



FEMISE RESEARCH
PROGRAMME

2002-2004

***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***

Volume I

***Research n°FEM21-30
Directed By
Carla Collicelli, CENSIS, Italie***

*In collaboration with
Faculty of Economics and Political Science - Cairo University, Egypt
Royal Scientific Society, Jordan
KEPE, Greece
Bogazici University, Turkey*

November 2003



Ce rapport a été réalisé avec le soutien financier de la Commission des Communautés Européennes. Les opinions exprimées dans ce texte n'engagent que les auteurs et ne reflètent pas l'opinion officielle de la Commission.

This report has been drafted with financial assistance from the Commission of the European Communities. The views expressed herein are those of the authors and therefore in no way reflect the official opinions of the Commission.

Femise Coordinators



Economic Research Forum
For the Arab Countries, Iran and Turkey

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**

Volume I

Rome, november 2003

The study was carried out by a working party of the Censis Foundation with the collaboration of Abaton-Ricerca, Progetti e Studi.

Working party:

Carla Collicelli (Leader); Rosario Sapienza, Massimiliano Valerii (Coordinator); Matteo Scaramella, Marta Piccarozzi, Andrea Baglioni, Gloria Pizzichemi, Giuseppe Lubrano, Elena Mariniello, Vittoria Coletta; Maria Antonella Di Candia, Roberta Bernardi, Sabrina Pusceddu (Secretariat).

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FOREWORD

This study represents the second research project submitted by Censis to the FEMISE network and thereby to the international scientific community. The first project dates from 2000, when the theme of poverty in the Mediterranean area was the object of a study, carried out by Censis and promoted by FEMISE, conceived as a contribution to the process of harmonisation aimed at creating a sustainable Euro-Mediterranean Partnership by 2010, as emphasised by the European Commission in its programme *Agenda 2000*.

Starting from the classic socio-economic definition of social deprivation and limited access to goods and resources due to low income, the 2000 study viewed and compared the main approaches and evolution of studies on poverty. The analysis concluded that the main developments in the international debate essentially agree on two main points:

- on the one hand, poverty is seen as *transcending its economic component* and involving social exclusion, exclusion from participation in the active life of the community, denial of fundamental individual freedoms, low social consideration, low skills and low education as well as personal insecurity due to socio-political or environmental causes;
- on the other hand, the concept of poverty is analysed *not only in an absolute sense but also relatively*, in relation to the moment in time, conditions in other countries, the view of the population (i.e. the opinion generally held within the community concerned, as well as that of those suffering from social exclusion) and the overall sum of socially determined values and needs.

On conclusion of the study, it became clear that it *was necessary to extend the discussion on poverty still further, from more specifically socio-economic aspects to considerations on welfare, education, safety and the freedom of the individual*, combining issues connected with human development with the more extensive protection of human, social and civil rights. This need to study the issue in greater depth represented the starting point for the present project.

Even in the study carried out in 2000, Censis made frequent reference to the data of the UNDP Report on Human Development, which does not only use macro-economic indices but also introduces various other parameters, generally aimed at more fully describing human development, and consequently the living conditions and well-being of the population, in the 175 countries considered.

Since 2000, further developments have taken place, modifying to some extent the situation in the Mediterranean area and the way it is viewed by the countries concerned. Recent trends, still being registered, and related developments in the debate on human development make it necessary to update the premises used to interpret the figures and the working hypotheses adopted. In particular, certain recent facts must be taken into consideration:

- first of all, *it is now almost taken for granted and viewed as necessary to reflect on the development of factors that are not purely economic*; this is the explicit aim of even the largest international economic organisations, headed by the World Bank which, in its last report, admits that relying on market factors alone is not enough to remove the obstacles to development and the reduction of poverty¹;
- on the one hand, the *Human Development Index (HDI)* drawn up by the UNDP *is ever more widely considered to be an important tool* for measuring development, not only in economic terms, and it is especially useful in the sphere of political commitment by governments and the international community towards establishing clear objectives and reaching the *Millennium Goals by 2025*;
- on the other hand, the *Human Development Index (HDI)* *is sometimes considered inadequate*, in the view of the various exponents of the scientific community and of many development operators, for studying at close hand the processes and mechanisms of development, describing current trends and clarifying specific phenomena, such as – to give a pertinent example – the level of Euro-Mediterranean agreement on the desired harmonisation;

¹ It is sufficient to glance at the introduction to the World Bank's World Development Report 2004, available at: www.worldbank.org/data/databytopic/databytopic.html

- furthermore, the *debate on the creation of new indicators able to shed light on the factors determining human development is still too theoretical and in its preliminary stages*; it is a heated, widespread debate, generally perceived as necessary, and there is agreement on the issues involved, but it is hard to reach any conclusion; the attention of the community has so far been of little use for rapidly creating new, universally accepted indicators to be used for reading and monitoring the modern development processes;
- meanwhile, there is a growing need to *integrate the theoretical study of indicators with other data, information and views in addition to those from consolidated international sources*, taking into account – now more than in the past – local or regional experiences able to reinterpret the causes of development, to find and verify new working hypotheses, to contribute to theoretical knowledge and to help in drawing up new models and tools for interpreting the situation.

It is precisely the need to tackle these problems that has encouraged Censis to integrate the reflection on Poverty begun in 2000 with this more detailed study. We naturally start by looking at the areas of Poverty that have already been explored, analysing and defining Poverty and distinguishing it from the adjoining areas, bordering on Poverty but not overlapping with it, which play an equally effective part in determining the other factors involved in human development.

From the theoretical point of view and for the purposes of interpretation, before these concepts are defined precisely, in operational and scientific terms, our reflection on poverty directly concerns other issues generally related to human development:

- human rights, in all their various aspects;
- health;
- access to or exclusion from goods, resources and services;
- state of personal security and climate of confidence or fear within the environment concerned;
- active participation by the individual in the life of his/her social context.

The object of the present study is to be the first step in exploring a number of the issues involved; attention will be focussed on some of these while others will be left for future research projects. The approach adopted has been to set aside the issues that are less well-defined, as far as evaluation tools are concerned, and to attempt to assess the situation with regard to the aspects that have already been considered in constructing the indicators and those that are most urgent because they represent a prerequisite for examining the others.

Besides the aspect of poverty, which greatly helps us to assess the state of access to or exclusion from goods, resources and services, the other aspects on which this study focuses are health and crime, together with personal security and the climate of confidence or fear within the individual's environment of reference.

Poverty, Health and Crime will therefore be the three axes on which the level of harmonisation of the 18 Mediterranean countries will be measured in this study, in a search for ways of interpreting the data and transversal phenomena that can help the community to identify ever more clearly the factors chiefly responsible for stimulating or obstructing the convergence of development processes in the Euro-Mediterranean area. The present study aims to evaluate the data relating to both these aspects, providing a comparative analysis and comparing these aspects with the state of Poverty.

The oft-debated question of human rights, together with the ability of the scientific community to define them in an agreed, objective and verifiable fashion, and the last, equally important aspect, that of the construction of the "skills" of the social body and civilised society, ranging from education to the promotion of freedom and the ability of human groups to express themselves and organise themselves, will be tackled only indirectly and by studying the three aspects we have selected. Both these high complex and multidimensional aspects, directly linked to Poverty, naturally deserve ample consideration. But this will be left to another time, when cultural, anthropological, historical and political issues can be examined, proceeding on the course set by this study and the previous one, in an effort to analyse the various aspects of human development.

Statement of Research Issue and Literature Review

A mosaic consisting of different geographical fragments and segments of social fabric that are far from homogeneous and often immobilized in hard-to-settle conflicts. This is still the general picture of the Mediterranean region: an extremely variegated economic and social reality, which is nevertheless gradually implementing the process of cooperation and integration launched by the Barcelona Declaration of 1995 between the countries of the European Union and those of North Africa and the Near East.

The accumulation of ideological, ethnic and religious tensions has always been an explosive mixture in various parts of the region, often leading to bloody conflicts. The pressure of immigration towards Europe, especially from the Muslim countries that surround the basin, aggravates national and international controversies. Over the last few years, the Gulf War, the dramatic conflicts unleashed in the Balkans and the frequent armed clashes in the Middle East have once more highlighted the critical problem of instability in the area.

It is for this reason that the proposed study emphasizes the goal of creating “an area of peace and stability [...], of shared prosperity [...]” in the Mediterranean basin, as stated in the Barcelona Declaration and reiterated in the European Commission’s recent communiqué “Reinvigorating the Barcelona Process”².

The starting-point of the proposal is the conviction that economic development (by the creation of a free trade zone by 2010) can only make progress if there is a commitment - no less important - towards cooperation with regard to the *social aspect of development* as well; otherwise, the foundations supporting the political sustainability of integration will be too fragile.

After a long period of protectionism, the progress of the developing economies of the Mediterranean basin towards an “open” model, with a new approach to the market, has often been accompanied by sharp decreases in the growth rate of per-capita GDP, rising levels of unemployment and

² COM (2000) 497.

widespread poverty. The structural adjustment programmes which guided the reforms of the 80s in the Middle East and North Africa (MENA) achieved important results with regard to stabilizing the macroeconomic indicators but at the same time caused a significant increase in unemployment and poverty (Hamdouch, 1998; Handoussa and Kheir-El-Din, 1998; Holland, 1998), generating “new poor” in various social groups as “direct victims” of the structural adjustment measures (Golbert and Kessler, 1996; Samad, 1996).

The economic growth that takes place when developing economies open up to the world markets and sign multilateral trade agreements may initially generate an improvement in the income poverty indices – as has been the case over the last few years, in which the economy has experienced a period of expansion – but there is a risk of leaving sizeable “holes” in the social fabric, aggravating the inequality and social exclusion affecting large segments of the population and fomenting tensions and hot-beds of discontent.

The results achieved by many MED countries on the economic plane, and sometimes with regard to the reduction of poverty too, conceal the strong social imbalances which still persist and which are not reflected in an equally satisfactory improvement in the effective living conditions of the inhabitants.

Now that the thresholds of development have been passed, the countries of the region find themselves in an extremely ambivalent situation:

- on the one hand, there has been a *marked reduction in income poverty* (measured on the basis of the international threshold of one dollar per person per day) over the last few years, as demonstrated by its incidence, which is on average less than 2% of the total population, and by the corresponding indices, which are lower than those typical of developing countries and still falling;
- on the other hand, *distributional inequality is relatively limited*, as compared with that of other countries at a similar stage of development (Page, 1998; Van Eeghen, 1998);
- nevertheless, the MENA countries *have not achieved equally encouraging results with regard to the reduction of human poverty and the*

improvement of social indicators (Shafik, 1994; UNDP, 1997; Van Eeghen, 1998; CENSIS, 2000b).

But the main objectives of the Euro-Med Partnership - trade and security - cannot be achieved unless priority is also given to creating social well-being in every corner of the Mediterranean region, as a necessary condition for the attainment of the other two goals (CENSIS, 2000a).

The proposed study therefore aims to contribute to an analysis of the effects of globalization, in general, and the Euro-Med Partnership, in particular, by looking at the social imbalances and differences between the societies involved along the *limes* that crosses the Mediterranean basin, marking the frontier between North and South.

The study concentrates chiefly on three areas of the social aspect of development (*health, poverty and crime*), in order to measure how these three fundamental sectors of a country's "state of health" are affected by the greater or lesser degree to which the Mediterranean countries carry on global relations.

The effective health of the population, multidimensional poverty, and crime and illegality continue to represent three extremely important factors, which must be the object of research, attention on the part of the international community and public intervention in order to reduce the distance separating the northern shores of the basin from the countries of the south-eastern Mediterranean and to ensure that development is sustainable.

The first aim of the study is therefore to draw up a new comparative analysis on health and poverty in the Mediterranean, extending the results of the previous research project conducted by CENSIS (2000a) within the framework of the FEMISE network and developing the various multidimensional profiles of the phenomenon of deprivation by disaggregating the research issue with respect to social and personal variables, type of family, type of territory (rural and urban, coastal and inland, stable and labile, historical and emergent poverty etc.).

The other aspect analyzed is the legal system in the various countries, since the sphere of crime, illegality and the judicial system - often neglected in analyses and studies - constitutes an important factor in promoting integration, especially in view of the fact that unsatisfactory guarantees in

this respect can discourage the North-South flow of investments and people within the basin³.

The conclusions of the study must also lead to suggestions and policy recommendations, particularly with regard to the orientation of the process launched with the Euro-Med Partnership.

Research Methodology

The project involved the following activities:

- an in-depth, comparative analysis of each of the 3 aspects considered through 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.);
- detailed study of the three aspects and of how they are interrelated, through five case studies, in Egypt, Jordan, Greece, Turkey and Italy, aimed at looking at the issue in greater detail, in quantitative and qualitative terms;
- study of the correlations of the variables for each of the 3 aspects, by means of the “Principal Components Analysis and Cluster Analysis” in order to identify the most significant correlations between the variables taken into consideration;
- 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);
- analysis of the Mediterranean area by means of the three aggregate indicators and their interrelations in order to adjust the loading of the

³ Recently, these aspects have also been stressed by the *World Development Report* of the World Bank, which dedicated a whole chapter of its last report to the judicial system for making State institutions more responsive to poor people (World Bank, 2004).

different aspects involved and determining the level of poverty/well-being of the countries considered and identifying any existing territorial disparity.

In order to optimise the presentation of the results of the above activities, this report is divided into three parts, preceded by these introductory notes and followed by a summary of the results:

- in the **first part**, poverty, health and crime are examined in a descriptive fashion and compared by analysing and partially reprocessing data taken from international sources;
- in the **second part**, the information is compressed and reprocessed by means of a complex system in which correlations are crossed and analysed to give an overall reading of the three aspects examined and to identify possible new indicators and tools for illustrating the issues studied;
- in the **third part**, the three themes are examined in greater depth with case studies on five Mediterranean countries, using more detailed sources and with the benefit of approaches and information endogenous to each of the five countries involved in the survey.

PART ONE

**COMPARATIVE STUDY OF POVERTY, HEALTH AND
CRIME IN THE MEDITERRANEAN COUNTRIES**

1. POVERTY

This study continues to analyse poverty along the lines of the work carried out in 2000, adopting an approach used to good effect in the past, which sees poverty as the lack of access not only to goods and services but also to information, skills and equal opportunities. The study investigates the following aspects:

- the measurement of human development and relative trends;
- economic deprivation;
- social exclusion;
- Millennium Goals directly linked to poverty.

This chapter uses a descriptive approach; data is re-examined, updated and compared, and where possible historic sequences are provided in order to illustrate development trends. Only in the second part of the study will poverty be analysed as a system of correlations. The task of creating aggregate indices is also left to the second part of this report.

1.1. Human development

To tackle the question of poverty we must start by reflecting on human development in general. The most recent figures come from the latest edition of the UNDP Report on Human Development (2003) and the latest World Bank World Development Report 2004. The most important aggregate index is the Human Development Index (HDI). The HDI is strongly interrelated with indicators linked to the various aspects of poverty.

The main advantage of the HDI does not lie its innovative nature or methodological strictness. As the authors of the Human Development Report state in the introduction: “because of changes in data and methodology, the human development index values are not strictly comparable with those in earlier Human Development Reports”. So the HDI is therefore not an entirely reliable indicator for historic comparison and thus for establishing trends.

By contrast, the almost universally accepted advantage of the HDI is probably its conciseness: the fact that, using just one indicator, countries may be compared even if they have widely differing levels of development. This strong point leads to another one, which is perhaps even more important: the fact that the HDI is considered as a set of parameters useful for defining the aims of a programme that involves various countries, thus making it possible to define an international development policy with a number of specific, measurable objectives (documented in the Millennium Goals), including those most directly connected with the reduction of the various aspects of poverty and exclusion.

Despite its usefulness in planning, the limits of the HDI are well known and regularly pointed out by the scientific community. These limits relate in particular to its excessive conciseness and its tendency to render data excessively homogeneous, making too few distinctions and thus producing a reassuring comparability which, for many, remains on paper rather than in practice.

It is significant to note how the ambivalence of these observations about the HDI directly affects the analysis of human development within the Mediterranean basin, leading to a dual plane of interpretation: the first is macroscopic, and looks at the Mediterranean region within the scenario of the planet as a whole, while the second looks more closely at the characteristics of the various countries of the area, revealing what an astigmatic view is given by the HDI.

From a macroscopic perspective, global human development has undoubtedly seen positive evolution in the course of the last 25 years. The Mediterranean countries have followed this trend, with an increase in the index between 1975 and 2001 amounting to +16.3% on average (Table 1). Certain countries have made a more substantial contribution to this increase, for example Egypt (+33.2%), Tunisia (+30.5%), Morocco (+29.5%), the Syrian Arab Republic (+21.8%), Turkey (+19.8%). The countries with less strong performances are of course the European countries that have higher standards of living, such as Greece (+6.8%), Italy (+8.5%), France (+8.5%) and Spain (+9.2%). This overall trend demonstrates a substantial convergence of the HDI towards similar standards of human development.

For although the UNDP Report of 2003 emphasised a general convergence of the Mediterranean regions towards more homogeneous standards of human development – particularly seen from a global point of view, including regions of the world that are very deprived, have slow development or even register worsening conditions, as in certain parts of

sub-Saharan Africa – a non-diachronic analysis, and above all one that looks more closely at the countries of the Mediterranean, shows the enormous gap that still needs to be closed before we can speak of a homogeneous area in the sense of human development as it is now universally considered.

Those who deal with development in the Mediterranean basin are well aware that the Straits of Gibraltar dividing Spain from Morocco are enough to reduce or increase life expectancy at birth by over 10 years; similarly, there is a difference of over 45% in the literacy rate for adults over 15 years of age between the countries of the southern shores, such as Egypt and Morocco, and those of the northern shores, such as Spain and Italy; or again, the spending power of an Italian (or, to a lesser extent, a French or Spanish citizen) is over seven times that of a Syrian (or Moroccan, or Egyptian, or Jordanian) (Table 2).

As a further demonstration of how the relationship between spending power and human development is dialectic and not mechanical, the UNDP registers the different correlations between per-capita Gross Domestic Product (GDP), expressed in PPP US\$, and the HDI index, explaining the differences by describing the various countries as being oriented towards greater wealth as opposed to human development or, on the contrary, towards a type of human development that is not proportionally reflected in an equivalent amount of wealth (expressed in terms of the per-capita distribution of the Gross Domestic Product):

- the countries, which, in this comparison, are found to be “richer” rather than “more developed”, are (starting with the countries for which the divergence between the two indices is greatest): Algeria (-31), Morocco (-19), Tunisia (-18), Turkey (-16), Egypt (-12), Italy (-5), Cyprus (-3) and Syria (-1);
- the countries which, on the contrary, are found to be “more developed” rather than “richer” are, in descending order, the Occupied Palestinian Territories (19), Lebanon (18), Jordan (13), Malta (8), Portugal (7), Greece (7), Spain (5), Israel (4), France (3) and Libya (2).

Table 1 - Human development index trends – UNDP 2003*

HDI rank (2001)		1975	1980	1985	1990	1995	2001
17	France	0.846	0.862	0.874	0.896	0.912	0.925
19	Spain	0.834	0.851	0.865	0.883	0.901	0.918
21	Italy	0.838	0.854	0.862	0.884	0.900	0.916
22	Israel	0.794	0.818	0.838	0.857	0.879	0.905
23	Portugal	0.785	0.799	0.821	0.847	0.876	0.896
24	Greece	0.831	0.847	0.859	0.869	0.875	0.892
25	Cyprus	..	0.800	0.820	0.844	0.864	0.891
33	Malta	0.716	0.751	0.778	0.812	0.835	0.856
61	Libyan Arab Jamahiriya	..	..	..	..	..	0.783
83	Lebanon	..	..	..	0.678	0.728	0.752
90	Jordan	..	0.637	0.659	0.675	0.702	0.743
91	Tunisia	0.514	0.572	0.620	0.654	0.693	0.740
96	Turkey	0.589	0.612	0.649	0.681	0.712	0.734
98	Occupied Palestinian Territory	..	..	..	..	..	0.731
107	Algeria	0.510	0.559	0.609	0.648	0.668	0.704
110	Syrian Arab Republic	0.536	0.578	0.612	0.632	0.664	0.685
120	Egypt	0.433	0.480	0.530	0.572	0.605	0.648
126	Morocco	0.427	0.472	0.506	0.538	0.567	0.606
	Average	0.678	0.709	0.735	0.760	0.784	0.811
	Var %	...	4,36	3,50	3,30	3,10	3,26

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis.

Table 2 - Le componenti dell'Indice di Sviluppo Umano (HDI) dell'UNDP*

HDI rank	Life expectancy at birth (years) 2001	Adult literacy rate (% age 15 and above) 2001	Combined primary, secondary and tertiary gross enrolment ratio (%) 2000-01	GDP per capita (PPP US\$) 2001	Life expectancy index	Education index	GDP index	Human development index (HDI) value 2001	GDP per capita (PPP US\$) rank minus HDI rank
17 France	78.7	..	91	23,990	0.90	0.96	0.91	0.925	3
19 Spain	79.1	97.7	92	20,150	0.90	0.97	0.89	0.918	5
21 Italy	78.6	98.5	82	24,670	0.89	0.93	0.92	0.916	-5
22 Israel	78.9	95.1	90	19,790	0.90	0.93	0.88	0.905	4
23 Portugal	75.9	92.5	93	18,150	0.85	0.97	0.87	0.896	7
24 Greece	78.1	97.3	81	17,440	0.89	0.93	0.86	0.892	7
25 Cyprus	78.1	97.2	74	21,190	0.88	0.90	0.89	0.891	-3
33 Malta	78.1	92.3	76	13,160	0.88	0.87	0.81	0.856	8
61 Libyan Arab Jamahiriya	72.4	80.8	89	7,570	0.79	0.84	0.72	0.783	2
83 Lebanon	73.3	86.5	76	4,170	0.80	0.83	0.62	0.752	18
90 Jordan	70.6	90.3	77	3,870	0.76	0.86	0.61	0.743	13
91 Tunisia	72.5	72.1	76	6,390	0.79	0.73	0.69	0.740	-18
96 Turkey	70.1	85.5	60	5,890	0.75	0.77	0.68	0.734	-16
98 Occ. Palestinian Terr.	72.1	89.2	77	..	0.79	0.85	0.56	0.731	19
107 Algeria	69.2	67.8	71	6,090	0.74	0.69	0.69	0.704	-31
110 Syrian Arab Republic	71.5	75.3	59	3,280	0.77	0.70	0.58	0.685	-1
120 Egypt	68.3	56.1	76	3,520	0.72	0.63	0.59	0.648	-12
126 Morocco	68.1	49.8	51	3,600	0.72	0.50	0.60	0.606	-19
Developing countries	64.4	74.5	60	3,850	0.66	0.70	0.61	0.655	..
High-income OECD	78.1	..	93	27,169	0.89	0.97	0.94	0.929	..
World	66.7	..	64	7,376	0.70	0.75	0.72	0.722	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

1.2. Economic deprivation

Whatever the changes in the methodological approaches to defining poverty, economic deprivation and lack of access to material resources, these will always be at the heart of the gap in human development. As was to be expected, and as has now been registered on a vast scale, over the last few years the most developed countries have been reducing their rates of economic growth while the less developed countries are hastening their step towards higher rates of development; the developing countries have increased their per-capita GDP by 2.9% in the last ten years as compared with 2.3% in the whole period 1975-2001, while the OECD countries have seen falling values. But apart from a global, macroscopic perspective, it is easy to see that this does not always hold true in the Mediterranean area.

The gap in per-capita GDP, which, according to these global trends, ought to be slowly closing, is still wide open in the Euro-Mediterranean region, particularly for countries such as Morocco, Egypt, the Occupied Palestinian Territories and Jordan, which are below the average of the developing countries and/or have seen little growth in the last ten years (Table3).

Some of the Mediterranean countries therefore appear to be hybrids, distinguished by the low growth rates typical of developed countries, but with economic values closer to those of less economically favoured countries. According to these figures, the process of economic harmonisation in the Mediterranean is not proceeding in a linear, progressive fashion towards convergence, but is evolving towards a situation in which economic differences between the various countries persist over a period of time, although this goes partially against development trends in other, less developed regions of the world. It seems very likely that economic development tends to slow down when a country emerges from a state of great need and poverty and has to build its own identity in the form of a sustainable economic system.

There is further evidence of inequality in the distribution of wealth, confirming that some countries in the Mediterranean area are more able and willing to distribute wealth than others. For example, the distribution of income and consumer spending between the poorest and richest members of

the population in the various countries allows us to identify the countries where a higher percentage of the population occupy the intermediate levels, as compared with those where the percentage of richer and poorer citizens is more uneven:

- the countries with a “fat” intermediate segment, i.e. a higher percentage of the population belonging to intermediate levels of income and spending, are found to be, in descending order, France, Spain, Italy, Algeria, Greece and Israel;
- whereas the countries with a “thin” intermediate segment, distinguished by a higher percentage of poor and rich citizens belonging to both the extreme segments, are, in ascending order, Tunisia, Morocco, Turkey, Egypt, Jordan and Portugal (Table 5).

The Gini index also confirms the trend towards a more limited redistribution of income in countries such as Tunisia, Turkey, Morocco and Portugal, where the ratio between richest and poorest citizens also registers the highest values (Table 6).

The figures relating to levels of extreme poverty and to individuals who live below the poverty threshold show that 10-15% of the population in Morocco, Algeria, Turkey and Tunisia live on less than 2 dollars per day, whereas, according to UNDP data, Egypt stands out from all the other countries, with 43.9% of the population living on less than this figure (Table 7).

