

# Obesity and cardiovascular disease



A clinical consensus statement  
from the National Heart Foundation  
of Australia

2026



## Appendices

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# Appendix 1

## Contributors to the clinical consensus statement

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The National Heart Foundation of Australia ('Heart Foundation') developed the Obesity and cardiovascular disease (CVD) clinical consensus statement ('the consensus statement') in collaboration with a network of leading Australian experts and consumers. A national multidisciplinary taskforce ('the Obesity and CVD Taskforce'; 'the Taskforce') was convened to guide the development of the consensus statement, with representation from cardiology, endocrinology/diabetology, bariatric surgery, general practice, First Nations health, epidemiology, dietetics, exercise physiology, pharmacy, public health, and consumers with lived experience. Four topic-specific expert subgroups were formed to develop the related recommendations, practice points and narratives (Figure 1).

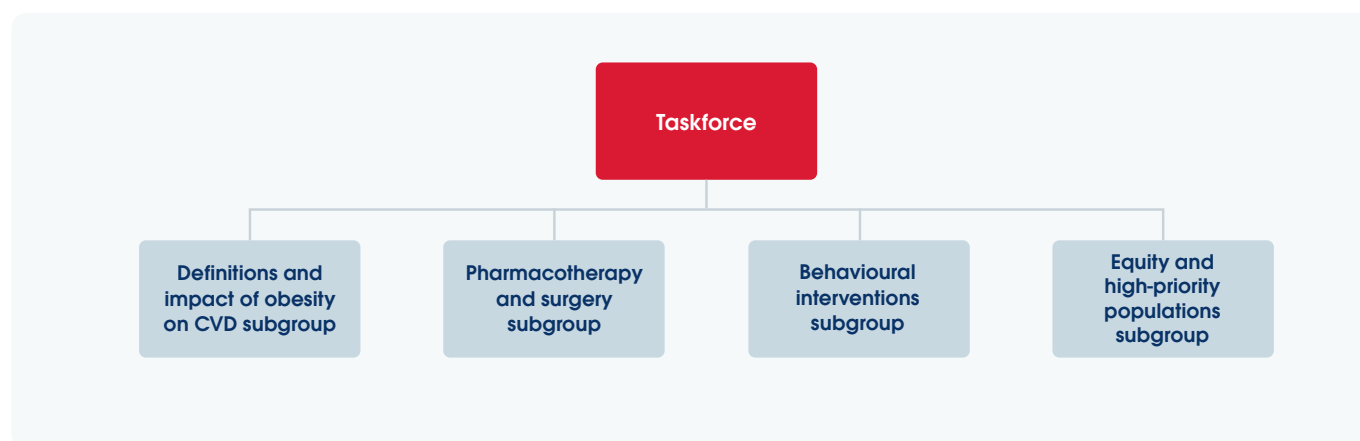


Figure 1: Obesity and CVD clinical consensus statement – expert subgroups

## Obesity and CVD Taskforce

### Establishment of the Taskforce

In June 2025, the Heart Foundation convened a Taskforce to guide the development of a new clinical consensus statement on obesity and CVD. The roles and responsibilities of the Taskforce included:

- endorsing the proposed clinical scope
- reviewing and providing feedback on the commissioned evidence review and environmental scan
- providing expert clinical input into the development of the consensus statement, including evidence-based recommendations and relevant practice points
- ensuring the consensus statement reflects current best practice and aligns with other major guideline recommendations, where appropriate
- assisting with writing, review and finalisation of the consensus statement.

