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**Public, official, and industry submissions on a Bill to increase the alcohol minimum
purchasing age: A critical analysis**

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Abstract

Background: In 2005 a Bill was introduced to the New Zealand parliament to increase the alcohol minimum purchasing age (MPA) from 18 to 20 years and submissions were invited from interested parties. We sought to characterise and critique the arguments tendered for and against the proposal.

Methods: We used template analysis to study written submissions on the Bill from 178 people and organisations in New Zealand. Independent raters coded submissions according to the source, whether for or opposed, and the arguments employed.

Results: The most common sources of submissions were members of the public (28%), the alcohol industry (20%), and NGOs (20%). Overall, 40% opposed increasing the MPA, 40% were in favour, 4% supported a split MPA (18 years for on-premise, 20 years for off-premise), 7% were equivocal, and 8% offered no comment. The most common proponents of increasing the MPA were NGOs (36%) and members of the public (30%) and their arguments concerned the expected positive effects on public health (36%) and public disorder/property damage (16%), while 24% argued that other strategies should be used as well. The most common sources of opposition to increasing the MPA were the alcohol industry (50%) and the public (20%). It was commonly claimed that the proposed law change would be ineffective in reducing harm (22%), that other strategies should be used instead (16%), that it would infringe adult rights (15%), and that licensed premises are safe environments for young people (14%). There were noteworthy examples of NGOs and government agencies opposing the law change. The alcohol industry maximised its impact via multiple submissions appealing to individual rights while neglecting to report or accurately characterise the scientific evidence. Several health and welfare agencies presented confused logic and/or were selective in their use of scientific evidence.

Conclusion: In contrast to the fragmented and inconsistent response from government and NGOs, the alcohol industry was organised and united, with multiple submissions from the sector with most at stake, namely the hospitality industry, and supporting submissions from the manufacturing, import, and wholesale sectors. Systematic reviews of research evidence should be routinely undertaken to guide the legislature and submissions should be categorised on the basis of pecuniary interest.

Key words: alcohol, minimum purchasing age, drinking age, public, official, industry, submissions

Introduction

There is extensive evidence from the USA, Canada, and Australia demonstrating deleterious effects of lowering the minimum legal drinking or purchasing age (Shults et al., 2001; Wagenaar & Toomey, 2002). In the late 1970s and early 1980s, several states in the USA increased the minimum legal drinking age to 21 years. In a meta-analysis of 23 studies on the effects of increasing the drinking/ purchasing age, median reductions in the incidence of various traffic crash outcomes were 12%–16% (Wagenaar & Toomey, 2002). Another review (Shults et al., 2001) concluded: “...there is an inverse relationship between the [Minimum Legal Drinking Age] and two outcome measures: alcohol consumption and traffic crashes” (p.206).

In 1999, New Zealand reduced the minimum alcohol purchasing age (MPA) from 20 to 18 years. This occurred in the context of a comparatively high rate of adolescent injury morbidity, particularly from traffic crashes (Kypri, Chalmers, Langley, & Wright, 2002) to which hazardous alcohol consumption was a leading contributor (Connor, Norton, Ameratunga, & Jackson, 2004). Independently conducted studies concluded that it had detrimental effects on the incidence of emergency department admissions for intoxication (Everitt & Jones, 2002) traffic crash injuries (Guria, Jones, Leung, & Mara, 2003; Huckle, Pledger, & Casswell, 2006; Kypri et al., 2006) and disorder offences (Huckle et al., 2006), while the short-term effects on alcohol poisoning and assault could not be determined because of inadequate data (Kypri, Davie, Langley, Voas, & Begg, 2009). More recent studies show that excess morbidity from traffic injury has been sustained (Huckle & Parker, in press) and that the law change was also associated with long-term increases in hospitalised assaults among 15-19 year-old males (Kypri, Davie, McElduff, Connor, & Langley, in press).

In May 2005 the *Sale of Liquor (Youth Alcohol Harm Reduction) Amendment Bill* (SLAB) was introduced to the New Zealand parliament. The SLAB proposed six changes to

the existing legislation: (1) a return of the minimum purchasing age to 20 years, (2) prohibiting supply of alcohol to minors in private parties, (3) a removal of the requirement to show intention to supply, (4) changes to provisions concerning restricted areas in licensed premises, (5) restriction of broadcast advertising of alcohol to after 10pm, and (6) moving the responsibility for regulating broadcast advertising from an industry body (“self-regulation”) to a statutory body. The dominant feature of the Bill, reflected in public discussion and political debate, was the proposed increase in the MPA. Accordingly, this paper focusses on the discourse concerning the MPA.