Table 3 - Economic performance UNDP 2003*

HDI rank	GDP per capita annual growth rate (%)		GDP per capita		Average annual change in consumer price index (%)	
	1975-2001	1990-2001	Highest value during 1975-2001 (PPP US\$)	Year of highest value	1990-2001	2000-01
17 France	1.7	1.5	23,990	2001	1.6	1.6
18 Germany	1.8	1.2	25,350	2001	2.2	2.5
19 Spain	2.2	2.2	20,150	2001	3.7	3.6
21 Italy	2.0	1.4	24,670	2001	3.5	2.8
22 Israel	2.0	2.0	20,376	2000	8.9	1.1
23 Portugal	3.0	2.6	18,150	2001	4.3	4.4
24 Greece	1.0	2.0	17,440	2001	8.3	3.4
25 Cyprus	4.8	3.2	21,190	2001	3.5	2.0
33 Malta	4.5	3.8	13,427	2000	3.0	2.9
61 Libyan A. J.	..	..	..	..	..	..
83 Lebanon	4.0	3.6	4,244	1998	..	..
90 Jordan	0.3	0.9	4,698	1986	3.3	1.8
91 Tunisia	2.0	3.1	6,390	2001	4.2	1.9
96 Turkey	2.0	1.7	6,495	1998	77.9	54.4
98 Occ. Palest. Terr.	..	-3.0	..	..	..	..
107 Algeria	-0.2	0.1	6,836	1985	15.5	4.2
110 Syrian A. Rep.	0.9	1.9	3,487	1998	5.9	0.4
120 Egypt	2.8	2.5	3,520	2001	8.1	2.3
126 Morocco	1.3	0.7	3,600	2001	3.5	0.6
Developing countries	2.3	2.9	..	..	..	..
OECD	2.0	1.7	..	..	..	..
World	1.2	1.2	..	..	..	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 4 - Economic performance UNDP 2003*

HDI rank	GDP		GDP per capita US\$ 2001	GDP per capita PPP US\$ 2001
	US\$ billions 2001	PPP US\$ billions 2001		
17 France	1,309.8	1,420.0	22,129	23,990
19 Spain	581.8	828.4	14,150	20,150
21 Italy	1,088.8	1,429.7	18,788	24,670
22 Israel	108.3	125.9	17,024	19,790
23 Portugal	109.8	181.9	10,954	18,150
24 Greece	117.2	184.7	11,063	17,440
25 Cyprus	9.1	16.1	12,004	21,190
33 Malta	3.6	5.2	9,172	13,160
61 Libyan Arab Jamahiriya	34.1	..	6,453	..
83 Lebanon	16.7	18.3	3,811	4,170
90 Jordan	8.8	19.5	1,755	3,870
91 Tunisia	20.0	61.9	2,066	6,390
96 Turkey	147.7	390.3	2,230	5,890
98 Occupied Palestinian Territory	4.0	..	1,286	..
107 Algeria	54.7	187.9	1,773	6,090
110 Syrian Arab Republic	19.5	54.4	1,175	3,280
120 Egypt	98.5	229.4	1,511	3,520
126 Morocco	34.2	105.0	1,173	3,600
Developing countries	6,110.3	18,579.4	1,270	3,850
OECD	25,124.2	26,501.8	22,149	23,363
World	30,720.9	44,995.3	5,133	7,376

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 5 - Inequality in income or consumption – Share of income or consumption UNDP 2003*

HDI rank	Survey year	Share of income or consumption (%)				
		Poorest 10%	Poorest 20%	Richest 20%	Richest 10%	
17	France	1995	2.8	7.2	40.2	25.1
19	Spain	1990	2.8	7.5	40.3	25.2
21	Italy	1998	1.9	6.0	42.6	27.4
22	Israel	1997	2.4	6.9	44.3	28.2
23	Portugal	1997	2.0	5.8	45.9	29.8
24	Greece	1998	2.9	7.1	43.6	28.5
25	Cyprus	..	..	..	..	..
33	Malta	..	..	..	..	..
61	Libyan Arab Jamahiriya	..	..	..	..	..
83	Lebanon	..	..	..	..	..
90	Jordan	1997	3.3	7.6	44.4	29.8
91	Tunisia	1995	2.3	5.7	47.9	31.8
96	Turkey	2000	2.3	6.1	46.7	30.7
98	Occupied Palestinian Territory	..	..	..	..	..
107	Algeria	1995	2.8	7.0	42.6	26.8
110	Syrian Arab Republic	..	..	..	..	..
120	Egypt	1999	3.7	8.6	43.6	29.5
126	Morocco	1998-99	2.6	6.5	46.6	30.9

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 6 - Inequality in income or consumption – Inequality measures UNDP 2003*

HDI rank	Survey year	Inequality measures			
		Richest 10% to poorest 10%	Richest 20% to poorest 20%	Gini index	
17	France	1995	9.1	5.6	32.7
19	Spain	1990	9.0	5.4	32.5
21	Italy	1998	14.5	7.1	36.0
22	Israel	1997	11.7	6.4	35.5
23	Portugal	1997	15.0	8.0	38.5
24	Greece	1998	10.0	6.2	35.4
25	Cyprus	..	..	..	..
33	Malta	..	..	..	..
61	Libyan Arab Jamahiriya	..	..	..	..
83	Lebanon	..	..	..	..
90	Jordan	1997	9.1	5.9	36.4
91	Tunisia	1995	13.8	8.5	41.7
96	Turkey	2000	13.3	7.7	40.0
98	Occupied Palestinian Territory	..	..	..	..
107	Algeria	1995	9.6	6.1	35.3
110	Syrian Arab Republic	..	..	..	..
120	Egypt	1999	8.0	5.1	34.4
126	Morocco	1998-99	11.7	7.2	39.5

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 7 - Human and income poverty: Developing countries – UNDP 2003*

HDI rank		Population below income poverty line (%)			HPI-1 rank minus income poverty rank
		\$1 a day 1990-2001	\$2 a day 1990-2001	National poverty line 1987-2000	
90	Jordan	<2	7.4	11.7	3
91	Tunisia	<2	10.0	7.6	26
96	Turkey	<2	10.3	..	14
107	Algeria	<2	15.1	22.6	29
120	Egypt	3.1	43.9	16.7	20
126	Morocco	<2	14.3	19.0	37

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

1.3. Social exclusion

Poverty in the sense of social exclusion is a concept that is gaining ground. The struggle against social exclusion currently represents one of the fronts on which the welfare policies of the European countries are most strongly engaged. Furthermore, the definition of poverty as social exclusion lends itself particularly well to an interpretation that pays attention to the defence and protection of the civil and human rights of the people involved, and ensuring that the most vulnerable social categories are not excluded from active life is also one of the most urgent objectives in the richer and more developed countries of the northern shores of the Mediterranean: the first item on the agenda of community policies in the European Union.

There are numerous definitions of social exclusion and many initiatives aimed at redefining its contours, with the object of establishing accepted models for its recognition and interpretation. On the operational plane, and particularly on the comparative plane, however, all these reflections have been unable to establish a set of homogeneous, comprehensive indicators able to provide a universal definition of the various aspects that determine exclusion. Within the section, then, keeping faith with our task of examining the phenomena on the basis of a well-established sequence of comparable data, social exclusion has been defined in accordance with the variables provided by data from UNDP, WB, UNICEF, UNESCO and other international organisations. An overview of this data allows us to redefine social exclusion as:

- exclusion from work and from integration into society and the working world;
- exclusion from wealth and income;
- exclusion on account of gender;
- exclusion on account of age;
- exclusion from education;
- exclusion from civilised society;

- exclusion from a satisfactory life expectancy;
- exclusion from welfare services.

Some of the above-mentioned categories are dealt with in other sections of the present study. For example, exclusion from wealth and income is an issue that has already been covered to some extent in the previous section on economic poverty; in the same way, exclusion from welfare services will be dealt with mainly in the section devoted to health.

In this chapter we shall chiefly look at the issues linked to exclusion from work and education, focusing particularly on those aspects that are linked to the state of women and young people.

It is interesting to note that, although social exclusion is not well defined, it has a certain geographical continuity, with countries being grouped on the basis of homogeneous phenomena: in some cases, these are more homogeneous than other indicators. For example, in the case of exclusion from life expectancy, the countries of the northern Mediterranean have very similar values, with an oscillation of about 4%. The same relative homogeneity is found for the same countries in the Human Poverty Index (HPI-2), which averages 11% (Table 8).

All things considered, the unemployment figures for the countries of the northern Mediterranean are similar: apart from Portugal, they show rates of between 8 and 12% (Table 9).

The figures for long-term unemployment are less homogeneous, however: in Italy it stands at 6.1% of the working population while in Portugal, where there is higher mobility, the figure is 1.6% (Table 10).

Likewise, in the case of access to the labour market by women and young people, the homogeneity of the figures relating to the richer countries of the Mediterranean gives way to marked differences, with Greece and Italy distinguished by a high rate of unemployment among young people and Italy burdened by a high percentage of long-term unemployed for both sexes, while Greece, Spain and Portugal have a high rate of female unemployment (Table 11).

The state of the rest of the Mediterranean countries, too, is much less homogeneous with respect to the various aspects of social exclusion (Table 12):

- Morocco and Egypt have the highest Human Poverty Indices, followed by Algeria, Tunisia and Syria;
- life expectancy of less than 40 years is highest in Morocco (9.4%), Algeria (9.3%), Egypt (8%), Turkey (8%) and Jordan (6.6%);
- the highest adult illiteracy rates are found in Morocco (50.2%), Egypt (43.9%), Algeria (32.2%), Tunisia (27.9%) and Syria (24.7%);
- access to drinking water is still an ongoing problem for 28% of the population in Libya, 20% of the population in Tunisia and Morocco and 18% in Turkey;
- infantile malnutrition affects 13% of children in Syria, 9% in Morocco and 8% in Turkey.

Table 8 - Human and income poverty in OECD countries – UNDP 2003*

HDI rank	Human poverty index (HPI-2)		Probability at birth of not surviving to age 60 (% of cohort) 2000-05	
	Rank	Value (%)		
17	France	8	10.8	10.0
19	Spain	9	11.0	8.8
21	Italy	11	12.2	8.6
22	Israel	..	..	7.4
23	Portugal	..	..	11.7
24	Greece	..	..	9.1
33	Malta	..	..	7.7

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 9 - Unemployment in OECD countries (v.a. e val. %) – UNDP 2003*

HDI rank		Unemployed people (thousands) 2001	Unemployment		
			Rate (% of labour force) 2001	Average annual rate (% of labour force) 1991-2001	Female rate as % of male rate 2001
17	France	2,321.4	8.7	9.0	151
19	Spain	1,869.1	10.5	11.2	204
21	Italy	2,267.0	9.6	9.2	177
23	Portugal	211.8	4.1	4.7	158
24	Greece	456.1	10.4	10.1	228
96	Turkey	1,902.0	8.5	8.5	90
	OECD	32,790.3	6.4	6.6	111

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 10 - Human and income poverty in OECD countries – UNDP 2003*

HDI rank		Long-term unemployment (as % of labour force) 2001	Population below income poverty line (%)			HPI-2 rank minus income poverty rank
			50% of median income 1990-2000	\$11 a day 1994-95	\$4 a day 1996-99	
17	France	3.3	8.0	9.9	..	2
19	Spain	4.6	10.1	..	..	-1
21	Italy	6.1	14.2	..	..	-4
22	Israel	..	13.5	..	..	..
23	Portugal	1.6	..	..	..	..
24	Greece	5.5	..	..	..	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 11 - Unemployment in OECD countries (val. %) – UNDP 2003^a

HDI rank	Youth unemployment				
	Rate (% of labour force aged 15-24) 2001	Female rate as % of male rate 2001	Long-term unemployment (as % of total unemployment)		
			Female	Male	
17	France	18.7	135	37.6	37.6
19	Spain	20.8	168	48.6	37.9
21	Italy	27.0	139	63.1	63.7
23	Portugal	9.2	165	39.9	35.7
24	Greece	28.0	170	56.6	47.0
96	Turkey	19.9	88	32.3	20.1
OECD		12.4	97	31.4	28.7

a. for further details on sources and survey criteria:

http://www.unodc.org/unodc/en/analysis_and_statistics.html

b. The age range for the labour force may be 16-24 for some countries.

c. Data refer to unemployment lasting 12 months or longer.

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 12 - Human and income poverty in Developing countries UNDP 2003*

		Human poverty index (HPI-1)		Probability at birth of not surviving to age 40 (% of cohort) 2000-05	Adult illiteracy rate (% age 15 and above) 2001	Population without sustainable access to an improved water source (%) 2000	Children under weight for age (% under age 5) 1995-2000
HDI rank		Rank	Value Value (%)				
25	Cyprus	..	..	2.9	2.8	0	..
61	Libyan A. J.	29	15.7	4.5	19.2	28	5
83	Lebanon	15	9.5	4.3	13.5	0	3
90	Jordan	7	7.5	6.6	9.7	4	5
91	Tunisia	37	19.9	4.9	27.9	20	4
96	Turkey	22	12.4	8.0	14.5	18	8
98	Occ. Pal. Terr.	..	..	5.2	..	14	3
107	Algeria	42	22.6	9.3	32.2	11	6
110	Syrian Arab Republic	35	18.8	5.7	24.7	20	13
120	Egypt	47	30.5	8.6	43.9	3	4
126	Morocco	56	35.2	9.4	50.2	20	9

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

1.4. Millennium Goals directly linked to poverty

The Millennium Goals are useful as benchmarks for measuring the advances made by the various countries in different aspects of human development, especially with regard to poverty-related issues, where fixed benchmarks allow greater and easier measurement of the progress achieved, in both absolute and comparative terms.

There are three Millennium Goals in particular that are closely linked to poverty:

- Goal 1, with its mandate to “Eradicate extreme poverty and hunger”;
- Goal 2, with its mandate to “Achieve universal primary education”;
- Goal 8, with its mandate to “Develop a global partnership for development: work opportunities” and to “Develop a global partnership for development: access to new technologies”.

Let us look briefly at what progress has been achieved on these three fronts by the Mediterranean countries. With regard to the aim to halve by 2015 the proportion of people who in 1990 were living on an income below the threshold of 1 dollar a day, except for Egypt which continues to register 3.1% of the population, all the other countries show a drop in 2001 to less than 2% (Table 13).

On the other hand, in the case of infantile malnutrition there is a clear-cut break between the countries of the north and south, with worrying peaks, higher than the early 90s, in Morocco, Algeria and Jordan.

The figures for Goal 2, relating to primary education, show fairly clearly the advances made by almost all the Mediterranean countries, but Lebanon and Morocco have percentages below the average for the developing countries: 78 and 74% respectively, as compared with an average of 82% (Table 14). Despite this, great progress can be seen in Morocco, which began with 58% in 1990-91, and also in Jordan, Algeria and Tunisia.

Two countries, Syria and Spain, register a lower figure for enrolment at primary school with respect to the percentage found ten years previously.

Goal 8 concerns both the development of work opportunities for young people and increased access to new technologies. The lack of data for most of the countries on the southern shores is in itself an indication that much still remains to be done on this front. Where data is available, on the other hand, it illustrates negative trends in Morocco, the only southern country for which data exists, and also in the statistics of the richer countries (Table 15):

- there is a marked decrease in the employment of women and young people in the ten-year period 1990-2001 in Italy, Portugal, Spain and also Israel;
- a slight increase in female unemployment in France;
- the only positive statistic is the steady increase in employment in Greece.

As far as the use of new technology is concerned, an epoch-making change has taken place in the last 12 years, particularly with regard to the use of the Internet and computers. This revolution has spread at various speeds but it is clear that, starting from percentages close to zero in the early 90s, the average percentage for use of the telephone and computers is on the increase (Table 16). Enormous differences remain, however:

- with regard to telephones, in 2001 Italy had 135.5 telephone contracts per 100 people, while Algeria had only 6.4;
- Internet users represent 28.1% of the population in Portugal and 0.4% in Syria or Libya;
- personal computers are used by 32.9% of the French and 0.7% of the Algerian population.

Table 13 - UNDP Goal 1: Eradicate extreme poverty and hunger*

	Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day			Halve, between 1990 and 2015, the proportion of people who suffer from hunger		
	Population living below \$1 a day (%) ^a	Poverty gap ratio (%)	Share of poorest 20% in national income or consumption (%)	Children under weight for age (% under age 5)	Undernourished people (as % of total population)	
	1990-2001	1990-2001	1990-2001	1995-2001	1990/92	1998/2000
Algeria	<2	<0.5	7.0	6	5	6
Egypt	3.1	<0.5	8.6	4	5	4
Jordan	<2	<0.5	7.6	5	4	6
Lebanon	..	..	..	3	..	3
Libyan Arab Jamahiriya	..	..	..	5	..	..
Morocco	<2	<0.5	6.5	9	6	7
Occupied Palestinian Territory	..	..	..	3	..	..
Syrian Arab Republic	..	..	..	13	5	3
Tunisia	<2	<0.5	5.7	4	..	..
Turkey	<2	<0.5	6.1	8	..	..
France	..	..	7.2	..	..	..
Greece	..	..	7.1	..	..	..
Italy	..	..	6.0	..	..	..
Portugal	<2	<0.5	5.8	..	..	..
Spain	..	..	7.5	..	..	..
Israel	..	..	6.9	..	..	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 14 - UNDP Goal 2: Achieve universal primary education*

	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling					
	Net primary enrolment ratio**		Children reaching grade 5		Youth literacy rate	
	(%)		(%)		(% age 15-24)	
	1990-91	2000-01	1990-91	1999-2000	1990	2001
Algeria	93	98	94	97	77.3	89.2
Egypt	..	93	..	..	61.3	70.5
Jordan	66	94	100	98	96.7	99.3
Lebanon	..	74	..	97	92.1	95.4
Libyan Arab Jamahiriya	97	..	..	..	91.0	96.7
Morocco	58	78	75	80	55.3	68.4
Occ. Palestinian Terr.	..	97	..	..	..	..
Syrian Arab Republic	98	96	94	..	79.9	87.7
Tunisia	94	99	87	93	84.1	93.8
Cyprus	87	95	100	99	99.7	99.8
Turkey	89	..	98	..	92.7	96.7
France	101	100	96	..	..	..
Greece	94	97	99	..	99.5	99.8
Italy	..	100	100	..	99.8	99.8
Portugal	102	..	..	..	99.5	99.8
Spain	103	102	100	..	99.6	99.8
Israel	..	101	..	..	98.7	99.5
Malta	99	99	100	100	97.5	98.6
Developing countries	80	82	..	..	81.0	84.5
OECD	97	98	..	..	..	..
World	82	84	..	..	82.5	85.7

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

** a percentage greater than 100 indicates a lack of homogeneity in the data sources, between figures for the population and figures for those enrolled at school

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Tab. 15 - UNDP Goal 8 - Develop a global partnership for development: work opportunities*

		Develop and implement strategies for decent and productive work for youth					
		Youth unemployment (% of labour force aged 15-24)					
		Total		Female		Male	
		1990	2001	1990	2001	1990	2001
107	Algeria	39	..	14	..	46	..
120	Egypt	..	20	..	37	..	14
90	Jordan	..	..	..	..	..	..
83	Lebanon	..	..	..	..	..	..
61	Libyan Arab Jamahiriya	..	..	..	..	..	..
126	Morocco	31	15	32	15	31	16
98	Occ. Palestinian Terr.	..	..	..	..	..	..
110	Syrian Arab Republic	..	..	..	..	..	..
91	Tunisia	..	..	..	..	..	..
25	Cyprus	..	7	..	10	..	4
96	Turkey	16	20	15	18	17	21
17	France	19	19	24	22	15	16
24	Greece	23	28	33	36	15	21
21	Italy	32	27	38	32	26	23
23	Portugal	10	9	13	12	7	7
19	Spain	30	21	40	27	23	16
22	Israel	22	19	23	18	21	19
33	Malta	..	..	..	..	..	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 16 - UNDP Goal 8 (bis) - Develop a global partnership for development: access to new technologies*

		Make available the benefits of new technologies, especially information and communications					
		Telephone mainlines and cellular subscribers (per 100 people)		Internet users (per 100 people)		Personal computers in use (per 100 people)	
		1990	2001	1990	2001	1990	2001
107	Algeria	3.2	6.4	..	0.6	0.1	0.7
120	Egypt	3.0	14.7	..	0.9	..	1.5
90	Jordan	7.2	29.6	..	4.5	..	3.3
83	Lebanon	15.5	41.6	..	7.8	..	7.5
61	Libyan Arab Jamahiriya	4.8	11.8	..	0.4	..	..
126	Morocco	1.6	20.4	..	1.4	..	1.4
98	Occ. Palestinian Terr.	4.1	17.9	..	1.8	..	..
110	Syrian Arab Republic	4.1	11.5	0.0	0.4	..	1.6
91	Tunisia	3.8	14.9	..	4.1	0.3	2.6
25	Cyprus	42.4	108.7	0.1	21.8	0.9	24.7
96	Turkey	12.2	58.1	..	6.0	0.5	4.1
17	France	50.0	117.9	0.1	26.4	7.1	32.9
24	Greece	38.9	128.1	(.)	13.2	1.7	8.1
21	Italy	39.2	135.5	(.)	26.9	3.6	19.5
23	Portugal	24.3	119.9	0.1	28.1	2.7	11.7
19	Spain	31.7	116.7	(.)	18.3	2.8	16.8
22	Israel	34.6	137.3	0.1	27.7	6.3	24.6
33	Malta	36.0	114.1	..	25.3	1.4	23.0
Developing countries		2.1	16.3	..	2.6	..	2.5
OECD		40.2	106.2	0.3	33.2	9.4	36.3
World		10.0	32.2	..	8.0	..	8.7

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

2. HEALTH

The subject of health gives wide scope for exploring the various aspects of the well-being of the Mediterranean peoples. Our analysis of health conditions in the Mediterranean is divided into five sections:

- a section on *general trends*, giving general, basic data illustrating the current state of health in the Mediterranean;
- a section on the *healthy life expectancy* of the peoples inhabiting the various areas of the Mediterranean basin;
- a section on the level of *access to health services and resources* in the countries considered;
- a section on the commitment, in terms of investments, and *spending on health* by the countries of the Mediterranean basin;
- lastly, a section analysing how close the countries are to the Millennium Goals connected with health.

2.1. General trends and figures

The annual growth rate of the population ranges between 0.1% in southern Europe, as registered for Italy, Portugal and Spain, and about 3% in the Middle East, particularly Jordan (3.9%), Israel (2.9%) and Syria (2.7%). These figures confirm the trends indicating a progressive change in the demographic composition on opposite shores of the Mediterranean, at three different speeds (Table 17):

- in the Middle East, a high rate of demographic growth, around 3% per annum;
- in North Africa, less strong growth, around 2%;
- in Europe, a growth rate approaching zero.

In the last 10 years, the active proportion of the population has increased in all the countries concerned except France, Italy and Greece, resulting in an improvement, from this point of view, in their human resources, in some cases with giant strides, as in Libya, Jordan, Algeria and Tunisia.

The population over 60 has generally increased in the last 10 years, especially, as might be expected, in the countries on the northern shores, such as Greece, Italy, Spain and Malta. The countries with the smallest increases include those with the highest growth rates, i.e. Jordan (zero increase) followed by Algeria, Egypt, Israel, Lebanon, Morocco and Syria, all with less than 1%.

The fertility rate has fallen, to varying degrees, over the last 10 years, with some countries registering a more pronounced drop: Syria, Algeria, Jordan, Tunisia, Libya, Morocco.

Average life expectancy in the Mediterranean is now about 73 years, on the rise towards 74. The countries with figures considerably lower than this are, in ascending order: Egypt (decidedly lower at 66.6), Turkey, Algeria and Morocco. The countries with the highest figures are, in descending order: France and Italy, Spain and Israel (Table 18).

These departures from the average tend to become greater in the case of women. An examination of life expectancy by sex shows that it is chiefly women who help raise the average in countries such as Portugal, France, Italy and Spain, while in Egypt, Morocco, Algeria and Turkey the life expectancy of women is lower than that of men, substantially influencing the average, which is lower.

Practically all the countries of the Mediterranean are well above the average rate of malnutrition registered by the developing countries (18% of the population). Malnutrition figures are recorded in only 5 countries; Morocco and Jordan head the list, with 7 and 6% of the population respectively suffering from malnutrition, followed by Egypt with 4% and lastly Syria and Lebanon, both with 3% (Table 19).

A more complex phenomenon, and one that is less closely linked to the state of economic deprivation suffered by families, is the low birth-weight of infants, which affects 8 babies per hundred in the Mediterranean area. The figure is highest for Turkey, affecting 15% of all babies, followed by Jordan and Egypt with 10%. Lower percentages are found not only in the more

developed countries of the northern shores but also in countries such as Tunisia (5%, the lowest in the Mediterranean), Lebanon and Syria (6%) and Libya (7%).

The average incidence of people living with HIV/AIDS is 0.23% in the Arab countries, lower than that of the more developed countries, where 0.30% of the population are HIV-positive or suffering from AIDS. Higher rates are found in Portugal and Spain: together with Italy and France, these countries have rates exceeding the average for the more advanced countries (Table 20).

To complete the scenario, there are the figures for the incidence of malaria and tuberculosis. As far as the former is concerned, with the exception of Turkey, where an incidence of 17 per 100,000 is still reported, malaria seems to have been practically eliminated from the Mediterranean. The incidence of tuberculosis, which still exists in the area, is well below the world average (which is 119 per 100,000), but it still affects 47 people per 100,000 in Morocco and Syria and over 23 in Egypt and Turkey (Table 21).

Table 17 - WHO Basic indicators for all Member States: Population estimates^a

Member State	POPULATION ESTIMATES							
	Total population (000)	Annual growth rate (%)	Dependency ratio ^c (per 100)		Percentage of population aged 60+ years		Total fertility rate	
			1991	2001	1991	2001	1991	2001
Algeria	30 841	1,9	82	62	5,7	6,0	4,3	2,9
Cyprus	790	1,3	58	52	14,8	15,9	2,4	1,9
Egypt	69 079	1,9	77	64	6,1	6,3	4,0	3,0
France	59 452	0,4	52	53	19,3	20,5	1,7	1,8
Greece	10 623	0,4	49	49	20,4	23,7	1,4	1,3
Israel	6 171	2,9	67	61	12,5	13,1	3,0	2,8
Italy	57 502	0,1	45	48	21,5	24,3	1,3	1,2
Jordan	5 050	3,9	96	75	4,6	4,6	5,7	4,4
Lebanon	3 555	2,5	66	58	8,2	8,5	3,1	2,2
Libyan Arab Jamahiriya	5 407	2,1	83	58	4,3	5,6	4,6	3,5
Malta	391	0,8	51	48	14,8	17,2	2,0	1,8
Morocco	30 430	1,9	75	62	6,0	6,4	4,1	3,1
Portugal	10 032	0,1	50	48	19,3	21,0	1,5	1,5
Spain	39 920	0,1	49	46	19,6	22,0	1,3	1,1
Syrian Arab Republic ^b	16 609	2,7	101	76	4,5	4,7	5,3	3,8
Tunisia	9 561	1,4	71	53	7,0	8,4	3,4	2,2
Turkey	67 632	1,7	64	56	7,3	8,5	3,3	2,4

a For further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

b Figures not endorsed by Member State as official statistics.

c A percentage greater than 100 indicates incongruences between the different sources of the statistics necessary to calculate the index

Source: Data from WHO, 2003, elaborated by Censis

Table 18 - WHO Basic indicators for all Member States: Life expectancy*

Member State	LIFE EXPECTANCY AT BIRTH (YEARS)		LIFE EXPECTANCY AT BIRTH (years)							
	Both sexes		Males			Females				
	2000	2001	2001	Uncertainty interval		2001	Uncertainty interval			
Algeria	68,9	69,4	67,7	66,5	-	68,8	71,1	70,0	-	72,4
Cyprus	76,8	76,9	74,6	73,8	-	75,4	79,2	77,9	-	80,3
Egypt	66,3	66,5	65,3	64,5	-	66,0	67,8	66,8	-	68,9
France	79,1	79,3	75,6	75,3	-	75,9	82,9	82,8	-	83,1
Greece	78,0	78,1	75,5	75,2	-	75,7	80,8	80,5	-	81,0
Israel	78,5	78,5	76,1	75,6	-	76,7	80,9	80,6	-	81,1
Italy	79,1	79,3	76,2	75,8	-	76,6	82,2	81,9	-	82,4
Jordan	70,7	70,8	68,6	67,5	-	69,7	73,5	72,7	-	74,3
Lebanon	69,6	69,8	67,6	66,4	-	68,9	72,0	71,2	-	72,8
Libyan Arab Jamahiriya	70,0	70,4	68,3	67,1	-	69,5	73,1	72,1	-	74,4
Malta	77,9	78,1	75,8	75,0	-	76,5	80,3	79,8	-	80,8
Morocco	69,3	69,4	67,5	66,3	-	68,6	71,3	69,9	-	72,6
Portugal	76,4	76,5	72,7	72,2	-	73,2	80,1	79,8	-	80,4
Spain	78,8	78,9	75,3	74,5	-	76,0	82,6	82,3	-	83,0
Syrian Arab Republic**	70,6	70,9	68,7	68,0	-	69,4	73,2	72,5	-	73,7
Tunisia	70,9	71,1	69,0	68,3	-	69,7	73,5	72,8	-	74,3
Turkey	68,9	69,0	67,0	66,4	-	67,5	71,2	70,6	-	71,8

* For further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

** Figures not endorsed by Member State as official statistics.

Source: Data from WHO, 2003, elaborated by Censis

Table 19 - Leading global health crises and challenges*

HDI rank		Under-nourished people (as % of total population) 1998/2000	Infants with low birth-weight (%) 1995 - 2000
17	France	..	6
19	Spain	..	6
21	Italy	..	6
22	Israel	..	8
23	Portugal	..	7
24	Greece	..	7
25	Cyprus	..	..
33	Malta	..	7
61	Libyan Arab Jamahiriya	..	7
83	Lebanon	3	6
90	Jordan	6	10
91	Tunisia	..	5
96	Turkey	..	15
98	Occupied Palestinian Territory	..	9
110	Syrian Arab Republic	3	6
120	Egypt	4	10
126	Morocco	7	9

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 20 - Leading global health crises and challenges: People living with HIV/AIDS*

HDI rank		Adults (% age 15-49) 2001	Women (age 15-49) 2001	Children (age 0-14) 2001
17	France	0.33	27,000	1,000
19	Spain	0.50	26,000	1,300
21	Italy	0.37	33,000	770
22	Israel	0.10	..	..
23	Portugal	0.52	5,100	350
24	Greece	0.17	1,800	<100
25	Cyprus	0.25	150	..
33	Malta	0.13	..	..
61	Libyan Arab Jamahiriya	0.24	1,100	..
83	Lebanon	..	..	..
90	Jordan	<0.10	150	..
91	Tunisia	..	..	..
96	Turkey	<0.10	..	..
98	Occupied Palestinian Territory	..	..	..
110	Syrian Arab Republic	..	..	..
120	Egypt	<0.10	780	..
126	Morocco	0.08	2,000	..
	Developing countries	1.30	18,000,000	2,900,000
	OECD	0.30	360,000	19,000
	World	1.20	18,500,000	3,000,000

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 21 - Leading global health crises and challenges*

HDI rank		Malaria cases (per 100,000 people) 2000	Tuberculosis cases (per 100,000 people) 2001	Cigarette consumption per adult (annual average) 1992-2000
17	France	..	6	1,757
19	Spain	..	14	2,826
21	Italy	..	4	2,041
22	Israel	..	5	2,118
23	Portugal	..	17	2,036
24	Greece	..	11	3,230
25	Cyprus	..	5	..
33	Malta	..	3	..
61	Libyan Arab Jamahiriya	2	11	..
83	Lebanon	..	11	..
90	Jordan	3	5	1,686
91	Tunisia	1	18	1,775
96	Turkey	17	25	2,118
98	Occupied Palestinian Territory	..	19	..
110	Syrian Arab Republic	(.)	47	1,223
120	Egypt	(.)	23	1,201
126	Morocco	(.)	47	717
	Developing countries	..	144	..
	OECD	..	11	..
	World	..	119	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

2.2. Healthy life expectancy

In the Mediterranean countries, 2.3% of children die before the age of 5, while 12.5% of people over 15 do not survive beyond the age of 60. But apart from these average figures, with regard to infant mortality (generally homogeneous for both sexes) there are major differences between the various countries, which can be divided into (Table 22):

- countries where infant mortality is decidedly below average (all the European countries plus Israel, Cyprus and Malta);
- countries where infant mortality is close to or only slightly below average, such as Jordan, Lebanon, Libya, Syria and Tunisia;
- countries where infant mortality is considerably higher than the Mediterranean average, such as Algeria, Egypt, Morocco and Turkey.

