Public Health and European Integration:
A Difficult Match

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Recently, or to be more accurate during the last decade or so, the Commission has been involved in creating a new European Union sphere that specifically deals with issues related to public health. Whereas member states operate their healthcare systems in virtual isolation from one another because efforts at identifying the strengths and weaknesses of individual systems, through improved co-operation are only in their infancy, public health has been incorporated in the newly expanded jurisdiction of the Commission.

To be sure, there is a compelling reason for emphasizing public health above and beyond improving the performance of national health care systems. The heightened mobility of people accentuates threats to health and provides the real impetus for greater Community attention. Individual member states cannot protect their citizen's health through their own efforts alone. Certain threats and risks, notably communicable diseases, know no borders (Haour-Knipe and Rector, 1996). Other risks, such as stemming from drug-resistant microbes can only be tacked through European and international co-operation. The effectiveness of numerous drug prevention programs also depends on cross-border cooperation and the ongoing fight against drug misuse cannot succeed unless neighboring countries synchronize their police activities, sentencing laws, local zoning restrictions, and treatment (maintenance) options.

It would appear, therefore, that Community efforts to address public health challenges is an example of supranational institution building that enhances the control of member states over a sphere over which, considered in isolation, they would have no control at all. The reach of national politics is thus extended. It complements the objectives of individual member states and enlarges the impact of domestic decision-making. In a global world with increased mobility of people, goods, and capital, joint decision-making under the

aegis of the Commission complements, and is a normal reflection of, the limits of national democratic governance.

Public opinion polls seem to share this feeling. European citizens support joint national-EU decision-making in areas that transcend national borders or have limited impact on their day-to-day life. Nearly nine out of ten Europeans believe that the fight against drug trafficking and organized crime is a high priority for the European Union but only three out of ten feel that justice and police should be part of the joint national-EU decision-making processes. In 1996, nearly nine out of ten believed that cooperation in the fight against cancer/AIDS was a top priority for the EU and seven out of ten Europeans favored joint decision-making in science and technology. By contrast, only three out of ten Europeans supported joint decision-making in the field of health and social welfare (Eurobarometer 1996; Eurobarometer 2000).

Because effective drug control systems and public health policies (in contrast to health and social welfare) require extensive cross-border cooperation, 94 percent of European citizens support joint research funding for the fight against AIDS, 91 percent in favor of combined information campaigns, and 89 percent of European citizens would like to see greater collaboration in the treatment of those with AIDS (Eurobarometer 1996).

In response to the obvious advantages of pooling resources in the sphere of public health, different programs and initiatives have indeed produced a stronger and more visible public health dimension at the EU level. Nevertheless, a closer look reveals a more chaotic situation and less coordination or collaboration than we would consider feasible. The main obstacle to further deepening or institution building is that member states hold conflicting views of the risks of certain forms of anti-social behavior (i.e. drug taking) and of state responsibility in the sphere of public health. Social institutions in each member state set the boundaries between state responsibility and personal freedom differently with the result that national government agencies enjoy varied levels of freedom in framing and pursuing particular agendas.

But there is another reason why a heavy doses of skepticism seems warranted and why a Community public health framework is less attractive than we would at first blush believe. Community action points contradict whatever consensus has emerged among the member states to deal with certain issues in a particular fashion. The treatment of HIV/AIDS is mostly standardized and does not cause much controversy. But the approach to drug consumption is open to conflicting interpretations. A new division is appearing between national government agencies, which try to shun outright prohibitionist drug control policy in favor of harm reduction or risk minimization strategies, and the Commission whose principal focus is demand-reduction or supply-suppression. The conclusion of this paper is therefore that it is perhaps preferable if the Community domain remains underdeveloped because it privileges repression over therapeutic intervention just when member states are moving into the

direction of recognizing the futility of eradicating a youth culture, which partly revolves around illicit drug-taking.

The organization of this paper will illustrate and elaborate this argument. In the first part, I explain why public health (under which drugs and infectious diseases fall) reflects typical national values and gives rise to different policy strategies. Then, I describe the current state of affairs at the European level with special emphasis on the drug policy field. In the third section, I revisit the present situation in the member states to argue that public health measures and policy norms increasingly converge. The conclusion takes a second look at the tension between fresh Community developments and the new popularity of harm reduction strategies among the member states.

Public Health-Divergent Attitudes, Norms, and Institutions.

