

## 'It's all right for you thinnies'

'Obesity', eating disorders, and  
COVID-19

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Our title quotes what British Prime Minister Boris Johnson reportedly said when comparing his COVID-19 experience (which required intensive care) with cabinet members who had mild symptoms. It is suggested that Johnson's brush with mortality profoundly impacted him – it was followed by public declarations to lose weight and policy shifts he previously would have likely dismissed as nanny statism. While it is politically convenient for Johnson to link the severity of his illness (and by inference the impact of the virus more generally) with factors popularly promoted as within individual control (for example, bodyweight), he is not alone in exploiting this pandemic to promote simplistic and stigmatising ideas about bodyweight and health.

Although not popularly known or accepted, in recent decades research, advocacy, and activism has made significant progress in demonstrating the complexity of relationships between bodyweight and health, the multifaceted and interrelated biological, psychological, and social causes of 'obesity', and how common (mis)conceptions and prejudice ultimately promote discrimination of people who variously identify as (among others) Fat, higher weight, and living with obesity. Responses to the COVID-19 and Body Mass Index (BMI) link have largely ignored this. The urgency of a pandemic, and opportunism of those with vested interests in over-emphasising personal control and responsibility, create a perfect storm for harming people across the weight spectrum

– particularly those above and below what is considered ‘healthy’. We consider evidence that has been ignored and ways this pandemic is disproportionately harming those who transgress medically and/or popularly ‘acceptable’ bodyweight and eating norms – drawing on personal experiences of transgressing these norms, providing healthcare to those with eating disorders, and academic expertise (including that imbued with related ‘lived experience’).

### **Sobering conclusions and scapegoats**

Early evidence indicates that people with higher BMIs are at greater risk of severe COVID-19 outcomes (Popkin et al, 2020). However, the inaccuracy and harm that comes from assuming causality and homogeneity on the basis of BMI alone must not be forgotten. Retrospective analysis of studies from the 2009–10 influenza pandemic indicated that the initial association between ‘obesity’ and poor prognosis was no longer apparent after adjusting for early antiviral treatment (Sun et al, 2016). The initial finding was therefore more likely attributable to the well-documented relationship between weight stigma and poor/avoided medical interactions than physiology (Tomiya et al, 2018). This is not to claim the same thing is happening now, nor deny that on average people in higher BMI categories are at greater risk from COVID-19, but is a reminder that the full complexity of an issue can rarely be grasped from early findings or without due consideration of the social processes through which medical outcomes materialise.

The pandemic death toll is sobering – as is consensus that it would be significantly lower had the government acted more swiftly and effectively. This, together with the COVID-19 and BMI link and the dominant narrative that ‘obesity’ is a self-inflicted and costly condition of the slothful, stupid, and/or irresponsible, has made people who are Fat/higher weight/living with obesity convenient scapegoats. Pre-COVID-19, public bodies and popular media regularly disparagingly reported that the majority of the UK are ‘overweight’ or ‘obese’. If the priority now is to protect those at greatest

risk, these statistics should be used to protect (rather than blame) the majority of the country. To date, the advice is that people with a BMI of >40 should be particularly stringent in social distancing and potentially prioritised for vaccination only after everyone 65 or older is vaccinated. How are those who are Fat/higher weight/living with obesity supposed to interpret this? That we/they are unimportant or, more gravely, expendable? Patient advocates identifying as living with obesity reported increased fear, confusion, and stigma during the pandemic – particularly fearing not receiving necessary and appropriate medical support if admitted to hospital (Le Brocq et al, 2020). These are not baseless fears and it is therefore predictable and warranted that internationally those identifying as fat activists are rejecting fatness/'obesity' being used to distract from government responsibility for pandemic preparedness, response, and management (Pausé et al, 2021).

Are those driving the 'war on obesity' – including policymakers and even well-meaning healthcare professionals – unaware or unconcerned about collateral damage? Many hide behind the 'unintended consequences' explanation or claim a hoped-for future end justifies the harmful present means. Much of this harm is avoidable and greater consideration of the relationships between 'obesity' and 'eating disorders' helps demonstrate this.

