

Prevalence of eating disorders in Australian general from 2017 to 2022: a retrospective cohort

Carla De Oliveira Bernardo

carla.bernardo@adelaide.edu.au

Adelaide University

Viviane De Menezes Caceres

Adelaide University

David Gonzalez-Chica

Adelaide University

Campbell Thompson

Adelaide University

Amrit Kaur Sandhu

Royal Adelaide Hospital, Central Adelaide Local Health Network

Rami Tadros

Royal Adelaide Hospital, Central Adelaide Local Health Network

Ji Yann Siew

Royal Adelaide Hospital, Central Adelaide Local Health Network

Alice O'Connell

Royal Adelaide Hospital, Central Adelaide Local Health Network

Chloe Lukacejda

Southern Adelaide Local Health Network

Patrick Russell

Royal Adelaide Hospital, Central Adelaide Local Health Network

Research Article

Keywords: Eating disorders, general practice, epidemiology, COVID-19

Posted Date: October 18th, 2026

DOI: <https://doi.org/10.21203/rs.3.rs-11210606/v1>

License:   This work is licensed under a Creative Commons Attribution 4.0 International License. [Read Full License](#)

Additional Declarations: No competing interests reported.

Abstract

Purpose

To explore the prevalence of eating disorders over time (2017–2022) and identify associated sociodemographic factors in Australia.

Methods

This is a retrospective population-based cohort which included electronic health records of patients aged 18 + years attending 383 Australian general practices from 2017 to 2022. Eating disorders were identified through a GP diagnosis recorded in the patient medical record (e.g., eating disorder, anorexia nervosa, bulimia nervosa, other specified feeding or eating disorder - OSFED, eating disorder not otherwise specified - EDNOS, avoidant/restrictive food intake disorder - ARFID). Logistic regression models analysed associations between prevalence and sociodemographic factors.

Results

The prevalence of eating disorders doubled over time, from 0.21% (95% CI 0.19%;0.24) in 2017 to 0.42% (95% CI 0.38;0.46) in 2022, affecting one out of 25 Australian women aged 18–19 years in 2022. It was the highest among younger women and increased steadily both before (2017–2019) and during (2020–2022) the COVID-19 pandemic, while among older groups the increase was more pronounced on the onset of the pandemic. Prevalence was also higher among those attending practices in the wealthiest areas compared to their peers.

Conclusion

The increase in eating disorders prevalence was higher among younger women, as expected. Given the high mortality associated with eating disorders, evidence on their prevalence in the general population and among vulnerable groups is essential to inform prevention and management strategies, particularly during health emergencies. Strengthening support for GPs in the management of eating disorders in primary care may also improve early identification and timely response.

Level of Evidence

Level III, well designed cohort

INTRODUCTION

Eating disorders are complex mental health conditions with life-threatening complications that affect not only mortality but also functioning and quality of life (1, 2). The prevalence of eating disorders has increased globally, although in some regions it has remained stable or decreased, with variations also observed across specific diagnoses, such as anorexia nervosa and bulimia nervosa (3–7). Eating disorders are multifactorial conditions, and it is unclear which factors most strongly influence their prevalence across time periods or between countries. Previous research has found that sociodemographic factors (gender, race, age, education, and income) can influence prevalence in some, but not all, countries (5–13). A rapid review including 284 studies found that genetics, autoimmune diseases, childhood experiences or trauma, body image and social influence, and psychiatric comorbidities are additional factors that may have an impact (14).

In Australia, the prevalence of eating disorders has doubled since 2000, and it was estimated to affect 0.32% of the population in 2015/2016, according to data from the BEACH study with general practice patients (15). General practice is the first point of contact between patients and the Australian health care system, with approximately 85–90% of the general

population visiting general practitioners (GPs) each year (16). GPs deliver preventive care and manage patients' conditions throughout the life course, while also providing referrals to specialists and allied health services (17). Therefore, they play an important role in early detection and represent a valuable source of population-level medical data (15, 18). However, since 2016, no study has analysed eating disorders in the Australian general practice setting, including during the COVID-19 pandemic.

The global COVID-19 pandemic led to major lifestyles changes, as strict lockdowns, social isolation, food insecurity and other restrictions were enforced to varying degrees across countries. Social media use subsequently reached record levels and its adverse mechanisms, such as social comparison, fear of missing out, and exposure to harmful content, alongside the combination of reduced access to support networks, disrupted daily routines, and irregular eating behaviours, has been associated with poorer well-being and may have aggravated existing eating disorders and triggered new cases (19–26).