## Taskforce members

Name	Position
Prof Louise Baur	Professor of Child & Adolescent Health, University of Sydney
A/Prof Harsha Chandraratna	Consultant Surgeon, Obesity Surgery WA
Prof Clara Chow	Cardiologist; Academic Director, Westmead Applied Research Centre
Prof Clare Collins	Laureate Professor, Nutrition and Dietetics, College of Health, Medicine & Wellbeing, University of Newcastle
Dr Paresh Dawda	General Practitioner; Director and Principal, Prestantia Health
Prof Sandra Eades	Chief Medical Advisor - First Nations Health, National Heart Foundation of Australia; Deputy Dean, University of Melbourne
Prof Elif Ekinci (Co-chair)	Academic Endocrinologist; Head of Diabetes, Austin Health; Head of Department of Medicine, University of Melbourne
A/Prof Samantha Hocking	Endocrinologist, Royal Prince Alfred Hospital; Clinical Academic, University of Sydney
Prof Garry Jennings (Co-chair)	Chief Medical Advisor, National Heart Foundation of Australia
Mr Ray Kelly	Exercise Physiologist and Exercise Scientist; Casual Academic and Indigenous Researcher, University of Technology Sydney
Dr Mark Mellor	Specialist GP and Obesity Doctor, Perth Weight Clinic
Ms Tammy Merton	Consumer advocate
A/Prof Adam Nelson	Academic Cardiologist; Clinical Lecturer, University of Adelaide
Prof Rajesh Puranik	Consultant Cardiologist, Royal Prince Alfred Hospital; Clinical Associate Professor, University of Sydney
Prof Jonathan Shaw	Consultant Endocrinologist; Deputy Director (Clinical and Population Health), Baker Heart and Diabetes Institute
Dr Terri-Lynne South	General Practitioner and Dietitian; Director, Lifestyle Metabolic
Dr Irene Um	Pharmacist; Senior Lecturer, School of Pharmacy, The University of Sydney
Prof Emerita Alison Venn	Epidemiologist; Adjunct Professor, Menzies Institute for Medical Research, University of Tasmania
Mr Andrew Wilson	Engagement/Advocacy Lead & Board Member, Weight Issues Network
Prof Andrew Wilson	Professor and Co-Director of the Leeder Centre for Health Policy, Economics and Data, University of Sydney
Dr Anna Wood	Physician in Endocrinology and General Medicine, Royal Darwin Hospital; Senior Research Fellow, Menzies School of Health Research
Prof Sophia Zoungas	Clinical Endocrinologist; Head, School of Public Health and Preventive Medicine, Monash University

## Expert subgroups

The Taskforce members were each assigned to one of four topic-specific expert subgroups:

Subgroup	Focus
Definitions and impact of obesity on CVD	Definition of and diagnostic tools for clinical overweight and obesity to support risk assessment for the Australian population; impact of weight loss on CVD risk and clinical management of people with overweight or obesity and CVD.
Pharmacotherapy and surgery	Impact of weight loss on cardiovascular (CV) risk (including role of pharmacological and surgical interventions for obesity).
Behavioural interventions	Impact of behaviour change – diet and physical activity to support weight loss and improve CV outcomes or risk factors.
Equity and high-priority populations	Ensure that recommendations consider high priority groups; i.e. adults living with overweight or obesity from culturally and linguistically diverse communities, First Nations peoples, people living in rural and remote areas, people experiencing socio-economic disadvantage and people living with a mental health condition.

### Definitions and impact of obesity on CVD subgroup members

Name	Position
Prof Rajesh Puranik (Chair)	Consultant Cardiologist, Royal Prince Alfred Hospital; Clinical Associate Professor, University of Sydney
A/Prof Adam Nelson	Academic Cardiologist; Clinical Lecturer, University of Adelaide
Prof Jonathan Shaw	Consultant Endocrinologist; Deputy Director (Clinical and Population Health), Baker Heart and Diabetes Institute
Prof Sophia Zoungas	Clinical Endocrinologist; Head, School of Public Health and Preventive Medicine, Monash University

### Pharmacotherapy and surgery subgroup members

Name	Position
Prof Elif Ekinici (Chair)	Academic Endocrinologist; Head of Diabetes, Austin Health; Head of Department of Medicine, University of Melbourne
A/Prof Harsha Chandraratna	Consultant Surgeon, Obesity Surgery WA
Prof Clara Chow	Cardiologist; Academic Director, Westmead Applied Research Centre
Dr Paresh Dawda	General Practitioner; Director and Principal, Prestantia Health
A/Prof Samantha Hocking	Endocrinologist, Royal Prince Alfred Hospital; Clinical Academic, University of Sydney
Dr Irene Um	Pharmacist; Senior Lecturer, School of Pharmacy, The University of Sydney
Prof Andrew Wilson	Professor and Co-Director of the Leeder Centre for Health Policy, Economics and Data, University of Sydney

### *Behavioural interventions subgroup members*

Name	Position
Dr Terri-Lynne South (Chair)	General Practitioner and Dietitian; Director, Lifestyle Metabolic
Prof Louise Baur	Professor of Child & Adolescent Health, University of Sydney
Prof Clare Collins	Laureate Professor, Nutrition and Dietetics, College of Health, Medicine & Wellbeing, University of Newcastle
Mr Ray Kelly	Exercise Physiologist and Exercise Scientist; Casual Academic and Indigenous Researcher, University of Technology Sydney
Mr Andrew Wilson	Engagement/Advocacy Lead & Board Member, Weight Issues Network

