Project Report | June 2025

SIZE INCLUSIVE HEALTH SERVICES

Recommendations for Better Health Network
Summary Document

Acknowledgment of country

We acknowledge Aboriginal and Torres Strait Islander people as the first peoples and Traditional Owners and custodians of the land and waterways on which we live, and we acknowledge that sovereignty was never ceded. We honour and pay our respects to Elders past and present.

We express our sincere gratitude to all the individuals who have shared their lived / living experience for the development of this report.

About the author

This report was authored by **Jo Farmer**, an independent research consultant. They led the data collection and analysis for the project, supported by Tracy Taylor-Beck and Tara Kelly from the BHN Health Promotion team. Jo's work supporting organisations to restore individuals' and communities' autonomy and empowerment, prioritising marginalised communities. Jo identifies herself as fat and is passionate about improving outcomes for larger-bodied people in the health system.

Jo Farmer Consulting
POLICY AND EVALUATION

Better Health Network

Glossary

Words and terminology play a powerful role in public perspective and reinforcing systems. Here we define the key terms used in this resource.

Size inclusive: describes something (such as, an action, event, intervention, message and so on) that welcomes and caters to the needs of people from across the size spectrum, and will not expect or celebrate efforts to change body size.

Larger-bodied people / smaller-bodied people: neutral social descriptions for body size.

Weight neutral: any action or intervention that is not intended to change body weight and when implemented does not have a predictable effect on body weight.

Weight bias: a preference for, or positive attitude towards, thinner bodies, and negative attitudes towards larger bodies.

Weight stigma: negative social stereotypes and misconceptions about larger bodies and larger-bodied people.

Weight centric: used to describe something that uses body weight control as a rationale, intervention or key outcome measure.

Weight normative: an emphasis on weight and weight loss when defining health and wellbeing

Diet culture: refers to a set of ever-changing myths about food and bodies, promoting the idea that one's body weight equals health and that foods can be categorised as 'good' and 'bad'.

A note about other language

People use myriad terms to describe their body. During the project, we asked participants to document the terms that they used to describe their body, and clinicians to provide examples of language they used to discuss clients' bodies. While many terms were provided, there are several we have opted not to use in the report (unless within a quote), including:

Fat: some people have reclaimed fat as a self-identity; others find this term difficult. But we respect individuals' choice to identify with terms that are meaningful to them.

Obese: typically used in medical contexts, there is increasing recognition that the roots of the word result in language that is othering and reduces a person to a single characteristic.

Overweight / underweight: implies a 'normal' weight range without consideration of other health factors and a person's baseline weight.

Bariatric: typically used in medical contexts to refer to surgery and interventions with the purpose of weight loss; it can also refer to specialist equipment designed to be used by larger-bodied people.

Curvy / plus size: typically used in relation to fashion, these words are often gendered and associated with femme bodies.

Frail: typically used in medical contexts in relation to older people whose bodies are weak, which may be a result of chronic health conditions, malnourishment and age.

Additionally, many of the terms that people used were not value-neutral and demonstrated high levels of self-judgement and internalised weight stigma.

We also do not use body mass index (BMI) as a weight descriptor (unless within a quote or specified in guidelines). BMI was created as a population-level indicator, developed specifically on European white male bodies. As a result of this, there is increasing recognition that BMI is an unreliable indicator at an individual level. BMI classifications are also relatively arbitrary and rely on normative assumptions about a 'normal weight' that does not account for a person's sex, ethnicity, age, or specific health circumstances.

Neither do we use specific weights (e.g. kilograms) as weight descriptors. The use of specific weights can be unhelpful and harmful, particularly for people currently experiencing, or recovering from, eating disorders.

About the project

At Better Health Network, we believe that people of all shapes, sizes, genders, ages, sexualities, races, abilities, and identities, deserve to be treated with dignity, respect, and receive equitable healthcare services.

In 2023, BHN launched Towards Size Inclusive Health Promotion, a resource for health promotion professionals to help them apply a size inclusive lens to their health promotion work.

Building on this work, in 2024 BHN commissioned Jo Farmer to undertake research with the BHN community and its staff to understand current practice in relation to size inclusive healthcare.

The report primarily focuses on larger-bodied people as evidence suggests this is the group who experience the biggest weight-related stigma, and consequent impact on their health.

Recommendations provided in this report should also be considered for how they support inclusion among people of all body types, with feedback from very tall people, short people, and people with disabilities also provided through the project.

This resource provides a summary of the full report. For access to the full report please email healthpromotion@bhn.org.au or find it via the Better Health Network website.

The project was informed by several data sources. For more information on the approach, see Appendix 1: Project approach.

Community

192
Community survey responses

52
Written stories submitted

23
Intercept survey responses

7
Focus group participants

BHN staff

52
Staff survey repsonses

13
Interviews

Evidence scan

Brief literature review of academic and grey literature regarding size inclusive healthcare

Section 1

What is size inclusive healthcare?

> **"Practice where people who aren't in the normal BMI can go to a GP and get a script for whatever they need or get something looked at without the first thing going back to weight."**
>
> — Community focus group participant

Four core domains of size inclusive healthcare

Physical environment

All clients can access a physical environment where people of all body shapes and sizes are comfortable, welcomed and have access to spaces and equipment to meet their needs.

Attitudes of staff

All clients, regardless of body shape and size, are treated with dignity and respect; their weight is not centred in discussions of their health.

Organisational culture

An organisational culture that promotes the inclusion of people of all body shapes and sizes, internally and externally.

Treatment and care options

All clients, regardless of body shape and size, have equitable access to, and can exercise choice over their care and treatment.

Why does size inclusive healthcare matter?

A weight inclusive approach supports improved health for everyone, not just people in particularly larger or smaller-sized bodies.

Body shape, size and weight have long been considered an important aspect of understanding a person's overall health and wellbeing.

Commonly held assumptions among the community and health professionals are that:

- weight is an indicator of health – that higher body weight equals poorer health.
- long-term weight loss is achievable by the majority of people.
- weight loss results in consistent improvements to health.

However, evidence shows that many of these assumptions are not empirically evidenced. Instead, the relationship between body size and health outcomes is correlated, rather than causal, with several other factors driving health outcomes including lifestyle behaviours, genetics, and weight stigma (Hunger, et al., 2020).

Section 2

Weight stigma in healthcare settings

Considerable evidence suggests that the stigma experienced by larger-bodied people in society is also commonly experienced in a healthcare setting. On almost every measure in our community survey, larger-bodied people report a worse experience of care than non-larger-bodied people (see Appendix 2: Survey results).

As discussed in this section, the stigma that larger-bodied people experience results in distress, shame, and overall poorer health outcomes. When people do not feel good about their body, whatever their size, they are less likely to engage in healthy lifestyle behaviours and preventative healthcare.

More so, weight stigma contributes to poorer outcomes for the whole community. Throughout this project, participants identified that people can be sensitive about their body shape and size, regardless of how it looks, for all sorts of reasons.

- Poor treatment and care
- Misdiagnosis
- Focus on weight loss
- Negative impacts on pyshcological health
- Healthcare avoidance

> **“It's just shit because when your entire life growing you get crapped on for the way you look, even when you finally have the confidence and body autonomy to fully understand your own health needs it takes one small comment to make me absolutely be put back in my box.”**
>
> - Community story

Weight stigma contributes to poor treatment and care

Stigmatising weight does not promote weight loss and improved health (Hunger, et al., 2020). What we know is that stigmatising weight means that even where weight loss is a goal, weight stigma is counterproductive and harmful (Brown, et al., 2022; Tomiyama, et al., 2018).

Social stereotypes persist in healthcare

A common social stereotype (often unconsciously) is that larger-bodied people are less likely to actively engage with their health (Lee and Pausé, 2016; Phelan, et al., 2015). A meta-analysis of studies into health professional attitudes to larger-bodied clients showed that doctors, nurses, dietitians, psychologists, physiotherapists, occupational therapists, speech pathologists, podiatrists, and exercise physiologists hold both implicit and explicit weight-biased attitudes towards larger-bodied people (Lawrence, et al., 2021).

