



European Monitoring Centre
for Drugs and Drug Addiction

EMCDDA Scientific report

Public spending on drugs in the European Union during the 1990s

Retrospective research

EMCDDA 2003

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Acknowledgements

The EMCDDA is grateful to Professor Pierre Kopp (University Panthéon-Sorbonne) and to Professor Philippe Fenoglio (University of Nancy) for their commitment, understanding and professionalism in the realisation of this study. They have worked on this research far beyond the limited contractual conditions.

In a field where the collection of data often relies on a very personal knowledge of the local situation, finding the right person in the right place was absolutely indispensable to complete our work. The fact that the study required estimates of expenditure, and in some countries this information either concerns only selected domains or is not available at all, explains how grateful the authors are to all their correspondents.

We are indebted to all public servants or academic researchers in Member States we have contacted, each of whom made themselves available to answer our questions and who contributed to the information required for the study. However, it is impossible to list all those who answered our mail and phone calls. Most of them work in the institutions composing the network of Reitox focal points and have been crucial during the data-collection process, others work in public administrations or universities.

Introduction

Each Member State devotes a fraction of its budget to face the negative consequences of drug consumption and to combat trafficking and related crimes. The total amount of public expenditure in the area of drugs, which we generally call 'drugs budget', permits the financing of State action in prevention, health care and law enforcement.

Unfortunately, EU Member States do not generally calculate 'drugs budgets' as such, and what is more, the figures permitting this calculation are sometimes non-existent and often incomplete. In some countries existing figures relate just to treatment costs, in others just to law enforcement or to part of it. Yet the 'drugs budget' constitutes a valuable indicator of a country's effort in overall drug policy, not only in terms of resources but also in terms of setting priorities which translates itself in the balance between expenditure on law enforcement and on health care.

Nevertheless, in our effort to provide the best possible result, at least four constraints must be highlighted:

- **Data missing.** There are gaps in the statistics and consequently the results are sometimes incomplete and imprecise. In this sense, the present work is more of an exploratory study which should encourage the development of an *ad hoc* system for collecting data than the result one might expect from a study where sources were complete. It is therefore as much a question of increasing reader awareness of the value of this type of study as furnishing the first elements for analysis of public policies.
- **Data incomplete.** The study was conducted in a retrospective way, as the setting is the period spanning 1990 to 2000. This is because figures, when available in the countries, do not necessarily correspond to the same year. However, we feel that it is probable that the data has changed little since – our findings therefore illustrate the nature of past public policies rather than present choices.
- **Statistical caution.** In reading the study we must never over interpret the results. A comparison between two countries has sense only when all statistical precautions have been taken. It is necessary to avoid hasty conclusions and to take into account that two countries are neither of the same size nor do they possess the same wealth. Therefore we systematically carry out such corrections in order to arrive at conclusions which are as close to reality as possible. Nevertheless, despite these precautions, interpretation of the results often remains very difficult. For example, does the fact that a country has more people infected with HIV reveal an inadequate prevention policy or an injection tradition which is well-anchored in the user community or the inferior quality of the heroin which renders its consumption by smoking or inhaling more difficult? We therefore insist on indicating around each result all possible interpretations and underline the danger of formulating too hasty conclusions.
- **Balanced expenditure.** We insist that it is not because a country spends a great deal on law enforcement and very little on health care (or the opposite) that it is

possible to re-balance the budget by taking from one side to compensate the other. The rigidity of an administration's budget and the impossibility of reconverting specialised personnel from one area to the other explain this difficulty. The policy maker must therefore be aware that restoring the balance most often means an increase in the total drug budget, which is not necessarily easy due to the budgetary constraints of the Member States.

Despite the limitations mentioned above, the reader will discover much original information in this report. Over and above new statistics, this report offers new pathways of thinking. Current opinion considers some Member States as applying a more repressive policy and others as having a more tolerant approach to drug problems. We observe that the differences between countries, when looked at through the prism of public spending, are not necessarily those that we might think.

Finally, we must remind the reader, that the analysis of a country's public drug policy, through the prism of its public spending, only constitutes one angle of analysis among others. This must obviously be cross-checked with other studies; in this way it contributes to enlightening public policies and avoids pronouncing a definite orientation.

Executive summary

The national decision maker is preoccupied with the appropriate allocation of the precious resources at his disposal. Therefore he is entitled to demand from national and European public agencies information of high analytical quality on the actions undertaken in the field of drugs. Measuring public expenditure for these actions is an important indicator for assessing the commitment and efforts of any government in dealing with the drug problem.

This retrospective study goes in this direction offering a first overview of drug-related public expenditure engaged by the countries of the European Union during the last decade (1990–2000). Our results, although interesting, must be read in the light of the methodological constraints and the limits posed by the lack of comprehensive information throughout Europe.

In this research we aimed to collect at EU level existing figures on public expenditure in the field of drugs, what is usually called ‘the drugs budget’.

This is composed of two types of expenditure: public expenditure directly labelled as drug-related – ‘direct expenditure’ – and the resources spent by public authorities and generic services (police, customs, public health institutions etc.) to deal with questions arising from drugs – ‘indirect expenditure’. While the figures relating to ‘direct expenditure’ (such as a drug unit or a drug squad) are easy to retrieve, calculating the level of ‘indirect expenditure’ is based on a complex estimate of the proportion of activity each public authority carries out in the field of drugs. Moreover, public expenditure also includes expenditure at central, regional and local level.

In this study our calculations have been based on these two types of figures relying only on the data available. Unfortunately, not all EU countries have carried out expenditure surveys particularly as regards ‘indirect expenditure’ and this has partially affected the results of the study. In any case, the heterogeneity of data is frequent in the area of drug studies and the sizing up of the obstacles encountered will constitute a strong motive to homogenise the methods of compiling relevant data. The present study therefore represents a starting point opening the way for other work devoted to assessing public drug policy in the EU. Data collected come from different contacts in each Member State of the European Union ⁽¹⁾.

Although the reference period for this research is the decade 1990–2000, it contributes to enlightening current decisions in the field of drugs. Effectively, public spending is a macro-economic aggregate that evolves little, particularly in those countries belonging to the European Union. The largest portion of the ‘drugs budget’ covers the operating costs of the public administrations where public servants deal with the consequences of drug use. It is probable that the cost represented by the prison system (or health-care system) for drug addiction varies little from year to year. Certainly, when a change occurs, for example a new system of substitution treatment or the number of people infected with HIV, this will create consequences in matters of public spending. In any case, the extent

⁽¹⁾ Data used in this study are given in Annex 1. Table D in Annex 1 corresponds to the common table sent to and used by all our European contacts to collect data used in this study. Table A and C in Annex 1 summarise table D.

of these changes is so small in the total public cost for drugs, that even when these vary greatly it has little effect on total spending ⁽²⁾.

The study concentrated on data from EU countries although it contains, for the purpose of comparison, data concerning the United States of America and the Helvetian Confederation. The comparison with the United States is directed at better understanding the particular characteristics and originality of the public policy introduced by the European Union. The presence of the Helvetian Confederation is justified by the influence of debates in the area of health policy of this country on the other countries of the Union.

Having defined the 'drug budgets' and highlighted the constraints, we can now proceed to the presentation of the main results that are divided between two main facets of drug-related expenditure: health care and law enforcement.

Health care

Public spending in matters of health care includes all public spending devoted to the care of the consequences of drug consumption and related diseases, this being the cost of free care in specialised centres operated by the State and the amount of reimbursed health care. This also included the cost of treatment of HIV patients and those who contract hepatitis while using drugs as well as the cost for the administration of substitution treatment.

In a rational world, it is clear that health supply must be in proportion to demand. That is why we have chosen to compare it to its target population: *the number of problem drug users*, who are the main clients of drug-related health care.

According to the EMCDDA (1999), the number of problem drug users is calculated from figures furnished by the Member States all of whom use the same definition of problem drug consumption: '*addiction by injection or regular long term use of opiates, cocaine and/or amphetamines*'. This definition excludes consumption of 'ecstasy' and cannabis as well as occasional consumers of opiates, cocaine or amphetamines.

If we divide the public drug-related health expenditure by the number of problem drug users, we should obtain the drug-related health expenditure per capita and this should enable us to see how much a country spends on health services for each drug addict.

When drug-related health expenditure is calculated per problem drug user, the following decreasing ranking emerges in the Member States: Sweden, Belgium, Netherlands, Germany, Italy, Switzerland, Finland, France, the UK, Ireland, Luxembourg, Spain and Portugal. This ranking might be explained by several factors. Sweden, as we will see later in the study, dedicates a very large part of its drug budget to the health-care system. The group composed of Belgium, the Netherlands, Germany, Italy and Finland has, for a long time, introduced treatment for drug addicts (among others, methadone). The public cost of these treatments can undoubtedly explain this result. It is also logical that the low cost of buprenorphine treatment may possibly have an effect on the final figure involved in drug-related health-care expenditure in France. The UK, Ireland, Luxembourg, Spain and Portugal follow, although it is not possible to know whether their

² In France, public spending for drug-related matters was in 1995, 676 millions € (4435 million francs) while the expenditure for treatment of AIDS was only 149 millions € (983 million francs). When the expenditure for AIDS increased of 25%, this only represented a 5% increase of the total drugs expenditure.

figures can be explained as a lack of means dedicated to health care or whether, on the contrary, it is through large-scale savings.

Drug-related health expenditure per problem drug user

Country	Public health expenditure related to drugs (€ millions)	Number of problem drug users (high and low hypotheses)	Public drug-related health expenditure per problem drug user (mean hypothesis)
Sweden	103.0	14,000 – 20,000	6,058.8
Belgium	70.1	20,200	3,470.3
Netherlands	80.9	25,000 – 29,000	2,996.3
Germany	308.0	80,000 – 165,424	2,509.9
Italy	516.5	172,000 – 326,000	2,074.3
Finland	12.6	1,600 – 14,500	1,565.2
France	213.2	124,000 – 176,000	1,421.3
UK	268.2	88,000 – 341,423	1,246.5
Ireland	9.9	4,600 – 13,735	1,079.9
Luxembourg	1.9	1,900 – 2,200	926.8
Spain	95.3	83,972 – 177,756	728.2
Portugal	3.8	70,000	54.3
Average E.U	1697.8	(1)	2,011.0
USA	3,777.9	3,750,266	1,007.4
Switzerland	47.4	30,000	1,580.0

Source: Data on number of problem drug users: EMCDDA 1999 and UNDCP 1999. Estimate of data on drug-related health expenditure produced by this research and by ONDCP 1995. Data is missing for Greece, Denmark and Austria. (1): see Table 19.

Country's contribution to drugs expenditure in health care

One way to interpret drug-related health expenditure in the EU is to add the share of each country's expenditure in a theoretical 'European drugs budget' and then compare each share with a hypothetical 'European Union Average'.

The 'European Union Average' can be calculated by dividing the theoretical 'European drugs budget' by the number of countries. The purpose is to know whether, independently of the extent of the problem, EU countries dedicate analogous amounts to deal with the consequences of drug problems.

By this calculation, and by applying a same weighting to each country ⁽³⁾, each of the 13 Member States studied here, would equally contribute to 7.7% of the global European State expenditure in drug-related health care in the mid-1990s. However, the first element that comes across, not surprisingly, is the difference between the countries of the European Union. Italy, for instance, was still far above the 7.7% average with 18.32% of the total European health-care expenditure related to drugs with Sweden, at 16% of the total. Belgium at 10.9% and the Netherlands at 8% were also above the average. The different levels of expenditure among the countries may be due to a variety of factors such as different levels of prevalence, a particular emphasis in tackling the problem or different cost structures.

The 'largest' countries of the EU, for example Germany (5.6%) and France (5.7%) are well below the theoretical average contribution of 7.7%. The United Kingdom (7.2%) is far closer to this average contribution, while Portugal 1.5% and Finland 3.8% are quite

⁽³⁾ i.e. hypothesis that each EU Member State would have the same GDP, to compare financial efforts regardless of size and wealth.

far away from the European standards. It is also to be noted that Spain with 6.5% and Luxembourg with 6% contributed to a larger extent in European health expenditure than Germany and France. Finally, it is interesting to observe that the drug-related health-care expenditure of the first three countries – Italy, Sweden and Belgium – represents almost half of the total of the States' health expenditure related to drugs (45.3%). This could be the result of special attention paid by these countries to drug-related health problems during those years or just to lack of good data for the other countries. As said, we cannot provide exact interpretations being conscious of the rather large lack of data availability.

Law enforcement

Law enforcement includes expenditure by public administrations such as home affairs, justice, finance, customs. This constitutes another large facet of public action. Within it we find operating costs of the judicial system (police and justice), costs of the imprisonment of individuals convicted for drug-law offences and the costs of customs and other law-enforcement organisations involved in controlling the drugs problem. The methodology used here is the same as that used for calculating drug-related health-care expenditure. First, these expenditure are expressed in comparison with the number of problem drug users. Secondly, applying an equal economic weight, we can look at the individual contributions at European level.

When the public law-enforcement expenditure related to drugs per problem user is calculated, it appears that Germany, Belgium and the Netherlands were devoting larger sums than the European average to drug-related law-enforcement expenditure. Finland, France, Sweden, Ireland, Luxembourg, the United Kingdom, Spain and Portugal allocated fewer resources than the average.

Law-enforcement expenditure related to drugs per problem user

Country	Public law-enforcement expenditure related to drugs (€ millions)	Number of problem drug users (high and low hypotheses)	Public law-enforcement expenditure related to drugs per problem user (average hypothesis)
Germany	1590.9	80,000 – 165,424	12,964.5
Belgium	216.1	20,200	10,698.0
Netherlands	182.0	25,000 – 29,000	6,740.7
Finland	32.9	1,600 – 14,500	4,087.0
France	585.5	124,000 – 176,000	3,903.3
Sweden	61.2	14,000 – 20,000	3,600.0
Ireland	30.5	4,600 – 13,735	3,327.0
Luxembourg	5.9	1,900 – 2,200	2,878.0
UK	586.2	88,900 – 341,423	2,724.5
Spain	293.7	83,972 – 177,756	2,244.3
Portugal	11.7	70,000	167.1
Greece	44.7	n.a.	n.a.
Italy	n.a.	172,000 – 326,000	n.a.
Denmark	n.a.	10,200 – 14,000	n.a.
Austria	n.a.	15,984 – 18,731	n.a.
Switzerland	155.0	30,000	5,166.7
Average E.U	3,641.3	(1)	4,848.6
USA	11,869.5	3,750,266	3,165.0

Source: Data on number of problem drug users: EMCDDA 1999 and UNDCP, 1999. Estimate of data on law-enforcement expenditure related to drugs produced by this research and by ONDCP 1995. (1): see Table 19.

Country's contribution to drug expenditure on law enforcement

Again, as for health drug-related expenditure, when applying an equal economic weight to each of the 12 Member States (for which data on law enforcement are available ⁽⁴⁾), each of them would equally contribute 8.33% to the entire European State expenditure related to drugs for law enforcement in the mid-1990s.

However, Belgium spent twice as much as this average European contribution with 16.3%. Germany had a rate of 14%, above the European average, together with Spain 9.8%, Luxembourg 9%, the Netherlands 8.8%, while Greece with 8.1% was very close. We also note that two large countries of the EU, the United Kingdom and France spent slightly below the European average, both 7.6%. The last group of countries was significantly lower than this European average: Ireland at 6.8%, Finland 4.8%, Sweden 4.6% and Portugal 2.2%.

Other law-enforcement figures

We also considered activities undertaken by law-enforcement authorities dealing with drug crime. In other words, police, customs, and judicial interventions were analysed. It is therefore interesting to exploit this information in a comparative perspective to examine how not only the amount of the budgets devoted to law enforcement may vary from one country to another, but also how the allocation of these amounts may differ. Some of these differences are institutional choices. Thus, a country may decide to create a special police force to fight against drug trafficking. On the other hand, the number of observed customs violations in a country depends, of course, upon customs activity but also upon the country's geography. It is the same thing for the number of prosecutions or persons imprisoned.

- **Police forces.** Several countries have chosen to set up specialised police units to tackle drugs and related crimes. For the purposes of this research, we have calculated (for each of the 7 countries where data on police drug units were available) the ratio between the number of police officers specialised in drugs and the total number of police officers. Another way to evaluate the number of police drug units in each country is to calculate the portion of specialised police officers in the European total (demographical bias corrected). On this basis, we notice that the EU average ratio was 14.2%. Greece with 42.3% was far above the average, while Luxembourg reached 20.2%. Sweden was close to the EU average with 13.3% as well as Ireland, to a lesser degree, at 10.4%. Countries such as Spain with 5.4%, France 4.8% and Portugal 3.1% were far below this average contribution.

- **Customs drug-related offences.** Examining drug-related customs offences in each Member State and adding them to constitute a European average (only 8 countries analysed here disposed of relevant data), it appears that Luxembourg with 38.5% was the country where the drug-related customs offences were the largest in the European total, followed by France 27.8%, Sweden 19.1%, Ireland 8.5%, Denmark 2.6%, the United Kingdom 2.4%, Portugal 0.5% and Greece 0.2%. It must be noted that these figures were right under the hypothesis for which drug-related offences are corrected, for each country, by its demographic weight.

- **Prosecution of drug offences.** The average rate after demographic correction is 12.5%, which means that if all countries were of the same size, they would each record 12.5% of the total number of drug-related prosecutions in the EU. However, Luxembourg

⁽⁴⁾ No data were available for Austria, Italy and Denmark.

appeared to be the Member State with the largest proportion (at 22.1%) of prosecutions involving drugs. Out of the 8 countries where data were available, Portugal was the only country remaining in a marginal situation with a weight of 0.5%, whereas the other Member States were above this rate (Sweden 15.9%; Ireland 14.2% and Greece 13.1%) or close to this average weight (United Kingdom 11.4%; Italy 11.4% and Spain 11.1%).

▪ **Imprisonment related to drugs.** When data for each country are corrected by the demographic weight of that country, i.e. when we consider that all countries have the same population, the European average, calculated on 11 countries for which we have data at our disposal, was equal to 9.1% in the mid-1990s. We observe that Luxembourg, with a weight of 17.5%, Portugal 14.5% and Italy near to 12% were quite noticeably above this European average. Together they represented about 45% of the total number of persons in prison for drug offences. Spain was also above the average with 10% as well as Denmark with 9.6%. The other Member States situated below this average share were the Netherlands with 8.2%, France 7.9%, Greece 7.8%, Sweden 5.4%, the United Kingdom 4.3% and Ireland 2.4%.

Comparison of public drug expenditure in the EU

Following our calculations and examination of the total amount of public expenditure related to drugs in the 15 countries a strong convergence emerges at the level of state commitment in drug-related expenditure. Expressed in percentages of GDP, public expenditure related to drugs generally represented about 0.05%. There is no aberrant figure, despite the constant high degree of uncertainty regarding the area of illegal drugs, and the relative lack of figures for the countries considered.

**Public drug expenditure in the European Union countries,
in the Helvetian Confederation and in the United States**

Country	GDP	Drug-related Expenditure	As % of GDP
Belgium	221,860.0	286.2	0.13%
Germany	1,903,410.0	1,898.9	0.10%
Netherlands	347,033.0	262.9	0.08%
Spain	501,750.0	389.0	0.08%
Luxembourg	10,930.0	7.8	0.07%
Sweden	222,801.2	164.2	0.07%
UK	1,289,974.0	854.4	0.07%
France	1,293,853.0	798.7	0.06%
Greece	91,579.4	59.2	0.06%
Ireland	74,757.1	40.4	0.05%
Italy	978,400.0	516.5	0.05%
Finland	115,168.5	45.5	0.04%
Portugal	87,090.0	15.5	0.02%
USA	7,053,373.3	15,647.4	0.22%
Switzerland	234,998.2	202.4	0.09%

All figures are in € millions ⁽⁵⁾.
Figures for Austria and Denmark are missing.

It would seem quite logical that public expenditure on drugs would be greater when the country in question has a large drug-consumption problem. However, it seems that the amount of public drug expenditure for a given country does not rely on the prevalence

⁽⁵⁾ Euro conversion based on 07/31/2000 exchange rate for each national currency not in the euro zone (except for Luxembourg in ECU 1997) for GDP and state expenditure. All GDP are for 1999 (except Portugal 1998).

rate, or on the country's wealth, but depends on its population and on the size of the State's budget.

Law enforcement versus health care

The budget devoted to dealing with the drug phenomenon by the EU countries is divided between two main facets – law enforcement and health care. Despite a certain number of differences, during the 1990s, the countries of the Union displayed a rather similar policy for the allocation of resources in the field of drugs. However and again, our results may be affected not only by the lack of data but also by the fact that law-enforcement expenditure is more easily retrievable than that for drug-related health care which is more spread into decentralised budgets and therefore more difficult to find etc.

Globally between 70% and 75% of the drugs budget goes for law enforcement and the rest for health care. Germany stands alone in devoting a larger part of its drugs budget to law enforcement than the Union average. Sweden distinguishes itself by attaching a more marked priority to health care. On the contrary, France and the Netherlands, cases where their different choices in the field of drug-law enforcement have been largely commented upon, allocated their public expenditure related to drugs in a similar way among the two principal domains of law enforcement and health care. Nor did a country's wealth seem to influence the distribution of its efforts between law enforcement and health care. Greece and Finland were characterised by analogous percentages.

Government expenditure has to be compared to the target population, in this case the number of problem drug users. The only prevalence indicator available for Europe, and despite its imperfections, is the number of problem drug users.

The following table examines the distribution of resources between law enforcement and health care, per capita of problem drug users.

Functional distribution of public expenditure in the field of drugs per problem user (in euro)

Country	Number of problem users (average hypothesis)	Public expenditure for law enforcement per problem user (average hypothesis)	Public expenditure for health care per problem user (average hypothesis)	Total
Germany	122,712	12,964.5	2,509.9	15,474.4
Belgium	20,200	10,698.0	3,470.3	14,168.3
Netherlands	27,000	6,740.7	2,996.3	9,737.0
Sweden	17,000	3,600.0	6,058.8	9,658.8
Finland	8,050	4,087.0	1,565.2	5,652.2
France	150,000	3,903.3	1,421.3	5,324.6
Ireland	9,168	3,327.0	1,079.9	4,406.9
UK	215,162	2,724.5	1,246.5	3,971.0
Luxembourg	2,050	2,878.0	926.8	3,804.8
Spain	130,864	2,244.3	728.2	2,972.6
Portugal	70,000	167.1	54.3	221.3
Italy	249,000	n.a.	2,074.3	n.a.
Greece	n.a.	n.a.	n.a.	n.a.
Austria	17,358	n.a.	n.a.	n.a.
Denmark	12,100	n.a.	n.a.	n.a.
USA	3,750,266	3,165.0	1,007.4	4,172.4
Average EU	1,122,664	(1) 4,848.6	(2) 2,011.0	(1) 6,853.8
Switzerland	30,000	5,166.7	1,580.0	6,746.7

Sources: The public drugs expenditure comes from our study and the prevalence data from the 1999 report of the EMCDDA. The Portuguese and the American data come from the UNDCP. (1) = (total / 11); (2) = (total / 12).

