BRIEFING: **APRIL 2026**

The Food Foundation

THE GLP-1 REVOLUTION:

Implications for Health, Inequality and the Food System

ABOUT THE FOOD FOUNDATION

The Food Foundation is an independent charity working to address challenges in the food system in the interests of the UK public. Working at the interface between academia and policymakers (parliamentarians, civil servants, local authorities, business leaders and investors) we use a wide range of approaches to make change happen including events, publications, media stories, social media campaigns and multistakeholder partnerships. We also work directly with citizens to ensure their lived experience is reflected in our policy proposals. We work with many partners on a range of different thematic areas, working closely with academics to generate evidence and campaigners who can drive change. We are independent of all political parties and business, and are not limited by a single issue or special interest.

Visit: foodfoundation.org.uk

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Impact on Urban Health

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Conflict of interest declaration: The Food Foundation only accepts funding which does not compromise our independence. We do not take funding from food companies. Our policy is based on The Financial Relationship Policy developed by the World Obesity Federation to help us consider new financial engagements.

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This briefing primarily aims to inform, promote discussion and debate, and support investors to engage food businesses on food system risks and opportunities. It can also be used by investors, businesses and policymakers to support policy change towards a more sustainable and healthier food environment. This is part of a series of investor briefings; our previous briefings can be found **here**.

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INTRODUCTION

Four in 10 people in the UK say they are trying to lose weight most of the time[1] and 66% of the UK's population are currently living with obesity and overweight[2]. As a result, GLP-1s have perhaps understandably been hailed as one of the most groundbreaking and far-reaching pharmaceutical breakthroughs of recent years, given the number of potential candidates for weight loss interventions. GLP-1 medications have rapidly become household names, with brands such as Ozempic and Wegovy now part of the cultural zeitgeist. While such drugs offer remarkable weight loss effects in a matter of months and can be hugely beneficial for many people struggling with obesity – proving more effective than many traditional weight loss interventions that rely on a high degree of individual behavioural change and ignore the huge role played by unhealthy food environments – controversy rages as to the impact of such medication on the economy, food businesses, society and individuals.

While pharmaceutical companies and some others are currently positioning such drugs as a silver bullet for weight loss, there are still a number of unanswered questions. Important questions remain around equitable access to GLP-1s, given that lower income groups are disproportionately more likely to be living with obesity and weight-related health issues, while at the same time much less likely to be able to afford such drugs privately. While such drugs are available on the NHS, they are currently subject to strict eligibility criteria. Will the cost of the drugs end up coming down as they move off patent to the extent that large proportions of the population are permanently placed on them, as has been the case with statins? Or will current two-year long prescription protocols persist, with rapid weight regain swiftly following for the many who then return to life as normal in an obesogenic food environment that is no longer on policymakers' agenda to regulate? And will high demand in the general population for the drugs impact availability for those who need them most? Additionally, there are valid concerns that GLP-1s will drive an increase in eating disorders with the medication driving a new aesthetic standard[3], while it remains to be seen exactly what impact GLP-1s will have on food businesses and their investors.

Will GLP-1s lead to a new business model for those food businesses who for decades have relied on selling increasing volumes of (often unhealthy) food? Some remain optimistic that widespread uptake of GLP-1s will herald in a new era of nutrient-dense, smaller-portioned food options and shift consumer demand away from hyper-palatable, energy-dense, nutrient poor foods – thus breaking the current demand-supply feedback loop that ensures many food businesses are stuck in a 'junk food cycle'[4]. Yet there are currently a number of gaps in the evidence base that make it hard to estimate with any great accuracy the long-term impact of GLP-1s. We lack evidence on potential side-effects from long-term use of the drugs over many years, and the majority of the current evidence on food business impacts is from small studies looking at American, rather than British, consumers.

Four in 10 people in the UK say they are trying to lose weight most of the time and 66% of the UK's population are currently living with obesity and overweight

WHAT ARE GLP-MEDICATIONS AND HOW DO THEY WORK?

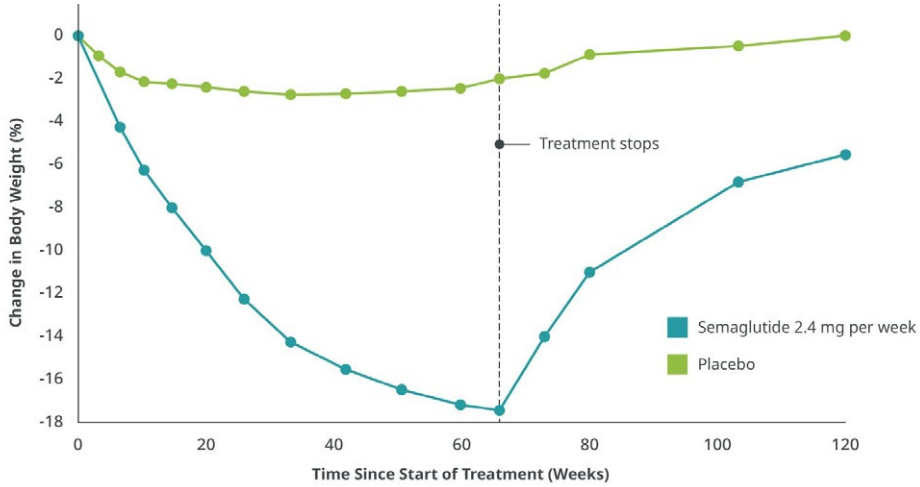
GLP-1 receptor agonists (GLP-1s[i]) are a class of medication that mimic the naturally occurring GLP-1 hormone released in the small intestine. This stimulates the pancreas to release insulin and signals the brain to reduce hunger, making users feel fuller and more satiated faster. They have historically been used to treat type 2 diabetes and are now licensed and increasingly prescribed for obesity and weight loss. They work by slowing digestion and reducing appetite to promote weight loss and blood sugar control. Medications and brand names include:

MEDICATION NAME	BRAND NAMES
Semaglutide	Wegovy, Ozempic
Tirzepatide (GLP-1 + GIP)	Mounjaro, Zepbound
Liraglutide	Saxenda, Victoza

Evidence from clinical trials shows average weight loss of between 15-20% of starting body weight, demonstrating their high levels of efficacy[5]. There can be wider health benefits in addition to weight loss, related to direct pharmacological impact on cardiovascular metabolic health with research finding benefit to heart and kidney health independent of weight loss[6]. In April 2026, it was announced that GLP-1s would be offered free on the NHS to over a million people in England who are at risk of heart attacks and strokes.