Similar trends may be seen in life expectancy before age 60, where the distribution of countries is similar to that described above but where the gap between the sexes tends to be to the disadvantage of females:

- in the block of European countries plus Israel, Cyprus and Malta, figures are well above average, with only one exception: Portugal, where the probability of death is lower than average (2.6%) for females under 60 years of age, rising to near average (15.8%) for males;
- in Egypt, Turkey, Lebanon, Libya, Jordan and Syria, life expectancy before 60 is decidedly lower than average for both sexes;
- in some countries, such as Algeria, Cyprus, Italy and Malta, there is a greater probability of death for males, while in others, such as Libya, Portugal, Spain and Turkey, the probability of death before 60 is proportionally higher for females.

Figures for healthy life expectancy registered by means of the HALE indicator created by the WHO also give a fairly variegated and discontinuous picture, with a higher risk of sickness at birth in certain countries, such as Morocco and Egypt (Table 23).

Table 22 – Life expectancy^a

Member State	PROBABILITY OF DYING (per 1000)							
	Under age 5 years				Between ages 15 and 59 years			
	Males		Females		Males		Females	
	2001	Uncertainty interval	2001	Uncertainty interval	2001	Uncertainty interval	2001	Uncertainty interval
Algeria	55	44 - 65	44	34 - 53	164	147 - 180	129	113 - 145
Cyprus	7	6 - 8	7	6 - 8	110	100 - 121	58	47 - 70
Egypt	46	41 - 52	44	39 - 51	230	213 - 248	160	139 - 183
France	5	5 - 6	4	4 - 5	134	129 - 139	60	58 - 62
Greece	7	6 - 8	6	6 - 7	119	115 - 122	50	48 - 53
Israel	7	6 - 8	6	5 - 6	115	108 - 122	55	52 - 57
Italy	6	5 - 6	5	5 - 6	100	95 - 105	51	49 - 53
Jordan	27	21 - 34	24	18 - 30	193	174 - 215	122	113 - 130
Lebanon	34	31 - 37	28	25 - 30	204	177 - 230	140	125 - 156
Libyan Arab Jamahiriya	31	25 - 37	29	23 - 34	194	177 - 211	118	107 - 129
Malta	8	7 - 9	6	5 - 8	89	82 - 97	48	44 - 52
Morocco	58	46 - 71	55	44 - 67	162	150 - 174	105	93 - 117
Portugal	7	7 - 8	6	5 - 6	158	150 - 167	67	64 - 70
Spain	5	5 - 6	4	4 - 5	124	114 - 135	48	45 - 51
Syrian Arab Republic ^b	27	24 - 29	23	21 - 25	192	177 - 207	129	120 - 139
Tunisia	33	30 - 36	27	24 - 30	174	162 - 188	117	104 - 129
Turkey	46	38 - 56	40	33 - 49	206	193 - 218	118	106 - 129

a For further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

b Figures not endorsed by Member State as official statistics.

Source: Data from WHO, 2003, elaborated by Censis

Table 23 - Healthy life expectancy (HALE), estimates for 2000 and 2001 (in years)^a

LEVEL	Healthy life expectancy in (HALE) (years)											
	Total population				Males 2001			Females 2001				
	Member State	At birth	2000	At birth	2001	At birth	Uncertainty interval	At age 60	Uncertainty interval	At birth	Uncertainty interval	At age 60	Uncertainty interval
Algeria	57,5		57,8		55,8	54.2 - 58.5	10,3	9.3 - 11.9	59,9	58.7 - 62.1	12,2	11.5 - 13.5
Cyprus	66,2		66,2		65,3	64.4 - 66.9	13,2	12.5 - 14.7	67,2	66.4 - 69.2	14,5	14.1 - 15.6
Egypt	56,4		56,7		56,4	55.8 - 57.6	9,4	8.8 - 10.4	57,0	55.9 - 58.9	9,2	8.9 - 10.0
France	71,1		71,3		69,0	68.7 - 69.7	16,1	15.8 - 16.5	73,5	72.9 - 74.3	19,1	18.9 - 19.5
Greece	70,4		70,4		69,0	68.6 - 69.8	15,7	15.4 - 16.2	71,9	71.3 - 73.2	17,1	16.9 - 17.5
Israel	69,4		69,4		68,0	67.2 - 69.3	15,8	15.4 - 16.7	70,8	70.1 - 72.4	16,9	16.4 - 17.8
Italy	70,9		71,0		69,2	68.8 - 70.2	15,5	15.2 - 16.2	72,9	72.4 - 74.0	18,2	18.0 - 18.6
Jordan	58,5		58,5		57,2	56.5 - 58.8	9,9	9.2 - 10.8	59,9	58.7 - 61.6	11,5	11.0 - 12.4
Lebanon	59,2		59,4		56,5	55.4 - 58.8	10,0	9.2 - 11.5	62,2	61.4 - 64.2	12,9	12.3 - 14.0
Libyan A. J.	59,3		59,6		56,8	54.1 - 59.7	9,8	8.3 - 11.5	62,4	58.6 - 66.4	12,9	10.4 - 15.3
Malta	69,2		69,2		67,6	66.9 - 68.6	14,3	13.9 - 15.0	70,9	70.2 - 72.2	16,5	16.2 - 16.9
Morocco	55,3		55,4		54,9	54.1 - 56.5	9,2	8.5 - 10.7	55,9	54.8 - 57.7	10,0	9.4 - 11.0
Portugal	66,8		66,8		64,3	63.6 - 65.3	13,4	13.0 - 14.0	69,4	68.6 - 70.7	16,2	15.9 - 16.7
Spain	70,7		70,9		68,7	68.0 - 69.7	15,2	14.8 - 16.0	73,0	72.5 - 74.2	18,2	17.9 - 18.7
Syrian A. Rep. ^b	59,0		59,2		58,0	56.9 - 60.3	10,0	8.9 - 11.6	60,5	59.3 - 62.6	11,5	10.5 - 13.0
Tunisia	61,1		61,3		58,9	57.9 - 60.4	10,8	10.3 - 11.4	63,7	62.8 - 65.5	13,4	12.9 - 14.6
Turkey	59,7		59,8		58,5	57.9 - 59.3	11,2	10.9 - 11.7	61,1	60.2 - 62.7	12,4	12.1 - 12.9

^a For further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

^b Figures not endorsed by Member State as official statistics.

Source: Data from WHO, 2003, elaborated by Censis

2.3. Access to health

With regard to improvements in the state of health of the Mediterranean peoples, in the sense of access to basic health services, the figures for the Mediterranean basin are well above the averages for the world as a whole. With the exception of Morocco, where such access is available only to 68% of the population, not far below the world average of 61%, all the other countries are positioned around an average of 97% (Table 24).

The problem of access to drinking water has not yet been solved for 7% of the Mediterranean population. The areas chiefly affected are those of the Maghreb, especially in Libya and Syria, where 20% of the population is affected. In Turkey, too, access to water represents a problem for 18% of the population.

Access to essential and basic drugs is a right that has substantially been attained in 11 countries of the Mediterranean. Tunisia and Morocco still have low rates of access: at least 20% of the population has no regular access to these drugs. In Lebanon, Syria and Egypt, at least 5% of the population has no access to drugs.

Rates of vaccination for infants and children are also generally higher than the world average.

Figures for access to contraceptives are incomplete. Considering the data available, we are struck by the fact that there is no marked difference between the countries of the southern shores and those of the north, in contrast to what might be expected (Table 25).

Births attended by skilled personnel represent an acquired right for 89% of the pregnant female population in the Mediterranean countries. Again, with the exception of Morocco (where 60% of births take place without the attendance of skilled personnel), all the other countries, including those on the southern shores, have figures above the world average (Table 26).

The ratio of doctors to inhabitants varies considerably between the countries of the Mediterranean basin: Italy holds the record, with one doctor per 177 inhabitants, and Spain is in second place, with a ratio of 1:230; at the other end of the scale we find Tunisia, with a ratio of 1:1,429 and Morocco, in last place, where a doctor has on average 2,041 patients (Table 27 and Fig. 1).

Table 24 – Access to health*

HDI rank		Population with	Population with	Population with	One-year-olds fully immunized	
		access to improved sanitation (%) 2000	sustainable access to an improved water source (%) 2000	sustainable access to affordable essential drugs (%) ^a 1999	Against tuberculosis (%) 2001	Against measles (%) 2001
17	France	..	..	95-100	84	84
19	Spain	..	..	95-100	..	94
21	Italy	..	..	95-100	..	70
22	Israel	..	..	95-100	..	94
23	Portugal	..	..	95-100	82	87
24	Greece	..	..	95-100	88	88
25	Cyprus	100	100	95-100	..	86
33	Malta	100	100	95-100	..	65
61	Libyan Arab Jamahiriya	97	72	95-100	99	93
83	Lebanon	99	100	80-94	..	94
90	Jordan	99	96	95-100	..	99
91	Tunisia	84	80	50-79	97	92
96	Turkey	90	82	95-100	89	90
98	Occupied Palestinian Territory	100	86	..	..	..
107	Algeria	92	89	95-100	97	83
110	Syrian Arab Republic	90	80	80-94	99	93
120	Egypt	98	97	80-94	98	97
126	Morocco	68	80	50-79	93	96
	Developing countries	51	78	..	78	69
	OECD	..	..	..	..	91
	World	61	82	..	79	72

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003, elaborated by Censis

Table 25 – Use of contraceptives*

HDI rank		Contraceptive prevalence (%) 1995-2001
17	France	..
19	Spain	81
21	Italy	60
22	Israel	..
23	Portugal	..
24	Greece	..
25	Cyprus	..
33	Malta	..
61	Libyan Arab Jamahiriya	40
83	Lebanon	61
90	Jordan	53
91	Tunisia	..
96	Turkey	64
98	Occupied Palestinian Territory	..
110	Syrian Arab Republic	..
120	Egypt	56
126	Morocco	50

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003,
elaborated by Censis

Table 26 - Births attended by skilled health personnel*

HDI rank		Births attended by skilled health personnel (%) 1995-2001
61	Libyan Arab Jamahiriya	94
83	Lebanon	88
90	Jordan	97
91	Tunisia	90
96	Turkey	81
98	Occupied Palestinian Territory	..
110	Syrian Arab Republic	76
120	Egypt	61
126	Morocco	40
	Developing countries	56
	OECD	94
	World	60

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003,
elaborated by Censis

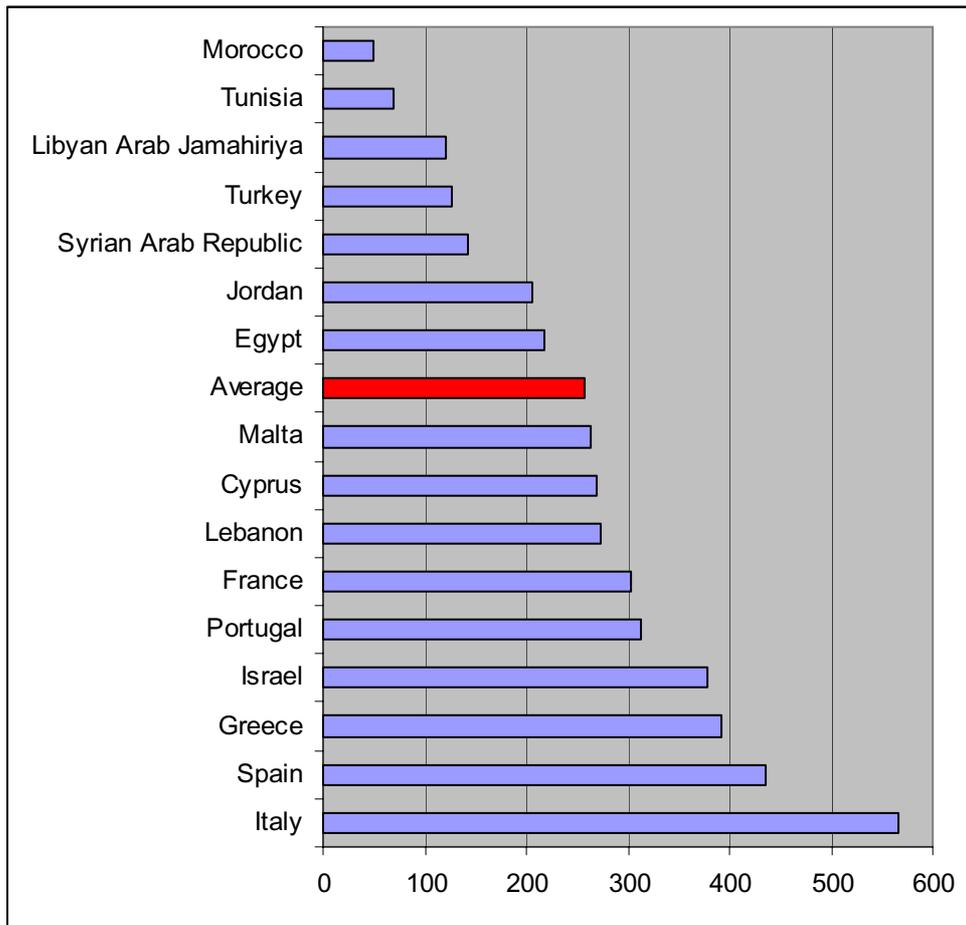
Tab. 27 - Doctors*

HDI rank		Physicians (per 100,000 people) 1990-2002
17	France	303
19	Spain	436
21	Italy	567
22	Israel	378
23	Portugal	312
24	Greece	392
25	Cyprus	269
33	Malta	263
61	Libyan Arab Jamahiriya	120
83	Lebanon	274
90	Jordan	205
91	Tunisia	70
96	Turkey	127
98	Occupied Palestinian Territory	..
110	Syrian Arab Republic	142
120	Egypt	218
126	Morocco	49

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, World Bank, UNICEF, UNESCO and others, 2003,
elaborated by Censis

Fig. 1 - Doctors per 100,000 people, 1990-2002



Source: Data from UNDP, WHO, World Bank, SIPRI and others, 2003, elaborated by Censis

2.4. Spending on health

The first figure that illustrates the commitment of the various Mediterranean countries towards promoting health is the percentage of public spending in relation to GDP and in relation to other sectors, in particular the ratio between spending on Health, Defence and Education (Table 28). Taking as a reference the latest figures available (2000), the Mediterranean countries fall into three main groups:

- countries that invest less than 2% of their GDP on health, such as Morocco, Syria, Libya and Egypt;
- countries that invest between 2% and 5% on health, such as Algeria, Turkey, Tunisia, Jordan, Cyprus and Greece;
- countries that invest more than 5% of their GDP on health, such as Spain, Portugal, Italy, Malta and France.

Israel's progress is particularly worthy of note: it has increased spending, from 3.8% in 1990 to 8.3% in 2000, and holds the record for the percentage of public money spent on health. The figures given below show trends in public spending (Fig. 2):

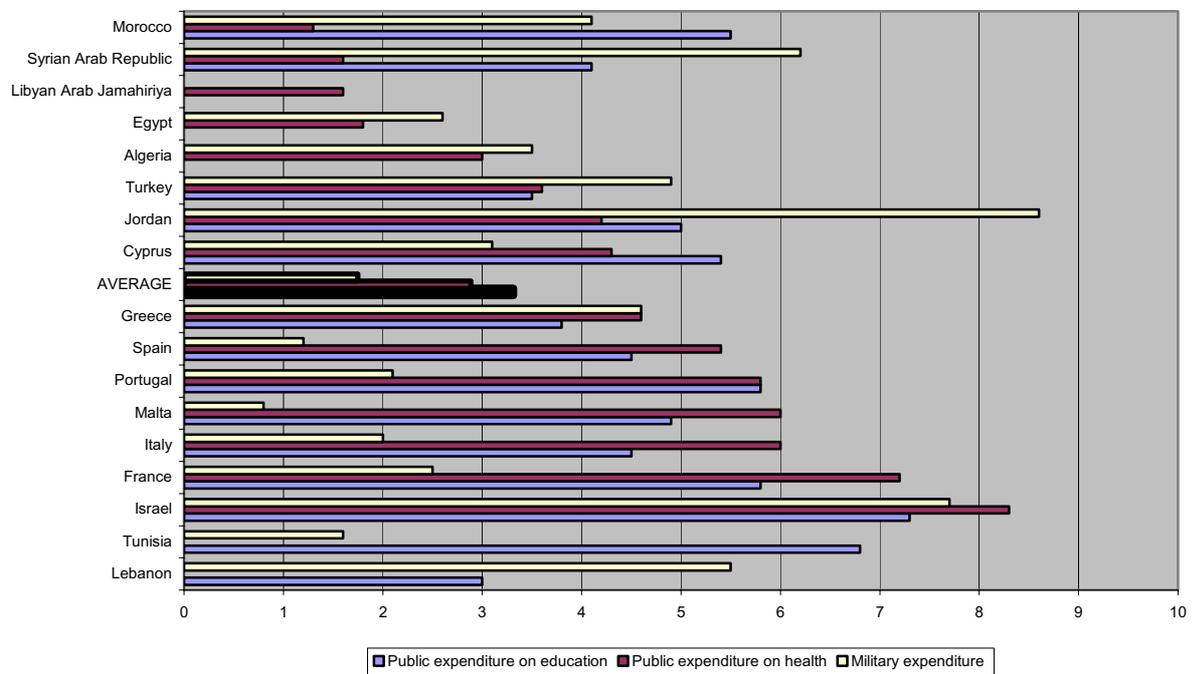
- some countries invest public money chiefly in the education sector, e.g. Morocco, Tunisia and Cyprus;
- some countries invest public money chiefly in the defence sector, e.g. Jordan, Syria, Lebanon and Turkey;
- some countries invest public money chiefly in health, e.g. France, Italy and Spain.

The public sector is also supported to a varying extent by the private sector. In countries such as Lebanon, Cyprus, Jordan and Morocco, the private sector is strongly committed to contributing to spending on health (Table 29). This commitment results in a certain redefinition of the overall commitment of the different spending systems (Table 30).

A historical sequence of data covering the years 1995-2000 illustrates ongoing trends (Tables 31-42). Generally speaking, the situation in the Mediterranean is by no means homogeneous:

- in the Mediterranean countries of Europe, there are fairly compact trends indicating stable or slightly falling spending over the five-year period, with relatively marked reductions in Greece and Cyprus;
- in the countries of the southern shores and the Maghreb, the trends are very disparate, with Tunisia and Morocco showing a tendency to increase spending on health, to differing extents, and countries like Algeria, Libya and Egypt showing varying degrees of reduction;
- in the countries of the Middle-Eastern block, trends of both kinds can be seen: towards increased spending in Israel, Syria and Lebanon and falling in Jordan.

Fig. 2 - Priorities in public spending (as % of GDP)



Source: Data from UNDP, WHO, World Bank, SIPRI and others, 2003, elaborated by Censis

Table 28 - Priorities in public spending*

HDI rank		Public expenditure on education (as % of GDP)		Public expenditure on health (as % of GDP)		Military expenditure (as % of GDP)		Total debt service (as % of GDP)	
		1990	1998-2000	1990	2000	1990	2001	1990	2001
		17	France	5.4	5.8	6.7	7.2	3.5	2.5
19	Spain	4.4	4.5	5.2	5.4	1.8	1.2	..	..
21	Italy	3.1	4.5	6.3	6.0	(.)	2.0	..	..
22	Israel	6.3	7.3	3.8	8.3	12.2	7.7	..	..
23	Portugal	4.2	5.8	4.1	5.8	2.7	2.1	..	..
24	Greece	2.5	3.8	4.7	4.6	4.7	4.6	..	..
25	Cyprus	3.5	5.4	..	4.3	5.0	3.1	..	..
33	Malta	4.3	4.9	..	6.0	0.9	0.8	2.0	3.8
61	Libyan Arab Jamahiriya	..	..	..	1.6	..	..	..	..
83	Lebanon	..	3.0	..	..	7.6	5.5	3.5	8.7
90	Jordan	8.4	5.0	3.6	4.2	9.9	8.6	15.6	7.6
91	Tunisia	6.0	6.8	3.0	..	2.0	1.6	11.6	6.8
96	Turkey	2.2	3.5	2.2	3.6	3.5	4.9	4.9	15.2
98	Occupied Palestinian Territory	..	..	..	..	..	..	..	..
107	Algeria	5.3	..	3.0	3.0	1.5	3.5	14.2	8.0
110	Syrian Arab Republic	4.1	4.1	0.4	1.6	6.9	6.2	9.7	1.4
120	Egypt	3.7	..	1.8	1.8	3.9	2.6	7.1	2.0
126	Morocco	5.3	5.5	0.9	1.3	4.1	4.1	6.9	7.7

* For further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, World Bank, SIPRI and others, 2003, elaborated by Censis

Table 29 - Health*

HDI rank	Health expenditure			
	Public (as % of GDP) 2000	Private (as % of GDP) 2000	Per capita (PPP US\$) 2000	
17	France	7.2	2.3	2,380
19	Spain	5.4	2.3	1,547
21	Italy	5.9	2.1	2,028
22	Israel	8.1	2.6	2,338
23	Portugal	5.8	2.4	1,397
24	Greece	4.6	3.7	1,349
25	Cyprus	3.9	4.1	904
33	Malta	6.1	2.8	803
61	Libyan Arab Jamahiriya	1.5	1.4	370
83	Lebanon	3.7	8.5	719
90	Jordan	4.3	3.8	341
91	Tunisia	5.5	1.5	472
96	Turkey	3.6	1.4	315
98	Occupied Palestinian Territory	..	..	..
110	Syrian Arab Republic	1.6	0.9	51
120	Egypt	1.8	2.3	143
126	Morocco	1.6	3.1	174

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, World Bank, SIPRI and others, 2003, elaborated by Censis

Table 30 – Classification of spending on health: public, private and total (as % of GDP 2000)

	Sistema pubblico		Sistema privato		Totale
Israel	8,1	Lebanon	8,5	Lebanon	12,2
France	7,2	Cyprus	4,1	Israel	10,7
Malta	6,1	Jordan	3,8	France	9,5
Italy	5,9	Greece	3,7	Malta	8,9
Portugal	5,8	Morocco	3,1	Greece	8,3
Tunisia	5,5	Malta	2,8	Portugal	8,2
Spain	5,4	Israel	2,6	Jordan	8,1
Greece	4,6	Portugal	2,4	Cyprus	8
Jordan	4,3	France	2,3	Italy	8
Cyprus	3,9	Spain	2,3	Spain	7,7
Lebanon	3,7	Egypt	2,3	Tunisia	7
Turkey	3,6	Italy	2,1	Turkey	5
Egypt	1,8	Tunisia	1,5	Morocco	4,7
Syrian Arab Republic	1,6	Libyan Arab Jamahiriya	1,4	Egypt	4,1
Morocco	1,6	Turkey	1,4	Libyan Arab Jamahiriya	2,9
Libyan Arab Jamahiriya	1,5	Syrian Arab Republic	0,9	Syrian Arab Republic	2,5

Source: Data from UNDP, WHO, World Bank, SIPRI and others, 2003, elaborated by Censis

Table 31 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Total expenditure on Health Share in GDP (%)					
	1995	1996	1997	1998	1999	2000
Algeria	4,8	4,4	4,1	4,4	4,2	3,6
Cyprus	7,0	7,7	8,2	7,9	7,8	7,9
Egypt	3,7	3,8	3,9	4	3,9	3,8
France	9,6	9,6	9,4	9,3	9,4	9,5
Greece	8,9	8,9	8,7	8,7	8,7	8,3
Israel	9,9	10,2	10,1	10	10,9	10,9
Italy	7,4	7,5	7,7	7,7	7,8	8,1
Jordan	9,6	9,9	8,8	8,8	8	8,1
Lebanon	10,8	10,9	11,3	11,6	11,7	11,8
Libyan Arab Jamahiriya	3,6	3,6	3,5	3,7	3,3	3,3
Malta	8,3	8,4	8,6	8,4	8,4	8,8
Morocco	4,6	4,5	4,4	4,3	4,4	4,5
Portugal	8,3	8,5	8,6	8,3	8,4	8,2
Spain	7,7	7,7	7,6	7,6	7,7	7,7
Syrian Arab Republic	2	2	2,1	2,3	2,5	2,5
Tunisia	6,8	6,6	6,4	6,8	7	7

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, World Bank, SIPRI and others, 2003, elaborated by Censis

Table 32 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	General Government expenditure on Health Share in Total expenditure on Health (%)					
	1995	1996	1997	1998	1999	2000
Algeria	78,8	80,8	79,8	80,2	81,3	82,2
Cyprus	55,4	52	51,3	53,1	53,3	53,8
Egypt	43,9	44,6	45,9	46	46,4	46,1
France	76,1	76,1	76,2	76	76,1	76
Greece	54,5	55,2	55,2	54,4	54,3	55,5
Israel	74,4	78,6	78,7	77	77,7	75,9
Italy	72,2	71,8	72,2	72	72,3	73,7
Jordan	49,8	50,2	56,9	56,9	55,3	51,8
Lebanon	28	28,4	27,7	27,5	27,5	27,8
Libyan Arab Jamahiriya	40,5	41,9	50	50	49,1	48,6
Malta	71,4	70	67,9	69,3	67,5	68,5
Morocco	28,7	29	29,5	28,2	29,4	29,6
Portugal	61,7	64,7	64,8	67,5	70,7	71,2
Spain	70,9	71,1	71,1	70,5	70,2	69,9
Syrian Arab Republic	76,1	71,9	68,8	66,6	64,8	63,4
Tunisia	56,1	67,5	77,7	79,1	78,8	78,2