This opportunity to change the law arose via a *Members’ Bill*, outside the government legislative programme, by a Progressive Party MP Matt Robson. Which Members’ Bills go before the House is determined by a random balloting process. The two major parties in parliament, Labour and National, confirmed that the SLAB would be subject to a conscience vote, i.e., for MPs to vote in accordance with their consciences rather than their party’s position (J Langley & K Kypri, 2006), and the Law and Order Select Committee made a public call for submissions.

Between June 2005 and May 2006, the Select Committee (comprising seven MPs from various parties) considered written and oral submissions from members of the public, health experts, community groups, and the alcohol industry, and in October 2006 reported back to Parliament summarising the submissions in terms of the number in favour of or against the proposed changes. On 8 November 2006, the parliament voted 72 to 49 against the Bill.

In contrast to the United Kingdom where Select Committees’ primary function is executive oversight (Benton & Russell, 2013), in the unicameral New Zealand parliament, their role is legislative review. Select Committees give detailed consideration to Bills following their first reading, calling for written submissions and hearing oral submissions

from the public, experts, and affected parties (<http://www.parliament.nz/en-nz/>). Their composition is determined by the Government of the day but committees typically include members of several parties and there is often extensive debate resulting in amendment of Bills at their second reading (<http://www.parliament.nz/en-nz/>). Examining the nature of submissions made to Select Committees is therefore important in understanding how alcohol legislation is developed.

Submitters can make arguments that ignore or cherry pick the evidence base because they have other agendas, think personal opinion is sufficient, do not know the literature, value individual rights above all else and so forth. While there have been numerous studies of Select Committee activity in various parliamentary systems [e.g., (Giddings, 1994)], there have been no studies concerning the content of submissions concerning alcohol legislation. We sought to determine who supported and opposed the proposal to increase the MPA, to characterise the basis of arguments according to who made them, and to reflect on the implications for how submissions on public health policy might be better handled. We hypothesised that government and non-government public health organisations would support the law change citing the research evidence for its likely effect on the health of young people, and that the alcohol industry would oppose it, citing likely negative effects on business and individual freedoms, while public submissions were expected to be more heterogeneous.

Methods

All 178 written submissions were obtained from the clerk of the committee. Some of these were accessed via requests pursuant to the Official Information Act (1982).

Procedure

Submission eligibility

One reviewer (KK) assessed the eligibility of each submission, i.e., whether it addressed the MPA. It should be noted that some were concerned only with other aspects of the SLAB, e.g., proposed changes to broadcast advertising rules.

Characteristics of submissions

We used template analysis to guide the development of a coding scheme and interpretation of data (King, 1998). In this approach, sometimes referred to as “thematic coding”, the investigators produce “a list of codes (a ‘template’) representing themes identified in their textual data. Some of these will usually be defined *a priori*, but they will be modified and added to as the researcher reads and interprets the texts.” (King, 1998, p. 118).

This method can be used to analyse textual data in a range of epistemological contexts (King, 1998), including *common sense realism* (Boas, 1957), which we considered an appropriate framework given the relatively unambiguous nature of the communications in question, namely formal, written submissions on a specific provision in a Bill. Accordingly, priority was given to obtaining reliable agreement between two raters (LW and MH) who were not specialists in the subject matter and who would therefore be less likely to bring strong pre-conceived positions to the analysis. We conducted a sufficient number of iterations in the development of the template to reach consensus on the types of arguments present and code them reliably (King, 1998).

Initially a random sample of 20 submissions was drawn and reviewed by three authors (KK, LW, MH) to determine whether they expressed support or opposition to the MPA amendment and to identify the characteristics of the arguments underpinning the positions taken. Another 20 submissions were then drawn randomly and analysed to refine and finalise the coding system. All eligible submissions were analysed and data were extracted by two

reviewers (LW, MH). Disagreements between reviewers were discussed and in all cases, reference to the coding scheme resolved them quickly.

From the 20 randomly selected submissions, four types of arguments in favour of increasing the MPA were identified (Table 1). An *Other* category included a broad range of unclassifiable comments, including those where no justification for a position was presented.

