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**THE MEDITERRANEAN LIMES.  
THE SOCIAL VARIABLES OF DEVELOPMENT:  
HEALTH, POVERTY AND CRIME**

**THE IMPACT OF THE EURO-MED PARTNERSHIP AND  
GLOBALIZATION ON SOCIAL IMBALANCES BETWEEN THE NORTH  
AND THE SOUTH OF THE BASIN**

**Rosario Sapienza  
CENSIS**

Étude Femise FEM21-30, CENSIS – Italie ; KEPE – Grèce ; Bogazici University – Turquie ; Royal Scientific Society – Jordan ; ERF fellow – Egypte



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Institut de la Méditerranée



## Research in the FEMISE network

STUDY D2: POVERTY, INFORMAL SECTOR, HEALTH AND LABOUR

### THE MEDITERRANEAN *LIMES*. THE SOCIAL VARIABLES OF DEVELOPMENT: HEALTH, POVERTY AND CRIME

### THE IMPACT OF THE EURO-MED PARTNERSHIP AND GLOBALIZATION ON SOCIAL IMBALANCES BETWEEN THE NORTH AND THE SOUTH OF THE BASIN

#### Synopsis

By Dr Rosario Sapienza  
[r.sapienza@censis.it](mailto:r.sapienza@censis.it)

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## 1. THE TERMS OF REFERENCE OF THE STUDY

This study is the second to be presented by Censis to the FEMISE network and via the network to the international scientific community. As early as 2000 the theme of poverty in the Mediterranean was the subject of a study carried out by Censis and promoted by FEMISE, whose aim was to contribute to the harmonisation process for the creation of a sustainable Euro-Mediterranean partnership by 2010, and reaffirmed by the European Commission in its *Agenda 2000*.

Starting with the classic socioeconomic definitions of economic deprivation and reduced access to goods and resources caused by low income, the 2000 study investigated and compared the main approaches and the evolution of the analyses dealing with the theme of poverty. According to the analysis carried out, the main evolution of the international debate essentially converged upon two main fronts:

- on the one hand, poverty is also considered *in terms that go beyond the economic component* and especially with regard to social exclusion, exclusion from participation in the active life of the collectivity, loss of basic individual liberties, lack of social esteem, lack of skills and education, and personal insecurity caused by socio-political or environmental causes;
- on the other, the concept of poverty is not only declined *in absolute terms but also in relative terms*, dependent upon historical events, comparisons with other countries, the perception on the part of the population (both on the part of the socially excluded themselves and according to widespread opinions among the reference communities) and socially determined values and needs as a whole.

The conclusion of the study confirmed *the need for further broadening of the debate on poverty from the more immediately socioeconomic aspects to the socio-medical and educational aspects and to safety and individual liberty*, bringing together questions linked to human development with the wider sphere of protecting human, social and civil rights. The need for a more in-depth study provided the stimulus for our latest Censis survey.

*Poverty, Health and Crime are the three yardsticks used by our study to measure the level of harmonisation in the Mediterranean countries in its search for interpretative hypotheses and transversal phenomena that allow us to identify more clearly the factors representing the greatest stimulus or obstacle to the convergence of development processes within the Euro-Mediterranean area.*

In the course of recent years, further evolutions have taken place that have partially modified Mediterranean scenarios and the perception that the various bordering countries have of them. Recent and on-going trends and correlated evolutions of the human development debate concern:

- *the widening of the development debate to also include non-economic components is by now considered necessary* and is explicitly hoped for even by the leading international economic organisations beginning with the World Bank who, in its most recent report, admits that a market approach alone is inadequate to the task of removing the obstacles to development and reducing poverty<sup>1</sup>;
- *the Human Development Index (HDI) developed by UNDP which is increasingly considered an important tool* for the measurement of development that is not exclusively economic and is especially useful with regard to the political engagement of governments and of the international community in setting clear objectives and in achieving the *Millennium Goals* for 2025;
- however, in the eyes of various representatives of the scientific community and of many development operators the *Human Development Index (HDI)* sometimes *proves to be insufficient* in observing development processes and mechanisms close up, in describing current trends and in throwing light upon particular phenomena like the tones of Euro-Mediterranean convergence towards the hoped-for harmonisation, to give just one pertinent example;
- *even today the debate on the construction of new indicators capable of strengthening our understanding of the dimensions of human development continues to be excessively theoretical and exploratory*; it is

<sup>1</sup> See the introduction of the World Development Report 2004 of the World Bank, also on-line at: [www.worldbank.org/data/datatopic/datatopic.html](http://www.worldbank.org/data/datatopic/datatopic.html)

a lively debate, widespread and perceived as necessary, whose problems though shared still encounter difficulties in finding consensus; collective reflection is still of little use in the rapid construction of new, universally shared indicators that can be used to interpret and accompany modern development processes;

- *there is an increasingly pressing need to integrate a theoretical reflection on indicators with more data, information and points of view in addition to the consolidated international sources*, taking into account – today more than ever – local or regional experiences capable of reinterpreting development factors, discovering and describing in detail new work hypotheses, and contributing to the theoretical knowledge and benchmarking of new interpretative models and tools.