> **"She told me to 'lay off the ice cream' and talk about my diet with my mum."**
>
> - Community story

> **"I feel I'm constantly spoken down to as if I'm someone that chooses to sit on the couch all day and eat junk food. The constant 'have you been to see a dietitian?' as if I don't know how to prepare meals or portion control."**
>
> - Community story

> **"I've never forgotten how the doctor made me feel so ashamed to be me, with my body, when I was six years old."**
>
> - Community story

In our community survey:

34%

of larger-bodied people reported a health professional said unkind things about their weight or body shape (compared to 6% of people who reported they were not larger-bodied)

19%

of community stories reported instances where health practitioners had said hurtful comments in relation to their body shape or size.

Unconscious biases exist towards larger-bodied people

It has been shown that health professionals take less time, and are less client-centred, with those who they believe are 'non-compliant'. Studies of communication between health professionals and their clients show that communication with larger-bodied people is worse than comparable clients and they are less likely to build emotional rapport (Gudzune, et al., 2013; Phelan, et al., 2015).

This is reflected in our community survey and stories:

23%

of larger-bodied people reported they got the impression that their body size would mean they could not have access to a particular treatment or medicine (compared to 3% of people who reported they were not larger-bodied)

19%

of community stories contained experiences of not feeling listened to and 12% felt judged.

34%

of larger-bodied people reported they felt a health professional treated them differently because of their weight (compared to 7% of people who reported they were not larger-bodied)

48%

of larger-bodied people reported experiences of a health care provider that made them feel safe and comfortable (compared to 72% of people who reported they were not larger-bodied)

Health professionals lack access to appropriate equipment

It is common for health professionals to lack access to appropriate equipment for larger or smaller bodies, including vaccine needles and blood pressure cuffs. Using inappropriate equipment can result in poor outcomes based on inaccurate measurements and a failure to deliver the required treatment (Chhabria and Stanford, 2022; Ishigami, et al., 2023).

People who participated in our community survey and focus groups reported they are attuned to cues, such as chairs in the waiting rooms or the availability of size inclusive equipment, as to whether a health service will likely be welcoming of their body shape and size.

In our community survey:

27%

of larger bodied people reported **the service didn't have medical equipment that was made for their body size/or fit** them comfortably (compared to only 3% of people who reported they were not larger-bodied).

29%

of larger-bodied people reported the waiting room or consultation room chairs, or beds were **too narrow or uncomfortable** for them (compared to only 4% of people who reported they were not larger-bodied)

People who are not larger-bodied are **more than twice** as likely to report feeling comfortable in healthcare settings, compared to larger-bodied individuals (68% compared to 29%)

Weight stigma contributes to misdiagnosis

1 in 7

community stories included examples of misdiagnosis due to a focus on weight; participants spoke of the ongoing pain and impact on their quality of life seeing their genuine health condition dismissed as a result of their body shape and size.

Research Insights

Studies across a range of health conditions, including asthma, cancer, and chronic obstructive pulmonary disease (COPD), show that chronic health conditions are misdiagnosed in larger-bodied people (Bagcchi, 2014; Lee and Pausé, 2016; Scott, et al., 2012).

Health professionals have been shown to over-attribute health issues to clients' weight and dismiss genuine concerns (Lee and Pausé, 2016; Phelan, et al., 2015). There is also evidence that this is a gendered experience, with women's health concerns likely to be dismissed due to their body shape and size (Lee and Pausé, 2016; Wijayatunga, et al., 2023).

Larger-bodied people are less likely to receive screenings and diagnostic tests (Lee and Pausé, 2016). One community focus group participant spoke about their experience at multiple sizes, and that when they experienced issues in a smaller body they would be sent for more tests and scans than when they were larger-bodied.

Community participants spoke of how weight centric misdiagnosis undermined their trust in health professionals.

> **"Because, you know, for a long time, everyone's like, 'if you lose weight, all your problems will be fixed.' And then you lose a lot of weight, and you still have all your problems. And then it's like do you actually mean it? So, with this issue, it takes me a long time to build that trust with health professionals. And the ones that I do find that I do trust, I like to stick with them for a long time because it's so hard to find that."**
>
> - Community focus group participant

Misdiagnosis of eating disorders

There is strong evidence that health professionals lack awareness of the indicators of disordered eating behaviours, and eating disorders are often undiagnosed, particularly in 'non-stereotypical presentations', including people assumed to be at a 'healthy' weight level or larger-bodied people (Barakat, et al., 2023; Ralph, et al., 2022).

> **"I'd never even been to this GP before. And I said, 'I really want to lose weight. I'm desperate to lose weight. What can I do?' And I gave like a description, I think looking back now it is quite obvious that they were eating disorder traits, but it wasn't picked up at the time. And as I'm describing this, the script starts to print out of the printer, and I get it handed it to me. I'm 16 and it's a script for a weight loss drug."**
>
> - Community focus group participant

In our community stories

15%

of community stories discussed experiences of eating disorders not being recognised or being dismissed.

> **"Even though I was in a smaller body, I was told to lose weight. I had some disordered eating at the time, and they didn't even ask about that. Nor did they tell me why or how I needed to lose more weight."**
>
> - Community story

Weight bias can lead to unsolicited weight loss advice

Larger-bodied people report that a common experience when seeking healthcare is unsolicited weight loss advice, including when their body shape and size is unrelated to their presenting healthcare concern (Lee and Pausé, 2016).

In our community survey;

71%

of larger-bodied people reported they have had a health professional talk to them about their weight at least once (compared to 28% of people who reported they were not larger-bodied).

44%

of larger-bodied people reported that a health professional suggested they need to lose weight even though it's not what they were there to discuss (compared to 8% of people who reported they were not larger-bodied).

> "I was seeing a doctor I don't regularly see and we were talking about doing a blood test and at the end of it he made a comment along the lines of 'next time we should look into Ozempic for you' which stunned me because I was not there for my weight and I know the side effects and the shortage so I was even more surprised a doctor would recommend it."
>
> - Community story

> "At my most recent GP appointment, my GP looked me up and down as I walked in and said "My, my, we'll have to get you on the scales today, won't we?'. I was there to get a tetanus shot."
>
> - Community story

Unintentional consequences of weight loss advice

Community and staff participants identified that there was often a lack of consideration of a client's situation, and factors that may impact upon their body shape and size. Weight loss is suggested with little consideration of whether that might be achievable for a particular client. Evidence suggests that most attempts at weight loss fail to achieve significant results in the long term, with some suggesting that 95% of diets 'fail' (Anderson, et al., 2001; Chastain, 2021; Hall and Kahan 2018).

This can have several potential consequences. If weight loss is the goal and is not achieved by the client, this can lead to dissatisfaction, feelings of failure and apathy towards their health. This can be harmful in and of itself, but also risks clients abandoning positive lifestyle changes because they are not leading to the supposed successful outcome. It can also risk clients pursuing extreme and unhealthy weight loss tactics, including disordered eating symptoms.

Weight loss has shown to be unsustainable over the long-term for a large proportion of people, and there are health risks associated with 'weight cycling' (losing weight and regaining it repeatedly) across a range of health conditions and overall mortality (O'Hara and Taylore, 2018; Hall and Kahan, 2018; Tylka, et al., 2014; Varkevisser, et al., 2019).

Relatedly, larger-bodied people often report praise for weight loss regardless of how it has been achieved.

