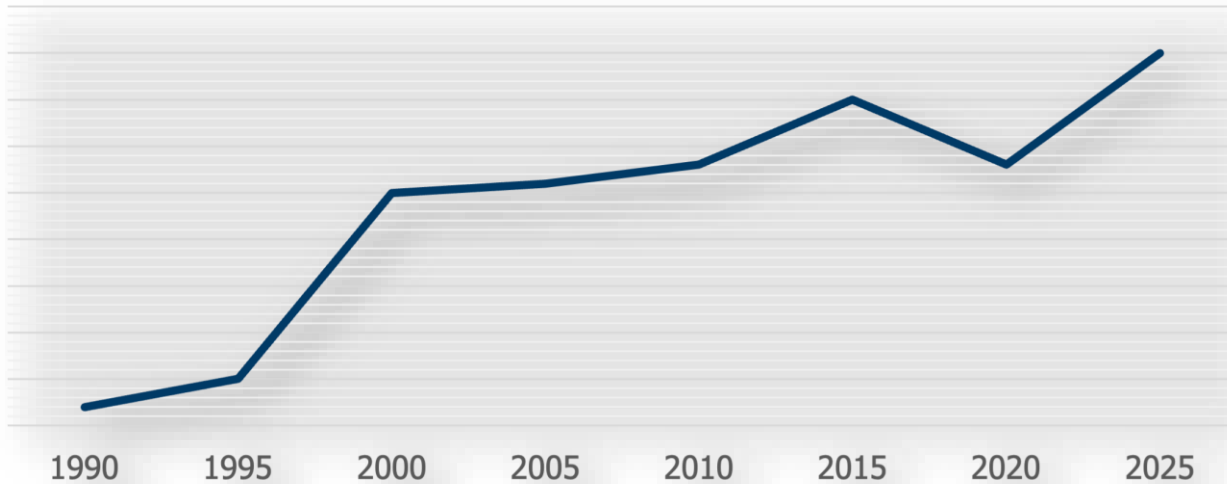


Standard Coverage will prevail for the Treatment of Obesity

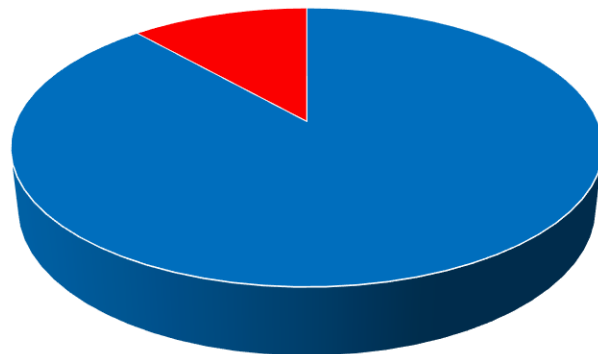


Prof. Ralph Peterli
Department of Clinical Research University of Basel, Switzerland
Senior Consultant Visceral Surgery: ViszeraMed Zürich & Spital Männedorf

DISCLOSURES

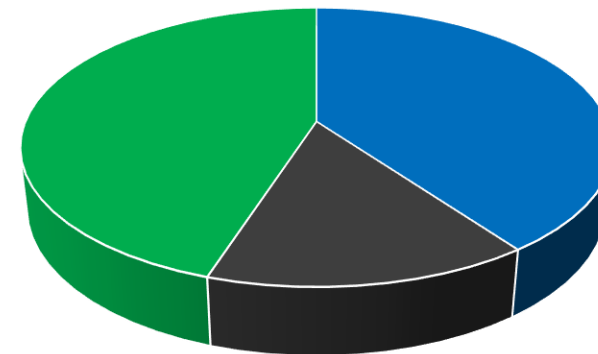
- Research grants: Swiss National Science Foundation, Johnson & Johnson, Hirzbrunnen Foundation
NovoNordisk, UKBB, Novartis
- Lecture/consulting fees: Johnson & Johnson, Viatris, Falk Foundation, NovoNordisk, Lilly, Medtronic
- Case mix disclosure