Despite evidence that the COVID-19 pandemic impacted eating disorder symptoms worldwide (23–26), several studies reported positive results (24, 25). In Australia, national-level evidence remains limited (27, 28). Findings from the COLLATE online survey indicated that 65% of adults with a pre-existing eating disorder reported increased food restriction during the pandemic compared with before it (28). However, there are currently no published data examining the distribution, management, or associated factors of eating disorders within the Australian population (29). Therefore, this study aimed to identify the prevalence of eating disorders among adults attending general practices across Australia from 2017 to 2022, including before and during the COVID-19 pandemic, and explore associated sociodemographic factors.

MATERIAL AND METHODS

Data source and sample

This retrospective cohort study used a national general practice database (MedicineInsight) that consists of de-identified routinely collected data from patient electronic medical records (EMRs) across all Australian states and jurisdictions (30). Considering that 87% of all Australians visit their practice annually, and that MedicineInsight patients are broadly similar to the government medical insurance scheme (Medicare Benefits Schedule) data, this sample resembles and is representative of the Australian general population, in terms of age and sex (30).

Extracted data include sociodemographic and medical history, including diagnoses, reasons for consultation, immunisations, prescribed medications, test requests and laboratory results. To improve data quality, only data from practices established for at least two years with no interruptions in data transfer greater than six weeks were included in this study.

This study included information from all 'regular' patients (3 + consultations in the last two years) aged 18 years or over in each year of interest (2017–2022). This definition follows recommendations for improving diagnostic accuracy when using electronic medical record (EMR) to avoid underestimated prevalences, as non-regular patients tend to lack a complete list of diagnoses and prescriptions in the EMR (31, 32).

Outcome

Outcome

To calculate the prevalence of eating disorders in this study, we identified patients with a clinical diagnosis of an eating disorder recorded by their general practitioner (GP) in different fields of the MedicineInsight database (i.e., 'diagnosis', 'reason for encounter' and 'reason for prescription'). Although GPs are encouraged to record patients' medical data by using medical vocabulary coding systems (i.e. 'DOCLE', 'PYEFINCH'), its use is not compulsory, and medical terms can be entered as free text. For that reason, the research team elaborated an algorithm with terms included in the description of ICD-10 codes used to identify eating disorders, based on the validated UK phenotype library (<https://phenotypes.healthdatagateway.org/phenotypes/PH1116/version/2459/detail/>), and used in previous studies with

similar general practice databases (33). Still, the terms were reviewed by clinicians and experts in eating disorders to adapt them to the Australian setting. Misspellings were also checked. Terms included in the algorithm are presented in supplementary Table S1. To ensure we identify only diagnosed patients, we excluded records where GPs included terms suggesting further investigation such as 'investigation', 'possible', 'risk', 'like', or used a question mark with the terms related to eating disorders in the free text field. The prevalence of eating disorders was estimated annually from 2017 to 2022, based on individuals who were regular patients in each respective year (i.e. patients could contribute to the data for multiple years if they met the regular patient criteria in those years).

From the first consultation the patient was diagnosed with an eating disorder, the individual was considered as having the clinical problem in all subsequent consultations (i.e. prevalence including old and new cases), since eating disorders are considered, as many other mental disorders, as chronic conditions.

Covariates

The list of covariates included in the study were selected based on evidence from the literature (9–11, 14) and their availability in MedicineInsight. Among general practice characteristics included as covariates in our models to investigate associated factors related to eating disorders are the practice rurality (major cities, inner regional, outer regional/remote areas), and a macro-economic indicator of socioeconomic position based on the practice postcode (the Index of Relative Socioeconomic Advantage and Disadvantage, IRSAD, in quintiles), and state or territory (New South Wales, Victoria, Queensland, Western Australia, Tasmania, South Australia, Australian Capital Territory/Northern Territory). IRSAD was developed by the Australian Bureau of Statistics based on a range of census variables (e.g. income, educational level, occupation, marital status, internet access), and represents a relative measure of socioeconomic advantage or disadvantage for each area in Australia (34). Patient's sociodemographic characteristics included sex (male, female), age groups (18–19, 20–29, 30–39, 40 + years), and IRSAD in quintiles (based on patient's postcode).

Statistical analysis

The prevalence of eating disorders was calculated for each year of interest among all 'regular' patients included in the study. Logistic regression models were performed to analyse the associations between practice or patient's characteristics and the prevalence of eating disorders in each year. These variables were included in the models considering two hierarchical levels of adjustment. First, only practice variables (i.e., rurality and IRSAD) were included and mutually adjusted. Second, patient's age, sex and IRSAD quintiles were added to the model (i.e. patient characteristics were mutually adjusted and adjusted for practice variables). Adjusted odds ratios (aOR) resulting from the logistic regression models were used to estimate the adjusted prevalence of eating disorders in each category of sociodemographic variables. For this purpose, we used the Stata command "margins" that calculates adjusted outcome probabilities for each category of the independent variable, averaging or integrating the results over the remaining covariates included in the regression model (i.e. confounders). Analyses with adjusted odds ratios (aOR) can be found in supplementary Table S2.