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 33 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Private expenditure on Health Share in Total expenditure on Health (%)					
	1995	1996	1997	1998	1999	2000
Algeria	21,2	19,2	20,2	19,8	18,7	17,8
Cyprus	44,6	48	48,7	46,9	46,7	46,2
Egypt	56,1	55,4	54,1	54	53,6	53,9
France	23,9	23,9	23,8	24	23,9	24
Greece	45,5	44,8	44,8	45,6	45,7	44,5
Israel	25,6	21,4	21,3	23	22,3	24,1
Italy	27,8	28,2	27,8	28	27,7	26,3
Jordan	50,2	49,8	43,1	43,1	44,7	48,2
Lebanon	72	71,6	72,3	72,5	72,5	72,2
Libyan Arab Jamahiriya	59,5	58,1	50	50	50,9	51,4
Malta	28,6	30	32,1	30,7	32,5	31,5
Morocco	71,3	71	70,5	71,8	70,6	70,4
Portugal	38,3	35,3	35,2	32,5	29,3	28,8
Spain	29,1	28,9	28,9	29,5	29,8	30,1
Syrian Arab Republic	23,9	28,1	31,2	33,4	35,2	36,6
Tunisia	43,9	32,5	22,3	20,9	21,2	21,8

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 34 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	General Government expenditure on Health Share in Total Government expenditure (%)					
	1995	1996	1997	1998	1999	2000
Algeria	12,1	12,1	11,6	11,3	11,5	10,2
Cyprus	12	11,4	11,4	11,4	11,6	11,6
Egypt	4,8	5,2	5,9	6,5	6,2	6,5
France	13,2	13,1	13,1	13,2	13,3	13,5
Greece	9,5	9,8	9,9	9,8	9,6	9,2
Israel	15,7	16,8	14,6	14,3	15,9	15,7
Italy	10	10,1	10,9	11,1	11,6	12,7
Jordan	12,2	12,3	12,3	12,3	12,3	12,4
Lebanon	8,5	8,1	7,3	9,8	9,9	9,8
Libyan Arab Jamahiriya	2,2	2,3	2,6	2,7	2,4	2,4
Malta	13	12,3	11,7	11,9	11,8	13,2
Morocco	3,9	4,4	4,3	3,9	4	3,9
Portugal	11,4	12	12,5	12,9	13,1	13,1
Spain	12,2	12,6	12,9	12,9	13,2	13,5
Syrian Arab Republic	5,4	5,2	5,2	5,1	5,2	6
Tunisia	11,5	13,5	15,7	16,9	17,3	17,2

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 35 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	External Resources for Health					
	Share in General Government Expenditure on Health (%)					
	1995	1996	1997	1998	1999	2000
Algeria	0,1	0	0	0	0	0
Cyprus	0	0	0	0	0	0
Egypt	5,7	5,8	4,2	4,5	3,8	3,8
France	0	0	0	0	0	0
Greece	0	0	0	0	0	0
Israel	0	0	1,4	0	0,3	0,4
Italy	0	0	0	0	0	0
Jordan	2	2,1	3,6	4,1	4,2	4,3
Lebanon	2,2	2,3	2	1,7	1,6	1,6
Libyan Arab Jamahiriya	0	0	0	0	0	0
Malta	0	0	0	0	0	0
Morocco	6,4	8,8	9,3	8,7	6,7	7,7
Portugal	0	0	0	0	0	0
Spain	0	0	0	0	0	0
Syrian Arab Republic	0,7	0,5	1,1	0,8	0,5	0,4
Tunisia	1,2	0,9	0,9	0,7	0,6	0,7

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 36 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Out-of-Pocket Expenditure Share in Total Expenditure on Health (%)					
	1995	1996	1997	1998	1999	2000
Algeria	20,7	18,8	19,7	19,3	18,3	17,4
Cyprus	44,6	48	48,7	46,9	46,7	46,2
Egypt	51	50,4	49,5	49,5	49,3	49,6
France	11,1	10,6	10,5	10,4	10,3	10,2
Greece	35,2	38,6	36,9	36,6	35,7	37,4
Israel	22,2	21,4	21,3	23	22,3	24,1
Italy	24,4	24,2	24,1	24,5	24	22,9
Jordan	42,1	41,6	33,7	33,5	34,4	37,6
Lebanon	58,1	57,9	58,5	59,6	59,3	58,6
Libyan Arab Jamahiriya	59,5	58,1	50	50	50,9	51,4
Malta	28,6	30	32,1	30,7	32,5	31,5
Morocco	56,3	54,9	53,2	54,3	53,5	53,6
Portugal	21,4	20,4	19,5	20,5	21	19,6
Spain	26,1	25,7	25,7	26,2	26,4	26,6
Syrian Arab Republic	23,9	28,1	31,2	33,4	35,2	36,6
Tunisia	37,2	42,2	45,3	47,1	47,8	47,6

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 37 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Social Security spending on Health					
	Share in General Government Expenditure on health (%)					
	1995	1996	1997	1998	1999	2000
Algeria	61,1	64	65,2	65,2	63,2	63,5
Cyprus	48	46,8	44,7	44,6	44,2	44,2
Egypt	27,9	28,3	28	28,4	29,5	29,5
France	96,9	96,9	96,8	96,8	96,7	96,8
Greece	23,6	25,2	28	38,6	38,4	36,9
Israel	23,8	24,9	25,6	26,3	24,3	25,8
Italy	0,4	0,4	0,4	0,1	0,1	0,1
Jordan	0	0	0	0	0	0
Lebanon	48	47,6	49,7	45,6	45,9	45,5
Libyan Arab Jamahiriya	0	0	0	0	0	0
Malta	61,5	56,5	64,5	68,9	68	59,9
Morocco	9,1	8,2	8,4	9,2	9,1	9,3
Portugal	7,2	6,6	6,7	7,7	7	7,2
Spain	23,8	20,2	13,5	11,6	9,2	0
Syrian Arab Republic	0	0	0	0	0	0
Tunisia	37,2	42,2	45,3	47,1	47,8	47,6

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 38 - Measured National Expenditure on Health selected variables, 1995 – 2000*

Member State	Prepaid plans Share in Private Expenditure on Health (%)					
	1995	1996	1997	1998	1999	2000
Algeria	0	0	0	0	0	0
Cyprus	0	0	0	0	0	0
Egypt	0,4	0,5	0,5	0,6	0,5	0,5
France	49,5	51,5	51,7	52,3	52,7	53,1
Greece	4,8	4,9	4,9	4,7	4,6	4,9
Israel	0	0	0	0	0	0
Italy	3,5	3,6	3,6	3,3	3,4	3,4
Jordan	4,1	4,3	5,8	5,9	6,2	6,1
Lebanon	16,6	16,5	16,7	15,4	15,8	16,4
Libyan Arab Jamahiriya	0	0	0	0	0	0
Malta	0	0	0	0	0	0
Morocco	19,6	21,2	23	22,9	22,9	22,4
Portugal	3,4	3,9	4,3	4,9	5,7	5,5
Spain	10,1	10,8	11	11,3	11,5	11,7
Syrian Arab Republic	0	0	0	0	0	0
Tunisia	13,2	16,6	22,8	21,9	20,5	19,5

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 39 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Per capita Total expenditure on Health at average exchange rate (US\$)					
	1995	1996	1997	1998	1999	2000
Algeria	73	73	69	72	69	64
Cyprus	839	911	913	933	925	888
Egypt	36	41	46	48	52	51
France	2566	2545	2260	2303	2282	2057
Greece	998	1044	1006	1002	1034	884
Israel	1653	1823	1819	1767	1888	2021
Italy	1415	1605	1571	1599	1605	1498
Jordan	148	149	135	137	137	137
Lebanon	375	431	504	534	590	590
Libyan Arab Jamahiriya	334	352	328	327	241	246
Malta	714	739	747	761	782	807
Morocco	55	59	53	54	53	50
Portugal	902	959	922	941	962	862
Spain	1137	1190	1074	1123	1158	1073
Syrian Arab Republic	18	21	24	26	28	30
Tunisia	137	142	133	145	155	145

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Tab. 40 - Measured National Expenditure on Health selected variables, 1995 – 2000*

Member State	Per capita Total expenditure on Health at International Dollar rate (\$)					
	1995	1996	1997	1998	1999	2000
Algeria	158	149	146	163	162	142
Cyprus	987	1106	1217	1242	1292	1415
Egypt	100	110	121	127	133	138
France	1970	1985	2032	2094	2211	2335
Greece	1131	1176	1220	1301	1368	1390
Israel	1777	1921	1941	1966	2188	2338
Italy	1486	1566	1685	1776	1886	2040
Jordan	361	370	338	341	320	325
Lebanon	537	560	604	590	684	696
Libyan Arab Jamahiriya	406	407	402	422	375	392
Malta	720	740	739	758	780	803
Morocco	142	155	152	156	157	166
Portugal	1146	1210	1359	1344	1413	1469
Spain	1168	1222	1278	1366	1451	1539
Syrian Arab Republic	43	39	43	47	51	51
Tunisia	332	347	361	400	442	472

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 41 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Per capita Government expenditure on Health at average exchange rate (US\$)					
	1995	1996	1997	1998	1999	2000
Algeria	58	59	55	58	56	53
Cyprus	465	474	468	495	493	478
Egypt	16	18	21	22	24	24
France	1954	1937	1722	1751	1736	1563
Greece	544	576	555	545	561	491
Israel	1229	1432	1431	1361	1467	1534
Italy	1022	1153	1133	1151	1161	1103
Jordan	74	75	77	78	76	71
Lebanon	105	123	140	147	162	164
Libyan Arab Jamahiriya	135	147	164	164	118	119
Malta	510	517	507	527	528	553
Morocco	16	17	16	15	15	15
Portugal	556	620	597	635	681	614
Spain	806	846	764	792	813	750
Syrian Arab Republic	14	15	16	17	18	19
Tunisia	77	96	103	115	122	113

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

Table 42 - Measured National Expenditure on Health: selected variables, 1995 – 2000*

Member State	Per capita Government expenditure on Health at International Dollar rate (\$)					
	1995	1996	1997	1998	1999	2000
Algeria	125	121	117	131	132	117
Cyprus	547	575	624	659	689	762
Egypt	44	49	55	58	61	64
France	1500	1511	1548	1592	1683	1775
Greece	616	649	673	708	742	772
Israel	1321	1510	1527	1515	1699	1776
Italy	1073	1125	1216	1279	1364	1503
Jordan	180	186	193	194	177	168
Lebanon	150	159	167	162	188	193
Libyan Arab Jamahiriya	165	170	201	211	184	190
Malta	514	518	502	525	527	550
Morocco	41	45	45	44	46	49
Portugal	707	782	880	907	1000	1045
Spain	828	869	909	963	1019	1076
Syrian Arab Republic	33	28	30	31	33	32
Tunisia	186	234	280	316	348	369

* for further details on sources and survey criteria: <http://www.who.int/whr/2002/annex/en/>

Source: Data from WHO, 2003, elaborated by Censis

2.5. Millennium Goals for health

Many of the Millennium Goals are more or less directly linked to health issues. Access to services, greater life expectancy, and better lifelong physical well-being are aims closely connected with the promotion and defence of wider-ranging, more general human rights.

The Millennium Goals have the merit of documenting these rights by means of “SMART” indicators (Specific, Measurable, Available, Reliable and Timely), making it possible to measure progress towards the set goals.

One example is that of access to drugs, contained in Goal 8, “Develop a global partnership for development”: in this connection we can state that five of the Mediterranean countries have not yet attained their objectives, three of them being very close (Egypt, Lebanon and Syria) and two less close (Morocco and Tunisia) (Table 43).

Another eloquent goal is to reduce infant mortality among children under five (Table 44). The Mediterranean basin is actively engaged in pursuing this goal and most of the countries have responded well, particularly in comparison with the average of the world as a whole and that of the developing countries. Nevertheless, some countries lag behind: in 2001, slightly less than half-way through the programme, Lebanon, had closed only 20.3% of the gap, Jordan 34.9% and Algeria 43.5%. Of the other countries, Greece, Libya, Portugal, Egypt and Malta had covered over 80% of the distance separating them from their goals, while the remaining countries were somewhere in between.

Another crucial aspect is that of reliable access to drinking water in the countries of the southern and eastern Mediterranean. Unlike the other goals, the problem of water is as vital as it is difficult to solve (Table 47). Of the eight countries affected by the problem for which data is available, Algeria and the Occupied Palestinian Territories do not have data for 1990 and it is therefore impossible to calculate how much ground they have covered. For the other countries, progress can be measured in both towns and rural areas:

- in rural areas, Egypt and Turkey have already reached the goal of halving the percentage of the population with no access to water by 2015; in

urban areas, Egypt has improved by 2% (leaving it only 0.5% in order to reach its goal), but in Turkey the position has worsened, with 2% less in 2000 than in 1990

- the situation in Libya did not change in the ten years 1990-2000: 16% of the population has no access to drinking water, both in towns and in rural areas;
- in Morocco and Jordan, over the ten-year period, the situation has deteriorated in rural areas, with 8% more of the Jordanian population and 2% more of the Moroccan population having no access to water in 2000 as compared with 1990; in towns, progress has been negligible, amounting to 1% for the towns of Morocco and 0.5% for those of Jordan;
- in Tunisia the situation has improved slightly, with 4% more of the population having access to water in rural areas and 1% more in towns.

Table 43 - UNDP Goal 8 - Develop a global partnership for development: access to drugs*

HDI Rank	Provide access to affordable essential drugs in developing countries	
	Population with sustainable access to affordable essential drugs (%) 1999	
107	Algeria	95-100
120	Egypt	80-94
90	Jordan	95-100
83	Lebanon	80-94
61	Libyan Arab Jamahiriya	95-100
126	Morocco	50-79
98	Occupied Palestinian Territory	..
110	Syrian Arab Republic	80-94
91	Tunisia	50-79
25	Cyprus	95-100
96	Turkey	95-100
17	France	95-100
24	Greece	95-100
21	Italy	95-100
23	Portugal	95-100
19	Spain	95-100
22	Israel	95-100
33	Malta	95-100

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, ILO, ITU, UNICEF and others, 2003, elaborated by Censis

Tab. 44 - UNDP Goal 4 - Reduce child mortality*

		Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate					
		Under-five mortality rate (per 1,000 live births)		Infant mortality rate (per 1,000 live births)		One-year-olds fully immunized against measles (%)	
HDI rank		1990	2001	1990	2001	1990	2001
107	Algeria	69	49	42	39	83	83
120	Egypt	104	41	76	35	86	97
90	Jordan	43	33	35	27	87	99
83	Lebanon	37	32	32	28	61	94
61	Libyan Arab Jamahiriya	42	19	34	16	89	93
126	Morocco	85	44	66	39	80	96
98	Occu. Palestinian Terr.	53	25	42	21	..	..
110	Syrian Arab Republic	44	28	37	23	87	93
91	Tunisia	52	27	37	21	93	92
25	Cyprus	12	6	11	5	..	86
96	Turkey	74	43	61	36	78	90
17	France	10	6	7	4	71	84
24	Greece	11	5	10	5	76	88
21	Italy	10	6	8	4	43	70
23	Portugal	15	6	11	5	85	87
19	Spain	9	6	8	4	97	94
22	Israel	12	6	10	6	91	94
33	Malta	14	5	9	5	80	65
Developing countries		104	90	70	62	71	69
OECD		22	13	18	11	81	91
World		93	81	63	56	72	72

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, ILO, ITU, UNICEF and others, 2003, elaborated by Censis

Tab. 45 - UNDP Goal 5 - Improve maternal health*

		Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	
HDI Rank		Maternal mortality ratio (per 100,000 live births) 1995	Births attended by skilled health personnel (%) 1995-2001
107	Algeria	150	92
120	Egypt	170	61
90	Jordan	41	97
83	Lebanon	130	88
61	Libyan Arab Jamahiriya	120	94
126	Morocco	390	40
98	Occ. Palestinian Terr.	120	..
110	Syrian Arab Republic	200	76
91	Tunisia	70	90
25	Cyprus	0	..
96	Turkey	55	81
17	France	20	..
24	Greece	2	..
21	Italy	11	..
23	Portugal	12	100
19	Spain	8	..
22	Israel	8	..
33	Malta	0	..
Developing countries		463	56
OECD		25	94
World		411	60

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, ILO, ITU, UNICEF and others, 2003,
elaborated by Censis

Tab. 46 - UNDP Goal 6 - Combat other diseases (than malaria and HIV/AIDS)*

HDI Rank	Have halted by 2015 and begun to reverse the incidence of other major diseases (than malaria and HIV/AIDS)	Tuberculosis-related mortality rate (per 100,000 people) 2001	Tuberculosis cases		
			Per 100,000 people 2001	Detected under DOTS (%) 2001	Cured under DOTS (%) 2000
107	Algeria	2	23	114	87
120	Egypt	4	23	39	87
90	Jordan	1	5	47	90
83	Lebanon	2	11	53	92
61	Libyan Arab Jamahiriya	2	11	..	..
126	Morocco	10	47	81	89
98	Occ. Palestinian Terr.	3	19	..	..
25	Cyprus	1	5	..	..
96	Turkey	6	25	..	..
17	France	1	6	..	..
24	Greece	3	11	..	..
21	Italy	1	4	10	74
23	Portugal	4	17	83	79
19	Spain	3	14	..	..
22	Israel	1	5	63	78
33	Malta	1	3	25	100
<hr/>					
	Developing countries	32	144	..	..
	OECD	3	11	..	..
	World	26	119	..	..

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, ILO, ITU, UNICEF and others, 2003, elaborated by Censis

Tab. 47 - UNDP Goal 7 - Ensure environmental sustainability: water*

Hdl Rank	Halve, by 2015, the proportion of people without sustainable access to safe drinking water			
	Population with sustainable access to an improved water source			
	Rural (%)		Urban (%)	
	1990	2000	1990	2000
107 Algeria	..	82	..	94
120 Egypt	92	96	97	99
90 Jordan	92	84	99	100
83 Lebanon	..	100	..	100
61 Libyan Arab Jamahiriya	68	68	72	72
126 Morocco	58	56	94	98
98 Occ. Palestinian Terr.	..	86	..	97
91 Tunisia	54	58	91	92
96 Turkey	72	86	83	81
Developing countries	..	69	..	92
OECD	..	..	..	..
World	..	71	..	95

* for further details on sources and survey criteria: http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, ILO, ITU, UNICEF and others, 2003, elaborated by Censis

Tab. 48 - UNDP Goal 7 - Ensure environmental sustainability: sanitation*

HDI Rank	Have achieved, by 2020, a significant improvement in the lives of at least 100 million slum dwellers	
	Urban population with access to improved sanitation (%)	
	1990	2000
107 Algeria	..	99
120 Egypt	96	100
90 Jordan	100	100
83 Lebanon	..	100
61 Libyan Arab Jamahiriya	97	97
126 Morocco	88	86
98 Occ. Palestinian Terr.	..	100
91 Tunisia	96	96
25 Cyprus	100	100
96 Turkey	97	97
17 France	..	..
24 Greece	..	..
21 Italy	..	..
23 Portugal	..	..
19 Spain	..	..
22 Israel	..	..
33 Malta	100	100
Developing countries	..	77
OECD	..	..
World	..	85

* for further details on sources and survey criteria:
http://www.unodc.org/unodc/en/analysis_and_statistics.html

Source: Data from UNDP, WHO, ILO, ITU, UNICEF and others, 2003, elaborated by Censis

3. CRIME

3.1. A problem of approaches and definitions

Security is a more difficult and controversial issue to analyse. A study of health has the advantage of well-pondered considerations that have kept international organisations and institutions in many different countries debating for years on end about a complex and increasingly homogeneous system of indicators, and the issue of poverty, though much less well established than that of health, tends to see general agreement on the concepts and definitions of the terms “poverty”, “exclusion” and “lack of access”, whereas in the case of crime and security, although these subjects have come to the fore in the last few years within the political debate, and even within development policies, a unanimously accepted definition of their conceptual benchmarks has yet to be found.

The problem naturally becomes more complex when we look at the data available, i.e. national crime statistics or the figures on crime provided by international organisations such as UNICRI, Interpol, ICVS or Eurobarometer. There are various reasons why it is difficult to find comparable indicators:

- the methods by which crime figures are registered vary considerably from one country to another, depending on the legislation in force and the procedures of the local courts and penal system;
- the definition of security and crime, both formal and informal, is determined by the culture of each country and by the social environment: a crime may be considered irrelevant in one country and very serious in another, owing to different socio-cultural and legal contexts;
- the submerged component of the phenomena of crime, illegality, violence and insecurity is often the greater, varying considerably according to the phenomenon and the social context: even where legal statistics are available, they rarely give a reliable picture of the phenomenon;

- the political contexts of the Mediterranean countries vary considerably, with regard to the issues of liberty, democracy and civil and human rights among other things; these aspects are often linked to social and political tensions that can have direct repercussions on the sphere of national security, civil disobedience, delinquency and conflict with the institutions; it is therefore hard to view them objectively or compare them.

We are fully aware of these difficulties as we go on to give an outline of comparative crime statistics in the Mediterranean countries.

3.2. Comparative analysis of crime statistics

The penal and legal systems, the definitions of offences and the contexts of reference have peculiar effects on crime statistics, rendering them slippery and difficult to compare. To overcome this problem, some international organisations are making important progress in harmonising crime statistics. This is happening within Europe, too, with the consolidation of the so-called Third Pillar of the European Union, whose goals include the harmonisation of Justice and the Interior, with an impact on the crime statistics not only of the member countries but also of states implicated as countries where international crime transits or originates (above all trafficking in human beings, arms and drugs). Eurogol, created in the second half of the '90s partly for this purpose, is stepping up its efforts and investments with the construction of a single database accessible to the "law agencies" of the various member states.

Despite the various initiatives, however, it must be recognised that the results obtained relate chiefly to the preparatory phase and to the construction of a system that will bear fruit, in terms of data and truly reliable chronological sequences, only in several years' time.

For the moment, we have utilised figures from Interpol, which harmonises the crime statistics of the various countries and makes them available on the Internet (Tables 49-51). For the year 2000, on the other hand, sufficiently representative statistics are available for a good number of Mediterranean countries: with regard to these we shall make a few introductory observations. Crimes have been divided into seven categories:

- murder and homicide;
- sex offences, with rape as a sub-category;
- serious assault;
- theft (all kinds of theft), including aggravated theft, robbery and violent theft, breaking and entering, theft of motor cars and other thefts;
- fraud;
- counterfeit currency offences;
- drug offences.

The absolute number of crimes ranges from just under 3.8 million in France to 17,000 in Malta, but these figures are of little statistical value unless they are related to the population (Table 52). Even when they are related to the population, the crime rates for the various countries are still very disproportionate. France holds the record for crime in general, with 6,446 crimes per 100,000 inhabitants (Table 52). Algeria, Turkey and Portugal have the lowest crime rates.

The figures seem to confirm the hypothesis suggested by Censis more than once: that crime is inversely related to human and economic development. With regard to crimes reported in relation to population, the countries can be listed in ascending order as follows:

1. Algeria;
2. Turkey;
3. Portugal;
4. Spain;
5. Lebanon;
6. Greece;
7. Italy;

8. Cyprus;
9. Malta;
10. France.

On the other hand, the HDI puts the countries almost exactly in reverse order, as described several times in this report:

1. France;
2. Spain;
3. Italy;
4. Portugal;
5. Greece;
6. Cyprus
7. Malta;
8. Lebanon;
9. Turkey;
10. Algeria.

Proceeding to compare the various crimes, still with regard to crimes reported in relation to population, we can see that:

- homicides are more frequent in Turkey, Italy and France;
- sexual violence in France;
- assault in Lebanon;
- theft in France, Malta, Italy and Spain;
- fraud in Portugal;
- crimes connected with drugs in Spain and France.

Again, in the case of crimes solved by the police (crimes reported that have led to arrests and successful investigations), we have a series of statistics that must be considered with caution and cannot simply be taken as indicating the working efficiency of the police forces of the various countries.

Nevertheless, the figures have a strong inverse relation to the number of crimes reported, ranging from 22.4% of cases solved in Malta and 23.5% in Italy to a surprising 81.2% in Greece and 81% in Algeria (Table 54).

3.3. Governance as the habitat of security

In view of the difficulty of comparing crime figures for the Mediterranean countries that constitute the object of our research, and seeing the scant validity of a theoretical approach to the issues of security and crime, capable of transcending the different legislative contexts of the various countries, we think it necessary and helpful to move on from studying the crime figures available to examining other related aspects that look at the context of security in which crimes take place rather than at the crimes themselves. We therefore propose to analyse the political, legislative and regulatory systems of the various Mediterranean countries by analysing other data, produced by the World Bank, relating to the various aspects of governance. According to the approach adopted by the World Bank, governance can be defined by means of aggregate parameters illustrating six extremely interesting factors that describe the context of security in a given country:

- control of corruption;
- government effectiveness;
- regulatory quality;
- rule of law;
- political stability;
- voice and accountability.

It is interesting to look at the trends, which have been recorded since 1996 and illustrate the evolution of each parameter, frequently slow and non-linear (Tables 56-612), but it is also interesting to compare the imbalances registered within each country, as well as the differences between the various countries, often extremely significant, for each of the parameters considered (Table 55).

By adopting this approach, we can see that some countries tend to give better results in one of the parameters rather than another, for example:

- particularly good figures are registered for *control of corruption* as compared with the other parameters, especially in Israel and Libya;
- the figures for *government effectiveness* are proportionally better than those for the other parameters, especially in France, Jordan, Spain and Tunisia;
- the same high figures are registered for *regulatory quality* in countries such as Cyprus, Greece, Italy, Portugal and Turkey;
- *rule of law* has a proportionally higher value than the other parameters in countries with generally low or negative values, such as Algeria, Egypt, Lebanon and Morocco;
- *political stability* has particularly positive values in Libya, Malta and Syria.

In the same way, it is interesting to highlight certain imbalances of the opposite kind, i.e. to look at some of the figures that are proportionally worse with respect to the other parameters for each country: a procedure which leads us to describe some of the *relative deficiencies* to be found in the Mediterranean regions. In particular:

- *poor control of corruption*, found to be proportionally higher with respect to the other parameters, especially in Greece, Italy and Malta ;
- *low voice and accountability*, even in countries with high political stability such as Libya and Syria, and also affecting others such as Egypt, Lebanon, Morocco, Tunisia;

- *low political stability*, identified as one of the few truly transversal phenomena, affecting both northern and southern shores of the Mediterranean and shared by countries such as Algeria, Cyprus, France, Israel, Italy, Jordan, Spain and Turkey.

Table 49 – Crimes: number of cases known to the police (a.v.) – different years

	Algeria 2001	Cyprus 2000	Egypt 1998 (***)	France 2002	Greece 2002	Israel 2001	Italy 2001	Jordan 1999	Lebanon 2002	Libya 1999	Malta 2000	Portugal 2002	Spain 2001	Syria 1999	Tunisia 2002	Turkey 2002
<i>Inhabitants</i>	30.127.199	693.600 (*)	63.976.000	59.344.025	10.939.771	6.508.200	57.728.714	4.900.000	4.500.000	5.000.000	410.604	10.355.559	41.116.842	17.460.000	9.979.500	68.000.000
1 Murder	450	13	1.058	2.415	232	223	2.162	310	152	104	8	266	1.193	166	120	2.820
2 Sex offences (including rape)	3.527	39	176	37.813	845	3.554	2.447	2.713	406	631	69	1.624	6.907	1.035	12.188	6.429
2.1 Rape	315	13	21	10.460	219	658	-	105	112	-	13	404	1.219	50	306	1.448
3 Serious assault	31.220	98	91	125.371	7.499	2.748	30.693	686	10.007	272	75	842	8.730	11	14.889	95.574
4 Theft (all kinds of theft)	48.868	1.977	39.279	2.507.027	73.507	209.627	1.303.366	10.517	20.620	17.318	10.465	194.186	798.046	4.359	25.696	147.244
4.1 Aggravated theft	12.827	1.050	6.778	579.386	238	56.914	-	1.920	3.165	526	5.264	64.739	335.148	2.732	6.798	89.411
4.1.1 Robbery and violent theft	3.188	39	410	133.137	2.131	1.972	38.056	400	502	-	146	13.806	102.808	12	1.104	3.614
4.1.2 Breaking and entering	9.063	1.011	6.368	432.593	31.655	54.942	-	1.520	2.663	-	5.118	44.979	232.340	2.720	5.694	78.782
4.2 Theft of motor cars	1.910	52	10.641	284.765	15.865	30.777	235.946	2.557	2.776	-	1.051	30.250	145.222	469	1.690	20.750
4.3 Other theft	32.133	927	24.935	1.642.876	19.173	122.436	332.795	6.040	17.455	16.792	5.118	32.152	317.676	1.627	17.208	37.083
5 Fraud	2.568	1.371	2.849	351.914	850	10.341	38.934	1.557	6.063	2.536	198	8.052	17.867	654	2.304	6.913
6 Counterfeit currency offences	1.350	1	56	3.428	3.101	373	-	57	386	77	-	6.030	2.057	173	155	1.665
7 Drug offences	3.665	292	36.109	108.121	9.994	23.121	36.045	575	1.256	505	-	4.400	16.116	981	1.030	7.890
8 Total contained in national crime statistics	91.648	4.400 (***)	-	4.113.882	453.441	383.231	2.163.830	61.523	134.609	53.226	17.016	391.599	972.418	7.379	130.376	387.590

(*) The total official population of Cyprus in 2000 was 781,500, including the Turkish-Cypriot community living in the occupied Turkish part of the country. However, crime rates are based on the 693,600 inhabitants of the area under government control because the crimes known to the police refer to that area.