Primary Procedures



■ RYGB ■ Sleeve

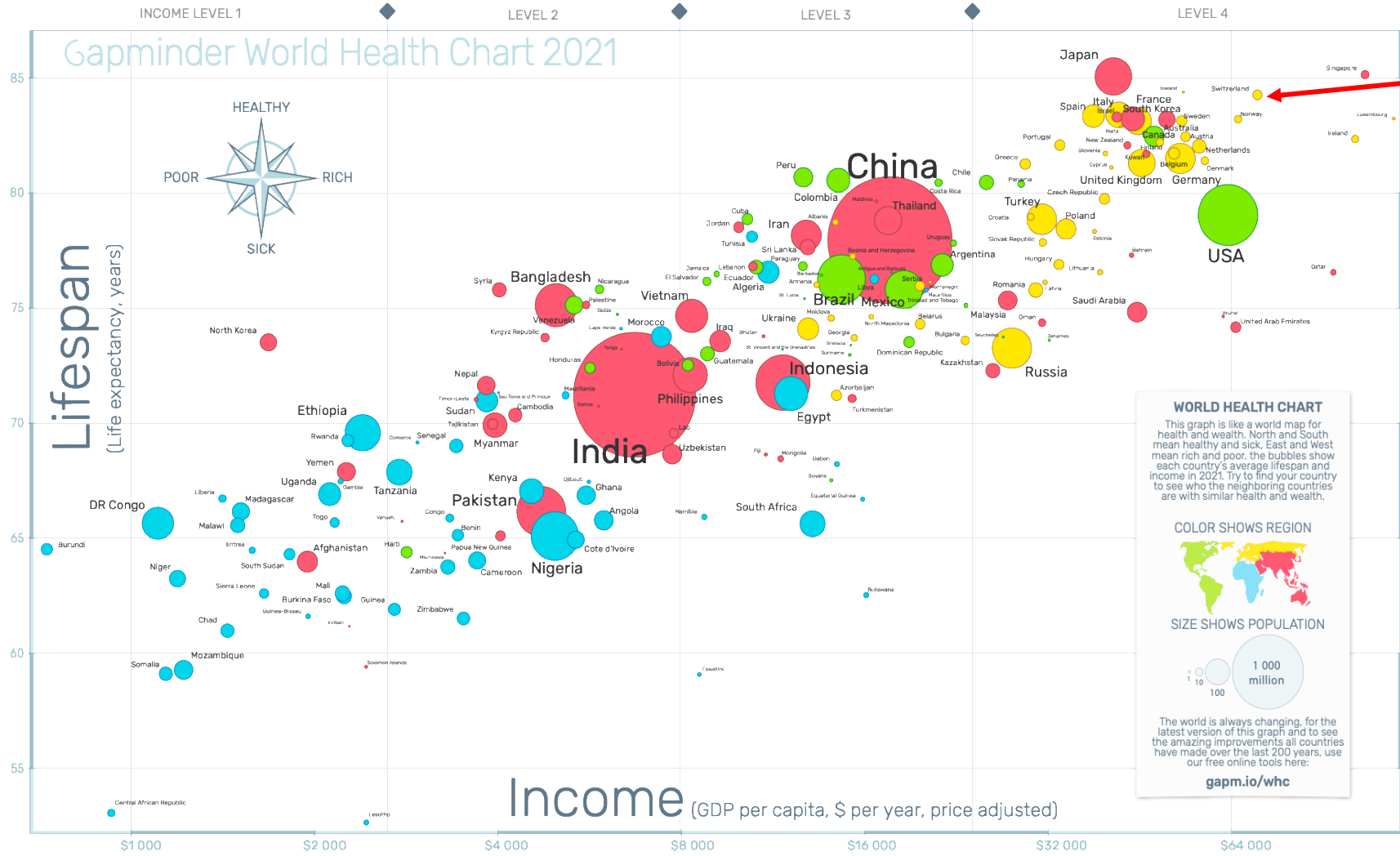
Revisional Procedures



■ RYGB ■ BPD / SADI ■ Other

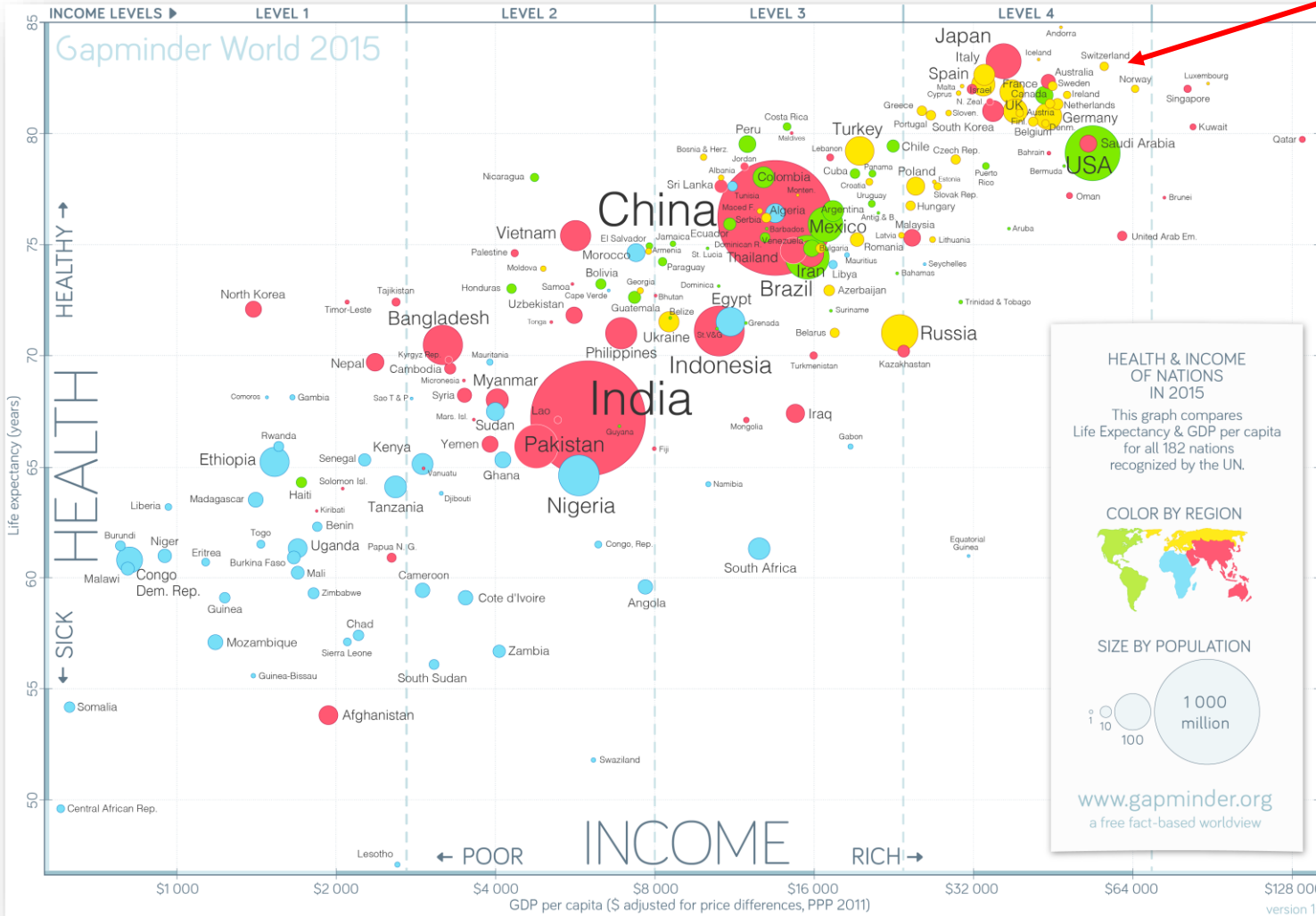
BACKGROUND

Life Expectancy and Income in different Countries



BACKGROUND

Health and Income in different Countries



Annual costs per pt/y *	\$
USA	13'432
Switzerland	9'688
Comparable country average	7'393
Australia	6'931
UK	6'023
Japan	5'640
Chile	2'699

Health care in Switzerland

- Mandatory health insurance paid by each individual
 - Covers most outpatient costs and in hospital care (state government pays 55%)
 - Costs per month:
 - ~ 200 – 400 \$ for basic insurance (~ 8% receive state government support)
 - Up to 1500 \$ for private insurance (free choice of institution/surgeon)
 - Max 800 \$ per patient/year out of pocket
 - Most hospitals treat private and basic insured patients
 - Academic hospitals = public
- General Surgeons:
 - Separation of trauma and visceral surgery recently
 - Most surgeons have more than one speciality
 - Nobody is exclusively a metabolic-bariatric surgeon

