Interview

“Prevention and evidence-based treatment are an investment”

In Germany, obesity is officially recognised as a chronic condition. Yet this realisation has not yet reached the consulting room, the Social Security Code, or the minds of many people. The gap between what is already medically possible today and what actually reaches patients is huge. How do we bridge this gap? Prof. Dr Philipp Wild, one of the leading figures in the curATime future cluster, and Dr Alexander Horn, Managing Director of Lilly Germany and initiator of the “Blickwechsel Stoffwechsel” platform, sat down together to advance this important topic.





In the cover interview (left): Prof. Dr Philipp Wild (Clinical Epidemiology at Mainz University Medical Centre) and Dr Alexander Horn (Managing Director of Lilly Germany)

>> The gap between what is already medically possible today and what actually reaches patients is huge. On the one hand, there is the vision of precision medicine that uses artificial intelligence to identify individual disease mechanisms; on the other, a reality in which effective and highly innovative therapies are dismissed as 'lifestyle drugs' and structured treatment programmes get bogged down in bureaucratic red tape. The crucial question: how do we bridge this gap?

Wild: Germany is one of the countries with a very high prevalence of obesity, and we are seeing a sharp rise in this condition worldwide. At the same time, new scientific findings are leading to a fundamental shift in perspective: the condition is not simply shaped by individual behaviour alone. It is a complex interplay of genetic predisposition and an 'obesogenic' environment – that is, living conditions that facilitate its development. This relates to diet and lack of exercise, but also to stress, socio-economic factors or medical causes. The individual context is crucial: this complexity explains why the course and severity of the condition vary so much from person to person.

Research today also looks at obesity far beyond the simple Body Mass Index, or BMI for short.

For example, scientists in the curA-Time research cluster are using vast amounts of data from cohort studies such as theGutenberg-based'Health Study' to identify so-called endotypes – subgroups of the condition, each requiring a specific treatment.

Wild: Correct. These factors must be assessed and addressed on an individual basis. We divide this into two areas: the medical-molecular domain – that is, genetics, metabolism, inflammation levels – and the exposome, meaning everything to which a person is exposed.

Let's take an example.

Wild: If we have therapies that ensure a lasting feeling of satiety – and these already exist! – that is a successful concept. But if people have learnt from childhood to use food as a reward or a sedative – out of habit, even without feeling hungry – then that is not enough. Stress hormones such as cortisol lead to tension and increase feelings of hunger. Simply reducing appetite is then not enough ; therapies must be combined. This is precisely what we are working on: using artificial intelligence to identify signatures that predict which intervention will work for whom, or indeed why it might not work.

"The literature clearly shows that far too many doctors still hold the basic view that obesity is a matter of willpower. This view is wrong and long outdated."

Prof. Dr Philipp Wild, Clinical Epidemiology at Mainz University Medical Centre

Even the best science is of no use if it doesn't reach those affected. This seems to be the core problem in healthcare: obesity is often not treated as a disease at all. That is why you, Dr Alexander Horn, are fighting precisely against this under-treatment with the "Blickwechsel Stoffwechsel" initiative, which is still all too often based on ignorance and misjudgements.

Horn: Unfortunately, particularly in Germany – even by international standards – we still see it very widely that almost more than 60 per cent of doctors tell patients: "Eat less, and you'll lose weight." But this does not do justice to the chronic condition, because it is a highly complex problem. It starts with the fact that many doctors still view obesity as a lifestyle issue rather than recognising it as a chronic condition. The consequence is that the diagnosis is often not made at all, and consequently, no guideline-based treatment is initiated. However, the stigma is not limited to inadequate recommendations or hurtful comments: it is deeply embedded in the structures of our healthcare system. Those suffering from severe obesity face barriers that would be unthinkable for other common conditions such as diabetes or high blood pressure.