(**) The number of cases solved as a percentage of the number of cases known to the police may exceed 100% as a result of general instruction 1.1.6

(***) The number of offences refers to serious offences reported to the police in 2000.

(****) The figures for murder, serious assault, theft (all kinds of theft), fraud and counterfeit currency offences refer to 1995; figures for drug offences are for 1997

Source: Data from Interpol (<http://www.interpol.com/Public/Statistics/ICS>) elaborated by Censis

Table 50 – Crimes: Cases solved (val. %) – different years

	Algeria 2001	Cyprus 2000	Egypt 1998 (****)	France 2002	Greece 2002	Israel 2001	Italy 2001	Jordan 1999	Lebanon 2002	Libya 1999	Malta 2000	Portugal 2002
<i>Inhabitants</i>	30.127.199	693.600 (*)	59.344.025	10.939.771	6.508.200	57.728.714	4.900.000	4.500.000	41.116.842	17.460.000	9.979.500	68.000.000
1 Murder	20,00	107,70	75,80	82,30	66,40	69,14	95,16	47,37	90,95	94,00	95,83	84,30
2 Sex offences (including rape)	1,16	128,20	70,60	86,50	65,90	81,20	95,83	62,07	72,49	99,80	97,96	94,10
2.1 Rape	1,90	146,20	73,90	72,60	72,90	-	94,34	58,04	76,13	100,00	97,71	91,90
3 Serious assault	0,54	166,30	71,80	90,80	79,70	76,60	95,92	25,29	84,80	100,00	96,56	93,50
4 Theft (all kinds of theft)	1,81	121,00	10,90	18,10	9,60	4,13	69,68	9,81	14,55	80,00	67,81	43,70
4.1 Aggravated theft	0,64	116,60	9,50	71,40	9,30	-	73,45	16,11	17,06	81,00	72,22	41,10
4.1.1 Robbery and violent theft	0,40	100,00	13,30	31,10	39,40	20,11	90,25	17,33	21,42	75,00	84,51	66,90
4.1.2 Breaking and entering	0,72	117,20	8,10	16,00	8,30	-	69,01	15,88	15,12	81,00	69,84	36,00
4.2 Theft of motor cars	0,47	-	7,30	12,40	7,40	2,42	96,64	38,65	18,34	77,00	56,27	35,70
4.3 Other theft	0,76	126,10	12,10	14,80	10,30	5,32	78,00	8,66	10,17	77,50	67,20	54,20
5 Fraud	0,04	137,40	56,14	50,40	41,80	46,14	92,81	23,54	53,88	99,00	92,10	72,70
6 Counterfeit currency offences	0,07	200,00	53,10	19,30	23,30	-	100,00	43,26	72,48	91,00	36,77	98,50
7 Drug offences	0,00	148,60	103,00	97,70	87,50	94,87	98,60	31,13	100,00	100,00	99,02	98,80
8 Total contained in national crime statistics	1,30	128,10	26,30	84,80	34,00	24,86	96,96	-	25,88	87,00	89,72	73,64

(*) The total official population of Cyprus in 2000 was 781,500, including the Turkish-Cypriot community living in the occupied Turkish part of the country. However, crime rates are based on the 693,600 inhabitants of the area under government control because the crimes known to the police refer to that area.

(**) The number of cases solved as a percentage of the number of cases known to the police may exceed 100% as a result of general instruction 1.1.6

(***) The number of offences refers to serious offences reported to the police in 2000.

(****) The figures for murder, serious assault, theft (all kinds of theft), fraud and counterfeit currency offences refer to 1995; figures for drug offences are for 1997

Source: Data from Interpol (<http://www.interpol.com/Public/Statistics/ICS>) elaborated by Censis)

Table 51 – Crimes: volume of crime per 100,000 Inhabitants Cases solved (val. %) – different years

	Algeria 2001	Cyprus 2000	Egypt 1998 (****)	France 2002	Greece 2002	Israel 2001	Italy 2001	Jordan 1999	Lebanon 2002	Libya 1999	Malta 2000	Portugal 2002	Algeria 2001	Cyprus 2000	Egypt 1998 (****)	France 2002
<i>Inhabitants</i>	30.127.199	693.600 (*)	63.976.000	59.344.025	10.939.771	6.508.200	57.728.714	4.900.000	4.500.000	5.000.000	410.604	10.355.559	41.116.842	17.460.000	9.979.500	68.000.000
1 Murder	1,49	1,73	1,65	4,07	2,12	3,43	3,75	6,33	3,38	2,08	1,95	2,57	2,90	0,95	1,20	4,15
2 Sex offences (including rape)	11,71	5,18	0,28	63,72	7,72	54,61	4,24	55,37	9,02	12,62	16,80	15,68	16,80	5,93	122,13	9,45
2.1 Rape	1,05	1,73	0,03	17,63	2,00	10,11	-	2,14	2,49	-	3,17	3,90	2,96	0,29	3,07	2,13
3 Serious assault	103,63	13,02	0,14	211,26	68,55	42,22	53,17	14,00	222,38	5,44	18,27	8,13	21,23	0,06	149,20	140,55
4 Theft (all kinds of theft)	162,21	262,58	61,40	4.224,57	671,92	3.220,97	2.257,74	214,63	458,22	346,36	2.548,68	1.875,19	1.940,92	24,97	257,49	216,54
4.1 Aggravated theft	42,58	139,46	10,59	976,32	2,18	874,50	-	39,18	70,33	10,52	1.282,01	625,16	815,11	15,65	68,12	131,49
4.1.1 Robbery and violent theft	10,58	5,18	0,64	224,35	19,48	30,30	65,92	8,16	11,16	-	35,56	133,32	250,04	0,07	11,06	5,31
4.1.2 Breaking and entering	30,08	134,28	9,95	728,96	289,36	844,20	-	31,02	59,18	-	1.246,46	434,35	565,07	15,58	57,06	115,86
4.2 Theft of motor cars	6,34	6,91	16,63	479,85	145,02	472,90	408,72	52,18	61,69	-	255,96	292,11	353,19	2,69	16,93	30,51
4.3 Other theft	106,59	123,12	38,98	2.768,39	175,26	1.881,26	576,48	123,27	387,89	335,84	1.246,46	310,48	772,62	9,32	172,43	54,53
5 Fraud	8,52	182,10	4,45	593,01	7,77	158,89	67,44	31,78	134,73	50,72	48,22	77,76	43,45	3,75	23,09	10,17
6 Counterfeit currency offences	4,48	0,13	0,09	5,78	28,35	5,73	-	1,16	8,58	1,54	-	58,23	5,00	0,99	1,55	2,45
7 Drug offences	12,17	38,78	56,44	182,19	91,35	355,26	62,44	11,73	27,91	10,10	-	42,49	39,20	5,62	10,32	11,60
8 Total contained in national crime statistics	304,20	584,41	-	6.932,26	4.144,89	5.888,43	3.748,27	1.255,57	2.991,31	1.064,52	4.144,14	3.781,53	2.365,01	42,26	136,44	569,99

(*) The total official population of Cyprus in 2000 was 781,500, including the Turkish-Cypriot community living in the occupied Turkish part of the country. However, crime rates are based on the 693,600 inhabitants of the area under government control because the crimes known to the police refer to that area.

(**) The number of cases solved as a percentage of the number of cases known to the police may exceed 100% as a result of general instruction 1.1.6

(***) The number of offences refers to serious offences reported to the police in 2000.

(****) The figures for murder, serious assault, theft (all kinds of theft), fraud and counterfeit currency offences refer to 1995; figures for drug offences are for 1997

Source: Data from Interpol (<http://www.interpol.com/Public/Statistics/ICS>) elaborated by Censis)

Table 52 – Crimes: number of cases known to the police (v. a.) – 2000

	Algeria	Cyprus	France	Greece	Lebanon	Malta	Portugal	Spain	Turkey	Italy
Inhabitants	29.276.766	693.600 (*)	58.518.748	10.264.156	4.000.000	410.604	9.997.590	39.852.651	62.810.111	57.728.714
1 Murder	286	13	2.166	282	164	8	332	1.158	3.088	2.165
2 Sex offences	5.600	39	33.538	750	351	69	294	6.964	3.844	2.336
2.1 Rape	199	13	8.458	235	93	13	141	1.230	1.462	NA
3 Serious assault	24.700	98	106.484	7.163	8.586	75	151	8.829	74.928	29.068
4 Theft (all kinds of theft)	27.600	1.977	2.334.696	72.335	21.971	10.465	23.612	704.650	105.744	1.367.216
4.1 Aggravated theft	4.560	1.050	495.499	347	545	5.264	13.903	303.005	61.766	NA
4.1.1 Robbery and violent theft	NA	39	109.836	1.707	395	146	5.193	91.628	1.858	37.726
4.1.2 Breaking and entering	8.089	1.011	370.993	31.840	3.065	5.118	8.710	211.377	59.908	NA
4.2 Theft of motor cars	2.480	52	302.626	16.550	1.686	1.051	2.706	132.598	15.269	243.890
4.3 Other theft	Na	927	1.536.571	18.440	14.632	5.118	7.003	269.047	28.709	341.958
5 Fraud	286	1.371	350.689	818	5.123	198	2.241	14.855	3.579	33.564
6 Counterfeit currency offences	566	1	1.475	3.139	468	NA	6.157	1.942	1.000	NA
7 Drug offences	3.387	292	103.731	7.785	801	NA	1.343	100.386	4.010	34.800
8 Total container in national crime statistics	62.425	NA	3.771.849	369.137	121.478	17.016	42.682	881.778	196.193	2.205.778

* The total official population of Cyprus in 2000 was 781,500, including the Turkish-Cypriot community living in the occupied Turkish part of the country. However, crime rates are based on the 693,600 inhabitants of the area under government control because the crimes known to the police refer to that area.

Source: Data from Interpol (<http://www.interpol.com/Public/Statistics/ICS>) and other national official sources, 2003, elaborated by Censis

Table 53 - Crime: volume of crime per 100,000 Inhabitants – 2000

	Algeria	Cyprus	France	Greece	Lebanon	Malta	Portugal	Spain	Turkey	Italy
1 Murder	1	2	4	3	4	2	3	3	5	4
2 Sex offences	19	5	57	7	9	17	3	17	6	4
2.1 Rape	1	2	14	2	2	3	1	3	2	NA
3 Serious assault	84	13	182	70	215	18	2	22	119	50
4 Theft (all kinds of theft)	94	263	3.990	705	549	2.549	236	1.768	168	2.368
4.1 Aggravated theft	16	139	847	3	14	1.282	139	760	98	NA
4.1.1 Robbery and violent theft	NA	5	188	17	10	36	52	230	3	65
4.1.2 Breaking and entering	28	134	634	310	77	1.246	87	530	95	NA
4.2 Theft of motor cars	8	7	517	161	42	256	27	333	24	422
4.3 Other theft	NA	123	2.626	180	366	1.246	70	675	46	592
5 Fraud	1	182	599	8	128	48	22	37	6	58
6 Counterfeit currency offences	2	0	3	31	12	NA	62	5	2	NA
7 Drug offences	12	39	177	76	20	NA	13	252	6	60
8 Total contained in national crime statistics	213	584 *	6.446	3.596	3.037	4.144	427	2.213	312	3.821

* The total official population of Cyprus in 2000 was 781,500, including the Turkish-Cypriot community living in the occupied Turkish part of the country. However, crime rates are based on the 693,600 inhabitants of the area under government control because the crimes known to the police refer to that area.

Source: Data from Interpol (<http://www.interpol.com/Public/Statistics/ICS>) and other national official sources, 2003, elaborated by Censis

Table 54 - Crime: cases solved (val. %) 2000

	Algeria	Cipro	Francia	Grecia	Libano	Malta	Portogallo	Spagna	Turchia	Italia
1 Murder	73,0	107,7	78	75,5	NA	NA	56,6	93,9	81,2	84,6
2 Sex offences	93,0	128,2	71,2	86,4	NA	NA	53,1	71,2	98,0	79,8
2.1 Rape	98,0	146,2	75,5	76,2	NA	NA	46,3	80,1	95,1	NA
3 Serious assault	88,3	166,3	71,8	93,4	NA	NA	60,4	83,9	96,0	74,7
4 Theft (all kinds of theft)	71,0	121,0	11,3	14,3	NA	NA	13,1	14,7	42,1	4,2
4.1 Aggravated theft	74,2	116,6	10,8	70,6	NA	NA	16,1	17,4	35,2	NA
4.1.1 Robbery and violent theft	Na	100,0	15,9	26,1	NA	NA	22,9	21,3	75,0	21,1
4.1.2 Breaking and entering	41,0	117,2	9,2	11,9	NA	NA	13,7	15,7	34,0	NA
4.2 Theft of motor cars	28,2	NA	7,2	6,8	NA	NA	3,8	18,5	57,0	2,6
4.3 Other theft	Na	126,1	12,2	25,4	NA	NA	8,8	9,9	48,9	5,2
5 Fraud	100,0	137,4	59,6	63,7	NA	NA	54,7	60,2	70,5	45,1
6 Counterfeit currency offences	14,5	200,0	74	9,8	NA	NA	3,8	75,7	97,7	NA
7 Drug offences	100	148,6	104,2	97,1	NA	NA	66,6	100	86,3	94,8
8 Total contained in national crime statistics	81	128,1 (***)	26,7	81,2	NA	NA	22,4	27,6	66,1	23,5

* The number of cases solved as a percentage of the number of cases known to the police may exceed 100% as a result of general instructions e da una disomogeneità delle fonti

Fonte: elaborazione Censis su dati Interpol (<http://www.interpol.com/Public/Statistics/ICS>) ed altre fonti ufficiali nazionali, 2003

Table 55 - L'habitat della sicurezza: le dimensioni della governance (2002)

Country	Control of Corruption	Government Effectiveness	Regulatory Quality	Rule of Law	Political Stability	Voice and Accountability
Algeria	-0.70	-0.59	-0.54	-0.54	-1.54	-0.96
Cyprus	+0.89	+1.00	+1.24	+0.83	+0.36	+0.94
Egypt	-0.29	-0.32	-0.45	+0.09	-0.35	-0.87
France	+1.45	+1.67	+1.25	+1.33	+0.73	+1.29
Greece	+0.58	+0.79	+1.13	+0.79	+0.83	+1.05
Israel	+1.08	+1.02	+1.03	+0.97	-1.35	+0.61
Italy	+0.80	+0.91	+1.15	+0.82	+0.81	+1.11
Jordan	0.00	+0.36	+0.10	+0.33	-0.44	-0.41
Lebanon	-0.34	-0.41	-0.47	-0.27	-0.59	-0.54
Libya	-0.82	-0.87	-1.59	-0.91	-0.43	-1.70
Malta	+0.80	+1.16	+1.11	+1.08	+1.50	+1.29
Morocco	-0.04	+0.07	+0.02	+0.11	-0.14	-0.30
Portugal	+1.33	+1.03	+1.47	+1.30	+1.43	+1.31
Spain	+1.46	+1.53	+1.41	+1.15	+0.82	+1.24
Syria	-0.29	-0.57	-0.97	-0.41	-0.14	-1.56
Tunisia	+0.35	+0.65	-0.02	+0.27	+0.24	-0.83
Turkey	-0.38	-0.20	+0.08	0.00	-0.61	-0.47

Source: World Bank data 2003 (<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

Table 56 - Control of Corruption, Point Estimate

Country	2002	2000	1998	1996
Algeria	-0.70	-0.65	-0.70	-0.31
Cyprus	+0.89	+1.09	+1.38	+1.47
Egypt	-0.29	-0.19	-0.25	+0.11
France	+1.45	+1.46	+1.75	+1.30
Greece	+0.58	+0.80	+0.85	+0.35
Israel	+1.08	+1.25	+1.40	+1.38
Italy	+0.80	+0.89	+1.00	+0.43
Jordan	0.00	+0.13	+0.20	-0.09
Lebanon	-0.34	-0.53	-0.32	-0.17
Libya	-0.82	-0.94	-0.91	-0.84
Malta	+0.80	+0.18	+0.66	+0.34
Morocco	-0.04	+0.36	-0.10	+0.21
Portugal	+1.33	+1.41	+1.55	+1.14
Spain	+1.46	+1.66	+1.58	+0.72
Syria	-0.29	-0.75	-0.58	-0.66
Tunisia	+0.35	+0.70	+0.11	-0.04
Turkey	-0.38	-0.30	-0.01	+0.08

Source: World Bank data 2003 (<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

Table 57 - Government Effectiveness, Point Estimate

Country	2002	2000	1998	1996
Algeria	-0.59	-0.75	-0.95	-0.70
Cyprus	+1.00	+1.08	+1.34	+1.05
Egypt	-0.32	+0.35	+0.01	-0.36
France	+1.67	+1.45	+1.64	+1.41
Greece	+0.79	+0.79	+0.77	+0.57
Israel	+1.02	+1.04	+0.92	+1.05
Italy	+0.91	+0.82	+1.05	+0.68
Jordan	+0.36	+0.43	+0.63	+0.09
Lebanon	-0.41	-0.21	+0.28	-0.19
Libya	-0.87	-1.18	-1.49	-0.88
Malta	+1.16	+0.88	+0.89	+1.01
Morocco	+0.07	+0.08	+0.29	-0.10
Portugal	+1.03	+1.08	+1.49	+0.87
Spain	+1.53	+1.81	+2.04	+1.27
Syria	-0.57	-0.83	-1.36	-0.43
Tunisia	+0.65	+1.32	+0.85	+0.39
Turkey	-0.20	-0.06	-0.34	-0.06

Source: World Bank data 2003 (<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

Table 58 - Regulatory Quality, Point Estimate

Country	2002	2000	1998	1996
Algeria	-0.54	-0.80	-1.20	-0.65
Cyprus	+1.24	+1.06	+1.13	+0.63
Egypt	-0.45	+0.10	+0.16	-0.18
France	+1.25	+0.77	+0.97	+0.98
Greece	+1.13	+0.91	+0.83	+0.65
Israel	+1.03	+0.93	+0.73	+1.03
Italy	+1.15	+0.76	+0.81	+0.70
Jordan	+0.10	+0.67	+0.59	+0.00
Lebanon	-0.47	+0.28	+0.53	+0.14
Libya	-1.59	-1.98	-3.00	-1.77
Malta	+1.11	+0.44	+0.55	+0.14
Morocco	+0.02	+0.42	+0.25	-0.06
Portugal	+1.47	+1.03	+1.19	+1.22
Spain	+1.41	+1.36	+1.16	+0.96
Syria	-0.97	-0.77	-1.13	-0.96
Tunisia	-0.02	+0.65	+0.50	-0.01
Turkey	+0.08	+0.24	+0.86	+0.39

Source: World Bank data 2003 (<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

Table 59 - Rule of Law, Point Estimate

Country	2002	2000	1998	1996
Algeria	-0.54	-0.79	-0.79	-0.59
Cyprus	+0.83	+1.01	+0.88	+0.58
Egypt	+0.09	+0.23	+0.17	+0.22
France	+1.33	+1.49	+1.44	+1.56
Greece	+0.79	+0.75	+0.66	+0.74
Israel	+0.97	+1.08	+1.09	+1.11
Italy	+0.82	+0.94	+1.07	+0.84
Jordan	+0.33	+0.57	+0.60	+0.19
Lebanon	-0.27	-0.09	+0.16	-0.26
Libya	-0.91	-0.90	-1.11	-0.94
Malta	+1.08	+0.75	+0.69	+0.04
Morocco	+0.11	+0.33	+0.54	+0.18
Portugal	+1.30	+1.16	+1.31	+1.28
Spain	+1.15	+1.38	+1.35	+1.16
Syria	-0.41	-0.31	-0.25	-0.50
Tunisia	+0.27	+0.48	+0.44	+0.06
Turkey	0.00	+0.07	+0.19	+0.02

Source: World Bank data 2003 (<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

Table 60 - Political Stability, Point Estimate

Country	2002	2000	1998	1996
Algeria	-1.54	-1.70	-2.65	-2.48
Cyprus	+0.36	+0.53	+0.49	+0.50
Egypt	-0.35	+0.05	-0.11	-0.25
France	+0.73	+1.16	+0.79	+1.00
Greece	+0.83	+0.86	+0.32	+0.38
Israel	-1.35	-0.47	-0.38	-0.36
Italy	+0.81	+0.81	+1.18	+0.68
Jordan	-0.44	+0.25	+0.05	+0.36
Lebanon	-0.59	-0.50	-0.31	-0.31
Libya	-0.43	-0.49	-1.21	-1.55
Malta	+1.50	+1.11	+1.40	+0.78
Morocco	-0.14	+0.13	+0.13	-0.36
Portugal	+1.43	+1.44	+1.41	+1.22
Spain	+0.82	+1.07	+0.73	+0.60
Syria	-0.14	-0.40	-0.08	-0.48
Tunisia	+0.24	+0.86	+0.61	+0.28
Turkey	-0.61	-0.99	-1.06	-1.03

Source: World Bank data 2003 (<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

Table 61 - Voice and Accountability, Point Estimate

Country	2002	2000	1998	1996
Algeria	-0.96	-1.31	-1.46	-1.11
Cyprus	+0.94	+1.22	+1.06	+1.01
Egypt	-0.87	-0.81	-0.83	-0.70
France	+1.29	+1.07	+1.09	+1.43
Greece	+1.05	+1.01	+0.92	+0.93
Israel	+0.61	+0.94	+1.01	+1.02
Italy	+1.11	+1.06	+1.21	+1.05
Jordan	-0.41	-0.19	-0.19	-0.14
Lebanon	-0.54	-0.37	-0.51	-0.40
Libya	-1.70	-1.60	-1.58	-1.38
Malta	+1.29	+1.39	+1.36	+1.05
Morocco	-0.30	-0.44	-0.53	-0.60
Portugal	+1.31	+1.35	+1.38	+1.25
Spain	+1.24	+1.10	+1.27	+1.10
Syria	-1.56	-1.64	-1.59	-1.30
Tunisia	-0.83	-0.71	-0.92	-0.50
Turkey	-0.47	-0.65	-0.92	-0.39

Fonte: elaborazione Censis su dati World Bank 2003; Source: World Bank data 2003
(<http://www.worldbank.org/data/databytopic/governance.html>) elaborated by Censis

PART TWO

ANALYSIS OF MAIN FACTORS, CREATION OF NEW INDICATORS AND STUDY OF CORRELATIONS

1. PREMISES FOR ANALYSIS

In the preceding sections we have looked at Health, Poverty and Crime, with the aim of drawing a map of the Mediterranean that is able to integrate the more usual socio-economic similarities and differences with a description of trends in human development in the region.

In reinterpreting the most important comparative data currently available, we have tried to measure the position of each country in relation to the others and to see how their respective situations compare with the objectives for 2015 set out in the Millennium Goals. Most of the components of the Human Development Index (HDI), commonly used to sum up and compare the state of human development in the various countries, have been analysed in order to make a detailed assessment of the factors that determine the position of each country.

What we aim to do in this section, however, is to reconstruct aggregate indicators for the Mediterranean region that make it possible to illustrate human development by examining the spheres of Health, Poverty and Crime.

From a theoretical point of view, this operation meant rethinking human development as the sum of the phenomena linked to the three spheres of Health, Poverty and Crime. From the methodological point of view, on the other hand, the operation consisted of dismantling the ingredients of human development, and in particular the Human Development Index (HDI) and data relating to Governance, so as to use them to build three new sets of “intelligent” variables which, in the form of indicators, would express more clearly the Health component, the Poverty component and the Governance component of human development. The technique utilised to construct these indicators was that of Principal Component Analysis (PCA).

2. METHODOLOGICAL APPROACH TO PRINCIPAL COMPONENT ANALYSIS (PCA)

The object of this section is to explain the various aspects that combine to determine the level of poverty/well-being and the state of health in the countries under examination, and thus to identify aggregate indicators.

With regard to the phenomena under examination, the totally heterogeneous territorial areas covered by the study were the countries on the northern and southern shores of the Mediterranean⁴:

- France;
- Italy;
- Greece;
- Malta;
- Cyprus;
- Spain;
- Portugal;
- Israel;
- Lebanon;
- Tunisia;
- Libya;
- Syria;
- Jordan;

⁴ The lack of data for the Occupied Palestinian Territories obliged us to exclude them from the study in order to avoid the distortions that would have resulted in elaborating the statistics necessary for constructing the indicators.

- Turkey;
- Algeria;
- Egypt;
- Morocco.

The five phases that made up the study aimed:

1. to define the concepts under examination;
2. to make an operational definition of the macro-phenomena by means of multiple characteristics, allowing territorial evaluation comprising many different aspects and points of view;
3. to identify the evaluation criteria, i.e. the indicators able to provide a multidimensional picture of the phenomena concerned;
4. to combine the indicators, using the Principal Component Analysis method (PCA), which makes it possible to study the relations between the various indicators, in order to identify the different aspects of the macro-phenomena under examination and to measure the contribution made by each indicator to the definition of the said macro-phenomena;
5. lastly, to rate the territorial statistical units according to the territorial distribution of the variables defining each macro-phenomenon analysed.

The following pages will therefore trace the work carried out, according to the above points, and the choices made, which together constitute our unique contribution to research on the phenomena in question.

2.1. Defining the concepts

From a methodological point of view, the choice of the indicators necessary to describe the macro-phenomena in question posed fairly complex problems. While the primary requirement is obviously to give a full description of the concepts in question, there are other issues that should be given equally careful consideration:

- the logical procedure for dealing with these choices;
- the link between the macro-phenomenon being described and individual indicators that may define various aspects;
- respect for the need to allow comparisons between the objects of evaluation – i.e. statistical units – in terms not only of size but also of variability with regard to the phenomena;
- choice of a suitable scale of measurement for each of the indicators: a choice that must take into account on the one hand the need to compare units, on the other the possible subsequent construction of combined indicators for each of them;
- the importance of the quality of the data, in terms of the statistical significance of the sample or sphere of reference, homogeneous methods of survey or assessment, subsequent verification and checking of results;
- possibility of updating information, in terms of the periodic availability of homogeneous data, or comparable data for different periods or geographical areas;
- knowledge of the relationships between the variables: fundamental on the one hand in order to assess the redundancy/autonomy of the various items of information and on the other for the subsequent construction of combined indicators that take them into account.

2.2. Definition of macro-phenomena and identification of evaluation criteria

In making a synthesis by means of a classification on the basis of many different indicators, as well as selecting the indicators to be used there is also the question of defining the system of preferences to be given to each of them. Generally speaking, these preference functions can relate both to the indicators and to the individual territorial units to be described. For reasons of transparency and objectiveness, it is necessary to specify the possible methods of constructing these systems and the aggregating “indicator-preference” and “territorial unit-preference” functions utilised.

Scientific literature has much to say about the procedures adopted for identifying preference systems; the conditions for posing questions related to determining their loading, together with subsequent data processing, can be carried out very strictly. It should be noted, however, that failure to take the said preferences into account is only apparently neutral: in effect it represents a specific choice in favour of attributing the same importance to all the different parameters and different units under examination.