Ideally, those taking GLP-1s for targeted clinical reasons would have their prescriptions coupled with psychological, dietetic and behavioural change support during treatment and afterwards, given that trials show the vast majority of individuals using GLP-1s simply regain the weight once stopping medication[7,8](Figure 1). Any cardiometabolic improvements also return to baseline as weight is regained[9]. However, the reality is this wrap-around support does not always happen, particularly with private access. Even on the NHS, current prescriptions are for two years only. On average people return to their baseline weight within 18 months of coming off the drugs[10], with weight regain faster after stopping GLP-1s compared with weight gain after stopping behavioural programmes, regardless of how much weight was lost during treatment[11].

FIGURE 1:
Weight regain after discontinuing GLP-1 treatment[12]



Source: https://khni.kerry.com/articles/white-papers/an-overview-of-weight-loss-glp-1-drugs/

[i] *There are GLP-1s and GLP-1+GIPs (which is a dual hormone agonist, for example Tirzepatide) – this briefing covers both but for ease we refer to both as GLP-1s.*

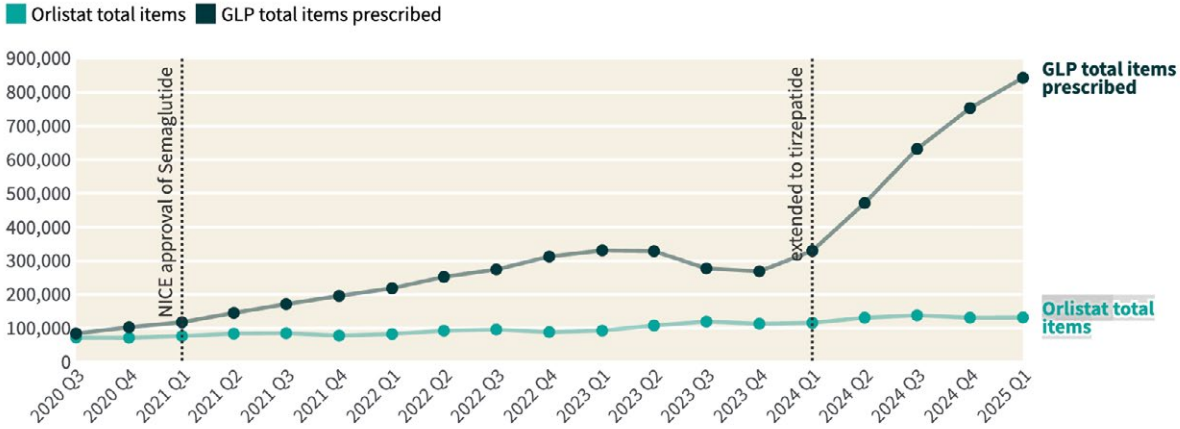
WHO IS CURRENTLY ELIGIBLE FOR GLP-1S?

The NHS in England currently prescribes GLP-1s to patients living with obesity who meet specific criteria. GLP-1s are recommended only after dietary, exercise and behavioural approaches have first been started and evaluated in adults living with overweight or obesity, and where prescribed, should be used alongside a reduced calorie diet and increased physical activity[13]. To be eligible adults typically must have a BMI of at least 35 as well as at least one weight-related co-morbidity (such as type 2 diabetes)[14]. Prescriptions are usually accessed for up to two years.

Some estimate that around 50,000 people are currently prescribed GLP-1s by the NHS[15]

In October 2023 NICE (the national health body responsible for evidence-based guidance on cost-effective treatments within the NHS in England) approved semaglutide and tirzepatide for weight loss. Uptake of the drug thereafter has been rapid (Figure 2), although accurate figures for NHS prescriptions of the drug to date are hard to come by. Some estimate that around 50,000 people are currently prescribed GLP-1s by the NHS[15].

FIGURE 2: **NHS England prescriptions for semaglutide and tirzepatide since 2020**



Source: OpenPrescribing.net, Bennett Institute for Applied Data Science, University of Oxford, 2025 · This time series shows the surge in NHS England prescriptions for semaglutide and tirzepatide (GLP-1 receptor agonists) since 2020, plotted against prescribing levels of Orlistat, a traditional anti-obesity medication. Following the NICE approval of semaglutide in 2021 and tirzepatide guidance in early 2024, GLP-1 prescribing surpassed Orlistat by a wide margin, growing by over 700% from 2020 to 2025.

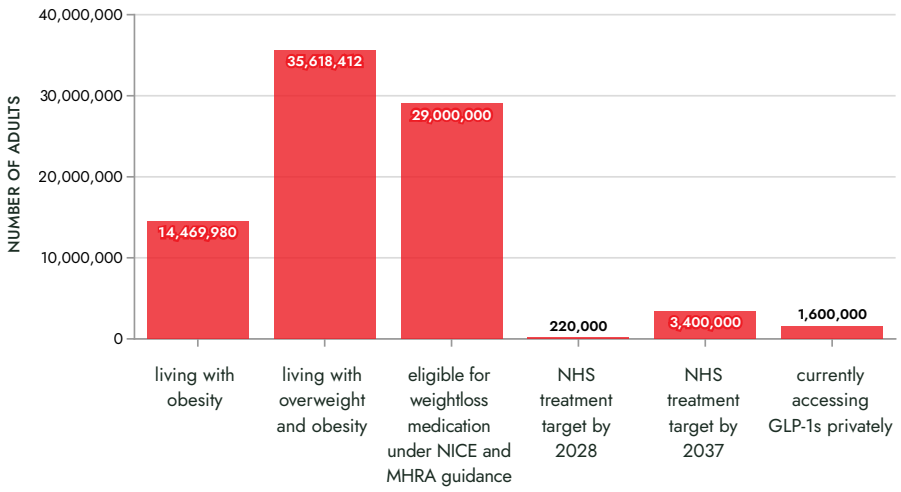
Data ranges from May 2020 - June 2025

While GLP-1s semaglutide and liraglutide must be prescribed only by specialist weight loss services which severely limits their reach, in December 2024 NICE published additional guidance recommending that tirzepatide (brand name Mounjaro®) could be prescribed in primary care settings (i.e. by GPs and community nurses as well as in specialist secondary care settings). **NICE guidance recommended that the NHS roll out tirzepatide to 220,000 patients within three years starting from June 2025 with a target of reaching 3.4 million people within 12 years[16]**.

CURRENT UPTAKES OF GLP-1S

While this recent development theoretically makes GLP-1s much more widely available to those living with obesity, around 29 million people in England are currently eligible for GLP-1s under NICE and MHRA guidance[17] – a vastly larger number than the NHS's target of reaching 220,000 people over three years. UK obesity rates also look set to rise faster over the next decade than the rate at which NHS can deliver GLP-1s[18]. Even if individuals are eligible for NHS prescription of GLP-1s, access can be a postcode lottery, with provision of specialist weight loss services (Tier 3 weight management services) varying widely across England.