## 2 THE METHODOLOGY

The study took place during 2003 and was divided into 2 volumes.

### Volume I

#### Part I

- an in-depth comparative analysis of the three dimensions using data supplied by the international sources available (mainly the World Bank, UNDP, World Health Organization, UNICEF, United Nations Interregional Crime and Justice Research Institute, United Nations Office for Drug Control and Crime Prevention, European Institute for Crime Prevention and Control, Interpol, etc.);

#### Part II, involving 4 phases:

- the construction of a set of simple variables illustrating the basic socioeconomic characteristics of the countries in question;
- the study of the correlations of the variables within each of the three dimensions, using the “Principal Components Analysis and Cluster Analysis” in order to identify the most significant correlations between the variables taken into consideration;
- the identification of complex, multidimensional indicators, constructed by combining the simple indicators, by means of a factorial analysis carried out by the Principal Component Analysis (PCA);
- the analysis of the Mediterranean area using the three simple indicators and their intercorrelations made it possible to reflect on the different aspects involved, determining the level of poverty/well-being of the countries considered and identifying any existing territorial disparity.

### Volume II – The case-studies in the 5 countries

- the in-depth study of the three dimensions and their intercorrelations using 5 case-studies in Egypt, Greece, Italy, Jordan and Turkey aimed at looking at the issue in greater detail, in both quantitative and qualitative terms.

### 3. VOLUME I

#### Part I – Comparative Analysis

Various phenomena leading to a failure to converge exist with regard to human development and the evolution of health, poverty and safety in the 18 countries considered<sup>2</sup>.

#### The non-linearity of socioeconomic development

The socioeconomic and human development harmonisation process in the Mediterranean is not proceeding towards convergence in a progressive and linear way, but is evolving towards scenarios in which the economic differences in the various countries involved are maintained as time passes (a partial countertendency with respect to the less developed evolution in other large regions of the world).

#### The new demographic scenarios

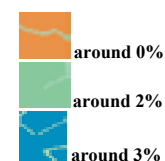
Annual population growth ranges from 0.1% in southern European countries like Italy, Portugal and Spain, to rates around 3% in the Middle East, especially in Jordan (3.9%), in Israel (2.9%), and in Syria (2.7%).

<sup>2</sup> The 18 countries are: France, Italy, Greece, Malta, Cyprus, Spain, Portugal, Israel, Lebanon, Tunisia, Libya, Syria, Jordan, Turkey, Algeria, Egypt, Morocco, Occupied Palestinian Territories.

Figure 1 – The evolution of the demographic scenario



Growth demographic ranges:



Source: Censis 2003

This data confirms the known trend towards the progressive modification of the demographic structure on the different shores of the Mediterranean taking place at three different rates: a) the Middle East, with rapid population growth, around 3%; b) North Africa, with slower growth, around 2%; c) Europe with a growth rate close to zero.

### The discontinuities of absolute poverty

Childhood malnutrition again reveals a gap between northern and southern countries, with worrying peaks - on the increase with respect to the early 90s - in Morocco, Algeria and Jordan. 2.3% of children in Mediterranean countries die before the age of 5, while 12.5% of those aged over 15 do not reach the age of 60. Leaving these averages aside, infant mortality rates (which tend to be similar for both sexes) differ vastly in the various countries. We can distinguish three types of country:

- countries where infant mortality is significantly lower than the average (all the European countries as well as Israel, Cyprus and Malta);
- countries where infant mortality is close to or just below average, like Jordan, Lebanon, Libya, Syria and Tunisia;
- countries where infant mortality is considerably higher than the Mediterranean average like Algeria, Egypt, Morocco and Turkey.

### The difficulties in increasing jobs for the young

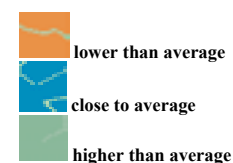
In the Mediterranean area the Millennium Goal relative to the development of employment opportunities for the young<sup>3</sup> seems a long way from being reached. The lack of data on the incidence of youth unemployment upon most of the countries on the southern shores implies a big delay not only in the attainment of the goal and in the policies intended to achieve this, but also in the fine-tuning of the observation instruments intended to record the current situation.