Western societies subscribe to one fundamental idea-the idea that the body is a machine and that health is about providing curative care to individuals once they become ill. In this biomedical conception, disease is an individual condition to be cured by individual action. It discounts the effects of environment, race, class, or gender. By comparison, public health fits another paradigm in which societal-level factors determine health and illness and the focus is mostly on disease prevention and health promotion. In the biomedical model, which dominates, the medical profession plays a key role and public resources go into health services under the control of the medical establishment, which is responsible for prevention. Public agencies, aside from supplying resources and structuring the delivery of health services, do not directly curb the ability of the medical profession to define disease in accordance with its own terms.

By contrast, classical public health policy looks after the health of the population as a whole and involves quarantine regulations, immunization program, clean water and safe food regulations. It found an academic home in epidemiology and biostatistics and has not commanded much government funding since the 1950s. Many of the most challenging public health threats were conquered thanks to universal immunization programs, improved sanitation, and better preventive care. Instead, since the early 1980s, it is the 'new public health' that has taken the center stage. New public health differs from its earlier variant because it refers to a collectivist view of responsibility for health and illness. It falls under public health because it is concerned with the aggregate population rather than the individual. But it differs from the earlier public health framework because it focuses on community and societal structures and assigns responsibility for health to society (Lewis, 1999: 154-56).

In this new approach to public health, there is often a tension between the collectivist objectives and the Western celebration of individual autonomy and self-governance. Tobacco smoking, drugs, and alcohol are part of our mode

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of self-expression. Yet these consumer choices or freedoms hurt the community and invite detailed legal regulations and administrative rules. Since the right of the individual to choose is taken for granted—our whole being is shaped by consumption—post-industrial societies are havens of consumer choices and regulations. The new public health paradigm addresses this tension between our free will to express ourselves through consumption and its negative impact on the health and stability of the community. Harm reduction, harm minimization, and risk-reduction are concepts widely used to map out a consistent strategy that reconciles the inviolability of the self-governing individual with an well-ordered society. The sort of government intervention programs that fits the label of harm reduction are needle exchanges for drug users or safe sex campaigns to counter the spread of AIDS. Such programs are considered post-moralistic, neutral, and respectful of individual rights. They empower the drug user, the sexually active, or the drinker to regulate and control his/her activities and thus avoid harm. In truth, many harm-oriented programs are more concerned with harm to society than the drug user or drinker and possess a strong disciplinary bent. The therapeutic community and local agencies in charge of public health and social welfare are quick to blame the individual for failing to uphold the good of the society. Harm reduction means often harm to society's values and morals (Valverde, 1998).

Both Aids and drug use are health care topics that epitomize the essential elements of the new public health model. Drug use and 'unsafe sex' have both individual medical implications and collective social consequences. Obviously, infectious diseases fall under the category of public health since altering behavior and taking preventive actions can stop their spread. Drug misuse is also a public health challenge as it encompasses more than just biomedical dysfunction since it determines and is determined by social adjustment, psychological functioning, employment, family functioning, and criminal activity. Patterns and frequency of drug use have both physical ramifications for the user and social costs for society. Treatment, moreover, requires involvement by the family, community, or local authorities in addition to the patient/user. Both AIDS and drug misuse are regarded challenging social problems because they require behavior modification as well as medical treatment.

However, each EU member state has its own ideas with respect to public health, social and individual behavior, and health care delivery systems. Whereas it is dangerous to draw broad generalizations about which configuration of factors mold a particular national frame of reference, countries with a tradition of strong centralized state powers, which grant police organizations substantial authority to defend the state against internal enemies, are more likely to take a repressive or restrictive view of drug-taking and are less likely to define drugs in terms of the new public health paradigm. A police force that is endowed with militarized powers to protect the state from internal threats possesses the legal means to employ its resources to persecute drug-users. Its statutory position is

such that legal norms impose few restraints on the actions of law enforcement that would prevent an infringement of personal liberties. By the same token, countries that fear the concentration of police powers and therefore impose considerable restrictions on police organizations are more likely to take a softer view of drug users, unwilling to employ the criminal justice system to prosecute recreational drug users, and more cognizant of the sanctity of personal freedoms and individual rights (Anderson, 1996; Punch, 1983).

In countries with a tradition of militarized policing and centralized state structures, drug trafficking and drug consumption are undifferentiated criminal offenses and the law puts as much emphasis on the suppression of the demand for drugs as on its supply. Drug users encounter repression because they are blamed for abetting organized crime and are therefore regarded as tacit accomplices of the criminal underworld. By contrast, in countries with a legal tradition of delimited police powers, the drug problem is more likely split between a policy aimed at drug users (treatment, maintenance programs, curbing nuisance) and at combating drug trafficking.

France is a prime example of a country that takes a harsh attitude towards drug users or toward the personal consumption of drugs. It considers drug-taking not only a threat to the moral fiber of the nation but also a security challenge because virtually all of the intoxicants are smuggled from abroad. Their presence is said to undermine middle class work ethic in addition to posing a challenge to the stability of the state (Stengers and Ralet, 1991).