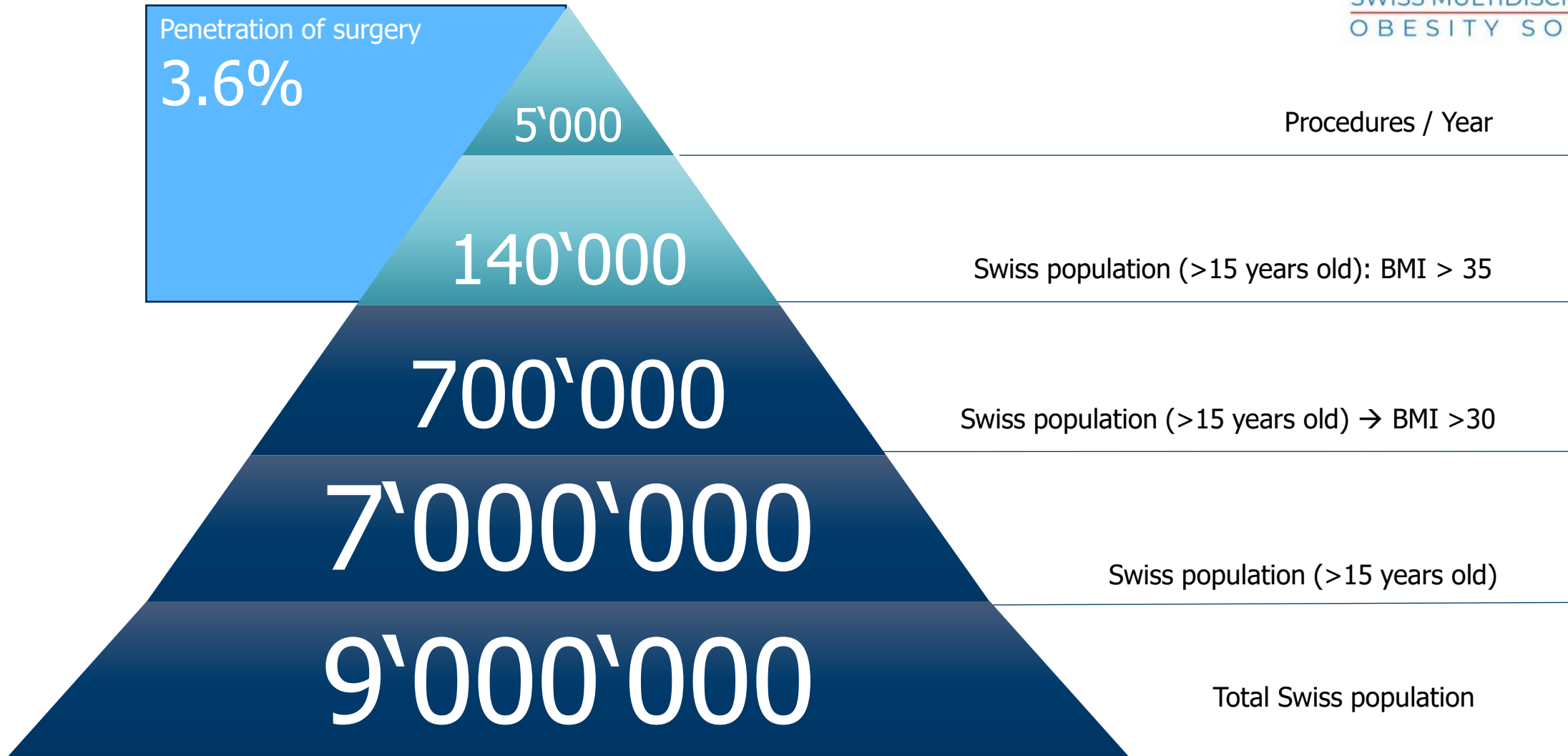


Metabolic-bariaric Surgery in Switzerland

- Mandatory coverage by health insurance since 2011
- SMOB-Guidelines: *
 - BMI > 35
 - 2 years of unsuccessful conservative treatment
 - Since 1.1.2021 **metabolic surgery**:
 - Poorly controlled T2DM (HbA1c not <8% treated by endocrinologist/diabetologist)
 - BMI 30-35
- Quality measures:
 - Basic- / Reference centres
 - Minimal experience, case load
 - National registry
 - Multidisciplinary management before and follow-up
 - Minimal delay of first contact to operation = 3 months
 - FU rate > 75% at 5y
- Access to surgery can depend on capacity of institution