FIGURE 3: **The gulf between obesity prevalence and GLP-1 access in UK adults[19]**

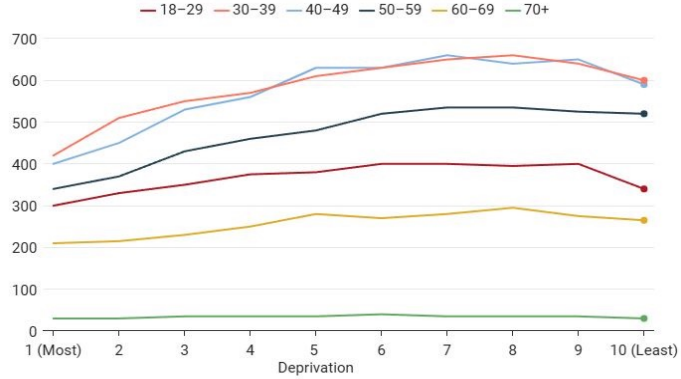


Source: BNF 2025, UK Gov, NIC, Jackson, S.E., Brown, J., Llewellyn, C. et al. 2026

However, the number of people taking GLP-1s is likely to be vastly higher than NHS prescriptions indicate when private or off-label prescriptions are taken into account, with between 1.4 and 1.6 million people thought to be using them privately[20,21]. This means that around 90% of UK patients access GLP-1 medications through private, non-NHS channels[22]. Given the huge demand for the drugs through private channels there are concerns around some individuals being at risk of taking unsafe or unregulated medication with the potential for negative side-effects (there is a booming black market for such drugs[23]). There are also concerns around the lack of behavioural and psychological wrap-around support for individuals taking private prescriptions that ought to be provided alongside GLP-1 medication.

Data from a private online prescriber of GLP-1s indicates that among women, those on higher incomes aged between 30 and 50 are most likely to be purchasing such drugs off-label, suggesting that lower income groups are indeed currently less likely to be able to access private prescriptions, risking further exacerbating health inequalities.

FIGURE 4: **GLP-1 prescriptions in the UK per 100,000 female population and levels of deprivation, Nov 2024 to Oct 2025**



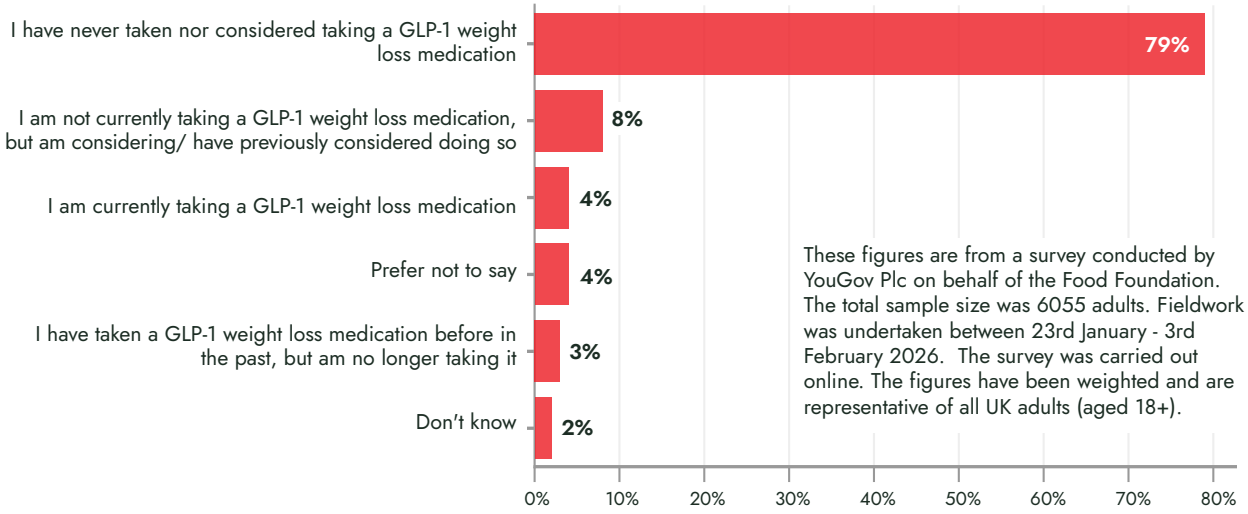
Source: The Health Foundation, using data from Voy, an online prescriber of GLP-1s.

PROJECTED UPTAKES OF GLP-1S

New data from a nationally representative survey undertaken by The Food Foundation in January 2026, indicates that 7% of the UK population are or have previously taken GLP-1 medication, with a further 8% of adults currently or previously considering the drug which would equate to approximately 8.25 million people[24] (see Figure 5).

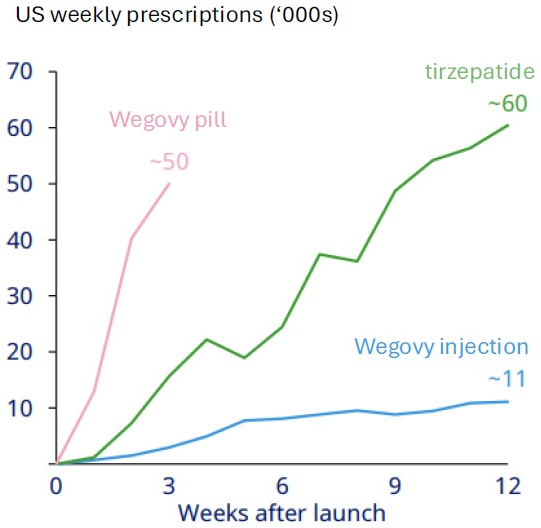
To date, most GLP-1s are taken as an injection. However, pill or tablet formats of GLP-1s licensed for use in obesity are currently being rolled out in the UK from 2026 onwards, which is expected to increase use of the medication. Figure 6 shows prescription data from the US following the launch of Wegovy in tablet form, showing that the rate of uptake for the pill was significantly faster than for any former version of the drugs in injection format.

FIGURE 5: **Have you ever taken GLP-1s before?**



Source: The Food Foundation, January 2026. Some examples of these medications include Wegovy, Ozempic or Mounjaro.

