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Should the NHS Pay for Bariatric Surgery?

Anqi Liu

University College London(UCL), London WC1E 6AE, UK.

Abstract: Obesity has become an increasingly serious public health problem. This trend poses a serious threat to global public health. Bariatric surgery has been one of the most popular forms of weight loss in recent years, but there is controversy over whether the NHS should pay for obesity caused by personal responsibility. This paper places the research in the context of the UK health service system, using qualitative research as the main method. It first affirms the rationale and role of personal responsibility in illness, while also pointing out the limitations and challenges of implementing personal accountability for illness within the existing theoretical framework. It then describes the adverse consequences of eliminating the NHS from paying for bariatric surgery in terms of cost-benefit as well as universal health coverage. Ultimately, we believe that the NHS should continue to fund bariatric surgery. Overall, this study offers new ideas for assessing public health policy and welfare from the perspective of personal responsibility for illness.

Keywords: NHS; Bariatric Surgery; Personal Responsibility; Cost-Benefit Analysis

1. Introduction

Obesity has become an increasingly serious public health problem. Rates of obesity (body mass index $\geq 30\ kg/m^2$) in males stepped up from 3.2% to 10.8% and from 6.4% to 14.9% in females between 1975 and 2014 (Kinlen, Cody and O'Shea, 2017) [1]. If current trends continue, it is anticipated that 18% of males and 21% of females would be obese globally by 2025 (Ibid.). According to the International Association for the Study of Obesity, due to an increased prevalence of related comorbidities such as type 2 diabetes, hyperlipidemia, hypertension, obstructive sleep apnea, heart disease, stroke, asthma, back and lower extremity weight-bearing degenerative problems, cancer, and depression, obesity has been linked to more than 2.8 million deaths globally each year.

Bariatric surgery, one of the most popular weight-loss manners in recent years, is usually performed with a gastric sleeve resection (removal of a portion of the stomach) or a gastric band (reduction of stomach capacity). A study published in the journal Public Library of Science, which involved a total of 8,000 bariatric surgeries over four years, clearly demonstrated that bariatric surgery not only has a definite effect on obesity but also reduces the incidence of diabetes and myocardial infarction. Currently, the NHS offers free bariatric surgery to UK citizens, but there is debate as to whether the NHS should continue to pay for bariatric surgery. Those who oppose the NHS paying for bariatric surgery claimed that a group of obese patients can be considered 'self-inflicted', which means that they can be held responsible for becoming morbidly obese (Burguera et al., 2007) [2], and as such, they should bear the costs of bariatric surgery themselves.

This essay intends to refute the idea that bariatric surgery should be removed from the NHS coverage by analysing the benefits and drawbacks of personal responsibility for obesity. First, we affirm the validity of the existence of personal liability. We then explore the role of personal responsibility in the public health system. Afterward, we point out the limitations of the existing personal responsibility framework. At the same time, we analyse the adverse effects of stopping the NHS from paying for bariatric surgery. Finally, based on these findings, we display new ideas for the delineation of individual health responsibility and the development of health benefits.

2. Rationality of Personal Responsibility for Obesity

Luck egalitarianism provides a theoretical framework for the responsibility that individuals need to take in weight management. As emphasised by luck egalitarianism theory, the inequalities that need to be compensated for are those that are caused by factors which the individual cannot choose, such as genetic make-up and environmental conditions. While for inequalities caused by freely chosen behaviour, compensation should not be taken into account and individuals should bear the risks resulting from such behaviour. In the language of Keith et al. (2006) [3], irrational rest schedules, the popularity of high-calorie foods and the neglect of daily exercise all contribute to the rapid increase in obesity rates in modern society. Given that the obesity triggers mentioned in this statement are basically within human control, we believe it further confirms that obesity-induced disease is indeed an inequality caused by individual free choice. Luck egalitarianism therefore supports the view that the NHS should stop paying for bariatric surgery.

The argument from attributive responsibility is also parallel with personal responsibility. It explains that depriving individuals of care for self-inflicted illnesses is just if their behaviour is voluntary and they have the ability to assess their own behaviour as well as to anticipate their future illness and be aware that their behaviour may reduce the priority of treatment (Glannon, 1998; McMillan, 2019) [4][5]. Although in reality, it is rare for obese patients to meet all of these conditions when describing their condition due to the diachronic (disease can be caused by the long-lasting effects of many adverse factors) and the dyadic (the surrounding environment can contribute to the development of disease) nature of responsibility, described in Brown and Savulescu (2019) [6], the above limitations provide a fair measure of the individual's responsibility for the disease caused by obesity. When a patient's health behaviour matches the description above, we are justified in refusing to fund an individual for bariatric surgery.

