Australian Psychological Society

Invited Submission to Senate Economics References Committee

Inquiry into personal choice and community impacts

Australian Psychological Society

APS contact:
Heather Gridley
Manager, Public Interest
Phone: (03) 8662 3327
Email: h.gridley@psychology.org.au

September 2015

Level 11, 257 Collins Street
Melbourne VIC 3000
PO Box 38
Flinders Lane VIC 8009
T: (03) 8662 3300
F: (03) 9663 6177
www.psychology.org.au

Senate Economics References Committee
Inquiry into personal choice and community impacts

The Australian Psychological Society (APS) welcomes the opportunity to respond to the Senate Economics References Committee Inquiry into personal choice and community impacts, and the associated economic and social impact of legislation, policies or Commonwealth guidelines to restrict personal choice 'for the individual's own good'.

The APS anticipates making further contributions to address several of the specific Inquiry terms of reference at later dates, as stipulated by the Senate Committee. This submission will address general issues of personal choice and community impacts, citing examples that in some instances relate to one or more of the specific terms of reference.

The APS is the national professional organisation for psychologists with more than 22,000 members across Australia. Psychologists are experts in human behaviour and bring experience in understanding crucial components necessary to support people to optimise their function in the community.

A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing. Psychology in the Public Interest is the section of the APS dedicated to the communication and application of psychological knowledge to enhance community wellbeing and promote equitable and just treatment of all segments of society.

Key points

- Personal choice does not exist in isolation. Personal choices and associated behaviours are shaped and influenced by a wide range of biological, social, environmental and economic factors. Given increasing research about the multitude of potential influences on personal choice, measures to restrict or enhance personal choice should be assessed on an issue-by-issue basis and supported by a sound evidence base.

- Care needs to be taken that the shift in focus towards individual choice and responsibility does not result in the structural and societal causes of health and social problems and unhappiness being overlooked, and environmental hazards, inequality and oppression becoming normalised.

- Care also needs to be taken to avoid a victim blaming approach, whether intentional or unintentional. The notion of personal choice should never hold disadvantaged groups responsible for situations that

have demonstrable structural and social causes beyond their control, which could further marginalise already vulnerable people.

- The notion of personal choice should not be used to support punitive measures like withholding (or charging more for) health care for individuals who appear to have made poor choices with regard to health and lifestyle behaviours. Our shared responsibility for the health of our community takes priority over the arguably illusory operation of personal choice.

- In contrast to purely punitive measures, interventions that limit personal choice as a consequence of previous poor decision-making (such as ignition interlocks for drivers charged with alcohol driving offences that restrict their driving choices but reduce their alcohol driving offences) may be justified as promoting behaviour change while minimising harm. Such 'health consequence' policies should be based on ethical principles and evaluated on their merit.

- A distinction should be drawn between those (very few) actions that have consequences for the individual 'chooser' only, and those that might jeopardise the health and wellbeing (and financial security) of others, directly or indirectly. Public health measures that restrict personal choice may be implemented 'for the individual's own good', but should be directed more at those personal choices that can harm others. Such harm might well extend to increased strain on health systems, services and costs from behaviours that jeopardise individual and community health.

- Consideration needs to be made to the impact of laws about personal choice as they relate to children, young people and those with cognitive vulnerability who have limited capacities to make informed decisions to protect themselves or others.

- It is important to highlight the many, often hidden, influences on choice and both expose their influence and develop policy responses that address harmful impacts. For example, the junk food industry already exerts influence on personal choice by mass advertising, cheaper products and prolific availability.

Responding to the Inquiry

Psychological, philosophical and ideological debates on the nature of freedom and choice range from BF Skinner's 1971 behaviorist (and interventionist) manifesto *Beyond Freedom and Dignity*, through Freudian notions of unconscious determinism to the postmodern representation of human agency as a socially constructed illusion. The libertarian creed of individual freedom has its place, but it must always be countered by an acknowledgement of how it can lead to victim-blaming. The role of individual agency in the lived experience of disadvantage, and the potential for individuals and families to counteract adversity are certainly limited.

Like other scientists and health professionals, psychologists prioritise evidence-based practices. We consider it unethical and incompetent to ignore the evidence as to 'what works' in psychological practice. So too it could be argued that public policy is unethical if it fails to take account of what we now know on the effectiveness of well-accepted measures such as random breath testing and environmental tobacco bans, along with the growing evidence for policy consequences available through initiatives such as the Cochrane Collaboration. The examples of tobacco and gambling show that vested interests often try to disguise or manipulate evidence by promoting the notion of 'personal choice' in order to further their economic interests.

The APS therefore considers it important to clarify that personal choice, or human agency, does not exist in isolation. Rather, research evidence is unequivocal that personal choices and associated behaviours are shaped and influenced by a multitude of biological, social, environmental and economic factors. A common misconception is that our health and wellbeing are predominantly influenced by the individual choices we make. Rather, it has bene estimated that health behaviour choices (such as personal decisions to engage in smoking and alcohol use) only account for about a fifth of total population health (Tarlov, 1999). The social determinants of health (social environment, physical environment/total ecology, and health services/medical care) account for 75%, with genetics and biology making up the remainder (~5%). Furthermore, the social determinants of health interact with and influence individual behaviours, confirming that personal choices do not occur and cannot be viewed in isolation.

