A call for integrated, multidisciplinary models of care from Accredited Practising Dietitians and Accredited Exercise Physiologists alongside GLP-1RA therapies.

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Recipient

Pharmaceutical Benefits Advisory Committee

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About us

Exercise & Sports Science Australia (ESSA)

Exercise & Sports Science Australia (ESSA) is the national peak body for exercise and sports science, representing more than 11,600 university qualified professionals, including 10,107 accredited exercise physiologists (AEPs) nationwide.

ESSA is the leading voice of the exercise physiology profession, advocating for the recognition, funding and appropriate use of AEPs across the health, disability, aged-care and compensable systems, so that more Australians living with chronic and complex conditions can access safe, evidence-based exercise care.

ESSA is the national voice of the exercise physiology profession, advocating for the recognition, funding and appropriate integration of AEPs across Australia's health, disability, aged-care and compensable systems. AEPs are university-qualified allied health professionals clinically trained to assess risk and prescribe safe, evidence-based exercise for people with chronic and complex conditions, including in the presence of comorbidities, polypharmacy and medication-related physiological change.

ESSA's rigorous accreditation and credentialling framework provides assurance of professional competency, safety and quality and underpins the profession's self-regulation in Australia.

Dietitians Australia (DA)

Dietitians Australia is the national association of the dietetic profession with over 9000 members, and branches in each state and territory. Dietitians Australia is the leading voice in nutrition and dietetics and advocates for the profession and the people and communities we serve.

The Accredited Practising Dietitian (APD) accreditation program provides an assurance of safety, quality practice, and is the foundation of self-regulation of the dietetic profession in Australia.

Accredited Practising Dietitians are university-qualified and uniquely trained to provide medical nutrition therapy to consumers in a clinical context across a broad range of disease and health conditions. APDs are integral to improving the health, function, and wellbeing of Australians by delivering evidence-based care, including in weight management and disease prevention. Their expertise enhances quality of care, drives health care efficiency, and contributes to long-term cost-effectiveness for the health system.

Summary of recommendations

ESSA and Dietitians Australia recommend that the PBAC:

- **Include in its advice to government that PBS-funded access to GLP-1RAs should be accompanied by funded, voluntary referral pathways to Accredited Practising Dietitians and Accredited Exercise Physiologists during treatment and following dose reduction or cessation.**

- **Refer the need for complementary Medicare funding to the Australian Government, including up to 12 funded APD and AEP services in the first year of GLP-1RA treatment, front-loaded during titration, with ongoing access in later years during treatment and following dose reduction or cessation.**

    - **Recommend that funded items can also be delivered by telehealth and virtual models of care to support equitable access in regional, rural and remote communities.**

- **Recommend that post-listing evaluation include nutrition status, muscle strength and physical function alongside weight loss and cardiovascular outcomes.**

    - **Evaluation should also consider treatment durability, functional outcomes and downstream healthcare utilisation when assessing the whole-of-care value of PBS-funded GLP-1RAs**

Executive summary

The Pharmaceutical Benefits Advisory Committee (PBAC) is considering equitable access to glucagon-like peptide-1 receptor agonist (GLP-1RA) medicines through the pharmaceutical benefits scheme (PBS) for individuals with established atherosclerotic cardiovascular disease (eASCVD) and obesity.[1]

The PBAC has highlighted the urgent need for equitable access of GLP-1RA medicines to improve the health and wellbeing of all Australians.[2] The PBAC highlighted the need to improve access to non-pharmacological interventions such as diet and physical activity support, that digital models may provide an equitable avenue, and that there should be no mandatory wraparound allied health requirements.[2]

Dietitians Australia and Exercise & Sports Science Australia (ESSA) recommend that these medicines are accompanied by funded, voluntary referral pathways to Accredited Practising Dietitians and Accredited Exercise Physiologists during treatment and following dose reduction or cessation, to maximise the clinical and economic value of this PBS investment.

GLP-1RAs are an important therapeutic advance, by reducing appetite, total energy intake, cravings and "food noise", they may create a valuable window for health and behaviour change.[3] However, reduced appetite and energy intake do not necessarily equate to sufficient nutritional intake or sustained health outcomes. Without accompanied dietetic and exercise physiologist support, GLP-1RA treatment may increase the risk of nutritional deficiencies, gastrointestinal issues, disordered eating behaviours, adverse psychological effects, loss of lean mass and physical function, and lead to poorly sustained health outcomes during and following GLP-1RA treatment.[4567]

Accredited Practising Dietitians (APDs) provide medical nutrition therapy (MNT), while Accredited Exercise Physiologists (AEPs) deliver individualised exercise assessment and prescription. These services are complementary: nutrition supports dietary adequacy and preservation of lean tissue, while structured exercise protects muscle strength, physical function and psychological wellbeing. Both should be recognised as core components of GLP-1RA care, not optional adjuncts to prescribing.