In our case, our choice was to a large extent determined by the availability of data, from official international sources, that could be relied upon to be homogeneous and comparable. Besides the problem of lack of information, we should also add that the data available did not always allow reliable international comparisons, on account of distortions due both to the survey phase and to the definitions adopted. As a result, even the choice of the countries to be included in the study (and for example the exclusion of the Occupied Palestinian Territories) was dictated by this constraint; in particular, our efforts in this direction were aimed at finding a compromise between the availability of information and the need for a reasonable number of observations in order to ensure significant territorial variability.

2.3. Aggregation of indicators: Principal Component Analysis (PCA)

The indicators used to describe the individual aspects were subsequently combined together by means of the Principal Component (PC) method.

This method has a dual objective: on the one hand, to compress the information available into a single indicator, and on the other to capture the various components involved in determining the level of poverty/well-being and the state of health in the countries considered, highlighting existing territorial disparities. PCA is a method of multivariate analysis generally used to reduce the number of variables considered by extracting new variables (factors) that sum up the information contained in the original battery of data. The factors extracted have a linear relationship with the original variables and “explain” ever-smaller proportions of the overall variability. Essentially, they constitute completely new variables, independent of one another, each of them summing up a particular aspect of the phenomenon under examination – and therefore of the original set of

simple indicators – and contributing its own information. These aspects can be identified on the basis of the importance of each original variable in the determination of that factor (*factor score*); the specific contribution can be identified by analysing the correlations between the factor extracted and the original variables.

The proposed technique therefore makes it possible to arrive at an efficient method of aggregation and loading, summing up the situation illustrated by the data utilised. The fundamental characteristics of the aggregate values obtained by the Principal Component method can therefore be defined as follows:

- explanation of the components in descending order with regard to their importance in relation to the general phenomenon;
- independence (linearity) of the factors;
- utilisation of an implicit loading system.

Particularly in the case of the second characteristic, the independence (linearity) of the factors, the first variable (first component) explains most of the overall variability, the second explains most of the residual variability and so on.

Arranging components in this way makes it possible, with only minimal loss of information, to reduce the number of variables required to define the original information, while the fact that the components are unrelated makes it possible to define the phenomenon under examination by means of “non-redundant” data. The Principal Component method therefore allows any co-linear links to be highlighted, since in this case the last components take on constant values for all statistical units.

An evaluation of variability and the possibility of aggregation is clearly given by the variance explained by the PC, which makes it possible to assess how many different aspects (axes or factors) are contained within the macro-phenomenon concerned. Furthermore, an analysis of the contributions made by each of the original variables in defining a given factor (calculated by means of the correlations) helps to demonstrate how much weight the variables have in determining the said factor, thus making it possible to exclude from the analysis those which have little effect on the definition of the latent dimensions of the phenomenon being studied.

By analysing the original indicators to find their principal components, we arrive at a smaller number of aggregate variables (principal components), which represent the input necessary to form the rating.

2.4. Rating

The breakdown into principal components results in the original Z indicators being replaced by a number $Y < Z$ of new, independent variables, obtained by combining the former in a linear fashion. The advantage of conciseness naturally means a loss in terms of overall variability with regard to the original matrix of data. In order to establish the number of factors that combine maximum conciseness with minimum loss of information, the rule adopted is to select principal components with an auto-value of more than one.

Once the number of factors to be used in the analysis has been established, the next step is to distribute the corresponding variability between the coordinates of the territorial statistical units considered.

In this way, the position of each unit changes, producing ratings that bring to the top of the list those units that are most representative of the macro-phenomenon under examination.

3. CREATION OF POVERTY AND ACCESS INDEX (PAI)

The problems encountered in undertaking research on the territorial distribution of poverty and social exclusion are present in the very name of the phenomenon under examination. Unlike what happens in other fields of science, the concepts to be examined are highly abstract and the operational definitions may not be universally determined or commonly accepted.

Poverty represents one of the ways of measuring hardship and can be interpreted in both absolute and relative terms. A relative interpretation is necessary in order to relate the concept to its context of reference, which may be spatial (as in comparisons between different countries, different regions, different cities) or temporal (as in the case of the definition of the poverty threshold, which varies in the course of time). But then, the concept of poverty can have many meanings, ranging from the traditional sense of material poverty to less certain meanings of a relational kind (with respect to something or someone).

At present, the absence of a universal definition, widely accepted in the international sphere, of who is to be considered poor, together with the lack of reliable, complete data, especially for the developing countries, represents the main obstacle in trying to make a comparative study of the incidence and profile of poverty in the Euro-Mediterranean area.

The indicators taken into consideration are set out in the following table:

Table 1 - Indicators taken into consideration for the construction of the poverty and access index

Indicator	Year	Source
Life expectancy birth (years)	2001	UNDP
Life expectancy birth (years) - Femane	2001	UNDP
Life expectancy birth (years) - Men	2001	UNDP
Adult literacy rate (% age 15 and above)	2001	UNDP
Adult literacy rate (% age 15 and above)- Female	1990-2001	UNDP
Adult literacy rate (% age 15 and above)- Men	2001	UNESCO
Human development index (HDI) value	2001	UNESCO
Youth literacy rate (% age rate)	2001	UNESCO
Net secondary enrolment (%)	2001	UNESCO
Combined primary, secondary and tertiary gross enrolment ratio (%)	2001	UNDP
Combined primary, secondary and tertiary gross enrolment ratio (%) - Female	1990-2001	UNDP
Combined primary, secondary and tertiary gross enrolment ratio (%) – Male	2001	UNESCO
Estimated earned income (PPP US\$)- Femmine	2000-2001	UNESCO
Estimated earned income (PPP US\$)-Maschi	2000-2001	UNESCO
GDP per capite PPP US\$ (b)	2000-2001	UNESCO
GDP per capite annual growth rate (%)	2001	UN
Average annual change in consumer price index (%)	2001	UN
Telephone mainlines and cellular subscribers (per 1.000 people)	2001	UNESCO
Internet users (per 1.000 people)	2001	UNESCO
Research and development (R&D) expenditures (as % of GDP)	1995-2001	UN
Scientists and engineers in R&D (per million people)	2001	World Bank
Public expenditure on education as % of GDP	1990 - 2001	World Bank

Source: Censis 2003

A preliminary analysis of the correlation matrix resulted in the identification of the variables that have the highest degrees of interdependence (and which therefore produce redundant information). The following variables (defined as active) were therefore broken down into principal components:

- Estimated income (PPP ES\$);
- Per-capita GDP (PPP US\$);

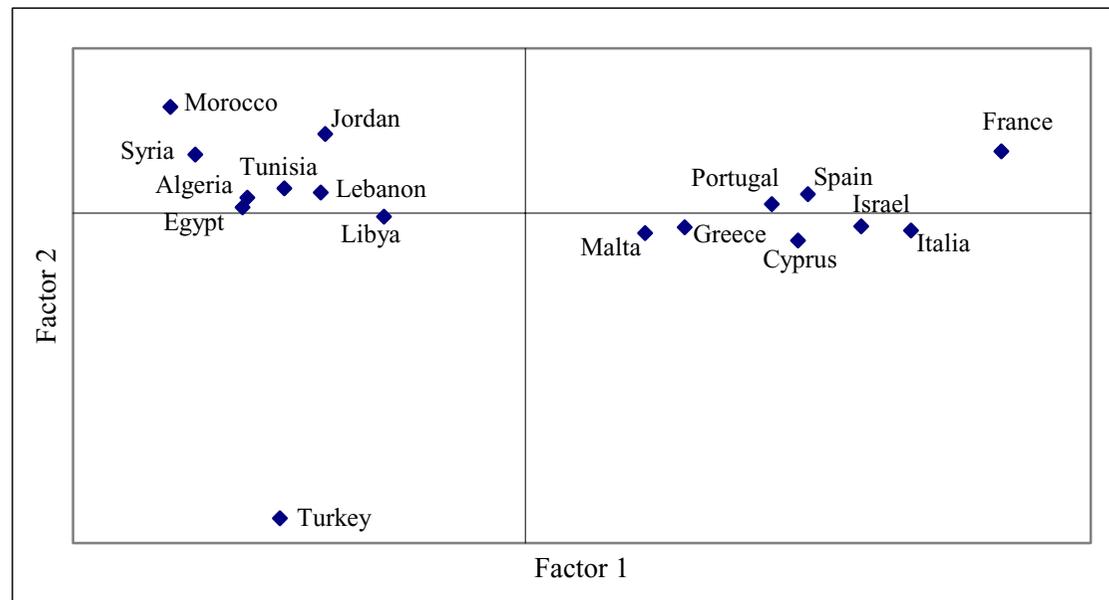
- Trend of consumer price index;
- Scientists and engineers engaged in R&D (per million people);
- Phone users, landline and mobile (per 100 people);
- PCs in use (per 100 people);
- Internet users (per 100 people);
- Rate of enrolment at secondary school.

For the purposes of interpreting the factors, however, the other variables were still considered as illustrative, although they had been excluded.

The PCA technique made it possible to identify 3 significant axes or factors which, taken together, explain 89.92% of the overall variability (Figs. 3 and 4).

The first factor, of the greatest importance in terms of variability, since it represents 69.31%, shows the highest correlations to the indicators that have a significant effect on a country's level of economic development: per-capita GDP, estimated income, Internet users and usage of PCs (expressed per 100 people). The polarisation of the axis is clear-cut: a position towards the negative (or left) extreme signifies a very marginal economic and social context, while the opposite extreme represents development. This axis therefore reproduces the contrast between the countries of the northern and southern shores of the Mediterranean. The other component that has a decided weight in the first factor is the use of new technologies, i.e. personal computers and the Internet: these figures help to explain the strange gap between Italy and France, where the use of computers is much more widespread than in any other country, even among those on the northern shores.

Fig. 3 – Coordinates of the PAI (Poverty and Access Index): factor 1 (per-capita GDP, estimated income, Internet and PC users) and factor 2 (trend of consumer price index) in the Mediterranean countries



Source: Censis, 2003

Subsequent factors are more difficult to interpret, partly because the indicators are not widely available.

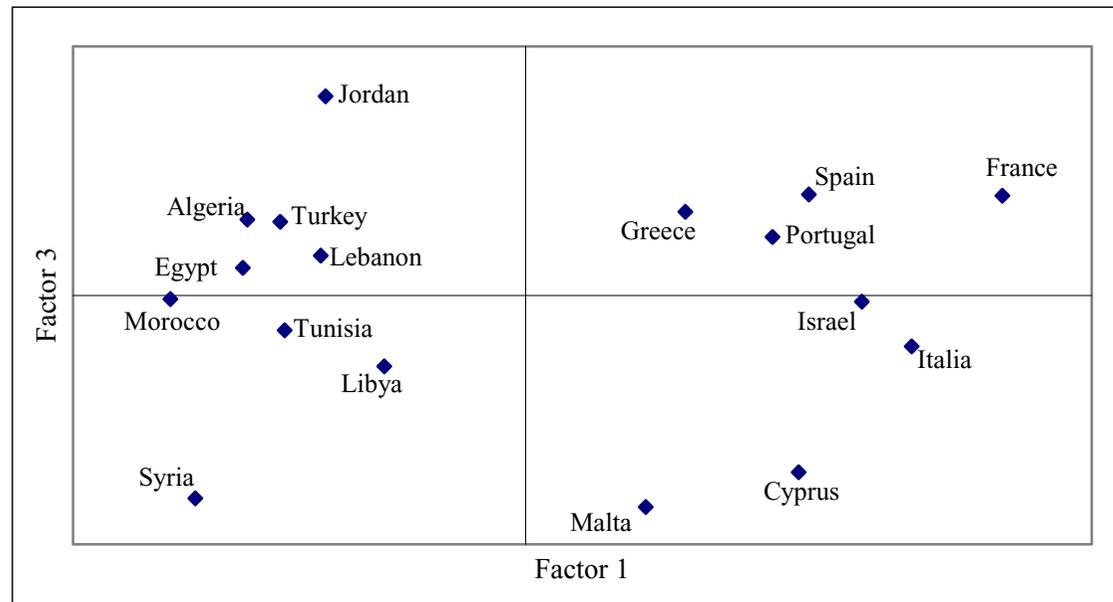
The second factor (which accounts for 11.68% of variability) identifies the trend of the consumer price index, which measures variations over time in the prices of a basket of goods and services available to consumers: at the negative pole we see the countries in which the cost of living rose considerably in the period 2000-2001 (Turkey, Cyprus, Malta, Greece and Italy). At the opposite end of the scale we find the countries distinguished by a much gentler trend, for example, France, Jordan and Morocco.

Lastly, the third axis (associated with 8.83% of variability) identifies an aspect linked specifically to knowledge and technological development, because the positive semi-axis is strongly correlated to the presence of scientists and engineers in the Research and Development sector; Malta, Syria, Cyprus and Libya have a lower concentration of specialists in this sphere, as opposed to countries such as France, Spain and Jordan. The gap between Italy and France is increasing because the latter is strongly committed to Research and Development.

The correlation matrix has therefore identified as active those variables that consider poverty as a lack of access with regard not only to material resources, such as income and distribution of GDP or spending power, but also to education, research and innovation, use of the Internet and new technologies, which are seen as opportunities for growth and development. At this stage of the analysis it is already clear that our poverty indicator does not only indicate material poverty; it also measures access to material resources, information and means of communication, which allow the advantages to be exchanged. The poverty indicator (PAI) therefore indicates access rather than poverty in the traditional sense: access to goods, knowledge and communications tools.

Once the indicator had been identified, we proceeded to establish the ranking of the various countries and to elaborate the aggregate indicator, constructed by adjusting each country's coordinates with regard to the factors concerned on the basis of the variance respectively accounted for (Table 62).

Fig. 4 – Coordinates of the PAI (Poverty and access Index): Factor 1 (per-capita GDP, estimated income, Internet users and use of PCs) and Factor 3 (access to knowledge and technological development) in the Mediterranean countries



Source: Censis, 2003

Table 62 - Poverty in the Mediterranean countries according to the Poverty and access Indicator (PAI)

	Aggregate indicator	Min- max distance	Index no. 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: Data from UNDP, Unesco, World Bank, ILO, ITU elaborated by Censis

4. CONSTRUCTION OF THE HEALTH SYSTEM INDEX (HSI)

The evaluation of all the data relating to health posed considerable methodological problems.

In order to provide as complete a picture as possible of the phenomenon under examination, it was necessary to define the concept underlying the “state of health” of a community.

Since no universal definition exists, it was decided to base the analysis on components viewed as constituting and representing the said phenomenon.

The following aspects were therefore considered, allowing the indicators to be divided into various categories:

- state of health of the population;
- spending on health;
- health services and mortality rate.

As mentioned above in relation to poverty, in this case, too, the choice of variables was to a large extent determined by the availability of data from official international sources, so as to guarantee its homogeneity and comparability. For each of these spheres a set of variables was therefore identified such as to describe the relative sector as completely as possible. Below we give the indicators taken into examination for each of the sectors considered (Tables 2, 3 and 4).

Table 2 – Indicators taken into examination for state of health of the population

Indicators	Year	Source
Annual growth rate (%)	1991-2001	WHO
Dependency ratio (per 100)	2001	WHO
Trend of dependency ratio (per 100)	2001	WHO
Percentage of population aged 60+ years	2001	WHO
Trend of percentage of population aged 60+ years	1991-2001	WHO
Total fertility rate	2001	WHO
Trend of total fertility rate	1991-2001	WHO
Life expectancy at birth (years)-both sexes	2001	WHO
Life expectancy at birth (years)-males	2001	WHO
Life expectancy at birth (years)-females	2001	WHO
Probability of dying under age 5 years (per 1000)-males	2001	WHO
Probability of dying under age 5 years (per 1000)-females,	2001	WHO
Probability of dying between ages 15 and 59 years (per 1000)-males	2001	WHO
Probability of dying between ages 15 and 59 years (per 1000)-females	2001	WHO
Healthy life expectancy in at birth (years) - total population	2001	WHO
Healthy life expectancy in at birth (years) - males	2001	WHO
Healthy life expectancy in at age 60 (years) - males	2001	WHO
Healthy life expectancy in at birth (years) - females	2001	WHO
Healthy life expectancy in at age 60 (years) - females	2001	WHO
Percentage of total life expectancy lost in, males	2001	WHO
Percentage of total life expectancy lost in, females	2001	WHO

Source: Censis 2003

Table 3 – Indicators taken into examination for spending on health

Indicators	Year	Source
Total expenditure on Health Share in GDP (%)	2000	WHO
Difference of total expenditure on Health Share in GDP	1995-2000	WHO
General Government expenditure on Health Share in Total expenditure on Health (%)	2000	WHO
Difference of general Government expenditure on Health Share in Total expenditure on Health	1995-2000	WHO
Private expenditure on Health Share in Total expenditure on Health (%)	2000	WHO
Difference of private expenditure on Health Share in Total expenditure on Health	1995-2000	WHO
General Government expenditure on Health Share in Total Government expenditure (%)	2000	WHO
Difference of general Government expenditure on Health Share in Total Government expenditure	1995-2000	WHO
External Resources for Health Share in General Government Expenditure on Health (%)	2000	WHO
Difference of external Resources for Health Share in General Government Expenditure on Health	1995-2000	WHO
Out-of-Pocket Expenditure Share in Total Expenditure on Health (%)	2000	WHO
Difference of Out-of-Pocket Expenditure Share in Total Expenditure on Health	1995-2000	WHO
Social Security spending on Health Share in General Government Expenditure on health (%)	2000	WHO
Difference of Social Security spending on Health Share in General Government Expenditure on health	1995-2000	WHO
Prepaid plans Share in Private Expenditure on Health (%)	2000	WHO
Difference of prepaid plans Share in Private Expenditure on Health	1995-2000	WHO
Per capita Total expenditure on Health at International Dollar rate (\$)	2000	WHO
Difference of Per capita Total expenditure on Health at International Dollar rate	1995-2000	WHO
Per capita Government expenditure on Health at International Dollar rate (\$)	2000	WHO
Difference of per capita Government expenditure on Health at International Dollar rate (\$)	1995-2000	WHO
Public expenditure on health (as % of GDP)	2000	UNDP
Health expenditure public (as % of GDP)	2000	UNDP
Health expenditure private (as % of GDP)	2000	UNDP
Health expenditure per capita (PPP US\$)	2000	UNDP
Physicians (per 100.000 people)	1990-2002	UNDP

Source: Censis 2003

Table 4 – Indicators taken into examination for health services and mortality rate

Indicators	Year	Source
Infants with low birth-weight (%)	1995-2000	UNDP
Under-five mortality rate (per 1.000 live births)	2001	UNDP
Difference of under-five mortality rate (per 1.000 live births)	1990-2001	UNDP
Infant mortality rate (per 1.000 live births)	2001	UNDP
Difference of infant mortality rate (per 1.000 live births)	1990-2001	UNDP
One-year-olds fully immunized against measles (%)	2001	UNDP
Difference of one-year-olds fully immunized against measles	1990-2001	UNDP
Maternal mortality ratio (per 100.000 live births)	1995	UNDP
Malaria-related mortality rate (per 100.000) - all ages	2000	UNDP
Malaria-related mortality rate (per 100.000) - children aged 0-4	2000	UNDP
Tuberculosis-related mortality rate (per 100.000 people)	2001	UNDP
Tuberculosis cases per 100.000 people	2001	UNDP

Source: Censis 2003

Once the indicators had been defined, we proceeded to apply the Principal Component method described in a previous section.

A preliminary analysis of the correlation matrix made it possible to identify the variables that have high levels of interdependence (and which therefore produce redundant information).

This allowed the method to be applied to a smaller number of variables.

Below we give the active variables introduced into the analysis for each of the three spheres examined.

For state of health of the population:

Indicators

Annual growth rate (%)

Dependency ratio (per 100)

Total fertility rate

Trend of total fertility rate

Life expectancy at birth (years)-both sexes

Life expectancy at birth (years)-females

Probability of dying between ages 15 and 59 years (per 1000)-males

Probability of dying between ages 15 and 59 years (per 1000)-females

Healthy life expectancy in at birth (years) - total population

Healthy life expectancy in at birth (years) – females

For spending on health:

Indicators

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)

Health expenditure public (as % of GDP)

Health expenditure private (as % of GDP)

Health expenditure per capita (PPP US\$)

For health services and mortality rate:

Indicators

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 immunized 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

When the PCA was carried out, confirming the hypothesis that the variables considered were entirely homogeneous, it allowed the extrapolation of the first factor, which account for almost 52% of the overall variability; from now on, this factor will be referred to as the “state of health and standard of living indicator”.

It shows the highest correlations with the indicators that have a significant effect on the level of welfare development reached by a country: per-capita spending on health, public spending on health as a percentage of GDP, life expectancy, low infant mortality, absence of infectious diseases such as malaria or tuberculosis, consequent expectancy of active life and structures for old people - the weak point of the more developed countries.

The polarisation of the axis is clear-cut: a position towards the negative (or left) extreme denotes an extremely marginal context with regard to “state of health and standard of living”, while the opposite extreme represents advanced development. This axis basically exemplifies the contrasts, already noted, between north and south (Table 63).

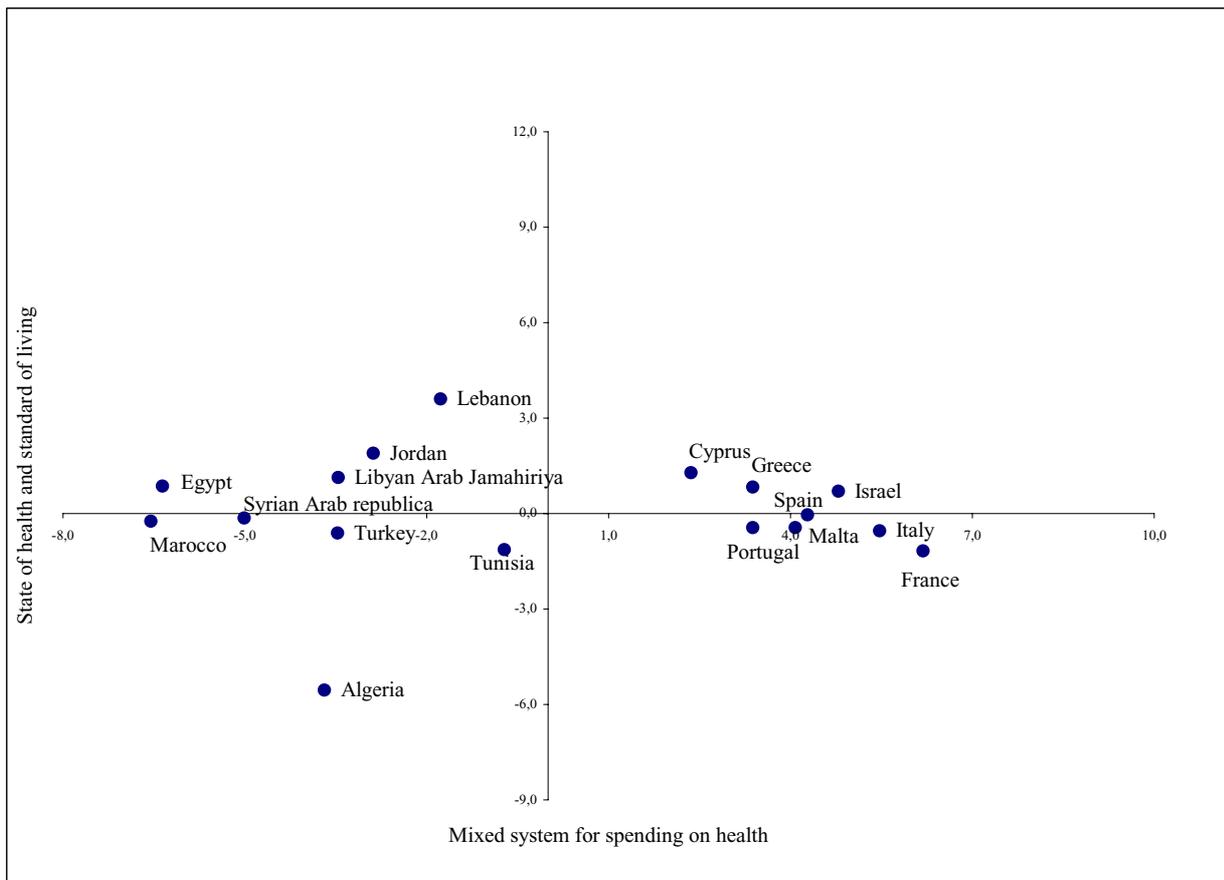
The second factor (accounting for 9.15% of variability) captures the territorial disparities inherent in the different ways of financing spending on health and describes the “mixed system of spending on health”, which tends to take on positive values in the presence of greater commitment with regard to health, not only by the public administration, in the Welfare Community.

Along the positive semi-axis we find the countries, in descending order, that have made use of various forms of private financing for spending on health; as an example, we can cite Lebanon, which used this form of financing in 2000 for 72.2% of its total expenditure on health. For examples of the above, see the graph illustrating the factors deriving from the PCA for the various countries (Fig. 5).

This graph makes it possible to identify France, Italy and Israel as the countries of the Mediterranean with the health systems most capable producing a positive effect on their inhabitants' health and standard of living. Proceeding from right to left, the level of development declines, and at the opposite extreme we find the less developed countries of the area considered, such as Morocco, Egypt and Syria.

The last stage of the analysis involved applying the procedure for elaborating the aggregate indicator, constructed by adjusting the coordinates for each country in accordance with the various factors, on the basis of the variances respectively accounted for. Below we give the results obtained, which confirm the above observations:

Fig. 5 – Coordinates of HSI (Health System Index): the health system in the Mediterranean countries



Source: Censis 2003

Table 63 – Health in the Mediterranean countries according to the Health System Index

	Aggregate indicator	Aggregate indicator (Min=Max-Min)	Index no. 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 Repubblica	-214	320	41	15
Egypt	-263	270	34	16
Morocco	-280	254	32	17

Source: Data from WHO, UNDP 2003, elaborated by Censis

5. CONSTRUCTION OF THE GOVERNANCE SECURITY INDEX (GSI)

After analysing the health system and the degree of well-being or level of poverty in its widest sense, it seemed opportune to identify and examine the level of security in each of the 17 countries included in the study. For this purpose, we looked at the concept of “governance”.

In other words, our goal was to identify the socio-political context and the corresponding level of efficiency of the countries considered.

From a purely methodological point of view, this posed considerable problems, on account of the lack of data.

The choice was in practice limited to six indicators provided by the World Bank that were considered to be suitable for attaining our objective:

- Control of Corruption
- Government Effectiveness
- Regulatory Quality
- Rule of Law
- Political Stability
- Voice and Accountability

These indicators were subsequently aggregated by calculating their simple arithmetic average.

This method was chosen because of the need to make do with the poor amount of information available.

In effect, the application of the Principal Component method and the preliminary analysis of the correlation matrix would have further reduced the data available, with the risk of rendering the aggregation invalid from a statistical point of view.

Table 64 shows the results obtained; these are also illustrated by the following diagram (Fig. 6).