FIGURE 6: **Prescription data from the US following the launch of Wegovy in tablet form**



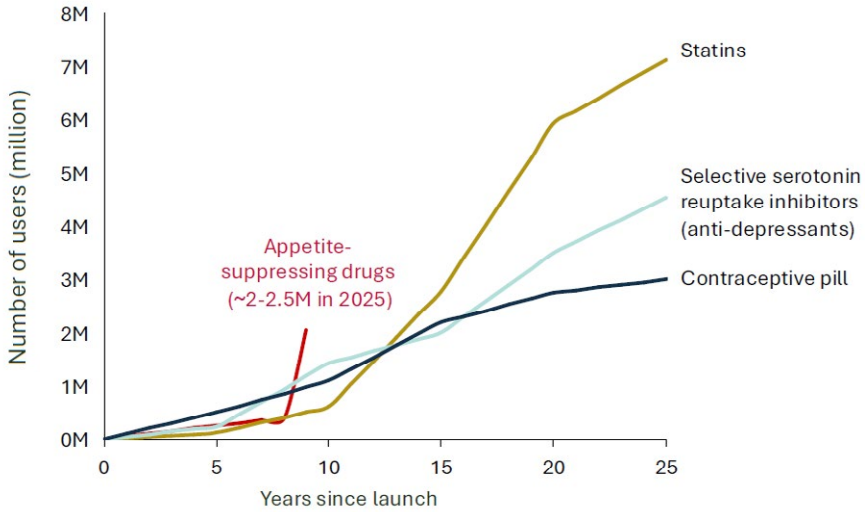
Each line in the chart shows prescription volumes in the weeks after launch.
Blue = Wegovy injection
Green = Mounjaro injection
Pink = the Wegovy pill

Source: Appetite-Suppressing Drugs Factbase, Bramble Intelligence; Novo Nordisk Q4 2025 Investor Presentation[25]

Certainly, the uptake of GLP-1s to date has significantly outpaced the uptake historically of other drugs which are now widely prescribed at a significant scale across the population. Statins (taken for high blood pressure) and SSRI's (anti-depressants) were both approved for UK use in 1989, but the time between launch and having at least one million users was over a decade for both of these drugs. In contrast, it has taken less than five years from launch for GLP-1s to pass the same milestone (Figure 7).

Based on their rapid uptake to date and the huge amount of interest from citizens in such drugs, it is likely that the next few years will see continued and sustained growth in the numbers taking GLP-1s. Bramble Intelligence estimate that there could be over 13 million users in the UK by the early 2030s, while global consulting firm AlixPartners forecasts that as many as 50% of UK households could adopt these medications by 2030 – once the drugs are available in pill format, and should further research support the emerging evidence demonstrating the drugs' potential to positively impact on other diseases[27].

FIGURE 7: **Uptake of GLP-1s vs statins and anti-depressants (years since launch)**



Note: Selective serotonin reuptake inhibitors (SSRIs) and statins were approved in the UK in 1989. GLP-1 RAs for weight management on NHS were approved in the UK in 2020 (Saxenda), followed by Wegovy (2023) and Mounjaro (2024) – Saxenda was approved for private use in 2017. Sources: IQVIA (2025), NHSBSA (2024), Masson et al. (2024). Circana GLP-1 report, Early days of a revolution (2024), The Times, Tony Blair Institute; The Guardian; Science Direct (1999)

Source: Appetite-Suppressing Drugs Factbase, Bramble Intelligence[26]

Bramble Intelligence estimate that there could be over 13 million users in the UK by the early 2030s, while global consulting firm AlixPartners forecasts that as many as 50% of UK households could adopt these medications by 2030

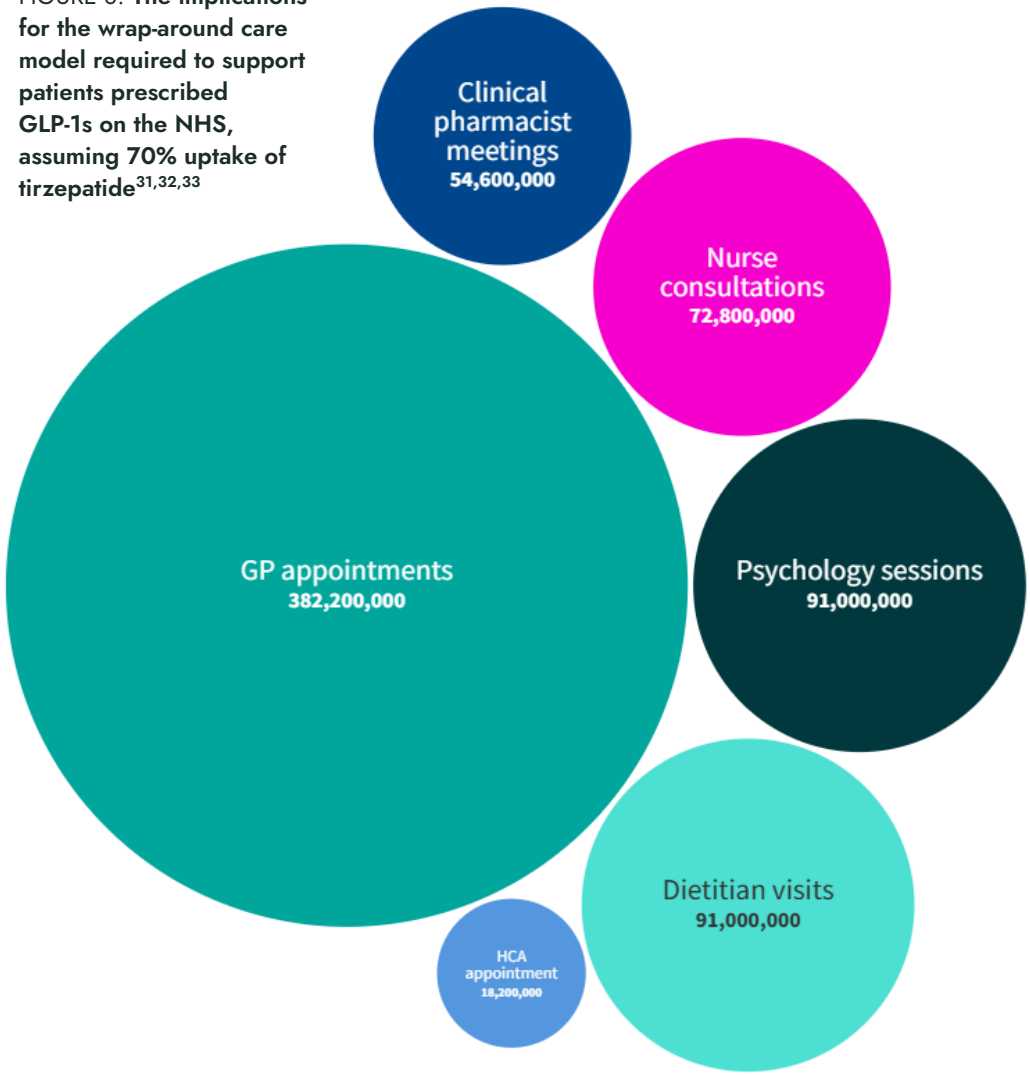
CURRENT AND PROJECTED COST IMPLICATIONS FOR GOVERNMENT

Rolling out tirzepatide at scale could transform millions of lives – but if this drug were rolled out to all eligible patients (the Medicines and Healthcare products Regulatory Agency has licensed tirzepatide for patients with a BMI of 27 or over, i.e. about 26-29 million people) it could also cost up to £38 billion a year for the medication alone, nearly a fifth of total NHS spending[28].

