thrivable

HOW GEOGRAPHY AND URBANICITY SHAPE GLP-1 ACCESS, EXPERIENCE, AND OUTCOMES IN THE UNITED STATES

Insights from 1,000+ GLP-1 candidates and 130 healthcare providers.

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Introduction: High Need, Uneven Access

GLP-1 therapies are transforming obesity care and reshaping expectations for what effective treatment can look like. But even as demand surges, access to these medications remains uneven—and often misaligned with where clinical need is greatest. National obesity maps consistently show the highest disease burden concentrated in the South and in rural communities. Yet in our latest research, drawn from more than 1,000 GLP-1–eligible individuals and 130 healthcare providers, these same regions are least likely to be using a GLP-1, least likely to receive a provider recommendation, and most likely to discontinue therapy.

These gaps represent more than geographic variation. They signal a breakdown in the GLP-1 patient journey—one shaped by differences in provider familiarity, insurance coverage, rural access constraints, and patient motivation. And importantly, they appear in the very populations who report the strongest improvements in satisfaction and quality of life when they stay on therapy.
For commercial and brand leaders, this mismatch between where need is highest and where engagement is lowest creates a clear strategic challenge. Understanding how geography and urbanicity influence awareness, initiation, and persistence is essential for deploying resources effectively, shaping targeted education, and identifying high-impact markets where support can drive disproportionate value.

This whitepaper examines these regional and rural-urban dynamics in depth, revealing where the GLP-1 funnel breaks down—and what those breakpoints mean for teams responsible for driving reach, uptake, and sustained patient success.

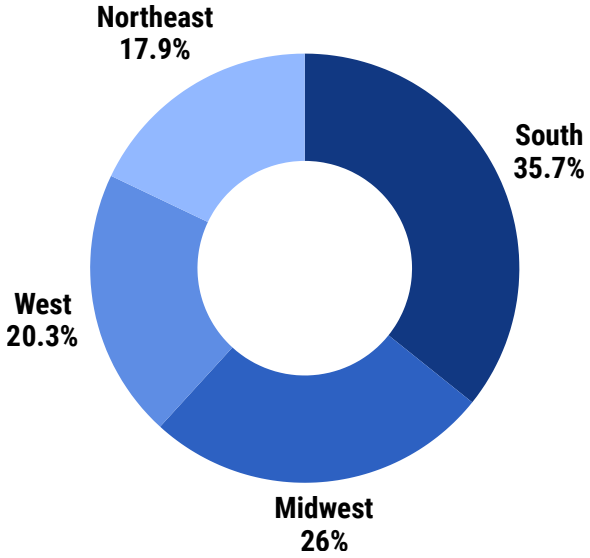
The South and Rural Areas Lag Behind in GLP-1 Adoption Despite Comparable Clinical Need

In our sample of 1,049 GLP-1-eligible individuals (BMI > 30 or BMI >27 with a qualifying health condition), the regional distribution was: South 35.7 %, Midwest 26.0 %, West 20.3 % and Northeast 17.9 %. These proportions align with national adult obesity prevalence patterns—where the South and Midwest carry the highest burdens—supporting the validity of our sample's regional spread.

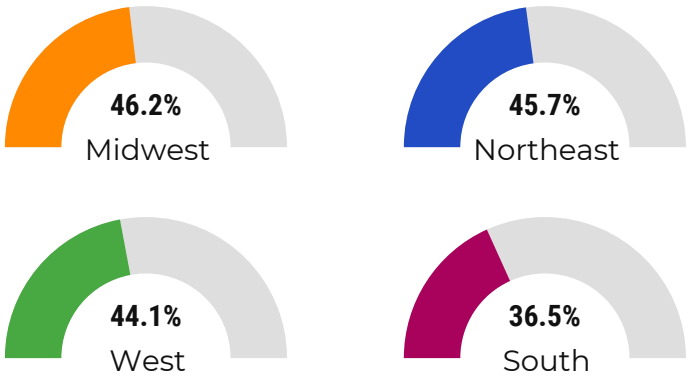
While the south constituted the largest GLP-1 eligible pool at 35.7%, it also had significantly lower levels of current users suggesting environmental, economic, and healthcare access barriers that go beyond individual-level clinical factors.