While dietetic and exercise physiologist support should be recognised as a core component of GLP-1RA care, services provided by APDs and AEPs are predominantly accessed through limited Medicare funded services. Care for those on GLP-1RAs requires more than a single consultation and cannot be adequately delivered within the current limit of five Medicare funded allied health services shared across all eligible professions, per calendar year.[8]

Dietitians Australia and Exercise and Sports Science Australia, recommend that the PBAC, include in its advice to government, that PBS-funded access to GLP-1RAs should be accompanied by funded, voluntary referral pathways to APDs and AEPs during treatment and following dose reduction or cessation. It is also recommended that the PBAC refer the need for complementary Medicare funding to the Australian Government, including up to 12 funded APD and AEP services in the first year of GLP-1RA treatment, front-loaded during titration, with ongoing access in later years during treatment and following dose reduction or cessation.

If public investment focuses on subsidising GLP-1RA medicines without enabling access to the care needed to optimise health outcomes and translate their effects into sustainable behaviours, there is a risk that pharmaceutical expenditure will deliver short-term change without delivering equivalent long-term health and economic value.

Benefits and considerations associated with GLP-1RA use

GLP-1RA's are effective therapies for improving glycaemic control, cardiometabolic biomarkers, and supporting weight loss in people with obesity, type 2 diabetes (T2DM), and cardiovascular disease improvements.[9] This presents an important opportunity to improve population-health in Australia, given the rapidly rising rates of chronic disease and patient complexity.[10] However, the weight loss associated with GLP-1RA consumption carries an under-recognised impact to energy and micronutrient consumption, body composition and function that, left unmanaged, poses a significant health impact and may generate avoidable downstream costs.

Accredited Practising Dietitians and Accredited Exercise Physiologists are uniquely trained to address the adverse outcomes associated with GLP-1RA use, including;

Nutrient deficiencies:

- GLP-1RA intake results in significant overall energy deficits and subsequent increased risk of nutrition deficiencies.[4] Within 1 month of GLP-1RA intake, patients across BMI categories failed to meet recommended nutrient intakes for fibre, calcium, iron, magnesium, potassium, choline, and vitamins A, C, D, and E.[11]
- In patients with obesity, T2DM, and hypertension, nutrition deficiencies were diagnosed in 12.7% of patients within 6 months following GLP-1RA initiation and 22.4% within 12 months.[4]

Lean tissue loss:

- Around 15–40% of weight lost can come from lean tissue, including skeletal muscle and bone; the concern is not lost mass alone but accompanying loss of muscle strength, quality and physical function, especially in older people and those with low muscle reserve.[3,6,12,13]
- Skeletal muscle is the primary site of insulin-mediated glucose disposal, taking up as much as ~80% of glucose under insulin stimulation.[1415] Muscle loss works against the glycaemic and cardiometabolic goals of the treatment and raises vulnerability to insulin resistance and weight gain.

Function, frailty and falls:

- Loss of muscle strength and physical function raises the risk of sarcopenia, falls, hospitalisation and loss of independence, greatest in older patients and those with existing frailty or low muscle reserve.[16]
- Sarcopenia, the combined loss of muscle mass, strength and function, is independently associated with falls, fractures, physical disability, longer hospital stays and mortality.[17] Rapid weight loss may compound this risk in susceptible patients unless muscle strength and function are actively monitored and protected throughout treatment.[18]

Gastrointestinal Issues (GI):

- Up to 75% of users experience GI issues including, nausea, vomiting, diarrhoea, constipation, dyspepsia, and abdominal pain, reducing GLP-1RA tolerance. Additional less common adverse effects include headache, dizziness, eructation, flatulence, and hypoglycaemia.[19],[20] Together these can reduce food and fluid intake, contributing to an increased risk of malnutrition.

Weight regain:

- Post-cessation weight regain is common, some individuals report up to 60% of lost weight is regained at 1 year.[21] Weight regain is significantly associated with reinitiation of GLP-1RA's.[7,22] In a study of 125,474 patients initiating GLP-1 RAs, 47.3% of patients with and 36.3% without T2DM subsequently reinitiated a GLP-1 RA within 1 year of cessation. [23] Without care that supports sustainable outcomes, the PBS may risk funding repeated treatment episodes without a commensurate reduction in disease burden.

Eating disorders and psychological implications:

- Depression, anxiety and psychological distress may coexist with obesity and may also arise or change during periods of rapid weight loss.[24] Integrating appropriately prescribed exercise and nutrition support with GLP-1RA treatment may support psychological wellbeing and self-efficacy alongside physical health.
- Appetite suppression, rapid weight loss and an intensified focus on body weight can unmask or entrench disordered eating, expressed through both restrictive intake and compulsive exercise, so dietary and exercise patterns require careful and professional joint monitoring in people at risk of eating disorders. [2526]

Multidisciplinary Care Required

To ensure the considerations of GLP-1RA medications are addressed, and the benefits of these medications are translated into sustainable health outcomes, GLP-1RA therapy should be accompanied by comprehensive multidisciplinary Accredited Practising Dietitian and Accredited Exercise Physiologist care.

Safe and effective dietary and exercise prescription for individuals on GLP-1RAs is not as simple as advising patients to move more and eat better. It must account for clinical complexity, co-existing chronic conditions, be adjusted for medication effects and rapid changes in energy intake, weight and function, and incorporate behaviour-change tools to promote sustained health outcomes. As university-qualified health professionals trained to prescribe evidence-based exercise and nutritional support in the presence of comorbidity and polypharmacy, AEPs and APDs are equipped to provide this complex level of clinical care.