3. Roles of Personal Responsibility in the Public Health System

Emphasising the significance of personal responsibility in weight management can facilitate the efficient allocation of health resources. Constrained by inadequate financial resources, time, political capital and health care professionals, the scarcity of health care resources has evolved into a globalised problem (Chen et al., 2004) [7]. Bariatric surgery, however, has gone beyond prevention before injury occurs or early diagnosis and has been categorised as tertiary prevention in public health. With the increasing budgets of health care, the cost of meeting medical needs through tertiary prevention is climbing at an even faster rate. Since the NHS is essentially using limited medical resources to treat self-inflicted health problems by paying for bariatric surgery, this has indirectly harmed those who are not suffering from obesity. Minkler (1999) mentioned that the concept of 'doing our best as individuals' can lead patients to set goals for improving health behaviours before the outbreak of obesity-induced diseases [8], thereby reducing the consumption of health resources and allowing scarce medical resources to play a greater role in policies that improve the health of the whole population, rather than targeting only some of them. Just as the NHS constitution provides ‘The NHS belongs to all of us. There are things that we can all do for ourselves and for one another to help it work effectively, and to ensure resources are used responsibly...’ (Department of Health and Social Care, 2021) [9]. In short, highlighting personal responsibility for health can reduce the drain on self-inflicted illnesses, leading to a more rational allocation of the limited resources currently available.

Macroscopically speaking, guiding individuals to take responsibility for their health behaviour could prevent personal preferences from overriding the common good in the healthcare system. According to the proponents of communitarian theories, individual preferences endanger any public system in the long run because of a lack of consideration of the overall benefits (Hadorn, 1991) [10]. The common good should therefore be given a higher status in order to ensure the effective functioning of the healthcare system. Given that bariatric surgery continues to be characterised as an escalating cost arising from the individualistic pursuit of the best and longest life (Mosko and Nguyen, 2011) [11], communitarians deny this procedure a priority in the allocation of health care resources. Consequently, the abolition of the NHS policy of paying for bariatric surgery is in line with the demands of the common good.

Furthermore, personal responsibility brings many benefits to the overall health promotion of society. Unlike the traditional disease-oriented approach, most of the projects developed in the new wave of health promotion and disease prevention that began in the late 1970s have tended to focus on health planning at the level of individual behaviour change (Minkler, 1999) [8]. Data from clinical trials also confirm the feasibility of this approach, to detail this, I would like to introduce the experiment conducted by the Stanford Coronary Risk Intervention Program (SCRIP) [12]. The programme divides experimental and control groups and emphasises comprehensive lifestyle modification including behaviours such as diet, exercise and smoking. With strict control of cholesterol consumption, nicotine intake and implementation of an exercise program, the experimental group showed a significant advantage in physical function and future health expectations compared to the control group after 4 years (Keith et al., 2006) [3]. Kass (2001) also confirms that the health dilemma of most citizens at this stage stems from the neglect of healthy behaviours [13], and that when citizens begin to consciously take their own responsibility in health management, the overall health of society will improve unexpectedly. It follows that emphasising individual responsibility in weight control, and thus changing health behaviours, can play an important role in stimulating overall health in society before the epidemic of diseases caused by obesity.

4. Limitations of the Personal Responsibility Paradigm

While we have demonstrated the rationale for personal responsibility in weight management behaviours and the beneficial effects of responsibility on the public health system, the theory of personal responsibility for obesity still has practical and ethical flaws.

4.1 Obstacles to the Practice of Personal Responsibility for Obesity

On one hand, the deterrent effect of this punishment is not as perfect as we might have thought. Marmot (2015) once gave an interesting exposition in which he said that 'People become overweight and obese over a lifetime [14]. The idea that a slice of chocolate gateaux would be foregone at age twenty-five in order to avoid the burden of having to pay for diabetes at sixty-five is completely fanciful'. It is indeed difficult to take all precautions in advance for an unpredictable future. Therefore, this measure, which is essential to preserve the future welfare of patients at the expense of their present lifestyle, is almost impossible to achieve in reality. In other words, while the original intention of eliminating free bariatric surgery was for people to take more responsibility in the matter of weight management, realistically, except for the financial loss they will suffer from, this practice will not make obese patients voluntarily change their current living situation out of fear for their future health condition.

On the other hand, with the aim of making reliable personal responsibility judgements, we need access to a sufficient amount of patient medical data (Wolff, 1998) [15], the collection of which may pose a threat to patient privacy and the doctor-patient relationship. As warned by General Medical Council (2018) [16], the disclosure of medical information for research purposes must be subject to patient consent or be of overall benefit to patients who lack the capacity to consent. Considering that the practice of determining responsibility for disease based on medical data from obese patients will not benefit the majority of the obese population, it is difficult to persuade patients to divulge information about their diagnosis to investigators. In this case, forcibly obtaining information about a patient from the doctor would not only challenge the patient's privacy but would also undermine the relationship of trust between the patient and the doctor. Thus, we lack much evidence and reference material to assess personal responsibility due to the lack of information sources.