<sup>3</sup> Millennium Goal No. 8: "Develop a global partnership for development: work opportunities... Develop and implement strategies for decent and productive work for youth"

Figure 2 – The infant mortality in the Mediterranean countries



Infant mortality rates:



Source: Censis 2003

The data available shows negative trends in Morocco (the only southern country for which data exists) as well as in the richer countries.

### Lack of homogeneity in terms of expenditure for health

As far as expenditure for health is concerned, the countries can be divided into three groups:

- Countries whose health investment is less than 2% of their GDP (in order of increasing percentage: Morocco, Syria, Libya and Egypt);
- Countries whose health investment is over 2% and less than 5% of their GDP (in order of increasing percentage: Algeria, Turkey, Tunisia, Jordan, Cyprus and Greece);
- Countries whose health investment exceeds 5% of their GDP (in order of increasing percentage: Spain, Portugal, Italy, Malta, France).

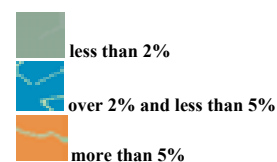
However, this is not a static situation. Data for 1995-2000 reveals an overall lack of homogeneity during the course of time:

- Countries on the northern shores and belonging to Mediterranean Europe experienced either fairly homogeneous level trends or a slight drop in health expenditure during the course of the five-year period, with falls (of varying gravity) in Greece and Cyprus;
- Countries on the southern shores and in Maghreb are characterised by extremely inhomogeneous situations; in Tunisia and Morocco there is the tendency for health expenditure to grow (to varying degrees), while countries like Algeria, Libya and Egypt are experiencing reductions (also to varying degrees);
- countries in the Middle Eastern area (which is fairly inhomogeneous) register growing health expenditure trends (the case of Israel, Syria and Lebanon, to varying degrees) as well as drops (the case of Jordan).

Figure 3 – Expenditure for health in the Mediterranean countries



#### Expenditure for health on GDP:



Source: Censis 2003

### The lack of homogeneity in the security habitat

Data supplied by the World Bank on various governance-related aspects confirms the gap dividing Mediterranean countries:

- a) *control of corruption* registers particularly positive values in Spain, France and Portugal;
- b) *government effectiveness* shows better values in France, Spain and Malta;
- c) *regulatory quality* registers positive trends especially in Portugal, Spain and France;
- d) *the rule of law* reaches its highest values in France, Portugal and Spain;
- e) *political stability* registers particularly positive values in Malta, Portugal and Greece;
- f) *voice and accountability*, registers particularly positive values in Portugal, France, Malta and Spain.

### Styles of governance

If we analyse the performance of each country, not compared to the others but compared to six different parameters constituting governance, we see that some countries tend to achieve better results with regard to one particular parameter rather than another. It is also interesting to highlight the negative values in proportion to other parameters for each country: this process allows us to describe some of the relative lacks present in the Mediterranean regions (Table 1).

**Table 1 - Relative incidence of the “ingredients” of governance**

|                                 | High relative incidence                    | Low relative incidence   |
|---------------------------------|--|--|
| <i>Control of corruption</i>    | Israel and Libya                           | Greece, Italy and Malta  |
| <i>Government effectiveness</i> | France, Jordan, Spain and Tunisia          | Portugal and Lebanon   |
| <i>Regulatory quality</i>       | Cyprus, Greece, Italy, Portugal and Turkey | Egypt, Libya and Syria   |
| <i>Rule of law</i>              | Algeria, Egypt, Lebanon and Morocco        | Greece and Italy   |
| <i>Political stability</i>      | Libya, Malta and Syria                     | Algeria, Cyprus, France, Israel, Italy, Jordan, Spain and Turkey |
| <i>Voice and accountability</i> | Greece, Italy and Malta                    | Libya, Syria, Egypt, Lebanon, Morocco and Tunisia                |

Source: Censis processing of 2003 World Bank data

## Part II - Principal Components and Cluster Analysis

The next step of the analysis was the construction of three complex indicators:

- Poverty and Access Index (PAI).
- Health System Index (HSI).
- Governance and Security Index (GSI).

More than just a material poverty indicator the Poverty and Access Index (PAI) measures accessibility to material resources, to information, culture and communication tools that allow advantages to be exchanged. PAI could be more accurately described as an indicator of accessibility rather than of poverty in the classic sense: accessibility of goods, knowledge and communication tools. It is the fruit of analysis in terms of principal components applied to the following variables (defined as active):

- Estimated income (PPP US\$)
- per capita GDP (PPP US\$)
- Rate of change of consumer price index
- Scientists and engineers in R&D (per 1,000,000 people)
- Users with land-lines and mobile phones (per 100 people)
- PCs in use (per 100 people)
- Internet users (per 100 people)
- Secondary school enrolment rate

Using this index the classification of the countries<sup>4</sup> is as follows (Table 2):