GLP-1s typically cost £92–£122 per month, but significant pressure comes from the wrap-around care model required to support patients GLP-1s on the NHS. This wrap-around care would likely include several GP appointments plus multiple specialist visits per patient who starts on tirzepatide in any given year, adding over £1,200 per person in the first year alone (see Figure 8). That would mean hundreds of millions of extra appointments in an already stretched system[29,30].

Yet obesity is a leading driver of chronic illness, workforce absence and lost economic productivity. Obesity and overweight currently cost the UK up to £126 billion annually, including almost £31 billion in lost productivity[34]. As such, the use of GLP-1s could be part of a wider agenda for treating overweight and obesity and reducing the cost to the NHS and wider economy of associated ill health. The Tony Blair Institute has modelled the economic impact of people living healthier, more productive lives under a) the NHS England scenario (where 220,000 people will be initiated on GLP-1s in the first three years and 3.4 million after 12 years), and b) a scenario in which there is a faster roll-out to approximately 15 million people with a BMI of 27 or more in the first two years. This modelling found:

FIGURE 8: **The implications for the wrap-around care model required to support patients prescribed GLP-1s on the NHS, assuming 70% uptake of tirzepatide**[31,32,33]



- **Under scenario a:** for the first 11 years the cost (mainly comprising the medication) rises faster than the macroeconomic benefits appear; after this, the macroeconomic benefits would accelerate and costs would fall, so that the government could expect to achieve cost-benefit neutrality by 2053.

- **Under scenario b:** for the first three years of rollout, the cost rises faster than the macroeconomic benefits appear. However, after the third year, year on year net costs begin to fall and the government could expect to achieve cost-benefit neutrality by 2035. After 2035, there is a net gain year on year, with cumulative fiscal benefits estimated at £52 billion by 2050. GDP could be expected to increase 0.3% at five years and 0.55% at ten years. DWP spending could be expected to reduce by £2.08 billion at five years and £3.47 billion at ten years[35].

Smarter rollout of GLP-1s alongside wrap-around support services and a policy environment that enables greater change to food environments could further reduce long-term disease, welfare spending, and demands on the NHS while simultaneously improving the affordability of rolling out GLP-1s. For example the government could look to negotiate lower prices with manufacturers of GLP-1s, redesign care around digital-first and community models that would require fewer in-person appointments and ongoing monitoring of GLP-1 users, and embed treatment within a broader prevention strategy – reducing cardiovascular disease, boosting GDP, lowering welfare costs and keeping people healthier and economically active for longer. It should be noted that there are some NHS-pharma projects underway to develop innovative weight management care pathways, which could include, for example, community pharmacy led services, digital or remote solutions, and integrating existing community based services into weight management care[36]. The risk otherwise of not having a smarter roll-out of GLP-1s with wrap-around support is overwhelmed NHS budgets and services without a healthier, more productive nation[37].

> ***The risk of not having a smarter roll-out of GLP-1s with wrap-around support is overwhelmed NHS budgets and services without a healthier, more productive nation.***

ACCESS AND EQUITY IMPLICATIONS FOR LOW-INCOME GROUPS

Inaction on overweight and obesity deepens both health and economic inequalities, and a person's chance of NHS treatment can depend more on their postcode and their access to specialist weight-management services rather than on their clinical need[38]. People in deprived communities – who face double the obesity rates – access 32% fewer prescriptions and start treatment later, at higher BMIs[39]. Without integration of lifestyle services, patients risk long-term reliance on costly drugs but without sustained support.

To make access to GLP-1s fairer, NHS access to these drugs for those living with obesity ought to be expanded, alongside fully funded wrap-around services and integrated digital referrals. National funding for this could be ringfenced, and medication paired with behavioural support and upstream prevention policies, including policies to improve the current food environment that is contributing to poor diets – especially for those on lower incomes – in the first place. Ideally, eligibility – not income or postcode – ought to determine access; where medication is combined with lifestyle care; and where prevention reduces long-term demand, narrowing health inequalities instead of widening them. Policymakers, NHS leaders and industry should act to fund, integrate and equitably scale obesity treatment – or risk entrenching a two-tier system that leaves the most vulnerable behind[40].

Citizen perspective: Food Ambassadors with lived experience of, or interest in, GLP-1 medication or waiting for GLP-1s on the NHS[ii]

FOOD AMBASSADOR A:

"There is still quite a lot of judgement and stigma attached to using weight loss medication at the moment. I have told a few people that I was using GLP -1 meds over the last few months and their reactions weren't all that positive.

I've been taking Mounjaro since October 2025 and, for me, it has been genuinely life changing. I've lost 23kg in that time. I was struggling quite significantly with perimenopause symptoms... Since starting the GLP-1 medication, I've been able to prioritise smaller portions and focus much more deliberately on good quality protein, fibre and hydration. As the weight started to come down, exercise became far easier.

Another big change has been cravings. They have essentially vanished. I've stopped drinking wine and I can now comfortably stop eating when I feel full, which was always something I struggled with before.

Access hasn't been easy though. My GP couldn't prescribe it for weight loss, so I currently access Mounjaro through a private prescription from Boots. I've managed to stay on the lowest dose (2.5 mg) the entire time and that costs £176 a month, which is a significant expense. We have had to make sacrifices in our household budget to afford it.

From my perspective it's an excellent tool, but it absolutely needs to be accompanied by education. People need clear guidance about nutrition, resistance exercise and hydration while taking these medications. Without that, there is a real risk of nutrient deficiencies, muscle loss or issues such as hair loss.

> ***Access hasn't been easy though. We have had to make sacrifices in our household budget to afford it.***

Overall, I see GLP-1 medications as incredibly powerful tools when used alongside proper education and support. At the same time, it is concerning that access for weight loss is currently limited largely to those who can afford private prescriptions."

[ii] *The Food Foundation's Food Ambassadors are citizens from across the UK who are experts by experience of food insecurity. They contribute to our campaigns, events and research to provide insights into the realities of the UK's broken food system. These perspectives from the Food Ambassadors have been anonymised at their request.*

FOOD AMBASSADOR B:

"Being someone with polycystic ovaries (or PCOS) and in the 'overweight category', I see them [GLP-1s] as a positive.