Patient Representation by Region

n = 1,049



GLP-1 Use by Region



Specialty Care Differences

Those in the South were least likely to report being under care of an endocrinologist (30.7%), with those in the Northeast reporting significantly more endocrinology oversight (47.3%). Notably, those not under the care of an endocrinologist were significantly more likely to discontinue their GLP-1 (17.3% v. 12.5%).

Urbanicity Factors

Respondents from the South were also most likely to reside in a rural area, significantly more so compared to those in the West (28.8% v. 20.7%) and significantly less likely to reside in an urban area (20.3% in the South v. 29.8% and 31.0% in the Northeast and West, respectively). Those living in a rural area were significantly less likely to use a GLP-1 (35.9% v. 45.8% and 43.9% for urban and suburban residents, respectively).

GLP-1 USE BY UBANICTY

n = 1,049

45.8% **43.9%** **35.9%**

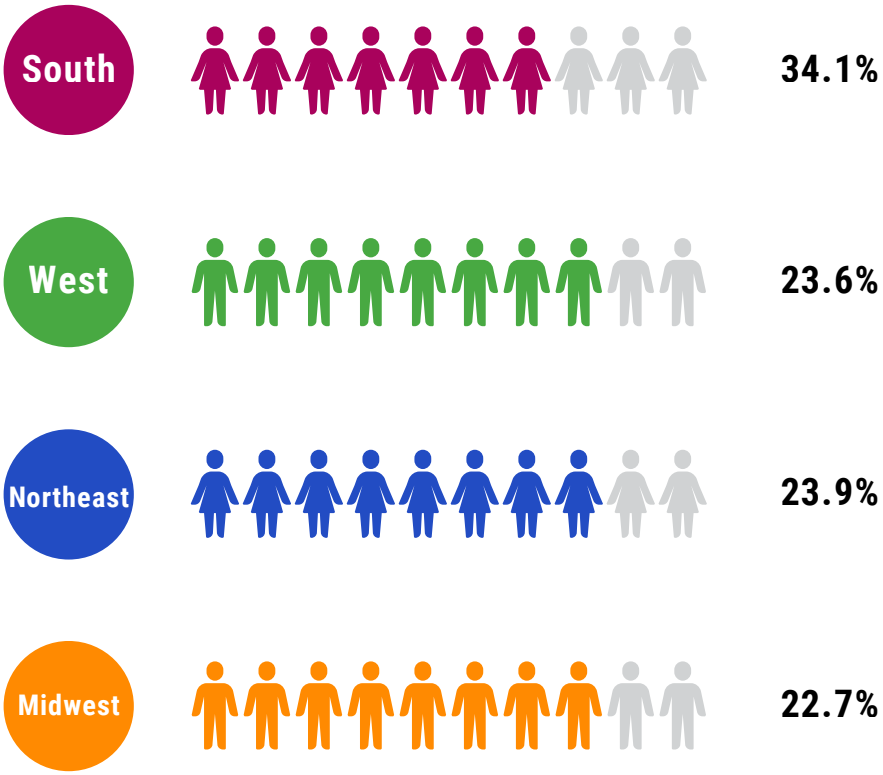
Insurance Disparities

The South reported the highest proportion of uninsured at 5.3% of respondents, significantly more as compared to only ~1% or less in other regions. Access to insurance coverage is crucial: 49.5% of those with private health insurance in our sample were current GLP-1 users, compared to just 12.5% among the uninsured.