The Netherlands and Britain are examples of countries with state structures that possess weak policing capacity and decentralized law enforcement agencies. Respect for civil liberties and suspicion of concentration of powers subordinate law enforcement agencies to elected officials. Because police powers are carefully circumscribed by parliamentary legislation, these countries adopt a more relaxed view of drug taking by ignoring personal consumption.

Although the historic evolution of police institutions goes some ways in accounting for divergent interpretations of the drug problem and subsequent policy measures to contain it, this argument needs to be supplemented by other considerations. For example, the Scandinavian countries do not fit the French model of policing and central state powers to silence 'enemies.' Yet the Scandinavian countries (with the exception of Denmark) also pursued an unmitigated zero-tolerance policy against drugs and relied on repression to stamp out the demand and supply of drugs. The Scandinavian obsession with the preservation of public morality originates with the special legacy bequeathed by the temperance movement. Dating from the late 19th century, temperance activists sought to ban alcohol from society in order to end intoxication and civilize the lower classes. They claimed that a ban on alcohol would modernize the nation and help prepare agricultural workers for employment in the emerging woodworking industries and growing cities (Kurzer, 2001). Fear of intoxication, first articulated by the temperance movement, spilled over into the drug field.

Whereas Sweden (and Norway) possess some of the best treatment centers for drug users, the state is extremely hostile to recreational drug taking and aggressively upholds zero tolerance (Gould, 1994; Henriksson and Ytterberg, 1992: 334-36; Stenbacka, 2000: 232-251:).

Thus, at the very minimum, two different institutional legacies account for why the public health perspective dominates state attitudes and intervention techniques. The statutory position of law enforcement and the general functioning of the criminal justice system account for whether prohibitionist drug policies are acceptable or not. In addition, successful mobilization of temperance or teetotaler movements legitimizes strongly negative views towards all sorts of intoxicants and fosters a zero-tolerance climate.

Indeed, in the 1980s, member states adopted different drug prevention programs, testimony of different philosophies and state structures. France and Germany embraced the viewpoint that the best treatment was totally abstinence and all drugs were considered equally harmful and dangerous. Medical prescription of substitute drugs was prohibited and needle exchange programs were banned since the purpose was to eradicate all drug use. French and German officials mostly defined the whole drug debacle in terms of public order or law enforcement. Coercion and repression were seen as a way to achieve an absolute ban, and drug users were considered delinquents who threatened the established order. By the early 1990s, France and Germany still adhered to this viewpoint while the UK, Italy, Denmark, and the Netherlands embraced a more liberal and pragmatic tradition, recognizing that drug usage could not be eradicated so that reducing health risks became the main goal. The Netherlands, in particular, pioneered the concept of drug decriminalization by allowing licensed coffee shops to sell small amounts of cannabis to consumers for personal use. It also tolerated street scenes where hard drugs were openly traded in order to forestall greater drug-related criminality (Korf, Riper, and Bullington, 1999). Denmark, too, officially allowed certain areas of Copenhagen to become open drug scenes. In Denmark, the Netherlands, and the UK, the tendency was to regard drug users more like patients or social welfare recipients and less like criminals.

Just as countries take a different approach to drugs in accordance with their institutional structures and cultural legacies, the sudden appearance of a new infectious disease also generated divergent response strategies, at least in the beginning. European countries had relatively sporadic encounters with public health emergencies since the risks of serious infectious diseases had lessened. So, when first confronted with HIV/AIDS, EU members took one of two different approaches. They either opted to take a more liberal approach or they decided on a restrictive 'contain-and-control' strategy. In the latter, this involved mandatory testing, detention or perhaps quarantine of the victim, and repressive measures against 'risk groups.' In the more liberal 'cooperation-and-inclusion' approach, the mode of action was to promote voluntary testing, counseling, and

health education campaigns. Education and information were the preferred modes of engagement in more liberal countries while legal restrictions characterized a more authoritarian response.

Government responses to AIDS were shaped by the structures of the welfare state system, cultural norms guiding the demarcation of responsibilities between state and society, the input by non-governmental organizations, and the organizational features of the health care system (Steffen, 1999). For example, integrated health systems, which enjoy wide public control over activities, are more likely to sustain links between care and prevention and between hospitalization and primary care structures. Comprehensive health system coupled with advanced local or regional intervention mechanisms are also better equipped to create and maintain specific modalities to assist vulnerable groups suffering from AIDS or hard drug addiction.