Poisson regression models were also used to analyse changes in the prevalence of eating disorders from 2017 to 2022 according to sociodemographic variables. Trend results were presented as percentages (i.e. average annual change) with their 95% confidence intervals (CI) in tables and graphically. Additional analyses stratified by sex were also performed, since prevalence of eating disorders is more frequent in females than males according to the literature (5, 6). Stata 18.0 (StataCorp, Texas, USA) was the software used for analyses and all models considered the clustering of patients within the practice.

RESULTS

The number of regular patients in the MedicineInsight database ranged from 796,774 in 2017 to 1,296,791 in 2022. The sample distribution over the years according to practice and patient's characteristics was similar (Table 1). Approximately

60% of patients attended practices in major cities, and one quarter attended practices in more advantaged (wealthier) areas. Women represented 58% of our sample and up to 30% of patients were younger than 40 years of age.

The overall prevalence of eating disorders doubled over time, from 0.21% (95% CI 0.19%;0.24) in 2017 to its peak in 2021 at 0.42% (95% CI 0.38;0.46), which might be partly attributed to the COVID-19, however, it remained stable in 2022 (Table 1). The prevalence of eating disorders did not vary according to practice rurality (remoteness) but differed across states. In every year examined, prevalence was highest in Tasmania compared with other states (e.g., 0.60% in Tasmania vs. 0.36% in Queensland in 2021; $p < 0.001$). It was also at least twice as high among patients attending practices in more advantaged areas than in less advantaged areas (0.62% vs. 0.23%, in 2021; $p < 0.001$), approximately eight times higher among women than men (0.63% vs. 0.08%, in 2021; $p < 0.001$), and up to 17 times more frequent among those aged 18–19 years than in the 40+ year-olds (2.07% vs. 0.13%, in 2021; $p < 0.001$). Despite the clear association between practice-level socioeconomic status and the prevalence of eating disorders, patient-level socioeconomic status did not appear to influence prevalence.

When exploring changes over time, it is noted that there was an average annual increase in the prevalence of eating disorders of 11.7% (95% CI 10.2;13.3) for the whole sample. However, the more pronounced increase was found among those aged 18–19 years (average annual change + 14.1, 95% CI 10.7;17.5), with prevalence rising from 1.22% in 2017 to 2.26% in 2022.

Table 1

Prevalence^{\$} of eating disorders and annual changes by sociodemographic variables. Regular patients (18 + years).

	Sample distribution in 2017 (N = 796,774)	Prevalence before COVID-19 (%)			Sample distribution in 2020 (N = 1,126,927)	Prevalence during/after COVID-19 (%)			Average annual change (%)
		2017	2018	2019		2020	2021	2022	
Practice characteristics									
Rurality									
Major cities	59.4	0.21	0.24	0.29	60.8	0.35	0.42	0.42	+ 11.9 (10.0;13.8)
Inner regional	24.2	0.22	0.25	0.30	23.4	0.37	0.43	0.44	+ 10.3 (7.3;13.3)
Outer regional/remote areas	16.4	0.18	0.19	0.22	15.8	0.30	0.36	0.36	+ 14.0 (8.9;19.4)
Socioeconomic status (IRSAD Quintile)									
Very high (more advantaged)	25.4	0.30	0.35	0.41	24.5	0.53	0.62	0.60	+ 11.3 (9.0;13.7)
High	16.2	0.24	0.28	0.32	17.7	0.41	0.47	0.50	+ 12.1 (8.8;15.5)
Middle	18.4	0.18	0.20	0.25	19.2	0.31	0.38	0.38	+ 14.3 (10.0;18.8)
Low	20.9	0.17	0.18	0.22	20.3	0.26	0.32	0.32	+ 10.6 (6.9;14.5)
Very Low	19.1	0.14	0.15	0.18	18.4	0.19	0.23	0.22	+10.0 (6.7;13.5)
State									
New South Wales	33.4	0.22	0.25	0.31	33.3	0.38	0.44	0.43	+ 11.3 (8.7;13.9)
Victoria	23.0	0.24	0.26	0.31	21.7	0.36	0.43	0.42	+ 9.5 (7.1;12.1)
Queensland	16.9	0.17	0.19	0.22	18.7	0.30	0.36	0.38	+ 15.6 (11.1;20.2)
Western Australia	12.7	0.17	0.19	0.25	13.1	0.32	0.39	0.38	+ 15.0 (10.0;20.3)
Tasmania	8.3	0.27	0.35	0.41	7.6	0.50	0.60	0.60	+11.0 (3.9;18.5)
South Australia	2.9	0.24	0.22	0.26	2.8	0.34	0.42	0.43	+ 13.2 (7.9;18.8)
ACT/NT	2.8	0.16	0.21	0.28	2.8	0.32	0.35	0.34	+ 8.5 (1.7;15.7)