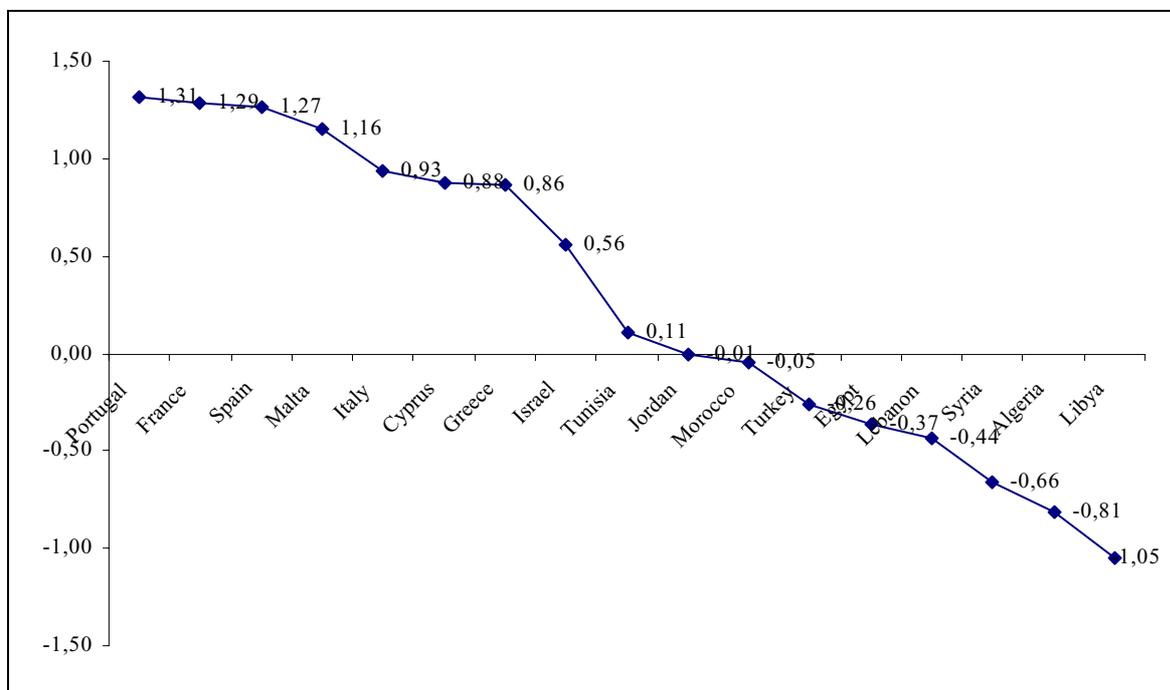
At the top of the list, and separated only by minimal differences, we find Portugal (1.31), France (1.29) and Spain (1.27), immediately followed by Malta (1.16). There are only small differences between Italy (0.93), Cyprus (0.88) and Greece (0.86), while Israel is some distance away (0.56). At the bottom of the list are countries distinguished by a low level of transparency and/or efficiency with regard to governance, including Libya (-1.05), Algeria (-0.81) and Syria (-0.66).

Table 64 – Habitat of security: aspects of governance (2002)

	Governance index	Aggregate indicator (Min=Max-Min)	Index no. 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: Data from World Bank, 2003, elaborated by Censis

Fig. 6 - Coordinates of the GSI (Governance and Security Index): the system of “governance” in the Mediterranean countries



Source: Censis 2003

6. INCIDENCE OF POVERTY, HEALTH AND GOVERNANCE IN HUMAN DEVELOPMENT IN THE MEDITERRANEAN REGION

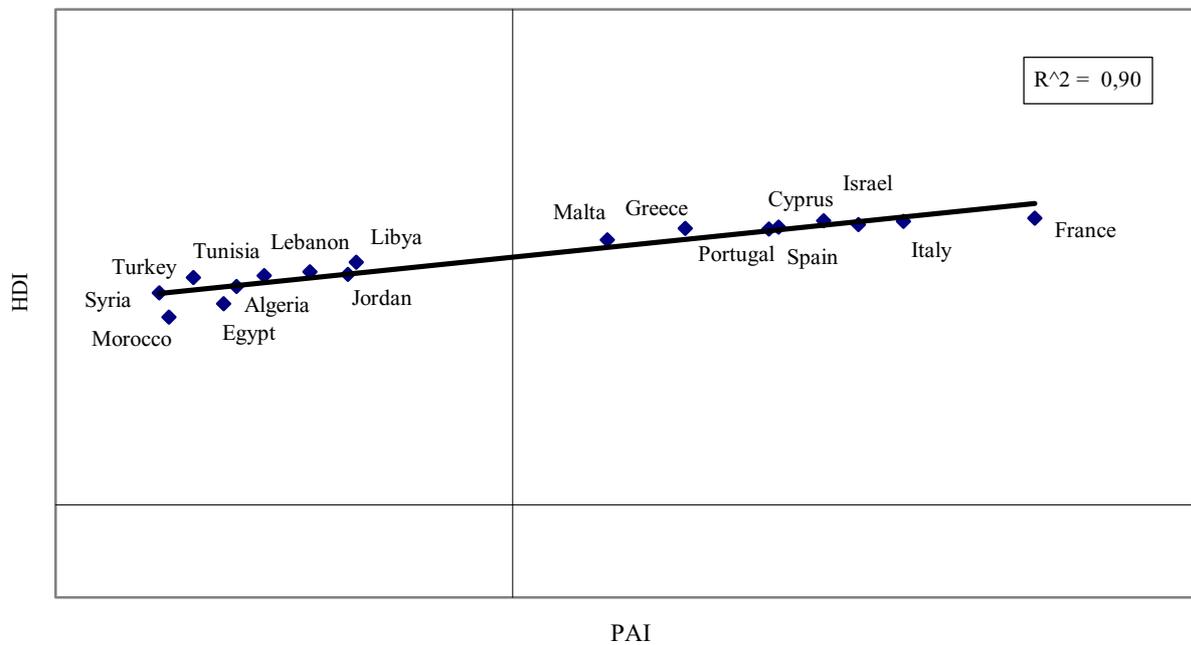
6.1. The three indicators in relation to the Human Development Index (HDI)

After constructing the aggregate indicators, the first step was to compare each of them with the Human Development Index. Each indicator reacted by giving the countries in a slightly different ranking, which made it possible to develop the analysis, comparing the HDI with the various components of Health, Poverty and Governance. This exercise was also useful for testing the loading of the various components contained in the HDI, thus allowing a more conscientious interpretation.

Crossing the Human Development Index (HDI) with the Poverty and Access Index (PAI) gave a high rate of correlation, about 0.90. Although the HDI is not an active variable within the PAI, many of the active components of the one are also active in the other. As compared with the HDI, the Poverty and Access Index (PAI) spreads the countries out very widely (Fig. 7). The differences that exist between the two indicators can be found in the filtered characteristics of the PAI, where the strong loading of the components “education”, “skills” and “access to new technologies” are added to material and economic access. The HDI, on the other hand, remains more closely linked to and conditioned by the health aspects and the physical living conditions of the population: aspects that are better tackled by the Health System Index (HSI).

It is interesting to note that crossing the data in this way arranges the countries along a continuous space, more homogeneously than in subsequent crossings, where poverty/access emphasises a less material way of conceiving social exclusion than the HDI and where countries such as Jordan, Lebanon, Algeria and Tunisia tend towards the right, reflecting their commitment towards education and other spheres that have an immediate impact on their inhabitants’ standard of living, though not necessarily in a material sense.

Fig. 7 - Analysis of correlations between the Human Development Index (HDI) and the Poverty and Access Index (PAI)



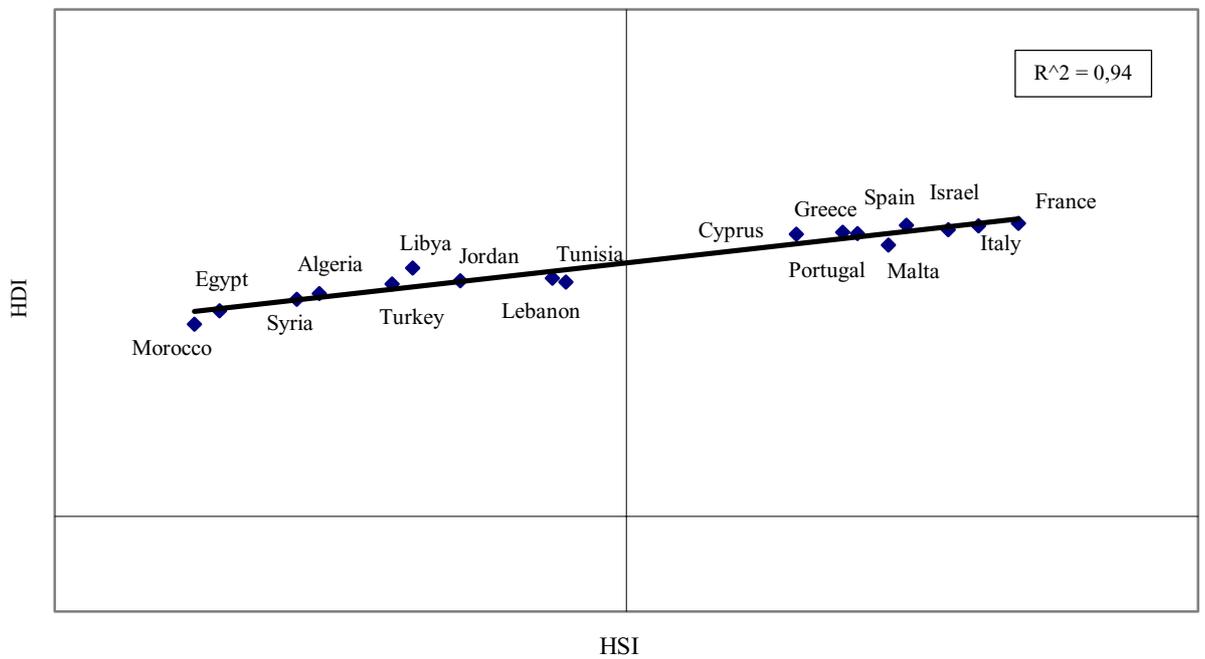
Source: Data from World Health Organization, United Nations Development Programme e UNESCO, 2003, elaborated by Censis

Crossing the Human Development Index (HDI) with the Health System Index (HSI) gave a higher rate of correlation, only just under 1 (0,94). Unlike the previous observation, in this case the countries seem to concentrate markedly in two areas of the graph, inexorably sanctioning the difference between the countries of the north, plus Israel, and the countries of the south and south-east of the Mediterranean area. Even in this crossing with the Human Development Index (HDI), the Health System Index (HSI) demonstrates its “systemic” nature, rewarding the more enterprising countries rather than those that are less organised or reactive. Together with Turkey, small, more agile countries such as Syria, Lebanon, Jordan and Tunisia gain ground with respect to Egypt, Morocco, Algeria and Libya (Fig. 8).

Crossing the Human Development Index (HDI) with the Governance and Security Index (GSI) produces a fairly weak correlation coefficient (0.65). This weak correlation suggests that there is room for further analysis and exploration of well-being, which has been incompletely covered and examined in traditional studies on human development. The arrangement of the countries on a plane allows the countries to be divided into three main groups, along the line of a weakly rising trend (Fig. 9):

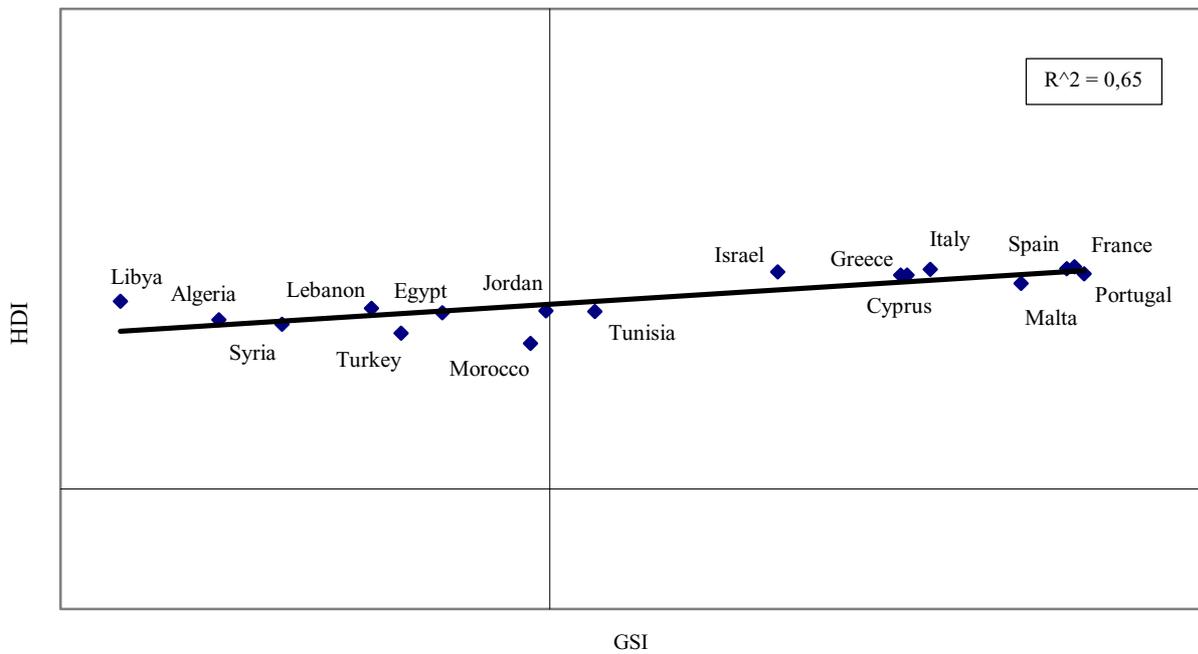
- a large group of countries located to the south, which, however, have widely varying characteristics, especially with regard to governance, although they all lie chiefly within the area of the graph where human development has the lowest values;
- a group of intermediate countries, representing the least continental part of the Mediterranean area and including Italy, Greece, Cyprus, Israel and Malta, distinguished by a very homogeneous level of human development and governance, with average values;
- a small group of European countries, France, Spain and Portugal, which share high levels of both governance and human development.

Fig. 8 – Analysis of correlations between the Human Development Index and the Health System Index (HSI)



Source: Data from World Health Organization, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

Fig. 9 – Analysis of correlation between the Human Development Index (HDI) and the Governance and Security Index (GSI)



Source: Data from World Bank, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

6.2. Crossing the three indicators Health, Poverty and Governance with one another

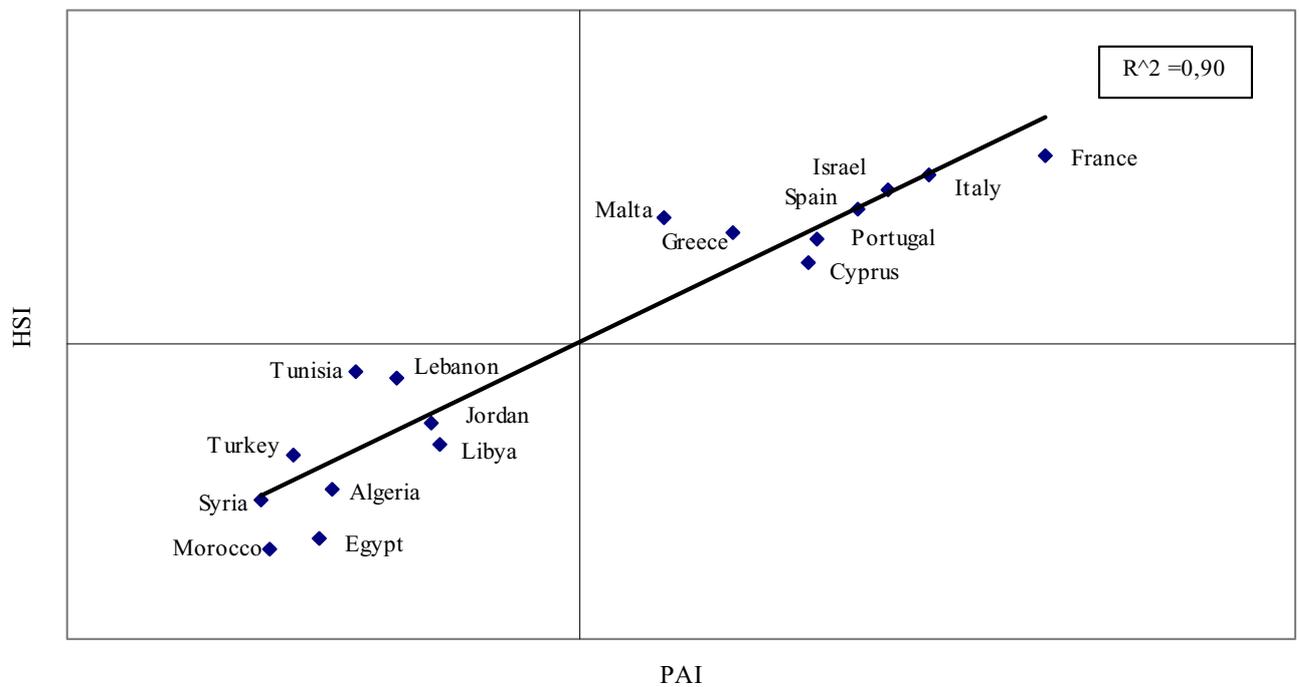
First we crossed the Poverty and Access Index (PAI) with the Health System Index (HSI): again, there was a high rate of correlation, amounting to 0.90. In this case, too, the countries are clearly divided into two obvious clusters, one in the negative zone and one in the positive zone of the graph, with the countries of the north (plus Israel) located at the top on the right and the countries of the south placed in the quadrant at the bottom on the left (Fig. 10).

But as well as this first, macroscopic and to some extent obvious difference, it is interesting to note how certain countries, whatever their level of development and wealth, have a tendency to respond better to one or other of the indicators, revealing their orientation towards an efficient health system or, on the other hand, a vocation towards widespread access:

- Malta, Tunisia, Lebanon, Greece and Turkey are countries that are better at creating an efficient health system;
- Algeria, Libya, Cyprus and France, on the other hand, appear to focus more on the aspects relating to access to economic resources, education, innovation and new technology.

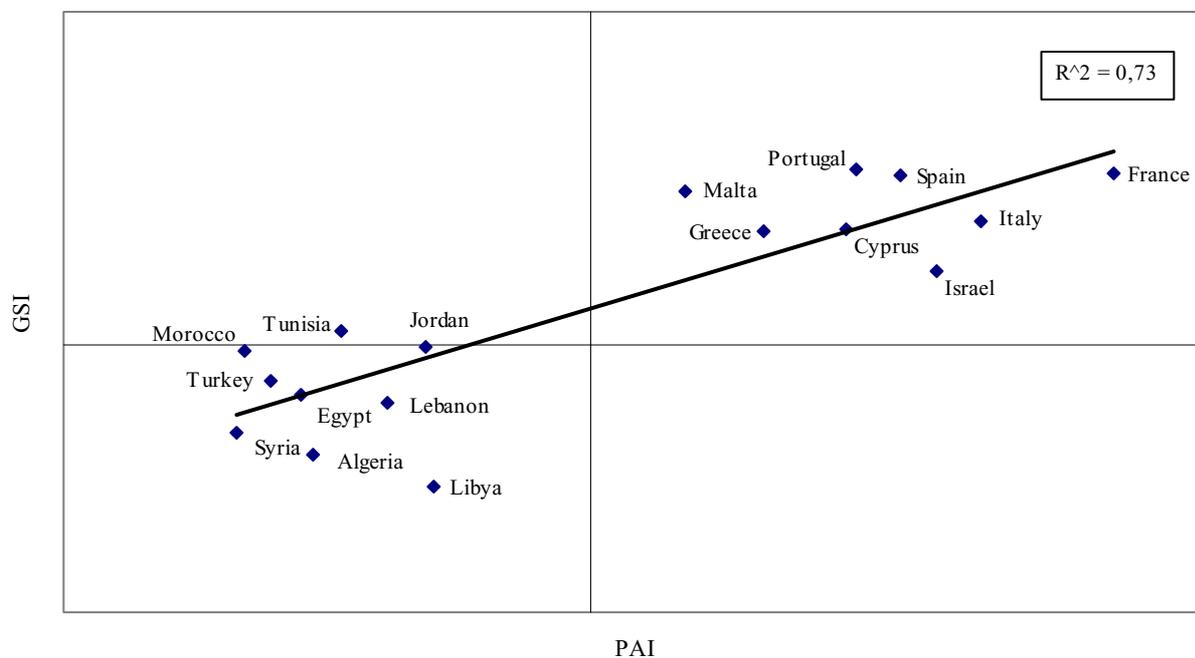
The correlation between the Poverty and Access Index (PAI) and the Governance and Security Index (GSI) produced an average rate of correlation, amounting to 0.73. The interesting thing to note is that, unlike what was found for Health and to some extent for Poverty, the distinction between north and south is less marked in the case of Governance. Although it still exists, the positive correlation between Governance/Security and Poverty/Access sees the countries arranged in a way that is in some ways unprecedented. Countries with low relative values for Governance, such as Libya, Algeria, Israel, Lebanon and Syria, can be directly compared with the same number of countries having a high governance value but similar values for Poverty/Access: Jordan, Tunisia, Spain, Morocco and Egypt have higher values for Governance but no evident correlations between this and their Poverty/Access values (Fig. 11).

Fig. 10 – Analysis of correlations between the Poverty and Access Index (PAI) and the Health System Index (HSI)



Source: Data from World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

Fig. 11 – Analysis of correlations between the Poverty and Access Index (PAI) and the Governance and Security Index (GSI)



Source: Data from World Bank, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

There is a slightly higher correlation between the Health System Index (HSI) and the Governance and Security Index (GSI), amounting to 0.76. This correlation confirms the structural nature of the HSI, which registers the efforts made by the country system rather than the state of the population, with governance clearly playing an active role. In the face of this correlation we find the polarisation already noted between the countries of the north (plus Israel), which are concentrated at the extreme right of the graph, and the countries of the south (Fig. 12). It is interesting to see how the countries of the south, which certainly lag behind and are all confined to the left-hand side of the graph, nevertheless appear to be experimenting with different approaches:

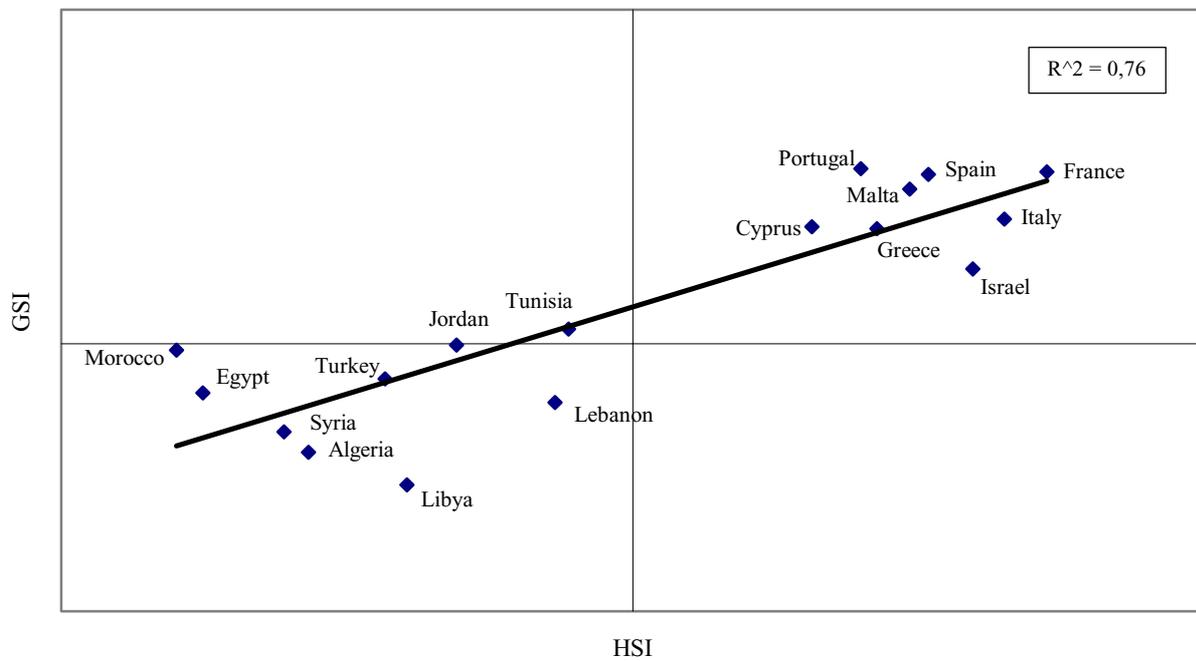
- Libya, Lebanon and Algeria have different rates with regard to the health system but all have a low rate of governance;
- Morocco and Egypt, despite better levels of governance, seem to be denied an efficient, up-to-speed health system;
- Tunisia, Jordan, Turkey and Syria, on the other hand, seem to have a more balanced relationship between governance and the health system.

6.3. Crossing the three indicators (PAI, HSI and GSI) with a number of active variables present in each of them

In order to look more closely at the relationship between the coordinates identified in our study, in an attempt to allow the analysis of human development to roam within a three-dimensional space consisting of health, access and governance, we proceeded to cross each of the indicators constructed with several variables of significant importance for one or other of the spheres considered.

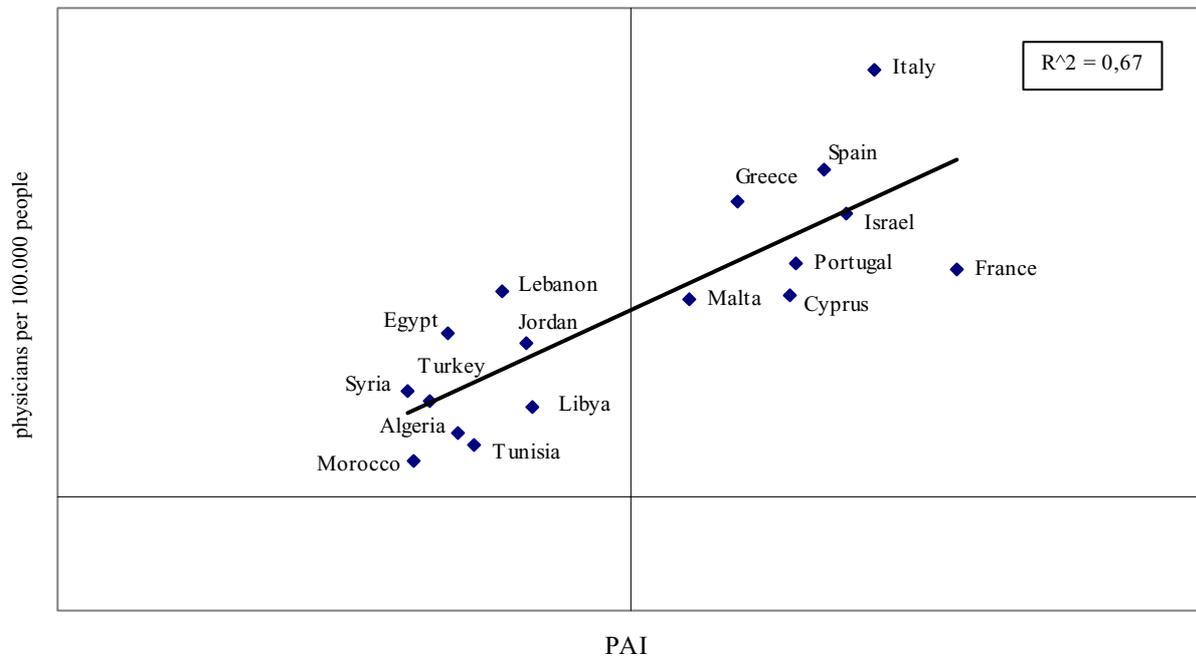
The first experiment was made by crossing the Poverty and Access Index (PAI) with human resources for health, expressed as the number of doctors per 100,000 inhabitants. The rate of correlation between the two indicators is clearly low, amounting to 0.67. This low correlation seems to reinforce the idea expressed on previous occasions, that material access is not correlated to the percentage of good doctors available but rather, as we shall soon see even more clearly, to the availability of a comprehensive system and an efficient organisation (Fig. 13).