But the type of health care system is only one variable. Norms about acceptable levels of state intervention in private affairs of citizens also framed original response to HIV/AIDS. Again, Sweden is a good illustration. The Swedish government brought AIDS into the ambit of preexisting law on venereal diseases. By taking recourse to the Infectious Disease Act, government officials were allowed to impose a number of legal restrictions on patients. A person could be isolated in a hospital if deemed a threat to others while the general community received warning of the case. Each person had to be registered by number, gender, and locality, which was anonymous but in some cases could lead to easy identification. This reaction dovetailed with the social democratic urge to put life in order for all people. It mirrored the repressive and patronizing attitude to drinking and alcoholics in an earlier age when drunkards were forcefully placed in treatment centers that were actually dressed-up prisons (Henriksson and Ytterberg, 1992)

In Germany, AIDS politics was caught between two competing visions as a conflict emerged between the federal ministry of health and the state of Bavaria. The federal government adopted a liberal line while Bavaria identified prostitutes and injecting drug users as particular risks groups and carried out mass screening of prisoners and foreigners who applied for a resident permit (Steffen, 1996).

Both the Netherlands and Denmark took more liberal efforts and the tracking of HIV infections itself became a major controversy. Neither country imposed any restrictions on gay life such as the closing down of bathhouses and resisted the idea of keeping records (Van Wijngaarden 1992). Of course, both countries possess 'liberal' drug laws.

France took a more authoritarian approach because it called for compulsory detection tests. Although France was one of the firsts to tackle the AIDS phenomenon, its infection rate was high. Public health had a weak administrative position in the French state system and interministerial

coordination was lacking. The medical establishment had different priorities and obsession with scientific accomplishments delayed the introduction of new techniques to treat blood specimens (Steffen 1996).

In Spain, AIDS was dismissed as someone's else problem until the late 1980s and then a panic took hold that prompted even eminent research officials to suggest that HIV-infected people be quarantined. There, the disease affected intravenous drug users and their families and the Spanish government at first ignored the problem. Its lack of response and treatment put it out of step with its neighbors. When it did respond, it adopted the Northern European model by focusing its prevention and information campaign on youth and gay men. But it was mostly intravenous drug users who picked up the disease (De Miguel and Kirp, 1992: 168-184).

In addition, HIV/Aids also touches on ideas about sexual morality since AIDS prevention requires an open discussion on safe sex and the use of condoms. Countries with long tradition of ecclesiastic monopoly on the definition of morality encountered much greater difficulties in reaching out to society to warn against the hazards of unprotected sex or multiple partners (De Miguel, 1992; Fasolo).

Countries with strong separation of public and private life also found it difficult to design programs to get their message across. As the epidemic has stabilized, most AIDS victims are found in disadvantageous groups like drug users, illegal immigrants, prostitutes, or prison inmates. Generally, these social groups are difficult to reach because social welfare officials and official state agencies tend to overlook those who find themselves at the fringes of society. Social welfare states do not easily cater to those who live isolated lives in contrast to non-governmental organizations, which are better equipped to reach out to marginal social groups. In particular, in countries with repressive drug laws, inadequate local social services, and underfunded health care centers were at a disadvantage to isolate and implement an effective response to the emergence of HIV/AIDS. In retrospect, the ongoing commitment to an abstinence-oriented ethos helped spread HIV/AIDS because authorities in these countries resisted substitution treatment programs like syringe exchanges (Davoli, Patruno, Camposeragna, 2000: 146-59).

In summary, drug policy and HIV/AIDS are public health challenges but EU member states tend to define the level of health risks differently. The treatment of HIV/AIDS is now mostly normalized and approaches to care do not differ much. Only in the area where HIV/AIDS intersects with patterns of drug consumption are there still some visible differences among the member states. This difference, in turn, mirrors disagreements on how to assess the risks of stimulants and how to treat drug consumers.

The Creation of an European Dimension

The Treaty for European Union paved the way for European-wide coordination in the field of drug policy. Article K1 of the TEU stipulates that the fight against drug addiction, therefore against drug use, is a matter of common interest. Policing and justice are the likely area where the competencies of the member states permit for cooperation and the European Drug Unit was set up to concentrate on fighting corruption, money laundering, and organized crime.

The transfer of major areas of the 'old' Third Pillar into the Community pillar after the Amsterdam summit in 1997 bolstered Community-wide efforts in the sphere of drug policy. Presently, Title VI (or the 'old' Justice and Home Affairs arrangements) is more or less limited to judicial cooperation in criminal matters while the new chapter on "free movement, asylum, and immigration" opens the way for considerable Europeanization in related fields such as the combat against organized crime (Monar, 2000).