### *Equity and high-priority populations subgroup members*

Name	Position
Dr Mark Mellor (Chair)	Specialist GP and Obesity Doctor, Perth Weight Clinic
Prof Sandra Eades	Chief Medical Advisor - First Nations Health, National Heart Foundation of Australia; Deputy Dean, University of Melbourne
Ms Tammy Merton	Consumer advocate
Prof Emerita Alison Venn	Epidemiologist; Adjunct Professor, Menzies Institute for Medical Research, University of Tasmania
Mr Andrew Wilson	Engagement/Advocacy Lead & Board Member, Weight Issues Network
Dr Anna Wood	Physician in Endocrinology and General Medicine, Royal Darwin Hospital; Senior Research Fellow, Menzies School of Health Research

## Heart Foundation project team

Name	Position
Natalie Raffoul	Senior Manager Healthcare Programs and Clinical Strategy
Christine Sarie	Project Management Coordinator, Healthcare Programs
Emily Bradburn	Senior Healthcare Programs Officer, Patient Support Lead
Kelly Donnelly	Senior Healthcare Programs Officer
Jasmine Just	Senior Healthcare Programs Officer, Clinical Communications
Tina Garcia	Senior Medical Writer

# Appendix 2

## Developing the clinical consensus statement

# 2

The Heart Foundation led the development of the consensus statement in collaboration with expert members of the Taskforce. The statement was based on a review of published literature and an environmental scan, and was developed through a structured process to distil practical guidance based on evidence-informed expert consensus. It addresses common clinical challenges and highlights rapidly emerging evidence, with a strong focus on clinical management to support informed, evidence-based care.

## Clinical scope

The clinical scope of the consensus statement was prepared by the Heart Foundation project team with direction and input from the Taskforce. The scope was reviewed, refined and signed off by the Taskforce.

The Taskforce agreed on the following 14 clinical scoping questions:

1. How should clinical obesity and overweight be defined and characterised to support accurate diagnosis and risk assessment for the Australian population?
2. What is the association between overweight or obesity and the risk of experiencing a CV event – in the primary and secondary prevention setting – in adults?
3. In adults living with overweight or obesity, how do structured weight management interventions – compared to standard care or no intervention – impact CV outcomes?
4. What is the impact of overweight or obesity on the diagnosis, clinical management and outcomes for people living with or at high risk of CVD?
5. What are the unique clinical considerations for the management of obesity or overweight in people living with or at high risk of CVD?
6. In adults living with overweight or obesity and CVD or at high risk of CVD, what nutritional interventions support weight loss and improve CV outcomes or risk factors?
7. In adults living with overweight or obesity and CVD or at high risk of CVD, what physical activity interventions (including type, time and intensity) support weight loss and improve CV outcomes or risk factors?
8. In adults living with overweight or obesity and CVD or at high risk of CVD, which pharmacological therapies are effective in achieving weight loss and improving CV outcomes and risk factors?
9. What is the impact of bariatric surgery (focusing on the common techniques in Australia) on CVD outcomes, morbidity and long-term or sustained improvements in complications of obesity?

- |     |  |
|-----|--|
| 10. | In adults living with overweight or obesity from culturally and linguistically diverse communities, how do tailored or integrated management strategies improve CV outcomes, weight reduction and overall health outcomes? |
| 11. | In First Nations people living with overweight or obesity, how do tailored or integrated management strategies improve CV outcomes, weight reduction and overall health outcomes?  |
| 12. | In adults living with overweight or obesity who have mental health conditions, how do tailored or integrated management strategies improve CV outcomes, weight reduction and overall health outcomes?                      |
| 13. | In adults living with overweight or obesity from rural and remote communities, how do tailored or integrated management strategies improve CV outcomes, weight reduction and overall health outcomes?                      |
| 14. | In adults living with overweight or obesity from low socioeconomic status, how do tailored or integrated management strategies improve CV outcomes, weight reduction and overall health outcomes?                          |

## Out of scope

The Taskforce agreed that the following areas were out of scope for the consensus statement:

- detailed advice for children and adolescents
- very detailed recommendations on behaviour modifications (e.g. nutrition and physical activity)
- detailed system/environment level factors (e.g. food supply chain, food availability, built environment)
- detailed advice on eating disorders
- detailed advice on surgical procedures
- detailed consideration of complementary medicines
- detailed or new economic analyses.

