘magic bullet’ is enticing and dangerous

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Pop a pill to lose weight? The GLP-I ‘magic bullet’ is enticing – and dangerous

Like antibiotics, the weight-loss drugs are at risk of being misused.

Teo Yik Ying

It used to be that to lose weight, short of surgery, one had to endure the rigours of exercise and diet changes. Then came the GLP-I drugs, better known by their proprietary names Wegovy, Ozempic and Mounjaro.

Originally prescribed for Type 2 diabetes patients, the drugs soon became famous, hyped by celebrity endorsers and influencers as a “magic bullet” for rapid weight loss. They are not. But the idea is attractive – and is propelling the world towards a potentially hefty health problem if left unchecked.

In an age that prizes convenience, the appeal of GLP-I drugs is understandable when a weekly injection can deliver fast and visible results. But new evidence is emerging that there are health costs to the individual that may not show up initially. At a broader societal level, there are dangers too arising from growing access and use of the drugs.

GLP-I use globally is currently still relatively low, at about 7 per cent of diabetes patients and 2 per cent of the obese population, according to one estimate by JPMorgan. But two changes this year are expected to accelerate both demand and supply.

The first is the arrival of oral pills – much easier to take and store. The second is the expiration of patents in major markets that will greatly boost supply with the production of cheaper generic versions.

In March, the patent on semaglutide – the active ingredient in Wegovy and Ozempic – expired in India and China, both countries major manufacturers of generics, in what one market analysis described as a potential billion-dollar “magic pill moment”.

Wellness clinics have begun advertising so-called “Mounjaro Bride” packages in India, centred on the use of GLP-I medication in weight-loss programmes. Similar offerings are already well established in the United States and, closer to home, are beginning to emerge in parts of Singapore’s aesthetic and private healthcare sectors.

Given the well-known health problems associated with obesity, one may ask what’s the worry about the expanded use of these

drugs that were once confined to specialist endocrinology clinics.

But there are good reasons to be concerned about the normalisation of GLP-I use for cosmetic weight loss rather than genuine clinical need. Risks arise when the line between medicine and lifestyle products is blurred.

UNDERSTANDING GLP-I MEDICINES

To understand why, we must first be clear about what GLP-I medicines are, and what they are not.

GLP-I receptor agonists mimic a naturally occurring hormone that regulates blood sugar and appetite. By slowing gastric emptying and increasing satiety, they help patients feel full sooner and for longer, while also improving insulin response.

While these drugs have only recently gained widespread attention, their origins date back several decades. GLP-I was first discovered in the 1980s, with early clinical applications emerging in the 2000s. It was first approved for the treatment of Type 2 diabetes and, later in 2024, for weight management.

What truly propelled GLP-I medicines into the mainstream was the development of semaglutide. With greater efficacy and a more convenient once-weekly dosing schedule, semaglutide transformed both clinical outcomes and public

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perception. Today, when GLP-I drugs are discussed, it is often in the context of popular semaglutide drugs like Wegovy and Ozempic.

However, convenience and effectiveness do not change the fundamental purpose of these medications. Their primary purpose has always been the management of metabolic disease, particularly Type 2 diabetes, and the reduction of associated complications such as cardiovascular and kidney disease.

Their role in weight management is clinical, not cosmetic, targeted at individuals whose excess weight poses a measurable risk to health.

This is reflected in international guidelines. In September 2025, a World Health Organisation (WHO) expert committee set out several specific recommendations on the use of GLP-I receptor agonists. One was that the drugs were to be used for managing Type 2 diabetes in patients at elevated risk, and for controlling obesity in those with diabetes.

What constitutes obesity was also clearly spelt out, defined as a body mass index (BMI) of 30 and above, a threshold associated with increased risk of serious health conditions.

In December 2025, WHO guidance was expanded to include the conditional use of GLP-I medicines for long-term obesity management. But the conditions were explicit: These drugs should be prescribed under medical supervision and used alongside sustained behavioural interventions.

In other words, GLP-I medicines were never meant to replace lifestyle changes, but to complement them.

Singapore’s regulatory stance reflects this caution. The Ministry of Health and the Health Sciences Authority allow GLP-I prescriptions for adults with Type 2 diabetes, and for weight management only in individuals with a BMI of 30 or above, or 27 and above with at least one weight-related condition such as hypertension or sleep apnoea.

These criteria serve as important safeguards. Yet the current wave of demand increasingly bypasses them, reframing a therapeutic intervention into a lifestyle choice.

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concern lies with well-intentioned physicians who prescribe GLP-I medicines to help patients lose weight, but lack the time or resources to ensure the necessary lifestyle interventions are implemented and sustained. Prescribing the medication is, in many ways, the easy part. The more difficult and time-consuming task is guiding patients through sustained behavioural change, monitoring adherence and providing ongoing support. Without this, the prescription risks becoming a standalone intervention, detached from the broader context in which it is meant to function. In such a scenario, patients may achieve initial weight loss, but remain ill-equipped to sustain it. When the medication is stopped, the weight returns, and the cycle begins anew. The current narrative that frames GLP-I medicines as a "miracle solution" obscures these complexities, by focusing on access for those who can pay, while paying insufficient attention to whether patients are receiving appropriate care.

