

# Evidence Over Ego: How Australian Private Digital Weight-Loss Services Need to Respond to Continual Scepticism from Prominent Medical Bodies

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**Abbreviations:** WHO: World Health Organization; MDT: multidisciplinary team; F2F: face-to-face; PDWLSs: private digital weight-loss services

Rising obesity prevalence has emerged as arguably the most serious international public health concern of the modern era [1, 2]. Experts typically attribute the issue to several factors, including urbanization; automation and technological development; and the spread of Western culture [3, 4]. A factor that does not receive nearly as much attention in these discussions as it should is the ineffectiveness of traditional weight-loss therapy. While it is now widely accepted that obesity is a chronic disease of unique complexity, commentary around the complications of treating the disease in traditional care settings is scarce. The World Health Organization (WHO) emphasizes in their 2023 obesity management framework that “lifelong support” and a “full spectrum of services” should be essential features of national obesity strategies [5]. This indicates that patients need to have access to a coordinated, multidisciplinary team (MDT) of clinicians for both regular, scheduled consults and those of an ad-hoc nature. For anyone with significant work or family commitments, acquiring this level of access through face-to-face (F2F) clinics is incredibly difficult. The degree of difficulty increases for anyone living outside a city center.

In response to this challenge, numerous private companies have launched digital weight-loss services in recent times. By delivering care through digital platforms, providers can largely relieve patients of the significant temporal and emotional burden of attending ongoing consults across multiple F2F clinics. Well-designed platforms can also improve care coordination, as they facilitate data centralization – a process that many public health systems have struggled with [6, 7]. Despite the growing uptake of private digital weight-loss services (PDWLSs), research on their safety and efficacy is underdeveloped. Providers of these services often cite general telehealth studies in attempts to justify the quality of their modality [8, 9]. However, many medical bodies remain sceptical and appear determined to steer overweight and obese patients away from digital clinics [10]. The tension has been particularly salient in

Australia where certain primary care organizations and PDWLSs have been trading criticisms in the media for well over a year.

It appears that PDWLS sceptics in Australia base their sweeping criticisms of the modality on low-quality varieties, failing to recognize the broad quality spectrum. A popular low-quality PDWLS in Australia, for example, simply connects patients with GPs, who then do no more than write eligible patients scripts for weight-loss medications [11]. Higher-quality PDWLSs connect patients with a coordinated MDT that guides them through personalized comprehensive treatment on an ongoing, proactive basis [12]. They also have safety mechanisms embedded in the service's platform to protect patients from human errors and alert MDTs of severe adverse events. Yet, rather than targeting lower-quality PDWLSs, Australian primary care organizations have repeatedly cast aspersions on the sector as a whole [13]. This approach seems unreasonably conservative given the difficulty of accessing quality weight-loss treatment in traditional settings and the emerging body of evidence of the quality of digital care for other chronic conditions such as mental illnesses and diabetes [14–16]. However, instead of persisting with heated disputes in the media, PDWLSs should view the criticisms as a blueprint for their clinical research strategies. Generating rigorous quality and safety evidence should be a cornerstone of every novel care provider. This article aims to identify the precise concerns that Australian medical bodies have raised against PDWLSs to guide future research on a care modality that could vastly improve obesity outcomes.

## The Concerns

Over the past year, three clear themes have emerged in the arguments of Australian primary care organizations against PDWLSs. To emphasize the tendency to group all PDWLSs in these arguments, the following analysis only selected media articles that made specific references to a company that claims to distinguish itself from competitors as a high-quality PDWLS, Eucalyptus. It is feasible that sceptics single out Eucalyptus because the company is the largest PDWLS provider in Australia and is perceived to have the greatest influence on public health, having already expanded its operations to Germany, Japan, and the UK.