	Sample distribution in 2017	Prevalence before COVID-19 (%)			Sample distribution in 2020	Prevalence during/after COVID-19 (%)			Average annual change (%)
	(N = 796,774)				(N = 1,126,927)				
		2017	2018	2019		2020	2021	2022	
Patient's characteristics									
Gender									
Male	41.4	0.04	0.04	0.06	41.8	0.07	0.08	0.07	+ 10.6 (6.7;14.5)
Female	58.6	0.31	0.35	0.41	58.2	0.52	0.63	0.63	+ 11.8 (10.3;13.4)
Age (years)									
18–19	2.1	1.22	1.32	1.61	2.3	1.77	2.07	2.26	+ 14.1 (10.7;17.5)
20–29	10.5	0.83	0.90	0.99	12.8	1.16	1.25	1.29	+ 10.1 (8.0;12.2)
30–39	13.5	0.28	0.30	0.33	15.5	0.41	0.46	0.47	+ 12.8 (10.2;15.4)
40+	73.9	0.07	0.08	0.10	69.4	0.12	0.13	0.13	+ 12.9 (10.5;15.4)
Socioeconomic status (IRSAD Quintile)									
Very high (more advantaged)	22.7	0.22	0.26	0.29	22.5	0.37	0.44	0.42	+ 11.2 (8.7;13.8)
High	18.7	0.20	0.23	0.27	19.4	0.33	0.38	0.40	+ 11.4 (8.5;14.4)
Middle	19.8	0.19	0.21	0.26	20.5	0.32	0.40	0.42	+ 14.9 (11.3;18.6)
Low	21.1	0.21	0.23	0.30	20.5	0.37	0.44	0.44	+ 11.3 (8.0;14.7)
Very Low	17.3	0.21	0.21	0.31	16.6	0.37	0.43	0.41	+ 9.8 (6.3;13.3)
Total	100	0.21	0.24	0.29	100	0.35	0.42	0.42	11.7 (10.2;13.3)

§Adjusted prevalence: analyses with practice characteristics were adjusted for practice variables only and analyses with patient's variables were adjusted for practice and patient's variables. Numbers in bold indicate P-value < 0.001 for Wald test comparing categories of independent variables; numbers not in bold indicate p-value > 0.05. IRSAD: Index of Relative Socioeconomic Advantage and Disadvantage. ACT: Australian Capital Territory.

Additional analyses stratified by age and sex showed that prevalence was highest among individuals aged 18–19 years in both sexes, and increased steadily in this age group over time, both before (~ 21% rise from 2018 to 2019) and during (~ 17% rise from 2020 to 2021) the COVID-19 pandemic (Fig. 1). However, in the other age groups, the increase was more

pronounced during the first year of the COVID-19 pandemic, reaching up to a 27% rise, particularly among older women, before stabilising.

In 2022, eating disorders affected 1 in 25 Australian women aged 18–19 years, with prevalence at least 75% higher than in older age groups. Among men, prevalence was substantially lower but still affected approximately 1 in 230 individuals, and the proportion of 18–19-year-olds diagnosed with eating disorders was nearly 22 times higher than that observed among men aged ≥ 40 years.

DISCUSSION

This study explored changes in the prevalence of eating disorders in a national sample of patients from Australian general practices before (2017–2019) and during (2020–2022) the global COVID-19 pandemic, and associated factors. Three main findings can be highlighted. First, the prevalence of eating disorders doubled between 2017 and 2022, mainly among women and the youngest age group, with eating disorders affecting 1 in 25 Australian women aged 18–19 years, although the influence of the COVID-19 pandemic appears to have been more evident in other age groups. Second, prevalence was consistently higher over time among those attending practices in more advantaged areas compared with their peers. Finally, increase in prevalence was similar among people attending practices in both urban and rural Australia.

The doubling of the prevalence of eating disorders over a relatively short period of time is alarming, especially when compared with previous Australian studies that reported similar changes occurring over a decade (8). One out of 25 Australian women aged 18–19 years had a diagnosis of an eating disorder. This finding is consistent with epidemiological studies showing that eating disorders typically first emerge during adolescence and that prevalence continues to increase worldwide among young people (6, 7, 14, 18).