## Evidence review and environmental scan

To address the clinical scoping questions identified above, a targeted evidence review and accompanying environmental scan were independently commissioned. Dr Shelley Keating from the University of Queensland undertook this work.

Unlike the Heart Foundation's clinical guidelines, this consensus statement did not apply the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology or involve undertaking new systematic reviews. It also did not seek to address broader policy, environmental or social issues. The statement does not intend to replace the forthcoming National Health and Medical Research Council's *Clinical Practice Guidelines for the Management of Overweight and Obesity for Adults, Adolescents and Children in Australia*. Rather, the consensus statement complements them with more detailed guidance to address the specific clinical considerations in people living with overweight/obesity with established CVD, or at high risk of CVD.

See supporting document *Evidence Review and Environmental Scan: Clinical Management of Obesity and Overweight in the Context of Cardiovascular Health (2025)*

## Developing the recommendations

The consensus statement was developed through a rigorous and transparent process, underpinned by published evidence and expert clinical judgment. The multidisciplinary membership of the Taskforce ensured a breadth of perspective and expertise. Clinical recommendations and/or narrative pieces were developed to address each of the clinical scoping questions.

### Evidence-to-recommendation template

The evidence-to-recommendation template provides a structured framework for translating evidence into clinical advice. It includes dedicated sections where the following are documented:


- Recommendations and their strength of advice
- Rationale for the recommendations, narrative summary and practice points
- A brief summary of benefits and harms, weighing desirable and undesirable outcomes
- Certainty of evidence, including relevance and missing data
- Preferences and values, reflecting variability in an individual's priorities
- Resources and other considerations, such as out-of-pocket costs, feasibility in the Australian context and accessibility across diverse communities

### Strength of advice

To support the consistency and integrity of the recommendations, a structured framework for strength of advice was specifically developed to guide the evaluation of evidence and formulation of advice (Table 1). This framework was adapted from the European Society of Cardiology's Scientific Documents Policy.<sup>1</sup>

Based on evidence quality and consensus among the Taskforce members, the strength of advice is both evidence-based and practical. Generally, the more high-quality studies and robust research designs included in an analysis, the stronger its evidence rating. Systematic reviews, meta-analyses and randomised controlled trials typically represent the highest level of evidence due to their rigorous methodology and strong indications of effectiveness.<sup>2</sup>

**Table 1. Strength of advice hierarchy**

<p><b>A. Strong advice</b>, based on robust published evidence* and supported by expert consensus.** High confidence that benefits clearly outweigh risks. Supported by consistent robust high-quality evidence and expert consensus.</p>	
<p><b>B. Moderate advice</b>, based on some published evidence* and supported by expert consensus.** Benefits likely outweigh risks, but with some uncertainty. Evidence may not be as strong or expert opinion may not reach unanimous consensus.</p>	
<p><b>C. May be appropriate</b>, based on published evidence* and expert consensus.** Insufficient evidence in this area. Recommendation based primarily on expert consensus.</p>	
<p><b>D. Area of uncertainty.</b> Insufficient evidence or consensus to support a clear position. Clinical practice may vary in this area.</p>	

\* Systematic reviews, meta-analyses and randomised controlled trials constitute the highest level of evidence. Observational studies constitute a lower level of evidence and are considered less robust. Case studies and grey literature constitute the lowest level of evidence.

\*\* While formal voting thresholds were not specified, recommendations were retained only where there was strong majority support and no substantive unresolved objections.

1 European Society of Cardiology. ESC Scientific Documents Policy. 2021. <https://www.escardio.org/guidelines/scientific-documents/scientific-document-policy/>

2 Murad MH, Asi N, Alsawas M, Alahdab F. New evidence pyramid. *BMJ Evid Based Med.* 2016;21:125-127. doi: 10.1136/ebmed-2016-110401

## Drafting the consensus statement

The Heart Foundation project team brought together the evidence-to-recommendation templates signed off by each subgroup to draft the consensus statement. The first draft was reviewed and approved by the Taskforce prior to targeted public consultation.

Following consultation, the consensus statement was updated and the final draft was approved by the Taskforce.

## Targeted consultation

Targeted public consultation was conducted between 16 February and 9 March 2026, to seek feedback on the draft consensus statement prior to finalisation. The draft was circulated to a targeted group of stakeholders, including experts in cardiology, endocrinology and diabetology, bariatric surgery, general practice, First Nations health, epidemiology, nutrition and dietetics, exercise physiology, physiotherapy, pharmacy, public health and research, as well as representatives from peak health bodies, government and consumer peak bodies. Consultation was conducted within a defined scope, focusing on the clarity, balance, and clinical applicability of the draft.