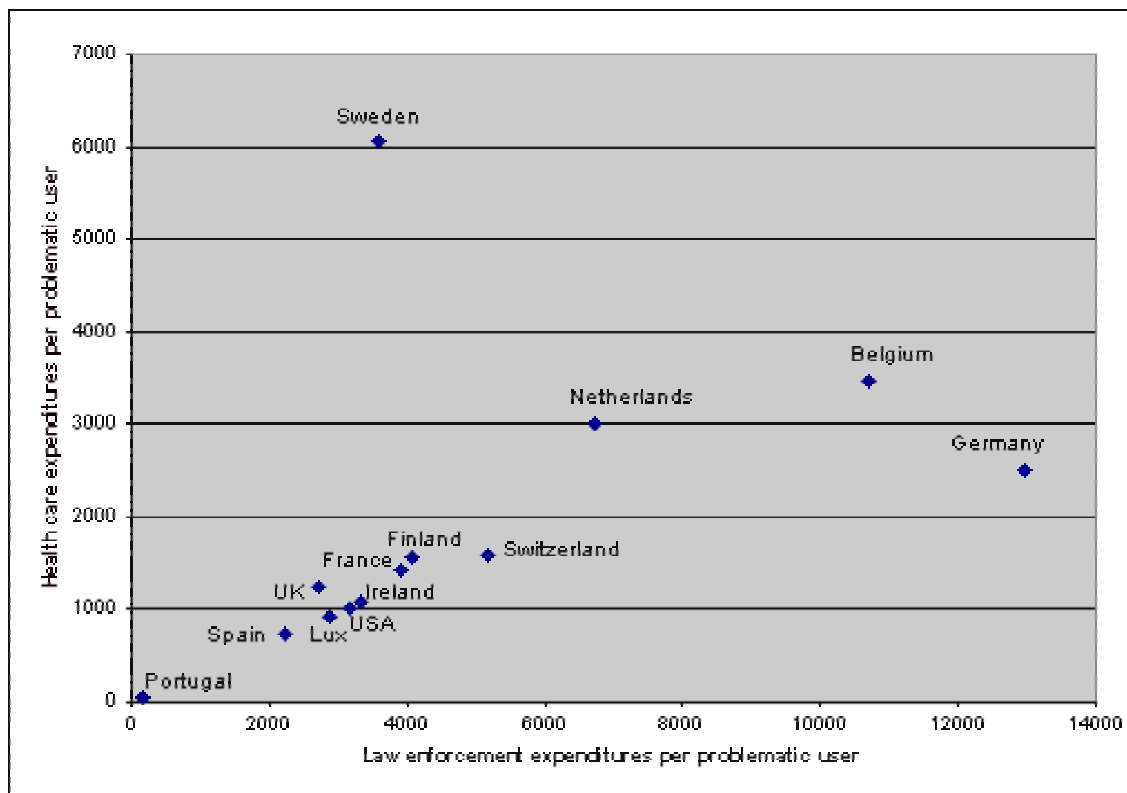
A more visual approach to the situation is provided in a presentation with a cloud of points (see figure below). We see that six countries of the Union had a similar drug expenditure profile in the mid-1990s (France, UK, Spain, Ireland, Finland and Luxembourg). Not only did the percentage distribution of drug expense between law enforcement and health care keep within the norms (70% to 30%), but also the drug expenditure per capita was very close.

Five countries deviate from the norm (70% to 30%). Belgium divided its drug resources between law enforcement and health care in a classical manner (75% to 25%), but spent more per capita than the standard for law enforcement (2.2 times more) and for health care (+72.57%). As for Portugal, although the resources divided between law enforcement and health care followed the European average (75.5% to 24.5%), we notice a very definite weakness in the drug resources allocated per problem user, not only for law enforcement (29 times less than the European average) but also for health care (37 times less than the European average).

Two countries had a relatively similar configuration – Germany and the Netherlands. These two countries, as is the case with Belgium, stressed law enforcement. In Germany, which devoted 84% of its drug resources to law enforcement against the European average of 70%, it is clear, but less so for the Netherlands which divided its drugs budgets according to the common key of (70% to 30%). However like Belgium, Germany and the Netherlands spent more per capita than the European standard in law enforcement (2.67 times more in Germany and 1.4 times more in the Netherlands). However, this repressive effort was not made at the expense of health care, as these two countries, like Belgium, exceed the European standard.

Sweden was the last exception. This country clearly emphasised the health-care facet (62% of the drug budget against the usual 30%). The effort put on health care was exceptional, three times more than the European standard. This effort was not accompanied by an investment on the drug law enforcement side that was too weak (just 1.39 times less than the average), close to the French figure and countries such as the United States and the United Kingdom.

Functional distribution of public expenditure in the field of drugs per problem user (in euro)



Finally, as the data is available we also report on Switzerland. The Swiss configuration appeared to conform to the standard of the European Union (76.6% to 23.4%), but on the contrary, this country spent slightly more per capita than the norm in the field of law enforcement (1.1 times more) but less for health care. Switzerland was ahead of countries such as France and the United Kingdom in terms of law-enforcement and health-care expenditure dedicated to drugs.

United States and European Union – an attempt at comparison

The main surprise of the analysis lies in the comparison between the United States and the countries of the European Union. In the end, in the mid-1990s, the United States turns out to spend less per problem user (4,172.4 euro) than the average of the countries of the European Union (6,853.8 euro). Compared with the United States, 'the average country' of the European Union spent 1.53 times more for law enforcement per problem user and twice as much for health-care costs per problem user. In total, the average EU country spent 1.64 times more per problem user than the United States.

It seems that the United States was characterised by a public drug-expenditure structure rather different from that of the European Union: 76% of the drug budget was dedicated to law enforcement and only 24% to health care, against 68 and 32% for the European Union.

After correction, to enable comparison, it can be seen that the United States spends 2.6 times more per inhabitant on the fight against drugs than the European Union ⁽⁶⁾. The law-enforcement expenditure was 2.8 times higher than that of the European Union, whereas in health care the expenditure was 2.2 times more than the EU.

To further refine the calculation, we now compare the data corrected by demographic and wealth weights (row c) with the target of the public measures – problem drug users. This last comparison (row e), undoubtedly closest to reality, indicates that the European Union's budget per problem drug user was 2.04 times higher than that of the United States.

**Comparison of anti-drug expenditure per capita
between the United States and the European Union (€ million)**

		EU (2)	USA	Ratio (USA=x E.U)
	Population	375.3	263.2	-
a. Gross figures	Overall drug budget	5 339.2	15 647.4	x 2.90
	- drug law-enforcement budget	3 641.3	11 869.5	x 3.25
	- drug health-care budget	1 697.9	3 777.9	x 2.22
b. Gross figures per capita	Drug budget per capita	16.6	59.5	x 3.60
	- drug law-enforcement budget per capita	12.0	45.1	x 3.75
	- drug health-care budget per capita	4.6	14.4	x 3.10
c. Figures corrected for differences in wealth and demography	Overall drug budget	5 339.20	14 190.02	x 2.66
	- drug law-enforcement budget	3 641.30	10 366.47	x 2.85
	- drug health-care budget	1 697.90	3 823.55	x 2.25
d. Figures corrected for differences in wealth and demography, per capita	Drug budget per capita	16.6	44.63	x 2.68
	- drug law-enforcement budget per capita	12	34.07	x 2.85
	- drug health-care budget per capita	4.69	10.57	x 2.25
e. Figures corrected for differences in wealth and demography, problem drug users	Drug budget by problem drug user	6 378.09	3 132.34	: 2.04
	- drug law-enforcement budget by problem drug user	4 715.45	2 390.85	: 1.97
	- drug health-care budget by problem drug user	1 662.64	741.48	: 2.24

The data available for the EU do not cover the same countries for health care and for law enforcement. The law-enforcement data correspond to a population of 304 million inhabitants and the health-care data to a population of 361 million.

Anti-drug expenditure = EU law-enforcement expenditure + EU health-care expenditure; law enforcement expenditure = (Swe + Bel + Ire + Spain + Port + Fra + UK + Neth + Lux + Ger + Finl + Gre) ; Health-care expenditure = (Swe + Bel + Ire + Spain + Port + Fra + UK + Neth + Ita + Lux + Ger + Finl + Gre).

Therefore, when one compares the United States and the European Union under the best possible technical conditions (bearing in mind the lack of data), it emerges clearly that the European Union spends more on law enforcement (1.9 times more) and on health care (2.2 times more) than the United States.

Weight of public expenditure on drugs

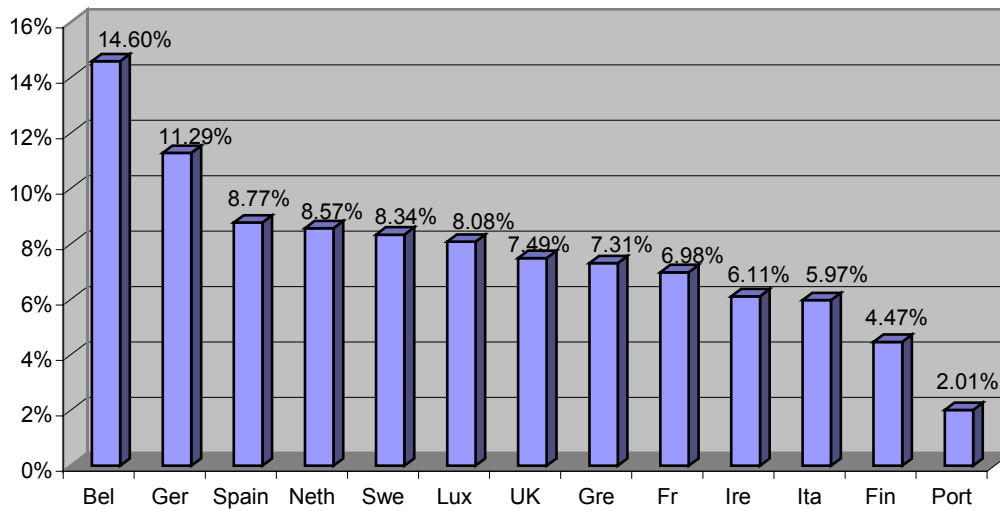
It is possible to calculate the total overall amount of drug expenditure in the countries of the European Union and by examining each country's share in this expenditure, the ratio of each Member State in the hypothesis of European drug-related public expenditure. In fact, with the same economic weight, all the 13 Member States studied should contribute identically (7.7%) towards the total of European drugs-related public expense.

⁽⁶⁾ This result is obtained by converting the US data already given in Table B.2, Annex 1, to a size and wealth comparable with the EU. Account must be taken of the fact that data are not available for all the European countries, and that we do not always have data on repression and treatment in countries for which we have other data.

In this case, Belgium had the greatest contribution to the European total with 14.6%, followed by Germany 11.2%, Spain 8.7%, Sweden 8.3% and Luxembourg 8%. All these countries contributed more than the average contribution of 7.7%.

A second group of countries, composed of the United Kingdom 7.4% and Greece 7.3%, was near this average contribution.

**Share of each State in European anti-drug public expenditure
(corrected by GDP weight)**



The third group of countries was composed of France 6.9%, Ireland 6.1%, Italy 5.9%, while Finland's 4.4% and Portugal's 2% contribution was well below the EU average.

This classification order confirms our previous notes. The large, rich countries of Northern Europe where the welfare system is well developed participated intensively in the total expense in the field of drugs of European countries – Belgium, Luxembourg, Germany, Netherlands, and Sweden joined by Spain. The southern countries of Europe, France, Italy and Portugal, contributed less than the average towards the total expenditure of European countries, as did Ireland and Finland ⁽⁷⁾.

Final considerations

Through all these calculations, and despite the methodological constraints, we can observe the usefulness for decision makers of a possible indicator on public drugs expenditure as an element to assessing national drugs policies. Such an indicator would enable a more exact picture of national commitment in the field of drugs to be gained, allowing public power to be optimised.

The work covered by this research suggests the following considerations:

- Although the study reveals some interesting figures and comparisons, promoting reflection in this field, we have to recognise the fact that data are poorly available and lack uniformity to respond with scientific rigour to the EU action plan on drugs

⁽⁷⁾ Finland constitutes a particular case, which may be created by a statistical aberration in the gathering of the data or by the size of the country.

which requests that: '*a list of all public expenditure related to drugs in the EU countries*' should be produced.

For an accurate answer to this question, it is necessary to implement a system of data-gathering in the different countries which would allow the statistical gap to be filled through a routine data-collection system. Prior to this, a uniform methodology of data collection and analysis should be agreed among Member States. The EMCDDA and the Reitox network of focal points are actively engaged in performing this task.

- Knowledge of public expenditure is certainly important to assess government efforts against drugs but it represents just a part of the economic studies which should also cover the social cost of drugs. Therefore, it would be desirable to widen the socio-economic knowledge of the consequence of drugs on society through launching a project calculating the social costs of drugs in the countries of the European Union.

Methodology and definitions

Public drug expenditure is of two types. On the one hand, we have the expenditure that appears in public finance directly labelled as being related to drug problems, the so-called 'direct expenditure'. On the other hand, general authorities such as police, customs and public health institutions devote part of their resources to deal with the issues generated by drugs, the so-called 'indirect expenditure' ⁽⁸⁾. This last type of expenditure is not available in all EU countries ⁽⁹⁾. We should remember that the difficulty in collecting statistics is particularly acute in the area of health care as these costs are very decentralised at local level as opposed to law-enforcement costs which are more centralised and therefore easier to ascertain. On the contrary, on the law-enforcement side, the operation of public services does not demand such accounting. So, this figure will unfortunately not be available unless the Union countries undertake specific studies in this field ⁽¹⁰⁾. The analysis of European public expenditure for illicit drugs comes up against this first technical difficulty.

Another point to note is that public expenditure corresponds to expenditure at central, regional and local levels. This point is important because depending on the country, the expenditure can take place at all levels of government – central, regional and local – or at the level of central government alone. In other words, to consider expenditure by the central government alone would be devoid of meaning since the allocation of tasks varies from one country to another.

It is also important to note that public expenditure does not include amounts spent by private agents through, for instance, private insurance. In the comparison between Europe and the USA, we know that much of the health-care expenditure in the latter is private and, consequently, not included in budgetary estimates.

Globally, construction of the 'drug budget' and the distribution of this budget between health care and law enforcement relies on data furnished by specialised institutions and researchers contacted for each of the 15 Member States of the EU which are studied in this report, the United States and the Helvetian confederation. The procedure used in this report is based on Table D enclosed in Annex 1 ⁽¹¹⁾. In fact, each specialised institution and researcher contacted was required to complete Table D for his country and provide all available drug-related information presented. Moreover, some existing studies were used to complete the data obtained through specialised institutions and researchers. Finally, all available data has been used to build lines related to drug budgets in Table A (available in Annex 1).

⁽⁸⁾ To illustrate let us take the example of the Ministry of Justice where imprisonment expenditure appears in the accounting. The aim is to calculate the part that corresponds to convicts imprisoned for drug offences. To do this, it is necessary to choose – and this is the crux of the problem – a key (percentage of the infractions of the laws on drugs in comparison with the total number of offences, percentage of inmates sentenced for drug use or trafficking in comparison with the total number of inmates, or number of drug-addicted prisoners of the total inmates) which allows the division of the overall Justice expenditure into 'drug expenditure' and 'non-drug expenditure'.

⁽⁹⁾ To establish this expenditure, all European Union countries should engage in an extremely detailed study.

⁽¹⁰⁾ Up until the beginning of 2000, only 6 EU countries had implemented a specific study: Sweden, France, UK, the Netherlands, Germany and Finland. The cost of such a study amounts to about 50,000 euro. Without this kind of study, it is not possible to put forward provisional estimates. It should be noted that Luxembourg is currently launching a study.

⁽¹¹⁾ It should be noted that some of the public budgetary expenditure appearing in Table D is not used at all in our study (for instance, public expenditure for research). In fact, this report focuses mainly on 'drug-related health-care expenditure' versus 'drug-related law-enforcement expenditure'. The reason for such a construction is due to the fact that data for these other budgetary expenditure are only available for very few countries, and their small scale would not affect our results.

Of course, a problem of data homogeneity arises from this procedure. In other words, it is rather complex to create a system that allows the comparison of several countries' expenditure. It implies defining the expenditure for all countries in the same manner over the same period, and for each category of expenditure. Unfortunately, this work has not yet been done. For example, under health-care costs, there are diagnoses that are attributed by definition to drug use (for example, drug psychosis, drug overdoses, etc.) and other diagnoses where drug use is a contributory but not the sole cause (for example, AIDS and hepatitis cases caused by sharing of injection equipment). For each of these causes where drug use only partially accounts for the total number of cases, it is not certain that each country determines the proportion attributable to drug use in the same manner. It is also important to note that the attributable fraction caused by drug use for such causes varies between countries. For instance, the proportion of AIDS cases attributed to drug use should vary between countries due to differences in the prevalence of needle sharing, differences in prevention programmes, levels of law enforcement which can impact on risk-taking behaviour, overall levels of AIDS in the general population, and changes in the incidence of other factors related to contracting AIDS, etc.

More generally, as data expressing the law-enforcement facet only exists for six countries of the Union, we have tried to overcome this difficulty by calculating a provisional estimate. Our hypothesis is that when we do not know the amount of spending for law enforcement we suppose it to be equal to the European average. This provisional estimate will be corrected when we have exact data for the 15 countries. In fact, this estimation corresponds, in the first stage, to the two following equations:

$$\text{Health-care weight} = \frac{\sum_{i=1}^6 HC_i}{\sum_{i=1}^6 (HC_i + LE_i)}$$

$$\text{Law-enforcement weight} = \frac{\sum_{i=1}^6 LE_i}{\sum_{i=1}^6 (HC_i + LE_i)}$$

Where HC_i corresponds to health-care expenditure for the i country and LE_i to law-enforcement expenditure for the i country (data concerning both health care and law enforcement being available for six countries of the EU). The second stage corresponds to the use of these weights to determine law-enforcement expenditure for countries for which only health-care expenditure is known. Appropriate studies and further work will have to replace the results of this evaluation as soon as they become available ⁽¹²⁾.

In fact, this calculation of the data for the countries for which we do not have information concerning law-enforcement expenditure supplies an approximation. If the method used appears simplified, it seems the only way to continue at the moment. Thus, for a country ⁽¹³⁾ for which we do not have law-enforcement expenditure, we apply from the health-care expenditure the portion of this expenditure in the total amount of public expenditure

⁽¹²⁾ In order to underline the fact that the figures obtained through this estimation are of lower quality in comparison with those directly collected in the countries.

⁽¹³⁾ For example, in the case of Belgium, the public-health expenditure linked to illicit drugs amounts to 70.1 million euro. As a consequence, the anti-drug public expenditure generated following our processes amounts to 286.2 million euro (70.1/0.245) and law-enforcement expenditure reaches 216.1 million euro (286.2 - 70.1), i.e., 75.54% of the overall anti-drug public expenditure.

(i.e., 24.5%) in order to generate a total of anti-drug public expenditure and then to determine the law-enforcement expenditure.

For some countries we only had data available for one part of the two types of expenditure (either drug-related health care or law enforcement).

Aiming to compare a large number of countries we have decided to make estimations for those countries in which some figures were missing. This estimation is therefore based on the countries for which we dispose of both types of figures (drugs-related health care and drugs-related law enforcement).

The procedure has been calculated in the following way:

1. Adding together the two types of drugs-related expenditure (health care and law enforcement) for those countries for which data are available, allow us to determine the total 'drugs budget' of these countries, *total drugs budget (a)*;
2. Adding together drugs-related health-care expenditure for those countries for which data are available, allows us to determine the 'drugs-related health-care expenditure' of these countries, *'health-related drugs expenditure' (b)*;
3. Adding together expenditure related to drugs for law enforcement of those countries for which data are available, allow us to determine the 'drugs-related law-enforcement expenditure' of these countries, *'law-enforcement related drugs expenditure (c)*;
4. The division of (b) by (a) allow us to obtain the weight of the drugs-related health expenditure on the total drugs-related expenditure, as well as the division of (c) by (a) allows us to obtain the weight of the drugs-related law-enforcement expenditure on the total drugs-related expenditure;
5. For those countries for which we do not dispose of one of the two types of expenditure, we will estimate it applying the weights previously calculated.

Thus, having bypassed the difficulties which arise from the lack of statistical data, the drug budgets may finally be calculated by country. In order to compare them, it is necessary to express them in percentage of other standardised macro-economic aggregates. For example, the ratios (drug budget/GDP) or (drug budget/overall public expenditure) permit an evaluation of the effort made by the States to face drugs problems. This exercise also allows us to note how the choice in drug policy is translated into very contrasting budget profiles depending on the country.

The comparison of the overall drug budgets may then be complemented by an analysis of their composition. Public action may be classified into two groups of expenditure: law enforcement and health care ⁽¹⁴⁾.

The law-enforcement expenditure includes among other things the cost of running the police forces, the judicial and jail systems, etc. The health-care expenditure includes the

⁽¹⁴⁾ Anti-drug prevention is often general and thus is not a direct concern of the drug budgets. For example, a campaign promoting healthy life for youth is not directly labelled 'drug' and cannot then be charged to the drug budget. Only the campaigns directly targeting drugs enter into the budget. The sums spent in this way are not easy to calculate and of little importance in view of the law-enforcement and health-care expenditure.

amounts dedicated to drug abuse, prevention and treatment of the consequences of drug use, social support, and rehabilitation.

It is not an easy task to distinguish between public spending on law enforcement by the public authorities and public spending on measures taken by them to treat the consequences of drug use. A precise conceptual distinction cannot be made, but one can distinguish more prosaically the way in which the data collected for each country classify different expenditure. Of course, expenditure such as treatment given to drug addicts in prison may be classified as part of the criminal-justice system and therefore considered as law-enforcement spending in one country and as spending on health care in another. Given the diversity of the data with which we are working, we have made no attempt to reclassify them and have opted to stick to the descriptions given by the Member States themselves to their public expenditure.

It is possible to explain the nature of the balance between law enforcement and health care for each country of the Union by calculating the percentages of the overall drug expenditure mobilised by public authorities in these two fields. However, the diptych 'law enforcement–health care' in which the drug policy of a country is embodied, constitutes only one of the ways through which a country's policy influences the problems posed by drugs. The more or less extensive nature of the public-health system and notably the extent of the rights to health care and housing for the poorest also play an important role. Thus, the meaning of inappropriate public expenditure in the field of health care linked to drugs is not the same in all countries

The reader will also note that the law-enforcement share in drug budgets often appears greater. The explanation for this is not only choices made by the EU countries but also statistical one. Firstly, law-enforcement authorities are more centralised than those giving medical care and their expenditure is therefore better identified. Secondly, imprisonment is expensive, and all the more expensive if imprisonment conditions are good.

In consequence, the significance of the conclusions drawn from the examination of the ratio (law enforcement/health care) must be related to the value of the statistical uncertainties interfering with the calculation.

The idea of restoring ⁽¹⁵⁾ the balance of expenditure in favour of one or other facet (law enforcement or health care) by dipping into the resources of one to favour the other is utopian. Such a readjustment can only be made by increasing the overall drug expenditure budget. Actually, taking into account the share of personnel expenditure and knowing that it is almost impossible to transfer civil servants from one administration to another, the room for manoeuvre allowing the reallocation of a portion of the expenditure from one part of the diptych to another is very small.