The APS also has concerns about the potential ramifications when public issues are incorrectly reconceptualised as individual problems. For example, Cederstrom and Spicer (2015) warn that "when happiness is recast as an individual choice, politicians have a convenient excuse to stop looking at structural issues like socioeconomic inequality and poverty". The shift in focus towards individual choice and responsibility means that structural causes of

unhappiness are not addressed, and inequality and oppression become normalised.

The APS recognises the role of structural factors, including access (or lack thereof) to material and social resources, in maintaining and/or counteracting disadvantage. We are concerned that attributing the causes of disadvantage to individuals and families risks further marginalisation of already vulnerable groups, holding them responsible for situations that have demonstrable social causes beyond their control. This approach perpetuates victim blaming and leads to stigma, at both an individual and community level. Primary prevention is always preferable to 'picking up the pieces', and public health interventions at a whole-of-community or universal level have been shown to be of greatest benefit to those population sub-groups most in need.

Given the multitude of potential influences on people's choices, when considering appropriate measures to restrict or enhance personal choice, the APS believes that such measures should be assessed on an issue-by-issue basis and supported by a sound evidence base.

In addition, the APS proposes that a distinction be drawn between those (very few) actions that have consequences for the individual 'chooser' only, and those that might jeopardise the health and wellbeing (and financial security) of others, directly or indirectly.

The APS believes that the discipline and profession of Psychology has contributions to offer in striking an evidence-based balance between notions of individual liberty, responsibility, 'personal choice' and 'nanny state' concerns on one hand, the related risks of 'blaming the victim' by expecting people to bear the health care costs of those choices, and of direct or indirect harm to others, versus adopting a whole of community approach to prevention and health promotion.

At one end of the personal choice continuum, a number of submissions to the current Inquiry argue against laws requiring cyclists to wear helmets, on the grounds that the safety measure is dissuading unfit Australians from riding their bikes, and that there is insufficient evidence that wearing helmets saves lives. Furthermore, these submissions argue that any risk of injury is confined to individual users themselves (aside from the potentially considerable risk to the public purse in terms of health and rehabilitation and lost productivity costs).

The APS does not propose to directly address the issue of bike helmets *per se*, but the example is illustrative of the complexity of decision-making and legislating around matters of possible personal choice. For example, a

legislative response requires consideration of the evidence-base on the safety record of bike helmets and potentially the cost implications to the broader community in terms of health and rehabilitation services and lost productivity. However this evidence would need to be compared to the evidence-base on the potential gains to be accrued from an increase in bike use/decrease in car usage and the impact this would have on the health of the nation. In summary, responding to issues of perceived personal choice is unlikely to be straightforward – rather decisions must be made on a case-by-case basis with thorough review of the full range of evidence.

Extreme caution is also warranted to avoid implementing inappropriate legislation or imposing punitive actions on people on the basis of value-based perceptions of what constitutes a 'good' or 'bad' choice (for example, withholding or charging more for health care services for individuals who are perceived to have engaged in 'poor' health behaviours).

A public health model would hold that our shared responsibility for the health of our community takes priority over the arguably illusory operation of personal choice. For example, it is probably acceptable to prevent non-immunised pre-schoolers from attending child care centres as it protects other children and creates limited harm; it is far less acceptable to withhold social security payments from parents who do not vaccinate their children, because such a measure creates the potential for harm to the child and their family and does not protect other children.

In contrast to purely punitive measures, interventions that limit personal choice as a consequence of previous poor decision-making (such as ignition interlocks for drivers charged with alcohol driving offences that restrict their driving choices but reduce their alcohol driving offences) may be justified as promoting behaviour change while minimising harm. Such 'health consequence' policies should be based on ethical principles and evaluated on their merit.

The APS also proposes that consideration be given to the impacts of laws about personal choice as they relate to children and young people (and others with limited capacity for informed decision-making). The previous bike helmet example illustrates this well. Children and young people are unable to apply the same sophisticated risk analyses that adults are capable of, because of their immature cognitive development. Their capacity to make 'good' personal choices is therefore limited. They require more external support for making 'good' decisions, like wearing bike helmets or choosing healthy food. In part this is provided by parents, and in part, by appropriate legislation. Parents' capacity to apply and enforce limits and boundaries on children's behaviour is

facilitated by appropriate legislation. Similar considerations apply to adults with cognitive vulnerability.

The APS position is that the evidence for preventive measures that restrict choice should be assessed on an issue-by-issue basis, taking into account the following distinctions:

- when a behaviour primarily involves risk of harm to the individual, more than to anyone else, such as cycling without a helmet or overeating (although it can be argued that such behaviours do result in indirect harm to others, via increased strain on health systems, services and costs from behaviours that jeopardise individual and community health)
- when a behaviour involves risk of harm both to the individual and to those around her/him (e.g., gambling, smoking, substance use, non-vaccination)
- when personal choices are made by those who do not have a fully developed capacity to assess the risk of harm to self or others
- when a behaviour primarily involves risk of harm to others (e.g., use of firearms).