A total of 833 individual pieces of feedback were received via an online form from 34 organisations and 13 individual contributors. All feedback was initially reviewed by the project team to determine whether it was in or out of scope. For feedback that was considered in scope, the project team determined whether it should be accepted, accepted with amendment, escalated to the Taskforce, noted, considered for implementation or rejected (giving rationale). This process was guided by the Taskforce Co-Chairs and broader Taskforce at regular meetings. Feedback considered outside the agreed scope was noted but not incorporated. Key changes to the statement resulting from targeted consultation were deliberated by the Taskforce, and the final document was approved following incorporation of feedback.

## Summary of consultation feedback

### Overall support and value of the statement

Respondents broadly welcomed the development of a national, evidence-informed consensus statement addressing the intersection of obesity and CVD. Many described the document as comprehensive, timely, and clinically valuable, particularly its recognition of obesity as a complex, chronic condition and its emphasis on multidisciplinary care, equity considerations, and weight stigma.

### General feedback

Overall, consultation feedback was highly engaged and constructive, with strong support for the statement's intent and scope. Suggested revisions largely focused on improving balance, clarity, equity, and real-world applicability, while preserving the evidence-informed, consensus-based foundation of the document.

### Defining overweight and obesity

Feedback suggested:

- stronger positioning of waist-based measures and metabolic markers
- clearer articulation of obesity as a chronic disease rather than solely a risk factor.

## Weight stigma and high-priority populations

Feedback suggested:

- the inclusion of weight stigma, but recommended strengthening access and equity considerations, as well as practical guidance for healthcare professionals
- the inclusion of high-priority populations, with requests for more detailed guidance on practical implementation and the inclusion of women-specific information.

## Nutrition

Feedback suggested:

- the need for additional information to address the specific nutritional considerations for people taking obesity management pharmacotherapy and post metabolic bariatric surgery, including protein adequacy and lean mass preservation for people during weight loss
- the inclusion of information on other dietary approaches (e.g. carbohydrate-reduced approaches for people with metabolic dysfunction)
- stronger recognition of the central role of Accredited Practising Dietitians within multidisciplinary care.

## Physical activity

Key themes from the feedback included:

- the need to acknowledge potential barriers to physical activity, including obesity-related pain, disability, deconditioning, and stigma
- request for the inclusion of guidance for the specific physical activity requirements for people on incretin-based therapies to preserve lean muscle mass
- the need to strengthen the reference to physiotherapists, exercise physiologists, and allied healthcare professionals in assessment, rehabilitation, and safe progression of activity, particularly for people with CVD and complex comorbidity.

## Pharmacotherapy

Common themes included:

- avoiding class-based language where evidence is agent-specific
- clarifying recommendations to better align with trial populations, dosages and outcomes
- greater transparency around access, cost, Pharmaceutical Benefits Scheme status, and real-world adherence
- need to address lean muscle mass loss, nutritional risk, and weight regain following treatment discontinuation, with informed consent and ongoing monitoring emphasised
- stronger safety and monitoring guidance.

## Metabolic bariatric surgery

Key feedback included:

- the importance of clearly articulating the rationale underpinning eligibility thresholds for metabolic bariatric surgery
- opportunities to further emphasise multidisciplinary care and the role of lifelong follow-up
- the value of including tailored dietary information for people who have undergone metabolic bariatric surgery
- the importance of describing care pathways, supporting timely referral, and ensuring language and evidence presentation are contemporary and aligned with best practice.

# Appendix 3

## Conflicts of interest

# 3

The Heart Foundation and members of the Taskforce acknowledge the importance of both transparency and appropriate management of conflicts of interest.

Conflicting interests were considered within a framework of both:

- i. the relationship (direct or indirect) of the participating individual to any third party with interest in the topic under consideration during the development process of the consensus statement
- ii. the nature (financial and non-financial) of the potential conflict.

Conflicting interests among the subgroups required appropriate management to ensure clinical recommendations were not compromised. Processes employed by the Heart Foundation project team aimed to ensure the integrity of the Taskforce and to strike an appropriate balance between the existence of interests in a topic under review and the expertise required to make sound and meaningful recommendations.

