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# Public expenditure in the area of drug-demand reduction

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*In EMCDDA 2003 Annual report on the state of the drugs problem in the European Union and Norway*

## Public expenditure in the area of drug-demand reduction <sup>(199)</sup>

The European Union drugs strategy (2000–04) specifies that the Council and the EU Commission should, based on work by the EMCDDA and the Pompidou Group, attempt to itemise a list of all public expenditure in the field of drugs.

In its efforts to respond to the European Union drugs strategy, the EMCDDA, with the valuable contribution of the Reitox national focal points, is investigating in this report direct public expenditure in the field of drug-demand reduction incurred in 1999 <sup>(200)</sup>. It concentrates on expenditure at national and regional level, on drug-use prevention, treatment of addiction (in- and outpatient, substitution and drug-free), rehabilitation and reintegration, outreach work, harm reduction and education, and research and coordination when related to demand reduction. To better delineate our research, we have excluded direct expenditure sustained by private health organisations (therapy centres, clinics, etc.) and indirect expenditure sustained by general services such as general hospitals and emergency rooms. Finally, the broader and much more complex question of the social costs of illegal drugs has not been considered.

In addressing the question of public expenditure in the field of drugs (albeit in a restricted domain), this report aims primarily to increase awareness in the EU countries of the relevance of a drug policy indicator, rather than to produce empirical evidence.

### Limitation and reliability of data

Nevertheless, although we have restricted our scope, the results that emerge confirm the difficulties caused by limited data availability and data collection in a field that is relatively undeveloped in the EU. In fact, other than the 'ad hoc' research undertaken during the preparation of this report <sup>(201)</sup>, only a few studies have been conducted with the aim of quantifying public resources allocated to drug issues in the EU <sup>(202)</sup>. As matter of record, the majority of countries in the EU cannot say precisely how much they spend on combating drugs and drug addiction.

Most of the participants in this research, therefore, could not provide comprehensive data. In fact, some figures are missing, and often calculations have been based on estimation and extrapolation methodologies <sup>(203)</sup>.

As reported by a large number of focal points, and confirmed by literature in the field, at least five factors can limit such research: (1) the lack of data for some areas and some countries; (2) the difficulty in isolating data on illicit drugs from data covering both illicit drugs and alcohol; (3) the variety of actors and organisations at central, regional and local level accountable for spending; (4) the difficulty of precisely dividing public expenditure among theoretical categories, such as demand and supply reduction; and (5) the complexity of breaking down expenditure, within these two categories, by area of intervention (treatment, primary prevention, rehabilitation, cooperation, coordination, etc.).

It is, however, interesting to note that, although studies of this kind are obviously complicated by methodological problems, decision-makers are showing growing interest in public spending reviews <sup>(204)</sup> both as a basis upon which to make decisions and as a means of measuring performance.

### Expenditure in drug-demand reduction

In the process of calculating 'a list' of all direct public expenditure in drug-demand reduction in the EU Member States, and on the basis of the data received from national focal points, a comparison of similar expenditure has been attempted.

Although all possible statistical precautions have been taken, it is not possible to avoid the problem that the reported figures may sometimes correspond to different categories in different countries and the fact that in some countries figures are just not available. Indeed, for Belgium, Denmark, Italy and especially Germany and Sweden, some relevant information on demand-reduction expenditure is missing and, thus, the total figure is certainly grossly underestimated. In the case of other countries (Greece, Spain, France, Luxembourg, Austria and Portugal), data can be considered to be more comprehensive despite some residual uncertainty regarding the categories of spending

<sup>(199)</sup> The differences in the data available limited the possibility of drawing cross-country comparisons. For a more complete picture of expenditure in the field of drugs in the individual EU Member States, see [http://www.emcdda.eu.int/policy\\_law/national/strategies/public\\_expenditure.shtml](http://www.emcdda.eu.int/policy_law/national/strategies/public_expenditure.shtml).

<sup>(200)</sup> Year of reference for the European Union drugs strategy (2000–04) 'snapshot' reporting exercise.

<sup>(201)</sup> The EMCDDA is particularly grateful to the Greek, Austrian and Portuguese focal points for undertaking specific research and investigations in this field, increasing the value of this annual report. Acknowledgement should also be given to Professor Pierre Kopp for peer review of the research.

<sup>(202)</sup> Belgium (2003), Luxembourg (2002), the United Kingdom (2002); for more references see [http://www.emcdda.eu.int/policy\\_law/national/strategies/public\\_expenditure.shtml](http://www.emcdda.eu.int/policy_law/national/strategies/public_expenditure.shtml).

