Fair Allocation of GLP-1 and Dual GLP-1–GIP Receptor Agonists

TO THE EDITOR: The distribution framework for glucagon-like peptide-1 (GLP-1) receptor agonists proposed by Emanuel et al. in their Perspective article (May 30 issue)[1] considers potential years of life lost (PYLL) from obesity-related disease, but not race. How can clinicians and policymakers implement this framework "irrespective of factors such as race" (Table 1 in the article) when race and ethnic group are strongly associated with both PYLL and the risk of obesity-related disease?

The PYLL metric — life expectancy minus the age at which a person dies — is seldom used in clinical medicine. But PYLL and life expectancy are often used to describe enormous racial health disparities.[2,3] In England, type 2 diabetes is more prevalent among Arab, Black, Chinese, and South Asian persons with obesity than among White persons with obesity, after accounting for age, sex, and body-mass index (BMI).[4]

The current framework doesn't address these salient associations with race and ethnic group. In light of a previous framework proposed by the authors, this omission is surprising. In 2023, the authors warned against distributing scarce resources according to standards that exacerbate "prior inequities based on life expectancy between races." They asserted that mitigating disadvantage — which is fundamental to distribution of scarce resources — might involve preferentially allocating resources toward persons disadvantaged by race or ethnic group.[5] However, their current, race-blind framework seemingly contradicts their previous, race-conscious framework. Why?

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TO THE EDITOR: We commend Emanuel et al. for proposing a framework to fairly allocate incretin mimetic drugs, given the limited supply. However, the identification of patients who will benefit most from such drugs cannot be achieved without assessment of cardiovascular risk. Relying on glycated hemoglobin levels and BMI (Table 2 in the article) is inadequate. The cardiovascular benefits associated with incretin mimetic drugs have been established only among persons at high cardiovascular risk.[1,2] Cardiovascular effects among persons who are not at elevated cardiovascular risk are uncertain. To maximize the benefits of a scarce resource, cardiovascular risk assessment is therefore essential.

The authors also prioritize younger patients over older ones to maximize the reduction in PYLL. For this survival benefit to be achieved, however, the supply shortage would need to continue for 10 to 20 years, which seems highly unlikely. Without a longer period to accrue benefit, an older person, whose age significantly increases their short-term cardiovascular risk, will benefit more from the use of an incretin mimetic than will a younger person. It is therefore more appropriate to focus on reducing immediate risk than on reducing the risk of premature death.

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THE AUTHORS REPLY: Our ethical framework for fairly allocating GLP-1 receptor agonists addresses the associations with race and ethnic group that Mensah and colleagues reference. We use a racism-conscious approach that is operationalized by means of the PYLL metric. Fashaw-Walters and McGuire describe racism-conscious policies as ones that address the "downstream manifestations of racism," whereas race-based policies allocate benefits and burdens on the basis of a person's race.[1]

Mensah and colleagues note that racism inflicts a disproportionate burden of type 2 diabetes on marginalized racial and ethnic groups. The same is true for severe obesity.[2] These disproportionate burdens in turn produce disparate loss of life at earlier ages, a loss which is itself a profound disadvantage.[3] A framework that considers PYLL recognizes and seeks to mitigate the disparate burden of premature death associated with obesity and diabetes without imposing a disadvantage on populations that have a shorter life expectancy. When the distinction made by Fashaw-Walters and McGuire is applied,[1] the use of PYLL is thus racism-conscious but not race-based.

In our published frameworks for allocating GLP-1 receptor agonists and other scarce medical resources, we do not propose allocation on the basis of self-identified or societally ascribed race, which would present legal, logistical, and ethical concerns. Racism-conscious frameworks are legally preferable to race-based frameworks.[4] They also are more applicable internationally because racism invariably worsens health even though patterns of racial categorization and subordination vary among countries.[5] Mensah and colleagues propose no alternative framework, thereby leaving their stance on race-based allocation unclear.

Allocation that is based on immediate risk, as proposed by Gong and Shaw, merits evaluation with respect to the ethical objectives we delineate. However, their proposal seemingly focuses only on maximizing benefit and ignores the importance of other fair-allocation objectives included in our framework. Mitigating disadvantage is not simply a means of maximizing the benefits of scarce medical resources. It is an independently valuable end. Focusing solely on immediate risk of death and ignoring PYLL would not mitigate the disproportionate disadvantage of premature death.[3] We welcome efforts to model the outcomes of different allocation frameworks, including frameworks incorporating evolving data on cardiovascular risk, but remain committed to the importance of equal concern and mitigation of disadvantage.

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Since publication of the article, the authors report no further potential conflict of interest.

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