Eleven types of argument used to oppose increasing the MPA were identified from the initial random sample, and a further three were identified during coding of the remaining submissions, giving a total of 14 types of argument (Table 1). An *Other* category included various other comments. Some submissions contained more than one type of argument in which case each argument was categorised such that the number of arguments is not equal to the number of submissions.

Measures

Type of submitter. Submissions were classified according to who made them: member of the public, non-government organisation/community group (defined as a non-commercial private entity), youth organisation, District Health Board, government organisation, university or other tertiary education provider, “Youth Access to Alcohol” group, Local Authority, alcohol industry—hospitality, alcohol industry—producer/importer/wholesaler, advertising industry, other commercial entity, and “other”. The classification was made on the basis of how the submitters represented themselves in the written submission.

Support of or opposition to the MPA amendment. Submissions were classified as in support of the MPA amendment if they contained an explicit statement or one clearly implying support for the proposed law change. Conversely, submissions were classified as opposing

the amendment if they contained an explicit statement or one clearly implying opposition to the law change.

Results and Discussion

Of the 178 submissions, 72 were judged to be in favour of increasing the MPA, 74 were opposed, 15 were neither in favour nor opposed, and a further 16 concerned only the advertising provision of the Bill, making no comment on the MPA. One submission was illegible. Results presented hereafter include only the 146 submissions that were either in favour of or against the proposed increase in MPA.

Table 2 shows the proportion of submissions, by type of submitter, that were either in favour of or against increasing the MPA. Members of the public and NGOs predominantly supported increasing the MPA, while the alcohol industry groups were all against it.

Table 3 summarises the themes of arguments used for increasing the MPA. The total number of themes presented was 133, from 57 submissions. In 17 submissions favouring an increase in the MPA, no argument was tendered to support the position. These cases are not included in Table 3. Commonly used arguments in favour of increasing the MPA were presented on the grounds of public health and safety (n=48), and public disorder and property damage (n=21). In 32 cases, submitters argued for the importance of other strategies being used along with increasing the MPA (e.g., regulating the promotion of alcohol to youth).

Table 4 summarises the themes of arguments used against increasing the MPA. The total number of themes presented was 226 across 74 submissions. Relative to those favouring an increase, a greater variety of themes was evident in submissions opposing the law change. The most common of these consisted of the assertion, unsupported by reference to research evidence, that increasing the MPA would be ineffective in reducing youth drinking (n=49). In 37 submissions it was argued that other strategies (e.g., education programs) should be used

instead but no evidence regarding their effectiveness was offered. In 33 submissions it was argued that 18 years was the age at which adult rights, including the right to purchase alcohol, should be conferred to individuals. The following sections examine submissions from major stakeholders, namely, health service providers, government agencies, non-government organisations, and the alcohol industry.

Health service providers

In New Zealand, at the time the submissions were made, government funded health care services were provided or funded by 21 District Health Boards composed of health professionals responsible for the population of specific geographical areas (Ministry of Health, 2007). Of eight boards that made a submission, five supported increasing the MPA and three opposed it.

Taranaki District Health Board wrote “We support all aspects of the raising of the purchase age from 18 to 20 years” on the grounds that “this will reduce the ability of mature looking 15 to 17 year olds being able to purchase their own alcohol.” They cited the results of their own investigations in support of the position:

“Since March 2001 we have carried out 18 pseudo patron operations...These operations are performed by young looking 18 year olds who carry no ID... Despite...persistent monitoring and regular meetings with the licensed premise managers, results have varied from 78% of attempts being successful to one occasion when we achieved no successful sales. The average result is that 31% of attempts are successful.”

“To provide evidence of how simple it is for teenagers to acquire alcohol, TDHB Health Promotion Unit has conducted the only ‘shoulder tapping’ operations in New Zealand... Young people aged 18 and 19 years approached strangers entering off licenses and asked them if they would buy alcohol for them...30 percent to 50 percent of strangers approached were happy to make the purchases.”

Auckland Regional Public Health Service wrote (p.3): “We support amendments in the Bill aimed at raising the Minimum Legal Purchase Age from 18 to 20,” on the grounds that:

“...it will (inter alia):

- reduce teenage consumption of liquor (Toomey et al. 2006)

- reduce traffic related injuries (Wagenaar & Toomey 2002)
- reduce non-traffic-related injuries (Jones, Pieper, & Robertson, 2002)
- reduce sexually transmitted infections and teenage pregnancy (Harrison & Kassler, 2000)."