**Table 2 - Poverty in the Mediterranean countries according to the Poverty and Accessibility Index (PAI)**

|                        | Complex indicator | Min- Max deviation | Index number max=100 | Rank |
|------------------------|-------------------|--------------------|----------------------|------|
| France                 | 114.2             | 305.7              | 100.0                | 1    |
| Italy                  | 85.5              | 277.0              | 90.6                 | 2    |
| Israel                 | 75.5              | 267.1              | 87.4                 | 3    |
| Spain                  | 68.0              | 259.5              | 84.9                 | 4    |
| Portugal               | 58.1              | 249.6              | 81.7                 | 5    |
| Cyprus                 | 55.9              | 247.4              | 80.9                 | 6    |
| Greece                 | 37.7              | 229.3              | 75.0                 | 7    |
| Malta                  | 20.7              | 212.2              | 69.4                 | 8    |
| Libyan Arab Jamahiriya | -34.2             | 157.3              | 51.5                 | 9    |
| Jordan                 | -36.1             | 155.4              | 50.8                 | 10   |
| Lebanon                | -44.4             | 147.1              | 48.1                 | 11   |
| Tunisia                | -54.4             | 137.1              | 44.9                 | 12   |
| Algeria                | -60.5             | 131.1              | 42.9                 | 13   |
| Egypt                  | -63.3             | 128.3              | 42.0                 | 14   |
| Turkey                 | -69.9             | 121.6              | 39.8                 | 15   |
| Morocco                | -75.3             | 116.3              | 38.0                 | 16   |
| Syrian Arab Republic   | -77.4             | 114.2              | 37.3                 | 17   |

Source: Censis processing of data from UNDP, Unesco, World Bank, ILO, ITU

The Health System Index (HSI) shows the population's state of health and living conditions and the characteristics of the national health service, including the different funding methods used for health expenditure which

<sup>4</sup> The lack of data relative to the Occupied Palestinian Territories forced us to exclude them from our analysis to avoid the distortions this lack would have produced in the preparatory statistical processing for the construction of the indicators.

tends to assume positive values in the presence of a greater commitment, not only public, on the health front by the Welfare Community. The active variables introduced to the analysis refer to three separate contexts.

For the population's health conditions:

- Annual growth rate (%).
- Dependency ratio (%).
- Total fertility rate (%).
- Life expectancy at birth (years).
- Life expectancy at birth (years)-females.
- Probability of dying between 15 and 59 years (per 1,000).
- Healthy life expectancy at birth (years).

For health expenditure:

- Total expenditure on health share in GDP (%).
- General government expenditure on health share in total expenditure on health (%).
- Difference of private expenditure on health share in total expenditure on health.
- General government expenditure on health share in total government expenditure (%).
- Out-of-pocket expenditure share in total expenditure on health (%).
- Difference of out-of-pocket expenditure share in total expenditure on health.
- Social security spending on health share in general government expenditure on health (%).
- Prepaid plans share in private expenditure on health (%).

- Difference of prepaid plans share in private expenditure on health.
- Per capita total expenditure on health at international dollar rate(\$).
- Per capita government expenditure on health at international dollar rate (\$).
- Public expenditure on health (as % of GDP).
- Public health expenditure (as % of GDP).
- Private health expenditure (as % of GDP).
- Per capita health expenditure (PPP US\$).

For health service and mortality risks:

- Infants with low birth-weight (%).
- Under-five mortality rate (per 1,000 live births).
- Difference of under-five mortality rate (per 1,000 live births).
- Infant mortality rate (per 1,000 live births).
- Difference of infant mortality rate (per 1,000 live births).
- One-year-olds fully immunised against measles (%).
- Maternal mortality ratio (per 100,000 live births).
- Malaria-related mortality rate (per 100,000) - all ages.
- Malaria-related mortality rate (per 100,000) - children aged 0-4.
- Tuberculosis-related mortality rate (per 100,000 people).
- Tuberculosis cases per 100,000 people.

Using this index the classification of the countries is as follows: (Table 3):