The new Directorate General for Justice and Home Affairs (DG-JHA) has the task of formulating a European action plan against the circulation of drugs and its use (Monar, 2000). It is responsible for coordinating the activities of the Commission's services involved in the different aspects of the fight against drugs, notably, prevention, education, research, health, training, precursors control, money laundering, police, and customs and judicial cooperation. It is also in charge of coordinating the implementation of the European Union Action Plan on Drugs for the years 2000-2004. This coordination function is essential to ensure a global, integrated and balanced approach of the drug phenomenon in line with the EU Drugs Strategy endorsed by the Helsinki European Council. To meet these goals, DG JHA runs an interservice group on drugs and coordinates the relations of the Commission services with the European Monitoring Center for Drugs and Drug Addiction (EMCDDA) based in Lisbon. The latter organization is the overall drugs information system in the EU and maintains contact with national coordinating agencies in the member states.

Drug control policies are also the remit of Europol whose convention was ratified in October 1998. Following a number of legal acts related to the Convention, Europol commenced its full activities on 1 July 1999. Europol is mainly an intelligence agency that facilitates exchange of information, in accordance with national law, between Europol Liaison Officers (ELOs). Article 31 of the Treaty of Nice mentions support for the creation of Eurojust to which prosecutors, magistrates, and other law enforcement officials will be seconded and assist with crimes common to the EU.

Coinciding with growing commitment to seek a Community-wide action plan to combat drug-related problems and crime, the member states have also added a stronger public health dimension in the treaties of the European Union. The original motivation actually stemmed from food scares (mainly mad-cow disease) and from the disaster with HIV-contaminated blood products.

Regardless of what prompted this new focus on public health and consumer protection, the advent of the Treaty on European Union in 1993 boosted cooperation in the field of drug addiction/misuse, since the Treaty identified drug dependence as a priority for Community action in the field of public health. Title X Public health in the Treaty on European Union granted the EU authority to act in public health matters.

The mission of DG Health and Consumer Protection is to ensure a high level of protection of consumers' health, safety and economic interests as well as of public health at the level of the European Union. In May 2000, the Commission proposed a new European Community strategy on public health. The central core of the new strategy is an incentive program, with a proposed budget of 300-million euros over six years, with three major strands of action. The first strand aims to put in place a comprehensive data system on the major determinants of health in the EU, together with mechanisms to evaluate this data. The second goal aims to ensure that the Community is in a position to counter threats to health, which cannot be tackled by member states in isolation. The third will put in place strategies to identify the most effective policy for combating disease and promoting health. The new strategy also outlines legislative initiatives being considered under the Community's direct competence in relation to public health.

From the start, specific actions in the AIDS field consisted of encouraging cooperation between member states by relying on the activities of non-governmental organizations and by supporting national agencies with the specific tasks of caring for patients and running prevention campaigns (Altenstetter, 1994). Considering the diversity of national health care systems and modest EU funding, Health and Consumer Protection plays the role of network facilitator. Member states are extremely reluctant to yield any authority over health care to the Commission and HCP must operate within the parameters of subsidiarity. Most of the efforts by the Commission focus on transnational prevention projects set up by non-governmental agencies. Critical in all of this networking is the MMCDDA, which maintains relations with fifteen separate national drug coordinator agencies, many of which were specifically created to meet the goals of the EU 2000-2004 Action Plan on Drugs.

Convergence of Drug Policy and Public Health Models

In spite of weak efforts to coordinate and institute top-down harmonization, national policy regimes in the field of drug prevention and HIV/AIDS have lost some of their distinctiveness. This is not because of Community legislation, which hardly exists. And it is too premature to declare that all national divergences are disappearing. But it seems fair to conclude that end goals converge while the implementation or execution of broad targets continues to diverge since the institutional capacity of state agencies and non-profit organizations to deliver funding, programs, and services differs. Generally

speaking, however, the trend has been towards greater conformity in public health thinking and action.

One manifestation of the trend towards convergence is that an increasing number of drug policy regimes differentiate between categories of drugs and level of drug dealing (i.e. personal consumption or wholesaler). Many countries accept some sort of decriminalization standards or tolerance with respect to soft drugs and are more likely to perceive hard core addicts as needy patrons of the social welfare state. The combination of soft drug tolerance and treatment programs for drug addicts has blunted the sharpest divisions among competing national drug policy regimes. In addition, local authorities in many member states are now looking to bring social services such as methadone prescriptions, needle exchange programs, or counseling to areas of heavy drug usage (Kaasjager and De Kort, 1997). Methadone substitution treatment is widely available while this same mode of intervention was extremely controversial barely ten years ago (Boekhout van Solinge, 1999; EMCDDA, 2000). User (shooting) rooms, where hard-core addicts can quietly inject heroin, are now found in Austria, Germany, the Netherlands, and Spain and Portugal. Some doctors in the UK prescribe heroin (Kaasjager en De Kort, 1997). Clearly, by the late 1990s, abstinence policies have fallen out of favor. The main factor for the decline in popularity of prohibitionist drug policies is the arrival of the HIV/AIDS crisis. The sharing of contaminated syringes is directly related to the spread of HIV/AIDS and intravenous drug taking is one of the most common routes for the disease. Thus, after a period of indecisiveness, just about all countries have come to the conclusion that providing maintenance programs such as needle exchanges to hard core drug users best contains HIV/AIDS epidemic.