Two particular models that may be useful for the committee in their investigation are outlined below. The models provide tools to support decision-making about appropriate measures of intervention.

The Nuffield Council on Bioethics stewardship model

The Nuffield Council on Bioethics stewardship model of public health (2007) seeks to clarify ethical boundaries for public health interventions. It recommends that public health programs: not attempt to coerce adults to lead healthy lives; minimise introduction of interventions without consent; and minimise interventions that are unduly intrusive and in conflict with personal values. The stewardship model proposes an 'intervention ladder', to encourage thinking about the different ways in which public health policies can influence people's choices. The rungs range from 'no intervention', to 'eliminating choice' altogether, as follows:

- *Eliminate choice* – e.g. compulsory isolation of patients with infectious diseases
- *Restrict choice* – e.g. removing unhealthy ingredients from foods, or unhealthy foods from shops or restaurants
- *Guide choice through disincentives* – e.g. through taxes on cigarettes, or by discouraging the use of cars in inner cities through charging schemes or limitations of parking spaces

- *Guide choices through incentives* – e.g. offering tax breaks for the purchase of bicycles that are used as a means of travelling to work
- *Guide choices through changing the default policy* – e.g. in a restaurant, instead of providing chips as a standard side dish (with healthier options available), menus could be changed to provide a more healthy option as standard (with chips as an available option)
- *Enable choice* – e.g. by offering participation in a National Health Service (NHS) stop-smoking program, building cycle lanes or providing free fruit in schools
- *Provide information* – e.g. campaigns to encourage people to walk more or eat five portions of fruit and vegetables per day
- *Do nothing or simply monitor the current situation*.

The stewardship model of public health emphasises the state's responsibility to address the needs of both individuals and the population, but is careful to articulate what the practical limits of this responsibility might be and how such limits might be identified. The options higher up the ladder are more intrusive and therefore require more justification.

'Optimal defaults' model

Brownell and Frieden (2009) use an 'optimal defaults' model in which public policies can determine what the optimal default positions are, yet the choice remains with the individual to opt out. The model describes conditions that promote beneficial or healthy choices as the optimal default option. Rather than focusing on changing people's behaviour one person at a time, good public policy makes positive changes in the environments that support particular behaviour patterns. For large scale effectiveness, this sort of intervention is much more successful. Practising more healthful behaviour becomes the optimal default – that is, choosing a more healthful behaviour becomes easier, if not automatic.

Brownell and Frieden cite organ donation as an example of where personal choice could be guided to better support desirable outcomes for the community. An optimal default could be created whereby people are automatically signed up for organ donation at the time of getting their driver's licence. If people do not want to donate their organs, they need to ask to opt out. In countries where optimal defaults have been used, the sign-up for organ donation has changed from 10 per cent to 98 per cent. In Australia, where we are merely encouraged to opt in, the rate is less than 15 per cent. Brownell pointed out that no public education campaign could ever hope to achieve such a massive swing in collective behaviour.

Thus, the optimal defaults model (which is similar to the *Guide choices through changing the default policy* rung of the Nuffield Foundation ladder

above) is another policy measure which could be used effectively to influence personal choices for whole-of-community gain.

Conclusion

In all the cases listed in the terms of reference, there are additional costs to taxpayers and social networks if individual choices result in disability or death. The *Hidden Harms of Alcohol* report (Laslett et al., 2015) is an example where the evidence is growing that an individual's choices regarding alcohol use can cause disability to others. Some evidence would suggest the same for the potential for parental obesity to flow on to damage their children. It is therefore simplistic to rely on 'nanny state' accusations to argue that matters of 'personal choice' be insulated from state intervention.

In conclusion, the APS recommends that any measures introduced to restrict personal choice are informed by clear evidence and take into consideration the complex interplay of individual freedom and public health gains.

References

Brownell, K.D., & Frieden, T.R. (2009). Ounces of Prevention: The Public Policy Case for Taxes on Sugared Beverages. *New England Journal of Medicine*, 360 (18), 1805-1808.

Cederstrom, C. & Spicer, A. (2015). *The Wellness Syndrome*. NY: Wiley. ISBN: 978-0-7456-5561-1

Laslett, AM., Mugavin, J., Jiang, H., Manton, E., Callinan, S., MacLean, S., & Room, R. (2015). *The hidden harm: Alcohol's impact on children and families.* Canberra: Foundation for Alcohol Research and Education. Retrieved 13 August from http://www.fare.org.au/wp-content/uploads/research/01-ALCOHOLS-IMPACT-ON-CHILDREN-AND-FAMILIES-web.pdf

Nuffield Council on Bioethics (2007). Public health: Ethical issues. London, UK: Nuffield Council on Bioethics. Retrieved 17 September from http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf

Tarlov, A.R. (1999). Public Policy Frameworks for Improving Population Health. *Annals of the New York Academy of Sciences*, 896 (Socioeconomic Status and Health in Industrial Nations: Social, Psychological, and Biological Pathways), 281-293.