In contrast, Regional Public Health (the authority for the Greater Wellington region) wrote:

"At this stage we are not convinced either way that the legal purchase age should be raised to 20 or remain at 18," on the grounds that:

"There is evidence to support raising the age however our own data and experience working with on and club-licensed premises leads us to believe that lowering the purchasing age to 18 did not necessarily result in increased alcohol related offending harm amongst 18 and 19 year olds drinking in our bars, clubs and taverns."

Canterbury District Health Board wrote: "We doubt that *unilaterally* raising the Minimum Legal Purchase Age from 18 to 20 years will, in the short term, significantly reduce alcohol related harm in New Zealand in our present situation." [Italics in the original] They argued that:

"Alcohol related harm is impacted by more powerful determinants than legal purchase age alone. The wider context of drinking attitudes and behaviour must be considered.

A conservative approach to the relationship between purchase age and harm may appear compelling if one accepts the popular proposition that: '*Fewer people in New Zealand will be hurt or killed by limiting direct supply of alcohol to those 20 and over, as opposed to 18 and over.*' [Italics in the original]

"The proposition can be supported by evidence and, on the surface, seems sensible. However, the integrity, or soundness of this proposition must be tested within the context of its application, that is, our present circumstances, and the implications of altering them."

Government agencies

Of three government agencies that made submissions, one—the Children's Commissioner—opposed the amendment. The Children's Commissioner is a statutory advocate, who "speaks out on behalf of all children to ensure their rights are respected and upheld."

(<http://www.occ.org.nz/> accessed 3/3/2008). In summarising her submission, the

Commissioner stated (p.2):

“International evidence suggests strongly that raising the minimum legal purchase age is likely to have a beneficial effect on underage drinking prevalence and patterns.”

but asserted that reductions in harm would not necessarily follow. The submission did not make reference to the extensive research literature on the effects of increasing the drinking/purchasing age on child injury morbidity and mortality (Shults et al., 2001; Wagenaar & Toomey, 2002). It should be noted that there is considerably more research on these effects than on the effects of law changes on drinking behaviour *per se* (Shults et al., 2001).

The submission argues for compliance by government and non-government agencies with the United Nations Convention on the Rights of the Child (UNCROC), making reference to various elements of the convention. It notes that “UNCROC does not...provide any rationale for or against raising the purchasing age for alcohol above the age of majority” (p4). Later it states that “UNCROC places particular importance on obtaining the views of children and young people...”. The submission called for a “full policy analysis to determine the appropriate age to which the purchasing age should be raised” (p.2). This recommendation appears to imply that the MPA should be raised, but potentially to an age other than 20 years.

The Alcohol Advisory Council was a statutory body whose primary function was “The promotion of moderation in the use of alcohol and the development and promotion of strategies which will reduce alcohol-related problems for the nation”(Alcohol Advisory Council, 2005). It was the lead government agency on alcohol at the time the Bill was being considered.

In its submission ALAC noted that the proposed law change concerned the purchasing of alcohol by young people and not drinking *per se*, and accordingly discounted the relevance of US evidence to the New Zealand situation (Alcohol Advisory Council, 2005). It should be noted that in some American states, drinking *per se* is not prohibited in

any age group (Fell, Fisher, Voas, Blackman, & Tippetts, 2008) such that some of the evidence pertains to changes in purchasing age. The submission cited a report (Kypri & Dean, 2002) (reference “20” in the quote below) in support of the claim that parents are the main source of alcohol for young people rather than commercial purchase:

“In a survey undertaken in 2000 as part of a community action project²⁰ 59 per cent of parents agreed to the statement ‘No one should supply alcohol to someone who is underage’ and yet over 36 per cent of the same parents reported they supplied alcohol to their underage children in the past month.”

In fact, the report shows that only 2% of parents indicated that they had supplied alcohol to their underage children in the preceding month. The study also showed that a common source of alcohol for underage youth was underage friends and that underage purchase was also common. The figure of 36% was based on adolescent reports of parental behaviour. This misreporting is noteworthy given the extensive discussion of possible reporting bias and other reasons for the discrepancy in the report that had been commissioned by ALAC, and in a subsequent paper (published before the ALAC submission) on which the Deputy Chief Executive of ALAC was a co-author (Kypri, Dean, Kirby, Harris, & Kake, 2005).