Second, bilateral cooperation among police officers and other law enforcement agencies has grown since the 1980s and has in fact brought about alignment in police procedures, sentencing, and policing organizations (Anderson, 1996: Anderson, 1994). Many countries have seen a surge in hard drug use in the 1990s with an accompanying rise of public nuisance complaints and drug-related petty crime. Some of this nuisance is the direct outcome of divergent drug policies and different levels of national drug tolerance. Regions with a liberal attitude towards street dealing draw users from regions with harsher drug laws and witness an inflow of drug tourists. Border towns in regions with tolerant drug approach become thriving centers for the drug trade, catering to users from countries with strict anti-drug dealing laws. To tackle the flow of drugs and tourists, law enforcement agencies must cooperate with their counterparts in neighboring countries. Increased interactions among law enforcement agencies have the long-term effect of diluting the thrust of eradication programs and of toughening tolerant pro-consumer policies. As prohibitionist countries become less coercive while liberal countries become more restrictive, the result is convergence (Kurzer, 2001; Laursen, 1996).

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An example of gradual liberalization partly in response to continuous border frictions and tourist flows is German drug policy. Especially, the state governments that border the Netherlands coped with a surge of drug traffic and rising public nuisance complaints at home. State governments in northwestern Germany after years of criticizing the Dutch, decided to follow the Dutch example to reduce drug fatalities and drug-related crime. Many cities in these states have moved to decriminalize soft drugs consumption and have created centers for hard core users. In the meantime, the Netherlands in response to inflows of drug tourists has taken stronger action against foreign drug users and toughened local police laws (Baerveldt, Bunkers, De Winter, and Kooistra, 1998). Step by step, the Dutch have become less forgiving of the negative externalities of drug tolerance while the Germans have become worried about the social costs of repression.

Above all, AIDS forced through adjustments and changes in institutions and structures long resistant to change. France is the most striking example of the new trend in the 1990s to take a gentler approach to drug users. Whereas the French health care system was barely involved in drug treatment strategies in the 1980s, its clinics or institutions treated an estimated 60 000 opiate-dependent users in 1998. Since the total population of hard-core addicts is estimated to be between 150 000 and 300 000, somewhere between 20 to 40 percent receive substitution treatment at any one time. While this does not approach the Dutch ratio, it is still a major move away from the previous system, which offered only prison sentences to drug users (Auriacombe, 2000: 119-27).

The drug situation in Europe is still heterogeneous but the clash is often found between cities or regions in one country. In many member states, local administration is in charge of public order and public health and local city councils may pursue different objectives. Large metropolitan areas with a high concentration of drug users are more likely to experiment with innovative treatment strategies than regions with low rate of drug addiction.

Although the gap between different treatment philosophies and risk assessment has decreased, countries still deal with the after effect of a previous reluctance to acknowledge a correlation between intravenous drug use and HIV/AIDS infections. Accordingly, AIDS cases per million inhabitants, as reported by December 1999, showed huge variations across the EU. Spain reported 176 cases of AIDS per million people while Italy had 99, and France recorded 88 cases per million population. By contrast, Austria, Belgium, Germany, and Sweden recorded between 20 and 25 cases per million. Most of the differences in AIDS infections can be traced to patterns of drug use and official attitudes towards drug prevention programs and hard drug addicts. In Spain, 32 percent of drug users tested positive for the AIDS virus and 16 percent of drug users in Italy and France were infected in 1998-1999. By contrast, Belgium, the UK and Sweden had a rate of infection of 1 to 2.5 percent among drug users. It follows that the incidence of *drug-related AIDS* per million population also varies. In

1999, Portugal had the highest rate of 60, Spain had 45 cases per million, down from 103 in 1996, and Italy recorded 15 cases of drug-related AIDS per million people, down from 50 in 1996. France registered 5 infected cases per million in 1998, down from 16 in 1996. Other EU countries (Belgium, Denmark, Germany, Greece, Netherlands, Finland, Sweden and UK) had less than 2 drug-related AIDS cases per million population in 1999 (EMCDDA, 2000b).