Our findings also showed that prevalence among middle-aged adults were impacted by the COVID-19 pandemic. This may be related to the fact that even individuals with no previous eating disorder symptoms, or those whose symptoms were previously controlled, experienced onset or worsening of symptoms due to COVID-19–related stress, anxiety, and other adverse emotions (23, 27).

In our study, although men had a lower proportion of eating disorders compared to women, they also had an increase in prevalence over time, corroborating findings of an expanded distribution of eating disorders in the male community (35, 36). Global estimates found that the burden of specific eating disorders, such as anorexia nervosa and bulimia nervosa, has increased rapidly among males in terms of prevalence (7).

In Australia, the state of Victoria experienced the most extensive lockdown measures during the COVID-19 pandemic. Despite expectations that this would result in higher prevalence of eating disorders, Tasmania consistently reported the highest prevalence (12%–86% higher than other states). This aligns with previous evidence that Tasmania has a higher prevalence of several chronic conditions than the rest of Australia, often attributed to socioeconomic disadvantage, geographic isolation, and more limited access to healthcare services. Mental health issues are also particularly pronounced, with national data showing that Tasmania has the highest proportion of mental health-related prescriptions in the country (37, 38).

Our results showed no difference in the prevalence of eating disorders according to patients' socioeconomic status (IRSAD quintiles). Although this finding is consistent with previous studies in Australia (39), it challenges the common perception that eating disorders primarily affect white women from higher socioeconomic backgrounds. On the other hand, when analysing the general practice socioeconomic level, we observed a higher prevalence among patients attending practices located in the wealthiest areas. This may reflect differences in detection and recording practices, as GPs working in more advantaged areas may be more prompt to record and attribute certain symptoms to an eating disorder, possibly due to greater access to training, or more consultation time to detect and manage these conditions (40).

In the same context, previous studies have found that GPs are more willing to diagnosis eating disorders when their practice are physically close to specialist services (40). This may contribute to an underestimation of prevalence in rural settings, where specialist care is scarce. Therefore, the similar increase in the prevalence of eating disorders observed in both urban and rural areas may reflect improved access to care during the pandemic, but it could also mask an even higher true prevalence in rural populations.

This study has several strengths, including the use of a large sample of patients from primary healthcare service (general practices) across all Australian states and territories, with a distribution resembling the general Australian population (34). Considering that 80–90% of people visit their GPs annually, these consultations represent an opportunity to improve the detection and management of eating disorders, particularly when patients seek care for other issues but present eating disorders-related symptoms (15, 18). Moreover, the inclusion of middle-aged and older adults adds to the existing literature, as most studies on eating disorders during the COVID-19 pandemic focus primarily on young adults (25).

Strengths and limits

Although its strengths, the study has also limitations. Firstly, we used GP records to identify eating disorders rather than strict DSM-5 diagnostic criteria. However, GP training in eating disorders recommend that high-risk patients, once identified, should be screened and, if required, assessed comprehensively. Only after completing all stages of a comprehensive assessment, GPs would record a diagnosis using DSM-5 diagnostic criteria (17). Secondly, trends in prevalence may also differ by eating disorder subtype, however, this could not be examined in our dataset, as many cases were recorded non-specifically as “eating disorder”. Thirdly, there is a likelihood of underdiagnosis due to challenges such as limited GP training and the ego-syntonic nature of eating disorders. Nonetheless, these factors are expected to have remained relatively stable over time and therefore do not bias the observed trends.

What is already known on this subject?

Eating disorders are complex, life-threatening mental health conditions with rising global prevalence, including in Australia. However, no study had evaluated eating disorder trends in the Australian general practice setting since 2016, leaving an important gap in understanding nationwide primary care trends leading into and during the COVID-19 pandemic.

What this study adds?

GP-diagnosed eating disorder prevalence doubled in Australia from 0.21% in 2017 to 0.42% in 2022. Despite the highest prevalence in young women - in 2022, eating disorders affected 1 in 25 Australian women aged 18–19 years -, the COVID-19 pandemic's onset triggered a more pronounced spike in prevalence among middle-aged adults. Findings highlight an urgent need to enhance GP training, diagnostic tools, and support systems in primary care to foster early detection and timely intervention, particularly during public health emergencies.

CONCLUSION

In Australia, the prevalence of eating disorders is increasing and is higher among younger women, affecting 4% of women aged 18–19 years, which is particularly alarming considering the elevated mortality associated with a diagnosis of eating disorder. On the other hand, the impact of COVID-19 pandemic appears to have been more pronounced in other age groups. which may inform the planning of intervention strategies in primary care, especially during health emergencies. Strengthening GPs training and support may also improve early identification and timely response.