The submission placed emphasis on developmental psychopathology in the aetiology of alcohol use disorders in late adolescence and early adulthood:

“...prevention and treatment interventions may need to address these (lifestyle) clusters rather than concentrating on one behaviour (early onset drinking) only. Furthermore, the study suggests, that as these lifestyles are influenced by both family background and problem behaviours this suggests the need for some interventions long before adolescence” (p.11).

It made claims concerning the supposed acceptance of alcohol in New Zealand culture, e.g.,:

“The focus becomes sharper if we look at New Zealand’s general acceptance that alcohol has a place in our society (although there are some New Zealanders that would support far greater restrictions perhaps even prohibition) and that moderate use of alcohol is a desirable part of a healthy lifestyle (p.12)”

No reference was made to national surveys showing public opinion to favour greater restriction of availability and promotion of alcohol [e.g.,(Hoek & Gendall, 2006)]. The

submission included the following summary of the overall argument on the likely effect of the proposed law change:

“Taken in the context of ALAC’s own work on how New Zealanders are drinking (the drinking culture) and the influence culture has on the way young people drink, this suggests that it is unlikely that increasing the minimum legal purchase age to 20 will:

- prevent young people under the minimum legal purchase age from obtaining alcohol – parents are the main suppliers
- improve the likelihood of off-licence bottle store managers asking for ID before selling
- influence outcomes for those drinking at age 16 across the domains of substance dependence, mental health, education and employment
- encourage the development and delivery of prevention activity and treatment interventions
- change embedded lifestyle clusters and associated behaviours and outcomes.” (pp.12-13)

Despite these qualifications the submission concluded:

“ALAC agrees that increasing the minimum legal purchase age to 20 years will effectively reduce some of the harm that is occurring and, hopefully, indicate to those parents already supplying their underage young people that this is not acceptable practice.” (p.14)

The overall impression conveyed by the submission was of grudging support or at best ambivalence about the proposed MPA amendment.

Only two of New Zealand’s 73 local authorities made submissions and only one of those declared a position on the MPA. Since the 1989 changes to liquor laws, much of the regulation of alcohol (e.g., licensing, locations of outlets, trading hours) has been the responsibility of local government. While the MPA is not under local government control, a change in the MPA would have profound effects on communities, so their silence on the matter raises several questions. Do local authorities treat government Bills as a *fait accompli*? Do they take the view that it is not the role of local government to advocate for what they consider to be in their best interests? Alternatively, does the lack of comment reflect competing views within local authorities on the proposed changes? Analysis of local authority submissions on other central government Bills might provide answers to the first two questions. Research concerning the formation of local alcohol policy in New Zealand suggests that some councillors have potential conflicts of interest due to their involvement in

the alcohol industry while others place a high value on encouraging and maintaining a night-time economy in their communities (MacLennan, Kypri, Room, & Langley, 2013). In addition, there is evidence that New Zealand communities are not meaningfully engaged in decision-making about the operation of the liquor market (Kypri & MacLennan, 2014).

Non-government organisations

Given the role played by similar bodies in other countries in relation to drinking age legislation (American Public Health Association, 2008), there was surprising opposition to increasing the MPA from some quarters, e.g., the Public Health Association of New Zealand.

The PHA describes its goal as follows:

“...to improve the health of all New Zealanders by progressively strengthening the organised efforts of society by being an informed collaborative and strong advocate for public health”
(<http://www.pha.org.nz/>, accessed 28/2/2008)

In its submission the PHA wrote:

“the changes that have followed the law changes in 1999 have resulted in worse health for young people. We do not have a fixed view on what the minimum purchase age should be. We do, however, have a [sic] several strong views on minimum purchase age” (p.3).

The last of five views described was that “the age chosen should have a consistency with other age limits for responsible decisions or dangerous activities”. It cites voting, marrying, driving a car, going to war, and having an abortion as examples. It goes on to admit that

“...it may be that the age for consumption and purchase of alcohol should be staggered, similar to marriage or driving a car. For example, there are particular restrictions on young people obtaining a full driving license up until age 25. It may be that a similar gradation for people up to age 25 should be applied for alcohol purchase.”

This argument is difficult to follow. It starts with a call for consistency but ends with the recognition that inconsistency might be appropriate. In addition, the basis for consistency is not as strong as the submission implies, e.g., at the time of the submission, the age for

obtaining a learner driver license in New Zealand was 15 years, a person could marry from age 16, could be convicted of certain criminal offences from age 10, and the school leaving age was 17.