HIV occurrence is up to six times higher in France than in the UK. And all the Mediterranean countries have higher prevalence rates than northwestern Europe. Spain had a total of 52,216 reported AIDS cases in December 1998 while the UK and Germany had respective 15,675 and 17,836 cases (Steffen, 1999: 7).

Public health care methods, information campaigns, and programs geared to marginalized subgroups mattered tremendously in the 1990s because they influenced the number of people infected with the AIDS virus. Countries with high rates of HIV infections have dropped their objections to harm reduction out of enlightened self-interest since this is one sure way to arrest the future increase of victims.

Conclusion: The Future of an EU Public Health Domain

Because drug policy, HIV/AIDS programs, and public health approaches have to some extent converged, the time seems ripe to proceed with the construction of a European public health domain. But it is questionable whether institution building at the EU level is to the real advantage of the member states. On the one hand, Community measures have certainly facilitated better coordination and information flows combined with greater openness to alternative models of intervention. Obviously, this interaction benefits the EU and is beneficial generally since it is impossible to pursue an effective national drug policy program in the absence of any coordination with neighboring countries. In this sense, Community institutions are critical because much can be learned from the trials of other countries. In addition, it is senseless and ultimately destructive to conduct a drug policy regime apart from and in isolation of neighboring countries. In this day and age of borderless frontiers, it is counterproductive to be out of harmony with other countries.

On the other hand, one of the curiosities is that the DG for JHA, which is in charge of drug coordination, is spearheading the debate on drugs. To be expected, JHA defines the main challenge as protecting society from recreational drug taking and sees itself as guaranteeing internal security and social order. JHA operates under the assumption that demand reduction of illicit drugs is feasible and that improved policing techniques, coordinated sentencing systems, harsher penalties, and better intelligence gathering will result in less drug use. But it seems obvious that recreational drugs are part and parcel of the global Western youth culture. Many EU member states have abandoned the notion that

government action can prevent drug consumption, which is why they have become more receptive to the concept of harm reduction or risk minimization.

Notions of what is a good polity are constantly subject to revision and reconsideration. For a while, it was fashionable to believe that a wholesome society banned youth craving for stimulants or intoxicants and thus many countries declared a war on drugs. Nowadays, after years of disappointing results and with the new risk of HIV, the thinking has changed to include notions of keeping public nuisance down by providing addicts or users a safe place to engage in their activities. If some countries procrastinated and refused risk minimization model, the arrival of HIV/AIDS tipped the balance in favor of drug maintenance treatments. By contrast, the JHA underplays or minimizes the important public health dimension of drug misuse, discounts the individual rights of drug users, and is reluctant to differentiate drugs according to their harm. By contrast, scores of countries distinguish between hard and soft drugs. Even a majority of Commissioners (9 out of 17) recommended decriminalization of the use of cannabis and possession of small quantities of drugs (Castaignede, 1999: 313). Yet the annual report of Justice and Home Affairs is a blueprint for accelerating the construction of European policing powers and criminal justice system with the aim of solving the drug issue.

Of course, it is the function of the JHA to deal with internal security and law enforcement issues. But drug prevention programs do not work well if drug control policies are framed in terms of threats to the established order. The strongest proponent of harm reduction is DG Health and Consumer Protection, but it plays a subordinate role in the formulation of a drug policy program. The Treaty of Amsterdam has given Health and Consumer Protection no new competencies to implement an action plan to combat drugs and drugs are still not mentioned as a major health scourge in Art. 152(1) TEC. Moreover, JHA carries the responsibility for coordinating common drug policy and enjoys a full mandate while funding for any new projects is limited, hurting Health and Consumer Protection.

In summary, most of the debate and activities concerning drug policy takes place in the office of Justice and Home Affairs. This poses a risk to harm reduction strategies of the member states. For example, a key element of harm reduction is to decriminalize the sale of cannabis for personal consumption. How does that square with the call to step up the investigation, prosecution, and punishment of agents who supply the market with cannabis for individual consumers? The situation gets very confusing if consumers are free to buy soft drugs while their suppliers are prosecuted. Another example is the current fashion of providing addicts a safe space to inject heroin. How does that fit with the JHA mobilization to stamp out heroin trafficking? The annual report of the International Narcotics Control Board, a UN agency, makes the same point (INCB, 2000: 65-66). The INCB has strong misgiving with regard to harm reduction and points out that the opening of drug injection rooms where non-

medical use of drugs takes place is contrary to international conventions. National health care systems or social service agencies run these centers and are thus indirectly abetting the demand for such drugs, thereby sustaining the supply networks of illegal drugs. Creating a comfortable environment for drug users fails to reduce demand, according to this view, and thus fails to arrest social disorder. The Board mentions that recreational drug users receive a mixed message if authorities by running hygienic injection rooms facilitate drug-taking.