Without complementary support, nutritional inadequacy, loss of lean mass and strength, functional decline, falls and psychological distress may continue to generate demand for primary care, hospital services and other supports, even where pharmacotherapy achieves

substantial initial weight loss. The economic value of GLP-1RA therapy should therefore be assessed across a long-term whole care pathway, not solely by the cost or short-term effects of the medicine.

The role of the APDs in supporting GLP-1RA care

Accredited Practising Dietitians- are university-qualified allied health professionals who provide expert nutrition and dietary support. APDs deliver individualised medical nutrition therapy to improve nutrition intake, address weight-related concerns, and manage chronic and complex conditions. Their care considers each person's clinical needs, readiness for change, knowledge, skills, cultural preferences and access to resources.[27]

Medical nutrition therapy (MNT) includes comprehensive nutrition assessment, identification of individual goals and priorities, practical dietary advice, behaviour-change counselling and ongoing review to support disease prevention, and management, and improve one's quality of life.[28]

In the context of GLP-1RA treatment, delayed gastric emptying, increased satiety and reduced appetite can substantially alter food and energy intake.[29] APDs tailor MNT to these changes, helping patients maintain nutritional adequacy, manage gastrointestinal symptoms and reduce the risk of malnutrition, disordered eating and loss of lean tissue and bone health.[29] This care also supports self-management and sustainable dietary behaviours during treatment and if pharmacotherapy is reduced or ceased.

Within GLP-1RA care, the APD's essential clinical functions include:

- screening and monitoring nutrition status, malnutrition risk, dietary patterns, disordered eating, gastrointestinal symptoms and relevant social determinants of health;
- determining individual energy, protein and nutrient requirements and prescribing dietary strategies that account for reduced appetite, changing intake and weight loss;
- monitoring nutritional adequacy and relevant body-composition risks, including factors affecting preservation of lean tissue and bone health;
- providing responsive eating education, goal setting, behaviour-change support and relapse-prevention strategies; and
- adapting nutrition interventions to the person's medical needs, circumstances, cultural preferences, lifestyle and access to food and other resources.[30,27,29,51]

Given the direct correlation between GLP-1RA intake and appetite suppression, individualised nutritional support cannot be overlooked. Dietary prescription delivered by an APD is a safeguard for patients physical and mental health, ensuring that weight reduction from GLP-1RA's deliver broader health and functional outcomes, rather than weight loss alone.

The role of the AEPs in supporting GLP-1 care

Accredited Exercise Physiologists (AEPs) are university-qualified allied health professionals who prescribe exercise for people with chronic and complex conditions. This clinical expertise is particularly relevant to GLP-1RA care, where patients may have multimorbidity, including type 2 diabetes, cardiovascular disease, musculoskeletal conditions and mental health concerns, and use multiple medicines. AEPs are trained to assess clinical risk, undertake exercise testing safely and prescribe and adapt exercise in the presence of comorbidities, functional limitations and medication-related considerations.[31]

Within pharmacologically assisted weight loss, the AEP's central role is to deliver individualised and progressive exercise, particularly resistance training, to preserve muscle strength, physical function and metabolic capacity. Skeletal muscle is the principal site of insulin-mediated glucose disposal and an endocrine organ that releases myokines involved in metabolic regulation, inflammation and systemic energy balance. Protecting muscle is therefore integral to the glycaemic and cardiometabolic objectives of treatment, rather than incidental to them.[12,14,32]

Structured exercise, and progressive resistance training in particular, is the primary intervention to preserve muscle strength and physical function during GLP-1 therapy.[18,33] Mechanical loading may also help attenuate lean-tissue loss, complementing the APD's role in supporting adequate energy, protein and nutrient intake. AEPs also monitor fatigue, cardiovascular responses, treatment tolerance and functional capacity, adapting exercise as weight, symptoms and clinical risk change.

Within GLP-1RA care, the AEP's essential clinical functions include:

- assessing functional capacity, muscle strength and cardiometabolic risk;
- prescribing individualised exercise to preserve strength, physical function and lean tissue during weight loss;
- monitoring fatigue, mobility, exercise tolerance and physical capacity as treatment progresses;
- adapting exercise for chronic-disease comorbidities, medication effects and musculoskeletal limitations; and
- supporting behaviour change and sustainable physical activity and long-term weight maintenance if pharmacotherapy is reduced or ceased.

Australia has 10,107 AEPs (as of August 2026) who deliver more than 451,000 Medicare-funded services annually to approximately 179,000 Australians. Across all healthcare settings, AEPs provide essential clinical services to approximately 243,000 clients each week, equating to over 1.16 million unique patients each year.[34,35,] More than one-third already work with people with type 2 diabetes, and approximately 2,600 provide services by telehealth.[34] Telehealth can improve access for people in regional, rural and remote communities, although affordability, connectivity and local service availability remain important considerations. People

with type 2 diabetes may currently access AEP services through Medicare GP Chronic Condition Management Plans, group allied health arrangements or private funding.

Given the physiological changes associated with GLP-1RA therapy, clinical exercise prescription delivered by an AEP safeguards physical function, independence and longer-term health. It helps ensure that weight reduction translates into meaningful health gain rather than a lower number on the scale alone.