MBS in Switzerland



Penetration of MBS in different countries today

Country	Population (Mio)	BMI>30 %	BMI>40 %	N with BMI>40	N Procedures	“Penetration”	Public Health care system / Costs MBS covered
USA	314	40.3	9.4	12690000	209'527	0.71	(+) / (+)
Mexico	131	24	3.6	4860000	* 7'058	0.15	+ / -
Chile	20	42	9.7	13095000	17'604	0.91	+ / +
Brazil	212	22.4	1.9	2565000	70'490	1.75	+ / +
France	69	21.6	2	2700000	38'890	2.82	++ / ++
Italy	59	19.9	0.6	810000	15'890	4.49	+ / (+)
UK	69	27.8	3.5	4725000	6'734	0.28	++ / (+)
Sweden	11	20.6	4.2	5670000	4'900	1.06	++ / +
Switzerland	9	19.5	0.9	1215000	5'000	6.17	(+) / ++
Australia	27	32	4.6	6210000	20'222	1.63	+ / (+)

* how many outside registry?

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* how many outside registry?

How did I increase patient numbers?

the old way

1. Referring physicians
 - Good documentation
 - Humble communication
 - Low complication rate
2. Interdisciplinary and interprofessional team:
 - >25 y outpatient clinic run by physicians (n=6)
 - At same eye level
 - Primary contact for patients
 - If indicated: start with OMM's
 - “Metabolic boards”
3. Inhouse Organization
 - OR capacity, access to robot
 - SOP's
 - High quality of nursing
4. Research
 - Convince medical community with evidence
 - Accept talks to “defend” MBS at meetings of other disciplines
 - Publish in their journals also
 - Active work in surgical societies boards, congress organization



How did I increase patient numbers?

the old way

5. Training young surgeons & physicians (=future referring GP's)
 - In house
 - Practical courses (Davos course)

6. Direct patient contact
 - Clinic: provide good information
 - 45 min. in groups, followed by individual evaluation
 - Obesity = disease
 - Mechanisms and principles of different procedures
 - Know your own results (early and late, database > 29y)
 - Information brochure

 - Empathy throughout treatment pathway

7. Patient referrals:
 - Network of referring physicians to institution
 - Institution's network with referring hospitals
 - Provide surgical support for primary patients in smaller hospitals
 - Own national network
 - Referrals from other surgeons
 - Patient to patient

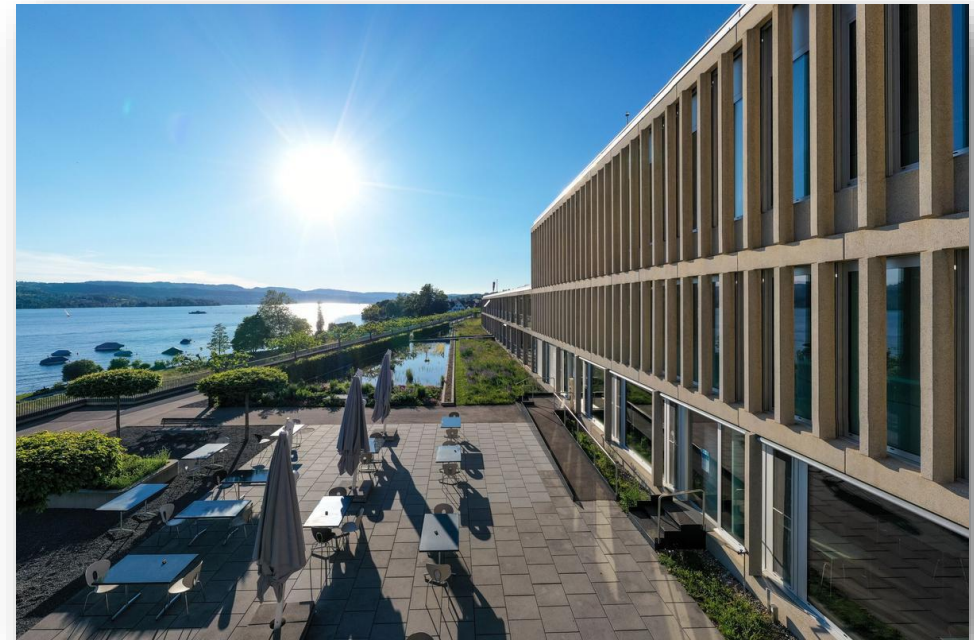


How do I keep the case volume

- New setting
 - Public (primary center) and private (reference center)
 - University affiliation for research
- Maintain contacts to referring GP, surgeons and institutions
- Clinics in various obesity centers
- Continue research and medical societies activities