### Conflicts of interests were managed in the following ways:

- All Taskforce members were required to disclose potential conflicts of interest at the commencement of membership, and to update the Taskforce and their subgroups during the project if there were any changes to this declaration.
- Conflict of interest declarations were revisited at each Taskforce and subgroup meeting to ensure new disclosures were recorded and considered.
- In circumstances where a conflict of interest was identified and deemed significant, it was managed by ensuring that the member had limited involvement in the deliberation of the evidence (with the possibility of bias noted), or in discussions on the wording, structure, intent or formulation of the clinical recommendation relevant to disclosure of a conflict.

All conflict-of-interest declarations were regularly reviewed by the project team (Table 2).

**Table 2. Conflict of interest register**

Taskforce member name	Involvement in project	High level benefit (Y/N)?	Low level benefit (Y/N)?	If yes, details	No benefit but position held, or investment in an activity that does not provide cash incentive
Louise Baur	Taskforce member, Public health professional	N	Y	<p><b>Low level benefit</b></p> <p>Speaker fees (non-personal): Speakers bureau, Lilly; Speakers bureau, Novo Nordisk (funds directed to institutional cost centre). Commissioning/funding research (non-personal): Australian PI of ACTION Teens Study (Novo Nordisk sponsored; conducted in 2021).</p>	Holding office (personal): Past-President, World Obesity Federation (2024–2026).
Harsha Chandraratna	Taskforce member, Bariatric surgeon	N	Y	<p><b>Low level benefit</b></p> <p>Speaker fees (personal): Paid lecture fees.</p> <p>Travel, accommodation and conference registration (personal): Provided in connection with attendance at overseas meetings.</p>	N
Clara Chow	Taskforce member, Cardiologist	Y	Y	<p><b>High level benefit</b></p> <p>Professor of Medicine, Academic Director (WARC, USyd), Cardiologist – Westmead Hospital</p> <p><b>Low level benefit</b></p> <p>Membership of Advisory Boards (personal): WSLHD Board; Heart Foundation Board. Speaker fees (personal): previously received speakers’ fees including Novartis; Limbic; Eli Lilly; Novo Nordisk; Amgen.</p> <p>Expenses/hospitality: Novartis; Limbic; Eli Lilly; Novo Nordisk; Amgen (conference and advisory meeting attendance abroad). Commissioning/funding research: NHMRC Investigator grant recipient; investigator on MRFF/NHMRC grants; previously received grants from NSW Health; Australian Digital Health Agency; Google. Other support (non-personal): The George Institute patent applications for low fixed-dose combination products (no direct financial interests).</p>	
Clare Collins	Taskforce member, Nutrition and dietetics	N	Y	<p><b>Low level benefit</b></p> <p>Member of Research Advisory Committee, Health and Well-being Queensland (personal) and co-investigator on a co-funded pilot study with University of Newcastle and Honeysuckle Health testing addition of telehealth Medical Nutrition Therapy to Healthy Weight For Life telehealth coaching (non-personal).</p> <p>Amgen-sponsored meeting travel support.</p>	Opinions informed by personal evaluation of research studies and role as a researcher and clinician (Accredited Practising Dietitian) and commonly conveyed via the media. Host of a podcast Nutrition Science Bites and leader of the No Money No Time website.

Taskforce member name	Involvement in project	High level benefit (Y/N)?	Low level benefit (Y/N)?	If yes, details	No benefit but position held, or investment in an activity that does not provide cash incentive
Paresh Dawda	Taskforce member, GP	Y	Y	<p><b>High level benefit</b> Directorship/work (personal): Director in Prestantia Health (healthcare consultancy services); Director at Next Practice Canberra Pty Ltd (general practice).</p> <p><b>Low level benefit</b> Speaker fees (personal): BMJ IHI Quality Forum conference organising committee – complimentary access</p>	
Sandra Eades	Taskforce member, Public health professional	N	N	N/A	N
Elif Ekinici	Taskforce member, Co-Chair & Endocrinologist/diabetologist	N	Y	<p><b>Low level benefit</b> Membership of advisory boards (institutional): Eli Lilly; Boehringer Ingelheim; Novo Nordisk (advisory board fees paid to institution for diabetes research). Membership of advisory boards (institutional): CSL (fees donated to the university; no personal remuneration). Other: Novo Nordisk provided direct payment in circumstances where payment to the institution was not possible.</p>	N
Samantha Hocking	Taskforce member, Endocrinologist/diabetologist	N	Y	<p><b>Low level benefit</b> (Personal): Lilly; Seqirus; Novo Nordisk. Commissioning/funding of research (non-personal): Amgen; Astra Zeneca; Lilly; Novo Nordisk; Pfizer; Harmony Biosciences; Impact Obesity; Endogenex; Spruce Biosciences. Eli Lilly advisory board regarding SURPASS CVOT.</p>	Holding office (non-personal): President NACOS; Member of Council ANZOS
Garry Jennings	Taskforce member, Co-chair & Cardiologist	N	N	N/A	Trustee & Director Baker Foundation; Honorary Professor University of Sydney; Honorary Professor Monash University; Honorary Cardiologist Alfred Health; Life Governor & Cardiologist Baker Heart & Diabetes institute; Board Member Global Cardiovascular Research Funders Forum; AHA Journal Associate Editor Hypertension; Board Member Hypertension Australia