PROCEED WITH CARE

GLP-I medicines are, without doubt, a significant advancement in the management of metabolic disease. Like antibiotics in an earlier era, they have the potential to improve and save lives. But history also offers a warning. The very success of antibiotics led to their overuse, fuelling resistance and undermining their long-term effectiveness. The lesson is not that such innovations are problematic, but that they must be used responsibly. I see a similar principle here. There will always be commercial incentives to expand markets and providers willing to meet demand, even when the demand is driven by convenience rather than necessity. The proliferation of telehealth platforms adds another layer of complexity, raising questions about the adequacy of assessments conducted remotely. As GLP-I medicines become more widely available, similar vigilance will be needed to ensure prescriptions are issued appropriately, with proper evaluation and follow-up. But regulation alone is not sufficient. At its core, this issue reflects a broader societal mindset that prioritises quick fixes over long-term solutions. The belief that health can be achieved through a pill or an injection is deeply appealing, but ultimately misleading. It diverts attention from the structural drivers of poor health, including dietary environments dominated by ultra-processed foods and increasingly sedentary lifestyles. When medicines are used indiscriminately, they risk reinforcing the very behaviours and systems that contribute to metabolic disease in the first place. A responsible public health system must not allow the structural drivers of poor health to continue unchallenged while tethering individuals to a lifelong dependency on medications.

Complexities obscured in framing GLP-I drugs as 'miracle solution'

FROM BI

SIDE EFFECTS AND WEIGHT REBOUND

Much of the enthusiasm surrounding GLP-I drugs stems from their visible results. But like all medications, they come with trade-offs, some well known and others only now becoming better understood.

The most commonly reported side effects are gastrointestinal. Nausea affects a substantial proportion of users, often accompanied by fatigue, headaches and a markedly reduced appetite. These effects are not incidental, but part of how the drugs work, effectively reducing calorie intake by making eating less appealing.

However, weight loss achieved in this manner is not purely fat loss. Studies have shown that a significant proportion of the weight lost may come from lean muscle mass.

This is an important consideration, as muscle plays a critical role in metabolic health. Losing muscle while losing weight can result in a less favourable body composition, even if overall weight decreases.

There are also rarer but more serious risks, including pancreatitis, gallbladder disease and kidney complications. These underscore the need for proper patient selection and medical supervision, something that may be lacking in casual or aesthetic use.

Equally concerning is what happens when the medication is stopped. Recent meta-analyses, which

are scientific research that combines data from multiple studies to provide more robust conclusions, have found that discontinuing GLP-I therapy often leads to rapid and substantial weight regain. In many cases, the weight returns with a vengeance, erasing earlier gains within months.

More troubling is the composition of this regained weight. Evidence suggests that it is disproportionately fat, while the initial weight loss may have included a significant amount of muscle. This can leave individuals metabolically worse off than before they began treatment.

What appears to be a quick fix may in fact create a cycle of dependency, where continued use becomes necessary not just for further weight loss, but to maintain prior results.

However, encouraging long-term use of GLP-I medicines to prevent such rebound is not straightforward. It risks further medicalising health, where weight becomes the dominant marker of well-being at the expense of other indicators such as body composition, cardiovascular fitness and metabolic health.

The financial burden of long-term use remains substantial even with the entry of generics, and patients may need to tolerate side effects over extended periods, not to mention the limited data on the health consequences of sustained use.

IMPORTANCE OF BEHAVIOURAL AND LIFESTYLE CHANGES

The appeal of GLP-I drugs must

be understood in the broader context of society's enduring search for shortcuts.

For decades, societies have cycled through a succession of "miracle" diets promising effortless weight loss – from Atkins and ketogenic diets to paleo regimes, juice cleanses and intermittent fasting. Each has surged in popularity, often driven by anecdotal success and media amplification.

Yet the underlying pattern remains unchanged. Restrictive approaches are difficult to sustain. When they are abandoned, weight is typically regained. This cycle of loss and regain, commonly referred to as yo-yo dieting, is not only frustrating but also potentially harmful.

GLP-I drugs risk becoming the pharmaceutical extension of this cycle.

The key principle of healthy weight management is not simply weight loss, but sustained weight loss. This requires consistent behavioural change in nutrition, physical activity and eating habits.

Even in clinical settings, GLP-I therapy is not intended to function in isolation. Patients are advised to engage in strength or resistance training to preserve muscle mass, and to adopt dietary patterns that support long-term health, including higher fibre intake and reduced consumption of ultra-processed foods.

Without these changes, the benefits of GLP-I drugs are likely to be temporary.

For individuals seeking weight loss primarily for aesthetic reasons, this reality is even more

stark. No medication can substitute for the behavioural consistency required to maintain a healthy body composition over time.

ACCESS, PRICE AND APPROPRIATE USE

Beyond individual risks, the rise of GLP-I medicines also raises broader questions about equity and the structure of healthcare systems.

At present, access to these drugs is uneven. Their relatively high cost means they are more readily available to individuals with greater financial means. Yet obesity and metabolic diseases disproportionately affect lower-income populations.

This creates a troubling paradox. Those who stand to benefit most from effective treatment may be least able to access them, while those seeking cosmetic improvements are more likely to obtain them.

In this way, GLP-I medicines risk exacerbating existing health

inequities, with obesity and its complications becoming further concentrated among less privileged groups.

The anticipated entry of lower-cost generics may improve affordability, but price alone does not guarantee equitable or appropriate use.

Three considerations are critical.

First, access: Can patients with genuine clinical need obtain these medications in a timely and appropriate manner?

Second, price: Can patients afford sustained use, especially if long-term therapy is required?

Third, and perhaps most importantly, clinical guidance: Are these drugs being prescribed and used appropriately, with adequate supervision and support for the necessary lifestyle modifications?

It is this third dimension that I worry about.

There is a tendency to attribute overuse solely to profit-driven practices. While this may be true in some cases, a more nuanced

At its core, this issue reflects a broader societal mindset that prioritises quick fixes over long-term solutions. The belief that health can be achieved through a pill or an injection is deeply appealing, but ultimately misleading. It diverts attention from the structural drivers of poor health, including dietary environments dominated by ultra-processed foods and increasingly sedentary lifestyles.

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