Wild: Stigmatisation goes very, very far. It affects not only social interaction but also, quite specifically, medical treatment. Think of treatment tables with weight restrictions, or seating in public areas that is unsuitable for severely affected people. But there are still barriers in the minds of healthcare professionals too: the literature clearly shows that far too many doctors still hold the basic belief that obesity is a matter of willpower. This view is wrong and long outdated. There is still an enormous need for action here. We still have a great deal of educational work ahead of us to break down stigma and ensure appropriate care.

Two structural problems currently appear to be massively blocking progress: the stalled Disease Management Programme (DMP) and the controversial Section 34 of the Social Code Book V. Whilst politicians demonstrate a willingness to act on paper, the reality in the federal states is different. What is your view on this?

Horn: The Obesity Disease Management Programme was launched by the federal government and the self-governing bodies and has been in place for more than twelve months. That is a good thing in itself. Unfortunately, however, the Obesity DMP has not yet been effectively implemented in a single federal state.

Why is that?

Wild: The structural problem is clear: although the DMP formally exists at federal level, it must be specifically negotiated at state level between health insurance funds and associations of statutory health insurance physicians – and this is where the major sticking point lies. Even more serious is undoubtedly the so-called 'lifestyle clause' 34 in SGB V. It categorically excludes weight-regulating medication from reimbursement by statutory health insurance funds – a relic from a time when even severe obesity was regarded as a purely private matter.

Horn: Paragraph 34 contributes enormously to stigmatisation. Obesity is, unfortunately, the only chronic condition for which effective treatments are excluded from reimbursement – regardless of medical necessity and

current scientific evidence. We consider this unfair to patients, but also very short-sighted from a medical and health policy perspective. That is why we advocate opening up this provision, at least for certain patient groups that are particularly affected. The key point is: this is not about funding lifestyle choices, but about managing a chronic condition with significant consequences and systemic costs.

Another hurdle in care is certainly the 'tabloidisation' surrounding the topic of 'weight-loss injections'. Furthermore, the media hype is driving a dangerous development: the black market.

Horn: We object to the term 'weight-loss injection' as it trivialises the suffering involved. Our medicines are intended for people with a confirmed diagnosis of obesity. This is a serious chronic condition. Another problem is the trade in counterfeit versions of these medicines – regardless of the manufacturer – via dubious online channels, often because the costs are not currently reimbursed. Every course of treatment must be strictly supervised by a doctor to monitor and prevent side effects.

This is precisely where a critical gap lies in the care pathway: qualified medical supervision presupposes, after all, that those providing treatment actually understand the disease. But if obesity continues to be viewed in practice as a character flaw rather than a metabolic disorder, even the best treatment programmes will come to nothing.

Wild: Unfortunately, that is the case. That is why it may not be enough simply to introduce a DMP for obesity. We need to do much more to educate the medical profession. And at the same time, we must also discuss remuneration structures: the 'consultative medicine' required to assess the complex individual circumstances of patients and derive a treatment plan from them is poorly remunerated. Here, too, a fundamental overhaul is long overdue.

The debate over the costs of new therapies is oftenconducted in a narrow- e manner, ignoring the enormous costs of inaction. As recently as January 2026, the Leopoldina called vehemently for a rethink in a policy brief. The German National Academy of Sciences estimates the economic costs of obesity in Germany at around 113 billion euros per year.

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Dr Alexander Horn, **Managing Director of Lilly Germany**

Horn: That equates to around 2.6 per cent of gross domestic product. That is a great deal of money that could be put to far better use. But for me, it is primarily about a paradigm shift: away from the financing and management of diseases and towards the maintenance of health. Currently, around 6,000 euros per insured person goes towards treatment – that is, purely curative medicine – but only 10 euros towards prevention. This is a disproportion that we will only resolve if we finally view prevention and the

right evidence-based treatment as an investment.

It should have been absolutely clear long ago: anyone who fails to treat a disease – and obesity is certainly one of them – will inevitably trigger an avalanche of serious comorbidities that will burden the healthcare system for decades.