New:

- Social media
 - yes, but not me
- Podcasts “Adipodcast” by Marco Bueter & Andi Thalheimer



SUMMARY

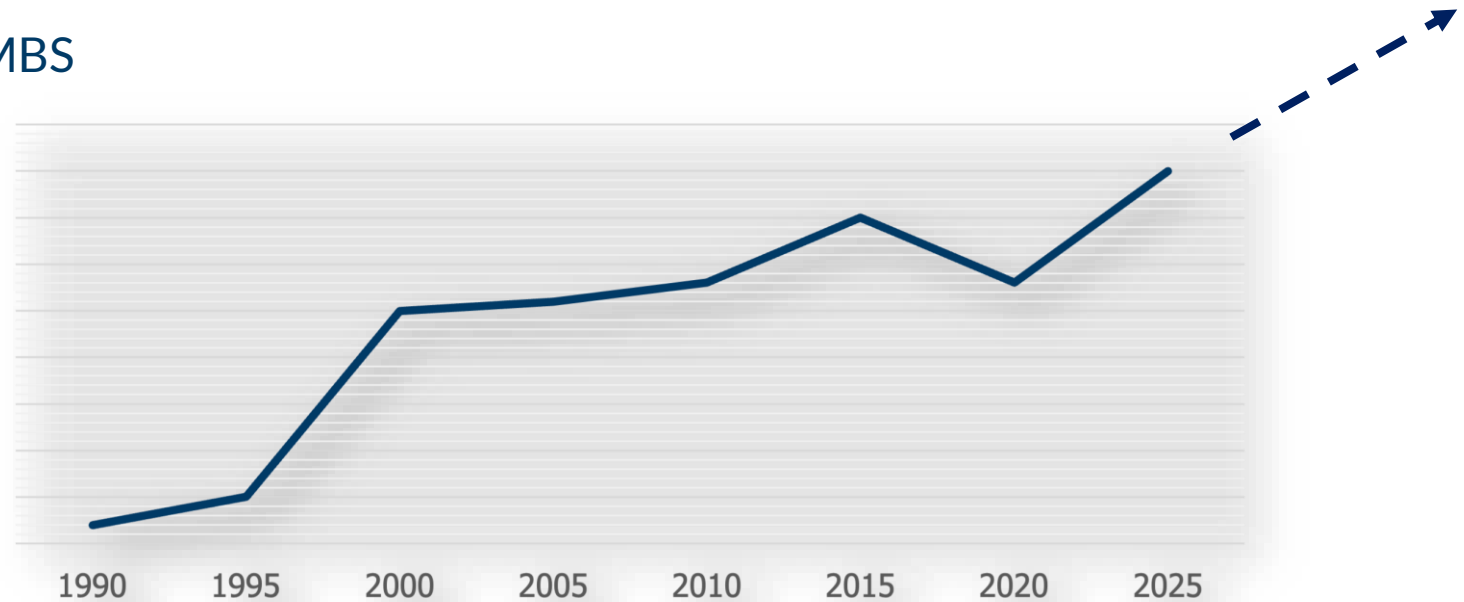
- Good access to care for patients eligible for MBS depends on:
 - Obesity accepted as a disease by patients, HCP, politics, health insurance
 - Health care system: costs covered or self paying
 - Reputation of institution and/or surgeon
 - Experience
 - Low complication rate
 - Publications & presentations at congresses and other events
 - Media presence
 - Respectful and humble communication with all HCP involved AND patients
 - Today and in future: excellent marketing & social media presence



CONCLUSION

Health care systems that

- Accept obesity as a disease
- Offer free of charge coverage of multimodal treatments for patients with obesity
- Will lead to highest penetration of MBS



Advanced Course in Metabolic-Bariatric Surgery



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COURSE**
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GASTROINTESTINAL SURGERY WORKSHOP

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April 13-17, 2027
Basel, Switzerland



THIS IS
BASEL

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