The South's High Discontinuation Rate

Across everyone in our sample who had ever used a GLP-1 (n=607), discontinuation rates were highest in the South. Southern respondents were significantly more likely to have stopped using their GLP-1 compared with ever-users in other regions: 34.1% in the South vs. 22.7% in the Midwest, 23.9% in the Northeast, and 23.6% in the West.

GLP-1 ATTRITION BY REGION
n = 607



The data points to a critical vulnerability in the Southern treatment pathway—patients may be reaching GLP-1 therapy, but they are not staying on it.

When Patients Stay on Therapy, It Works —Especially in the South

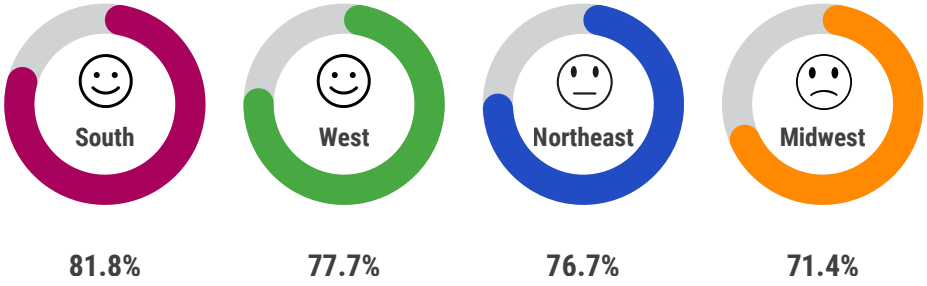
GLP-1 Satisfaction

Despite these access and retention challenges, Southern patients who do remain on GLP-1 therapy report the greatest satisfaction and quality of life benefits of any region.

Across the segment of current users (n=443), people are generally satisfied with their current GLP-1. Strikingly, those in the south report significantly higher satisfaction levels (top 2 box) as compared to other regions.

GLP-1 SATISFACTION BY REGION

n = 443

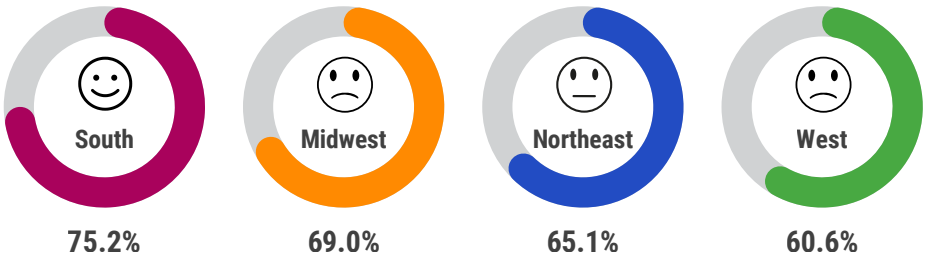


Quality of Life Metrics

Respondents from the South were most likely to report an improvement in their quality of life since starting on a GLP-1 (top 2 box). This finding underscores the urgency of addressing access barriers in the South—the potential for impact is exceptionally high.

QUALITY OF LIFE IMPROVEMENT AMONG GLP-1 USERS

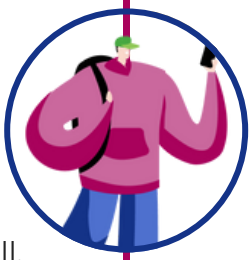
n = 443



Being on this drug has given me my life back. It's made it to where I can walk. I can run a whole mile. I can walk probably 10 or 11. I have a full-time job now and before I didn't. It's given me my life back and let me be a present grandma and I don't really think about food very much and I have to meal prep to remember to eat because if I don't meal prep I will not remember to eat at all.

It's made me have my best A1C and lowest weight in probably two decades, so it's very much changed my life for the better. I hope it continues to do so, or perhaps they'll come out with an even better version, but I'm pleased with it so far, very much.