Improving Patient Access to Multidisciplinary Care

Outcomes for Australians on GLP-1RA medications can be improved by better access to APDs and AEPs under Medicare's General Practice Chronic Disease Management Program (GPCCMP) items (10953, 10954, 93000, 93013).[36]

Currently patients are only able to access five sessions under the Chronic Disease Management plan, shared across 13 allied health professionals.[8] Consequently, individuals may not have sufficient access to the complex multidisciplinary support required while on these medications and cannot meet best practice guidelines for nutritional or physical care.[3738] We are therefore recommending that the PBAC refer the need for complementary Medicare funding to the Australian Government, including at least 12 funded items to access APDs and AEPs annually for eligible people prescribed GLP-1RAs.

The Department of Veterans' Affairs recognises the need for additional consultations. The 2019 implementation of the Treatment Cycle Initiative under the Department of Veteran Affairs allowed 12 consultations per allied health profession per year for eligible veterans.[39] [40]

Access to care should be extended to all individuals, and GLP-1RA therapy should not be delivered as a medication-only intervention. APD and AEP's provide complementary support; each addressing a distinct and interrelated nutrition, behavioural, physical and functional considerations associated with GLP-1RA use. An increase to 12 sessions, can improve patient access to the complex care required during GLP-1RA therapy and can help patients embed sustainable behaviours and long-term health improvements alongside GLP-1RA treatment. Extending patient access to APD and AEP care alongside pharmacotherapy, may support sustained health gains, reduce preventable health complications and associated healthcare expenditure, and maximise the long-term value of GLP-1RA investment within the Australian healthcare system.

Savings to government: Reducing Obesity Related Costs and Inequities Through Multidisciplinary GLP-1 RA Care

The value of GLP-1 RA therapy to government is best assessed within a whole-of-care framework that considers treatment durability, functional outcomes and downstream healthcare utilisation, rather than the cost of the medicine in isolation.

To estimate the cost of a funded exercise physiology and dietetic pathway alongside GLP-1RA therapy, and the additional effectiveness required for that pathway to be cost-effective, ESSA and Dietitians Australia applied an established Australian cost-effectiveness model of semaglutide in adults with overweight or obesity and established cardiovascular disease.[41]

The modelled pathway is deliberately modest, including:

- 12 sessions shared across AEPs and APDs in the first year, front-loaded during the titration period.
- Followed by two sessions in year two and one annual review for as long as the patient remains on therapy.

For the purposes of the economic analysis, the pathway is costed using a cardiac rehabilitation delivery model, as reflected in Figure 1, incorporating individual APD/AEP consultations.

Costed at Medicare benefit rates, the pathway would cost **$1,232 per patient** over the model horizon, or **$747 per new patient** over five years once real-world persistence is applied to both the medicine and the support pathway.

Compared with **$8,430 in medicine expenditure** per initiator on the same basis, the proposed pathway represents only **8.9% of total medicine expenditure**. Because the first-year block is a fixed investment per initiator, cohorts with earlier discontinuation show a higher ratio of **12.2% under low persistence** and **5.9% under high persistence**.

The additional clinical effectiveness required from the support pathway is therefore correspondingly small.

Applying the cost of the pathway to the published Australian cost-effectiveness analysis, a 20-year Markov model reports an Incremental cost-effectiveness ratio (ICER) of $96,055 per Quality adjusted life year (QALY). At an assumed annual medicine cost of $4,175, our recomputation reproduces this at **A$96,042** per QALY**.** Adding the cost of the support pathway raises it to **A$98,630** per QALY.

The support pathway would therefore need to generate an additional 0.0128 QALYs per patient to offset its incremental cost and return the ICER to the level of the medicine-only scenario. This represents a small **2.7% increase** in health benefit, equivalent to a sustained utility increment of 0.0012, or approximately **one-eighth** of the increment attributed to semaglutide in the model.[42]

Integrating 12 items for APD/AEP support is an additional investment, but only a small improvement in patient health (2.7%) is needed to offset this investment.

Even under the least favourable unit-cost and maintenance assumptions, APD/AEP support would only need to deliver an 8.0% additional health benefit to make the cost of additional support worthwhile.

Both estimates are below most published estimates for supervised exercise and nutrition support in comparable populations, and above only the weakest estimates (Figure 1).[43444546474849] The closest applicable comparator, a lifetime model of exercise referral among sedentary adults with obesity, reported a gain of 0.011 QALYs at £14,618 per QALY.[48]