Declarations

Competing Interests

The authors have no relevant financial or non-financial interests to disclose.

Ethics approval

This is an observational study. The Human Research Ethics Committee of the University of Adelaide exempted the study from an ethical review as it used de-identified data, which posed no risk of re-identification. The independent MedicineInsight Data Governance Committee approved the study (protocol 2022-005), in accordance with its mandate to review all data requests to ensure they are ethically sound and consistent with the Declaration of Helsinki and the National Statement on Ethical Conduct in Human Research. The MedicineInsight programme had ethics approval by the Royal Australian College of General Practitioners (RACGP) National Research and Evaluation Ethics Committee (NREEC) in December 2017 (NREEC 17-017).

Consent to participate

Recruitment of general practices to MedicineInsight involved provision of information to GPs and patients about the programme and use of collected data. Each participating practice signed an informed consent and was required to display a poster to inform patients that their de-identified data would be collected by MedicineInsight. Patients could opt out of the programme by a process handled independently at the practice. Therefore, individual informed consent from all participants was not required, but all practices involved signed the consent and agreed with the requirements with the participants.

Funding

The authors declare that no funds, grants, or other support were received during the preparation of this manuscript.

Author Contribution

C.D.O.B, V.D.M.C, D.G and P. R. contributed to the study conception and design. C.D.O.B managed and analysed the data and all authors contributed to the interpretation of results. C.D.O.B, V.D.M.C, and P. R. have drafted the work, and all authors conducted a critical review of the manuscript and approved the final version.

Acknowledgement

We are grateful to the general practices and GPs participating in the MedicineInsight program and their patients who allow the use of de-identified information.

Data Availability

Data used in this study was obtained from a third party (MedicineInsight) for this specific project and cannot be released. The data extraction algorithms used in this study are available upon request.

References

1. Svirko E, Hawton K. Self-injurious behavior and eating disorders: the extent and nature of the association. *Suicide Life Threat Behav.* 2007;37(4):409–21.

2. van Hoeken D, Hoek HW. Review of the burden of eating disorders: mortality, disability, costs, quality of life, and family burden. *Curr Opin Psychiatry*. 2020;33(6):521–7.
3. Galmiche M, Dechelotte P, Lambert G, Tavalacci MP. Prevalence of eating disorders over the 2000–2018 period: a systematic literature review. *Am J Clin Nutr*. 2019;109(5):1402–13.
4. Smink FR, van Hoeken D, Donker GA, Susser ES, Oldehinkel AJ, Hoek HW. Three decades of eating disorders in Dutch primary care: decreasing incidence of bulimia nervosa but not of anorexia nervosa. *Psychol Med*. 2016;46(6):1189–96.
5. Qian J, Wu Y, Liu F, Zhu Y, Jin H, Zhang H, et al. An update on the prevalence of eating disorders in the general population: a systematic review and meta-analysis. *Eat Weight Disord*. 2022;27(2):415–28.
6. van Eeden AE, van Hoeken D, Hoek HW. Incidence, prevalence and mortality of anorexia nervosa and bulimia nervosa. *Curr Opin Psychiatry*. 2021;34(6):515–24.
7. Liu K, Gao R, Kuang H, E R, Zhang C, Guo X. Global, regional, and national burdens of eating disorder in adolescents and young adults aged 10–24 years from 1990 to 2021: A trend analysis. *Journal of Affective Disorders*. 2025;388:119596.
8. Mitchison D, Hay P, Slewa-Younan S, Mond J. The changing demographic profile of eating disorder behaviors in the community. *BMC Public Health*. 2014;14:943.
9. Udo T, Grilo CM. Prevalence and Correlates of DSM-5-Defined Eating Disorders in a Nationally Representative Sample of U.S. Adults. *Biol Psychiatry*. 2018;84(5):345–54.
10. Hay P, Girosi F, Mond J. Prevalence and sociodemographic correlates of DSM-5 eating disorders in the Australian population. *J Eat Disord*. 2015;3:19.
11. AlHadi AN, Almeharish A, Bilal L, Al-Habeeb A, Al-Subaie A, Naseem MT, et al. The prevalence and correlates of bulimia nervosa, binge-eating disorder, and anorexia nervosa: The Saudi National Mental Health Survey. *Int J Eat Disord*. 2022;55(11):1541–52.
12. Hay P, Mitchison D, Collado AEL, Gonzalez-Chica DA, Stocks N, Touyz S. Burden and health-related quality of life of eating disorders, including Avoidant/Restrictive Food Intake Disorder (ARFID), in the Australian population. *J Eat Disord*. 2017;5:21.
13. Brownlow G, Flack R, Burton-Murray H, Palsson O, Aziz I. The Prevalence and Burden of Avoidant/Restrictive Food Intake Disorder (ARFID) Symptoms in the Adult General Population of the UK and USA. *International Journal of Eating Disorders*. 2026;59(2):362–70.
14. Barakat S, McLean SA, Bryant E, Le A, Marks P, National Eating Disorder Research C, et al. Risk factors for eating disorders: findings from a rapid review. *J Eat Disord*. 2023;11(1):8.
15. Ivancic L, Maguire S, Miskovic-Wheatley J, Harrison C, Nassar N. Prevalence and management of people with eating disorders presenting to primary care: A national study. *Aust N Z J Psychiatry*. 2021;55(11):1089–100.
16. AIHW (2025). General practice, allied health and other primary care services. <https://www.aihw.gov.au/reports/primary-health-care/general-practice-allied-health-primary-care> (accessed 4 Mar 2026).
17. Royal Australian College of General Practitioners. Guidelines for preventive activities in general practice. 10th ed. East Melbourne: RACGP; 2024.
18. Micali N, Hagberg KW, Petersen I, Treasure JL. The incidence of eating disorders in the UK in 2000–2009: findings from the General Practice Research Database. *BMJ Open*. 2013;3(5):e002646.
19. Marciano L, Ostroumova M, Schulz PJ, Camerini AL. Digital Media Use and Adolescents' Mental Health During the Covid-19 Pandemic: A Systematic Review and Meta-Analysis. *Front Public Health*. 2021;9:793868.
20. Reas DL, Ro G, Ro O. Trends in the Observed Versus Expected Incidence of Eating Disorders Before, During, and After the COVID-19 Pandemic: A National Patient Registry Study. *Int J Eat Disord*. 2025;58(8):1469–76.
21. Sharma A, Vidal C. A scoping literature review of the associations between highly visual social media use and eating disorders and disordered eating: a changing landscape. *Journal of Eating Disorders*. 2023;11:1–11.