In addition, it is noteworthy that these NGO submissions are selective in their citations of research evidence. The submission includes reference to 15 scientific articles and reports yet makes no reference to the large and accessible literature concerning the effects of changes in the drinking/purchasing age. For an organisation that frequently urges government to adopt evidence-based policy, the poor coverage of the evidence and ambivalent position expressed is remarkable.

More remarkable still was the opposition to increasing the MPA from the New Zealand Medical Association (NZMA), which describes itself as “the country's foremost pan-professional medical organisation” (<http://www.nzma.org.nz/about/> accessed 28/02/2008):

“Although the NZMA opposed the original decision to lower the purchase age, we are not convinced that the problems associated with excessive alcohol use by young people can be curbed simply by re-raising the age to 20 years. Therefore, we do not support that proposal within the Bill.”

In his oral submission to the select committee, the NZMA chairman claimed that “There is no clinical evidence to suggest alcohol was more harmful to an 18-year-old than a 20-year-old.”

When asked to explain the statement, he responded evasively:

“We can find no clinical evidence (I expect readers will understand this term) that alcohol does harm to an 18-year-old that it does not do to a 20-year-old.” (J. Langley & K. Kypri, 2006)

The lack of support from the medical establishment may have weakened the resolve of MPs who were uncertain about how they would vote. It should be noted that in an age of electronic communication and a global alcohol industry, such positions have ramifications that quickly extend beyond national boundaries. The alcohol industry seized on the NZMA submission, using it to combat a proposal to increase the drinking age in the western Pacific island US

protectorate of Guam (Personal communication, Thomas Shieh, MD, Guam Memorial Hospital, 4 June 2006).

The NZMA's position stands in marked contrast to that of the American Medical Association. In its appraisal of the research evidence, which references reviews published in scientific journals the AMA says:

"A higher minimum legal drinking age is effective in preventing alcohol-related deaths and injuries among youth. When the MLDA has been lowered, injury and death rates increase, and when the MLDA is increased, death and injury rates decline (Wagenaar, 1993)...

A common argument among opponents of a higher MLDA is that because many minors still drink and purchasing alcohol, the policy doesn't work. The evidence shows, however, that although many youth still consume alcohol, they drink less and experience fewer alcohol-related injuries and deaths (Wagenaar, 1993).

Research shows that when the MLDA is 21, people under age 21 drink less overall and continue to do so through their early twenties (O'Malley & Wagenaar, 1991)." (<http://www.ama-assn.org/ama/pub/category/13246.html> - accessed 3/3/2008)

It also contrasts with more recent positions of the NZMA which has participated in a sustained campaign for liquor law reform (Kypri, Connor, Maclellan, & Sellman, 2013).

Alcohol industry

There were 12 similar submissions from the Hospitality Association of New Zealand (HANZ), including one from head office and 11 from its 21 local branches. This approach appears to reflect a strategy of maximising the number of submissions representing the interest group with probably the most to lose if the MPA were increased. All of the submissions expressed opposition to increasing the MPA.

Lion Nathan, a large multinational company primarily involved in beer production, importation, and marketing, describes its mission as "to make the world a more sociable place" (p.2 of its submission). It appraised the research evidence as follows: "There is no research which has yet established a link between a binge drinking culture and any legislated minimum age of purchase" (p.6), and cited an Alcohol Advisory Council document in

support of this claim. In light of the large body of evidence concerning the effects of changes in the drinking/purchasing age, the content and phrasing of this claim is reminiscent of the tobacco industry's persistent denial, until relatively recently, that smoking causes lung cancer (Carter & Chapman, 2003). It also reveals how a government agency's ambivalence about the MPA was used to promote vested interests.

Dominion Breweries, the other major brewer in New Zealand, made a one-page submission, referring the committee to the submission of the Beer Wine and Spirits Council, a (now defunct) public relations body it funded in partnership with Lion Nathan. The Beer Wine and Spirits Council wrote that it "holds no position on whether or not the legal purchasing age should be raised" (p.12), but nonetheless concluded that "The [BWSC] does not believe the...Bill is necessary or warranted, and recommends the status quo remain."

Diageo, one of the largest alcohol companies in the world, primarily involved in the production, importation and marketing of spirits and spirit-based mixed drinks, wrote that "the harm from alcohol arises from the persons who abuse it and not from the product itself". This was a common refrain in submissions from the alcohol industry.