**Table 3 – Health in the Mediterranean countries according to the Health System Index**

|                        | Complex indicator | Complex indicator (Min=Max-Min) | Index number max=100 | Rank |
|------------------------|-------------------|---------------------------------|----------------------|------|
| France                 | 254               | 787                             | 100                  | 1    |
| Italy                  | 228               | 761                             | 97                   | 2    |
| Israel                 | 208               | 742                             | 94                   | 3    |
| Spain                  | 181               | 714                             | 91                   | 4    |
| Malta                  | 170               | 703                             | 89                   | 5    |
| Greece                 | 150               | 683                             | 87                   | 6    |
| Portugal               | 140               | 673                             | 86                   | 7    |
| Cyprus                 | 110               | 643                             | 82                   | 8    |
| Tunisia                | -39               | 494                             | 63                   | 9    |
| Lebanon                | -48               | 485                             | 62                   | 10   |
| Jordan                 | -108              | 425                             | 54                   | 11   |
| Libyan Arab Jamahiriya | -138              | 395                             | 50                   | 12   |
| Turkey                 | -152              | 381                             | 48                   | 13   |
| Algeria                | -199              | 335                             | 43                   | 14   |
| Syrian Arab Republic   | -214              | 320                             | 41                   | 15   |
| Egypt                  | -263              | 270                             | 34                   | 16   |
| Morocco                | -280              | 254                             | 32                   | 17   |

Source: Censis processing of WHO and UNDP 2003 data

The Governance and Security Index (GSI) summarises the capacity to govern and therefore its effectiveness in managing the development and transparency of its regulatory system and therefore of its democratic apparatus.

The choice was limited to six complex indicators, originating from the World Bank, considered suited to the attainment of the objective laid down:

- Control of corruption
- Government effectiveness
- Regulatory quality
- Rule of law

- Political stability
- Voice and accountability

Using this index the classification of the countries is as follows (Table 4):

**Table 4 - The habitat of safety according to the Governance and Security Index (GSI) (2002)**

|          | Governance index | Complex indicator (Min=Max-Min) | Index number max=100 | Rank |
|----------|------------------|---------------------------------|----------------------|------|
| Portugal | 1.3              | 3.7                             | 100.0                | 1    |
| France   | 1.3              | 3.7                             | 99.3                 | 2    |
| Spain    | 1.3              | 3.6                             | 98.8                 | 3    |
| Malta    | 1.2              | 3.5                             | 95.8                 | 4    |
| Italy    | 0.9              | 3.3                             | 89.7                 | 5    |
| Cyprus   | 0.9              | 3.2                             | 88.2                 | 6    |
| Greece   | 0.9              | 3.2                             | 87.8                 | 7    |
| Israel   | 0.6              | 2.9                             | 79.6                 | 8    |
| Tunisia  | 0.1              | 2.5                             | 67.3                 | 9    |
| Jordan   | 0.0              | 2.4                             | 64.1                 | 10   |
| Morocco  | 0.0              | 2.3                             | 63.1                 | 11   |
| Turkey   | -0.3             | 2.1                             | 57.2                 | 12   |
| Egypt    | -0.4             | 2.0                             | 54.4                 | 13   |
| Lebanon  | -0.4             | 1.9                             | 52.4                 | 14   |
| Syria    | -0.7             | 1.7                             | 46.5                 | 15   |
| Algeria  | -0.8             | 1.6                             | 42.2                 | 16   |
| Libya    | -1.1             | 1.3                             | 35.7                 | 17   |

Source: Censis processing of 2003 World Bank data

## Rank of correlation

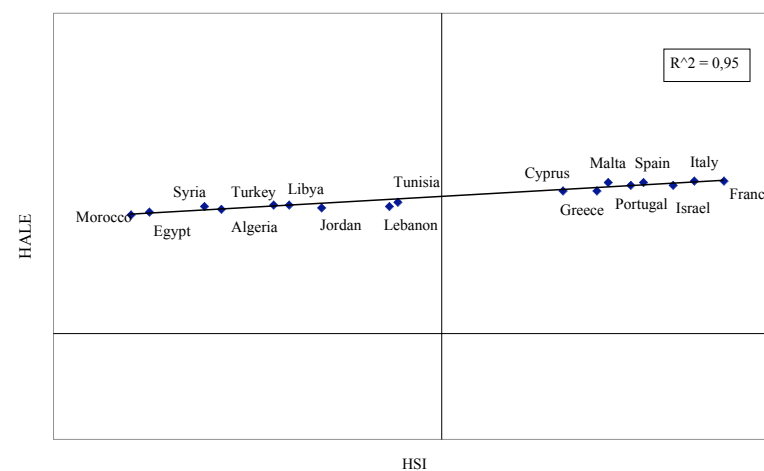
The correlation study allowed the study on the human development in the Mediterranean Region to be projected in a 3D space where PAI, HSI and GSI constitute the 3 coordinates. The correlations have been done at 3 levels:

- Correlations of the HDI with PAI, HSI and GSI
- Correlations between PAI, HSI and GSI
- Correlations of PAI, HSI and GSI with specific variables contained in one of the same indicators

The correlation study reveals that the deepest links exist between HSI and the Health life expectancy index (HALE) and the Human Development Index (HDI). This correlation confirms the strong impact that the national health system has both in terms of healthy life expectancy and human development.