According to sceptical Australian medical bodies, PDWLSs:

### 1. Prioritize business interests over healthcare standards.

“We also know that McDonald's is also a very convenient service, but it's not necessarily one that's very healthy in the long term.” [10]

“The direct-to-consumer marketing approach such companies are taking is ‘disturbing’... It's a language that's trying to hook patients, selling them something they want to hear.” [17]

“This (the stricter national Telehealth guidelines) is a healthcare decision, it's not a business solution.” [18]

### 2. Compromise prescription safety standards

“They're (PDWLSs) missing a whole heap of potential information... Oftentimes I'll (as an in-person GP) have a patient's chart – years' worth of history – and it won't be until I'm looking through and say ‘Oh, hang on, what about this?’ [and they'll say] ‘Oh, I didn't think that was relevant.’” [17]

“Prescribing is not a tick and flick exercise... It relies on a doctor's skill and judgement, having consulted a patient, and recognizes that prescription medication can cause harm when not used properly.” [18]

“There are lots of potential potholes – it relies on the patient's abilities to understand their health... They need to be proactive, honest – because it doesn't seem to be a two-way communication where the doctor can actually be clarifying any concerns.” [19]

### 3. Fragment care and disregard the importance of care continuity

“Obesity management should be provided in the context of a supportive multidisciplinary program... Services offering unitary approaches to chronic health conditions such as obesity, that on the face of things may seem patient friendly and offer convenience, lack the integration of ‘whole of health’ approaches.” [20]

“Those local practitioners will know what’s happening in their local community regarding access to food, what the shops are like, what the tips and practical tricks are regarding lifestyle change... So, I just feel there is less quality of care, less holistic care (from PDWLSs)” [17]

“X says telehealth providers tend not to know patients’ families like GPs do. And X worries about the care being ‘fragmented’, with no GP knowing every medication a patient is taking or following up if medicines are not being used.” [10]

All three themes were present in a recent radio debate between the President of Australia’s largest general practice organization and the CEO of Australia’s largest PDWLS provider (Table 1).

Concern theme	Quotes from the President of Australia’s largest general practice organization	Response from the CEO of Australia’s largest PDWLS
PDWLSs prioritize business interests over healthcare standards.	“We know we can go to Maccas and that’s nice and easy, but that’s not where we get long-term care from.”	<p>“This trade-off between safety and convenience. I just don’t think it’s a necessary trade-off...</p> <p>We’ve had far less (percentage) of reportable (prescribing) incidents than your standard GP clinic.”</p> <p>“The other reason people are coming to us is because we deliver outcomes over time.”</p>
PDWLSs compromise prescription safety standards.	“...they (GLP-1 RAs) interact with other drugs and cause complications for other conditions. It’s important for patient safety that there’s oversight...”	<p>“We have stricter guidelines than clinics because we have so much oversight - we see everything that happens on the platform.”</p> <p>“We refer fifty percent of our patients back to their regular GPs when that’s the right option.”</p>

PDWLSs fragment care and disregard the importance of care continuity.	“What happens when you start fragmenting and breaking medical care down into silos and not having continuity are all sorts of issues around safety – and no one’s monitoring.”	“We also have a high continuity care team where patients are being checked on weekly in many cases”
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**Table 1:** Australian medical body concerns about PDWLSs.

## The Opportunity

Certain PDWLSs could argue that they have been unfairly tarred with the same brush as their lower-quality competitors. They could also continue to engage in shouting matches with their sceptics, and possibly return from some with a sense of victory. But neither of these approaches will result in an optimal outcome for their businesses or for people living with overweight and obesity. Australian medical bodies have done all PDWLSs a favor in repeatedly questioning the quality and safety of the modality. In doing so, they have given providers a clear blueprint for demonstrating the legitimacy of their unique care models before stakeholder scepticism ends their business.