The most striking example of the confusion between legal and illegal is the dispensation of heroin to selected groups of hard core addicts, which turns local authorities, that is civil servants, into drug suppliers and blurs the lines between legitimate and illicit activities. Not surprisingly, Justice and Home Affairs whose philosophical sympathies are with UN agencies like the INCB fears that these policies contaminate the debate on drugs by sending ambiguous messages to users and obfuscates the boundary between legal and illegal intoxicants. By the same token, the JHA has little to say about how to deal with the enduring appeal of drugs and is mostly concerned with halting the growth of organized crime, drug trafficking, or money laundering. It is not the proper agency to help frame a solution to the dilemma that Western societies to some extent believe that individuals should not be punished for seeking recreational drugs when alcohol, which poses a much greater health risk, is freely available. Moreover, the member states have come around the idea that the youth culture is permanently bound up with drug-taking rituals as can be seen from the surge in popularity of synthetic drugs like Ecstasy.

It seems obvious why JHA dominates the incremental construction of a Community-wide drug control policy. Since the 1970s, with the creation of the Pompidou Group, drugs have been regarded as a civil order challenge. In addition, the United Nations treaties regulating interstate conventions on intoxicants, narcotics, and stimulants take a strongly prohibitionist line (Musto, 1987). All international conventions and conference reports always address the drug problem in terms of its ramifications for the legal order of the state.

Moreover, expert communities are divided about the correct approach to these controversies. Debate on drugs and AIDS is held in the domain of public health, social policy, and law enforcement and each community of experts has its own view on this matter. This is why the Amsterdam summit stressed subsidiarity and specifically proclaimed national governments to be the final arbiter over drug prevention programs. There is really no single overarching body of wisdom that is widely accepted as the conventional truth.

The confusion or diversity of opinions is further exacerbated by the fact that legislation on drug addiction and drug-related crime in many countries has not been amended in conjunction with new treatment practices. Although many countries decriminalized individual drug consumption, existing laws or administrative rules went unaltered. Advocates of the public health model must distinguish, case by case, between what the law says and how it is implemented.

This gap between official rules and informal practices makes it hard to construct a European public health model and a honest discourse on how to approach the circulation of illicit drugs. The agency that suffers the most from this confusion is the EMCDDA, which is supposed to collect data and create a European-wide snapshot of the current situation. But officials at the EMCDDA struggle to obtain relevant information because national officials themselves are not totally informed of how practices in the field differ from actual legislation (Flash Report, 2000). The public health model is not in a very strong position to be heard and be taken seriously at the EU level. After considerable delay, it has been adopted by national governments but its legal foundation is weak. To succeed, harm reduction requires a supportive environment because it relies on the cooperation of many rivaling agencies such as health care institutions, law enforcement agents, local city officials, and the wider community at large. The new initiatives at the EU level will eventually interfere with an effective harm reduction policy at home and undermines its legitimacy.

Although member states more or less agree on the medical profile of HIV/AIDS, its social aspects are still controversial. Care for drug addicts and prisoners, monitoring of HIV-infected mothers, safety standards in hospitals, sexually oriented education, counseling of prostitutes, testing and privacy rights, and assistance to disadvantaged social groups take on different hues in different countries. European countries will continue to display interesting differences in the way in which they deal with common problems and the complex aftermath of the failure of abstinence programs. The capability and commitment of governmental and non-governmental actors to pursue, implement, and monitor such programs varies not only across countries but also within each member state.

It is the DG for Justice and Home Affairs that is in the best position to step into this confusing situation. Owing to its antecedents in crime-fighting and law and order traditions, it continues to embrace the impossible goal of total eradication and the elimination of drug use just when many member states have come to the conclusion that drug use, insofar as it causes problems, is a public health challenge. The trend in the 1990s is just the opposite, away from criminal law and more towards community-based social intervention. The most likely agency at the EU, which would be sympathetic to this mode of discourse and type of intervention, is DG for Health and Consumer Protection and the EMCDDA. But neither is at a good vantagepoint to take over the leadership from the officials of Justice and Home Affairs. The real question is therefore whether the member states should aggressively support a stronger, better, or deeper EU drug prevention model when that model is perhaps outdated and infeasible. Undoubtedly, public health requires transnational cooperation because member states cannot tackle many of its present-day problems alone. But it is questionable whether Justice and Home Affairs should be the primary actor in the domain of drug policy. Yet the latter has strong public health features not

only because addiction is a medical condition but also because intravenous drug use is the main route through which the AIDS virus spreads in the EU.

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