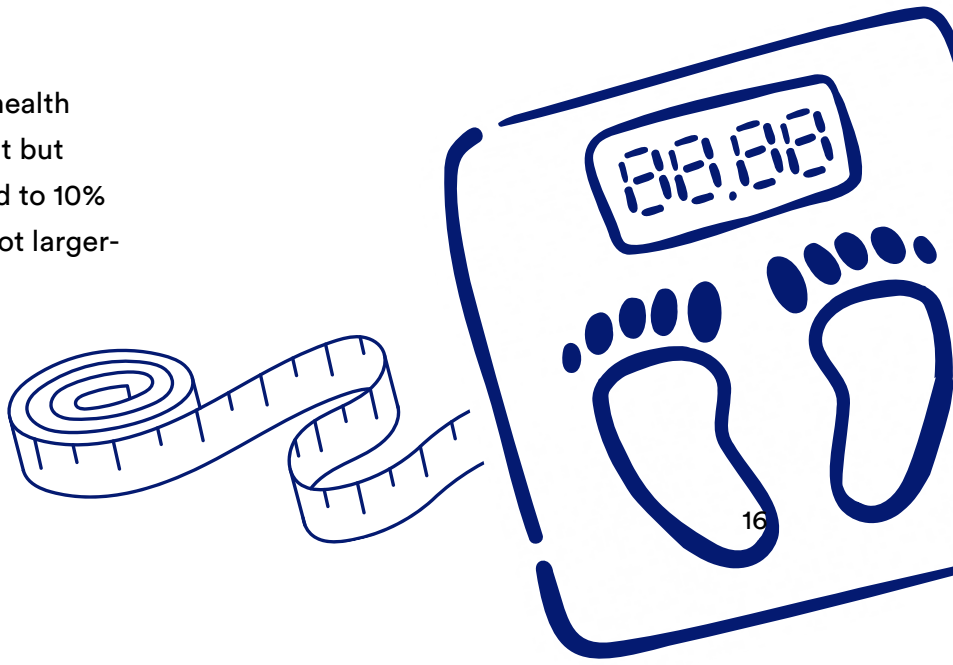
> **"...praise when my weight had dropped (even though it was because I was partying too hard and not eating properly)"**
>
> - Community story

> **"More than once, rather than being supportive and encouraging, doctors, especially, have been disparaging of my efforts regarding diet and exercising. These instances have left me feeling "what's the point of trying"."**
>
> - Community story

In our community survey;

48%

of larger-bodied people reported a health professional told them to lose weight but didn't explain why or how (compared to 10% of people who reported they were not larger-bodied).



Weight stigma impacts psychological health

Larger-bodied people are aware of their poor experiences with health professionals, and evidence suggests that they internalise these experiences (Phelan, et al., 2015).

A meta-analysis of 105 studies (including a total of almost 60,000 participants) found that weight stigma leads to negative effects on psychological health, including when controlled for other factors including body weight (Emmer, et al., 2020). Internalised weight stigma is associated with depression, anxiety, poor quality of life and self-esteem (Bidstrup, et al., 2022; Brown, et al., 2022).

This builds on existing social stigma that larger-bodied people experience. Society promotes a 'thin ideal'; this is also echoed in much public health and health promotion messaging (Bristow, et al., 2020; Orr, et al., 2023). Body dissatisfaction is a risk factor to numerous mental health conditions, particularly eating disorders (Barakat, et al., 2023).

Poor psychological health can also result in poor physical health, through the physiological manifestations of stress caused by biological processes and coping behaviours (Hunger, et al., 2020).

Weight stigma contributes to healthcare avoidance

Healthcare avoidance is a significant barrier to preventative healthcare and early intervention.

Larger-bodied people are less likely to seek healthcare as a result of their poor treatment and care experience, often anticipating that they will receive poor treatment (Lee and Pausé, 2016; Mensinger, et al., 2018; Phelan, et al., 2015). Healthcare avoidance is a significant barrier to preventative healthcare and early intervention.

Expectations of poor treatment and care from health professionals builds on the internalised weight stigma that many people feel about their own body. Evidence suggests that some people feel they 'deserve' any poor health they are experiencing and so do not take active steps to care for their own wellbeing (Brown, et al., 2006).

> In our community survey;

55%

of larger-bodied people reported they have **avoided seeking healthcare** at least once because they are worried a health professional will talk to them about their weight (compared to 10% of people who reported they were not larger-bodied).

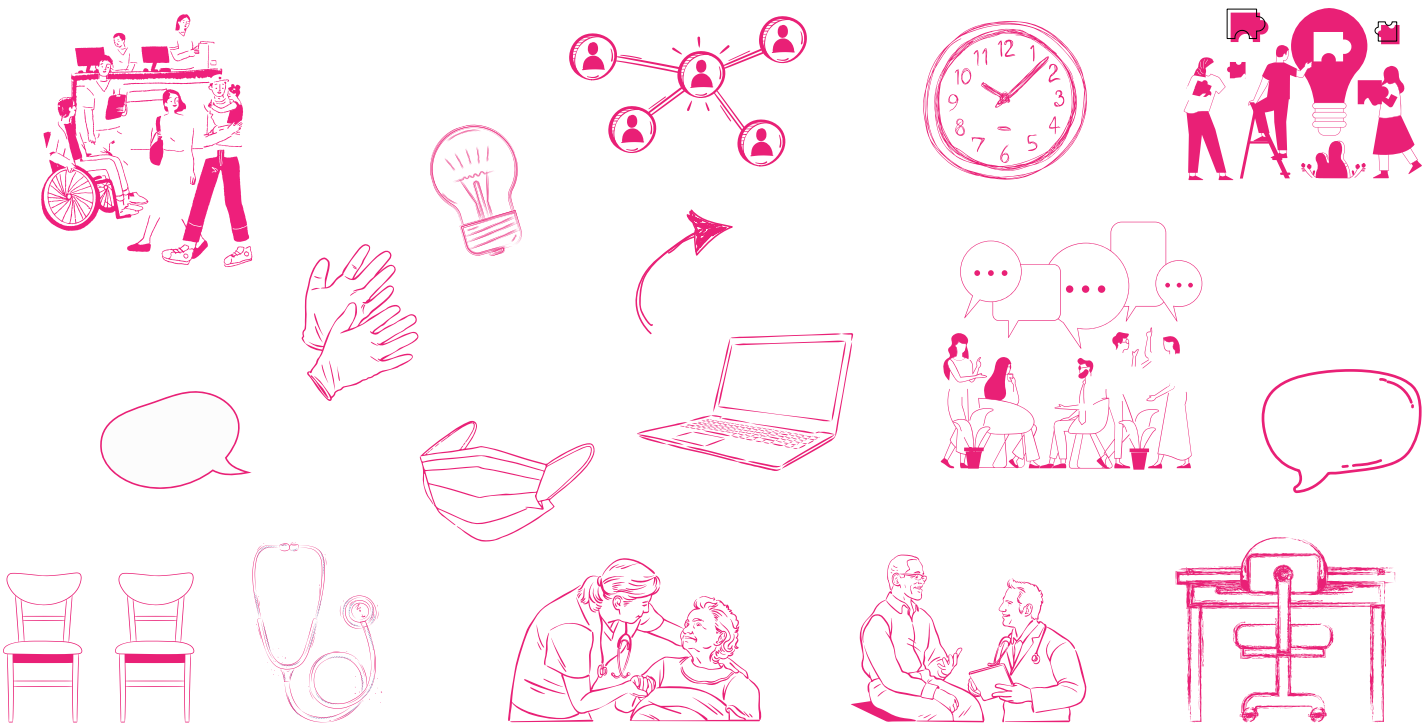
> **"I just nodded along thinking how I would not be doing that, and I would never be coming back."**
>
> - Community story

> **"I hate going to the doctors and get so anxious and stressed when I go. I feel like they aren't listening to what I am saying, and I end up feeling frustrated!"**
>
> - Community story

> **"I left the appointment and just cried already feeling at my lowest point and it took a lot of courage to return to seek support from another GP."**
>
> - Community story

> **"It's concerning if people feel like they can't come to a health service because they don't feel comfortable. We should be happy to talk about all aspects of their health and wellbeing."**
>
> - Staff interview

> **"It's a big issue, a barrier, in coming to see GPs. There's a perceived idea that dieticians will be worried about people's weight."**
>
> - Staff interview



Section 3

Towards size inclusive Better Health Network

Overall, participants in the project suggested that BHN's current approach to size inclusive healthcare was mixed. There are pockets of positive organisational culture and practice, and other areas where there are opportunities for improvement.