The most noticeable benefit I find is the absence of the food noise. And, like, it's life-changing because I'm not thinking about food like I used to, and how I used to think about food felt like an addiction rather than a legitimate need to eat. Like, I still like food and everything, but it's not the strong urge that I used to have before. So I am happy about that, and I'm, you know, having some steady, consistent weight loss as well.



Just that craving to eat was all but gone and my body seemed to overall be metabolizing like a well oiled machine. I still get the fullness or sensation of being full but not to the point of discomfort. And that was a big seller for me.

These patient verbatims come from a separate qualitative research initiative conducted by Thrivable during the same period. These insights reflect the experiences of GLP-1–eligible or current/former users in Southern states; they were not part of the quantitative survey dataset analyzed in this whitepaper.

HCP Insights: Familiarity and Patient Demand Vary Across Geographies

Insights from 130 healthcare providers add context to the patient experience.

The challenge is intensifying. Patient journeys are fragmenting across therapies, providers, and geographies. Commercial timelines are compressing. Traditional approaches, designed for a slower research cycle, now deliver static snapshots that miss the moment. This leaves leaders exposed to:

Rural Providers Report the Lowest Familiarity with GLP-1s

Rural HCPs were least likely to be “very familiar” (top 2 box) with GLP-1s as compared to urban and suburban counterparts. Urban providers were significantly more likely to be very familiar with GLP-1 that rural practitioners.

GLP-1 FAMILIAR HCPS BY AREA

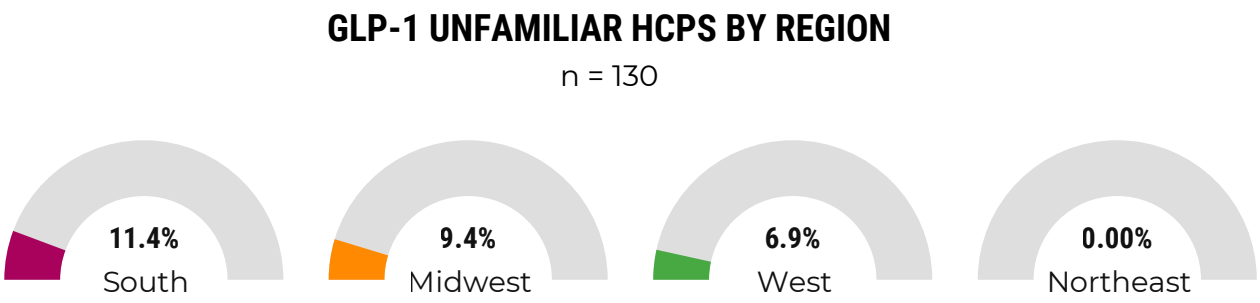
n = 130

88.9% 76.9% 60.0%

Strikingly, only 13.3% of rural HCPs reported being "extremely familiar” with GLP-1 drugs, significantly less than 63.5% and 44.2% in suburban and urban areas, respectively.

Southern Providers Are Most Unfamiliar with GLP-1

Providers in the South were most likely to be unfamiliar (bottom 2 box) with GLP-1 compared to other regions.



Patient Demand Is Rising—But Less in Rural Areas

When asked how patient demand for GLP-1s has changed over the past year:

- Over 85% of providers across all regions reported increased demand
- But only 63.6% of rural providers said demand had risen, significantly lower than in urban and suburban counterparts (87.9% and 85.4%, respectively). No such difference was observed by region.

This highlights a potential rural awareness gap and emphasizes that urbanicity is just as important as regional identity in shaping GLP-1 adoption. Altogether, the HCP findings align with our patient survey findings that fewer people in rural areas and the south use GLP-1s.

The Initiation Gap: Why Southern Patients Start GLP-1s Less Often

Digging into the motivations behind GLP-1 initiation reveals important regional differences.

Doctor Recommendation is Lower in the South

Southern respondents were least likely to report that they initiated a GLP-1 due to a doctor recommendation.