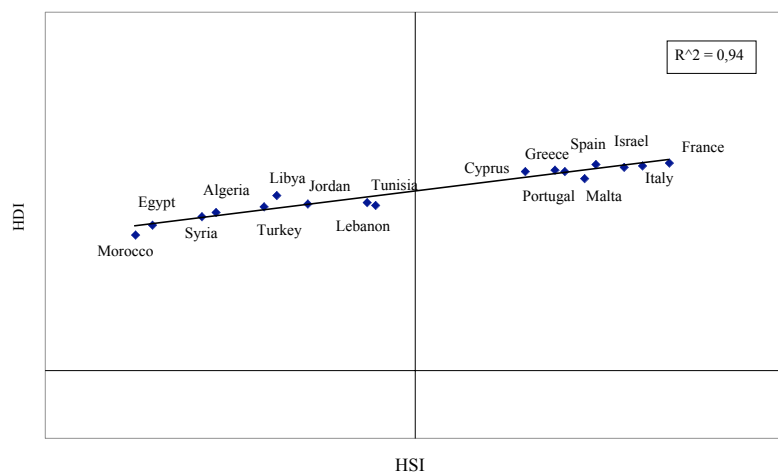
The weak correlations are also of particular interest. The Poverty and Access Index (PAI), for example, has a weak correlation with human resources for health, and in particular with the number of doctors per 100,000 inhabitants, showing that it is the health system overall that affects poverty rather than a higher or lower percentage of doctors. The weak correlation of the Human Development Index (HDI) and the Governance and Security Index (GSI) can be interpreted in two ways: on the one hand, it appears that human development does not depend strongly upon the style of governance, on the other, it might be that the conception of governance and security habitat is still too much in the early stages to be effectively integrated into our definition of human development, and that further investigation is necessary. Finally, the weak correlation between the Poverty and Access Index (PAI) and fertility rates discredits the myth of a high birth rate being linked to economic and cultural need, and leads us to demographic scenarios tending to differentiate.

Graph. 1 - Correlation between the Health System Index (HSI) and the Health life expectancy index (HALE)



Source: Censis proceedings on data World Bank, World Health Organization e United Nations Development Programme, 2003

**Graph. 2 - Correlation between the Human Development Index (HDI) and the Health System Index (HSI)**



Source: Censis proceeding on data World Health Organization, United Nations Development Programme and UNESCO, 2003

**Table 5 - The rank of correlations**

|  |      |
|--|------|
| <i>High correlations</i>   |      |
| Health System Index (HSI) with Health life expectancy index (HALE)   | 0.95 |
| Human Development Index (HDI) with Health System Index (HSI)   | 0.94 |
| Human Development Index (HDI) with Poverty and Access Index (PAI)  | 0.90 |
| Poverty and Access Index (PAI) with Health System Index (HSI)  | 0.90 |
| Poverty and Access Index (PAI) with per capita health expenditure  | 0.88 |
| Poverty and Access Index (PAI) with Health life expectancy index (HALE)                                    | 0.88 |
| <i>Medium correlations</i>   |      |
| Health System Index (HSI) with per capita GDP  | 0.85 |
| <i>Medium correlations</i>   |      |
| Health System Index (HSI) with Governance and Security Index (GSI)   | 0.76 |
| Health System Index (HSI) with Adult literacy rate   | 0.74 |
| Poverty and Access Index (PAI) with Governance and Security Index (GSI)                                    | 0.73 |
| <i>Low correlations</i>  |      |
| Poverty and Access Index (PAI) with human resources for health (number of doctors per 100,000 inhabitants) | 0.67 |
| Human Development Index (HDI) with Governance and Security Index (GSI)                                     | 0.65 |
| Health System Index (HSI) with the school enrolment rate   | 0.51 |
| Poverty and Access Index (PAI) with fertility rates  | 0.45 |

Source: Censis 2003

#### 4. VOLUME II – THE CASE-STUDIES IN 5 COUNTRIES

Partially confirming the trends summarised in the first two sections of the study, the five national analyses investigated various aspects in greater depth, corroborating the need to associate comparative analyses with qualitative studies capable of benefiting from more in-depth sources and interpretations. Each of the five studies deals with the three issues of health, poverty and crime in an integrated manner. This summary limits itself to mentioning a few starting points taken from the various studies, avoiding comparing them in order to respect the specific complementary approach of the comparative analysis carried out in the two previous parts of the study. For a more appropriate reading of a comprehensive analysis on each country, we will warmly advise to have access to the entire Volume II of the research.