Conclusion

In summary, there were 14 types of argument used to argue against the proposed increase in the MPA, several of which were empirical claims (e.g., it would not reduce drinking among young people) while others were normative claims (e.g., it is up to individuals to control their drinking). In contrast, there were only four types of argument used in favour of increasing the MPA, namely on public health grounds, to reduce public disorder, to reduce the economic burden, and that increasing the MPA would be wise but other strategies should also be used.

Several government public health organisations, including the lead agency on alcohol, failed to make reference to large bodies of relevant research evidence (e.g., systematic

reviews on the effects of similar law changes published in high impact scientific journals) and expressed either opposition to or ambivalence about the proposed law change. Some high profile NGO submissions appeared to reflect confused thinking about the issue and/or selective use of research evidence. The positions taken by the Public Health Association and New Zealand Medical Association stand in marked contrast to those adopted by their counterparts in the USA which were proponents of increasing the drinking age and which remain committed to retaining it at 21 years. Local government, an important stakeholder in the context of a country without state or provincial jurisdictions, was practically silent on the issue. In contrast to the fragmented and inconsistent response from government and NGOs, the alcohol industry was organised and united, with multiple submissions from the sector with most at stake, namely the hospitality industry, and supporting submissions from the manufacturing, import, and wholesale sectors.

Given the burden of alcohol on the community, parliamentary consideration of legislation aimed at mitigating alcohol-related harm is critical. Indeed, in the years that followed the SLAB debate in parliament, a ‘Root and Branch’ review of alcohol policy was undertaken resulting in a substantial issues paper (Kypri, Langley, & Connor, 2010; Law Commission, 2009) and a detailed case with 153 recommendations for legislative reform (Kypri, Maclellan, Langley, & Connor, 2011; Law Commission, 2010). Good governance requires parliamentarians to have a sound understanding of the likely impact of the legislation on the health of the population. If one excludes the alcohol industry, which had obvious pecuniary interests in the outcome of the MPA debate, the majority of submissions made by the public and other organisations supported an increase in the MPA to 20 years. The alcohol industry alone produced over 40% of all submissions opposing the Bill. Many of those were from regional offices of the same bodies, and none gave a balanced account of the research evidence. Legislators must ensure they are not fooled by such ploys.

The use of empirical evidence regarding the impacts of policy interventions should be formally incorporated into the process used to inform legislators. In the present case, expert reviews by bodies such as the WHO (Babor, 2003) could have been used to help critique the submissions. Systematic reviews were cited in some submissions but such methods are not routinely applied by advisors of the legislature. Systematic reviews, as recommended by the Cochrane (www.thecochranelibrary.com) and Campbell (www.campbellcollaboration.org/) collaborations of relevant evidence should be routinely used to guide legislatures along with a formal analysis of the vested interests of submitters in any Select Committee process. The approach could encompass oral submissions by permitting expert cross-examination of presenters.

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Table 1. Types of argument made for and against the proposed MPA amendment

For	<ol style="list-style-type: none"> 1. <i>Public health and safety.</i> Increasing the MPA would reduce the risk of chronic health problems (e.g., alcohol use disorders) and/or acute health effects (e.g., injury). 2. <i>Public disorder and property damage.</i> The amendment would reduce public disorder or property damage in the community. 3. <i>Use other strategies as well.</i> Increasing the MPA is wise but it should be accompanied by other evidence-based measures, e.g., better regulation of alcohol advertising and promotion. 4. <i>Economy.</i> Increasing the MPA will reduce the economic burden of alcohol on the community.
Against	<ol style="list-style-type: none"> 1. <i>The proposed law change will not reduce underage drinking.</i> Increasing the MPA will not change the behaviour of youth who misuse alcohol. 2. <i>Use other strategies instead.</i> The amendment should be replaced with other strategies to reduce the burden of alcohol on the community (e.g., education). 3. <i>Age of majority / adult rights.</i> It is not fair to increase the MPA to 20 when other rights and responsibilities are conferred on young people at age 18. 4. <i>Licensed premises are safe environments for young people.</i> Increasing the MPA to 20 will encourage 18-19 year-olds to drink in settings that are less safe than licensed premises. 5. <i>The evidence does not indicate that intervention is required.</i> Evidence suggests that alcohol-related harm/crime has not increased since the purchasing age was reduced in 1999. 6. <i>Public health and safety.</i> Increasing the MPA would <i>increase</i> the risk of acute health effects of drinking in unsupervised settings. 7. <i>Penalising the many to protect the few.</i> Heavy drinking in late adolescence is a minority behaviour. It is not fair to penalise the majority of young people who drink responsibly by denying them the right to purchase alcohol. 8. <i>It is up to individuals to control their drinking.</i> Individuals should be held accountable for their actions. 9. <i>Existing interventions are sufficient.</i> Existing interventions undertaken by the alcohol industry, hotels, clubs or the government are sufficient. 10. <i>Split purchasing age.</i> The age 20 requirement should be applied to off-licence sales of alcohol but not on-licence sales. 11. <i>Economy and employment.</i> Alcohol industry tax revenue and employment of 18-19 year-olds are being put at risk by the proposed law change. 12. <i>Public disorder / property damage.</i> The amendment will increase public disorder and property damage in the community. 13. <i>Penalising 18-19 year-olds for the binge drinking of 13-17 year-olds.</i> The amendment affects 18 and 19 years olds but not younger teenagers who cause most of the alcohol-related problems in the community. 14. <i>Without enforcement the law will be ineffective.</i> The amendment will be ineffective without enforcement.