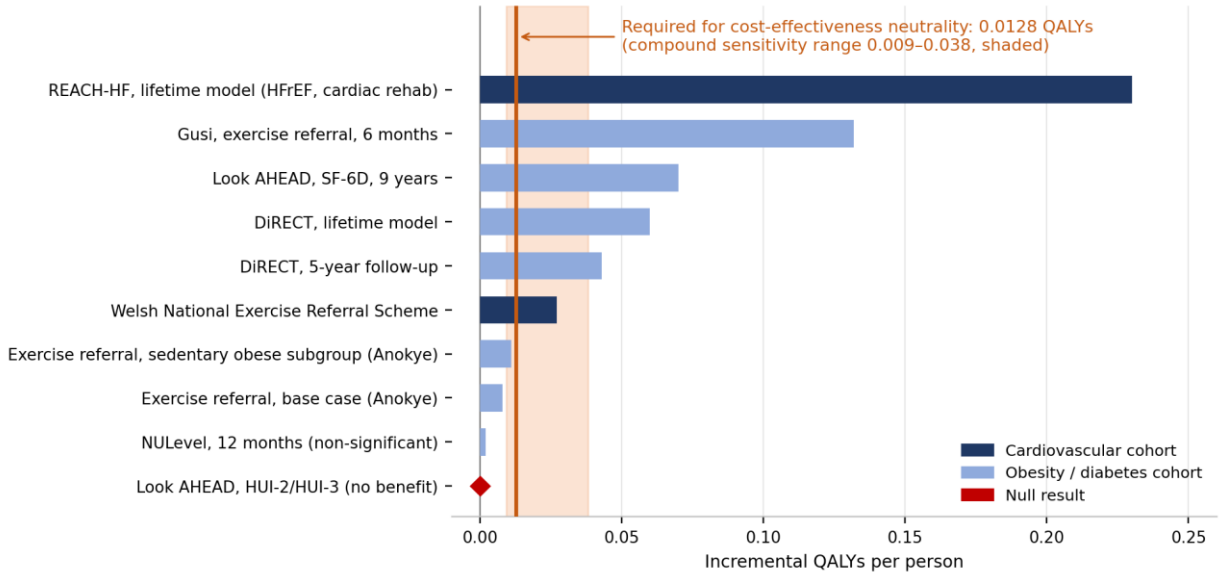

Figure 1 Comparator estimates from exercise and dietary interventions, set against the gain required here for cost-effectiveness neutrality (0.0128 QALYs; compound sensitivity range 0.009 - 0.038). Cardiovascular-cohort studies are the applicable comparators because cardiac rehabilitation is the proposed delivery route; obesity and diabetes gains are largely mediated by diabetes remission, which SELECT model excluded. Null results are shown because they are part of the same literature. The REACH-HF trial's own EQ-5D between-group difference at 12 months was −0.024 (95% CI −0.091 to 0.044, non-significant); it is not plotted because it is a utility difference at a single timepoint rather than a QALY.

Two features make this a conservative rather than an optimistic estimate. First, the source model[35,41] includes no pathway for lean-mass loss, sarcopenia, falls or functional decline. The principal mechanisms through which exercise physiology and dietetics may contribute to durable health outcomes are therefore absent from the model. The threshold reported here represents what the support pathway must achieve within the model, **not the full range of benefits it may deliver in practice**. Second, the range of QALY gains reported in the published literature indicates that AEP- and APD-led interventions for people with obesity and established cardiovascular disease **could plausibly exceed this threshold.**

On the cost side, group contacts are costed at the Medicare benefit, which represents a funding floor rather than the full cost of delivering a cardiac rehabilitation program. For comparison, the REACH-HF facilitated home-based cardiac rehabilitation program was delivered in the United Kingdom at £418 per participant for a mean of 6.5 contacts, compared with an NHS cardiac rehabilitation tariff of £477, approximately A$122 per contact at current exchange rates and before adjustment for inflation, compared with the A$63 applied here. Medicare benefits fund consultation time only and does not account for facilitator training, travel or non-contact time included in the REACH-HF estimate.[50]

The finding that semaglutide was not cost-effective in the Australian model[41] was driven largely by the assumed medicine cost of $4,175 per year, derived from comparable formulary medicines. The confidential effective price may be lower than this assumed cost. This would alter the specific estimates but not the central conclusion: **the proposed support pathway represents a small and predictable per-patient cost relative to the cost of pharmacotherapy.**

With GLP-1 RA use rising in Australia, alongside demand for more complex care, the question is not only whether these medicines will be dispensed at scale, but whether that expenditure will deliver durable health benefits. **Raising the Chronic Condition Management Plan limit from five individual services shared across all allied health professions to at least 12 services annually for this population, would involve a known and modest cost per patient.**

It would also place dietetic and exercise physiology care within reach of more people receiving GLP-1RA therapy and ultimately aid in reducing the potential cyclic health and economic burden on the Australian healthcare system, following GLP-1RA treatment cessation.

Conclusion

As the committee considers equitable access to GLP-1RA medicine through the PBS for individuals with eASCVD, Exercise and Sports Science Australia and Dietitians Australia encourage consideration of the broader model of care surrounding GLP-1RA therapy. The question is not only whether GLP-1RA therapies are prescribed appropriately, but whether patients are supported appropriately to achieve the best possible outcomes from these medications.

Structured exercise delivered by Accredited Exercise Physiologists and medical nutrition therapy delivered by Accredited Practising Dietitians are complementary, evidence-based components of GLP-1RA care. Advising government to extend Medicare funded access to both professions for eligible patients during GLP-1RA treatment and following dose reduction or cessation, protects muscle strength, physical function and nutritional health and supports the durability of treatment outcomes. As the accompanying economic analysis shows, this extension represents a small and known per-patient cost relative to the cost of PBS-subsidised GLP-1RA pharmacotherapy.

Exercise and Sports Science Australia and Dietitians Australia welcome the opportunity to work with the Committee and the Australian Government to ensure that PBS-supported GLP-1RA therapy is delivered within models of care that optimise patient outcomes, preserve physical function and nutritional health, and maximise the value of public investment.