Wild: Obesity is the root cause of a wide range of serious secondary conditions: cardiovascular disease, cancer, diabetes, gout, respiratory diseases, osteoarthritis and even dementia. There is hardly an organ system that is not affected. If we tackle the problem at this point and consistently treat the underlying condition, we could prevent a significant proportion of these serious consequences.

This is precisely where the German system seems to block almost reflexively: the regulatory framework of the AMNOG, by its very nature, looks only at the short-term drug costs for the next twelve months and thus ignores the long-term savings resulting, for example, from prevented heart attacks or cases of diabetes, and much more besides.

Horn: That is why we must finally carry out a medium- to long-term assessment of total costs across sectoral and social security boundaries, rather than looking solely at the costs in the first year in isolation. We advocate a three-pronged approach to preventing these comorbidities: naturally, we need greater personal responsibility through better diet and exercise. But we are firmly convinced that this alone is often insufficient in the case of chronic illness. We advocate the parallel use of highly innovative medicines that significantly aid weight loss and, for most patients, make lifestyle adjustments possible in the first place.

What do you think: when will precision medicine become part of standard care? Where will we be in ten years' time?

Wild: From a medical perspective, I expect we will see significant changes in obesity-related secondary conditions. The number of sick days taken by working people due to these secondary conditions will decrease. We willhave differentiated treatment – not a 'one-size-fits-all' approach, but tailored to different groups of people. This will fundamentally improve the quality of life and life expectancy of those affected. As a preventive medicine specialist, I am cautious about promising that we will ultimately really save costs – because other illnesses arise over the course of a longer life. But I expect significant health and social improvements, particularly among the working population.

Horn: And I would like to see 100 per cent of the German medical profession recognise obesity as a chronic condition and conduct consultations with the necessary empathy. That would contribute enormously to destigmatisation. I expect obesity to become eligible for reimbursement for a specific patient group, so that it is finally recognised for what it is: a disease. And finally, I would expect a significant reduction in the enormous costs of secondary conditions. Fewer strokes, fewer heart attacks, fewer cases of diabetes – because we have finally got to grips with the root of the problem: obesity.

Thank you very much for the interview.

The interview was conducted by MVF Editor Prof. Dr Reinhold Roski and MVF Editor-in-Chief Peter Stegmaier.

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Prof. Dr. med. Philipp Wild *is Professor of Clinical Epidemiology at Mainz University Medical Centre. He heads the Department of Preventive Cardiology and the Division of Clinical Epidemiology and Systems Medicine. He coordinates the renowned Gutenberg Health Study and is Research Director of the curATime Future Cluster. His research focuses on the development of personalised prevention strategies for cardiovascular and metabolic diseases by combining molecular medicine, big data and AI.*



Dr Alexander Horn *holds a PhD in Biology (University of Würzburg). He has been Managing Director of Lilly Germany since June 2023 and is also responsible for the business in Austria and Switzerland. Having been with the company for over 20 years, he spent twelve years in international leadership roles in the USA and Japan, including in oncology and global marketing. Through the "Blickwechsel Stoffwechsel" initiative, he is driving forward the destigmatisation of obesity and equitable access to care.*

The "Blickwechsel Stoffwechsel" initiative

With the "Blickwechsel Stoffwechsel" initiative, Lilly Germany has created a platform to bring all stakeholders in the healthcare sector together: doctors, scientists, patient organisations and policymakers. The aim: a radical shift in perspective. Obesity should be destigmatised and treated for what it is – a chronic condition requiring treatment. Among other things, the initiative calls for better training for the medical profession, the removal of legal barriers and a focus on the prevention of secondary conditions.

curATime – the future of precision medicine

The curATime (Curating Accurate Time for Medicine) future cluster, funded by the Federal Ministry of Education and Research (BMBF), aims to revolutionise prevention-oriented approaches to cardiovascular and metabolic diseases. By linking biomolecular data with environmental factors and utilising artificial intelligence, the aim is to decipher individual disease mechanisms. The aim is to predict the right time and type of intervention for each patient in order to treat metabolic diseases such as obesity in a more targeted manner.

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