Unfortunately, most access them privately. My GP won't prescribe me GLP-1s even though it would probably be the easiest way for me to lose weight. Ironically, the NHS would probably benefit if I could be less heavy due to the complications of overweight.

Being part of the PCOS community, many of us have been refused IVF because of our weight... It is very disheartening that those of us with PCOS who are also finding it hard to lose weight are left behind on something that could be absolutely amazing to support us to lose weight.

> ***I was told by the fertility doctor that unless I lost 4½ stone (to bring my BMI down to under 30) I would not be touched with a 10-foot barge pole for IVF.***

I was told by the fertility doctor that unless I lost 4½ stone (to bring my BMI down to under 30) I would not be touched with a 10-foot barge pole for IVF. *I was not given any help to lose weight. It was just "go out and do it". I tried tried tried. I've done tablets, binders, therapy, exercise plans, diet plans, dietician appointments. I've been on a diet throughout my life, hovering back-and-forth between slimming world and keto, this one and that one and nothing has made a difference.*

I know from other people in the PCOS community that the GLP-1s they have had privately have worked so I am currently waiting for them to be available for people with PCOS on the NHS. How much longer is that going to take? I have absolutely no idea."

FOOD AMBASSADOR C:

"At my women's group, many of the women are now using weight loss medicine. Most of the women are menopausal or post-menopausal – at this age losing weight becomes harder. Plus, the group is for minority ethnic women. I think sometimes society ignores that for people from different ethnicities, "healthy body" types differ. People with naturally bigger bodies are increasingly experiencing pressure to be thinner, to achieve something that might not even be their healthy weight.

For people who cannot afford private weight loss drugs, the only option given to you is diet (surgery also has a very long waiting list). For some people on the drugs, it is lifesaving. I am interested in taking them myself for my health.

A big issue for me is affordability. I've asked my GP about accessing weight loss drugs on the NHS and was told the waiting list was 1-2 years. This is even though the GP told me I need to lose weight. I've asked friends who pay privately for weight loss drugs how much they spend and done my own research. It usually starts at £100 and month and goes up to £150. You're told you must take the drugs for at least a year. And, you're also advised to take ...vitamins. When I calculated the costs, it came to be as high as £2500 a year. For someone on benefits, this kind of cost is impossible: how am I going to afford £100-150 a month when I have rent and bills to pay, and food to buy?

When people are under pressure or desperate, they take risks. I know someone buying the weight loss drug Retatrutide privately even though it is still in clinical trials in the UK. There is something unequal about the different experience of ethnic minorities with these drugs, as well as the affordability issue. More needs to be done to support weight loss management through diet or lifestyle, and in the community. Weight loss drugs can be a solution, but they are not the only one."

THE NO-HUNGER GAMES – what do we know about how GLP-1s' impact on food purchasing and intake and what impact might this have on food businesses?

GLP-1s are already profoundly changing the traditional weight loss industry, with Weight Watchers filing for bankruptcy in May 2025 in the US. While the evidence is still emerging on the impact of GLP-1s on food purchasing habits, should uptake of GLP-1s continue as is predicted, the impact on food businesses could be similarly seismic.

The drugs impact appetite (the overall amount being eaten) but also appear to impact the type of food being eaten. Taken together this may lead to a decrease both in the overall volumes of the food being sold by businesses, as well as a shift in the types of food being bought. While the former marks a paradigm shift for many food businesses who have traditionally been heavily reliant on selling ever increasing volumes of food in order to generate profit, the latter suggests there may be winners and losers across different food categories and types of business. To date studies show:

GLP-1 USERS TEND TO BUY LESS FOOD

- A representative US study that linked to transaction data found that households with at least one GLP-1 user reduced grocery spending by 5.3% on average within six months of starting medication, with higher-income households reducing spending by 8.2%. The same study also identified an 8% decline in spending at fast-food chains, coffee shops, and restaurants[41].

- This is supported by other research, such as a JP Morgan study that found that people on GLP-1 drugs spent 8% less on food over a 12-month period than average American consumers[42].

- There is also some emerging evidence that indicates GLP-1 medication may also help to temper other addictive behaviours, from drugs, to alcohol, to gambling. One large study in the US found that those with drug and alcohol use disorders were significantly less likely to binge or overdose on opioids and alcohol while on GLP-1 prescriptions[43]. This may therefore also impact on volume sales of alcohol for many food retailers and food service businesses.

SOME GLP-1 USERS BUY DIFFERENT TYPES OF FOOD

The evidence on the impact of GLP-1s on food choice is less clear than the evidence demonstrating that the drugs reduce the volume of food purchased overall. Nevertheless, those studies that have explored the impact on food choice find evidence that many using the drugs do change their food purchasing habits as a result, with a shift away from energy-dense foods (snacks and confectionary products in particular):

- A 2023 survey by Morgan Stanley of 300 patients taking the drugs found that participants cut back the most on foods high in sugar and fat, reducing their consumption of confectionary, sugary drinks and baked goods by as much as two-thirds[44].

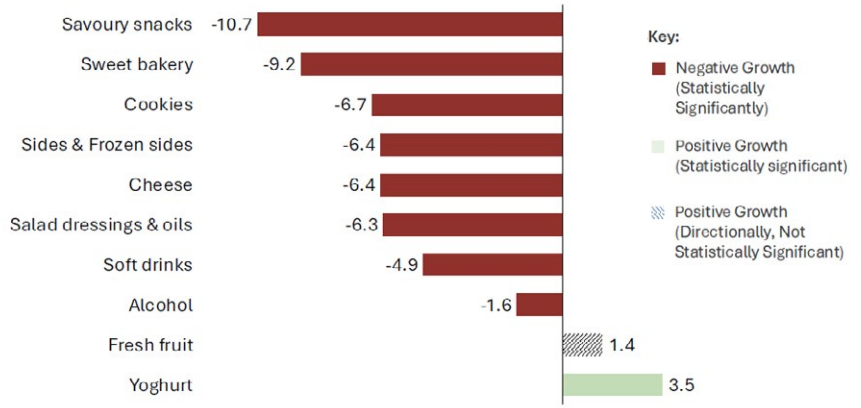
- A Danish study looking at 293 GLP-1 users and linking to supermarket receipts found that new GLP-1 users spent less on food supplies and purchased fewer calories, sugars, saturated fats, and carbohydrates, while modestly increasing protein purchases. The share of ultra-processed foods in shopping baskets also decreased[45].