Doctor Recommendation is Lower in the South

This mirrors provider-side data showing lower GLP-1 familiarity among Southern healthcare professionals—and suggests that many patients may not be receiving strong guidance or encouragement from their clinicians.

Improving Blood Glucose Is a Less Common Motivation in the South

While weight loss was the most consistent motivator across all regions—with about three-quarters citing it as a primary reason for starting a GLP-1—other drivers varied.

Improving blood glucose control was less motivating for Southern respondents, while those in the West were significantly more likely to say blood glucose improvements were a motivator for therapy initiation (n = 607, GLP-1 ever-users).

PROVIDER RECOMMENDATION AS A INFLUENCER OF GLP-1 INITIATION

n = 607

BLOOD GLUCOSE CONTROL AS A MOTIVATOR TO START ON GLP-1

n = 607

This reflects what may be a broader mindset difference: Southern patients may be approaching GLP-1 therapy more through the lens of weight, while other regions are integrating both glycemic control and cardiometabolic outcomes more fully.

The Discussion-to-Initiation Gap: A Key Breakpoint in Southern Care

Patients in the South are just as likely as those in other regions to talk with their clinician about these medications.

Yet they are far less likely to begin treatment—and even less likely to remain on it.

This reveals a critical breakpoint somewhere between the conversation, and the path to prescription, initiation, and continuation.

Possible explanations include:

- Provider discomfort or limited familiarity
- Insurance-related barriers
- Perceived cost or out-of-pocket concerns
- Cultural hesitancy
- Systemic access challenges in Southern healthcare settings

Understanding and addressing this gap is essential for improving equitable access.

Cost and Coverage Are the Most Consistent Barriers Across All Regions

Across our HCP sample, cost and insurance coverage were cited by over 85% of providers as the primary barriers preventing patients from starting or staying on GLP-1 therapy. Notably, this pattern did not differ by region or practice setting, indicating that affordability concerns are a universal constraint in GLP-1 access.

Among GLP-1–eligible individuals who are not currently using a GLP-1 (n=442), the same trend emerged: more than half reported cost or easier insurance coverage as factors that would make them more likely to try a GLP-1.

Together, these findings reinforce that financial and coverage barriers, not lack of interest or awareness, remain the dominant obstacles to adoption—even in high-need regions.

One of the most striking findings is there were no regional differences in the proportion of people who discussed a GLP-1 with their provider.

Synthesizing the Data: Geographic Access and Retention Gaps

Across all patient and provider datasets, a clear narrative emerges:

Southern patients discuss GLP-1s just as often as other regions,

- But they are less likely to receive a doctor recommendation
- Less likely to initiate therapy
- More likely to discontinue
- And yet, when they stay on therapy, they report the strongest improvements in quality of life

Taken together, this pattern reveals a treatment landscape filled with preventable barriers—and immense upside if those barriers are addressed.

Opportunities to Improve Equity and Outcomes for Commercial and Brand Leaders

The insights in this whitepaper surface a clear challenge—and opportunity—for commercial and brand teams: regions with the highest obesity burden and the strongest reported benefits from GLP-1 therapy are also the regions where recommendation, initiation, and continuation lag most. These patterns reflect differences in provider familiarity and structural access factors—particularly insurance—not patient interest.

Strengthen Provider Support in Low-Familiarity Markets

Southern and rural clinicians were substantially less familiar with GLP-1s, and their patients were the least likely to receive a provider recommendation. Increasing adoption begins with equipping the clinicians who manage most obesity care in high-burden regions.

High Impact Actions

- Prioritize field-force deployment in underpenetrated regions
- Deliver tailored GLP-1 education for PCPs and NPs who lack endocrinology support
- Provide region-specific initiation guidance, dosing confidence tools, and coverage insights

Improving provider readiness addresses key early breakpoints in the GLP-1 journey.

Use Strong Real-World Outcomes to Build Local Confidence

Southern patients who remain on GLP-1 therapy reported the highest satisfaction and QOL improvements of any region. These outcomes provide a powerful opportunity to reinforce value where hesitancy or access hurdles may be greatest.