Table 2. Summary of submissions on increasing the purchasing age by type of submitter

Type of submitter	% Against	% In favour	Number of submissions
<i>Public</i>	38	62	47
<i>Non-government organisation/community group</i>	21	79	28
<i>Youth organisations</i>	78	22	9
<i>District health boards</i>	38	63	8
<i>Government organisation</i>	33	67	3
<i>Universities</i>	17	83	6
<i>“Youth Access to Alcohol” groups</i>	33	67	3
<i>Local Authorities (Councils)</i>	0	100	1
<i>Alcohol industry – hospitality</i>	100	0	27
<i>Alcohol industry – producers/importers/wholesalers</i>	100	0	5
<i>Advertising industry and affiliates</i>	100	0	1
<i>Other commercial entities</i>	50	50	2
<i>Other</i>	50	50	6
Overall (n=146)*	51	49	146

*A further 32 submissions either favoured a split age or did not declare a position on the purchasing age

Table 3. Themes of submissions *in favour* of increasing the purchasing age by type of submitter

	<i>Type of submitter</i>		
	<i>% of themes</i>		
Theme (number of submissions including theme)	Public	NGO / community group	All other types of submitter*
<i>Public health and safety</i> (n=48)	33	35	31
<i>Use other strategies as well</i> (n=32)	22	34	44
<i>Public disorder / property damage</i> (n=21)	29	38	33
<i>Economy</i> (n=7)	29	57	14
<i>Other</i> (n=25)	36	32	32
TOTAL (N=133)	30	36	34

Note: the summary is of 133 arguments found in 57 of the 72 submissions favouring the increase in purchasing age

*Includes: local authorities, district health boards, universities, youth groups, *Youth Access to Alcohol* groups, non-alcohol commercial bodies.

Table 4. Themes of submissions *against* increasing the purchasing age by type of submitter

Theme (number of submissions including theme)	Type of submitter % of themes			
	Alcohol industry	Public	NGO / community group	All other types of submitter*
<i>The proposed law change won't reduce underage drinking</i> (n=49)	37	27	12	24
<i>Use other strategies instead</i> (n=37)	38	27	11	24
<i>Age of majority / adult rights</i> (n=33)	48	24	12	15
<i>Licensed premises are safe environments for young people</i> (n=32)	56	25	0	19
<i>The evidence does not indicate that intervention is required</i> (n=26)	69	0	8	23
<i>Public health and safety</i> (n=17)	76	0	12	12
<i>Penalising the many to protect the few</i> (n=17)	29	47	24	0
<i>It is up to individuals to control their drinking</i> (n=14)	79	0	14	7
<i>Existing interventions are sufficient</i> (n=12)	92	0	0	8
<i>Split purchasing age</i> (n=11)	27	27	0	45
<i>Economy</i> (n=10)	100	0	0	0
<i>Public disorder / property damage</i> (n=6)	50	33	0	17
<i>Penalising 18-19 year-olds for the binge drinking of 13-17 year-olds</i> (n=3)	0	66	33	0
<i>Without enforcement the law will be ineffective</i> (n=3)	67	0	0	33
<i>Other arguments</i> (n=39)	44	26	5	26
TOTAL (N=226)	50	20	8	23

Note: the summary is of 226 arguments found in the 74 submissions against increasing the purchasing age

*Includes: local governments, district health boards, universities, youth groups, *Youth Access to Alcohol* groups, non-alcohol commercial bodies.