Particular attention must be drawn to the notion of 'drugs budget' itself. As we have seen, it concerns the expenditure made by public authorities and appearing in their budgets. This conception deviates from a more extensive approach generally adopted by Anglo-Saxon public accounting of '*public spending*' or '*government spending*' taking into account not only the budgeted expense but also the total expense of transfers and notably those of social security. Inasmuch as the drugs budgets give an account of the

⁽¹⁵⁾ Apart from very positive experiences reported by Spain in the reallocation of seized assets and money (which are not public spending) into health and law enforcement expenditure (law of the Fund), it appears generally that reallocation of spending on a large scale is impracticable.

expenditure that the State spends for a policy, only the means spent in serving the instruments of its policy must be recorded. In fact, as medical care for the diseases generated by drugs are borne by the State, it does not fall directly into the 'drugs budget', as the social transfers replace the State's own resources to meet the expense. It is therefore not logical to record in the drugs budget, in the most restricted sense, non-budgeted expenditure financed by social transfers in which the State only plays an interface role. The most logical idea then is to present separately the drug expenditure financed by Social Security in such a way that adding up the drugs budget and the Social Security drug expenditure gives the 'collective drug expenditure', which is a more extensive notion than drugs budget.

Finally, the calculation of the 'drugs budgets' constitutes an important step in the calculation of the 'social cost of drugs' ⁽¹⁶⁾. This new indicator may be calculated by adding the amount of the harm incurred by the user (death, disease, etc.), the externalities that they impose on the community (socialisation of the care cost, transmission of diseases, loss of productivity, criminality) and the public expenditure induced by running the public policy (drugs budget).

The two concepts 'drugs budget' and 'social cost of the drug' must not be confused:

- the 'drugs budget' is a public policy indicator measuring the effort made by the government to confronting the drug phenomenon by adding all budgeted expenditure (direct and indirect) that has to be linked to implementation of the drug policy.
- the 'social cost of the drug' is an indicator of the resources which have been used up because of the existence of the drug phenomenon and which could be used elsewhere if the drugs problem did not exist.

To give the scale of importance; in the countries for which we already have results at our disposal, the drugs budget represents about 5% of the 'social cost of the drug'. When the difference in size is taken into account, it is understandable why the teams which have carried out the research on the social cost have contented themselves most often with making an inventory of public expenditure directly labelled 'drug' when calculating the drugs budget.

⁽¹⁶⁾ P. Kopp [1999] 'Economic Costs Calculation and Drug Policy Evaluation' *Addiction*, vol. 94, n°5, May. [2000], Le coût social des drogues licites (tabac, alcool) et illicites en France, OFDT, n°22.

Drug-related health care expenditure

Introduction

Countries of the European Union do not devote equal amounts of resources to face the health consequences of drug abuse. These differences may reveal different prevalence levels, a different degree of attention to the problem or different cost structures. Therefore, there may be several reasons why one country spends more than another on drug-related health care. Unfortunately, the present study cannot remove all ambiguity from the interpretation.

Public drug-related health expenditure per problem drug user

In a rational world, it is clear that health-care supply should be in proportion to demand. In the case of drugs, the health-related public expenditure has to be compared to its target population, i.e. the main recipients of drug-related health care: the problem drug users⁽¹⁷⁾.

The ranking which emerges for the mid-1990s in Table 1 is explained by several complex factors. Sweden's position at the head of the list may be explained by the fact that this country dedicated a high priority to health care related to drugs. The group composed of Belgium, the Netherlands, Germany, Italy and Finland has launched treatment aimed at drug addicts, by using, among others, methadone, already for a long period of time. The cost of these treatments may be an explanation. France's position may possibly be explained by the pre-eminence and low cost of buprenorphine treatments⁽¹⁸⁾. The United Kingdom, Ireland, Luxembourg, Spain and Portugal follow even though it is not possible to know whether their figures can be explained by a lack of means devoted to health care or, on the contrary, by large economies of scale⁽¹⁹⁾. The United States' position is interesting. It underlines the fact that this country could be allocating less to drug-related health care than the average EU country, if we take into account the scale of the drugs problem there (*measured by the prevalence rate of problem drug users*).

⁽¹⁷⁾ According to the EMCDDA *Annual report* (1999) the number of problem drug users is based on the figures provided by the Member States, all of whom use the same definition of problem drug use; addiction by intravenous injection, or regular and long term opiate, cocaine and/or amphetamine use.

⁽¹⁸⁾ The monthly cost for treatment of a drug addict with buprenorphine is 1252 FF or 600 million FF for 40,000 people, see Kopp, P., Rumeau-Pichon, C., Le Pen, C. (2000) 'Les enjeux financiers des traitements de substitution dans l'héroïnomanie : le cas du Subutex' *Revue Epidémiologique et de santé publique*, n° 48, pp 256-270.

⁽¹⁹⁾ When a small amount is allocated to treatment this may translate as absence of resources dedicated to this type of action or on the contrary, the presence of a scale economy: when a treatment is put into practice on a large scale its unitary cost is low.

Table 1 – Public drug-related health expenditure per problem drug user

Country	Public drug-related health expenditure (€ millions)	Number of problem drug users (high and low hypotheses)	Public drug-related health expenditure per problem drug user (mean hypothesis)
Sweden	103.0	14,000 – 20,000	6,058.8
Belgium	70.1	20,200	3,470.3
Netherlands	80.9	25,000 – 29,000	2,996.3
Germany	308.0	80,000 – 165,424	2,509.9
Italy	516.5	172,000 – 326,000	2,074.3
Switzerland	47.4	30,000	1,580.0
Finland	12.6	1,600 – 14,500	1,565.2
France	213.2	124,000 – 176,000	1,421.3
UK	268.2	88,000 – 341,423	1,246.5
Ireland	9.9	4,600 – 13,735	1,079.9
Luxembourg	1.9	1,900 – 2,200	926.8
Spain	95.3	83,972 – 177,756	728.2
Portugal	3.8	70,000	54.3
Greece	14.5	n.a.	n.a.
Denmark	n.a.	10,200 – 14,000	n.a.
Austria	n.a.	15,984 – 18,731	n.a.
Average EU	1,697.8	(1)	2,011.0
USA	3,777.9	3,750,266	1,007.4

Sources: The public drug-related health expenditure comes from our study and the prevalence data from the 1999 report of the EMCDDA and from UNDCP 1999. The US data come from ONDCP 1992. See Table 19.

Each country's share in 'EU drug-related health-care expenditure'

Another way to analyse the drug-related health-care expenditure of EU governments consists in determining the share of each country in a theoretical budget for European drug-related health care ⁽²⁰⁾.

The reader will note the change of perspective. The point is no longer to know whether public expenditure in the field of drug-related health care is proportionate to the extent of the problem generated by drugs for that country and calculated by the number of problem drug users. The point is to determine if independently of the extent of the problem, EU governments dedicate similar amounts to health care for the consequences of drug use.

The resources devoted by each country nationally to drug-related health care may then be added together to calculate the total expenditure at EU level and to estimate the contribution of each country.

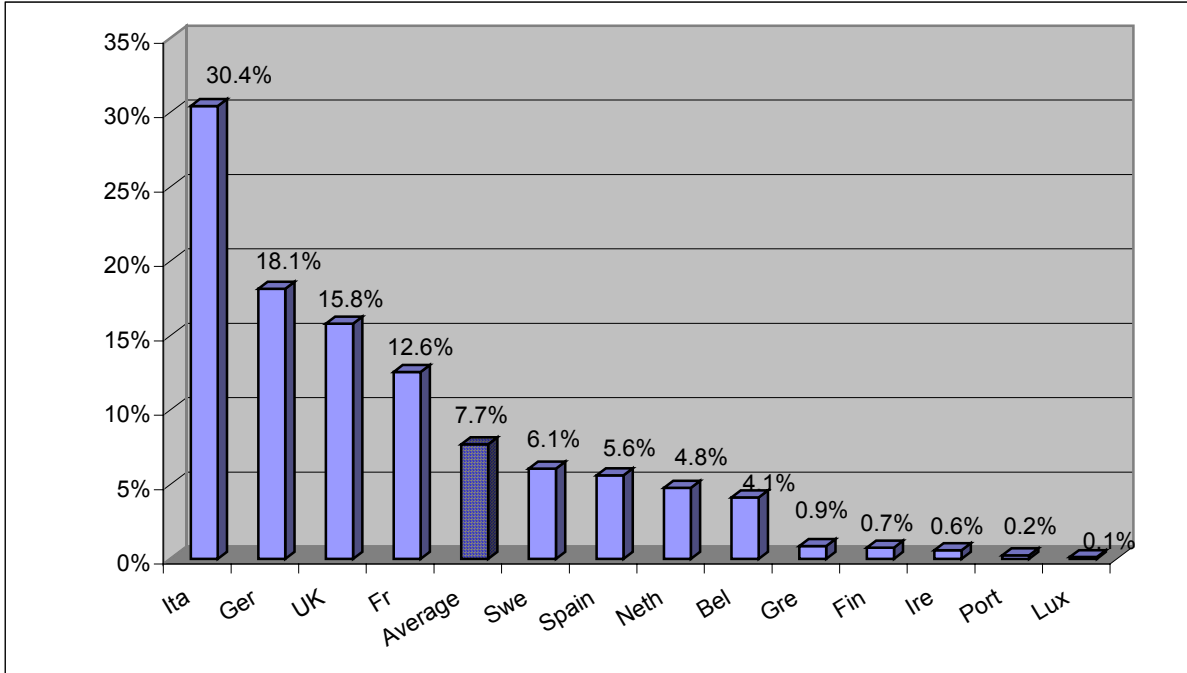
Without forgetting the methodological limitations of our calculation, we notice that Italy during the 1990s was the EU country that spent the most for health care related to drugs 30.42% of the total, followed by Germany 18.1%, the United Kingdom 15% and France 12.5%. In total, these four countries represented 76.9% of the entire EU public health expenditure related to drugs.

It is noticeable that Sweden, which is smaller than Spain and the Netherlands from a demographic and economic point of view, spent more in absolute value than these two countries. This is translated by a weight of 6.07% in the total of European health

⁽²⁰⁾ Total EU drug budget is calculated by adding together all national drug-related health care expenditure.

expenditure for Sweden, compared with 5.61% for Spain and 4.76% for the Netherlands. Belgium (4.13%), Greece (0.85%), Finland (0.74%), Ireland (0.58%), Portugal (0.22%) and Luxembourg (0.11%) follow in terms of health expenditure due to drugs.

Table 2 – Share of each EU country in the total drug-related health-care expenditure in the EU



However, these results do not totally explain the situation. Indeed, they tend to erase the differences in size between the various Member States. After all, is it not normal, as shown in the previous table, that Sweden spends three times less than Germany for drug-related health care if Sweden has at the same time a smaller population and has a smaller GDP than Germany? Is it not logical that a country whose population is two times smaller than that of another, spends two times less? Similarly, shouldn't a country producing two times less than another allocate two times less money for expenses for health care generated by drugs?

Therefore, if we use as a reference base the largest country (demographically and economically) among the Member States (Germany), we may sharpen the previous analysis by formulating the hypothesis according to which the magnitudes measured increase linearly with the size of the country, taking into account its structural specificity. Thus we would like to isolate the part of the differences in the budgetary expenditure choices of any two States, the part induced by structure effects (size and weight) and the part induced by national arbitration.

To carry out this approach, each Member State is given a weight in comparison with Germany, the latter having a weight of one. The table below gives the weight of each Member State, and also provides the simple calculation of these weights.

Table 3 - Demographic and economic weights of each Member State and the US in comparison with Germany

Country	Demo. weight	Econ. Weight	Country	Demo. weight	Econ. weight
Sweden	9.33	8.54	Netherlands	5.23	5.48
Belgium	8.05	8.58	Italy	1.43	1.95
Ireland	22.19	25.46	Luxembourg	205.25	174.15
Spain	2.08	3.79	Germany	1.00	1.00
Portugal	8.21	21.86	Finland	15.79	16.53
Denmark	15.49	12.75	Greece	7.82	20.78
France	1.39	1.47	Austria	10.14	10.18
UK	1.39	1.48	USA	0,3	0,27

Demographic weight of a country i = population of Germany / population of the country i

Economic weight of a country i = GDP of Germany / GDP of the country i.

If the demographic weight of Sweden is 9.33 it is necessary to multiply the Swedish population by 9.33 to obtain the German population. It is the same for the economic weight: the Swedish GDP is multiplied by 8.54 to obtain the German GDP.

In the light of these calculations, let us then reconsider Member State's expenditure in the field of drug-related health care. Thus, with an equal economic weight ⁽²¹⁾, each of the 13 countries studied here ⁽²²⁾ should contribute a similar amount (7.7%) to the theoretical European drug-related health-care expenditure ⁽²³⁾.

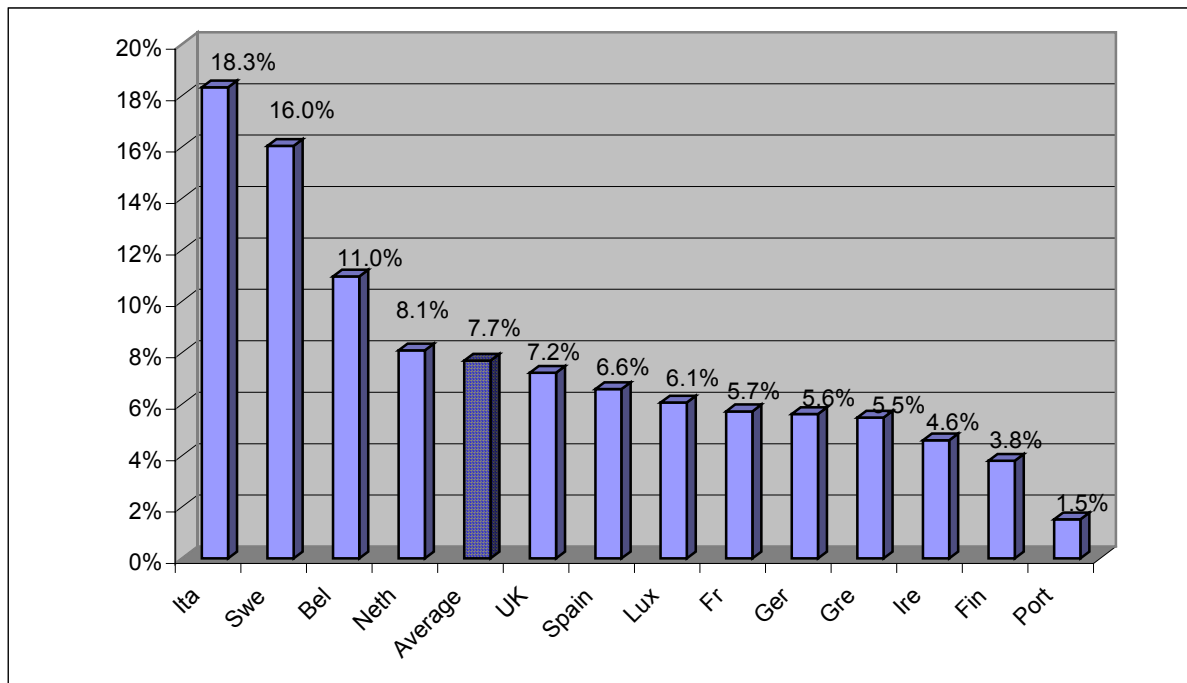
Although Italy remains the European country with the highest expenditure in terms of drug-related health care and is still far above the average EU contribution (18.32% of the total), we see that a small country such as Sweden, with 16.04% of the total, had a very large contribution to drug-related health expenditure in Europe. It should be noted that Belgium and the Netherlands were also above the average contribution with 10.97 and 8.09% respectively of the total.

⁽²¹⁾ We multiply single countries' expenditure by the coefficient of their economic weight. e.g. if we multiply the Swedish drug-related health expenditure by 8.54, the comparison with Germany becomes possible. In other words, we propose to express the public expenditure of the Member States in the field of drug health care as though all countries had the same economic weight. We then bring out the differences between the budgetary commitments of the States and not the differences induced by the level of wealth production. By using the technique of figures' rectification by economic weight, the previous table of public expenditure is greatly modified and undoubtedly better explains the real efforts of each Member State.

⁽²²⁾ Except Austria and Denmark.

⁽²³⁾ This theoretical EU drug budget in the field of health care is calculated by adding together all national drug-related health expenditure, each national drug-related health expenditure being multiplied by the economic weight of the country concerned.

Table 4 – Share of each EU country in the total of drug-related health-care expenditure in the EU (corrected by GDP weight)



Correcting the figures by the Gross Domestic Product (GDP) weight we notice that the 'largest' countries of the Union, and among others Germany and France (with similar 'contributions' of 5.62% and 5.72%) were well below the theoretical average contribution of 7.7%. The United Kingdom (7.22%) was far closer, while Portugal (1.51%) and Finland (3.8%) were quite far away from the 'European standards'. It should also be noticed that the participation of Spain (6.59%) and Luxembourg (6.06%) in European drug-related health expenditure was larger than that of Germany and France. Finally, it is interesting to note that the expenditure of the three first countries in terms of drug-related health expenditure represented almost half (45.33%) of the theoretical EU drug budget in the field of health care.

Drug-related law-enforcement expenditure

Introduction

The cost of law enforcement constitutes another important facet of public action. In this case the methodology used is the same as that used for drug-related health-care expenditure. First, expenditure is expressed in comparison to the number of problem drug users. This is in fact the population most likely to be arrested, prosecuted and imprisoned or punished in some way and therefore where the government budget on law enforcement related to drugs is more directed. Then we look at the European drug-related expenditure in total and finally we address the analysis of other relevant law-enforcement figures very important for the cost analysis ⁽²⁴⁾.

Public drug-related law-enforcement expenditure per problem drug user

If we divide the amount spent by each government in law enforcement to face drugs by the number of problem drug users, we should obtain the average hypothetical amount that each single country spent in law enforcement for every problem drug user ⁽²⁵⁾. The following table reproduces this calculation.

Table 5 – Public drug-related law-enforcement expenditure

Country	Public drug-related law-enforcement expenditure (€ millions)	Number of problem drug users (high and low hypotheses) (1)	Public drug-related law-enforcement expenditure per problem user (average hypothesis)
Germany	1,590.9	80,000 – 165,424	12,964.5
Belgium	216.1	20,200	10,698.0
Netherlands	182.0	25,000 – 29,000	6,740.7
Switzerland	155.0	30,000	5,166.7
Finland	32.9	1,600 – 14,500	4,087.0
France	585.5	124,000 – 176,000	3,903.3
Sweden	61.2	14,000 – 20,000	3,600.0
Ireland	30.5	4,600 – 13,735	3,327.0
Luxembourg	5.9	1,900 – 2,200	2,878.0
UK	586.2	88,900 – 341,423	2,724.5
Spain	293.7	83,972 – 177,756	2,244.3
Portugal	11.7	70,000	167.1
Greece	44.7	n.a.	n.a.
Italy	n.a.	172,000 – 326,000	n.a.
Denmark	n.a.	10,200 – 14,000	n.a.
Austria	n.a.	15,984 – 18,731	n.a.
Average EU	3,641.3	(1)	4,848.6
USA	11,869.5	3,750,266	3,165.0

Source: (1) EMCDDA 2000 report, ONDCP1992. (1) See Table 19.

⁽²⁴⁾ Although carrying over the health care expenditure to the number of problem drug users does not present any real problem, applying this approach in the case of spending on law enforcement can provoke discussion. Effectively, it is not certain that the States should calibrate their repressive spending pro rata to the number of problem users. We can foresee that a country determines the level of its repressive commitment in function of the number of consumers (problem or not, and regardless of the product used). Consequently our analysis probably has a normative connotation of which the reader should be aware.

⁽²⁵⁾ For example, the average number of problem drug users in Germany corresponds to 122,712, i.e. $(80,000+165,424)/2$.

The share of each country in 'EU drug-related law-enforcement expenditure'

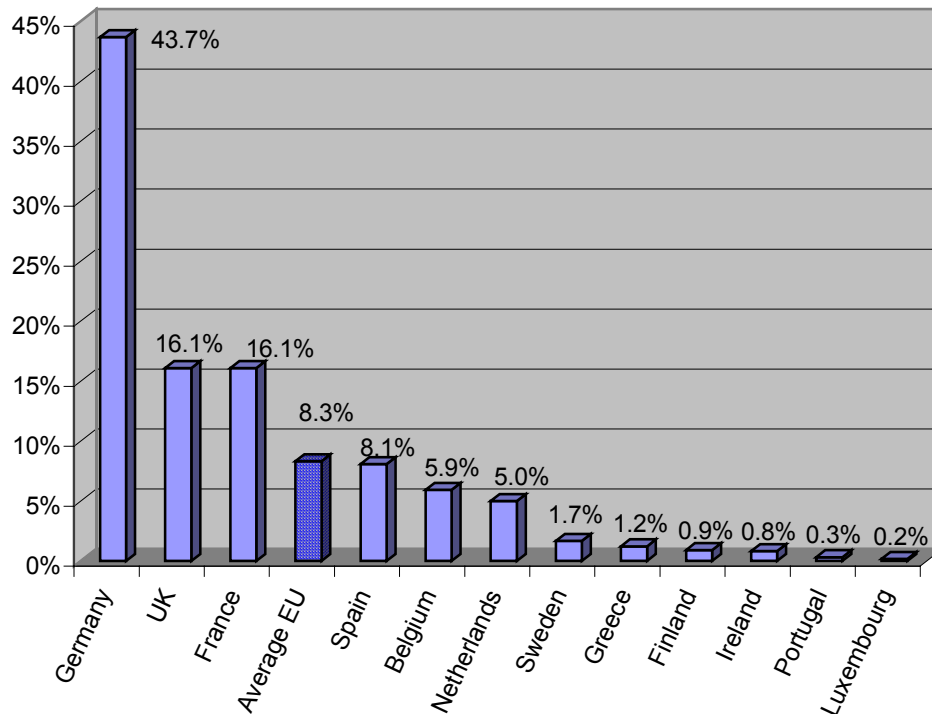
As for the previous chapter, another way to analyse the EU governments drug-related expenditure, in this case on law enforcement, consists in determining the share of each EU country in a theoretical European budget for law-enforcement activities ⁽²⁶⁾.

This European average is calculated by adding together all national drug-related law-enforcement expenditure and dividing the total by the number of countries. The objective is to know if independently from the extent of the problem, governments appear to dedicate analogue amounts to drugs activities.

Germany with 43.69% appeared to be the country spending more during the 1990s. The United Kingdom 16.1% and France 16.08% have respectively lower figures. However, on their own, these three countries represented 75.87% of the total drug-related law-enforcement expenditure engaged in the 1990s in the European Union.

In consequence, it turns out that the other Member States' shares in the field of drug law-enforcement expenditure were marginal. If Spain 8.1%, Belgium 5.9% and the Netherlands 5% had by and large a decent respective weight, on the contrary, the other Member States of the Union had an insignificant part in the hypothesis made of a European total (Sweden 1.7%; Greece 1.2%; Finland 0.9%; Ireland 0.8%; Portugal 0.3% and Luxembourg 0.2%).