Bibliography

[1] Care AGD of H and A. November 2026 PBAC Meeting | PBS [document] [Internet]. Australian Government Department of Health and Aged Care; [cited 2026 Sep 9]. Available from: https://www.pbs.gov.au/industry/listing/elements/pbac-meetings/agenda/november-2026-pbac-meeting

[2] Pharmaceutical Benefits Advisory Committee. PBAC advice on equitable access to GLP-1 obesity treatments [PBAC advice] [Internet]. Canberra: Australian Government Department of Health and Aged Care; 2025 Dec. Available from: https://www.pbs.gov.au/reviews/obesity-treatments-files/PBAC-advice-on-GLP1.PDF?

[3] Karakasis P, Patoulias D, Fragakis N, Mantzoros CS. Effect of glucagon-like peptide-1 receptor agonists and co-agonists on body composition: Systematic review and network meta-analysis. Metabolism. 2025 Mar;164:156113. doi:10.1016/j.metabol.2024.156113

[4] Scott Butsch W, Sulo S, Chang AT, Kim JA, Kerr KW, Williams DR, et al. Nutritional deficiencies and muscle loss in adults with type 2 diabetes using GLP-1 receptor agonists: A retrospective observational study. Obes Pillars. 2025 Sep;15:100186. doi:10.1016/j.obpill.2025.100186

[5] GLP-1 Medications and Eating Disorders. National Eating Disorders Association [Internet]. [cited 2026 Sep 9]. Available from: https://www.nationaleatingdisorders.org/glp-and-eating-disorders/

[6] Haner Wasserstein D, Whitford T, Whiteson HZ, Frishman WH. Lean Mass Loss in Glucagon-Like Peptide-1/GIP Therapy: Clinical Implications for Obesity and Cardiovascular Care. Cardiol Rev. 2026 Feb 4. doi:10.1097/CRD.0000000000001178 PubMed PMID: 41636548.

[7] Wu H, Yang W, Guo T, Cai X, Ji L. Trajectory of the body weight after drug discontinuation in the treatment of anti-obesity medications. BMC Med. 2025 Jul 22;23(1):398. doi:10.1186/s12916-025-04200-0

[8] Note MN.3.1 | Medicare Benefits Schedule [Internet]. [cited 2026 Sep 7]. Available from: https://www9.health.gov.au/mbs/fullDisplay.cfm?type=note&q=MN.3.1

[9] Obesity: GLP-1 therapies [Internet]. [cited 2026 Sep 9]. Available from: https://www.who.int/news-room/questions-and-answers/item/obesity-glp-1-therapies

[10] Prevalence of chronic conditions | Australian Bureau of Statistics [Internet]. 2025 [cited 2026 Sep 9]. Available from: https://www.abs.gov.au/statistics/measuring-what-matters/measuring-what-matters-themes-and-indicators/healthy/prevalence-chronic-conditions

[11] Johnson B, Milstead M, Thomas O, McGlasson T, Green L, Kreider R, et al. Investigating nutrient intake during use of glucagon-like peptide-1 receptor agonist: a cross-sectional study. Front Nutr. 2025 Apr 25;12:1566498. doi:10.3389/fnut.2025.1566498

[12] Prado CM, Phillips SM, Gonzalez MC, Heymsfield SB. Muscle matters: the effects of medically induced weight loss on skeletal muscle. Lancet Diabetes Endocrinol. 2024 Nov;12(11):785–7. doi:10.1016/S2213-8587(24)00272-9

[13] Barbat-Artigas S, Rolland Y, Vellas B, Aubertin-Leheudre M. Muscle quantity is not synonymous with muscle quality. J Am Med Dir Assoc. 2013 Nov;14(11):852.e1-7. doi:10.1016/j.jamda.2013.06.003 PubMed PMID: 23896368.

[14] Merz KE, Thurmond DC. Role of Skeletal Muscle in Insulin Resistance and Glucose Uptake. In: Terjung R, editor. Comprehensive Physiology [Internet]. 1st ed. Wiley; 2020 [cited 2026 Sep 1]. p. 785–809. Available from: https://onlinelibrary.wiley.com/doi/10.1002/cphy.c190029 doi:10.1002/cphy.c190029

[15] DeFronzo RA, Tripathy D. Skeletal Muscle Insulin Resistance Is the Primary Defect in Type 2 Diabetes. Diabetes Care. 2009 Nov 1;32(suppl_2):S157–63. doi:10.2337/dc09-S302

[16] Güngör M, Balcı C. Sarcopenia in older adults: A narrative review of current concepts in diagnosis and treatment. Clin Nutr ESPEN. 2026 Jun 1;73:103276. doi:10.1016/j.clnesp.2026.103276

[17] Cruz-Jentoft AJ, Bahat G, Bauer J, Boirie Y, Bruyère O, Cederholm T, et al. Sarcopenia: revised European consensus on definition and diagnosis. Age Ageing. 2019 Jan 1;48(1):16–31. doi:10.1093/ageing/afy169

[18] Exercise & Sports Science Australia. Exercise and Physical Activity in the Era of Obesity Pharmacotherapy: A call for integrated, multidisciplinary models of care to ensure safe, equitable and effective use of GLP-1 and related weight-management medications [International joint statement] [Internet]. 2026. Available from: https://www.essa.org.au/Common/Uploaded%20files/Submissions/Joint%20statement%20on%20exercise%20in%20obesity%20care.pdf