### **'Eat less, move more' rebranded**

The 'obesity' policy paper published during the pandemic *Tackling obesity: empowering adults and children to live healthier lives* (DHSC, 2020) is apt for the era, with 'empowerment' yet again doing heavy lifting for what largely represents responsabilisation through individual behaviour change interventions. It presents 'excess weight' as 'one of the few modifiable factors for COVID-19' and states the nation 'owe it to the NHS' to lose weight to reduce risk (DHSC, 2020). The resulting 'Better Health' campaign presents COVID-19 as a 'wake up call' for a complacent overweight nation, and proposes to 'kick start' the population's health, though it is essentially 'eat less, move more' rebranded – focusing on

weight-loss achieved through apps and commercial weight-loss services. Commercial partners include WW (Weight Watchers post-rebrand), Slimming World, and GetSlim.

The policy assumes mass scale weight-loss is achievable and will improve health. This overlooks evidence indicating that – by their own standards – ‘obesity’ policy and weight-loss interventions are largely ineffective (Hall and Kahan, 2018; Theis and White, 2021), weight/weight-loss focused anti-obesity campaigns risk exacerbating disordered eating (Bristow et al, 2020), and commercial interests and methods are not always conducive to promoting health. ‘Better Health’ draws on fears about COVID-19 to ‘motivate’ weight-loss. If scaremongering were effective then previous campaigns emphasising links between BMI and diabetes, heart disease, and cancer would have already achieved this. The focus on weight-loss undermines health promotion and does little to actually address COVID-19 risk.

My (Fiona) eating disorder initially developed from anti-obesity rhetoric. When ‘the obesity crisis’ came to prominence in the public health domain in the 1980s, the ‘pinch more than an inch’ weight-loss campaign, led by a commercial cereal company, was popular. I was relentlessly teased – on the end of jokes like ‘if you can pinch more than a foot’. Fast forward to 2021 and little has changed; ‘obesity’ campaigns continue their fear- and shame-inducing approach to health. The pandemic has brought about new challenges for me. The same circumstances that triggered my susceptibility to eating disorders – early weight-based teasing and repeated restrictive diets – have returned. Constant messages about weight-loss, individual responsibility, and taking pressure off the NHS brought me back to my childhood. Instead of feeling empowered and motivated, I felt shame, blame, and helplessness. Old habits returned – avoiding medical care, isolating myself, and feeling unworthy of care unless I lost weight.

Policies both shape and are shaped by contemporary culture, and popular media play significant roles. Early in the pandemic, the BBC broadcast *The Restaurant That Burns off Calories* – a programme investigating laboratory findings indicating that people generally eat less when calories are equated to

physical activity. People were invited to eat a free meal while, unbeknownst to them, people in an on-site gym burned their calories. Post-meal the sweaty squad were revealed to diners like a surprisingly costly bill. In response, Beat (UK's eating disorder charity) publicly discouraged people from watching and extended their support services' opening hours. Soon after, one of the programme's presenters helped organise an online conference: 'Covid-19: A lifestyle disease and the vital role GPs have in beating it'. Over 500 healthcare professionals attended the Royal College of General Practitioners (RCGP) and Sport England funded event. After protest, the RCGP clarified it did not consider COVID-19 a lifestyle disease (a term chiefly and problematically used to describe non-communicable diseases), and formally apologised for the offence this implication caused (Rimmer, 2020).

Sport England also funded research exploring pandemic physical activity (Sport England, 2020). The majority surveyed felt being active during the pandemic was more important compared to other times. It showed big increases in online activities with 26% naming Joe Wicks the most useful instructor/influencer. Wicks, a fitness coach, declared himself 'The Nation's PE Teacher' as he streamed free fitness classes on YouTube marketed as PE lesson replacements during school closures. We should consider what is lost when PE is reduced to fitness classes and the potential harms of training children using logic from the commercial fitness industry. For instance, when Wicks's wife stepped in as 'supply teacher', they celebrated her having 'earned breakfast'. From such logic, problematic relationships with bodies, diet, and exercise can spring.