Table 6 – Share of each EU country in the total of drugs-related law-enforcement expenditure in the EU

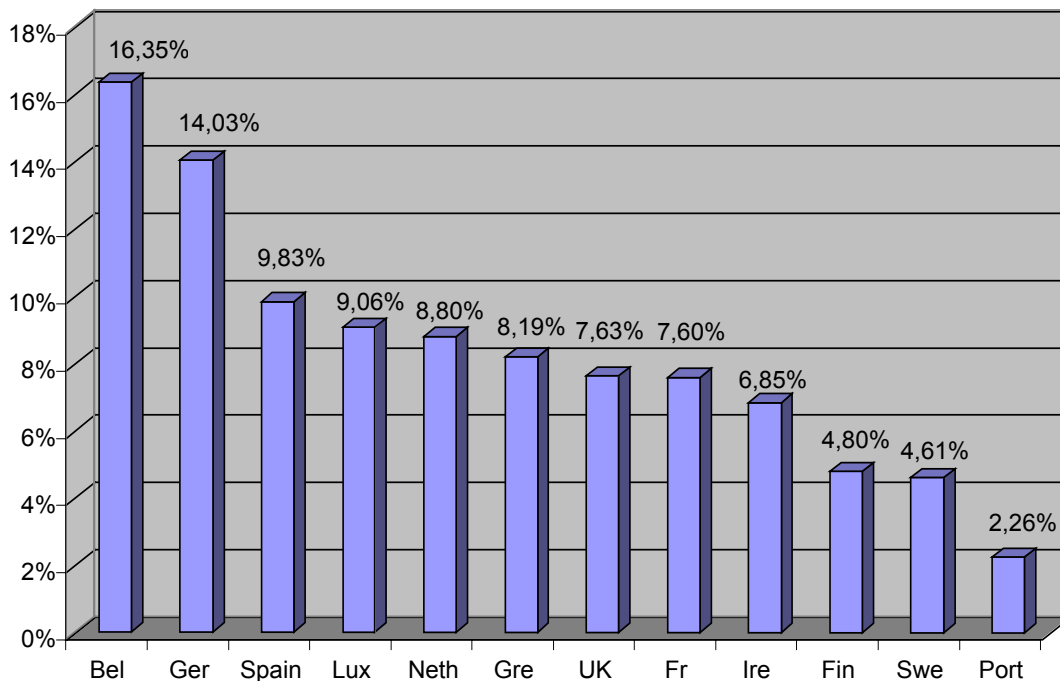


However, if we adjust the previous results with the economic weight (GDP) of each country considered in comparison with Germany, the positions alter appreciably. We remind the reader that the objective of this correction is to show how the law-

⁽²⁶⁾ Total EU drug budget is calculated by adding together all national drug-related law enforcement expenditure.

enforcement expenditure of each country would appear if they had the same economic weight. We can then identify the differences explained by budgetary choices or by the particular situation of the country and not by its economic wealth.

Table 7 - Share of each EU country in the total of drug-related law enforcement expenditure in the EU (corrected by GDP weight)



Thus, Belgium (16.35%) on its own contributed twice as much as the EU average (8.33%), and Germany decreases from 43.6% to 14% when we correct the data by economic weight. A group of countries composed of Spain (9.83%), Luxembourg (9.06%) and the Netherlands (8.8%) was above average contribution, while Greece (8.19%) was very close. United Kingdom (7.6%) and France (7.6%) were just below. The last group of countries was quite far from this average contribution, with Ireland, whose share attained 6.85% of the European total of drug-related law-enforcement expenditure, Finland (4.8%), Sweden (4.61%) and Portugal (2.26%).

Others law-enforcement figures

Aside from these financial estimates, we have also considered activities undertaken by law-enforcement authorities dealing with drug-related crimes. The elements collected from the EU countries shows interesting details of the law-enforcement activities. It is therefore interesting to exploit this information in a comparative perspective to examine how, not only the amount of the budgets devoted to law enforcement may vary from one country to another, but also how the allocation of these amounts may differ.

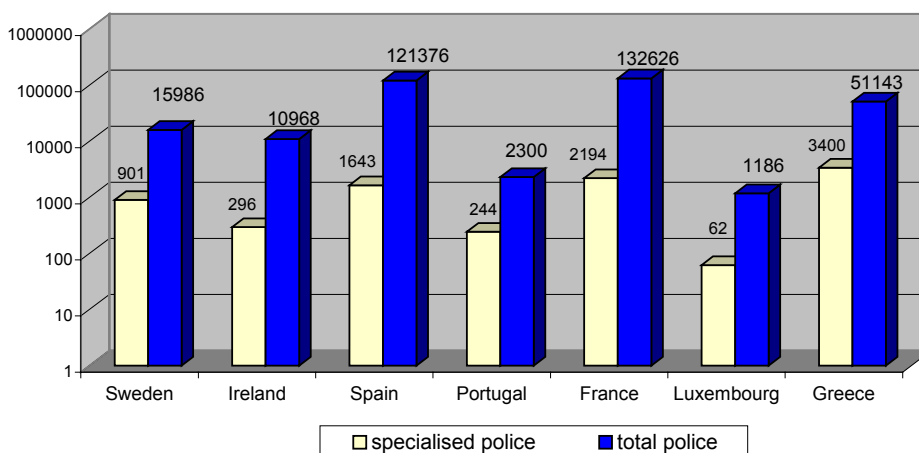
Some of these differences might be the consequence of institutional choices. Thus, a country may decide to create a special police force to face drug trafficking. On the other hand the number of observed customs violations in a country depends, of course, upon customs activity but also on the country's geographical situation. The same is true for the

number of prosecutions or for the number of the individuals imprisoned for crimes related to drugs.

We will therefore resituate the interpretation that can be given to each of the following results in a precise manner. However, we must point out that the lack of data or the difficulty of obtaining reliable figures (e.g. number of police or judicial drug-related interventions) can seriously affect the calculation. Nevertheless, these data are essential for the analysis of public expenditure on drugs.

Firstly, in the mid nineties, several countries chose to create a specialised police force to tackle the drug phenomenon. The graph below makes the link between the overall number of police in the European countries ⁽²⁷⁾ and the overall number of police officers who are specialised in anti-drugs activities.

Table 8 – Police forces specialised in anti-drugs activities in some EU Member States (logarithmic scale)



In the countries analysed, the total number of police officers reaches 335,585 ⁽²⁸⁾ and the total number of specialised officers corresponds to 8,740 individuals, i.e., 2.6% of total police manpower.

According to this, Portugal was the country with the largest number of specialised police officers (10.61%), followed by Greece (6.65%), Sweden (5.64%), Luxembourg (5.23%), Ireland (2.7%), Spain (1.65%) and France (1.35%). Thus a rate of specialisation of 2.6% for the whole of Europe can be explained by the relatively important weight of France and Spain in the total ⁽²⁹⁾.

We notice that the weight of Greece in the European specialised police force appears to be extremely large (38.99% of the police officers are specialised in work against illicit drugs in Greece). While, in the total of police forces for the seven countries for which we have data, France and Spain respectively represented 39.52% and 36.17%, contrarily, their share in the specialised police force in Europe decreased to 25.1% for France and

⁽²⁷⁾ Countries for which we have data at our disposal: Sweden, Ireland, Spain, Portugal, France, Luxembourg, Greece.

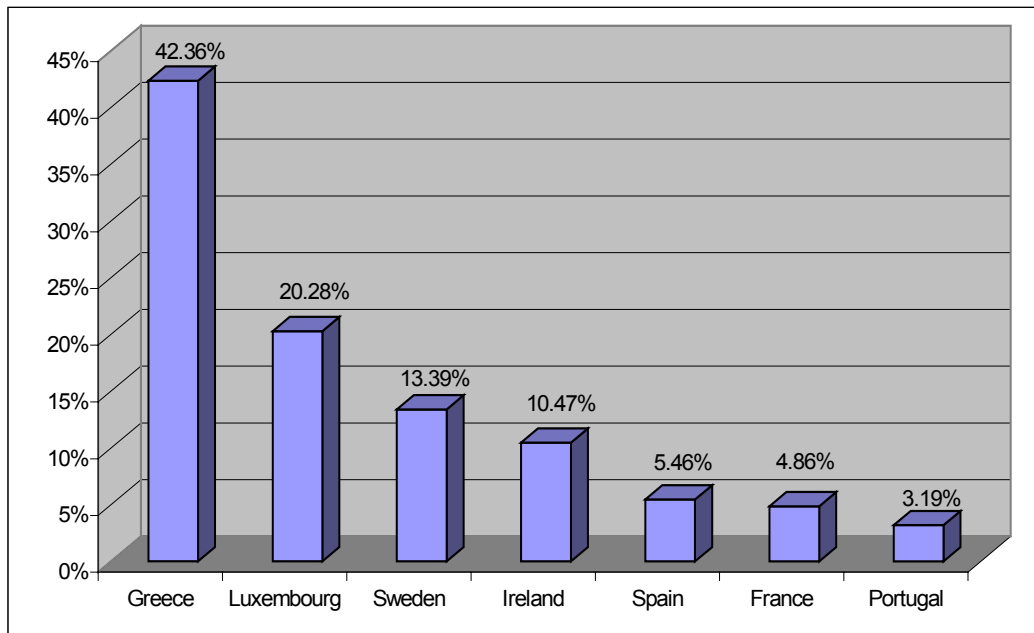
⁽²⁸⁾ We call a European specialised police force the sum of national specialised police forces, i.e. 8,740 persons for the 7 countries for which we have data.

⁽²⁹⁾ For date and sources see Annex.

to 18.8% for Spain. Then came Sweden (10.31%), Ireland (3.39%), Portugal (2.79%) and Luxembourg (0.71%).

However, once this data is corrected by the variations in population ⁽³⁰⁾, we observe a slightly different landscape. The 'real' efforts in terms of drug-specialised police appear more clearly in the following graph.

Table 9 – Share of each EU country calculated over the total of all European police forces specialised in anti-drugs activities (corrected by demographic weight)



We notice that if Greece's weight increases according to this calculation technique (42.36%), we see furthermore that Luxembourg's effort was very appreciable (20.28% of the whole). In fact, for 7 countries studied, the average contribution of each Member State should reach 14.29%. Thus, if Greece and Luxembourg were far above this average contribution and if Sweden is close to it (13.39%) as well as Ireland to a lesser degree (10.47%), countries such as Spain (5.46%), France (4.86%) and Portugal (3.19%) were far below this average contribution.

These calculations must not be over interpreted. In fact, nothing indicates that the existence of specialised police forces is an indicator of particular efficiency of repressive measures. It is just as likely that a general police force could be more performing than a specialised force as it is the contrary. It is also possible that each of these organisational forms is more or less complementary. Our remarks therefore point out a fact but do not constitute a precise judgement on the efficiency of repressive action.

Secondly, drug-related customs offences constitute another important indicator of drug trafficking. In the mid-1990s, the number of customs offences involving drugs on the total of customs offences reaches 24.61% for the 4 countries analysed in the table below (Sweden, Ireland, France, United Kingdom). In other words, on the whole, of customs offences discovered in these four countries, 24.61% involve illicit drugs. We also note that the total of customs offences revealed in the United Kingdom was extremely low

⁽³⁰⁾ This means that the weighting used here uses the demographic weight and not the economic one.

(3,259) in comparison with France (100,000) which translates for this country into a high proportion of customs offences involving drugs in the total (69.25%).

Table 10 – Customs offences related to drugs

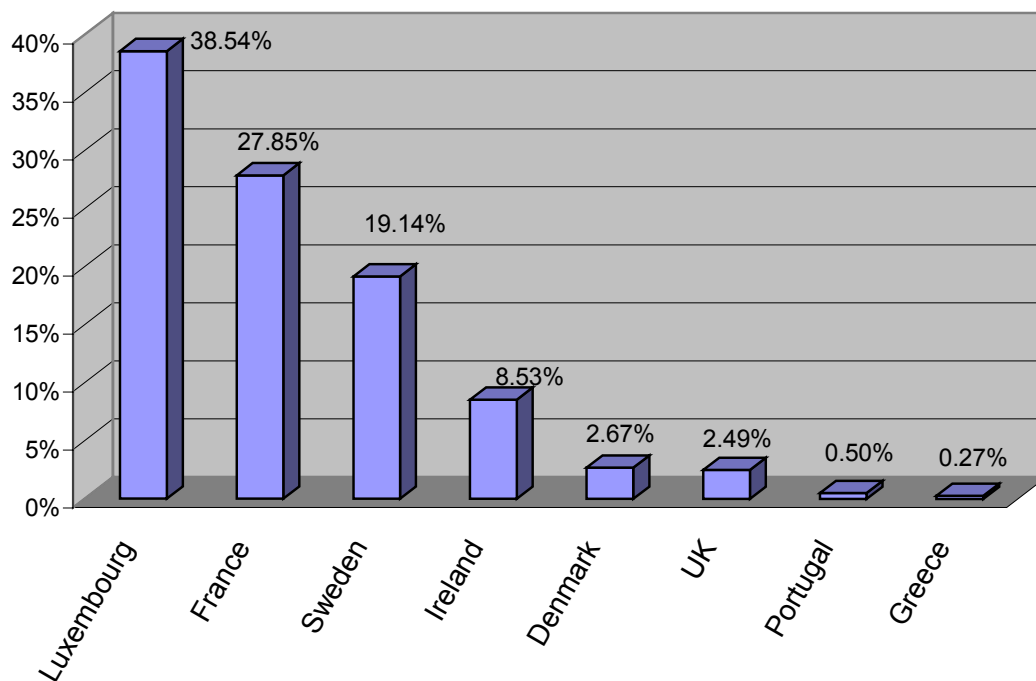
	Total	Sweden	Ireland	France	UK
1 - Customs offences involving drugs	30,514	2,579	483	25,195	2,257
2 - Total customs offences	123,980	18,367	2,354	100,000	3,259
3 - Line 1 / line 2	24.61%	14.04%	20.52%	25.20%	69.25%

Globally, we see that for the four countries for which we have figures, the share of customs offences involving drugs of all recorded customs offences was superior or close to 15%.

If we examine each Member State's share in the total of European drug-related customs offences, we observe that France faced 81.05% of the customs offences involving drugs. The other countries were far behind, Sweden representing 8.3% of the total, followed by the United Kingdom (7.26%), with quite marginal shares for Ireland (1.55%), Luxembourg (0.76%), Denmark (0.7%), Portugal (0.2%) and Greece (0.14%).

However, when we counterbalance this data by the demographic weight of each Member State, the previous observations change appreciably. Thus, Luxembourg (38.54%) was the country where the share of drug-related customs offences was the largest in the European total, followed by France (27.85%), Sweden (19.14%), Ireland (8.53%), Denmark (2.67%), the United Kingdom (2.49%), Portugal (0.5%) and Greece (0.27%).

Table 11 – Share of each country in the total of drug-related customs offences in the EU (corrected by demographic weight)



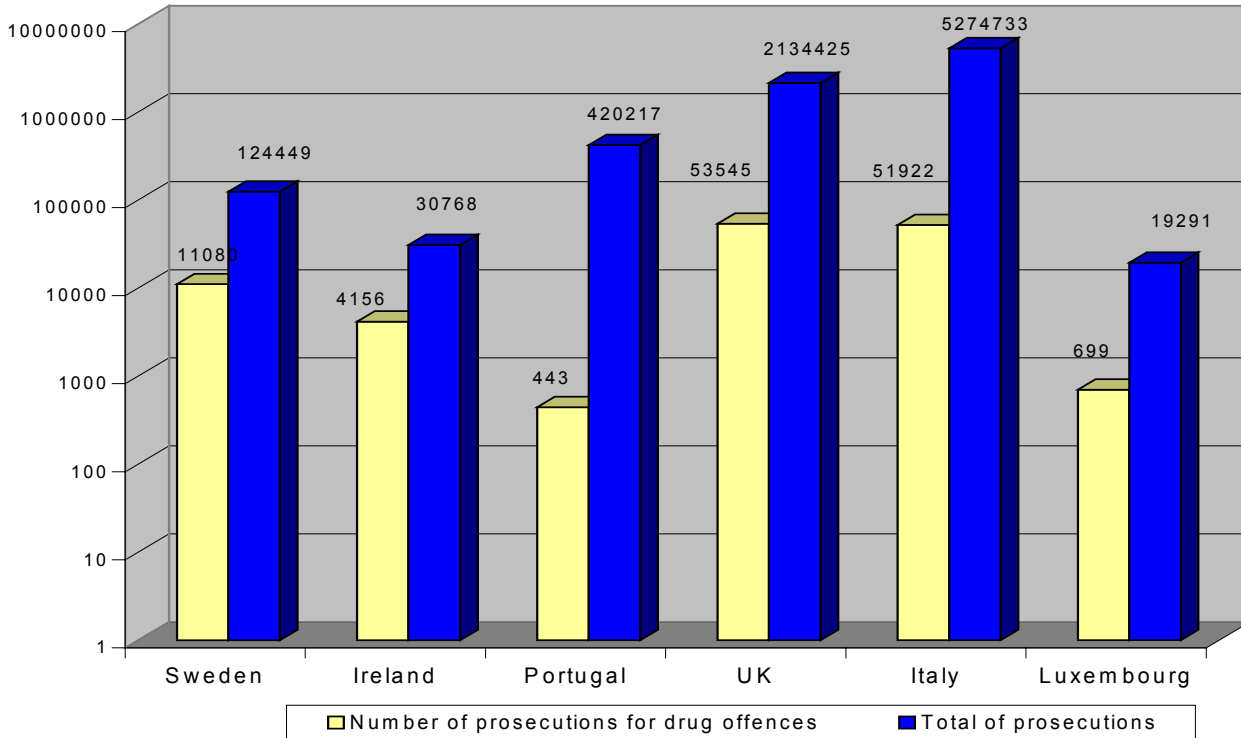
Aside from this, for the eight countries studied (where data is available), the average share of each State must reach 12.5%. On the whole, only three countries were above this average share (Luxembourg, France and Sweden) and represented 85.53% of the customs offences involving drugs. On the contrary, the other States were quite far from this average.

The interpretation of these results is not easy. In effect, the number of customs violations not only depends on the efficiency of customs, but also the country's exposure to traffic. The geographical location plays an important role; one country may serve as a turntable without having a large drug use problem, but the customs violations are numerous if the customs are active. Once again, it is necessary to examine the preceding figures with caution and to accept that their interpretation is necessarily a subject of controversy.

Thirdly, other relevant information concerning law enforcement related to drugs concerns the number of prosecutions involving drugs in each EU Member State during the mid nineties. Table 12 below compares for each Member State the number of drug-related prosecutions and the total number of prosecutions in the mid-1990s.

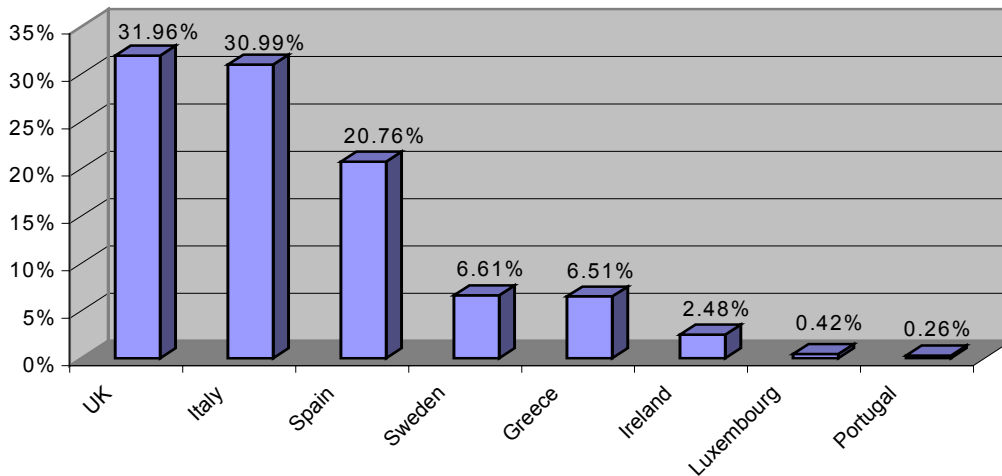
The total number of prosecutions involving drugs reached 1.52% of the total number of prosecutions for the 6 countries for which figures are available. Ireland had the highest rate with 13.51% of drug prosecutions, followed by Sweden (8.9%), Luxembourg (3.62%) and the United Kingdom (2.51%). As for Italy and Portugal, they had marginal rates (respectively 0.98% and 0.11%) compared with the total number in these two countries.

Table 12 – Number of prosecutions for drug law offences (logarithmic scale)



Now, if we calculate the share of each Member State in the European total as far as prosecutions involving illicit drugs are concerned, we observe that the United Kingdom represented 31.96% of the prosecutions involving illicit drugs in Europe, followed by Italy (30.99%), Spain (20.76%), Sweden (6.61%), Greece (6.51%) and Ireland (2.48). Portugal and Luxembourg had an insignificant share of the whole with 0.42% and 0.26% respectively.

Table 13 – Share of each country in the total of drug-related prosecutions in the EU

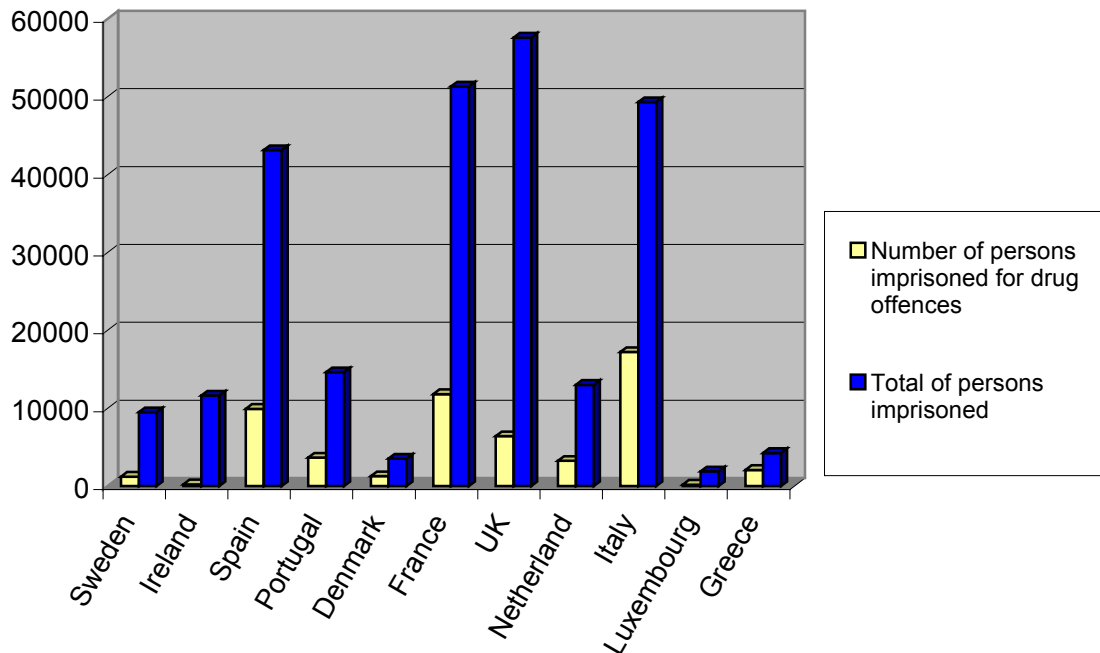


This presentation of the data is truncated, as is logical, given that the countries differ in size and that the number of prosecutions vary from one country to the other. Now we will recapitulate the previous data, correcting it by demographic weight. The purpose is to calculate the number of prosecutions as though all countries had the same population as Germany (the most populated). We will thus bring out the differences induced not by the population but by the particularities of the situation in the countries considered. When we correct the previous data with the demographic weight, Luxembourg appears to be the Member State with the most important weight (22.12%) in Europe, in the mid-1990s, for the total number of prosecutions involving drugs. In fact, when eight countries are considered, the average weight of each country should be equal to 12.5%. However, out of the eight countries studied, Portugal was the only country remaining in a marginal situation with a weight of 0.56%, whereas the other Member States were above this rate (Luxembourg, 22.12%; Sweden 15.93%; Ireland 14.22% and Greece 13.15%) or close to this average weight (United Kingdom 11.45%; Italy 11.41% and Spain 11.17%).