Participants also noted that attitudes to size inclusive healthcare have changed substantially over time. Health professionals spoke about how they learnt about body size, shape, and weight in their training, and how that compared to their current practice, with many noting that the focus on weight as a primary indicator of health had decreased over time. This has had a flow on effect to practice, for example with some teams now opting not to include weight as a standard part of their assessment.

> **"It's very hard to say. We're a big organisation in lots of different places."**
> - Staff interview

> **"I'm not sure it's something we think about, to be honest. We think about the Rainbow Tick but not a lot about size inclusivity… We're welcoming but could do more."**
> - Staff interview

Physical Environment

BHN staff reported that, from their perspective, BHN has invested in improving the availability of size inclusive furniture and equipment at its locations. However, staff and community members also identified that there were some significant challenges remaining regarding the physical environment, including how space and equipment are configured, and generally, how welcoming the spaces at BHN can be for larger-bodied people.

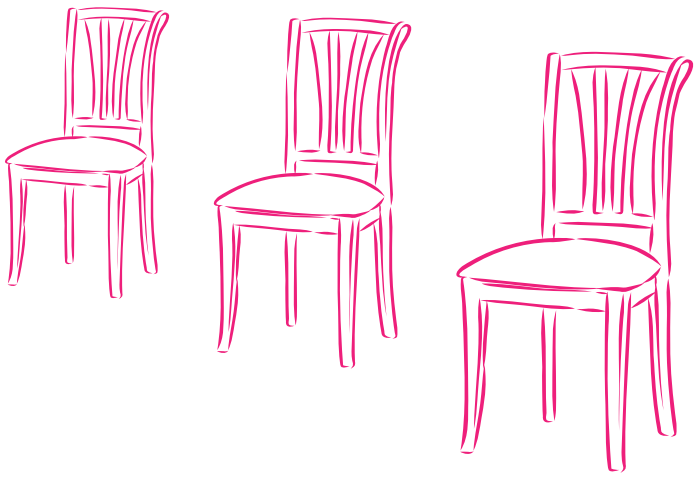
Seating for a range of body sizes

> **"I think if you are living in a bigger body, and you walk into a space, and you're like, I don't even know if I can comfortably sit down in this space, you're not going to feel super welcome."**
>
> - Community focus group participant

Almost everyone who participated in an interview or focus group mentioned chairs, particularly in relation to the waiting room. For clients, appropriately sized chairs in the waiting room can be one of the first visible cues of whether a health service is set up for them.

Participants also noted it was important to have a choice of chairs in consultation and treatment rooms, but that this was not always available due to space restrictions.

Some noted that BHN had invested in larger chairs for the waiting rooms, but that the approach to these chairs had been quite different across different BHN sites. In some sites (e.g. Parkdale), larger chairs are well-integrated into the design and space of the waiting room. In other sites (e.g. Bentleigh East), the larger chairs are not aesthetically pleasing and are situated off to the side of the other chairs.



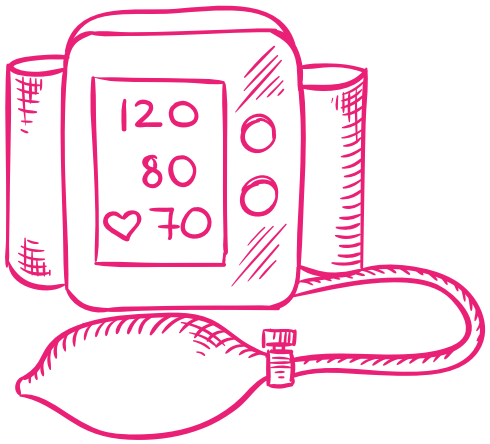
Access to medical equipment

> **"Even just the experience of like having to sit there while they rummage through like seven other beds to find the one that will fit you because they tried three times first, and the Velcro exploded off. And then they try to make it not uncomfortable, but then they make it worse. Maybe just also a little bit of education with some of the health practitioners about like how to navigate those sorts of situations if you don't have equipment immediately available. But obviously, the first port of call should be making sure that that is available to use."**
>
> - Community focus group participant

Staff highlighted other equipment that is important to provide to create a size inclusive health service, including blood pressure cuffs, gowns, needles, and physiotherapy plinths. The availability of these varied from site to site.

A challenge is where space or resourcing limits the number of size inclusive articles that are available. This means that equipment is only available in some rooms, or in common areas. In particular, several staff and community members noted that in some services, the scales are only available in a common area which requires clients to be weighed in public.

Where space and resourcing limits the availability of size inclusive equipment, it is important that clients who need these items are able to access them in a way that normalises their use and does not single them out as needing special or inconvenient equipment.



Importance of visual imagery

Community participants also spoke about the importance of visual imagery in health services that shows and celebrates a diversity of body shapes and sizes, and uses language that promotes a size inclusive approach.

Staff noted that this is happening in some BHN areas, but is largely dependent on individual staff activity.

> **"Language on the website like 'not operating around shame-based practice'**
>
> - Community focus group participant

> **"If they had posters up on the wall, like The Butterfly Foundation has posters you can print out that say, like, this is a health at every size kind of space, or, we don't talk about certain things in this area, or, or even just if they had resources, flyers, or postcards or brochures or whatever from body image kind of organisations, I think that's usually a pretty good sign."**
>
> - Community focus group participant

Attitudes of staff

When asked in staff interviews, most participants reported that BHN is an inclusive and non-discriminatory health service. Most participants reported that they had never heard their colleagues use rude or belittling comments about a client, their body shape or size. While it is undoubtedly a positive that staff report little explicit discrimination, the staff survey and interviews suggest that BHN staff hold complex attitudes with regards to larger-bodied clients.

Across those who participated in the project, there are inconsistent attitudes towards larger-bodied people and the role of health services in relation to weight.

BHN staff hold predominantly 'weight normative' attitudes towards body size and shape (an emphasis on weight and weight loss when defining health and wellbeing (Tylka, et al., 2014):

75%

of staff reported that weight is somewhat (35%) or very (40%) important in understanding a client's overall health

67%

of staff agreed or strongly agreed that being above a healthy weight significantly impacts overall health (compared to 19% who disagreed).

81%

of staff agreed or strongly agreed that obesity is a chronic complex disease (compared to 10% who disagreed).

23%

of staff agreed or strongly agreed that with healthy diet and exercise, everyone should be able to achieve a healthy weight, despite growing evidence that weight is influenced by a range of factors, including other lifestyle behaviours, genetics, and weight stigma (Hunger, et al., 2020). Social determinants of health, including education levels, housing security, food security, and income, are also related to weight (AIHW, 2021, Javed, et al., 2022).

58%

of staff disagreed or strongly disagreed that with healthy diet and exercise, everyone should be able to achieve healthy weight. This presents a potential challenge in that staff simultaneously believe that weight is a key driver of health, but that weight loss is not simple.

Discussing weight with clients

A substantial proportion of clinical staff report that there are instances where they discuss weight with a client, including instances where they are using their judgement to determine whether weight loss or gain would support a client's health goals.

Evidence from the staff survey and interviews suggests that discussion around achieving weight gain (for smaller-bodied clients) is more common than discussion around weight loss (for larger-bodied clients). In smaller-bodied people, their low weight is seen as evidence of malnutrition and eating disorders. There is a risk that focusing on weight as the primary indicator of these conditions' risks overlooking them in larger-bodied people; most staff interviewed emphasised the importance of talking about a range of lifestyle factors across the life course and with people of all body shapes and sizes to enable appropriate care and treatment conversations.

Several staff reported in interviews that they felt it was an important part of their role to raise and discuss weight with larger-bodied clients.