##### Egypt

*Coordinated by Dr Alia El-Mahdi (Cairo University)*

- Urban poverty is rising at a higher rate than rural poverty, though the incidence of poverty in rural areas is still higher.
- Poverty is higher in Upper Egypt, whether in rural or urban areas and among the workers in the private sector.
- Female-headed households are significantly poorer than male-headed households are.
- The stock of unemployment grew –according to official sources- from a modest 1.4 millions unemployed in 1996 to rise up to 2 millions of unemployed in 2000.
- Concerning the Health sector, there is a clear need for policy reform, especially because if the current population growth rate continues and the economy does not recover, in the near future health problems will aggravate.

- Poverty has increased on both national and regional level between 1981/82 and 1990/91, then stabilized in 1995/96 and then started to decline in 1999/00.
- The economical growth was not pro-poor, thus the non-poor benefited more than the poor did from the growth. In the meanwhile, urban poverty has increased more rapidly than rural poverty.
- Concerning violence against women, sexual harassment, marital violence, the marriage of underage females and female circumcision are all examples of acts prohibited by Egyptian law but exercised by society, which disregards judicial regulations in favour of customs and traditions.
- Social, economic and political aspects as well as factors relating to the police force and the judicial system have all played a vital role in motivating violent behaviours and on elevating the tendency towards crime and violence in Egypt.
- Lack of democracy and the distrust directed towards the government lead to overall feelings of uncertainty and anxiety, which are translated into aggressive conduct.
- Unequal income distribution and low incomes among public officials lead to a growing tendency to accept bribery or unofficial commissions.
- One of the main problems facing law enforcement in Egypt is that people do not regard or treat it with due respect.
- Crimes have continued to increase at a steady rate: new crimes related to corruption, rape, car thefts, fraud and pick-pocketing showed significant rise in their incidence during the nineties.
- The apparent increase in certain crimes such as thefts, pick pocketing, rape and corruption, is connected with unemployment, poverty and inability to afford a decent living.

## Jordan

*Coordinated by Dr Seyfedin Muaz (Royal Scientific Society)*

- In the past few decades the demand for health care continues to grow tremendously and the Government has decided to improve and develop the health care system.
- The Government of Jordan has decided against passive acceptance of the status quo and instead is embarking upon a long-term reform program.
- Investments are proposed to boost the vocational capacity of the near poor segments of society and young citizens, as another component of Jordan's national strategy.
- A challenge in Jordan is to move from the concept of poverty to the concept of deprivation. Many researchers believe that Jordan has reached a state of development that enables it to make this move.
- The most critical issue regarding crime prevention in Jordan is the challenge of facing the continuous growth in the crime phenomena and their increasing cost. The incidence of crime has increased in Jordan from 626 crimes per 100,000 in 1988 to 1,016 in 1997.
- Organized crime in Jordan is growing, and it is no longer limited to smuggling or drugs, which is causing strains in the judicial system, which needs more improvements.
- Before mid-1980s, poverty in Jordan was not seen as a problem, where the interest was to emphasize income distribution.
- Poverty, Health and Crime are interrelated, but poverty remains the father of all evil. Most of the studies that deal with poverty in Jordan reported a bad health situation in the poor communities, and the relation between health and poverty can go in both directions.
- In Jordan, criminal statistics show that the unemployed formed about 36% of the total crime offenders in 1997. In the last decade, when economic growth was relatively very slow in Jordan, the crime rate increased from 626 crimes per 100,000 citizens in 1988 to 1,016 in 1997, and to 1,255 in 1999.

## Greece

*Coordinated by Dr. Nicholas P. Glytsos (KEPE)*

- Persisting unemployment, especially of youth even educated youth, but also women, is a disturbing and painful problem affecting a considerable number of households, has economic, social and psychological implications and is a factor contributing to deviance and crime.
- The large number of illegal immigrants that still exist, despite the recent two efforts for their legalization, is a concern both of the government and the general public, and is also a source of poverty and crime.
- In the last 20 or so years crime has been rising at a rather fast pace. Figures presented by Police show a rapid rise of criminal activity, particularly of heavy crimes.
- It is very disturbing that, according to the special Juvenile Tribunal of Athens, juvenile crime climbed up in the region of Attica, mostly Athens conurbation, by 23 per cent in 2001.
- Five major laws for the reformation of the health care system in Greece were passed in the last 20 years (1983-2003).
- Due to the bureaucracy and the malfunctioning of the various government departments, citizens are often forced by the circumstances to pay either for avoiding delays in having their problems solved or bribing for illegal or irregular favours.
- Corruption is not limited to the "little envelop" got by certain civil servants for complementing their income, but it has become wide scale, taking advantage of international networks, including those of organized crime.
- Greece is experiencing the well-known connection between long-term unemployment and low income, which makes it vulnerable to poverty, in fact, this risk is considered as a major factor behind poverty and social exclusion.