<sup>(203)</sup> Our desire to include as many countries as possible in order to provide a complete European picture conflicts with the scarcity of data in some of the countries considered. Consequently, while a broad scope has been maintained, the capacity for analysis and comparison has been very much diminished by the uncertainty of the final figures.

<sup>(204)</sup> Belgium (2003), Luxembourg (2002), the United Kingdom (2002); for more references see [http://www.emcdda.eu.int/policy\\_law/national/strategies/public\\_expenditure.shtml](http://www.emcdda.eu.int/policy_law/national/strategies/public_expenditure.shtml).

included. In the Netherlands and Norway, in particular, the reported estimates concern both illicit drugs and alcohol, making the final figures for those two countries, in comparison with others, rather high. Finally, most data refer to 1999 as baseline figures for the EU action plan evaluation process, but there are some exceptions. For Ireland, the figures reported are planned State expenditure in the area of demand reduction for the year 2000, for France, the data date back to 1995; and for the United Kingdom, the data refer to the financial year 2000–01. The reading of the amounts shown in Table 6 must therefore take into account the above-mentioned constraints.

The total amounts spent by EU countries in the field of drug-demand reduction in 1999 basically seem to reflect the size and wealth of each country (Kopp and Fenoglio, 2003). Unsurprisingly, the largest and richest countries (Germany, France, Italy and the United Kingdom) appear to allocate, in absolute terms, more financial resources than the small countries, although spending is also relatively high in the Netherlands and Norway (possibly because alcohol addiction interventions are included in the figures).

Research shows (Godfrey et al., 2002; Origer, 2002; Kopp and Fenoglio, 2003) that estimates of this kind could be a valuable source of information at national level. Comparisons over time within a country can reveal an increase or decrease in drugs-related budgets. Comparison across sectors (demand, supply, international cooperation, etc.) might reveal, in addition to formal strategies, the concrete financial effort expended in tackling the drugs phenomenon.

At EU level, 'cross-country' comparisons (the most complex) can determine common patterns, or differences, in the amounts allocated to drug policy and allow expenditure to be compared against a European average or across world regions.

In addition, the use of macroeconomic indicators (such as gross domestic product (GDP), total population, total government expenditure or number of problem drug users) at national and European level can help to measure the extent of the expenditure and to give a more informative interpretation of data that, taken alone, would be of little value.

Indeed, the comparison of expenditure on drug-demand reduction and, for example, the GDP of each country could reveal how much of its wealth a country is likely to spend to prevent drug use and combat the consequences of drugs. According to the data collected in this research, it appears that in 1999 Norway allocated approximately 0.1 % of its

economic wealth (GDP), followed by the Netherlands (0.078 %) (although both countries included in their estimation drugs and alcohol). Portugal (0.074 %), Finland (0.073 %) and Ireland (0.070 %) spent the greatest proportion of GDP on drug demand-reduction activities; in comparison, the largest and apparently richest countries seem to lag behind. However, the known incompleteness of the data for the latter may bias the comparison.

The interpretation of this information is not straightforward, and not only because of the lack of data. The proportion of wealth that is dedicated to drug addiction control in the EU Member States can be interpreted as reflecting the extent of the drug problem or the size of the response to it (or both), or the level of the social and health interventions in the population. Exploring such questions can contribute to a better understanding of the phenomenon and deeper comprehension in the field of cost estimates.

Another way of analysing public expenditure is to look at it in the context of the area it is intended to deal with, in this case problem drug users <sup>(205)</sup>. Using as an indicator the estimated number of problem drug users, expenditure per individual most in need of assistance can be calculated. Unfortunately, this calculation is beset by two problems: first, the figures do not necessarily relate directly to problem drug users — drug addicts — as prevention, education and coordination can also be targeted at individuals who are not classified as problem drug users; and, second, calculation of the number of problem drug users is, for obvious reasons, rather uncertain.

Again, according to our data, the value of services consumed by each drug addict in need is considerably higher in some countries (Finland, Luxembourg, Austria) than in others (Greece, Portugal, France, United Kingdom). This could be interpreted as the result of a stronger commitment to drug services in the former group; however, it is more likely that the figures depend on the quality and type of intervention. Indeed, differences in the levels of expenditure do not automatically translate into the level of commitment, but rather represent a different level of reaction, which is determined by the specificity of the situation.