Taskforce member name	Involvement in project	High level benefit (Y/N)?	Low level benefit (Y/N)?	If yes, details	No benefit but position held, or investment in an activity that does not provide cash incentive
Ray Kelly	Taskforce member, Exercise physiologist	N	N	N/A	
Mark Mellor	Taskforce member, GP	Y	Y	<p><b>High level benefit</b>            Founder and clinical lead of Perth Weight Clinic. Clinical lead Cardiometabolic services, WA.</p> <p><b>Low level benefit</b>            Membership of advisory boards (personal): Novo Nordisk; Eli Lilly. Speaker fees (personal): Novo Nordisk; Eli Lilly (including presentations relating to semaglutide (Wegovy) and tirzepatide). Expenses/hospitality (personal): Novo Nordisk; Eli Lilly. Steering committee membership: Boehringer Ingelheim (general practitioner education). Other: Online media sponsored by Nestlé; webinar funded by the WA Primary Health Alliance.</p>	Holding office (personal): WA lead RACGP obesity specific interest group (2022 appointed); Chair of advocacy panel for equitable access to funded treatment for people with obesity (Mar 2025 on). Clinical lead Perth Weight Clinic and Cardiometabolic services.
Tammy Merton	Taskforce member, Lived experience representative	N	N	N/A	
Adam Nelson	Taskforce member, Cardiologist	N	Y	<p><b>Low level benefit</b>            Membership of Advisory Boards (personal): Astra Zeneca; Boehringer Ingelheim; Eli Lilly; GSK; Novartis; Novo Nordisk; Pfizer. Speaker fees (personal): Amgen; Astra Zeneca; Boehringer Ingelheim; CSL; Eli Lilly; GSK; Novartis; Novo Nordisk. Expenses/hospitality (personal): Eli Lilly; Novo Nordisk. Commissioning/funding of research (non-personal): Amgen; Boehringer Ingelheim; Eli Lilly.</p> <p><b>Additional notes</b>            Current grant: AMGEN – GOAL ASIA implementation trial (AUD \$1.2 million).</p>	
Rajesh Puranik	Taskforce member, Cardiologist	N	Y	<p><b>Low level benefit</b>            Speaker fees (personal): Astra Zeneca meeting, Dec 2023 (\$1852.50).</p>	Holding office: Board member, CSANZ.
Jonathan Shaw	Taskforce member, Endocrinologist/diabetologist	N	Y	<p><b>Low level benefit</b>            Membership of Advisory Boards of Novo Nordisk, Eli Lilly, Sanofi and Astra Zeneca. Speaker fees for Eli Lilly; Roche; Astra Zeneca; Novo Nordisk; Boehringer Ingelheim; GSK.</p>	Vice President of the Australian Diabetes Society (personal)