[19] McGuane C, Farhadhar N, Sharieff KA, Petrosky SN, Alabasi K. Nutritional Care for Adults With Obesity Treated With Glucagon-Like Peptide (GLP)-1 and Dual Glucose-Dependent Insulinotropic Polypeptide (GIP)/GLP-1 Receptor Agonists: A Review of Evidence, Gaps, and Clinical Implications. Cureus. 2026 May 27. doi:10.7759/cureus.109731

[20] Ghusn W, Hurtado MD. Glucagon-like Receptor-1 agonists for obesity: Weight loss outcomes, tolerability, side effects, and risks. Obes Pillars. 2024 Dec;12:100127. doi:10.1016/j.obpill.2024.100127

[21] Wilding JPH, Batterham RL, Davies M, Van Gaal LF, Kandler K, Konakli K, et al. Weight regain and cardiometabolic effects after withdrawal of semaglutide: The STEP 1 trial extension. Diabetes Obes Metab. 2022 Aug;24(8):1553–64. doi:10.1111/dom.14725

[22] Moolla A, Poolman T, Othonos N, Dong J, Smith K, Cornfield T, et al. Randomised trial comparing weight loss through lifestyle and GLP-1 receptor agonist therapy in people with MASLD. JHEP Rep. 2025 May;7(5):101363. doi:10.1016/j.jhepr.2025.101363

[23] Rodriguez PJ, Zhang V, Gratzl S, Do D, Goodwin Cartwright B, Baker C, et al. Discontinuation and Reinitiation of Dual-Labeled GLP-1 Receptor Agonists Among US Adults With Overweight or Obesity. JAMA Netw Open. 2025 Jan 31;8(1):e2457349. doi:10.1001/jamanetworkopen.2024.57349

[24] Steptoe A, Frank P. Obesity and psychological distress. *Philos Trans R Soc Lond B Biol Sci.* 2023;378(1888):20220225. doi: 10.1098/rstb.2022.0225

[25] Yuan TY, Bouzari N, Bains A, Cohen TR, Kakinami L. Weight-control compensatory behaviors patterns and correlates: a scoping review. **Front Psychol.** 2024;15:1383662. doi:10.3389/fpsyg.2024.1383662

[26] Gorrell S, Flatt RE, Bulik CM, Le Grange D. Psychosocial etiology of maladaptive exercise and its role in eating disorders: a systematic review. **Int J Eat Disord.** 2021;54(8):1358-1376. doi:10.1002/eat.23524.

[27] Dietitians Australia. The role of an Accredited Practising Dietitian [Internet]. Canberra: Dietitians Australia; [cited 2026 Sep 14]. Available from: The role of an Accredited Practising Dietitian | Dietitians Australia

[28] Dietitians Australia. Improving patient outcomes through Medical Nutrition Therapy [Internet]. Canberra: Dietitians Australia; [cited 2026 Sep 14]. Available from Improving_Patient_Outcomes-Updated2020.pdf

[29] Mozaffarian D, Agarwal M, Aggarwal M, Alexander L, Apovian CM, Bindlish S, et al. Nutritional priorities to support GLP -1 therapy for obesity: A joint Advisory from the American College of Lifestyle Medicine, the American Society for Nutrition, the Obesity Medicine Association, and The Obesity Society. Obesity. 2025 Aug;33(8):1475–503. doi:10.1002/oby.24336

[30] Mitchell LJ, et al. Effectiveness of dietetic consultations in primary health care: a systematic review of randomized controlled trials. Journal of the Academy of Nutrition and Dietetics. 2017 Dec 1;117(12):1941-62.

[31] Exercise & Sports Science Australia. Scope of Practice for Accredited Exercise Physiologists (AEPs) [Scope of Practice] [Internet]. ESSA. Available from: https://www.essa.org.au/Common/Uploaded%20files/Standards/AEP%20Scope%20of%20Practice.pdf

[32] Neeland IJ, Linge J, Birkenfeld AL. Changes in lean body mass with GLUCAGON-LIKE PEPTIDE -1-based therapies and mitigation strategies. Diabetes Obes Metab. 2024 Sep;26(S4):16–27. doi:10.1111/dom.15728

[33] Bellicha A, van Baak MA, Battista F, Beaulieu K, Blundell JE, Busetto L, et al. Effect of exercise training on weight loss, body composition changes, and weight maintenance in adults with overweight or obesity: An overview of 12 systematic reviews and 149 studies. Obes Rev. 2021 Jul;22(Suppl 4):e13256. doi:10.1111/obr.13256 PubMed PMID: 33955140; PubMed Central PMCID: PMC8365736.

[34] Exercise & Sports Science Australia. State of Exercise Physiology Workforce 2026 report [Workforce Report]. ESSA; 2026 Jul.