The last elements are easily interpreted in as much as we can suppose that the determining factors of prosecution of delinquents in general and drug delinquents are fairly close. Then the report of the percentage of drug prosecution within overall prosecutions is indicative of national drug policy.

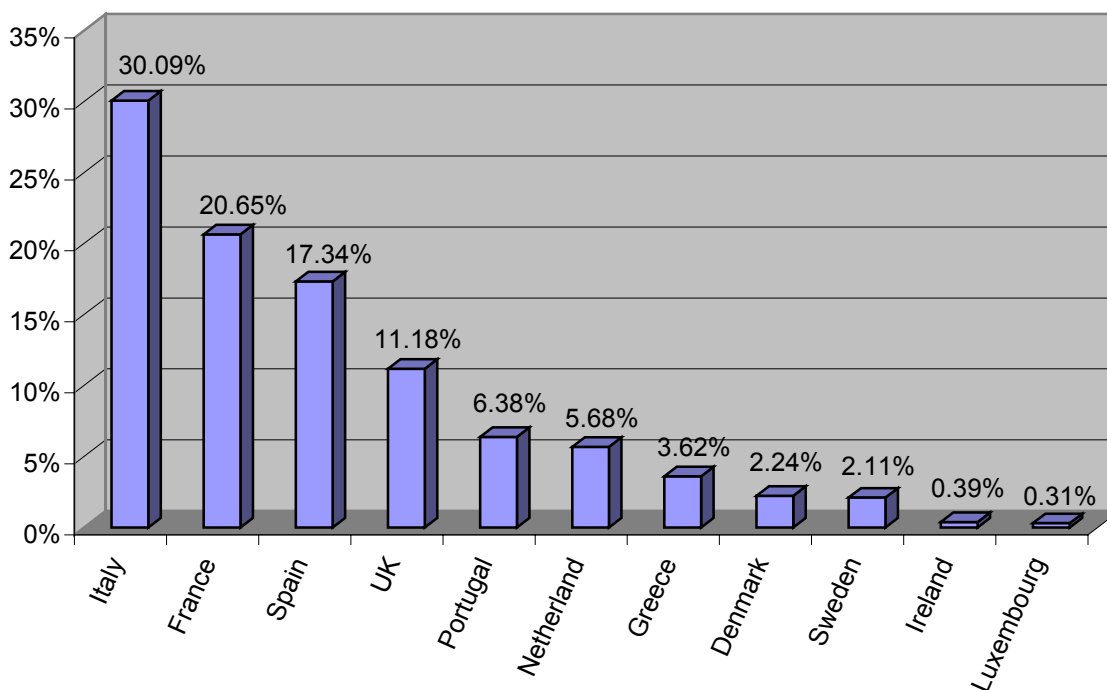
The last prism permitting us to analyse law-enforcement aspects concerns drug-related imprisonment in the various States of the European Union. For the reasons previously stated these results are directly interpretable. First, we note that 11 out of 15 Member States have been able to provide us with related data. According to the calculations it appears that the number of persons imprisoned in Europe for drug offences, in comparison with the total number of imprisoned persons, was relatively high, in the mid-1990s, as it reaches 22.02%. In other words, between 1 person out of 4 and 1 out of 5 was imprisoned in Europe for drug-related offences in the mid-1990s ⁽³¹⁾.

Table 14 – Number of imprisonments for drug-law offences



Among EU countries, Greece, Denmark and Italy had the highest rate with respectively 48.7%, 36.29% and 34.9% of imprisoned persons ⁽³²⁾ for drug offences. The Netherlands (25.0%), Portugal (24.9%), France (23.0%) and Spain (23.0%) formed a second group close to the European average. Finally, a last group quite far away from this European average, was made up of Sweden (12.7%), the United Kingdom (11.1%), Luxembourg (9.31%) and far behind Ireland with 1.94% of persons imprisoned for drug offences.

Table 15 – Share of each country in the total of individuals imprisoned for drug-laws offences in the EU



Out of the total number of individuals imprisoned for drug-law offences in Europe, Italy recorded 30.09%, followed by France (20.65% of the European total), Spain (17.34%) and the United Kingdom (11.18%). A second group of countries, some way behind the aforementioned States, was composed of Portugal (6.38%), the Netherlands (5.68%), Greece (3.62%), Denmark (2.24%) and Sweden (2.11%). These countries were followed far behind by Ireland (0.39%) and Luxembourg (0.31%).

In fact, to analyse the respective weight of these countries, it appears to be more interesting to compare the preceding data by correcting it with its own demographic weight.

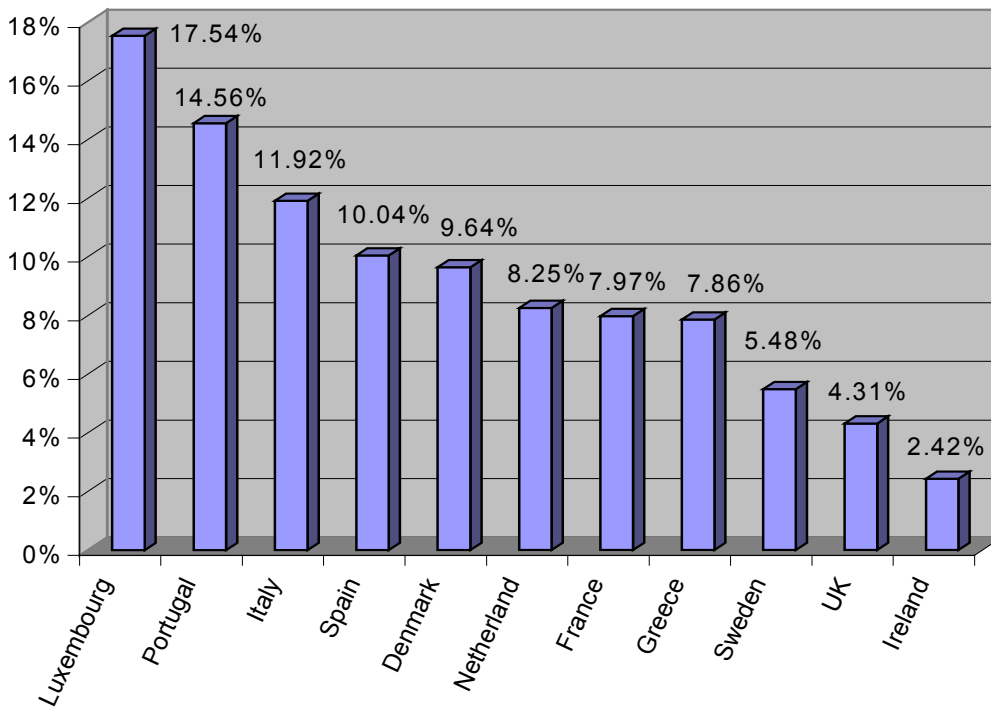
Table 16 shows, in fact, that the landscape described previously is appreciably modified. Three countries were far above the average Member State weight. In other words, for 11 countries, the average weight of each Member State in the European total should reach

⁽³¹⁾ We take into account the violations of drug laws as inventoried by our correspondents (see Table 2, section 2). We do not take into account the other offences that may have been committed while under the influence of drugs or in order to obtain an income to buy drugs.

⁽³²⁾ We follow the principle here that guides this report. We take the data furnished by the Member States being aware that they sometimes reveal different realities but without proceeding with re-classing which is the task of harmonisation of statistics of the EMCDDA.

9.1%. However, we see that Luxembourg, with a weight of 17.54% in Europe, Portugal (14.56%) and Italy near 12% (11.92%) were quite noticeably above the average share of 9.1%. Alone, they represented about 45% of the individuals imprisoned for drug-law offences, once the real figures are readjusted by the respective demographic weight. For its part, Spain was also above the average (10.04%), as was Denmark (9.64%), but in lesser proportions in comparison with the three leading countries. The other Member States were situated below this average share, with the Netherlands (8.25%) France (7.97%), Greece (7.86%), Sweden (5.48%), the United Kingdom (4.31%) and Ireland (2.42%).

Table 16 – Share of each country in the total number of individuals imprisoned for drug law offences in the EU (corrected by the demographic weight)



The analysis concerning law-enforcement expenditure related to drugs per problem user introduces evidence that, in the mid-1990s, three countries spent more than others: Germany, Belgium and the Netherlands. The second prism of analysis confirms this result: two of the three countries remained the main contributors to law-enforcement expenditure of the European Union (once the wealth figure is corrected).

To conclude, we observe how figures on police forces specialised in drugs, number of drug-related customs violations, number of imprisonments for drug-law offences, complete the understanding of the effort related to law-enforcement expenditure on drugs.

Public drugs expenditure – an overall comparison

Introduction

In this chapter, we first analyse the overall weight of public expenditure on drugs. Then we deal with the distribution on both sides (health care and law enforcement) and finally we compare individual countries' expenditure at EU level.

The weight of drug public expenditure in the countries of the Union

Following our calculations and examination of the total amount of public expenditure related to drugs in the 15 EU countries, a strong convergence emerges at the level of State financial commitment related to drugs. Expressed in percentages of Gross Domestic Product (GDP), public expenditure related to drugs generally represented about 0.05%. There is no aberrant figure, despite the constant high degree of uncertainty regarding the area of illegal drugs and the relative lack of figures for the countries considered.

Table 17 – Public drug expenditure in the European Union countries, in the Helvetian Confederation and in the United States of America

Country	GDP	Drug-related expenditure	As % of GDP
Belgium	221,860.0	286.2	0.13%
Germany	1,903,410.0	1,898.9	0.10%
Netherlands	347,033.0	262.9	0.08%
Spain	501,750.0	389.0	0.08%
Luxembourg	10,930.0	7.8	0.07%
Sweden	222,801.2	164.2	0.07%
UK	1,289,974.0	854.4	0.07%
France	1,293,853.0	798.7	0.06%
Greece	91,579.4	59.2	0.06%
Ireland	74,757.1	40.4	0.05%
Italy	978,400.0	516.5	0.05%
Finland	115,168.5	45.5	0.04%
Portugal	87,090.0	15.5	0.02%
USA	7,053,373.3	15,647.4	0.22%
Switzerland	234,998.2	202.4	0.09%

All figures are in € millions ⁽³³⁾.
Data is missing on Austria and Denmark.

It would appear quite logical that public expenditure concerning drugs would be all the greater when the country in question has a large number of problem drug users ⁽³⁴⁾. Public expenditure related to drugs would then translate into the States' awareness and action proportionate to the extent of the problem considered. However, given the figures in our possession, it is not possible to carry out a very sophisticated analysis. Moreover, we must consider the fact that several issues could influence the proportionality between public expenditure and extent of the problem: the level of tolerance towards some

⁽³³⁾ Euro conversion based on 07/31/2000 exchange rate for each national currency not in the euro zone (except for Luxembourg in ECU 1997) for GDP and public expenditure. All GDP are for 1999 (except Portugal 1998).

⁽³⁴⁾ Let us point out once again that although it is fairly certain that the offer of health care should be proportional to the number of problem users, the repressive commitment can be proportional to the number of users, or to the perception of the drug problem among the elite, or any other variable. So considering as good a public policy standard where the repressive commitment is proportional to the number of problem users may be perceived by certain readers as being an excessive normative drift.

patterns of consumption, the balance between health care and law enforcement, the size of the country and its public expenditure structure.

However, a rapid investigation shows that out of the twelve countries of the European Union for which we have enough information on prevalence and public expenditure data, there is a strong correlation between the amount of public expenditure related to drugs and the number of problem drug users. This means that these two variables are linked. Then, with the exception of Italy and Germany, a very rough reading of the data would underline that the Government effort is proportionate to the number of problem users ⁽³⁵⁾.

However, this first impression turns out to be wrong. The correlation between the amount of public expenditure related to drugs and the number of drug addicts is not as simple as it seems. Indeed, the two phenomena are linked, but the coefficient of correlation is weak ⁽³⁶⁾. If we carry out a causality test ⁽³⁷⁾, it appears that there is no causality link between public expenditure related to drugs and the number of drug addicts. In other words, the number of problem drug users does not explain the amount of public expenditure related to drugs. This result is very important as it demonstrates that the public financial effort engaged in facing drugs is not directly linked to the real condition of the drug problem from the very restrictive point of view of the prevalence rate.

Then, how can we explain the amount of public expenditure in the field of drugs in each country? Does this expenditure follow a clarified general rule that previous analysis could reveal? And why doesn't the amount of public expenditure related to drugs depend simply on the budgetary spending of the State in other fields?

In order to probe this idea more deeply, it is appropriate to test whether the share of drug expenditure in the overall budgetary expenditure is stable for each country.

⁽³⁵⁾ The prevalence data come from the 1999 report of the EMCDDA. We have tested the high and low hypotheses relating to the prevalence data.

⁽³⁶⁾ $R^2 = 0.54$.

⁽³⁷⁾ Pairwise Granger Causality Tests.

**Table 18 - Weight of public drug expenditure in the State budget
(European Union countries, Helvetian Confederation and the United States)**

Country	Total public expenditure	Drug-related expenditure	As % of public expenditure
Belgium	46,130.0	286.2	0.62%
Luxembourg	1,290.0	7.8	0.60%
Germany	361,340.0	1,898.9	0.53%
Greece	13,197.5	59.2	0.45%
Spain	85,510.0	389.0	0.45%
Ireland	9,453.2	40.4	0.43%
UK	239,222.2	854.4	0.36%
Netherlands	79,208.0	262.9	0.33%
Italy	174,600.0	516.5	0.30%
Sweden	55,152.7	164.2	0.30%
France	302,855.0	798.7	0.26%
Finland	23,995.7	45.5	0.19%
Portugal	16,250.0	15.5	0.10%
Denmark	38,161.4	n.a.	n.a.
Austria	36,542.6	n.a.	n.a.
USA	1,299,368.8	15,647.4	1.20%
Switzerland	35,656.9	202.4	0.57%

All figures are in € millions ⁽³⁸⁾.

At first glance, we notice that in the mid-1990s the countries of the Union dedicated a varying portion of their budget, depending on the country, from 1 to 6 ⁽³⁹⁾.

It was predictable that in general the State's rate of expenditure largely explains public expenditure specifically dedicated to drugs. The more a country invests in overall public expenditure, the more it spends on drug-related problems. However, this apparently commonplace result shows that public drug expenditure is trivialised and follows quite naturally the trend of the State's commitments.

The analysis shows that the demographic weight also plays an important role. The larger a population, the more the cost of control and medical care and, in consequence, the higher the level of public drug expenditure. On the contrary, the country's wealth is an explanatory factor but negatively fits in with an explanation of the drugs budget. This means that it is as if a rich country does not adapt its drug budget to its wealth and this in comparison with the poorer countries.

In conclusion, it seems that the amount of public drug expenditure for a given country does not rely on the prevalence rate, or on the country's wealth, but depends on its population and on the size of the State's budget.

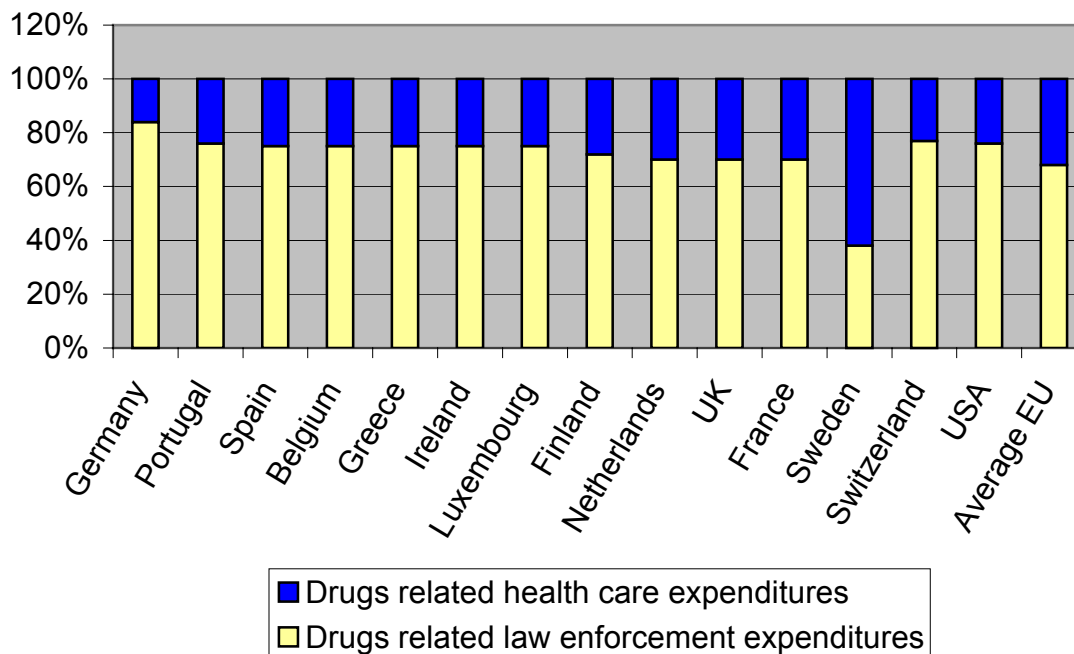
Health care versus law enforcement

We now divide (for simplicity and calculation) the budget devoted by the countries of the European Union to deal with the drug phenomenon between two main facets: law enforcement and health care.

⁽³⁸⁾ Euro conversion based on 07/31/2000 exchange rate for each national currency not in the euro zone (except for Luxembourg in ECU 1997) for GDP and state expenditure. All State expenditure and GDP are for 1999 (except Portugal 1998).

⁽³⁹⁾ $6 \times 0,1 = 0,6$.

Table 19 - Functional distribution of public expenditure in the field of drugs



Despite a certain number of differences, the countries of the Union have in fact quite a similar policy for the allocation of resources in the field of drugs. Here we have to remind you that the law-enforcement figure can be influenced by the statistical uncertainties linked to the data-collection patterns. Law-enforcement budgets are in fact more centralised and therefore more retrievable than health related ones, but also because good justice and imprisonment policies are rather costly.

However, having mentioned these limitations we can assume from the data processed in this research that globally between 70% and 75% of the budget goes for law enforcement and the rest for health care. Germany stands alone in devoting a larger part of its drug budget to law enforcement than the Union average. Sweden distinguishes itself by attaching a more marked priority to health care. On the contrary, France and the Netherlands, where the different choices in the field of drug law enforcement have been largely commented on, similarly allocated their State expenditure related to drugs among the two principal domains: law enforcement and health care. Similarly, the country's wealth did not seem to influence the distribution of its efforts between law enforcement and health care. Greece and Finland were characterised by analogue percentages.

Anyway, is it right that the countries of the Union make approximately the same choices in allocating their drugs budget between law enforcement and health care? Is it true that the United States is a country devoting so much to the 'war on drugs'?

In fact, drug policy and notably the corresponding public expenditure has to be compared to the target population, in this case the number of problem drug users. Those who, most likely, will have minor or serious health problems caused by the use of drugs and who come into contact with the criminal justice system.

If we divide the public drug expenditure dedicated to law enforcement and to health care by the number of problem drug users, we obtain the drug expenditure per capita. The following table examines the distribution of resources between law enforcement and health care, per capita: columns indicate the number of problem users and the drug expenditure for law enforcement and for health care per capita.

Table 20 – Functional distribution of public expenditure (€) in the field of drugs per problem user

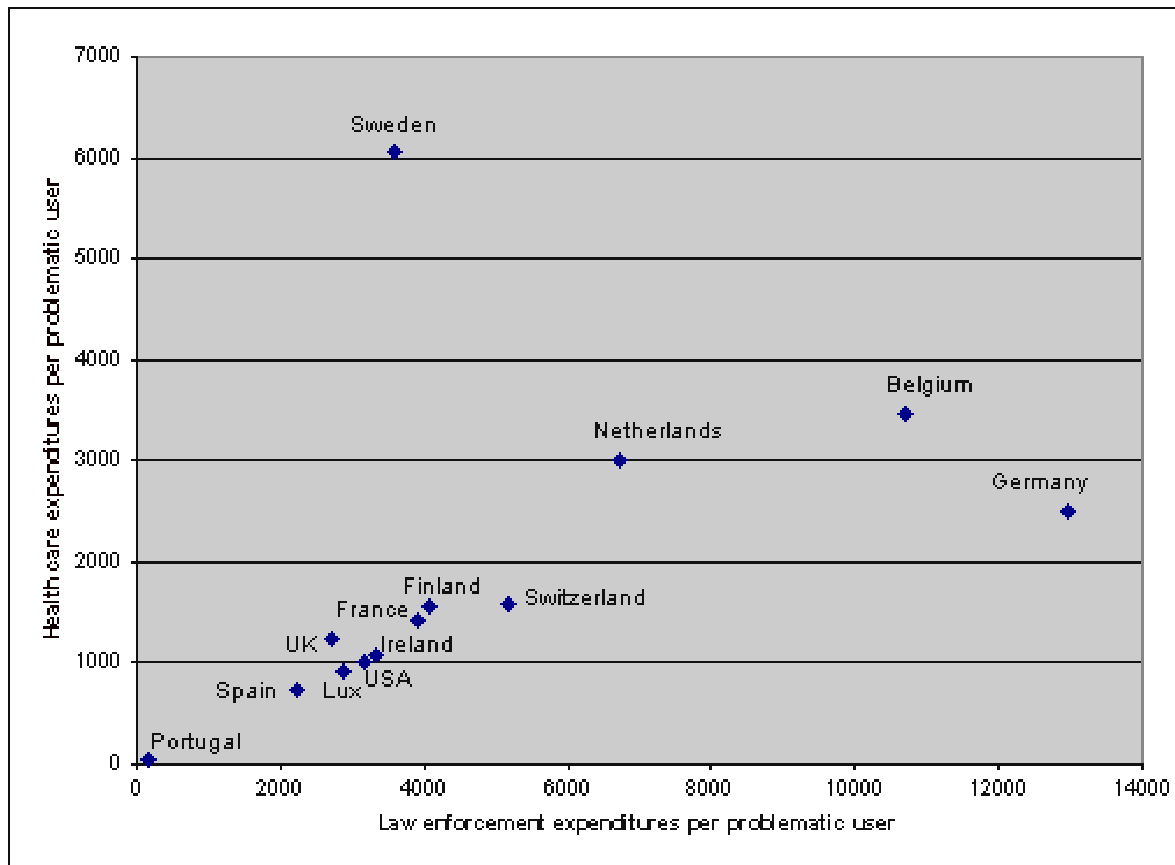
Country	Number of problem users (average hypothesis)	Public expenditure for law enforcement per problem user (average hypothesis)	Public expenditure for health care per problem user (average hypothesis)	Total expenditure per problem user (average hypothesis)
Germany	122,712	12,964.5	2,509.9	15,474.4
Belgium	20,200	10,698.0	3,470.3	14,168.3
Netherlands	27,000	6,740.7	2,996.3	9,737.0
Sweden	17,000	3,600.0	6,058.8	9,658.8
Finland	8,050	4,087.0	1,565.2	5,652.2
France	150,000	3,903.3	1,421.3	5,324.6
Ireland	9,168	3,327.0	1,079.9	4,406.9
UK	215,162	2,724.5	1,246.5	3,971.0
Luxembourg	2,050	2,878.0	926.8	3,804.8
Spain	130,864	2,244.3	728.2	2,972.6
Portugal	70,000	167.1	54.3	221.3
Italy	249,000	na	2,074.3	na
USA	3,750,266	3,165.0	1,007.4	4,172.4
Average EU	1,122,664	(1) 4,848.6	(2) 2,011.0	(1) 6,853.8
Switzerland	30,000	5,166.7	1,580.0	6,746.7

Sources: The public drug expenditure comes from our study and the prevalence data from the 1999 report of the EMCDDA. The Portuguese and the American data come from the UNDCP. (1) = (total / 11); (2) = (total / 12). Data is missing on Greece, Austria and Denmark.

