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 buprenomorphine 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

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[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).

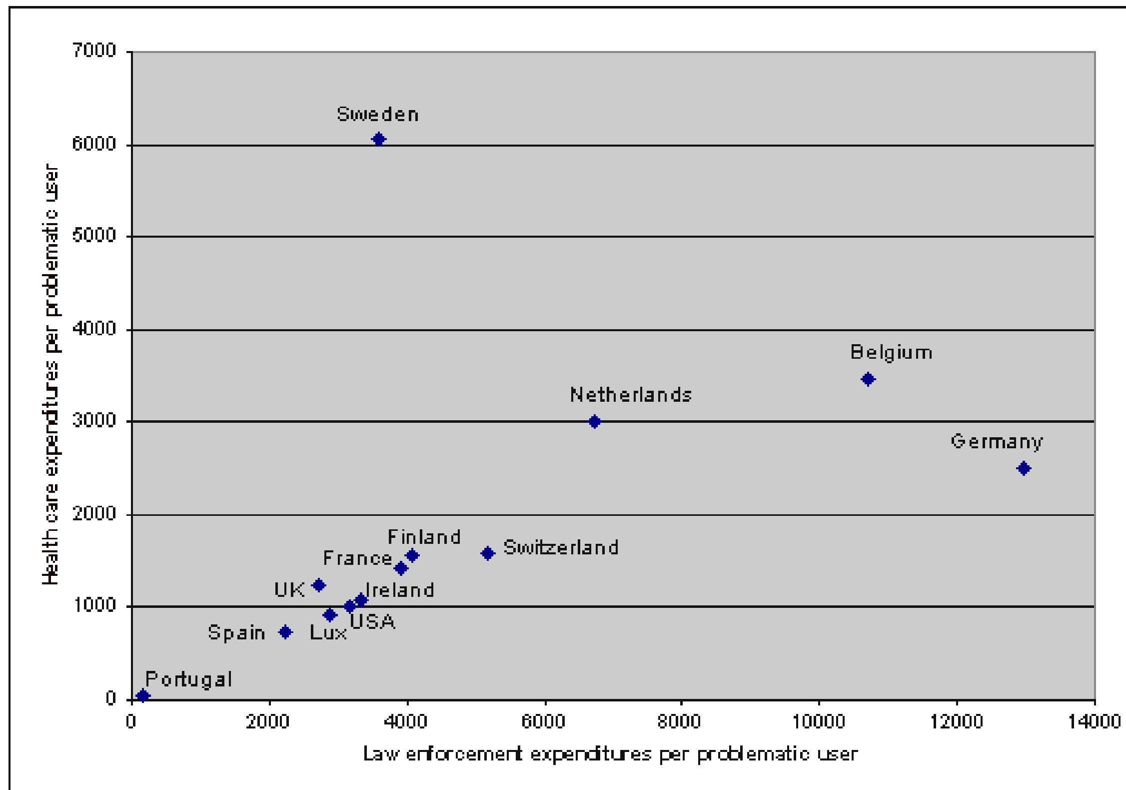
A more visual approach to the situation is provided in a presentation with a cloud of points (see figure below). We see that six countries of the Union had a similar drug expenditure profile in the mid-1990s (France, UK, Spain, Ireland, Finland and Luxembourg). Not only did the percentage distribution 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** **- drug law-enforcement budget** **- drug health-care budget**	5 339.2 3 641.3 1 697.9	15 647.4 11 869.5 3 777.9	x 2.90 x 3.25 x 2.22
b. Gross figures per capita	**Drug budget per capita** **- drug law-enforcement budget per capita** **- drug health-care budget per capita**	16.6 12.0 4.6	59.5 45.1 14.4	x 3.60 x 3.75 x 3.10
c. Figures corrected for differences in wealth and demography	**Overall drug budget** **- drug law-enforcement budget** **- drug health-care budget**	5 339.20 3 641.30 1 697.90	14 190.02 10 366.47 3 823.55	x 2.66 x 2.85 x 2.25
d. Figures corrected for differences in wealth and demography, per capita	**Drug budget per capita** **- drug law-enforcement budget per capita** **- drug health-care budget per capita**	16.6 12 4.69	44.63 34.07 10.57	x 2.68 x 2.85 x 2.25
e. Figures corrected for differences in wealth and demography, problem drug users	**Drug budget by problem drug user** **- drug law-enforcement budget by problem drug user** **- drug health-care budget by problem drug user**	6 378.09 4 715.45 1 662.64	3 132.34 2 390.85 741.48	: 2.04 : 1.97 : 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

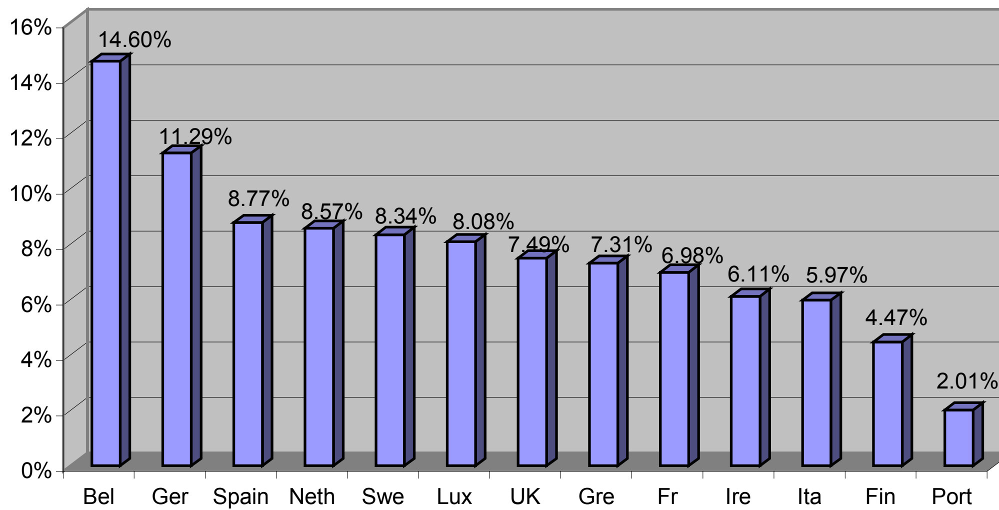
It is possible to calculate the total overall amount of drug expenditure in the countries of the European Union and by examining each country's share in this expenditure, the ratio of each Member State in the hypothesis of European drug-related public expenditure. In fact, with the same economic weight, 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.