Moreover, when we protested against the NHS policy of paying for bariatric surgery, we simply defined obesity as a disease caused by poor self-selection, but several external factors such as literacy, family atmosphere, social values and advertising inducements could also influence individual health behaviours and thus personal responsibility in weight management. These influences are often beyond human control and cannot be excluded. Marmot (2015) mentioned that people's ability to take personal responsibility is determined by their circumstances [14]; if people cannot control what happens to them, they could refuse to take responsibility. From this point of view, highlighting the role of personal responsibility in

weight management inherently fails to discipline patients as they currently do not possess the ability to control the impact of all external factors on obesity.

4.2 The Ethical Controversy of Personal Responsibility for Obesity

Attention also has been devoted to elucidating factors that might explain the relationship between personal responsibility and socioeconomic status. Richardson et al. (2015) has found that lower-income groups may be more prone to stress eating [17]. This trend is associated with marginalised social situations resulting from lower socioeconomic status and higher levels of psychological stress, which can enlarge our food intake and change our food choices. To make matters worse, when the health of these low-income people deteriorates, it is more difficult for them to get access to quality healthcare resources and have to rely on the NHS to pay for their medical care (Kirby, 2008) [18]. As a result, an overemphasis on the role of personal responsibility in weight management might break the only hope of treatment for those in lower socio-economic groups suffering from obesity-induced diseases.

Likewise, even in circumstances when it is evident that individuals are to blame for obesity and the adverse effects of such a condition, it may sound harsh to propose that the individual should not receive treatment. This discussion of harshness also challenges the luck egalitarian framework to some extent. Voigt (2007) argued that 'a consistent luck egalitarian will have to regard it as unjust if any assistance is provided to the victim of pure option luck' [19]. That is to say, when we provide health care without restriction to those who are supposedly responsible for their own health, those patients who are obese for their own reasons are also considered to be at a disadvantage position in the allocation of health care resources. From this perspective, the policy of removing the NHS from paying for bariatric surgery to enforce penalties on obese patients is not a blameless proposal. It may make the allocation of resources more efficient, but it does not completely address the issue of equitable distribution of resources.

5. Adverse Effects of Repealing the Policy

Beyond the limitations of the theory of personal responsibility for health management, we must also consider the adverse effects resulting from canceling the NHS funding for bariatric surgery. For advocates of abolishing the policy, the medical resources consumed by bariatric surgery are seen as a waste of resources that could have been avoided, but in fact, they ignore the cost benefits of bariatric surgery. As noted by Borisenko, Lukyanov and Ahmed (2018) [20], even under conservative assumptions, bariatric surgery was associated with reduced mean costs to the health service by nearly £2000 and gain of 4 quality-adjusted life-years (QALYs) over a lifetime compared with usual care. To be specific, for those with obesity and T2DM-Ins, McGlone et al. (2020) show that bariatric surgery was associated with high rates of postoperative cessation of insulin therapy [21], which could be taken as a major driver of overall thrifts to the national healthcare provider. Similarly, Rognoni et al. (2020) indicated that the net monetary benefit of bariatric surgery versus diet was positive over the entire life cycle and negative only for the first 3−4 years from a payer perspective [22]. Based on the existing cost-benefit analysis of bariatric surgery we can conclude that paying for bariatric surgery may not seem like a wise decision for the NHS at the moment, but the benefits of such expenditure will become more apparent over time and thankfully it will not take too long. In summary, the policy of removing the NHS funding for bariatric surgery does not take the sustainability that the cost benefits of the surgery bring to the healthcare system into account, and to some extent adds to the burden of healthcare on the NHS in the future.

Apart from this, repealing the NHS policy of funding bariatric surgery is not conducive to the goal of universal health coverage (UHC). As claimed by World Health Organization (2019) [23], UHC means that all individuals and communities could access the health services they need without suffering financial hardship. These health services include health promotion, prevention, treatment, rehabilitation and palliative care throughout the life course. It is clear that bariatric surgery for the purpose of improving health should be included in universal health coverage (UnitedHealthcare Commercial, 2020) [24]. Perhaps the current health care system does not possess the capacity to allocate sufficient overheads for bariatric surgery,

but the goal of universal health coverage should be to spread the cost of health care as much as possible, rather than to eliminate this expenditure thoroughly.

6. Division of Personal Responsibility and Improving Medical Benefits

Subject to some flaws in the theory of personal responsibility for obesity and the adverse impacts of abolishing the policy, it seems that the payment for bariatric surgery by the NHS cannot be abandoned for the time being. Notwithstanding this situation, some suggestions could be given on the division of responsibility in order to implement the role of personal responsibility in the public health system.