Two of us (Harry and Sophie) had treatment for anorexia during the pandemic. My (Harry) parents had been worried for years about how focused I was on healthy eating and exercising, but my doctor deemed me too well to need eating disorder services. When lockdown hit, things got more serious. I went from having a busy life, going to school, clubs, and hanging out with friends, to spending lots of time by myself at home. This gave me more time to think about what I *should* be doing and to look online for answers. I watched loads of videos by celebrities like Joe Wicks. I started exercising more.

I felt that to be healthy I had to exercise outside once a day like the government said. The restrictions made me think I really needed to make the most of that time. I was running 3 miles and doing Joe Wicks's workouts before breakfast. I ate less and less and then started skipping meals altogether. I bought into the idea of earning food and that developed into anorexia. Eating nothing became a good thing. Pretty quickly, I became unwell and was admitted to an inpatient eating disorder unit.

My (Sophie) issues with food began nine years ago. Past therapy had little effect, but I started seeing a dietitian and psychologist privately in January 2020 after my family suggested it. In March, I hit rock bottom. I finally realised my eating disorder was an issue, became really sick with COVID-19, and lost more weight. I was really down, but I had support. I was seeing my dietitian and psychologist regularly and being supported by my husband. Going into lockdown was a real turning point. My routine changed – I went from being at home alone all day to having my husband working from home and supporting me. This forced change meant I was able to address the more difficult behaviours that supported my anorexia. I often wonder what would have happened without that support. During lockdown, I knew there was lots of talk about health and weight and especially exercise, and that those messages were unhelpful for me. The people around me helped me to avoid being sucked in by them. I still have work to do, but I am grateful I was able to come through the lockdowns moving towards recovery.

Our (Fiona, Sophie, Harry) experiences chime with others. Research highlighted that people with experience of eating disorders commonly expressed that spending more time online during the pandemic had worsened their 'symptoms'. Increases in diet- and exercise-related messages were highlighted as particularly problematic. Disruptions to routine and reduced access to support and services have been common, with some people reporting positive experiences of people being at home to support them (Branley-Bell and Talbot, 2020).

### Support not stigma

The government response to the link between higher BMIs and poor COVID-19 prognosis highlights that 'following the science' is political rhetoric. This link could have been responded to in various ways. The notion that people who are Fat/higher weight/living with obesity are the problem and weight-loss is the solution was predictable because the pandemic merely offers the latest example of the prejudice and discrimination we/they face. The personal experiences and evidence we have shared demonstrate the ineffectiveness and harmfulness of anti-obesity campaigns and highlights the significance of support. Weight-loss focused anti-obesity campaigns create a need for support – both to cope with the hostility they create towards people who are Fat/higher weight/living with obesity and to mitigate the risks of developing/worsening eating disorders. This support is needed primarily because of pre-pandemic political failings to address the social determinants of health (*modifiable* factors related to the structural inequalities that significantly increase COVID-19 risk) and government policy and popular media proliferating weight stigma. Moving away from weight-focused approaches promoting individual behaviour change would reduce this need. Though this pandemic illustrates just how far away we are.

### What needs to be done

- Create research, policy, and practice in the areas of 'obesity' and eating disorders *with* people with a diversity of relevant lived experience.
- Research on the unintended consequences of anti-obesity messages, with attention given to all forms of eating distress.
- Increase availability and person-centredness of healthcare services for people who are Fat/higher weight/living with obesity and/or have experience of eating disorders.

- Move away from weight-focused, and to weight inclusive approaches to public health.
- Replace ‘anti-obesity’ public health policies and messages with policies that promote health equity by focusing on what governments can do to address the social determinants of health.

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