High Impact Actions

- Highlight regionally relevant outcome stories in provider and patient materials
- Feature functional improvements (energy, appetite control, mental health) that strongly resonate with patients
- Provide real-world evidence summaries contextualized for local populations

This reinforces the therapeutic value where barriers remain high.

Reduce Cost and Coverage Barriers That Prevent Initiation

While discussion rates were similar across regions, Southern patients were significantly less likely to start therapy—and our data point to cost and insurance barriers as the dominant drivers. Southern respondents were most likely to lack insurance coverage (5.3%), a likely contributor to lower adoption and higher attriton. Over 85% of HCPs cited cost and coverage as the primary obstacles their patients face. Among GLP-1–eligible individuals not currently using a GLP-1 (n=442), more than half said lower cost or easier insurance coverage would make them more likely to try one. Uninsured individuals were also four times less likely to be active GLP-1 users (12.5% vs. 49.5% privately insured).

High Impact Actions

- Offer payer-specific coverage guides aligned to regional Medicaid, ACA, and commercial plans
- Provide tools that clarify deductible, co-pay, and out-of-pocket expectations
- Equip clinicians with clear, simple materials that help patients understand coverage pathways

These interventions directly target the most widely reported barriers to GLP-1 initiation—affordability and coverage—not region-specific motivations.

The geographic patterns in GLP-1 engagement reveal access and structural frictions—not differences in clinical need or motivation. For commercial leaders, targeting provider support, coverage navigation, and regionally relevant value communication represents an opportunity to improve the efficiency of resource deployment and unlock disproportionate growth in high-need markets.

A Clear Call to Action for Commercial and Brand Leaders

This research surfaces a critical market reality: GLP-1 access is not aligned with need. The South and rural America carry the highest obesity burden yet show the lowest recommendation, initiation, and continuation rates—despite reporting the strongest quality-of-life gains once on therapy. These gaps represent more than geographic differences. They are missed opportunities for patients and lost value for brands.

For commercial and brand leaders, the imperative is clear: Invest where the need is greatest and the impact is highest.

That means focusing on the structural and provider-driven barriers that stall the patient journey—not on top-of-funnel awareness.

Brands that act now will:

- Equip clinicians in low-familiarity markets to confidently recommend therapy
- Break coverage and affordability bottlenecks that prevent initiation
- Reinforce real-world value with regionally relevant evidence
- Expand adoption and persistence exactly where unmet need is most concentrated

Closing: Win by Addressing Geographic Inefficiencies

In a category defined by demand, the next frontier of growth will come from addressing geographic inefficiencies—not generic market expansion. The data in this whitepaper provide a roadmap. The opportunity is disproportionate. And the time to act is now.

Appendix

Important Context for Understanding Geographic Patterns

Because this was a non-probability sample with quotas ensuring minimum representation of current, former, and GLP-1–eligible non-users, results should be interpreted as directional patterns within this sample rather than national prevalence estimates. The geographic and urbanicity-related disparities identified in this whitepaper are directionally supported by national research, but several considerations are important for interpreting the results accurately. While state-level studies confirm substantial variation in GLP-1 prescribing across the United States, the exact regional pattern observed in our survey (e.g., the South consistently lowest) does not appear identically in all external datasets. Analyses from the Journal of the American Heart Association, for example, show wide state-level differences in GLP-1 fills and spending, though the geographic pattern does not always align cleanly with Census regions.[1] Additional industry analyses similarly highlight uneven adoption across states, but without a uniform North–South divide.[2]

Our findings related to rural–urban differences—including lower provider familiarity and lower HCP-perceived patient demand in rural areas—reflect the experiences reported within our sample. However, a large national analysis of MEPS data found no statistically significant rural–urban difference in actual uptake of newer diabetes medications, including GLP-1 receptor agonists.[3]

Taken together, this suggests that rural disparities may be more evident in awareness, comfort, and provider experience than in prescriptions captured in claims data.