[35] Exercise & Sports Science Australia. Deloitte Access Economics. Economic value of exercise physiology in Australia [Economic Report] [Internet]. 2026 Aug. Available from: https://www.essa.org.au/Web/Resources/Reports/economic-value-of-exercise-physiology-in-australia-2026.aspx

[36] Jansen S, Ball L, Lowe C. Impact of the Medicare Chronic Disease Management program on the conduct of Australian dietitians' private practices. Aust Health Rev. 2015 Apr 2;39(2):183–9. doi:10.1071/AH14074

[37] Nagy A, McMahon A, Tapsell L, Deane F. Developing meaningful client-dietitian relationships in the chronic disease context: An exploration of dietitians' perspectives. Nutr Diet. 2020;77(5):529–41. doi:10.1111/1747-0080.12588

[38] Weight management | Dietitians Australia [Internet]. [cited 2026 Sep 9]. Available from: https://dietitiansaustralia.org.au/taxonomy/term/16

[39] Dietitians | Department of Veterans' Affairs [Internet]. [cited 2026 Sep 9]. Available from: https://www.dva.gov.au/providers/information-for-dental-psychology-allied-health-providers/dietitians

[40] Treatment cycle information for allied health providers | Department of Veterans' Affairs [Internet]. [cited 2026 Sep 9]. Available from: https://www.dva.gov.au/providers/information-for-dental-psychology-allied-health-providers/allied-health-treatment-cycle/treatment-cycle-information-for-allied-health-providers

[41] Zomer E, Zhou J, Nelson AJ, Sumithran P, Nanayakkara S, Ball J, et al. The cost-effectiveness of semaglutide in reducing cardiovascular risk among people with overweight and obesity and existing cardiovascular disease, but without diabetes. Eur Heart J Qual Care Clin Outcomes. 2025 Sep 12;11(6):857–67. doi:10.1093/ehjqcco/qcae063 PubMed PMID: 39096165.

[42] Taylor RS, Sadler S, Dalal HM, Warren FC, Jolly K, Davis RC, et al. The cost effectiveness of REACH-HF and home-based cardiac rehabilitation compared with the usual medical care for heart failure with reduced ejection fraction: A decision model-based analysis. Eur J Prev Cardiol. 2019 Aug;26(12):1252–61. doi:10.1177/2047487319833507 PubMed PMID: 30884975; PubMed Central PMCID: PMC6628466.

[43] Gusi N, Reyes MC, Gonzalez-Guerrero JL, Herrera E, Garcia JM. Cost-utility of a walking programme for moderately depressed, obese, or overweight elderly women in primary care: a randomised controlled trial. BMC Public Health. 2008 Jul 8;8:231. doi:10.1186/1471-2458-8-231 PubMed PMID: 18611277; PubMed Central PMCID: PMC2491610.

[44] Zhang P, Atkinson KM, Bray GA, Chen H, Clark JM, Coday M, et al. Within-Trial Cost-Effectiveness of a Structured Lifestyle Intervention in Adults With Overweight/Obesity and Type 2 Diabetes: Results From the Action for Health in Diabetes (Look AHEAD) Study. Diabetes Care. 2021 Jan;44(1):67–74. doi:10.2337/dc20-0358 PubMed PMID: 33168654; PubMed Central PMCID: PMC7783933.

[45] Xin Y, Davies A, Briggs A, McCombie L, Messow CM, Grieve E, et al. Type 2 diabetes remission: 2 year within-trial and lifetime-horizon cost-effectiveness of the Diabetes Remission Clinical Trial (DiRECT)/Counterweight-Plus weight management programme. Diabetologia. 2020 Oct;63(10):2112–22. doi:10.1007/s00125-020-05224-2 PubMed PMID: 32776237; PubMed Central PMCID: PMC7476973.

[46] Davies A, Grieve E, McCombie L, McIntosh A, McConnachie A, Leslie WS, et al. Cost-effectiveness of the diabetes remission clinical trial (DiRECT)/Counterweight-Plus weight management programme, based on 5-year follow-up. Diabet Med J Br Diabet Assoc. 2026 Jun;43(6):e70306. doi:10.1111/dme.70306 PubMed PMID: 41904649; PubMed Central PMCID: PMC13170983.

[47] Anokye NK, Trueman P, Green C, Pavey TG, Hillsdon M, Taylor RS. The cost-effectiveness of exercise referral schemes. BMC Public Health. 2011 Dec 26;11:954. doi:10.1186/1471-2458-11-954 PubMed PMID: 22200193; PubMed Central PMCID: PMC3268756.

[48] Sniehotta FF, Evans EH, Sainsbury K, Adamson A, Batterham A, Becker F, et al. Behavioural intervention for weight loss maintenance versus standard weight advice in adults with obesity: A randomised controlled trial in the UK (NULevel Trial). PLoS Med. 2019 May 7;16(5):e1002793. doi:10.1371/journal.pmed.1002793 PubMed PMID: 31063507; PubMed Central PMCID: PMC6504043.

[49] Dalal HM, Taylor RS, Jolly K, Davis RC, Doherty P, Miles J, et al. The effects and costs of home-based rehabilitation for heart failure with reduced ejection fraction: The REACH-HF multicentre randomized controlled trial. Eur J Prev Cardiol. 2019 Feb;26(3):262–72. doi:10.1177/2047487318806358 PubMed PMID: 30304644; PubMed Central PMCID: PMC6376602.

[51] Morgan-Bathke M, Baxter SD, Halliday TM, Lynch A, Malik N, Raynor HA, et al. Weight management interventions provided by a dietitian for adults with overweight or obesity: an Evidence Analysis Center systematic review and meta-analysis. J Acad Nutr Diet. 2023;123(11):1621–1661.e25. doi:10.1016/j.jand.2022.03.014.