> **"But we can't not approach it either… because you know there are going to be negative outcomes down the track. So, if we just ignore it, we're also doing the clients a disservice."**
>
> - Staff interview

> **"Have had hesitations in the past that there can be a fear of offending or labelling someone so there's an avoidance of an issue when it is a health condition that has a significant impact on mortality and morbidity. People need to be comfortable to come in and access a health service, need to be inclusive. Still, we need to be mindful to not avoid."**
>
> - Staff interview

> **"I also wouldn't like to go the opposite way and be, I was going to use the term 'accepting', and obviously you should be accepting of the person, but not being accepting of the situation and not trying to improve when you know the client's health is going to suffer long term because of it."**
>
> - Staff interview

Other staff interview participants reported a belief that body shape, size and weight is not a relevant indicator of health in and of itself. Differences of opinion were demonstrated and reported within every discipline within BHN and varied from practitioner to practitioner.

> **"My personal opinion is the only reason [weight] is a guideline is because they haven't worked out another way to do it."**
>
> - Staff interview

Staff acknowledge weight talk is sensitive

Most staff identified that discussions of weight can be a sensitive topic, particularly for larger-bodied people. Factors that clinical staff consider when deciding to raise the topic of weight include; when to have the conversation and how to raise the topic in a non-judgemental way.

> **"A lot of people by the time they get to see someone like me, they may have had a lot of traumatic experiences around conversations about weight and may have experienced years of frustration about trying to change weight or access treatments for weight, and so all that has to be taken into account."**
>
> - Staff interview

Staff gave examples of where they do not weigh clients, but have indirect conversations about weight, for example, whether clothes are fitting differently. It should be noted that participants in the community focus group had concerns about this, as they felt it was euphemistic way for health professionals to still talk primarily about weight.

> **"When they're trying to like to speak in code about your body. It's like you know what they're implying is you need to lose weight. It's like, if you're going to have some bias, say it out… Health is an environment where you just want people to tell you how it is."**
>
> - Community focus group participant

> **"We need education about language. Language can be appalling. It puts people off. Asking about weight unnecessarily when it doesn't matter."**
>
> - Staff interview

Treatment and care options

In general, staff reported that treatment and care options are equitable for people in a range of body shapes and sizes. Community and staff participants strongly reported the overlap with consent-based healthcare, for example, being asked before the practitioner touches someone to apply a blood pressure cuff.

Staff noted that, in some instances, consideration of weight and body size is structurally embedded into their practice. For example, a general practice quality measure for accreditation includes the need to collect the BMI of 75% of clients.

Staff reported it may be possible to consider which quality indicators align with a size inclusive approach and develop a consistent organisational approach to data collection (which could include not collecting BMI as standard).

> **"If these sorts of questions are being asked about your lifestyle at every size, then it becomes less of a target. It's not like my doctors are asking me these questions because I am fat… they're gaining information about me and my habits and my health."**
>
> - Community focus group participant

Holistic treatment approaches

While staff attitudes (discussed previously) suggest a weight normative approach is prevalent among staff at BHN, most participants in the interviews reported that an approach to health that focused on lifestyle behaviours, including improved nutrition and physical activity, but also sleep, social support and stress reduction, is their preferred approach as it is more likely to support a stronger therapeutic relationship with the client, as well as collecting more useful information for determining care and treatment plans.

> **"I think it's also important to listen to people listen to their journey. Where are they at and approach them from that perspective"**
>
> - Staff survey

> **"Somebody's weight is influenced by a whole number of things. That's exercise, obviously. But then it might be the medications they're taking, or an underlying health condition that hasn't been diagnosed. So having the skills and the time to go, 'What might be happening for this person?' Is it enough to just tell them to go away and eat a salad and hit the gym four times a week. Is that actually going to solve the issue? Of course not. I can tell you right now, probably one per cent of the time, but probably never."**
>
> - Staff interview

When the clients goal is weight loss

Among staff, there were strong differences in opinion on what to do when a client's primary goal is weight loss. A significant proportion of clients want to lose weight – seven (13%) community stories discussed this. The perspectives ranged from those who believed that clients should be commended and supported for those goals, to those who believed it was appropriate to centre these goals in alignment with client-centred care, to those who believed it was harmful to support clients' primary focus on weight.

A consistent theme across all staff was the importance of understanding why the client centred weight loss as a goal. This supports health professionals to develop a care and treatment approach that aligns with the client's motivations, and in some instances, supports health professionals to identify if the client is experiencing other health conditions, including mental health and body image concerns.

> **"To me it's really important to affirm them when they do [lose weight], because obviously, if they tell you they're really happy about that achievement as well."**
>
> - Staff interview

> **"The society we live in. There's always going to be people who come in and say, 'I want to lose weight', and it's then not appropriate to say to that person, 'Well, we don't do that here', and just like dismiss their concern at hand."**
>
> - Staff interview

> **"Develop a rapport, therapeutic relationship, and can then work with them to achieve their goals regardless of size."**
>
> - Staff interview

> **"Client comes in and want to be weighed. I ask why that is and have a conversation around that."**
>
> - Staff interview

> **"9 out of 10 clients will talk about their weight loss, over an extensive period of time, yo-yoing."**
>
> - Staff interview

Body size and life stage

Some interview participants also reported the importance of considering body shape, size, and weight within the context of the life course, noting that bodies change based on age, hormones, and experiences. This means that at different ages and stages, clients might need different information.

For example, a common concern among older people is ensuring they are receiving adequate nutrition, whereas for younger people, conversations should be grounded in setting up a healthy relationship with mind and body from a young age.

> **"Making sure it's covered across the whole spectrum of age… We need information and resources for everyone."**
>
> - Staff interview

> **"Childhood obesity and children in larger bodies are very sensitive topics and staff should be trained in how to navigate this topic with parents and children, to avoid potentially life long mental health issues."**
>
> - Staff survey participant

Referral pathways

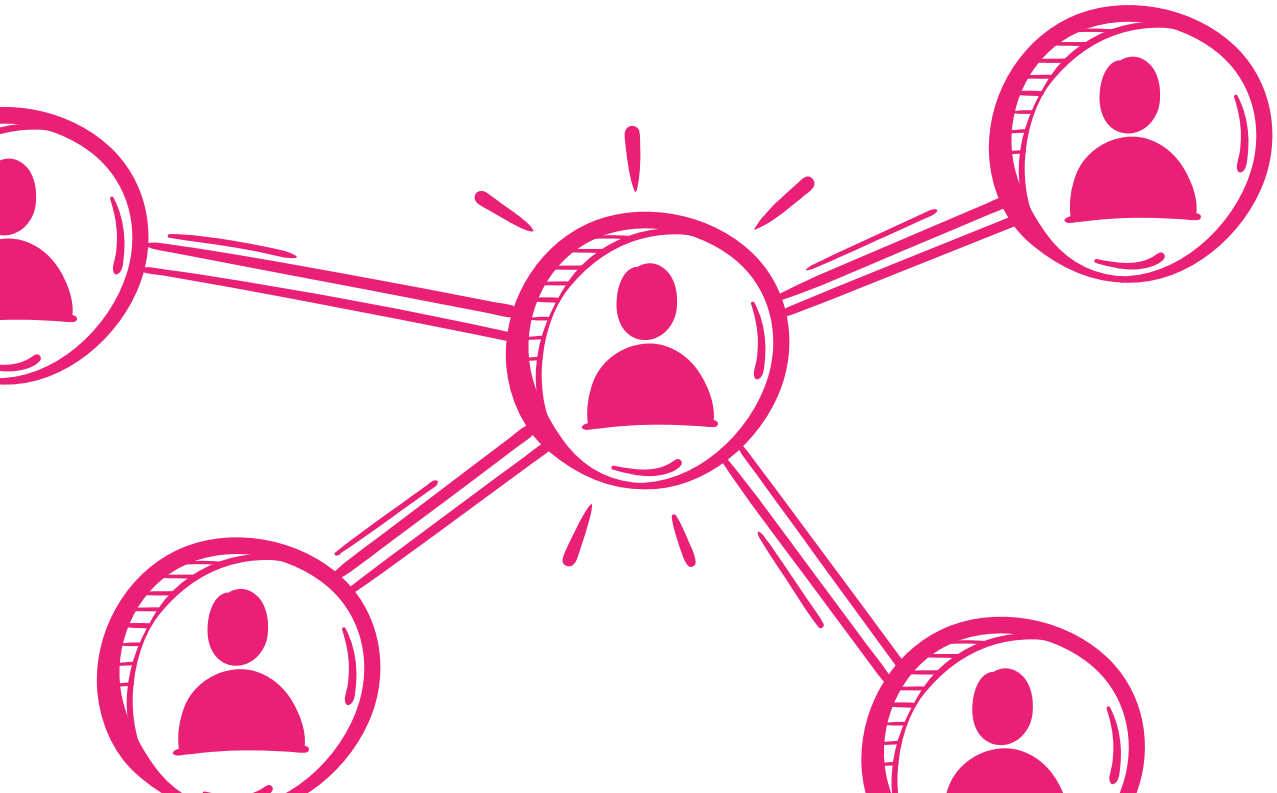
Some staff interview participants reported that referral pathways can be a challenge for creating a consistent size inclusive approach to healthcare. Firstly, some external referral pathways require inclusion of weight or BMI as part of the referral and assessment process.