A more visual approach to the situation is provided by a presentation with a cloud of points (see Table 21). We see that six countries of the Union had, in the mid-1990s, an identical drug expenditure profile (France, UK, Spain, Ireland, Finland and Luxembourg). Not only was the distribution in percentage of drug expenditure between law enforcement and health care kept within the norms (70% - 30%), but also the drug expenditure per capita were very close.

The result is logical, among others for France and the United Kingdom. These two countries presented in general very similar macroeconomic data and this is reflected also in the field of drugs. The fact that Ireland, Luxembourg and Finland belonged to the same group underlines that, independently from their wealth per capita, or from their size, these countries followed an implicit standard for law enforcement as well as for health care.

Five countries deviate from the norm. Belgium divided its drug resources between law enforcement and health care in a classical manner (75% - 25%), but spend more per capita than the standard for law enforcement (x2.2) and for health care (+72.57%). This recalls the fact that this country invested much more than the European norm to tackle the drug problem. As for Portugal, if its resources divided between law enforcement and health care followed the European trend (75.5% - 24.5%), we notice a very definite weakness in the drug resources allocated per problem user, not only for law enforcement (29 times less than the European average) but also for health care (37 times less than the European average).

Table 21 – Functional distribution of public expenditure (€) in the field of drugs per problem user

Two countries had a relatively similar configuration: Germany and the Netherlands. These two countries, like Belgium, stressed law enforcement. Clearly for Germany which devoted 84% of its drug resources to law enforcement, against 70% for the European average, less clearly for the Netherlands which divided its drug budgets according to the usual key of (70% - 30%). However like Belgium, Germany and the Netherlands spend more per capita than the European standard in law enforcement (2.67 times more for Germany and 1.4 times more for the Netherlands). However this repressive effort was not made at the cost of health care, as these two countries, like Belgium, exceed the European standard.

Sweden was the last exception. This country clearly emphasised the health-care facet (62% of the drug budget versus the usual 30%). The effort on health care was exceptional, three times more than the European standard. This effort was not accompanied by a too weak investment in the drug law-enforcement side (just 1.39 times less than the average), was close to the French figure and above countries such as the United States and the United Kingdom. This situation recalls that the overall drug budget of Sweden was slightly superior to the European average, and allowed this country to finance health-care effort in the field of drugs without restraining the amount allocated to drug-related law-enforcement expenditure.

Finally, given that we have data available we also report on Switzerland. The policy in the field of drugs led by this country slightly exceeded the European standard. Indeed, if

in terms of distribution of drug resources between law enforcement and health care, the Swiss configuration appeared to conform to the standard of the European Union (76.6% - 23.4%), on the contrary, this country spent slightly more per capita than the norm in the field of law enforcement (x1.1) but less for health care. This country was ahead of countries such as France and the United Kingdom in terms of drug law-enforcement expenditure and health-care expenditure dedicated to drugs.

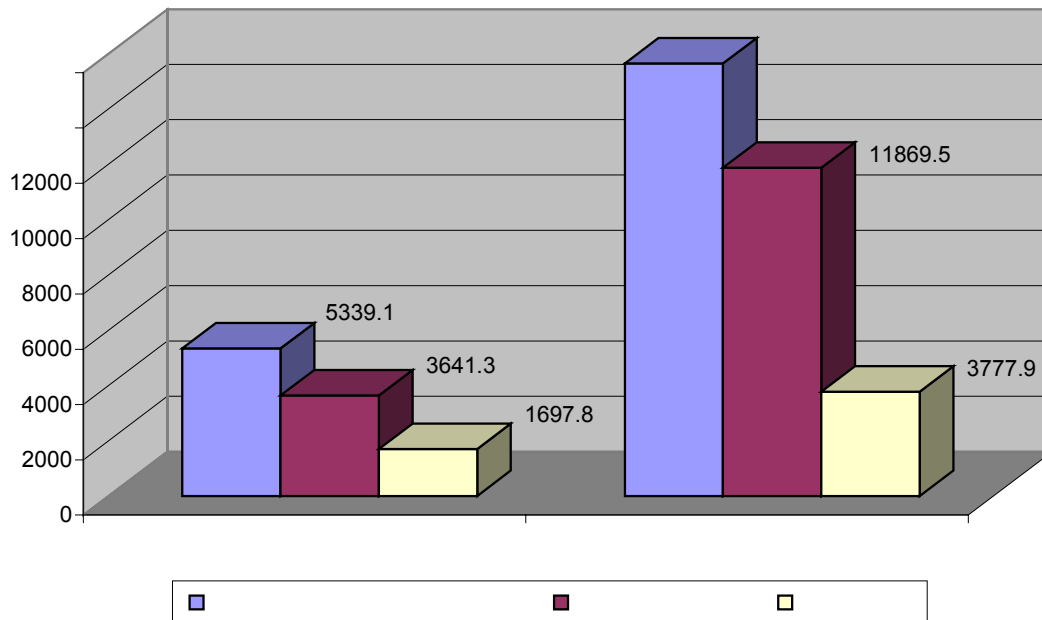
United States versus European Union

The major surprise of the analysis lies in the comparison between the United States and the countries of the European Union. The American public drug expenditure per problem drug user was quite moderate. In the end, the United States turns out to spend less per problem user, in the mid-1990s (4,172.4 euro) than the average of the countries of the European Union (6,853.8 euro). In comparison with the United States, 'the average country' of the European Union spends 1.53 times more for law enforcement per problem user and twice as much for health-care costs per problem user. In total, the average EU country spends 1.64 times more per problem user than the United States.

It appears that the United States was characterised by a public drug expenditure structure very different to that of the European Union: 76% of the drug budget was dedicated to law enforcement against only 24% to health care, compared to 68 and 32% for the European Union. This result is not surprising at all. The international scientific literature has largely underlined the particularity of the North American choice. However, it is necessary to note that the large share dedicated to law enforcement reflects the action of several variables specific to the American situation. First, the extent of the drug problem was far greater in the USA than in Europe, notably at the beginning of the nineties. Second, the imprisonment policy practiced in the United States generated a higher cost. Third, it is probable that the unit cost of imprisonment increased more quickly than the increase of the national wealth. Fourth, the United States had suffered from a shortage of imprisonment cells that may have increased the unit cost of imprisonment. Fifth, the operating cost of the American judicial system was probably quite high. In consequence, the judicial process and imprisonment could be expensive in the United States and could be applied to a large population as the prevalence is high and also as the policy in criminal matters requires it. North America could then dedicate large sums to law enforcement in the field of drugs because of its operating costs and its choices of public policy.

The choices of drug budgetary allocations within the European Union considerably differ from those observed in the United States. Table 22 below illustrates in a particularly clear manner the differences in structure between the European and the North American 'drugs budgets'. Indeed, the drug budget of the United States reached 15,647.4 million euro, i.e., more or less three times more than the 'budget of the European Union'. In total, the European Union spent 5,339.2 million euro for a population of 375.3 million people while the United States spend 15,647.4 million euro for 263.2 million people.

Table 22 – Comparison of the drug-related expenditure between Europe and the United States



These results do not, however, give a precise idea of the differences between the European Union and the United States. The following table (table 23) shows EU and US data in detail (row a). Row b shows that the United States spent about 3.6 times more per inhabitant in the field of drugs than the European Union, devoting sums approximately 3.7 times higher for drug law enforcement per inhabitant and 3.1 times more than the Union for drug health care. Row c is where we consider the correction of the figures by the demographic and wealth weights between the two regions.

After correction, to enable comparison, it can be seen (row d) that the United States spend 2.6 (and no longer 3.6) times more per inhabitant on the fight against drugs than the European Union ⁽⁴⁰⁾. The law-enforcement budget was 2.8 (and no longer 3.7) times higher than that of the European Union, whereas on health care the expenditure was 2.2 (and no longer 3.7) times more than the EU.

To further refine the calculation we now compare the data corrected by demographic and wealth weights (row c) with the target of the public measures: problem drug users.

This last comparison (row e), undoubtedly closest to reality, indicates that the European Union's budget per problem drug user was 2.04 times higher than that of the United States.

⁽⁴⁰⁾ This result is obtained by converting the US data already given in Table B.2, Annex 1, to a size and wealth comparable with EU. Account must be taken of the fact that data are not available for all the European countries, and that we do not always have data on repression and treatment in countries for which we have other data.

Table 23 – Comparison of anti-drug expenditure per capita between the United States and the European Union (€ million)

		EU (2)	USA	Ratio (Usa=x E.U)
	Population	375.3	263.2	-
a. Gross figures	Overall drug expenditure	5 339.2	15 647.4	x 2.90
	- drug law-enforcement expenditure	3 641.3	11 869.5	x 3.25
	- drug health-care expenditure	1 697.9	3 777.9	x 2.22
b. Gross figures per capita	Drug expenditure per capita	16.6	59.5	x 3.60
	- drug law-enforcement expenditure per capita	12.0	45.1	x 3.75
	- drug health-care expenditure per capita)	4.6	14.4	x 3.10
c. Figures corrected for differences in wealth and demography	Overall drug expenditure	5 339.20	14 190.02	x 2.66
	- drug law-enforcement expenditure	3 641.30	10 366.47	x 2.85
	- drug health-care expenditure	1 697.90	3 823.55	x 2.25
d. Figures corrected for differences in wealth and demography, per capita	Drug expenditure per capita	16.6	44.63	x 2.68
	- drug law-enforcement expenditure per capita	12	34.07	x 2.85
	- drug health-care expenditure per capita	4.69	10.57	x 2.25
e. Figures corrected for differences in wealth and demography, problem drug users	Drug expenditure by problem drug user	6 378.09	3 132.34	: 2.04
	- drug law-enforcement expenditure by problem drug user	4 715.45	2 390.85	: 1.97
	- drug health-care expenditure by problem drug user	1 662.64	741.48	: 2.24

The data available for the EU do not cover the same countries for health care and for law enforcement. The law-enforcement data correspond to a population of 304 million inhabitants and the health-care data to a population of 361 million.

Anti-drug expenditure = EU law-enforcement expenditure + EU health-care expenditure. Law-enforcement expenditure = (Swe + Bel + Ire + Spain + Port + Fra + UK + Neth + Lux + Ger + Finl + Gre). Health-care expenditure = (Swe + Bel + Ire + Spain + Port + Fra + UK + Neth + Ita + Lux + Ger + Finl + Gre).

Therefore, when one compares the United States and the European Union under the best possible technical conditions (bearing in mind the lack of data), it emerges clearly that the European Union spent more on law enforcement (1.9 times more) and on health care (2.2 times more) than the United States.

Weight of public expenditure on drugs

Drug policy is indeed a national matter, but notably in the field of law enforcement, the investments of some countries modify the effectiveness of the investment of other countries. The matter is all the more complex given the fact that a number of countries, investing much in law-enforcement activities urge some drug traffickers to try to force the weakest links in the European chain.

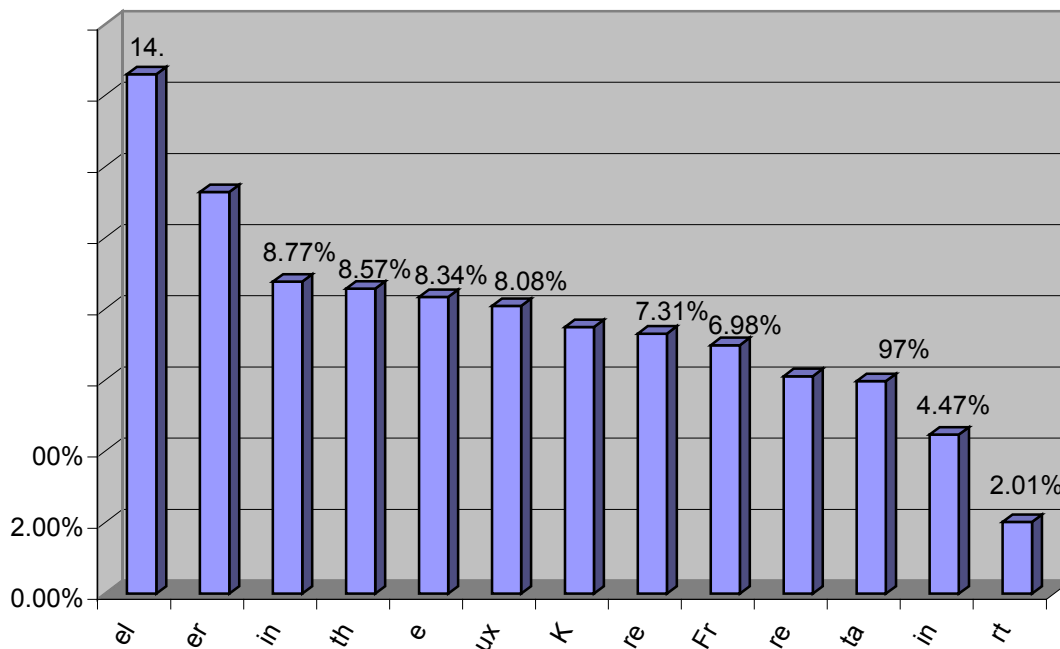
It is possible to throw some light on these questions by calculating the overall amount of drug expenditure in the 15 countries of the Union and by examining the share of each country in this expenditure, this means the ratio of each Member State in the hypothesis of the European law-enforcement public expenditure.

So, in order to compare the 'real' effort of each country in the field of public drug expenditure, the adjustment by the weight of each country in comparison with Germany seems essential in our view. In fact, with the same economic weight, all the 13 Member States studied should contribute identically (7.7%) towards the whole of European anti-drug public expenditure.

In this case, Belgium had the largest contribution to the European total with 14.6%, followed by Germany 11.2%, Spain 8.7%, Sweden 8.3% and Luxembourg 8%. All these countries contributed more than the average contribution of 7.7%.

A second group of countries, composed of the United Kingdom 7.4% and Greece 7.3%, was near this average contribution.

Table 24 – Share of each EU country in the total of European drug-related public expenditure (corrected by GDP weight)



The third group of countries was composed of France 6.9%, Ireland 6.1% and Italy 5.9%, while Finland's 4.4% and Portugal's 2% contribution was far away from the EU average.

This classification confirms our previous notes. The large rich countries of Northern Europe where the welfare system is well developed contributed intensively to the total expenditure in the field of drugs of European countries – Belgium, Luxembourg, Germany, Netherlands, and Sweden joined by Spain. The Southern countries of Europe, France, Italy, and Portugal, contributed less than the average towards the total expenditure of European countries, as did Ireland and Finland ⁽⁴¹⁾.

⁽⁴¹⁾ Finland constitutes a particular case, which may be created by a statistical aberration in the gathering of the data or by the size of the country.

Conclusions

In putting forward some final conclusions, we first of all have to acknowledge that this research has been based only on data existing in 2000. Therefore the lack of figures in certain sectors and countries has been overcome with estimations based on the available data. Accordingly, it would be very hard to conclude with scientific rigour what the exact expenditure of EU countries on drugs is on such a weak basis. However, the task is not impossible and the EU drugs action plan can be answered positively if data are calculated with uniform rules at national level and a routine system of data collection is established.

Nevertheless, this research reveals the benefits of comparing the views held by many on the European public anti-drug policies with the budgetary decisions made by Member States. The volume of public spending alone does not of course sum up a country's public policy. Nonetheless, three important conclusions can be drawn from these new elements.

Firstly, if one scrutinises the nature of the differences between the European countries, it appears that four of them spent substantially more than the European theoretical average (once GDP differences had been corrected): Belgium, Spain, Sweden and Luxembourg. Only in Sweden and Belgium did this input translate into a higher than 'average EU budget' per problem drug user. In view of the large number of problem drug users, Spain and Luxembourg were forced to spend so much that they came close to the average budget per problem drug user. In the future, these two countries will have to bank on either a drop in the number of problem drug users or an increase in their public anti-drug budgets if they are to fall within the theoretical norm for expenditure in the European Union.

Conversely, Germany and the Netherlands (and Switzerland) manage to spend more per problem drug user than the European Union's theoretical average, even though their level of public anti-drug spending lies below the EU average. A lack of real budgetary constraint is presumably what enables Germany and the Netherlands (and Switzerland) to spend more per problem drug user than the European norm.

It therefore appears that the amount spent by EU Member States on each problem drug user may be the result of a difficult decision made under the harsh constraint of scarce resources. The decision may, on the other hand, be made under less circumspect circumstances where the relative abundance of resources available for public spending allows for a fairly generous policy. This point is an important one, since it puts into perspective the difficulties faced by each country, in aligning itself with the European expenditure norm bearing in mind its size and wealth and the number of problem drug users. Ultimately, it points out that certain countries can afford original policies if they have relatively favourable public finances.

Six countries of the Union had an identical expenditure profile (France, UK, Spain, Ireland, Finland and Luxembourg). Not only is the percentage distribution of drug expenses between law enforcement and health care kept within the norms (70% - 30%), but also the expenses per capita were very similar. The fact that Ireland, Luxembourg and Finland belong to the same group emphasises that, independently from their wealth per capita, or their size, these countries followed an implicit standard for law enforcement as well as for health care in the field of drugs.

Five countries deviated from the norm. Belgium divided its drug resources between law enforcement and health care in a classical manner (75% - 25%), but spends more per capita than the standard for law enforcement (x2.2) and for health care (+72.57%). This reminds us that this country invests much more than the European norm to face the drug problem. As for Portugal, if its resources for law enforcement and health care followed the European trend (75.5% - 24.5%), we notice a very distinct weakness – during the 1990s - in the drug resources allocated per problem user, not only for law enforcement but also for health care. Concerning Germany and, to a lesser extent, the Netherlands, these two countries, like Belgium, stressed law enforcement. This is clear for Germany which devoted 84% of its resources to law enforcement, (the statistical reserve must be taken into account) compared to 70% for the average European, less obvious for the Netherlands which divided their budgets according to the usual key of 70% - 30%. However like Belgium, Germany and the Netherlands spend per capita more than the European standard in drug-related law enforcement (2,67 times more for Germany and 1,4 times more for the Netherlands). However, this effort in law-enforcement expenditure was not made to the detriment of drug-related health care, since these two countries, as did Belgium, exceed the European standard.

Sweden was the last exception. This country clearly emphasised the drug-related health-care facet (62% of the drug budget vs. the usual 30%). The effort for health care was exceptional, three times more than the European standard. This effort was not accompanied by a too weak investment in the law-enforcement side (just 1.39 times less than the average), was close to the French norm and above-mentioned countries such as the United States and the United Kingdom. This situation reminds us that Sweden's overall drug budget was slightly superior to the European norm, and allowed this country to finance the health-care effort without restraining law-enforcement expenditure to compensate for it.

Finally, regarding Switzerland, this country's policy slightly exceeded the European standard. Indeed, if in terms of drug resources divided between law enforcement and health care, the Swiss configuration appears to conform to the EU standard (76.6% - 23.4%), on the contrary, this country spent slightly more per capita than the norm in the field of law enforcement (x1.1) but less for health care. This country was ahead of countries such as France and the United Kingdom in terms of drug-related law enforcement and health care. In comparison with the United States, Switzerland spent 1.63 times more for law enforcement per problem user and 1.57 more for health care per problem user.

Secondly, this report firmly places the idea into perspective that the United States spends very sizeable sums against drugs. Certainly, if we look at the volume of US public spending on drugs, one cannot help being struck by the amount: EUR 15.6 billion, as opposed to EUR 5.3 billion for the European Union. We must however be careful as we do not have all the figures for Europe and, above all, the size and wealth of the European Union is different than that of the United States. Thus a comparison can only be made once the demographic and wealth differences between the two regions have been corrected.

Once this recalculation has been carried out, (i.e. once US public spending has been expressed in a common unit of size and wealth, and once account has been taken of the fact that some European data is lacking), it becomes visible that the United States spent 2.66 times more than the European Union to face the drugs phenomenon.

Careful examination however leads us to consider that a correct comparison of public spending must take into account the true scale of the drug problem. Indeed, drug budgetary expenditure in the European Union and the United States is determined not only by wealth and size, but also by the extent of the problem. It is for this reason that we compare European and US public spending per problem drug user. We then find that the European Union's expenditure per problem drug user was twice as high as that of the United States.

A coherent interpretation is obtained by bringing together these two angles of comparison. The United States spend (in comparable data) more than the European Union, but given the scale of the drug problem in that country, spent a smaller sum than did the EU for each problem drug user. This impression is borne out when we detail how the drug budget is divided between health care and law enforcement. When the two regions' drug budgets are corrected by economic and demographic weights, the United States spent 2.85 times more on drug-related law-enforcement than the European Union and 2.25 times more on drug-related health care.

Nevertheless, where this data relates to problem drug users, the drug law-enforcement budget was 1.97 times larger in the European Union than in the United States, and the drug health-care budget 2.24 times greater. It therefore appears obvious that, in relation to the scale of the drug problem in Europe, and when looked at in terms of the number of problem drug users, the European Union invested more than the United States in these two areas of drug policy: health care and law enforcement. Whereas many observers will no doubt agree with the first assertion, they are likely to be surprised by the latter.

Thirdly, this inter-regional comparison, European Union versus United States, is interesting, but masks certain variations within the EU. Whether it is a question of overall budget or expenditure per problem drug user, calculating a European average could hide some major differences existing from one country to the other.

It can be seen that although the US profile of public spending on drugs differed notably from the average European profile, it resembles that of a group of countries comprised of France, the United Kingdom, Spain, Ireland, Switzerland and Finland. The United States spend approximately the same sum per problem drug user as does this group of countries. Furthermore, the United States share out their drug expenditure between health care and law enforcement in much the same way as these countries do.

On the other hand, a real difference exists between the above-mentioned group of countries (USA, France, United Kingdom, Spain, Ireland, Switzerland, Finland) and the group comprised of the Netherlands, Belgium and Germany, which spend far more per problem drug user, while distributing their drug budgets between health care and law enforcement in more or less the same manner. Portugal appearing with a low level of public commitment, and Sweden with a very high level, are exceptions to the norm.

Decisions on resource allocation therefore differ not so much between the United States and Europe as between one group of European countries that invests heavily facing the drug problems and another group of countries, to which the United States can be added, whose spending is more modest.

Let us attempt to expand on this remark by taking a closer look at the breakdown of drug public spending for law enforcement and health care.