22. Phalswal U, Pujari V, Sethi R, Verma R. Impact of social media on mental health of the general population during Covid-19 pandemic: A systematic review. *J Educ Health Promot.* 2023;12:23.
23. Güzel Â, Mutlu NL, Molendijk M. COVID-19-related changes in eating disorder pathology, emotional and binge eating and need for care: a systematic review with frequentist and Bayesian meta-analyses. *Eating and Weight Disorders - Studies on Anorexia, Bulimia and Obesity.* 2023;28(1):19.
24. J. Devoe D, Han A, Anderson A, Katzman DK, Patten SB, Soumbasis A, et al. The impact of the COVID-19 pandemic on eating disorders: A systematic review. *International Journal of Eating Disorders.* 2023;56(1):5–25.
25. Vavassori M, Donzelli G. Impact of COVID-19 restrictive measures during lockdown period on eating disorders: An umbrella review. *Nutrition.* 2024;124:112463.
26. Laskowski NM, Brandt G, Reque CB, Sabel L, Pahlenkemper M, Zaiser C, et al. The collateral effects of the COVID-19 pandemic: A gender-specific systematic review of disordered eating behaviour in the general population. *European Eating Disorders Review.* 2025;33(2):254–88.
27. Miskovic-Wheatley J, Koreshe E, Kim M, Simeone R, Maguire S. The impact of the COVID-19 pandemic and associated public health response on people with eating disorder symptomatology: an Australian study. *J Eat Disord.* 2022;10(1):9.
28. Phillipou A, Meyer D, Neill E, Tan EJ, Toh WL, Van Rheenen TE, et al. Eating and exercise behaviors in eating disorders and the general population during the COVID-19 pandemic in Australia: Initial results from the COLLATE project. *Int J Eat Disord.* 2020;53(7):1158–65.
29. Bryant E, Broomfield C, Burrows J, McLean S, Marks P, Maloney D, et al. Gaining consensus on clinical quality outcomes for eating disorders: Framework for the development of an Australian national minimum dataset. *BMJ Open.* 2023;13(4):e071150.
30. Busingye D, Gianacas C, Pollack A, Chidwick K, Merrifield A, Norman S, et al. Data Resource Profile: MedicineInsight, an Australian national primary health care database. *Int J Epidemiol.* 2019;48(6):1741-h.
31. The Royal Australian College of General Practitioners. The RACGP Standards for general practices. Australia; 2015.
32. Benchimol EI, Smeeth L, Guttman A, Harron K, Moher D, Petersen I, et al. The REporting of studies Conducted using Observational Routinely-collected health Data (RECORD) Statement. *Plos Med.* 2015;12(10).
33. Trafford AM, Carr MJ, Ashcroft DM, Chew-Graham CA, Cockcroft E, Cybulski L, et al. Temporal trends in eating disorder and self-harm incidence rates among adolescents and young adults in the UK in the 2 years since onset of the COVID-19 pandemic: a population-based study. *The Lancet Child & Adolescent Health.* 2023;7(8):544–54.
34. Census of Population and Housing: Socio-Economic Indexes for Areas (SEIFA), Australia, 2016.
<https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/2033.0.55.001~2016~Main%20Features~IRSAD~20>
(accessed 04 Mar 2026).
35. Hay PJ, Mond J, Buttner P, Darby A. Eating disorder behaviors are increasing: findings from two sequential community surveys in South Australia. *PLoS One.* 2008;3(2):e1541.
36. da Luz FQ, Sainsbury A, Mannan H, Touyz S, Mitchison D, Hay P. Prevalence of obesity and comorbid eating disorder behaviors in South Australia from 1995 to 2015. *Int J Obes (Lond).* 2017;41(7):1148–53.
37. Australian Institute of Health and Welfare. (2021). Australia's health 2020: in brief. AIHW.
<https://www.aihw.gov.au/reports/australias-health/australias-health-2020-in-brief> (accessed 09 Mar 2026).
38. Tasmania Department of Health. Drivers of Tasmania's Future Population Health Needs. Hobart: Tasmania Government; 2022. https://www.health.tas.gov.au/sites/default/files/2022-06/Drivers%20of%20Tasmania%27s%20Future%20Population%20Health%20Needs_0.pdf (accessed 09 Mar 2026).
39. Mulders-Jones B, Mitchison D, Girosi F, Hay P. Socioeconomic Correlates of Eating Disorder Symptoms in an Australian Population-Based Sample. *PLoS One.* 2017;12(1):e0170603.
40. Reid M, Williams S, Hammersley R. Managing eating disorder patients in primary care in the UK: a qualitative study. *Eat Disord.* 2010;18(1):1–9.
41. STATEMENTS & DECLARATIONS