Specialists in the nutritional treatment of obesity medicine in China had introduced a self-diagnostic approach to obesity causation in clinical diagnosis in 2016. The doctor details 15 major behaviours that may contribute to obesity (including diet and exercise factors related to self-selection and other non-self-selective factors such as stress, medication side effects, familial inheritance, etc.) and asks the patient to rate these factors on a voluntary basis within a scale of 0 to 5, with 0 indicating that the factor has no influence on obesity, 5 indicating that the factor poses a complete threat to weight, and the higher the number on the remaining scale means the greater the degree of influence. From the patient's score, the doctor can initially determine the main source of obesity. If the patient gives a high score for all the disease triggers related to freedom of choice, he is disqualified from the benefits offered by the healthcare system. Affected by the multiplicity and complexity of obesity triggers, it is difficult to determine individual responsibility from a single health behaviour. For instance, one binge meal or a lazy day without exercise will not directly lead to obesity. Under this circumstance, self-evaluation is probably the most effective and straightforward method available, as the assessment gives us an idea of the patient's overall state of life (Ferraro et al., 2013) [25].

Nevertheless, despite the patient's consent to expose health data to the doctor, whether the self-assessed data is entirely truthful remains dubious given the nature of the individual's self-interest. At the same time, resolving the ethical controversy surrounding the removal of funding for bariatric surgery is always a difficult issue. After all, disparities in socioeconomic status cannot be compensated for by a single measure and the harshness of penalties would make luck egalitarianism unconvincing from the standpoint of both the obese and the normal population.

Last but not the least, after we obtained a cost-benefit analysis of bariatric surgery, we learned that the policy of paying for bariatric surgery lays the foundation for a sustainable health care system. Based on this, the government needs to maintain the stability of the healthcare funding pool, either through appropriate increases in healthcare spending or encouraging patients who can afford it to pay for their own surgery. Ensuring the proper functioning of the healthcare system before reaping the benefits of bariatric surgery, as well as making a wider range of healthcare services available to patients in need, guided by the goal of universal health coverage.

Conclusion

At a time when obesity-related diseases are becoming an international problem, emphasising the significance of personal responsibility in regulating health behaviours and managing weight has become a chief tool in tackling obesity and improving the health status of all people. Luck egalitarianism and the notion of attribution of responsibility provide the rationale for personal responsibility for obesity, and the NHS refused to pay for bariatric surgery is justifiable if the causative factors of obesity are motivated solely by the disadvantage of individual free choice. Additionally, many beneficial effects on the public health system can be demonstrated when individuals assume responsibility for their health, including promoting the efficient allocation of health care resources, safeguarding the common good and promoting overall health. In view of this, reducing the NHS spending on bariatric surgery to establish personal responsibility for health is a sensible proposal overall.

Even so, there are still many problems with recognising individual responsibility for health. From the practical side, it is difficult for patients to grasp the deterrent effect of personal responsibility. Besides, access to patients' medical information in a way that may invade their privacy and the influence of external factors that are impossible to be excluded are still obstacles to claiming personal responsibility for their health. To make matters worse, the changes in the NHS policy could also raise

ethical issues. The emphasis on individual responsibility for health can place marginalised groups with lower social status in a more unfavoured position in the public health system. Similarly, the harshness of this punitive discourse could challenge the definition of luck egalitarianism. In general, while we recognise the role of individual health responsibility in the public health system, the lack of practicality and ethical constraints makes it difficult to put it into practice at present.

When we look at the proposal to remove the NHS from paying for bariatric surgery in terms of the policy itself, neither a cost-benefit analysis nor universal health coverage would justify cutting off medical funding for bariatric surgery across the board. More surprisingly, when viewed in this light, reducing the NHS spending on bariatric surgery could be more costly to the health system in the future and detrimental to the full implementation of health benefits.

Based on these analyses, we believe that eliminating the NHS from paying for bariatric surgery appears to be something that has more disadvantages than benefits, so we do not recommend implementing this proposal. We could, however, make some suggestions about the current division of responsibility for individual illness and the improvement of health benefits. Patients, as subjects of health responsibility, and the articulation of their lifestyle and environment can be an important criterion for judging the causative factors of obesity and thus determining whether patients need to pay for their actions. It should be added that this approach should only be used as a reference, given the accuracy of the information provided by the patient and the unresolved ethical dilemmas. When it comes to the impact of non-free choice factors on obesity, we need to have a deeper understanding of the patient's life circumstances, which is suggested to be a major direction for future research on the attribution of responsibility for disease (Mayes and Thompson, 2014) [26]. Finally, from a healthcare effectiveness perspective, an appropriate increase in public healthcare expenditure could sustain the healthcare system until the gains of bariatric surgery are captured, while also contributing to the ultimate goal of universal healthcare coverage.

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