We shall begin with drug-related law-enforcement expenditure. We have seen surprisingly that once the sums spent on drug law enforcement in the United States are related to the number of problem drug users, they fall below the EU average. Care should be taken not to misinterpret this finding. This certainly does not mean that the United States are less 'repressive' or more 'repressive' than the average EU country, but that by European standards the budget per problem drug user was lower. How should we interpret this? Firstly, it may well be that the resources earmarked by the United States to manage the prison population are below the European average. If so, either the inmates had harsher conditions of detention, or the United States were becoming more efficient at prison management, which means that they were able to offer good detention conditions at a lower cost than in Europe. Secondly, it is equally possible that, in view of the scale of the drug problem, the funds spent on law enforcement were quite simply insufficient. No doubt, this question merits some comparative analysis.

The drug-related health-care budget is equally interesting. It is true that the United States spend less on the health care of a problem drug user than the European Union. Despite this, they still spend more than France, Switzerland, Luxembourg, Ireland, the United Kingdom, Spain and Portugal, and slightly less than five countries: Sweden, the Netherlands, Belgium, Germany and Finland.

It therefore emerges fairly clearly from the comparison between the United States and the European Union that the discrepancy in public spending profiles confirms not so much a continental divide between two models but, rather, that several models co-exist on this side of the Atlantic and that one of them is quite similar to the one prevailing in the United States.

Final considerations

From the work carried out during this research, despite the methodological constraints, we can perceive the usefulness for decision makers of an eventual indicator of public drugs expenditure as an element of assessment of national drugs policies. Thus, such indicator would enable us to have a more exact photograph of national commitment in the field of drugs, allowing public power to be optimised.

The work carried out by this research suggests the following considerations:

- Although the study reveals some interesting figures and comparisons, promoting reflection in this field, we have to recognise the fact that data are very poorly available or uniform to respond with scientific rigour to the EU action plan on drugs which requests that '*a list of all public expenditure related to drugs in the EU countries*', should be produced.

For an accurate answer to this question, it is necessary to implement a system of data-gathering in the different countries which would allow the statistical gap to be filled through a routine data collection system. Prior to this, a uniform methodology for data collection and analysis should be agreed among Member States. The EMCDDA and the Reitox network of focal points are actively engaged in performing this task.

- Knowing the level of public expenditure is certainly important to assess government efforts against drugs, but it represents just a part of the economic studies that should also concern the social cost of drugs. Therefore it would be desirable to widen the socio-economic knowledge of the consequence of drugs on the society through launching a project to calculate the social costs of drugs in the countries of the European Union.

Annexes – sources and figures

Annex 1 – Sources

In order to carry this study through to a successful conclusion, we have contacted various scientific correspondents in the European Union. We report here the results of our data collection and we emphasise the limitations of the latter.

The indications presented below correspond to the remarks made by the various correspondents contacted during the study, when the questionnaire they received was sent back.

AUSTRIA

No data has been gathered concerning Austria, despite various contacts.

BELGIUM

Concerning Belgium (1997), and according to J.M. Tecco, O. Le Bon, P. Kopp, L. Joris, P. Verbanck, I. Pelc. 'Le coût de la prise en charge des usagers de drogues en Belgique, The cost of addiction care in Belgium', *Acta Psychiatrica Belgica* 100 (3) May/June 2000 pp.105 –117.

- the police services' budget is divided between the personnel costs (60,681,851,270 Belgian Francs), the operating costs (5,878,325,143 BEF) and the investment costs (3,758,154,231 BEF). Apart from this, police manpower is divided between 18,745 local police officers, 15,929 gendarmes and 1,440 judicial police officers.
- Concerning questioning for drug matters (1996 figure), a distinction has been made between the questioning for drug possession (13,812), for drug import, export, fabrication and trafficking (8,362) and a category called 'miscellaneous' (1,588). As for the justice budget (1998 figure), it corresponds to a total including costs generated by personnel, buildings and equipment.
- Finally, for the 'Social Health Care and Prevention' point (points 2 and 3 of the questionnaire) a global figure has been given. This figure does not make the distinction between 'Social and Health Care' on the one hand and 'Prevention' on the other hand.

Moreover, we must mention that an unestimated part (equal to X) aimed at medical care of drug addicts in the budgets allocated to 'Mental health' up to 3,350,000,000 BEF should be added to the estimate of 280,000,000 BEF.

DENMARK

Concerning Denmark (1997), the police manpower figure includes all the security forces. On its own, the police consists of 10,034 officers. Concerning the questioning lines, the figures refer to the year 1997. Similarly, the number of customs officers for border control is made up on 01/01/1998. As for the 'Budget of the criminal-justice system', it consists of the 1997 figure. Finally, the points dealing with the number of people imprisoned for drugs and with the total number of people imprisoned referred to, the figures were made on 11/11/97. Source: National board of health, Copenhagen and EMCDDA Report 1998.

FRANCE

The figures mentioned in Table 3 are taken from the 1996 report of the M.I.L.D.T. and from the 1999 study of the O.F.D.T. On this point the table below gives the social cost of drugs in France allowing assessment of the gap between the two types of approach.

France: Synthesis of the expenses generated by drugs (in millions of francs)

	Social cost
Consumption	14 to 25,000.00
Health-care expenses	1,524.51
For: - AIDS	924.51
- Subutex	600.00
Public administration expenses	4,855.08
For: - justice	1,557.68
- customs	552.54
- gendarmes	469.67
- police	1,260.71
- social affairs, health care and city	798.75
- MILDT	45.36
- National education, higher education, research	56.01
- Youth and sport	17.08
- Foreign affairs	21.20
- Co-operation	44.40
- contribution of France to the EU drug budget	30.87
- Labour, Employment and professional training	0.81
Losses in incomes and production	6,099.19
For: - loss of income of private agents	1,774.73
for: - <i>medical cause of death (AIDS and overdose)</i>	205.39
- <i>imprisonment for OLD</i>	1,569.34
- <i>imprisonment for other crimes and offences</i>	not av.
- <i>hospitalisation</i>	not av.
- loss of production in the work place	4,324.46
for: - <i>medical cause of death (AIDS and overdoses)</i>	646.88
- <i>imprisonment for OLD</i>	3,677.58
- <i>imprisonment for other crimes and offences</i>	not av.
- <i>hospitalisation</i>	not av.
Loss of compulsory taxes	866.24
For: - medical cause of death (AIDS and overdoses)	100.25
- imprisonment for OLD	765.99
- imprisonment for other crimes and offences	not av.
- hospitalisation	not av.
Privately funded associations	n.a.
Other costs borne by private agents	5.26
For: - fines	5.26
- other penalties linked to OLD sentences	not av.
- lawyers costs	not av.
TOTAL (1) =	27,350.28
	to 38,350.28
TOTAL (2) =	13,350.28

(1) Total including the expenses of agents linked to tobacco consumption.

(2) Total excluding the expenses of tobacco consumption.

FINLAND

For Finland, data has been collected thanks to Ritva Hein, member of the Stakes (National Research and Development Centre for Welfare and Health). Unfortunately, these figures correspond to an estimation of the social cost of drugs and not to public expenditure strictly speaking. This causes an effect of over-evaluating the data presented here in comparison with the data of the other Member States of the European

Union which only takes into account public expenditure. If we confine ourselves to the costs directly associated with drug consumption, we may put forward the following data:

Finland: costs linked to drug consumption (millions of Finnish Marks, FIM)

	Minimum	Maximum
Health costs	74.7	136.6
Social costs	291.3	325.0
Control of criminality	195.6	279.2
Public awareness measures, research and control	20.0	22.0
Damage to property	27.7	138.3
Total	609.3	901.1

GERMANY

According to Mr Roland Simon, Director of the Institute for Therapy Research Parzivalstraße, 25 DE - 80804 Munich 'EMCDDA National Focal Point for Germany' there has been no national initiative to calculate a 'drug budget' over the last years. The federal structure as well as the integration of many drug-related costs in 'normal' budgets in health and social care and enforcement makes this a very difficult task. Both areas are the responsibility of the Federal Länder, which means that we have 16 budgets for each area of expenditure (health and law enforcement) plus a national budget. Nevertheless, the estimation of the public expenditure allocated to the fight against the consumption and the trafficking of illicit drugs, presented below, comes from Hartwig K. H. & Pies I. *'Rationale Drogenpolitik in der Demokratie'* J.C.B Mohr Tübingen, 1995.

The authors have taken into consideration the expenses related to the repressive mechanism, including expenses for police, justice and imprisonment. Then the expenses allocated to (medical) care of the drug addicts and the resources allocated to the prevention and research programs are in turn estimated.

Concerning the expenses related to the functioning of the repressive mechanism, the authors make the distinction between two types of expenses in the overall expenditure: those related to the repression of consumption, possession and trafficking of heroin and those linked to the fight against criminal activities revolving around heroin consumption (criminality, theft). In total, the following figures are put forward: As regards the police, and for an overall expenditure of 28,006 million (DM) in 1992, 480.4 million DM were allocated to the fight against trafficking and consumption of heroin (i.e., 1.715% of the total) and 1,288.3 million DM were allocated to the fight against criminal activities which might be necessary for the heroin addict to provide for his needs (i.e., an expenditure representing 4.6% of the overall expenditure). The total expenditure of the German judicial system reached 8,027 million DM in 1992. According the authors, 146.5 million DM were allocated to the treatment of cases dealing directly with trafficking and consumption of heroin and 369.2 million DM concerning the criminality attributable to heroin. Finally, as far as imprisonment is concerned, the expenditure reached 589.4 million DM linked to trafficking and consumption of heroin and 237.5 million DM for imprisonment linked to criminality related to heroin consumption.

For the public expenses relating to the health-care mechanism of drug addicts, the total amount reached, according to the authors, 602.4 million DM. These expenses are distributed between health-care services of the ambulatory sector (50.8 million DM), the detoxification institutions (490 million DM) and hospitalisation (61.6 million DM). Again

according to the authors, even if the figure of 602.4 million DM is a correct estimate of the public expenditure relating to medical aid for the benefit of the drug addict, it does not reflect the current situation, as the spreading of substitution therapies offered to drug addicts has increased since 1992.

As regards expenditure related to research and prevention, and although the effort on research and prevention concerning the fight against drug addiction is organised and financed largely by public authorities, it is nevertheless a fact that some private organisations participate. However, they evaluate the participation of the State and of its Länder, at 25 million DM.

Germany: summary table and overall public expenditure (in millions DM)

Expenses related to the repressive mechanism	3,111.6
- Consumption and trafficking	1,216.3
- Police	480.4
- Justice	146.5
- Imprisonment	589.4
- Criminality attributable to drugs	1,895.3
- Police	1,288.3
- Justice	369.2
- Imprisonment	237.8
Expenses related to the health-care mechanism for drug addicts	602.4
- <i>Care from the ambulatory sector</i>	50.8
- <i>Detoxification institutions</i>	490.0
- <i>Hospitalisation</i>	61.6
Prevention and research	25.0
Programme of aid for the developing countries	45.2
Total	3,784.2

Finally, to be complete, the study includes a final element: the participation of the German State in the program of financial aid granted to developing countries for the reconversion of plant farming from which drugs such heroin and cocaine are produced. This participation could have reached 42.5 million DM in 1992. It is however important to note that this expenditure, as well as that related to prevention and research, takes into account all illicit drugs and not only heroin.

GREECE

Concerning Greece, the data corresponds to the year 1999, with the exception of the number of people imprisoned for drug offences which dates back to 1997. It is necessary to note that all the lines dealing with the police correspond to an addition of three different categories: police, Port Police Corps, and Financial and Economic Crimes Offices. To simplify, the table below, compiled by the University of Mental Health Research Institute (UMHRI) 72-74, Vassilisis Sophias Avenue GR - 11528 Athens, institution – which provides the EMCDDA with the Greek focal point – gives the various elements for each category, with the exception of budgets.

1. LAW-ENFORCEMENT COSTS	
<i>1.1 POLICE</i>	
Police Manpower	45,000
Police Manpower specialising in the fight against drugs	1,200
Border-police Manpower (main task is the fight against drugs)	2,200
Legal actions for drug offences acted by the Police	7,014 (number of individuals charged 10,626)
Total number of legal actions acted by the Police	na
<i>1.2 PORT POLICE CORPS</i>	

Port Police Manpower	4,691
Legal actions for drug offences acted by the Port Police	166 (number of individuals charged 226)
Total number of legal actions acted by the Port Police	4,590
1.3 FINANCIAL AND ECONOMIC CRIMES OFFICE (FECO)	
Financial and Economic Office Manpower	1,452
Legal actions for drug offences enacted by the FECO	9 (number of individuals charged 15)
Total number of legal actions enacted by the FECO	518,764

Finally, it is necessary to note that the amount of 1,439.30 million euro listed in the line 'Budget of non-specialised institutions or cost indicators' corresponds to the budget of health-care expenditure. Source: University of Mental Health Research Institute (UMHRI).

ITALY

The difficulty in quantifying the costs of the fight against drugs and drug addiction in Italy is tightly interwoven with the incomplete and insufficient information available. This problem prevents us from estimating the actual amount of money the country spends in this sector. Moreover the sums invested in the activities connected with drugs cannot be determined as the funds allocated to Public Administrations cannot be subdivided in order to estimate the exact amount of money set aside for the different activities.

Some data concerning Italy is indicated in the following tables. They are considered as being indispensable for completing the information other European countries have provided by EDT research on drug addiction costs and specific research directed by Mrs Ariana Orasi, Rome University.

The data was collected by appealing to several sources and, primarily the Ministry of the Interior, the Ministry of Health, the Justice Department and the Central Administration for Anti-drug Services. The latter is an organisation composed of members of the State Police, the Carabinieri and the Customs Officers. The data was basically collected in 1998.

Italy: police forces

		Year	Source	
Total number of anti-drug actions	21,100	1998	Ministry of the Interior	
Number of people turned over to justice for infractions of the Law 309/90 on drugs	33,179	1998	Ministry of the Interior	Ratio: 4.1%
Total number of people turned over to justice	813,124	1998	Justice Department	
Number of arrests for people turned over to justice	23,577	1998	Ministry of the Interior	
Total number of police actions (State Police + Carabinieri + Customs Officer + Penitentiary Police)	not av.			

In this table we have inserted some information available at national level. It refers to the involvement of all the Police Forces (State Police, Carabinieri, Customs Officer and Penitentiary Police) in anti-drug use activities.

The first figure refers to the total amount of anti-drug actions carried out in 1998 by the four Police Forces involved. Then the number of people turned over to justice for infractions of the Law 309/90, the total number of people turned over to justice in 1998 together with the ratio existing between the two quantities, and the number of people turned over to justice and the number arrested are reported.

It would be useful to compare the total number of actions carried out by the Police Forces with the number of anti-drugs actions. Nevertheless this information is not available yet, though it should be available soon.

The number of police officers involved in these actions is not known either. This is principally due to the fact that these officers are not destined to be members of permanent staff taking part exclusively in anti-drugs actions over a long period of time. Therefore it has not been possible to estimate the total amount of the sum spent by the Police Forces in the fight against drug addiction.

		Year	Source		
Total number of anti-drugs actions carried out by the Customs Officers	4,652	1998	Ministry of Interior		
Total number of actions carried out by the Customs Officers	n.a.				
Total number of infractions occurring at the Customs Offices	5,734	1998	Finance Department		
Customs revenue dept. referrals to the Customs Department	18,886 (billion liras) (9,754 million euro)	1998	Finance Department		
Drug seizures carried out at the Customs Offices		1998	Finance Department		
	Marijuana	Hashish	Heroin	Cocaine	
(kg)	2,962	337	58	644	
National total quantity seized (kg)	38,786	15,413	706	2,144	

In the table above, the information referring to the Customs anti-drug actions is reported. The Customs Officers are Police Officers who control and carry out their activity at the Customs Offices. This is why the data concerning the anti-drug actions they carried out in 1998 are reported here. The total number of the Customs Officers is not yet available, so it cannot be compared with the number of anti-drug actions.

The total quantity of the different types of drugs seized at the Customs Offices compared with the total quantity of drugs seized at national level - both expressed in kilogrammes. - and the total number of law violations occurring at the Customs Offices in 1998 are also reported.

The Customs Offices budget includes figures referring to the EU revenues, to the State budget, to other financial sectors, to other Ministries and to local authorities.

Also in this case neither the number of the Customs Officers involved in anti-drug actions nor their cost have been established. It has been possible to subdivide the total amount of Customs revenues in order to learn the sum invested in the fight against drug addiction.

Italy: justice data

		Year	Source
Staff costs			
- Magistrates	1,671.8 billion Liras (863 million euro)		
- Administrative staff and technicians	2,602.6 billion Liras (1,344 million euro)		
- Penitentiary Police	2,215.7 billion Liras (1,144 million euro)		
Staff			
- Magistrates	8,813	1998	Justice Department
- Administrative staff and technicians	47,692		

- <i>Penitentiary Police</i>	41,436		
Financial appropriation of the Justice Department	9,896.93 billion Liras (5,111 million euro)		
Total number of proceedings for drug crimes	51,922		
Total number of proceedings	5,274,733		
Budget of penal justice	41,765,134 Liras (21,570 euro)		

For the Justice Department most of the problems are the same as the ones faced in the preceding sectors. In Italy there are no judges specifically appointed for proceedings concerning the production and trade of drugs or other crimes connected with drugs. Therefore it is not possible to know how many people working in the Justice Department are involved in drug addiction cases.

The national total number of the financial and human resources involved in the Justice Department is reported.

Moreover the total number of proceedings concerning the production and trade of drugs as well as facilitation of drug use and other crimes associated with drug addiction are reported. These are compared with the total number of proceedings in 1998.

For the penalty sector, the budget reported refers to all activities of the Department.

		Year	Source	
Total number of prisoners for violation of the law 309/90 art.73	17,216	1998	Justice Department	Product: L 3,837,945,66 4
Average cost for each prisoner	222,929	1998	Justice Department	(1,982,134 euro)
Total number of drug addicts imprisoned for violation of art. 73	6,800	1998	Justice Department	
Total number of drug addicts imprisoned for violation of other laws	6,767	1998	Justice Department	
Total number of prisoners	49,323	1998	Justice Department	
Budget of the Penitentiary Administration	4,477 billion L	1999	Justice Department	

The figure for the penitentiary Administration refers to funds set aside in the 1999 budget. In the Penitentiary sector data referring to the number of people imprisoned for violation of the law 309/90 art. 73, which concerns production, trade and sale of drugs, is reported. Moreover data referring to drug addicted people imprisoned for violation of art. 73 and for other crimes is reported. Thereafter the total number of prisoners is found.

By estimating the average daily cost for a prisoner, the average cost of all prisoners in violation of art. 73 has been approximately estimated.

Italy: health service data

		Year	Source
Total number of people treated in local care units	137,657	1998	Ministry of Health
Total number of local care units assessed*	518	1998	Ministry of Health
Total number of people treated in social-rehabilitation units	21,531	1998	Ministry of Interior

Number of social-rehabilitation units assessed**	1,282	1998	Ministry of the Interior	
Estimate of the total health cost of drug addiction in Italy	Approx 1,000 billion Liras	1998	Annual report to the Parliament on the state of drug addiction in Italy	
Staff assigned to public services for drug addictions		1998	Ministry of Health	
	Exclusively	Partially	Convention	Total
-Doctors	1,098	156	240	1,494
-Psychologists	875	128	145	1,148
-Social-health operators	2,742	317	165	3,224
-Administrative staff	535	139	101	775
-Total	5,250	740	651	6,641

* The structures having provided information on the characteristics of the people treated. The operating local care units are 554; ** These are the structures assessed in 1998 whereas the number operating is 1,344.

There is no national research in the health sector estimating the expenses covered by public and private agencies operating on drug addiction. Some research exclusively concerns the activity of local authorities, and that of Emilia Romagna and Veneto Regions are to be mentioned here.

Information about the people treated in the local care units and in social rehabilitation structures and the number of public and private structures assessed are reported.

By analysing the total costs of a local health-care unit, an estimate of the health expenses encountered by Italy in 1998 has also been reported.

IRELAND

As regards Ireland, the data concerning the police budget dates back to 1997 (Drug Misuse Research Division ; Health Research Board 73 ; Lower Baggot Street ; IRL - Dublin 2, EMCDDA Focal point and EMCDDA report 1998). Also the police manpower is a figure up to January 1998. At that time manpower specialised in the fight against drugs consisted of 50 members in a special unit called 'Garda National Drugs Unit' and 246 people in the national police. Although the number of people questioned for drugs is not specified, the number of prosecutions for drug offences in 1997 is available (4,156). The Customs budget is divided into the 'customs budget' itself and taxes. Nevertheless, the 'pensions and annuities' are excluded from this budget. For the operational budget of all penitentiary institutions (figure 1997), it includes the operating costs of the central stores and those of the training centre. Regarding the number of people imprisoned for drug, it should be noted that this information dates back to 1994, while the total number of imprisoned people is from 1997. The amount concerning actions on the international level represents Ireland's contribution to the UNDCP for 1997. Source : Drug Misuse Research Division Health Research Board and EMCDDA report, 1998.

LUXEMBOURG

For Luxembourg, the commentary on Table 1 provides some detail on certain appropriations. Thus, the police force consists of the police forces themselves (700 people) as well as the gendarme forces (486 people). As regards the police forces specialised in the fight against drugs, they are divided into 53 police officers and 17 gendarme officers, 9 of which work in the Special Drug Unit and 8 gendarme investigators. Aside from this it is specified that the number of interpellations for drug offence includes the number of those carried out by the police and the gendarmerie. Concerning the line named 'Statistics identifying which patients out of total admissions were treated for drug addiction', it is mentioned that the number of 160 expresses the

average number of people treated for drug use in hospital. As for the amount devoted to research, it concerns research in the fields of epidemiology, medicine, pharmacology and social sciences. The amount reported in Table 1 for action on an international level is divided into 0.41 million euro corresponding to the amount devoted to international action (including Europol - ECU, International conventions, Schengen, UNDCP and the Customs Co-operation Council) and 1.54 million euro funding the UNDCP project through the National Fund against the Drug Trafficking. Source : Administration of Health of the Ministry of Health (EMCDDA Focal Point Luxembourg).

THE NETHERLANDS

For the Netherlands, there is no special comment for Table 1. The only elements considered are those directly reported in the table. In other words, for 'interpellations for drug offences' and 'total number of interpellations', the data consists of the number questioned by the police and the customs services. Similarly, for prevention, the 'budget lines dedicated to the fight against drug consumption' and the 'agency budgets specialised in drug prevention' are included in the total given by the social and health services. Similarly, the monetary totals allocated to 'actions on an international level' are included in the previous amounts, with the exception of data furnished by the Trimbos Instituut Netherlands Institute of Mental Health and Addiction, Dutch EMCDDA focal point, where a study in terms of 'social cost' is available ('An Economic View on Dutch Drug Policy', D.J. Kraan, 1992). If we confine ourselves to the repression and health service aspects, the following data is available:

Police	266.0
Judicial services	19.0
- Offices of Public Prosecutors	7.0
- Judiciary	9.0
- Legal assistance	3.0
Penitentiary services	120.0
Total	405.0

Million Guildens

Clinics and departments of psychiatric hospitals	48.0
Alcohol and Drug Consultation Bureaus	48.0
Regional agencies for social and medical care	56.0
Municipal methadone programmes	7.0
Clinics for treatment of addiction for special groups	3.0
Institute for research, information and development of expertise	5.0
Action programme	6.0
Total	173.0

Million Guildens

PORTUGAL

All the information concerning Portugal dates back to 1997 (EMCDDA report 1998). For the police forces, the figure given here includes only the criminal investigation department (CID) manpower, while total manpower should consist of the CID (Policia Judiciara), the civil security police (Policia de Segurança Publica) and the National Guard (Guardia Nacional Republicana). Unfortunately, no information relating to the two last categories is available. Concerning police manpower specialised in the fight against drugs, only the CID officers are included. On the line 'Budget of the criminal-justice system', only the criminal court budget is taken into consideration. Nevertheless, even so, the figure mentioned seems incorrect (probable under-estimation). Moreover, the line

'Operating budget of all the judicial institutions' corresponds to the budget of the general administration of the penitentiary services. The line 'Budget of institutions specialised in the treatment of drugs abusers' includes the budgets of the public institutions (148,587,000 Escudos) and the budgets of the private institutions (614,348,000 Escudos).