Together with the expenditure per problem drug user, it is useful to calculate the burden of drug demand-reduction policy on society as a whole. Considering the expenditure on drug-demand reduction in the 16 countries studied (15 Member States and Norway), and from the limited data available (Table 6), the total (minimum) amount spent in the EU in 1999 on prevention of drug use and the care of drug addicts amounted to around EUR 2.3 billion. This means

<sup>(205)</sup> Injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines. To calculate expenditure per problem drug user, the estimates of numbers of problem drug users as reported by the national focal points using average rates were used. For more information, see Statistical Table 4: Estimated number of problem drug users in EU Member States, 1995–2001 (online version).

**Table 6: Breakdown of direct public expenditure figures in millions of euro as reported in the Reitox national reports 2002**

Country	EUR million	Categories of expenditure in 1999
Belgium	139	Treatment (100); rehabilitation (22.5); methadone (8.9); communities and regions: prevention, care, training, coordination (8.3) (not included: EUR 7 million allocated to the prevention of criminality by the Ministry of Internal Affairs)
Denmark	67	Expenditures on 'drug addiction' by counties and municipalities DKK 495.5 (66.5); prevention at central level DKK 6.2 (0.8), in counties and municipalities not known
Germany	343.2	Emergency accommodation (3.0); psychosocial accompanying (13.3); 951 outpatient counselling facilities (57.9); inpatient rehabilitation (25 % of EUR 434 million (99.7)); integration in work (4.3); cared housing (8.0); treatment in addiction departments in hospitals (97.0); substitution treatment (not known but estimated minimum of 30.0), <i>Länder</i> budget 'addiction' 23.9 % (drugs share) of EUR 127 million (30.0) (not included: prosecution and enforcement expenditure)
Greece	16.2	39 prevention centres (OKANA), salaries and staff (KETHEA), housing and operational costs (2.4); treatment: drug-free, substitution and low threshold (11.9); social rehabilitation (0.3); research (0.3) OKANA, data not included; education (0.8), some central administration costs (0.5)
Spain	181.5	Central level: Ministries of the Interior (GDNPD), Defence (prevention), Health and Consumption, Education and Culture; Foreign Affairs, Work and Social Matters (19.8); fund of confiscated goods allocated to demand reduction 66 % (2.8); autonomous communities (158.7, of which 22.3 from the GDNPD)
France (1995)	205.8	Subutex (91.4); Social Health and Urban Affairs (101.9); Education (Research) (6.6); Youth and Sport (1.3); Work, Employment and Training (0.12); MILDT (66 % of EUR 6.9 million (4.5) (not included: international cooperation and subsidies to international organisations)
Ireland (2000) Estimated State exp.	57.1	Department of Health and Children (treatment, prevention, research) (32.0); Department of Enterprise, Trade and Employment (reintegration) (6.0); Department of Education and Science (prevention) (7.5); Department of Tourism, Sport and Recreation (prevention, research, evaluation, coordination) (11.6)
Italy	278.5	Outpatient treatment (99.1); residential and semi-residential treatment (88.8); National Drug Fund projects promoted at the local/regional level (67.6); National Drug Fund projects sponsored by ministries (23.0). No data were available from eight regions and only partial data were available from most other regions
Luxembourg	13.7	Ministry of Health (5.7); Family, Social Solidarity and Youth (2.3); Education, Professional Training and Sport (0.5); other ministries (0.3); Social security reimbursement (4.9)
Netherlands	287.9	General Act on Special Disease Management (to regional care offices and addiction clinics) (76.0); Ministry of Health, Welfare and Sport (outpatient addiction care) (74.2); funds for homeless addicted, neglected drug addiction (about two thirds of EUR 150 million (112.5)); drug-related nuisance (24.1); drug-prevention activities (1.1) (most of the figures concern both drugs and alcohol)
Austria	52.3	Federal, provincial and municipal sources including health insurance funds, public employment services and the Healthy Austria Fund: primary prevention (2.4); outreach work and harm reduction (3.3); counselling, care and treatment (40.7); reintegration (4.2); quality assurance (0.6); other expenditures/not assignable (0.8)
Portugal	71.7	Presidency of the Council of Ministers (16.2); Ministries of Health (41.6); of Education (3.1); of Employment and Social Affairs (9.5); of Defence 1.2
Finland	76.2	Healthcare (inpatient) (15.1); healthcare (outpatient) (7.9); drug-related pensions (4.3); drug-related sickness benefits (0.5); compensation (insurance companies) (0.9); substance abuse services (in/outpatient) (26.5); living allowances (4.8); child welfare (10.9); research and prevention (5.2)
Sweden	62.5	Very rough estimate on costs for demand-reduction expenditures on alcohol and drugs (Tullverket, 2000). Municipalities SEK 300 (EUR 30), Counties SEK 250 (EUR 25) and State SEK 50 (EUR 5). Non-governmental organisations, foundations and companies SEK 25 (EUR 2.5)
UK 2000–01	466.3	Estimation for the financial year 2000–01 (12 months to 31 March 2001). 'Drug treatment' GBP 234 million (EUR 367.4); 'Protecting young people' (Prevention), GBP 63 million (EUR 98.9)
Norway	224.9	Estimation of costs at central, county and municipal level for drugs and alcohol-related services prevention, treatment and healthcare (in-/outpatient, drug free, substitution), social services for drug addicts outreach work, harm/risk reduction, rehabilitation and reintegration