- The representative US study referenced above identified the largest reductions in calorie-dense, processed categories, including an 11% decline in savoury snacks. They also found a drop in purchases of meat and some dairy products (in contrast to the Danish study) and a shift towards fresh produce and a significant increase in sales of yoghurt[46].
- Data from a Nielsen and Wells Fargo report in 2024 supports the findings that GLP-1 users buy more fruit and veg, although they also found evidence that GLP-1 users bought more energy drinks, soft drinks and spirits[47].
- The Agriculture and Horticulture Development Board (AHDB) predicts that GLP-1s may reshape the UK's dairy industry, citing data showing an increase in sales of plain yoghurt by almost 20% year on year and a 13% increase in sales of fat free yoghurt[48]; although this sales increase could be driven as much by wider interest in protein and gut health as an increasing number of GLP-1 users.
- GLP-1s are already being cited by companies as a potential driver of changing sales. Gregg's, for example, attributed falling profits in January 2026 to the impact of GLP-1s[49].
- Some speculate that GLP-1s are also having an impact on food commodity markets, with the price of sugar recently reaching a 5-year low and linked to increasing uptake of GLP-1s[50]. However, the impact of climate change and extreme weather on food supply chains may also be a driver here.

FIGURE 9: **% change in sales value by different food categories of GLP-1 users[51,52]**

Taken from transaction data, including receipts.

Source: Cornell/Numerator (2025); Dietary intake by patients taking GLP-1 and dual GIP/ GLP-1 receptor agonists (2024); Morgan Stanley consumer research (2023); Pyxis; Hall et al (2026); UCL health.



Assuming that widespread GLP-1 use does catalyse shifts in food choice and therefore consumer diets, it is likely we will see winners and losers emerging among the food industry and other organisations:

POTENTIAL LOSERS	POTENTIAL WINNERS
The snack and confectionary sector	Health focussed brands and businesses
Convenience stores, who often over index on HFSS impulse purchase options	Retailers with diverse portfolios, including those selling nutritional supplements
Companies with a large proportion of UPF and energy-dense foods in their portfolio	The fresh produce sector

Employers are also positioned to gain from improvements in their employees' health and overall wellbeing. In the United States, many companies are increasingly including GLP-1 medications for obesity in their employee benefits and health insurance plans, as they are seeing positive returns through higher retention and productivity, along with reduced absenteeism, healthcare expenses, and disability claims[53]. It is worth noting, however, that in a UK context this perhaps risks further equity issues for those employees working for organisations that do not offer health insurance but rely on the NHS alone. In the UK, GLP-1s are currently only partially covered by some but not all health insurance companies[54,55].

A NOTE ON SUSTAINABILITY

Although the current evidence is equivocal, many believe that wide-spread adoption of GLP-1s will benefit sales of protein and protein-rich foods, given that users tend to shift towards more nutrient-dense and satiating smaller portions of food. And protein certainly ought to play a role in the diet of GLP-1 users given the risk of muscle mass loss[56]. GLP-1s therefore need to be considered in the context of the need to shift diets towards more sustainable dietary patterns. Currently, 47% of food businesses' scope 3 emissions are driven by livestock production and consumption[57] and globally health and climate organisations agree that we ought to be eating less meat in order to meet both health and climate goals[58]. Food businesses responding to sales shifts driven by GLP-1 adoption should therefore look to ensure that high quality plant protein options are widely available and affordable so as not to inadvertently drive an increase in sales of meat.

WHAT MIGHT THIS MEAN FOR THE BROADER PREVENTION AGENDA?

While many remain optimistic that GLP-1s will catalyse a shift in dietary patterns by forcing businesses to shift away from energy-dense, often ultra-processed foods towards more nutrient-dense foods to meet changing demand, there remain risks and potential unintended consequences of assuming that changing demand will drive the market shifts needed to create a healthy food environment for all. For example:

- **Businesses may look to increase the price of food** to recoup any profits lost with a decline in volume sales, which would have a disproportionate impact on low-income households, with just under 6 million adults currently living with food insecurity[59].

- **Businesses may look to cater to existing GLP-1 users by launching premium versions of pre-prepared meals and products** that are designed and marketed to GLP-1 users[60]. This may potentially risk a further widening of dietary inequalities and the creation of a two-tier system if reformulation is then halted on standard range options. Already a number of major manufacturers and retailers have launched new products and ranges targeting GLP-1 users, with Marks & Spencer, Morrisons, Asda, Ocado and the Co-op among those targeting shoppers in January of this year with new GLP-1 focused launches. Many of these come with a price premium. The new Morrisons Counted and Protein ranges, for example, are priced at parity with larger sized range equivalents, which equates to a 35% price premium per 100g[61].

- **Governments may deprioritise policies and regulation aiming to shift the food environment** and ensure that healthy food is available and affordable to all, instead focussing on treatment over prevention. In such a scenario those not on GLP-1s in the wider population may be disadvantaged by a failure to progress the broader regulatory agenda to change the food environment, while those coming off prescriptions would simply return to food environments not optimally set up to support a healthy diet. A 'leave it to the market' approach would dominate.

- **Diet-related ill health is not solely driven by obesity and overweight.** For example, poor quality diets can lead to micronutrient deficiencies, diets high in sugar can cause dental decay, diets high in red and processed meat are strongly associated with an increased risk of cancer, and diets low in fibre can increase the risk of developing heart disease. While there is an assumption that diet quality may improve with

GLP-1s, it is not clear whether all those on the drugs significantly change the content of their diet or whether this only applies to a proportion of users. Some view GLP-1s as presenting an opportunity to increase focus and action on preventing and treating non-weight related ill health, speculating that once obesity is treatable focus will shift to improving other types of diet-related health (such as gut health), although this remains to be seen.

New products designed for GLP-1 users are increasingly being developed and launched by brands and retailers[62].

CONCERNS AROUND SIDE EFFECTS

GENERAL CONCERNS

Some of the more common symptoms of GLP-1s include gastrointestinal side effects in around 10% of patients, such as nausea, vomiting, diarrhoea, constipation, stomach pain and headaches. These symptoms can lead to dehydration and, in severe cases, kidney damage[63,64]. Less common but serious risks include gallstones, pancreatitis, severe allergic reactions and, in some cases, hypoglycaemia in non-diabetic users[65].

Furthermore, the Medicines and Healthcare products Regulatory Agency advises against use of GLP-1s during conception, pregnancy, or breastfeeding due to limited safety data among this population group. However, with 45% of all UK pregnancies unplanned[66], there is an urgent need for more research in this area[67]. Additionally, there are concerns around the possible reduced effectiveness of oral contraceptives for those on GLP-1 drugs[68], with many anecdotally referring to so-called 'Ozempic babies'.