SPAIN

Let us note simply that the total police manpower consists of the national police corps and the Guardia Civil. Moreover, Spain includes in the actions on an international level an amount which concerns a national plan for fighting drugs aside from its contribution to the UNDCP. Source : Plan Nacional sobre drogas.

UNITED KINGDOM

For the United Kingdom, according to HMSO ' *Tackling Drugs Together. A Strategy for England 1995-1998* ' HMSO, May 1995, the total police budget (1998/1999) consists of 7.15 billion pounds sterling (£) for England and Wales, £650.9 million for Scotland and £535 million for Northern Ireland.

For total police forces, total manpower for England and Wales reaches 179,480 people (126,862 officers and 52,618 civilians), while 19,235 people (14,788 regular police officers and 4,477 support staff members) compose Scotland's manpower and 11,757 people (8,429 officers and 3,328 civilians) Northern Ireland's. However, it should be noted that the figure of 998 arrests for drug offences and the total of 26,062 arrests refer only to Northern Ireland, as figures for England, Wales and Scotland are not available. In consequence, this data does not represent the reality for the whole of British territory.

As for the total number of customs offences (3,259), this figure refers to the number of people and companies involved in it. Moreover, this figure excludes tax offences and that linked to the non-payment of customs taxes.

For Justice, the budget is divided as follows: first for England and Wales, £590 million for the all courts of justice (not only the criminal courts), £300 million for the Prosecution Services and £225.7 million for the judicial aid (the latter being granted to the defendant and not to all criminals); for Scotland, £28.8 million for the courts of justice, £46.3 million for the Crown Office and the Tax Prosecutor Service, £89.7 million for judicial aid (in criminal cases); and finally for Northern Ireland, £31.5 million are granted to the courts of justice, £8 million for prosecutions and £28.6 million for judicial aid. Regarding the number of prosecutions linked to drug offences, 49,897 prosecutions have been carried out in England and Wales, 2,900 in Scotland and 748 in Northern Ireland. In the total number of prosecutions, England and Wales reach a total of 1,923,000, Scotland 175,457 and Northern Ireland 35,968. On the other hand, the budget of penal establishments amounts to £1.401 billion for England and Wales, £183 million for Scotland and £142 million for Northern Ireland. For the number of people imprisoned for drug offences, 5,269 people were imprisoned in England and Wales, 1,011 in Scotland and 120 in Northern Ireland. Similarly, the total number of people imprisoned is subdivided as following: 43,055 prisoners in England and Wales, 13,150 in Scotland and 1,393 in Northern Ireland. The budget of all the agencies dealing with the treatment of drug problems, represents 13% of the amount of £1.4 billion. From the same budget, 12% corresponds to the budget attributed to prevention and 13% constitutes the amount devoted to activity carried out on an international level.

SWEDEN

For Sweden, Table 1 data (compiled by Linnea Rask, member of the 'Swedish National Institute of Public Health') corresponds either to the year 1997 or 1998 or 1999. As mentioned in Table 1, the figures followed by one or more asterisks are defined as follows :

- * = number of suspects
- ** = number of seizures
- *** = number of people found guilty

Moreover, according to note(4) in Table 1, the social and health services correspond in reality to the health-care services, even if note (5) reveals that the major portion of the budget lines allocated to prevention of drug problems comes from the municipalities. This explains why the monetary amount of 3.55 million euro is listed in the line called 'Local'. With the exception of these remarks, we received no other precision.

However, Torbjorn Althén, Principal Administrative Officer of the 'National Board of Health and Welfare' has furnished other available figures, which are not listed in Table 1. It should be noted that the following figures concern the year 1991:

- The cost of specialised open-care in the municipalities was 150 million Swedish Kronor (SEK). Voluntary institutional care cost - 300 million SEK and compulsory treatment cost 84 million SEK.
- Hospital care costs 340 million SEK.
- Efforts for unemployed ex-abusers are estimated at several tens of millions SEK.
- The costs of prison and probation-systems are 1,000 million SEK.
- The specialised police-force cost is 270 million SEK. Approx 500 police officers are working mainly in the field of drugs on local and regional levels, 40-50 are working on a central level and 9 are placed abroad.
- The cost of prosecutors in drug-cases is 21 million SEK
- The cost of courts judging drug-cases is 24 million SEK.
- The cost of the social insurance system is 39-70 million SEK.

SWITZERLAND

Finally, for Switzerland, the figure indicating the number of interpellations corresponds to the number of procedures instituted by the police in 1996. This does not precisely correspond to the number of interpellations. Similarly, concerning the number of judicial procedures for drug abuse (41,000), this figure in fact represents the number of sentences in 1993. It is necessary to note that the study of Switzerland we have at our disposal gives a figure of 500 million Swiss Francs for 1991 which might correspond to the total cost of repression activity of justice and police. Unfortunately, no means of breaking down this figure between these two authorities is available. Finally, the police budget (1991 figure) corresponds to the costs of departmental police corps and does not include the traffic police. Source J.P Danthine et R.Balleto in '*Le problème de la drogue-en particulier en Suisse- considéré sous son aspect social et préventif*' Institut Suisse de Prophylaxie de l'Alcoolisme, Université de Lausanne/DEEP-HEC, Lausanne, 1992.

Annex 2 – Figures

The table below, recapitulates the principle data we have collected and calculated. The first line of the table describes the total public expenditure of the Member States, i.e., the State Budget. The second line indicates the GDP of the countries, i.e., their wealth production. The third line expresses public expenditure in percentage of GDP, which indicates the part of the national wealth allocated by country to the public expenditure. Line 4 presents the public expenditure in the field of drugs divided into two categories (law enforcement and health-care) in lines 5 and 6. Lines 7 and 8 respectively show the percentage represented by public expenditure in the field of drugs for each State in comparison with their GDP and with the overall public expenditure of the country.

Table A

	Austria	Bel.	Den.	Finl.	Fra.	Ger.	Greece	Ire.
1- All State expenditure (1), (2)	36542,6	46130,0	38161,4	23995,7	302855,0	361340,0	13197,5	9453,2
2- GDP (1), (2)	187046,5	221860,0	149309,8	115168,5	1293853,0	1903410,0	91579,4	74757,1
3- State expenditure as % GDP	19,54%	20,79%	25,56%	20,84%	23,41%	18,98%	14,41%	12,65%
4- Anti-drug Expenditure (1)	not av.	286,2	not av.	45,5	798,7	1898,9	59,2	40,4
5- law enforcement	not av.	216,1	not av.	32,9	585,5	1590,9	44,7	30,5
6- health care	not av.	70,1	not av.	12,6	213,2	308,0	14,5	9,9
7- As % of GDP	not av.	0,13%	not av.	0,04%	0,06%	0,10%	0,06%	0,05%
8- As % of State expenditure	not av.	0,62%	not av.	0,19%	0,26%	0,53%	0,45%	0,43%
9- Population (3)	8,1	10,2	5,3	5,2	59,1	82,1	10,5	3,7
Number of problem users (average hypothesis)	17358	20200	12100	8050	150000	122712	not av.	9168
Drug expenditure by problem user	not av.	14168,3	not av.	5652,2	5324,7	15474,4	not av.	4406,6
Law-enforcement expenditure by problem user	not av.	10698,0	not av.	4087,0	3903,3	12964,5	not av.	3326,8
Health-care expenditure by problem user	not av.	3470,3	not av.	1565,2	1421,3	2509,9	not av.	1079,8

Table A (continuation)

	Ita.	Lux.	Nether.	Port.	Spain	Swe.	UK	Switz.	USA.
1- All State expenditure (1), (2)	174600,0	1290,0	79208,0	16250,0	85510,0	55152,7	239222,2	35656,9	1299368,8
2- GDP (1), (2)	978400,0	10930,0	347033,0	87090,0	501750,0	222801,2	1289974,0	234998,2	7053373,3
3- State expenditure as % GDP	17,85%	11,80%	22,82%	18,66%	17,04%	24,75%	18,54%	15,17%	18,42%
4- Anti-drug Expenditure (1)	516,5	7,8	262,9	15,5	389,0	164,2	854,4	202,4	15647,4
5- Law enforcement	not av.	5,9	182,0	11,7	293,7	61,2	586,2	155,0	11869,5
6- health care	516,5	1,9	80,9	3,8	95,3	103,0	268,2	47,4	3777,9
7- As % of GDP	0,05%	0,07%	0,08%	0,02%	0,08%	0,07%	0,07%	0,09%	0,22%
8- As % of State expenditure	0,30%	0,60%	0,33%	0,10%	0,45%	0,30%	0,36%	0,57%	1,20%
9- Population (3)	57,6	0,4	15,7	10,0	39,4	8,8	59,2	7,0	263,2
Number of problem users (average hypothesis)	249000	2050	27000	70000	130864	17000	215162	30000	3750266
Drug expenditure by problem user	2074,3	3804,9	9737,0	221,4	2972,6	9658,8	3971,0	6746,7	4172,4
Law-enforcement expenditure by problem user	not av.	2878,0	6740,7	167,1	2244,3	3600,0	2724,5	5166,7	3165,0
health-care expenditure by problem user	2074,3	926,8	2996,3	54,3	728,2	6058,8	1246,5	1580,0	1007,4

(1) All figures are in millions euro. Euro conversion based on 07/31/2000 exchange rate for each national currency not in the euro zone (except for Luxembourg in ECU 1997 for GDP and State expenditure); (2) All State expenditure and GDP are for 1999 (except Luxembourg 1997); (3) Millions for the year 1998 (except Finland and Germany for the year 1999 and Greece and Luxembourg for the year 1997).

The following table gives conversion keys to correct the data according to the wealth and the demographic size of each country. We use as a referent the greatest country (demographically and economically) of the Member States (Germany). Each Member State is given a weight in comparison with Germany, the latter having a weight of one. Saying that the economic weight of Austria is 10,18 illustrates that it is necessary to multiply the Austrian GDP by 10,18 to obtain the German GDP. It is the same for the demographic weight.

Table B1

	Austria	Bel.	Den.	Finl.	Fra.	Ger.	Greece	Ire.	Ita.	Lux.	Nether	Port.	Spain	Swe.	UK	Switz	USA
Economic weight/Germany (GDP)	10,18	8,58	12,75	16,53	1,47	1,00	20,78	25,46	1,95	174,15	5,48	21,86	3,79	8,54	1,48	8,10	0,27
Demographic weight/Germany (Population)	10,14	8,05	15,49	15,79	1,39	1,00	7,82	22,19	1,43	205,25	5,23	8,21	2,08	9,33	1,39	11,73	0,31

Table B2 – Economic and demographic weights of Europe in comparison to USA

	EU law enforcement	EU health care
Economic weight	0,87	1,01
Demographic weight	1,16	1,38

Note: Each weight corresponds to the ratio (EU/USA)

The table below, recapitulates major data collected and calculated after correction of demographic size and wealth .

Table C

	Austria	Bel.	Den.	Finl.	Fra.	Ger.	Greece	Ire.
1- All State expenditure (1), (2)	371862,3	395764,5	486483,7	396581,1	445535,3	361340,0	274300,3	240690,4
2- GDP (1), (2)	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0
4- Anti-drug Expenditure (1)	not av.	2455,4	not av.	752,0	1175,0	1898,9	1230,4	1028,6
5- Law enforcement	not av.	1854,0	not av.	543,7	861,3	1590,9	929,1	776,6
6- health care	not av.	601,4	not av.	208,2	313,6	308,0	301,4	252,1
Number of problem users (average hypothesis)	175937	162590	187436	127097	208376	122712	not av.	203430
Drug expenditure by problem user	not av.	15101,8	not av.	5916,6	5638,8	15474,4	not av.	5056,4
Treatment expenditure by problem user	not av.	11402,9	not av.	4278,2	4133,6	12964,5	not av.	3817,4
Treatment expenditure by problem user	not av.	3698,9	not av.	1638,5	1505,2	2509,9	not av.	1239,1

Table C (continuation)

	<i>Ita.</i>	<i>Lux.</i>	<i>Nether.</i>	<i>Port.</i>	<i>Spain</i>	<i>Swe.</i>	<i>UK</i>	<i>Switz.</i>	<i>USA.</i>
1- All State expenditure (1), (2)	339672,3	224647,7	434440,8	355154,6	324385,8	471174,3	352982,3	288809,4	350645,2
2- GDP (1), (2)	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0	1903410,0
4- Anti-drug Expenditure (1)	1004,8	1358,3	1442,0	338,8	1475,7	1402,8	1260,7	1639,4	4222,6
5- law enforcement	not av.	1027,5	998,2	255,7	1114,2	522,8	865,0	1255,5	3203,1
6- health care	1004,8	330,9	443,7	83,1	361,5	879,9	395,7	383,9	1019,5
Number of problem users (average hypothesis)	354911	420763	141191	574700	272689	158602	298392	351857	1169821
Drug expenditure by problem user	2831,2	3228,3	10212,8	589,5	5411,6	8844,6	4225,0	4659,2	3609,6
Law-enforcement expenditure by problem user	not av.	2441,9	7070,1	444,9	4085,8	3296,5	2898,7	3568,1	2738,1
health-care expenditure by problem user	2831,2	786,4	3142,7	144,5	1325,8	5548,1	1326,2	1091,1	871,5

All figures are in millions euro. Euro conversion based on 07/31/2000 exchange rate for each national currency not in the euro zone (except for Luxembourg in ECU 1997 for GDP and State expenditure); (2) All State expenditure and GDP are for 1999 (except Luxembourg 1997); (3) Millions for the year 1998 (except Finland and Germany for the year 1999 and Greece and Luxembourg for the year 1997).

This table provides more detail on the different data collected. Costs are divided by group : Law enforcement, social and health services, prevention, research, action at international level.

Table D

	Austria	Belgium	Denmark	Finland (5)	France (2)	Germany (4)	Greece	Ireland	Italy
1. LAW-ENFORCEMENT COSTS									
1.1 Police									
Budget of all national police forces (1)	not av.	1,743.14	674.12	na	3,811.23	14,319.24	1,445.16	608.35	na
Police Manpower	not av.	36,114	12,965	na	132,626	na	51,143	10,968	na
Police Manpower specialising in the fight against drugs	not av.	not av.	not av.	na	2,194	na	3,400	296	na
Interpellations for drug offences	not av.	23,762	13,992	na	79,271	na	10,867	not av.	33,179
Total number of interpellations	not av.	not av.	531,115	na	790,000	na	523,354	not av.	813,124
1.2 Customs									
Customs budget (1)	not av.	not av.	not av.	na	590.13	na	1.52	63.76	na
Number of customs officers	not av.	not av.	250	na	20,000	na	not av.	85	na
Number of customs offences involving drugs	not av.	not av.	217	na	25,195	na	43	483	incl. above
Total nbr of customs offences	not av.	not av.	not av.	na	100,000	na	not av.	2,354	5,734
1.3 Justice									
Budget of the criminal-justice system (1)	not av.	468.79	1,073.02	na	3,120.17	4,104.14	246.92	876.77	2,156.99
Number of prosecutions for drug offences	not av.	not av.	not av.	na	not av.	na	10,910	4,156	51,922
Total number of prosecutions (excluding minor offences)	not av.	not av.	not av.	na	not av.	na	not av.	30,768	5,274.733
1.4 Custodial institutions									
Operational budget for all custodial institutions (1)	not av.	not av.	180.80	na	873.22	na	50.72	159.99	2,312.18
Number of persons imprisoned for drug offences	not av.	not av.	1,282	na	11,816	na	2,069	225	17,216
Total number of persons imprisoned	not av.	not av.	3,533	na	51,325	na	4,246	11,620	49,323
2. SOCIAL & HEALTH SERVICES									
Budget of institutions specialising in treating drug addiction (1)	not av.	70.12	not av.		213.24		14.45	9.89	(2) 516.46
State (1)	not av.	70.12	not av.		not av.		14.45	8.62	
Regions (1)	not av.	not av.	not av.	12,56	not av.	308.00	not av.	1.27	
Budget of non-specialised institutions or cost indicators (1)	not av.	not av.	not av.		not av.		1,439.40	not av.	

Public spending on drugs in the European Union during the 1990s

Statistics identifying which patients out of all admissions were treated for drug addiction	not av.	not av.	not av.	not av.	not av.	not av.	Not av.	not av.	(3) 159,188
3. PREVENTION			na						
Budgetary lines allocated to drug prevention (1)	not av.	not av.	not av.	3,36	2.73	12.78	3.5	0.45	not av.
State (1)	not av.	not av.	not av.		2.73		3.5	not av.	not av.
Regions (1)	not av.	not av.	not av.		not av.		not av.	not av.	not av.
Local (1)	not av.	not av.	not av.		not av.		not av.	not av.	not av.
Budget of institutions specialising in drug prevention (1)	not av.	not av.	not av.		not av.		0,91	not av.	not av.
Budget of non-specialised institutions (1)	not av.	not av.	not av.		not av.		not av.	not av.	not av.
Activities that ascribe part of their costs to the fight against drugs	not av.	not av.	not av.	not av.	not av.	not av.	not av.	not av.	not av.
4. RESEARCH									
Amount spent on research (1)	not av.	not av.	not av.	Include in prevention	16.98	na	0.13	1.27	not av.
State (1)	not av.	not av.	not av.		16.98	na	0.13	not av.	not av.
Regions (1)	not av.	not av.	not av.		not av.	na	not av.	not av.	not av.
5. ACTION AT INTERNATIONAL LEVEL									
Amount spent on international action (1)	not av.	not av.	not av.	not av.	10.67	21 ;73	0.09	0.19	not av.
UNDCP (1)	not av.	not av.	not av.	not av.	not av.	not av.	not av.	0.19	not av.
National Plan on drugs (1)	not av.	not av.	not av.	not av.	not av.	not av.	not av.	not av.	not av.

*In millions euro, conversion based on 07/31/2000 exchange rate for each national currency; (2) Koppe et Palle - MILDT report (1996); (3) 'Tackling drugs together strategy for England 1995-1998' HMSO ed., May 1995; (4) Health and Medical services; (5) The main part of the budgetary lines allocated to drug prevention comes from municipality budget; (6) Figures for Sweden are for 1997, 1998 and 1999. Also note that * number of persons suspected, ** number of seizures, *** number of persons found guilty.*

Table D (continuation)

	Luxembourg	Netherlands	Portugal	Spain	Sweden (6)	UK (3)	Switz.
1. Law-enforcement costs							
1.1 Police							
Budget of all national police forces (1)	70,77	319.01	57.96	3,187.82	1,334.63	13,536.70	898.71
Police Manpower	1,186	not av.	2,300	121,376	15,986	210,472	not av.
Police Manpower specialising in the fight against drugs	62	not av.	244	1,643	901	not av.	not av.
Interpellations for drug offences	797	7,700	9,333	79,445	* 10,625	998	42,000.00
Total number of interpellations	24,355	1,222.200	321,643	1,984,755	* 85,250	26,062	not av.
1.2 Customs							
Customs budget (1)	27,76	not av.	not av.	not av.	351.33	1,386.81	not av.
Number of customs officers	430	not av.	not av.	not av.	2,591	24,778	not av.
Number of customs offences involving drugs	236	Include above	77	not av.	** 2,579	2,257	not av.
Total nbr of customs offences	not av.		not av.	not av.	** 18,367	3,259	not av.
1.3 Justice							
Budget of the criminal-justice system (1)	28,47	3.33	not av.	711.90	2,531.54	2,189.99	not av.
Number of prosecutions for drug offences	699	not av.	443	34,772	*** 11,080	53,545	41,000.0
Total number of prosecutions (excluding minor offences)	19,291	not av.	420,217	not av.	*** 124,449	2,134.425	not av.
1.4 Custodial institutions							
Operational budget for all custodial institutions (1)	14,13	not av.	105,01	482.93	457.06	2,802.86	296.3
Number of persons imprisoned for drug offences	176	3,250	3,653	9,925	1,210	6,400	not av.
Total number of persons imprisoned	1,891	13,000	14,634	43,147	9,497	57,598	not av.
2. SOCIAL & HEALTH SERVICE							
Budget of institutions specialising in treating drug addiction (1)	1.90	130,42	3,80	95.25	40.20	295.55	47.3
State (1)	not av.	not av.	not av.	16.23	not av.	not av.	not av.
Regions (1)	not av.	not av.	not av.	79.02	(4) 40.20	not av.	not av.
Budget of non-specialised institutions or cost indicators (1)	not av.	not av.	not av.	not av.	not av.	not av.	not av.
Statistics identifying which patients out of all admissions were treated for drug addiction	160	(admissions) 21,361	not av.	not av.	not av.	not av.	not av.
3. PREVENTION							
Budgetary lines allocated to drug prevention (1)	1.18	Include in the amount of social and health service	12,24	37.02	3.55		5.7
State (1)	1.18		not av.	16.23	na	272.81	not av.
Regions (1)	not av.		not av.	20.80	na	not av.	not av.
Local (1)	not av.		not av.	na	na	not av.	not av.
Budget of institutions specialising in drug prevention (1)	0.38	idem	not av.	not av.	(5) 3.55	not av.	not av.
Budget of non-specialised institutions (1)	not av.	not av.	not av.	not av.	not av.	not av.	not av.
Activities that ascribe part of their costs to the fight against drugs	not av.	not av.	not av.	not av.	not av.	not av.	not av.
4. Research							
Amount spent on research (1)	0.30	2,50	not av.	7.40	not av.	not av.	not av.
State (1)	not av.	2,50	not av.	3.24	not av.	not av.	3.0
Regions (1)	not av.	not av.	not av.	4.16	not av.	not av.	not av.
5. ACTION AT INTERNATIONAL LEVEL							
Amount spent on international action (1)	1.95	Include in the amount above	0.01	4.29	5.38	24.36	not av.
UNDCP (1)	not av.		0.01	0.39	not av.	24.36	not av.
National Plan on drugs (1)	not av.		not av.	3.90	not av.	not av.	not av.

(1) In millions euro, conversion based on 07/31/2000 exchange rate for each national currency; (2) Estimate of the total health cost of drug addiction in Italy is around 1,000 billion Liras; (3) 159,188 corresponds to the total number of people treated in local care units(137,657) and the Total number of people treated in social-rehabilitation units (21,531); (4) Budgets for Germany are for 1992; (5) For Finland, figures are for 1995.

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