To address the concerns around prescription safety, PDWLSs have two obvious options. They could release an independently verified open-source portal that explains the processes its clinicians adopt to ensure safe prescribing, and/or publish these processes in peer-reviewed research, which should also seek to analyze medication prescribing and dispensing error rates. To demonstrate the care continuity of their programs, PDWLSs should quantitatively examine patient engagement rates through measures such as frequency of MDT contact, average time spent on the program app, and the type of engagement with the app, *e.g.*, diet and exercise tracking *vs.* the use of educational tools. Data from patient satisfaction surveys would likely supplement these findings. The criticism about prioritizing business interests over care standards arguably does not align as well with a distinct assessment tool. However, given the ultimate purpose of weight-loss services and the nature of the ‘McDonaldization’ commentary, it would appear logical that PDWLSs prove they “deliver outcomes over time” by publishing peer-reviewed sustainability studies that measure outcomes after patients discontinue the service. It is possible that peer-reviewed publications of the above results will lay bare the scarcity of such literature on F2F settings and stimulate research in that field as well. Finally, scholars should look to investigate the reasons why patients are using PDWLS instead of F2F alternatives in order to establish the degree to which digital modalities mitigate access barriers to obesity care.

Australia and many other nations have a growing obesity problem that is exacerbated by care access issues. Digital care models represent a means of overcoming the significant temporal, emotional, and geographical barriers to obesity treatment, which requires ongoing care from an MDT. However, these models cannot be widely embraced until there is rigorous evidence of their quality and safety. Until PDWLSs provide such real-world evidence, the medical industry’s scepticism of the modality should and will continue. The longer it takes to present this evidence, the longer many people may have to wait until they can access quality obesity care.

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## References

1. NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in body-mass index, underweight, overweight, and obesity from 1975 to 2016: a pooled analysis of 2416 population-based measurement studies in 128.9 million children, adolescents, and adults. *Lancet*. 2017;390(10113):2627-642.

2. OECD. Health at a Glance 2023: OECD Indicators. Paris: OECD Publishing; 2023. Overweight and obesity; p. 94-95.
3. Harvard T.H. Chan. Obesity Prevention Source. 2023.
4. Fox A, Feng W, Asal V. What is driving global obesity trends? Globalization or "modernization"? Global Health. 2019;15(1):32.
5. World Health Organisation. Health service delivery framework for prevention and management of obesity.
6. OECD. Integrating Care to Prevent and Manage Chronic Diseases: Best Practices in Public Health. Paris: OECD Publishing; 2023.
7. Davey M. My Health Record: after 12 years and more than \$2bn, hardly anyone is using digital service. The Guardian. 2022.
8. Talay L. Does telehealth compromise patient outcomes by fragmenting care? 2024.
9. Oviva. Next in healthcare: digital care, what is it? 2023.
10. Bonyhady N. 'Pill mills' or the future of medicine? The rise of the telehealth industry. The Sydney Morning Herald. 2023.
11. McKenna K. 'Instant' prescription providers prompt warnings from GPs and pharmacists. ABC News. 2020.
12. Talay L, Vickers M. Effectiveness and care continuity in an app-based, glucagon-like peptide-1 receptor agonist-supported weight-loss service for women with overweight and obesity in the UK: A real-world retrospective cohort analysis. Diabetes Obes Metab. 2024;26(7):2984-987.
13. Swan D. Australia's largest online weight-loss business at loggerheads with regulators. Sydney Morning Herald. 2024.
14. Bond RR, Mulvenna MD, Potts C, et al. Digital transformation of mental health services. Npj Ment Health Res. 2023;2(1):13.
15. Shan R, Sarkar S, Martin SS. Digital health technology and mobile devices for the management of diabetes mellitus: state of the art. Diabetologia. 2019;62(6):877-87.
16. Rhee SY, Kim C, Shin DW, et al. Present and Future of Digital Health in Diabetes and Metabolic Disease. Diabetes Metab J. 2020;44(6):819-27.
17. Tsirtsakis A. Debate over 'doctor-approved' weight loss drugs obtained online. newsGP. 2023.
18. Attwooll J. 'Clear and consistent' telehealth rules to start in September. newsGP. 2023.
19. SBS. A quiz, an email and a delivery: Why online sales of weight-loss drugs could be reined in. 2023.
20. Woodley M. Telehealth provider defies TGA semaglutide request. newsGP. 2023.

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