Sources: Reitox national reports, 2002.

that each EU citizen contributed between EUR 5 and 10. Of course, it is likely that this amount may be considerably higher.

Finally, as emphasised by several participants in the research, a common methodology would be crucial to cross-country research, assuming that this type of information, and its subsequent analysis, turns out to be relevant for decision-making.

### Repatriation of expenditure

With current data collection systems, it is very difficult to obtain a reliable breakdown of figures on spending by category. Nationally, areas such as treatment, harm reduction and prevention often merge into each other, and not all countries apply the same system of categorising expenditure. Consequently, international comparisons are hampered by the use of different data collection and classification methods, making it very difficult to compare expenditure in specific areas.

However, the methodological constraints aside, one rather solid conclusion can be drawn on the basis of the best data provided in this report: the area of healthcare and treatment seems to attract the lion's share of the money, accounting for 50–80 % of all direct government drug demand-reduction expenditure.

In Austria, 'counselling, care and treatment' for drug addicts in 1999 accounted for 78 % of federal demand-reduction expenditure. In Greece, the data show that almost 73 % of known expenditure was allocated to treatment (and secondary expenditure), while in Spain, in 1999, expenditure on treatment in the communities and autonomous cities accounted for 74 % of the total. In Portugal, 49 % of total drug expenditure in 1999 went on treatment, but with 25 % of the total expenditure allocated to drug-use prevention this is one of the highest rates (of the known data) in this area in the EU.

Direct expenditure on 'prevention' is, in fact, very difficult to identify, and as a result the data are more uncertain. Known rates range from 4 % in Austria, which provided data only on primary prevention, to 20 % in Greece (again only primary prevention) and are 15 % in the Spanish communities and autonomous cities and 10 % in Luxembourg.

The share of total drug-demand reduction expenditure allocated to rehabilitation and reintegration, and to outreach

and harm-reduction activities, seems to be lower, most likely because of the different scale of expenditure in comparison with treatment or because partially included in it.

### Final considerations

As far as analysis of drug-related expenditure is concerned, a distinction must be made between research on expenditure at national level and cross-country comparisons of this research.

Recent studies in some countries <sup>(206)</sup> have shown the possibilities of achieving satisfactory results even without applying an 'internationally agreed methodology'. Of course, on such a basis, the comparability among countries is certainly limited, but still at national level this research can increase knowledge of the responses to the drug phenomenon and can be a useful instrument for decision-makers, allowing them to assess the level of expenditure in their own countries over time (if repeated) and across sectors (if detailed enough). Moreover, when cost estimates are compared with other indicators, as seen earlier, it is possible to estimate how much is spent per drug addict or how much the drug-demand reduction policy costs compared with other policies, or how much citizens must contribute to drug-demand reduction.

These ratios and comparisons raise very relevant questions and hypotheses, the answers to which may be obtained through more in-depth studies.

Comparison 'across countries' (the scope of this study) is another dimension of drug-related cost estimates research. As shown in this report, such studies are highly dependent on different data sources and are therefore hampered by the lack of uniformity among the different countries' methodology, statistics and figures. To overcome these (and other) difficulties, common data collection standards should be implemented. However, such an approach would require investments without yet being certain of the quality and usefulness of the final results. Prior to such investment, further research is needed, together with a deeper reflection on the relevance and utility of such studies at European level.

In the meantime, and while reflection on further development is undertaken among European partners, it is the role of the EMCDDA to continue promoting the improvement of the statistical systems in the field and to disseminate information on the methodologies in use and the research undertaken.

<sup>(206)</sup> Uhl (2001), ONDCP (2001); Godfrey et al. (2002) and Origer (2002), Kopp and Fenoglio (2003). See also the national focal points from Austria, Portugal, Spain and Greece, in the framework of the 2002 Reitox national reports.