The elevated discontinuation rates among Southern respondents without diabetes extend existing national evidence showing high early discontinuation of GLP-1 therapy across the U.S.[4] Notably, no national dataset has demonstrated region-specific persistence gaps, making this pattern a novel contribution of our analysis.

Lower provider recommendation rates in the South align with broader evidence that prescribing confidence and familiarity with GLP-1s vary across provider types and practice settings.[5] However, regional differences in familiarity or recommendation behavior have not been comprehensively mapped in prior literature. Similarly, motivational differences—such as Southern respondents being less likely to cite blood glucose control as a driver of initiation—are consistent with national trends showing weight-forward demand for GLP-1s,[6] but have not been widely analyzed by geography.

Finally, our dataset reveals a discussion-to-initiation gap in the South: patients report discussing GLP-1 therapy at similar rates across all regions, yet are significantly less likely to start or continue treatment. National studies confirm large gaps between eligibility and initiation for GLP-1 therapies,[7] but few analyses have examined how these breakpoints differ regionally. Given that the South carries the highest burden of obesity and diabetes in the country,[8] the disparities we observe represent a meaningful equity concern rather than a reflection of lower clinical need.

In summary, our findings align with established evidence of geographic variation in GLP-1 utilization while adding new insight into regional discontinuation patterns, rural provider familiarity, and the discussion-to-action gap. These results should be interpreted as directional but not definitive, offering important hypotheses for future research and actionable opportunities for commercial and clinical stakeholders.

References

1. Geographic variation in GLP-1 prescribing (state-level / JAHA)
Khan T, Tsipas S, Loustalot F, et al. State-Level Variation in GLP-1 Receptor Agonist Fills and Spending by Obesity Prevalence, 2023. Journal of the American Heart Association. 2025;14(3):e043137. doi:10.1161/JAHA.125.043137.

2. Additional market evidence of state-level GLP-1 variation (industry report)
PurpleLab / Axios. U.S. Obesity Market Analysis: Exploring Demographic & Geographic Disparities in GLP-1 Use. November 2024. (Industry analysis).

3. No rural–urban difference in GLP-1 uptake (MEPS-based study)
Zhu B, Ding D, Luo J, Glied S. Rural–Urban Disparities in the Uptake of New Diabetes Medications Among U.S. Adults With Diabetes. Diabetes Spectrum. 2025;38(1):49–57. doi:10.2337/ds23-0075.
4. High national discontinuation rates for GLP-1s

Blue Cross Blue Shield, Blue Health Intelligence. GLP-1 Trends: Utilization, Costs, and Persistence. BCBS Issue Brief. 2024. Available at: https://www.bcbs.com/media/pdf/BHI_Issue_Brief_GLP1_Trends.pdf

5. Provider familiarity and prescribing confidence vary across provider types
Medical Economics. GLP-1s: A Blessing and a Burden for Primary Care. 2024. Available at: https://www.medicaleconomics.com/view/glp-1s-a-blessing-and-a-burden-for-primary-care

6. Weight-forward demand dominates GLP-1 initiation (national context)
“Study Identifies Benefits and Risks of GLP-1 Drugs Across 175 Health Outcomes.” JAMA. 2025;333(12):1023. doi:10.1001/jama.2025.0542.

7. National eligibility–to-initiation gaps for GLP-1 therapy
Vahratian A, Warren A. GLP-1 Injectable Use Among U.S. Adults With Diagnosed Diabetes: United States, 2024. NCHS Data Brief No. 537. National Center for Health Statistics; 2025.

8. Regional obesity burden context (CDC maps)
Centers for Disease Control and Prevention. Adult Obesity Prevalence Maps. 2025. Available at: https://www.cdc.gov/obesity/data/prevalence-maps.html