Figures

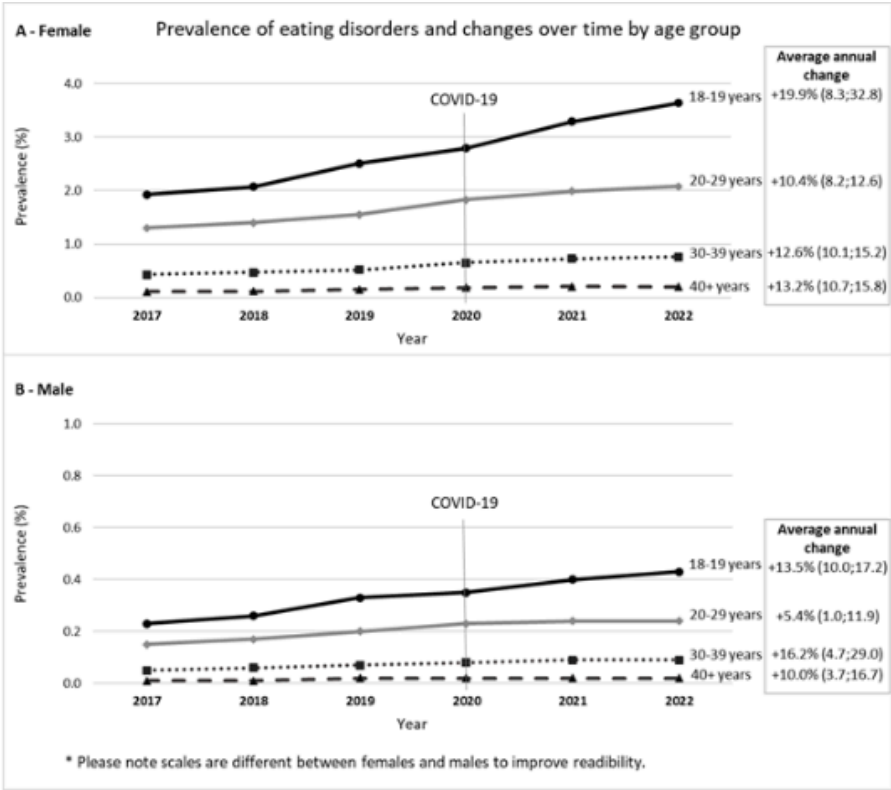


Figure 1

Prevalence of eating disorders over time among women and men by age groups. Regular patients, Australian general practice

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [Supplementarymaterial.docx](#)