- The linking of the NAPs for Social Inclusion, Employment and Health and Welfare in a concerted action for attacking this complex set of problems is evidence that the Greek government is well aware of the connection between employment and social exclusion, with all the undesirable ramifications that entails with respect to poverty and crime and their interrelationships.
- Many problems are beautifully solved in paper by laws and regulations, but if one looks at the real world, things are not working as they are supposed to: the 'paper-versus-reality' situation is vivid in Greece in the case of the National Health System (NHS).

## Italy

*Coordinated by Dr Rosario Sapienza (CENSIS)*

- The low birth rate and the aging of the population expose Italy to great risks in terms of the sustainability of the welfare systems, and of the pension schemes in particular.
- In 2002, 11% of Italian families and 7,140,000 individuals were living below a relative poverty threshold, set at a monthly expenditure of 823.45 Euros for a two-member family. In the south of Italy, 22.4% of families live below the relative poverty threshold.
- The youth unemployment rate in Italy is 27.2%, 31.4% among women and 24% among men. Here too considerable regional differences are evident: in the south 49.4% of young people aged between 15 and 24 are unemployed.
- "More market and less State" was the slogan accompanying the radical reform of the public administration system that took place in Italy from the mid-eighties onwards.
- The health market is an assisted market without any real business risk: competition between public companies and recognised private structures is non-existent because both public and recognised private structures are always funded or reimbursed by the National Health Services.
- The fragile relationship between the judicial system and politics, although causing much discussion and leading to rifts between the

leading representatives of executive power and of the judiciary, has created the conditions for reflection upon the negative aspects of the Italian criminal justice system.

- The trend of the diffusion of crime, registered in terms of number of crimes per inhabitant, has tended to be irregular for a variety of reasons: the increase in the social burden and the impact of the irregular immigrant population with little chance of regular integration; the fragmentation of organised crime and its evolution towards different crimes; the increase in microcriminality and its diffusion throughout the peninsula with respect to classic phenomena which tends to be concentrated in the metropolitan areas of the south.
- The correlation between wealth and health expenditure of Italian families is high and unquestionable, with a correlation rate of 0.9216. The increase in the wealth of families translates almost automatically into an increase in expenditure for health services.
- On the other hand, it is extremely significant that there is no correlation whatsoever, in either positive or negative terms, between increased wealth and the increase, or reduction, of the crime diffusion index, which is 0.0089.

## Turkey

*Coordinated by Dr Yilmaz Özkan (Center For Mediterranean Studies)*

- In Turkey migration is an important social and economic factor due to poverty, low life standards in rural areas and labour demand in urban centres.
- In recent years, Turkey became one of the main routes of illegal migration from Asia and Africa to Europe.
- The comparison of both 20% shares and Gini coefficients for 1980 and 1990 show that inequity in income distribution increases over time.
- Health expenditure per person has increased by 38% in last ten years. An increase in the health expenses in last years created an increase in health expenditure per person and, due to an increase in education expenses in last decades, the number of people per doctor has decreased.

- From December 1999, the Turkish Grand National Assembly has enthusiastically been working to make Turkish Law Regulations concordant with the EU.
- In crime law, on the pretext of solving the problems caused by the frequent, extraordinary situations that the society underwent, its oppressive and preferential characteristics were increased by the new modifications and reforms.
- There is a positive correlation between per capita income and the number of people imprisoned. The reason for that is because, even though total income level increases, the distribution of income has some problems. If the distribution of income works against most of the population, and the structure of economy makes the rich even richer while making the poor ever poorer, the number of people imprisoned expected to increase.

## 5. FINAL REMARKS

In conclusion, the study seems to amply confirm interest in breaking down the Human Development Index and of human development analysis in general into different sections and components. The Poverty and Accessibility Index (PAI) and the Health System Index (HSI) are its two main components.

There is also a degree of interest in the use of the Governance and Security Index (GSI) as an integration factor for the analysis of human development, where habitat security and individual liberty play an equally important role in bringing about well-being and social and economic evolution. The cross-referencing and study of correlations with the GSI opens up interesting new research perspectives. The following would be particularly useful in bringing this about:

- a) studies into a comparative definition of justice and crime;
- b) studies into the data collection procedures used for judicial statistics;
- c) studies into the perception of crime in the various judicial contexts;
- d) studies into the impact of crimes or of different sub-categories of crime upon the various human development scenarios.

The study of health, poverty and crime draws attention to the evident need to open up and link analysis to other research sources specifically dedicated to measuring the vitality of civil society. The following would be particularly useful in bringing this about:

- a) studies into associative capacities;
- b) studies into freedom of expression;
- c) studies into different capacities and human resources;
- d) studies into formal and informal networks;
- e) studies into the penetration and use of new technologies;
- f) studies into internationalisation trends and vocations;
- g) studies into culture in public administration.