NUTRITION RELATED CONCERNS

Studies have raised concerns over the potential of GLP-1s to cause nutritional deficiencies given the impact of the drugs on total food intake. For example, one study found that participants on GLP-1s consumed adequate amounts of some micronutrients (e.g. B-vitamins, copper, phosphorus, selenium, and zinc) but had insufficient intake of several others (e.g. calcium, iron, magnesium, potassium, choline, and vitamins A, C, D and E)[69]. It also found that participants overconsumed calories from fat and saturated fat and did not meet the daily recommended intake for fibre and protein. The knock-on effects of such deficiencies may impact on bone mass and on muscle mass loss, both of which may have long term impacts on health and normal growth trajectories, particularly for younger people on GLP-1s. This highlights the need for clear nutritional guidance for people on GLP-1s[70].

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Emerging evidence suggests that rapid weight loss linked to GLP-1s may reduce skeletal muscle mass, with potential knock-on implications for cardiovascular health[71]. The long-term implications of loss of muscle mass and bone density loss on health outcomes where these occur alongside fat loss are yet to be determined. Early data also indicate modest reductions in bone mineral density, though fracture risks remain unclear[72].

In young people, GLP-1s have shown strong short-term effectiveness for obesity and type 2 diabetes, improving metabolic health and wellbeing when combined with lifestyle changes. With the exception of liraglutide, the NHS can prescribe GLP-1 medications to under-18s if they are living with severe obesity, have serious health complications as a result of their weight, and all other interventions have failed[73,74]. However, long-term effects during growth and development remain uncertain. Appetite suppression could affect growth hormones, bone development and energy balance, and further research is needed[75,76].

There are also increasing concerns about eating disorders and associated misuse of GLP-1s. So far, studies show mixed effects on eating disorders, with some indicating potential benefits for those living with disordered eating, with the drugs reducing binge frequency and cravings through appetite suppression and reward pathway modulation[77]. However, those accessing GLP-1s through online private prescriptions may not have their BMI verified[78], and there are concerns that this may lead to those with already low BMIs and disordered eating using the drugs. Additionally, there are potential risks in that GLP-1s could worsen symptoms for some living with eating disorders by blurring hunger cues, reinforcing meal-skipping and food avoidance practices and risking malnutrition or refeeding syndrome[79,80,81,82]. To date, studies have been limited on the effects of GLP-1s on eating disorders and further research is needed. As a precaution, online prescriptions of GLP-1s ought to be much more tightly regulated.

GAPS IN THE EVIDENCE

There are currently a number of limitations in our knowledge of how GLP-1 medications will impact on population health and diet and health inequalities that require further research. These include:

- **The lack of studies looking at the longer-term impacts on health outcomes of sustained use of the drugs for longer than two years, and after initial weight loss has been achieved.**
- **There is a lack of evidence for the impact of GLP-1 'cycling', where users may come on and off the drug repeatedly, and the associated implications for weight loss and gain.**
- **The long-term impact on children and adolescents' health and growth trajectories where such drugs are prescribed to younger patients.**
- **Most studies looking at the impact of GLP-1s on food choice and intake rely on self-reported data. This can be very unreliable and is a key issue in nutrition science[83].**
- **The majority of studies looking at the impact on food choice and preference are small, with the current evidence base overwhelmingly based on US consumer data. There is a need for larger studies and more rigorous academic research in this area, with more representative UK data needed to be able to draw evidenced conclusions on the potential impact for the UK food industry.**

More generally there is a need for more participant diversity in randomised controlled trials and wider research to better understand the impact of GLP-1s on a broader spectrum of the global population (including in low- and middle-income populations, older people, adolescents, pregnant people; and those with comorbidities including depression)[84]. Further research is also required on the optimal duration, dosage pattern, and dosage of medication used[85].

CONCLUSION

Despite the many optimistic predictions being made for GLP-1s' potential to change the food system for the better by forcing companies to pivot towards healthier options in response to shifting consumer demands, some of this confidence should perhaps be tempered. There remain a number of gaps in the evidence base, wider unanswered questions around the potential impact on health equity, and the risk of unintended consequences from unregulated online prescription of the drugs and their long-term use. While there can be no doubt that GLP-1 drugs are a hugely helpful and effective treatment option for those living with obesity and related health conditions, it remains to be seen exactly what the impact will be in the long-run, and there is a lack of evidence on how such drugs impact on food choice in the UK. While access to GLP-1s as a healthcare treatment option for those who clinically need them ought to be expanded, if the government is serious about moving from sickness to prevention, expanded treatment must sit alongside stronger action and regulation to improve the food environment and prevent obesity in the first place.

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ENGAGEMENT QUESTIONS FOR INVESTORS

Investors in food businesses should focus on how GLP-1s are changing product demand, portfolios, pricing and business strategy. Below are some suggested questions investors could ask during their engagements with food businesses.

CONSUMER DEMAND AND PORTFOLIO MIX

- How are you tracking GLP-1 adoption in your core markets, and what assumptions about reduced calorie intake and basket size are embedded in your medium-term plans?
- Which of your brands or categories are most exposed to GLP-1 usage, and which stand to benefit (e.g. yoghurts, high protein, fresh fruit and veg)?
- What is your strategy for bolstering the availability and sales of categories that are most likely to benefit from wider GLP-1 usage? E.g. fresh fruit and veg, more minimally processed foods?

REFORMULATION AND INNOVATION

- How much of your NPD pipeline is aimed at "GLP-1 compatible" needs and how does this pipeline support healthier and more sustainable diets more generally?
- Where are you reformulating existing products versus launching new ones targeted at GLP-1 users?

CHANNELS AND PRICING

- How are GLP-1 driven behaviours (fewer eating occasions, more at home eating) playing out in your channels?
- Are you adjusting serving sizes to reflect lower consumption per occasion and how are you protecting margins while also bearing the affordability of nutritious food in mind?

DATA AND PARTNERSHIPS

- How precisely can you identify households or occasions influenced by GLP-1 usage (e.g. via retailers, health partners), do you have the digital infrastructure to measure this, and how are you disclosing and making use of that data?
- Are you exploring partnerships with healthcare providers, digital weight loss programmes etc. to support people to access healthier and more sustainable diets, as well as those on GLP-1s?

RISK, STRATEGY, AND CAPITAL ALLOCATION

- In your long-term scenarios, what is the downside case for volumes in your most exposed categories if GLP-1 adoption and competitor reformulation both accelerate?
- How are you reallocating capex and marketing from structurally declining segments to those categories likely to benefit from GLP-1s?
- Do you see GLP 1s as a cyclical threat that will be priced out, or as a structural shift in the food system, and how does that influence M&A, divestments, and portfolio strategy?

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