Within BHN, staff reported that different approaches to body shape and size across health practitioners meant that they were often working with clients from different paradigms. Staff reported that there are opportunities to strengthen interdisciplinary practice so that health professionals from different disciplines can understand each other's approach to health and how body shape and size factors into that. They identified that there are opportunities to spotlight good size inclusive practice across the organisation.

Several participants in staff interviews identified that eating disorder diagnosis and treatment is a significant gap in knowledge, understanding and available supports at BHN.

> **"We get a lot of clients with eating disorders. It can be challenging to broach with people. And it's hard to find the right supports for people. We don't have a specialist eating disorder psychologist. Many clients can't afford it."**
>
> - Staff interview

> **"Clients have a pre-conceived idea about losing weight, 'Can you help me?' or the GP says they are X kg overweight, and doctor has said they need to lose weight for pre-surgery, back pain, etc. I find that a bit challenging – forever talking about health and weight not being the same thing. Focus on health goals, not weight. I say it all and then the client still wants to lose weight. It's their prime motivator rather than their sugar levels."**
>
> - Staff interview



Organisational culture

> **"We're a bit niche, attract a particular type of staff… interested in working with our clients, complex, marginalised backgrounds. We naturally attract those people because we're up front about what we do. They want to be here, want to do the best for clients."**
>
> - Staff interview

Staff interview participants reported the importance of situating size inclusion within a supportive organisational culture.

Reflecting that a focus on body shape and size is very prevalent in society, some staff spoke about the importance of challenging weight stigma within BHN's internal culture. This includes avoiding conversations at work around weight loss or commenting on other people's lunch. It is also reflected in organisational policies, such as catering, and venue hire policies.

Multiple interview participants reflected that this project had prompted them to consider their workplace environment and culture, and they had sought out size inclusive resources and posters to place in staff and treatment rooms. This project was conducted at the same time as BHN's efforts to prepare for Rainbow Tick accreditation, and many interview participants drew parallels between the two projects. Many interview participants reflected that size inclusion is situated within a broader culture of inclusion and respect for diversity.

Most staff interview participants also reported that BHN is well-placed to work towards size inclusion given the ethos of the staff who are attracted to work in community health settings.

What are the barriers to size inclusive healthcare?

Participants identified several barriers to creating size inclusive healthcare, including time, resourcing, space, clashes of health paradigms, and social stigma.

Time

Time was identified as a challenge at two levels – in the client: health professional interaction, and more broadly, for BHN health professionals to have time to engage with becoming more size inclusive in their practice. Person-centred, consent-led healthcare takes time. Participants (staff and community) recognised that this was not always easy, particularly in general practice.

> **"If you're going to a bulk billing GP, and they have to see like 50 people a day and they get five minutes to sit down with you, they're not going to think about using soft approachable, language, saying that it's a safe space or it's okay for you to say this or not say that. I get that but I think I think all that sort of stuff does lead to it being more comfortable."**
>
> - Community focus group participant

Staff time to engage in change processes was identified as a particular challenge for BHN in the context of its recent amalgamation. Staff interview participants reported that staff have undergone a great deal of change in terms of both systems and cultures, and that change fatigue is a risk to implementation of other organisational change efforts.

> **"It takes time. [BHN has] change fatigue. More change onto people who have already been through a lot of change is tricky."**
>
> - Staff interview

> **"We just don't have time. Any time you talk to someone, they don't have time."**
>
> - Staff interview

Resourcing

Participants consistently identified resourcing as a challenge to implementing size inclusive healthcare, particularly in relation to improvements to the physical environment. Replacing existing equipment and furniture with size inclusive items comes with costs.
It was also noted that size inclusive items are often more expensive than the 'standard' option. Occupational therapist participants, who regularly source equipment for larger- and smaller-bodied clients, also noted that there are typically fewer design choices available for size inclusive equipment.

Space

Several participants raised challenges of space within BHN health service sites. For example, with regards to space to retrofit existing facilities such as toilets, and to include size inclusive equipment in every consultation and treatment room.

In situations where it is not possible to have size inclusive equipment in every consultation and treatment room due to space constraints, it will be important to have approaches that enable practitioners to use a room that they know has appropriately sized equipment for their client, without drawing attention to that.

> **"Our scales are in the corridor. It's hard to find space. Either scales have to be everywhere, or they're in the hallway."**
>
> - Staff interview

> **"We're not a new building. There's lots of things we have to try to adjust for lots of people… there are lots of problems in old buildings being adapted. We're making do with what we have."**
>
> - Staff interview

> **"If I think of the physical space, we have a lot of old buildings… and the toilet doors are really quite slim. So, if you were a bigger person… Even for me sometimes I think this door is skinny, quite small to get through."**
>
> - Staff interview

Clashes of health paradigms

Aside from the logistical challenges of implementing a size inclusive approach, staff interview participants consistently raised a challenge around the clash of paradigms between the size inclusive and weight normative approaches.

> **"Main barrier is the clash between the medical model and the social model of health. Trying to get everyone on the same page. Still struggle a little with trying to deal with the medical feedback that weight loss would lead to indicators improving. That may be true, but the pursuit of weight loss may not be realistic, achievable or the mental health cost may be too high. It may not be the main thing they need to do to improve their health. It's hard when that person is saying 'please help me lose weight'. If it was easy for them to lose weight, they would have."**
>
> - Staff interview

Staff identified that how body shape, size and weight are conceptualised as part of health has changed over time and varies between disciplines. Some staff reported that this created challenges when working with people from other paradigms.

> **"Literature seems to show that it's not specifically the weight that's causing the issues. It may be an inflammatory response. But I hear a lot of 'the surgeon says I need to lose weight."**
>
> - Staff interview

> **"I really worry about the idea of minimising obesity as a chronic disease. I'm not talking about somebody who's not the shape that they want to be, I'm talking about the chronic disease state."**
>
> - Staff interview

Regardless of paradigm, most staff recognised weight stigma is not helpful for treatment; there was a divergence of opinion in whether weight stigma should be challenged to enable clients to talk openly about and engage in weight loss, or whether weight stigma should be challenged as weight is not a relevant indicator of health (weight loss is not a goal).

Some staff however, raised concerns that a size inclusive approach would undermine clients' health by reducing the significance of their weight on their health.

> **"Historically, the lack of knowledge and acknowledgement of obesity as a chronic disease, and internalised stigma of the person or the healthcare profession, has become very problematic. And hopefully the way I try, and work is really to break that down and to help make the person feel like it's a shared responsibility."**
>
> - Staff interview

> **"I feel like we are doing a disservice to people, clinicians and most importantly clients, if we are living in two separate camps... I would like to work in an environment where there are people with knowledge either of one side or the other side, preferable of both sides, who are working in an integrated way."**
>
> - Staff interview

Social stigma

Several staff interview and community focus group participants reported that social stigma created a ceiling on the change that it would be possible for BHN to make.