Taskforce member name	Involvement in project	High level benefit (Y/N)?	Low level benefit (Y/N)?	If yes, details	No benefit but position held, or investment in an activity that does not provide cash incentive
Terri-Lynne South	Taskforce member, GP	Y	Y	<p><b>High level benefit</b> Director of Lifestyle Metabolic - a private clinic treating clients with obesity and associated conditions (2022 on).</p> <p><b>Low level benefit</b> Speaker fees (personal): Novo Nordisk; Eli Lilly; iNOVA; Nestlé. Advisory boards (personal): Novo Nordisk; Eli Lilly; Boehringer Ingelheim. Travel, accommodation and conference registration (personal): Novo Nordisk. Commissioning/funding of research: Nestlé. Educational grant: Impact Obesity. Advisory role: Impact Obesity.</p>	<p>Holding office (personal):</p> <ul style="list-style-type: none"> <li>• Chair RACGP obesity specific interest group (2022 appointed)</li> <li>• Advisor TOC (The Obesity Collective) 2022 onwards</li> <li>• Committee member NACOS (National Association Clinical Obesity Services) 2022 onwards</li> <li>• Member of advocacy panel for equitable access to funded treatment for people with obesity (Mar 2025 on)</li> <li>• Advisor: Impact Obesity 2022 onwards</li> </ul>
Irene Um	Taskforce member, Pharmacist/ pharmacologist	N	N	N/A	N
Alison Venn	Taskforce member, Epidemiologist	N	N	N/A	<p>Past and ongoing research roles as an epidemiologist investigating relationships between obesity and cardiovascular disease risk, and the health service use and outcomes of bariatric surgery. Currently Adjunct Professor at the Menzies Institute for Medical Research, University of Tasmania and formerly Institute Director (2016-22). Menzies receives funding from the Heart Foundation. Member of the Heart Foundation Tasmania Advisory Board (2025).</p>
Andrew Wilson	Taskforce member, Lived experience representative	N	N	N/A	<p>Obesity Australia Board Member (three years tenure - non financial) and Impact Obesity Advisory Group (nearly two years - non-financial).</p>

Taskforce member name	Involvement in project	High level benefit (Y/N)?	Low level benefit (Y/N)?	If yes, details	No benefit but position held, or investment in an activity that does not provide cash incentive
Andrew Wilson	Taskforce member, Public health professional	N	N	N/A	<p>Member, NSW Health Expert Advisory Group on Type 2 Diabetes Prevention.</p> <p>Chair, Health Technology Assessment (HTA) Review Implementation Advisory Group, Commonwealth Department of Health (no direct relationship to obesity treatment or CVD prevention).</p> <p>Chair, Pharmaceutical Benefits Advisory Committee (PBAC), including meetings with pharmaceutical companies marketing obesity medicines (e.g. Novo Nordisk, Eli Lilly); no benefits received.</p> <p>Chief Investigator / Co-author, NHMRC Medicines Intelligence CRE, including authorship of a manuscript under review on the use of weight-reduction pharmacotherapies in Australia.</p> <p>Lead Investigator, NHMRC Prevention Partnership Centre, involving research on obesity and prevention, jointly funded by NHMRC and government agencies (no industry involvement).</p> <p>Current grant holder, MRFF-funded research on ethnicity and cardiovascular disease (no industry funding; not focused on obesity).</p> <p>Other grant involvement, NHMRC- and Heart Foundation-funded projects on the prevention of cardiovascular disease (no industry sponsorship).</p>
Anna Wood	Taskforce member, Endocrinologist/diabetologist	N	N	N/A	N/A
Sophia Zoungas	Taskforce member, Endocrinologist/diabetologist	N	Y	<p><b>Low level benefit</b></p> <p>Speaker fees for sponsored educational events (non-personal); payment to institution. Expenses/hospitality for meetings/conferences (non-personal); payment to institution.</p>	N/A

# Appendix 4

## Mental health and eating disorder validated assessment tools

# 4

Tool	Items/format	Purpose/notes
<b>Depression</b>		
PHQ9	9 items	Screens and monitors severity of depression; widely validated in primary care.
DASS21	21 items (3 subscales)	Measures depression, anxiety and stress; brief and validated.
K10	10 items	Assesses psychological distress; recommended in Australian GP settings.
WHO5	5 items	Short wellbeing index; useful for monitoring emotional wellbeing.
<b>Anxiety</b>		
GAD7	7 items	Screens for generalised anxiety disorder; validated for primary care.
DASS21 (Anxiety subscale)	7 items	Measures anxiety symptoms alongside depression and stress.
K10	10 items	Captures general distress including anxiety.
<b>Eating disorders</b>		
SCOFF	5 items	Rapid screening for eating disorders; widely used in GP settings.
BEDS7	7 items	Screens for binge eating disorder.
InsideOut Screener	Variable	Australian developed tool for eating disorder risk assessment.
Eating disorder tool finder	<a href="https://hub.eatingdisordersresearch.org.au/tools">https://hub.eatingdisordersresearch.org.au/tools</a>	
<b>Neurodivergence</b>		
ASRS (Adult attention deficit hyperactivity disorder Self Report Scale)	18 items (short form available)	Screens for ADHD in adults; validated for primary care.
AQ10	10 items	Brief screening for autism spectrum traits; recommended.