Some participants reported that they believed it would be difficult to get people to care about implementing size inclusive healthcare as weight stigma attitudes towards larger-bodied people are normalised and accepted in society. While people may believe they are inclusive and welcoming, they hold unconscious discriminatory attitudes that can be hard to overcome.

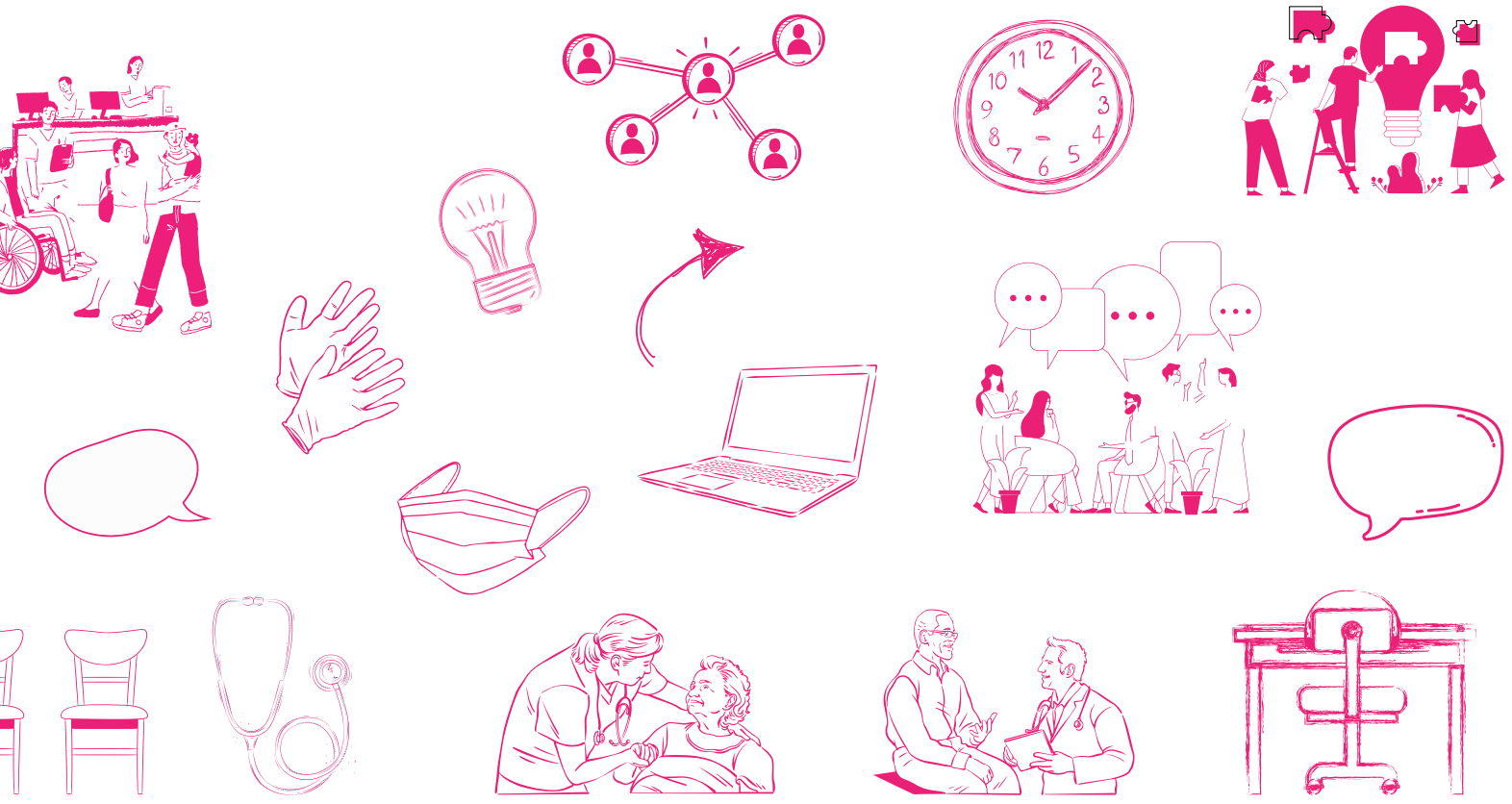
Several staff interview participants spoke about their own experiences of being conscious of their body shape and size, and of seeing how weight stigma and diet culture impacted upon their children.

> **"It's almost accepted as ok to make those judgements, which it's not and never has been. I equate it to saying if someone's unemployed – they don't want a job. There is prevalent disrespect – not with colleagues, but in society at large. It's discriminatory."**
>
> - Staff interview

> **"Living in a bigger body isn't just a physical thing. There's an emotional, mental side to it as well. And I think that the more I kind of look through stuff, the more I realise how much like diet culture is embedded into a lot. And in the health professional world, as well. So, it'd be really good for health professionals to know what their own biases and what their stereotypes are to kind of see if that's impacting on their practice."**
>
> - Community focus group participant

Section 4

Recommendations for Better Health Network



Creating a size inclusive Better Health Network

Based on the findings of this project, there are 10 recommendations to support BHN to become a size inclusive health service.

Physical Environment

1. Create physical and online environments that welcome people of all body shapes and sizes

- Represent people of all sizes, races, genders, and abilities in images online and in physical communications (see Towards Size Inclusive Health Promotion)

- Update inclusivity statement on the website / in BHN locations to include a commitment of equity irrespective of body shape or size.

2. Create physical environments where people of all shapes and sizes have access to comfortable spaces

- Conduct an environmental audit of all BHN sites, involving people with lived experience, identifying priorities for future investment in furniture and the architectural design of spaces (see Towards Size Inclusive Health Promotion: Resources for working towards size inclusive healthcare)

- When building or renovating BHN locations, ensure a size inclusive lens is incorporated into accessibility provisions for the site, including provision for larger-bodied people and people with disability.

- Develop guidelines to support procurement and availability of size inclusive furniture.

3. Support people of all body shapes and sizes to access equipment that meets their needs

- Conduct an environmental audit of all BHN sites, involving people with lived experience, identifying priorities for future investment in size inclusive equipment (see Towards Size Inclusive Health Promotion: Resources for working towards size inclusive healthcare)

- Develop guidelines to support procurement and availability of size inclusive equipment.

Attitudes of staff

4. Promote positive staff attitudes towards people of all body shapes and sizes

- Conduct reflective discussions with BHN staff regarding their attitudes to people of all shapes and sizes (see Towards Size Inclusive Health Promotion: Resources for working towards size inclusive healthcare)

- Implement training with BHN staff, led by lived experience, which outlines the importance of size inclusive healthcare, the impact of weight normative approach on health outcomes for the whole community, and frames positive, size inclusive conversations.

5. Implement practices to support size inclusive, not weight centric, conversations between clients and health professionals

- Develop a resource bank of size inclusive evidence and resources for staff and clients.

- Implement training with BHN staff that develops their skills in client-centred therapeutic conversations, including how to have conversations with clients whose goals include weight loss.

Organisational culture

6. Promote a positive organisational culture inclusive of all body shapes and sizes

- Incorporate size inclusion into diversity and inclusion outcomes (Pillar One), leadership and workforce diversity outcomes (Pillar Four) measured under BHN's Business Plan

- Implement size inclusive initiatives in staff common areas, for example, posters and celebration of 'No Diet Day'.

- Support staff mental health and wellbeing when implementing a size inclusive approach, noting that issues of weight stigma impact many staff and their loved ones, as well as clients.

Treatment and care options

7. Support client choice over discussions of weight and being weighed

- Develop consistent organisational guidelines on practices for discussing weight and weighing clients, including when, how and where clients should (and should not) be weighed.

- Share guidelines on practices for weighing clients prominently with clients so they are aware of their choices over discussions of weight and being weighed.

8. Support clients to access their preferred treatment and care options regardless of their body shape and size

- Audit clinical assessment tools to ensure a focus on lifestyle behaviours and context, rather than weight centric measures.

- Promote size inclusive treatment options:
  - options that focus on how people's bodies feel and function.
  - options that do not address weight as a priority factor in client's health.
  - provide a range of options centred on clients' needs and preferences.

- Hold size inclusive conversations with clients (see Appendix 3)

- Provide education and resources to clients on a size inclusive approach.

9. Develop consistent organisational approaches to body shape and size

- Showcase high quality size inclusive practice across disciplines, providing health professionals with the opportunity to learn from each other.

- Audit clinical guidelines and accreditation processes to identify how a size inclusive approach can be implemented in alignment with high quality care.

10. Improve eating disorder literacy and treatment approaches

- Support BHN staff to understand and implement the Eating Disorder Safe Principles.

- Support BHN staff to undertake training in eating disorder practice, which may include in-house or external training, or Eating Disorder Credentialing (ANZAED, n.d)

References

AIHW (2021). Inequalities in overweight and obesity and the social determinants of health. Accessed from: https://www.aihw.gov.au/getmedia/9cc2f996-cf45-4769-bfc7-20026a893ef9/aihw-phe-278.pdf?v=20230605184348&inline=true

Anderson, Konz, Frederich and Wood (2001). 'Long-term weight-loss maintenance: a meta-analysis of US studies' in American Journal of Clinical Nutrition, 74(5):579-84.

ANZAED (n.d.). Connecting people facing an eating disorder with Credentialed Eating Disorder Clinicians. Accessed from https://connected.anzaed.org.au/

Bagcchi (2014). 'COPD misdiagnosis linked to obesity' in Lancet Respiratory Medicine, 2(6):441.

Barakat, McLean, Bryant, Le, Marks, National Eating Disorder Research Consortium, Touyz and Maguire (2023). 'Risk factors for eating disorders: findings from a rapid review' in Journal of Eating Disorders, 11:8.

Bidstrup, et al. (2022). 'Internalised weight stigma mediates relationships between perceived weight stigma and psychosocial correlates in individuals seeking bariatric surgery: a cross-sectional study' in Obesity Surgery, 32:3675-3686.

Bristow, Meurer, Simmonds and Snell (2020). 'Anti-obesity public health messages and risk factors for disordered eating: a systematic review' in Health Promotion International, 1;35(6):1551-1569.

Brown, Flint and Batterham (2022). 'Pervasiveness, impact and implications of weight stigma' in eClinicalMedicine, 2022;47: 101408.

Brown, Thompson, Tod, and Jones (2006). 'Primary care support for tackling obesity: a qualitative study of the perceptions of obese patients' in British Journal of General Practice, 56(530):666-672.

Chastain (2021). It's the diets that fail, not the patients they are prescribed to. Substack, accessed from: https://weightandhealthcare.substack.com/p/its-the-diet-that-fail-not-the-patients

Chastain (n.d.). Weight and Healthcare. Substack, accessed from: https://weightandhealthcare.substack.com/

Chhabria and Stanford (2022). 'A long shot: the importance of needle length in vaccinating patients with obesity against COVID-19' in Vaccine, 40(1):9-10.

Eating Disorders Victoria (n.d.). Eating Disorders in Men and Boys. Accessed from: https://www.eatingdisorders.org.au/eating-disorders-a-z/eating-disorders-in-men/

Emmer, Bosnjak, and Mata (2020). 'The association between weight stigma and mental health: a meta-analysis' in Obesity Review, 21(1).

Gaesser and Angadi (2021). 'Obesity treatment: Weight loss versus increasing fitness and physical activity for reducing health risks' in iScience, 24, 102995.

Grimm, Morales and Ferentini (2021). Fat and Queer. Jessica Kinglsey Publishers, London, and Philadelphia. Gudzune, Beach, Roter and Cooper (2013). 'Physicians build less rapport with obese patients' in Obesity, 21(10):2146-52.

Hall and Kahan (2018). 'Maintenance of lost weight and long-term management of obesity' in Medical Clinics of North America, 102(1):183-197.

Hunger, Smith and Tomiyama (2020). 'An evidence-based rationale for adopting weight-inclusive health policy' in Social Issues and Policy Review, 14(1).

Ishigami, Charleston and Miller (2023). 'Effects of cuff size on the accuracy of blood pressure readings: The Cuff(SZ) randomised crossover trial' in JAMA Internal Medicine, 183(10):1061-1068.

Javed, Valero-Elizondo, Maqsood, Mahajan, Taha, Patel, et al. (2022). 'Social determinants of health and obesity: Findings from a national study of US adults' in Obesity, 30(2):491-502.

La Trobe University (2021). Weight Stigma: 2020-2021 National Survey. Accessed from: https://www.latrobe.edu.au/news/articles/2021/release/weight-stigma-2020-2021-national-survey#:~:text=The%20survey%2C%20commissioned%20in%20connection,shamed%20because%20of%20their%20weight.

Lawrence, Kerr, Pollard, Theophilus, Alexander, Haywood, and O'Connor (2021). 'Weight bias among health care professionals: a systematic review and meta-analysis' in Obesity, 29(11):1802-1812.

Lee and Pausé (2016). 'Stigma in practice: barriers to health for fat women' in Frontiers in Psychology, 7.

References

Mensinger, Tylka and Calamari (2018). 'Mechanisms underlying weight status and healthcare avoidance in women: a study of weight stigma, body-related shame and guilt, and healthcare stress' in Body Image, Jun:25:139-147.

National Eating Disorders Collaboration (NEDC) (2024). Eating Disorder Safe principles: Whole-of-community approaches to do no harm in relation to eating disorders, disordered eating and body image distress. Accessed from: https://nedc.com.au/assets/NEDC-Publications/ED-Safe-Principles/Eating-Disorder-Safe-Principles_Final.pdf

O'Hara and Taylor (2018). 'What's wrong with the war on obesity? A Narrative Review of the Weight-Centered Health Paradigm and Development of the 3C Framework to Build Critical Competency for a Paradigm Shift' in Sage Open, 8(2).

Orr, Kelly, Taylor-Beck, Rossiter, Badloe, Kostouros, Bast, Brassington and Willer (2023). Towards size inclusive health promotion. Accessed from: https://bhn.org.au/wp-content/uploads/2023/06/Final-Online-Version_Size-Inclusive-Resource-1.pdf

Phelan, Burgess, Yeazel, Hellerstedt, Griffin and van Ryn (2015). 'Impact of weight bias and stigma on quality of care and outcomes for patients with obesity' in Obesity Review, 16(4):319-26.

Ralph, Brennan, Byrne, Caldwell, Farmer, Hart, Heruc, Maguire, Piya, Quin, Trobe, Wallis, Williams-Tchen and Hay (2022). 'Management of eating disorders for people with higher weight: clinical practice guideline' in Journal of Eating Disorders, 10:121.

Scott, Currie, Albert, Calverley and Wilding (2012). 'Risk of misdiagnosis, health-related quality of life, and BMI in patients who are overweight with doctor-diagnosed asthma' in Chest, 141(3):616-624.

Tomiyama, Carr, Granberg, Major, Robinson, Sutin, and Brewis (2018). 'How and why weight stigma drives the obesity 'epidemic' and harms health' in BMC Medicine, 16:123.

Tylka, Annunziato, Burgard, Danielsdottir, Shuman, Davis and Calogero (2014). 'The Weight-Inclusive versus Weight-Normative Approach to Health: Evaluating the Evidence for Prioritizing Well-Being over Weight Loss' in Journal of Obesity, 2014.

Varkevisser, van Stralen, Kroeze, Ket and Steenhuis (2019). 'Determinants of weight loss maintenance: a systemic review' in Obesity Reviews, 20(2):171-211.

Wijayatunga, Wellman and Tomasko (2023). 'Exploring Factors Associated with Gender Differences in Perceived Stress among Adults with Higher Body Weight in the United States—A Cross-Sectional Analysis' in Obesities, 3(4).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