Fig. 12 – Analysis of correlations between the Governance and Security Index (GSI) and the Health System Index (HSI)



Source: Data from World Bank, World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

Fig. 13 – Analysis of correlations between the Poverty and Access Index (PAI) and human resources for Health (no. of doctors per 100,000 inhabitants)



Source: Data from United Nations Development Programme and UNESCO, 2003, elaborated by Censis

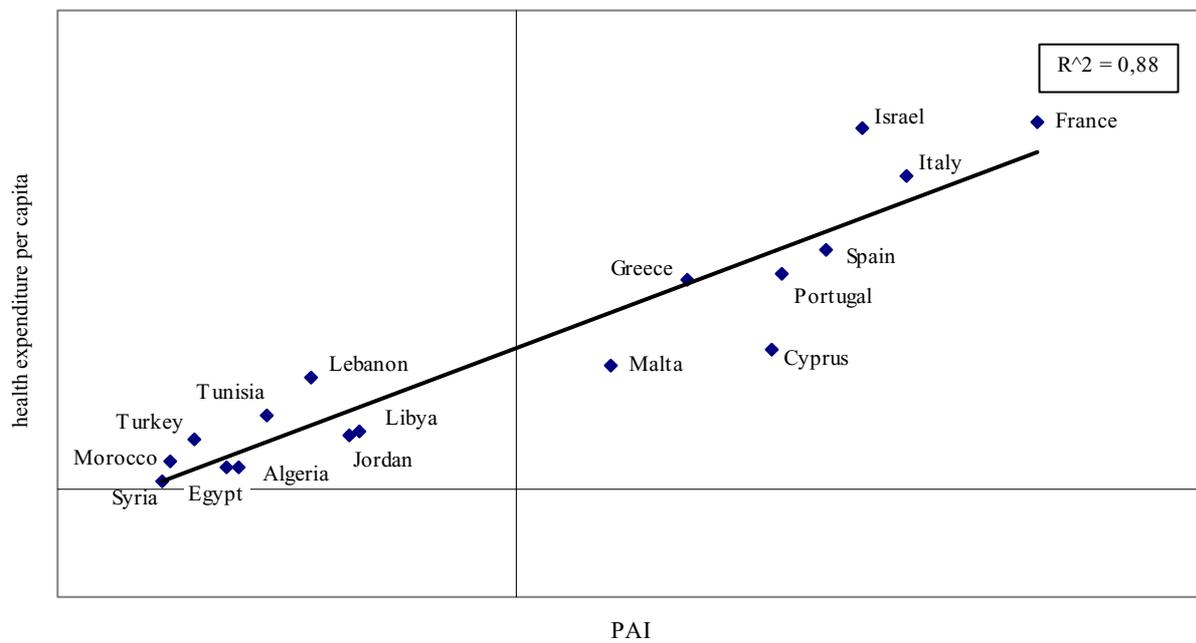
This correlation between access and type of organisation finds greater confirmation in the correlation between the Poverty and Access Index (PAI) and per-capita spending on Health, which is decidedly high and positive, amounting to 0.88. A functioning health system is dependent on a commitment in terms of investments (Fig. 14). The correlation previously found between PAI and HSI can therefore be explained by the correlation between the increase in items relating to access and the increase in per-capita spending on Health. Spending on Health therefore seems to be a good premise for increasing access and reducing Poverty. This, moreover, seems to explain the trends in countries like France, Israel and Italy, which spend a lot on health in comparison with chronically backward countries such as Morocco, Syria, Turkey and Algeria.

A very low, negative correlation, amounting to 0.45, is found when the Poverty and Access Index (PAI) is crossed with the fertility rates of the various countries. This lack of correlation contradicts the usual principle, according to which development corresponds to a fall in fertility rates (Fig. 15). This rule may hold good on a large scale and for other regions of the world, but it cannot always be applied within the Mediterranean basin, where:

- countries with high fertility rates occupy widely varying positions as far as the PAI is concerned, e.g. Syria, Jordan, Libya and Israel;
- on the other hand, there are countries with low fertility rates that also occupy different positions with respect to the PAI, e.g. Turkey, Tunisia, Lebanon, Greece, Spain and Italy.

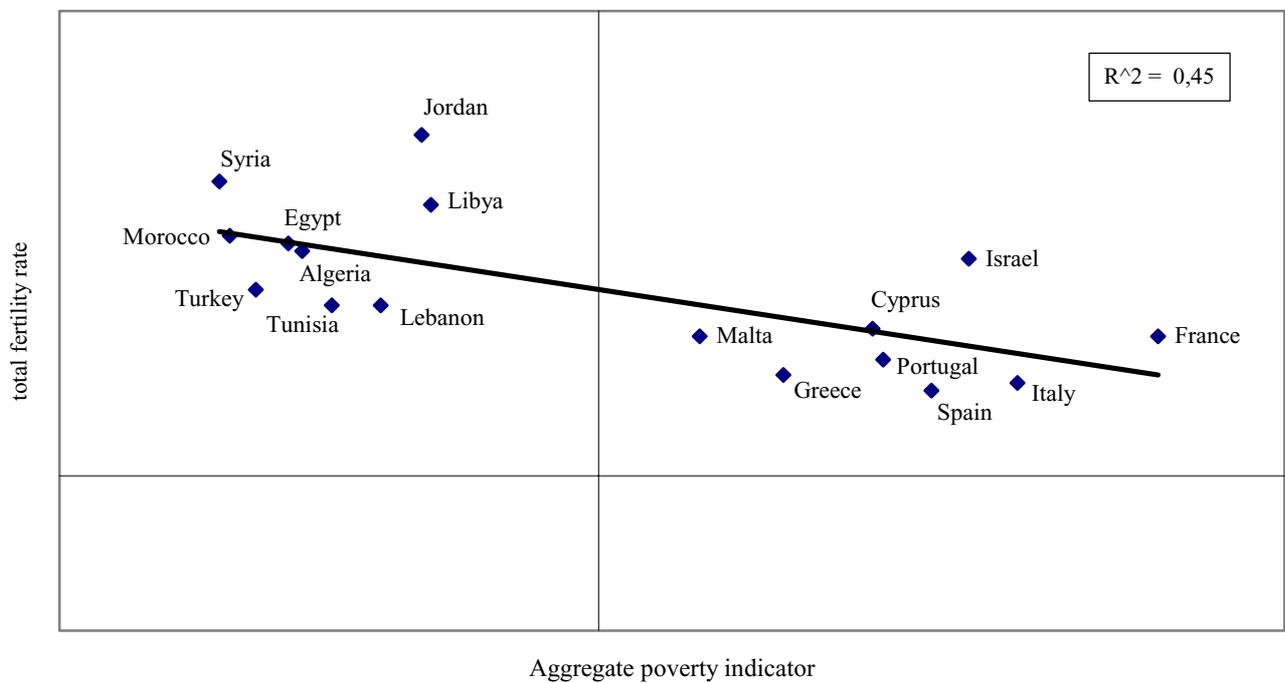
The correlation between the Poverty and Access Index (PAI) and the Healthy Life Expectancy Index (HALE) was found to be fairly high and significant: 0.88. Despite the fact that the active variables of the PAI were meticulously selected in order to prevent any incidence on health aspects, which for their part have such a marked effect on the life expectancy index, the strong correlation found confirms the theory, already suggested, that the two “pedals” of development, health and access, are strongly correlated, both of them being factors that influence well-being and also healthy life expectancy (Fig. 16).

Fig. 14 – Analysis of correlations between Poverty and Access Index (PAI) and per-capita spending on Health



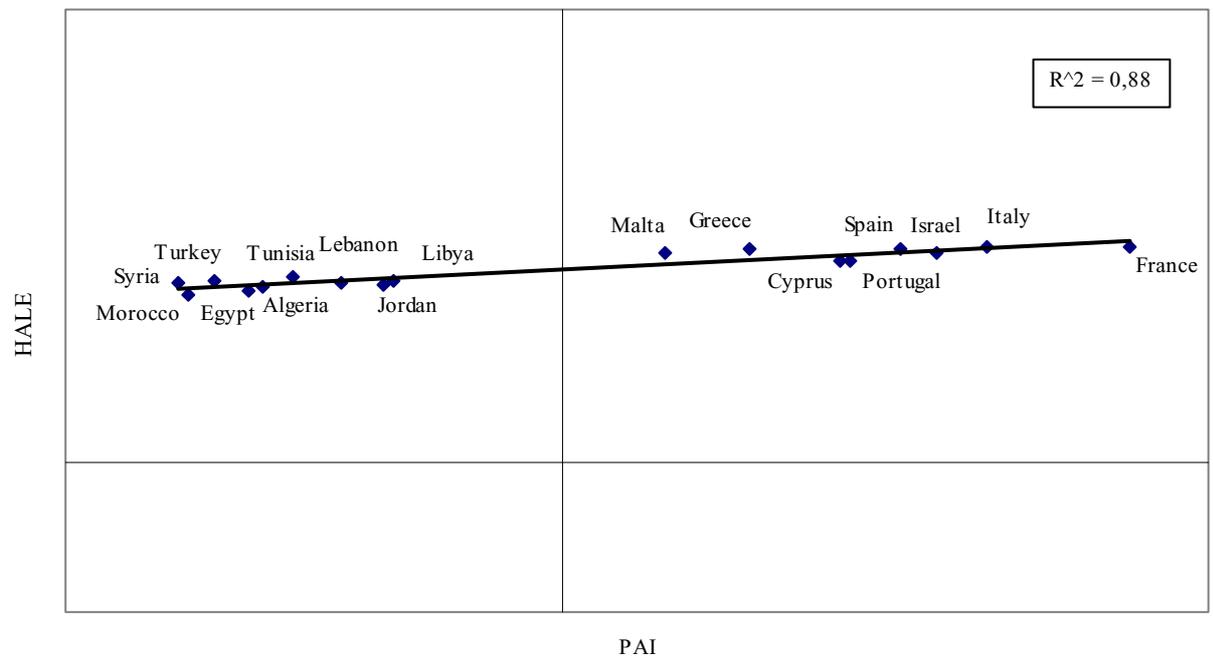
Source: Data from World Health Organization, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

Fig. 15 – Analysis of correlations between Poverty and Access Index (PAI) and fertility rate



Source: Data from World Health Organization, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

Fig. 16 – Analysis of correlations between Poverty and Access Index (PAI) and Healthy life expectancy index (HALE)



Source: Data from World Health Organization, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

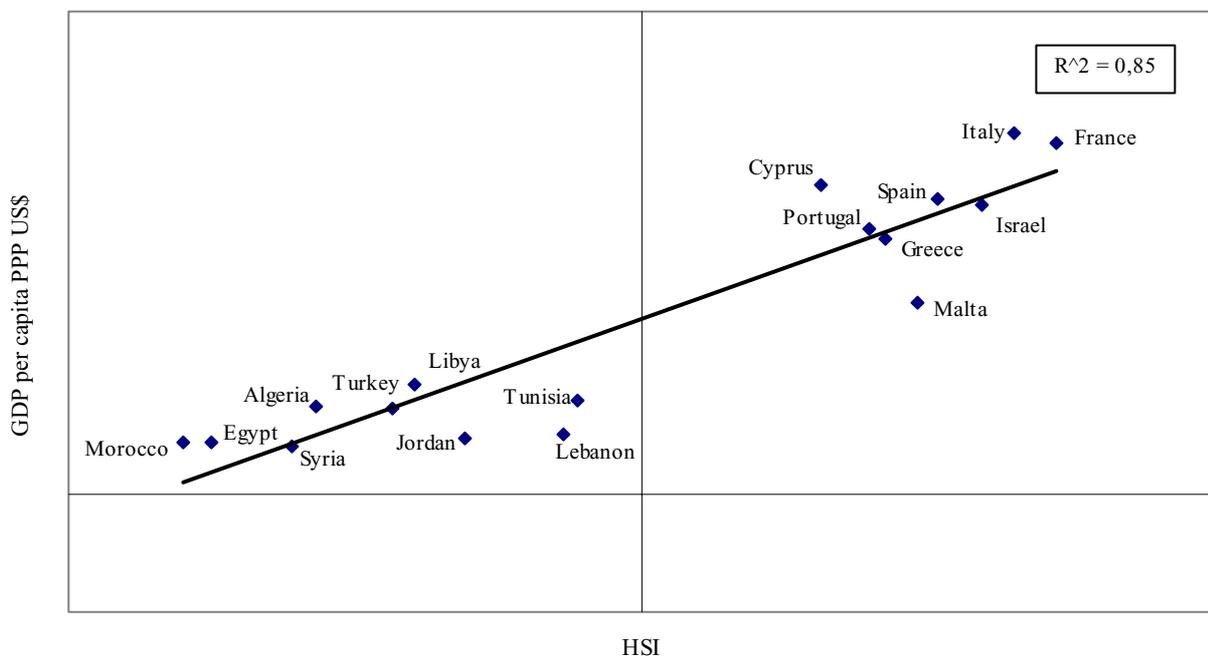
Another very significant relationship, albeit less so than the link between the PAI and wealth distribution, is the correlation between the Health System Index (HSI) and per-capita GDP - 0.85 - which aims to measure from a different point of view the value of wealth distribution in relation to the efficiency of the health system in the various countries. As might be expected, when GDP figures are elaborated, the southern and northern shores of the Mediterranean react with the usual polarisation, with Israel representing the only exception. And yet, beyond this initial, obvious distribution, there are interesting differences worthy of note. For example (Fig. 17):

- there are countries that have high per-capita GDP but show less strong values for the HSI, such as Cyprus, Portugal and Spain;
- there are countries that have low per-capita GDP but register encouraging values for the HSI, e.g. Tunisia, Lebanon and in some ways Jordan.

Low values – 0.51 – were found for the correlation between the Health System Index (HSI) and the rate of school enrolment. We should reflect on this lack of correlation between education and health. It almost seems as if the distribution of the countries in the graph means that the two development profiles are to some extent independent of one another: it is easy to pick out countries with high school enrolment rates, such as Libya or Egypt, where there is no corresponding improvement in the health system or, vice versa, countries with a strong health system, such as Italy, Malta or Cyprus, that have proportionally lower rates of enrolment at school (Fig. 18). Two profiles, two development options: they are undoubtedly correlated but it is difficult to establish a clear cause-and-effect relationship.

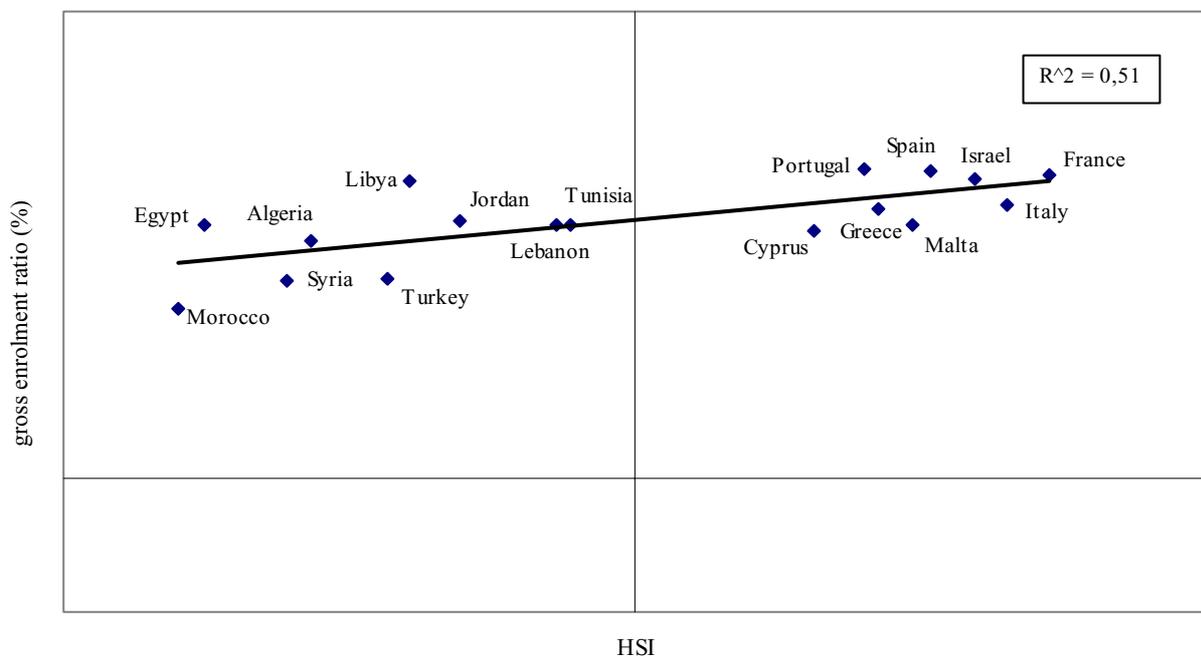
As we have already seen in the case of the PAI, and as was even more obviously to be expected, the Health System Index (HSI) responds in a strongly correlated fashion to the Healthy Life Expectancy Index (HALE), with a correlation rate of 0.95. It is obvious that health and life expectancy are indissolubly correlated and this link seems to consolidate the vocation and specific identity of the Health System Index (HSI), not only as an indicator able to measure the ability of a system to provide health-related goods and services but also as a factor that affects the beneficiaries by increasing their healthy life expectancy (Fig. 19).

Fig. 17 – Analysis of correlations between the Health System Index (HSI) and per-capita GDP



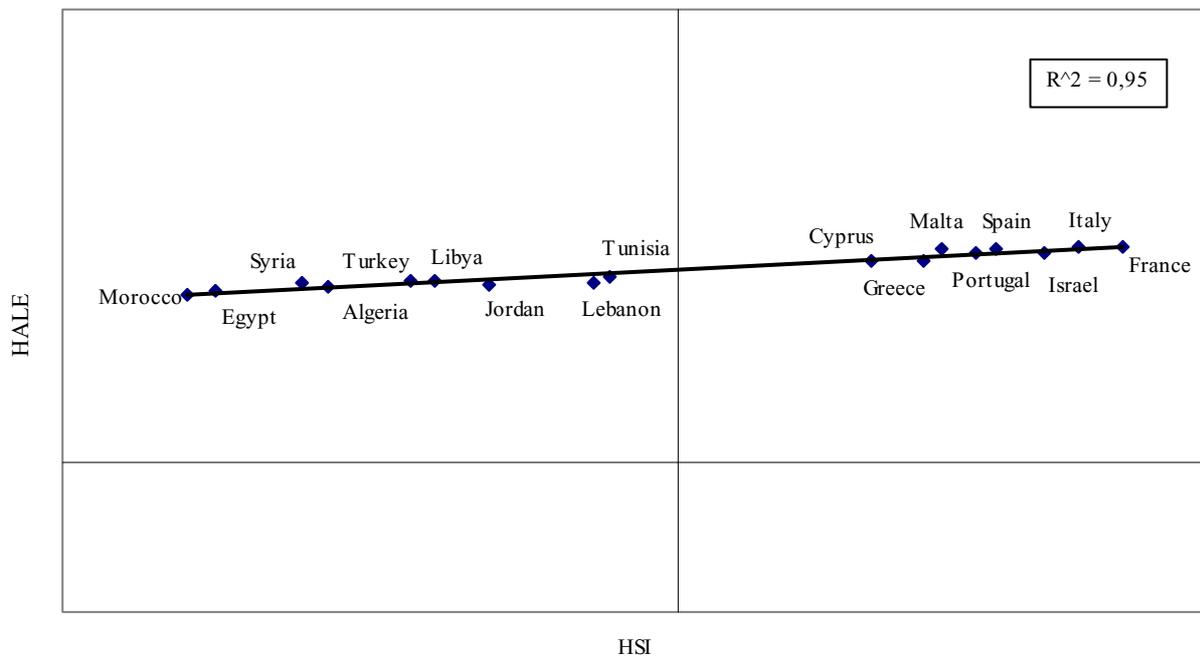
Source: Data from World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

Fig. 18 – Analysis of correlations between the Health System Index (HSI) and the rate of enrolment at school



Source: Data from World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

Fig. 19 – Analysis of the correlations between the Health System Index (HSI) and the Healthy life expectancy index (HALE)



Source: Data from World Bank, World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

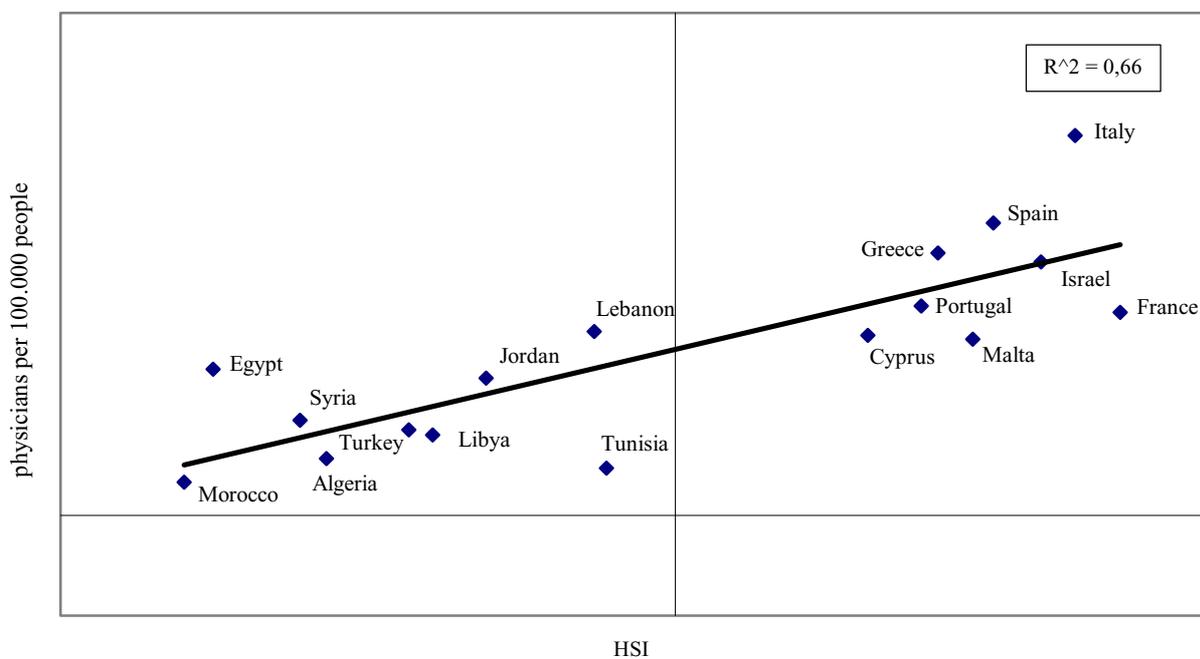
It is very interesting to note that the Health System Index (HSI) is only indirectly correlated to high rates of human resources for health, expressed as the ratio of doctors to inhabitants. Countries with different concentrations of doctors, such as France and Italy, Greece and Portugal, Lebanon and Turkey, Egypt and Morocco, have similar values with regard to the Health System Index (Fig. 20). In this context, once again, the systemic approach peculiar to the HSI prevails, since it is sensitive to the construction of an articulated series of conditions, resources and services, where the number of doctors represents one of the strong points.

There is a positive correlation – though not a very strong one – between the Health System Index (HSI) and the Adult Literacy Rate, amounting to 0.74 (Fig. 21). As is clear from the graph, the “healthier” countries, that is to say countries with higher values for the Health System Index, also tend to have a lower rate of illiteracy among adults, demonstrating how the two spheres of education and health, while independent in many ways, are nevertheless correlated, especially in the medium-long term, where the adult illiteracy rates are more meaningful than other education indicators.

The correlation between the Governance and Security Index (GSI) and the gross enrolment rate in primary schools is practically negligible, with a value of 0.25. Libya, Israel, Spain and France share the same enrolment ratios, independent of their level of governance.

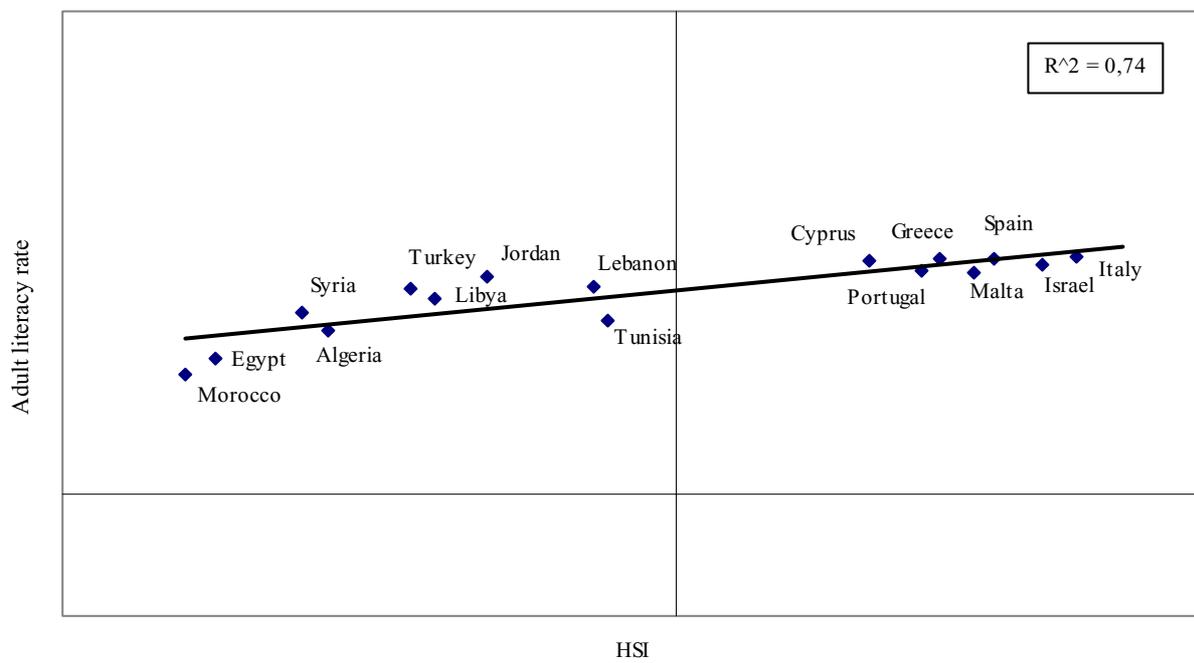
A slightly greater correlation can be seen between the Governance and Security Index (GSI) and the Adult Literacy Rate, equal to 0.40. Although this is still weak, a certain positive correlation may be identified between better governance and an increase in adult literacy (Fig. 23).

Fig. 20 – Analysis of correlations between the Health System Index (HSI) and doctors per 100,000 people



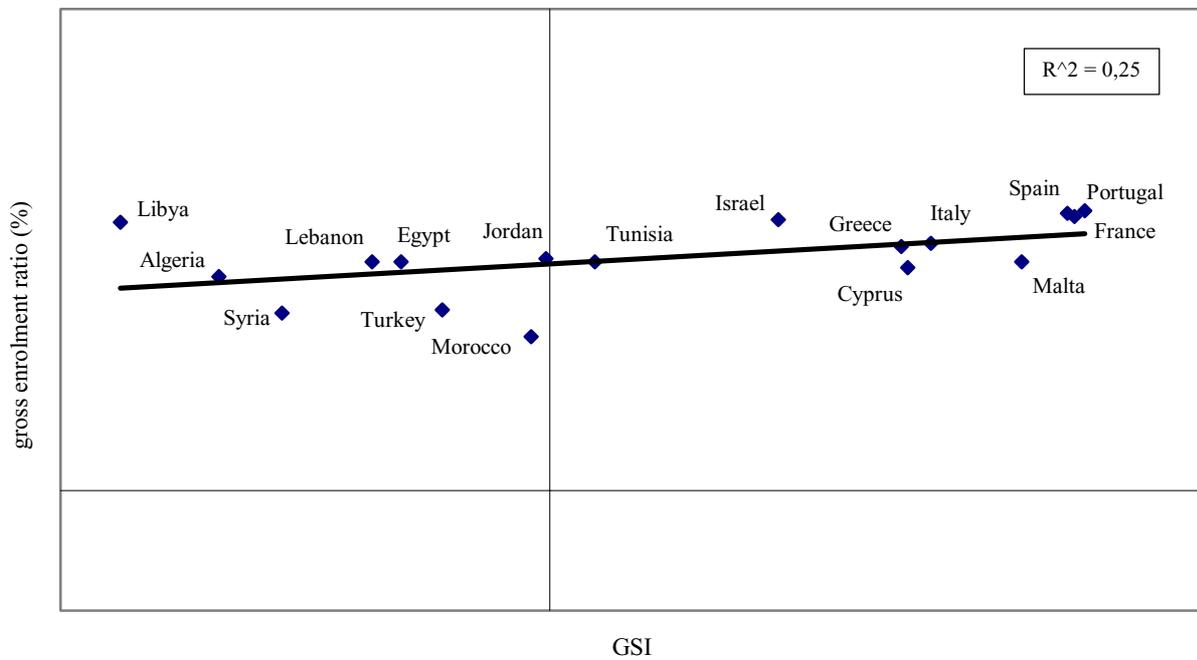
Source: Data from United Nations Development Programme and UNESCO, 2003, elaborated by Censis

Fig. 21 – Analysis of correlations between the Health System Index (HSI) and the Adult literacy rate



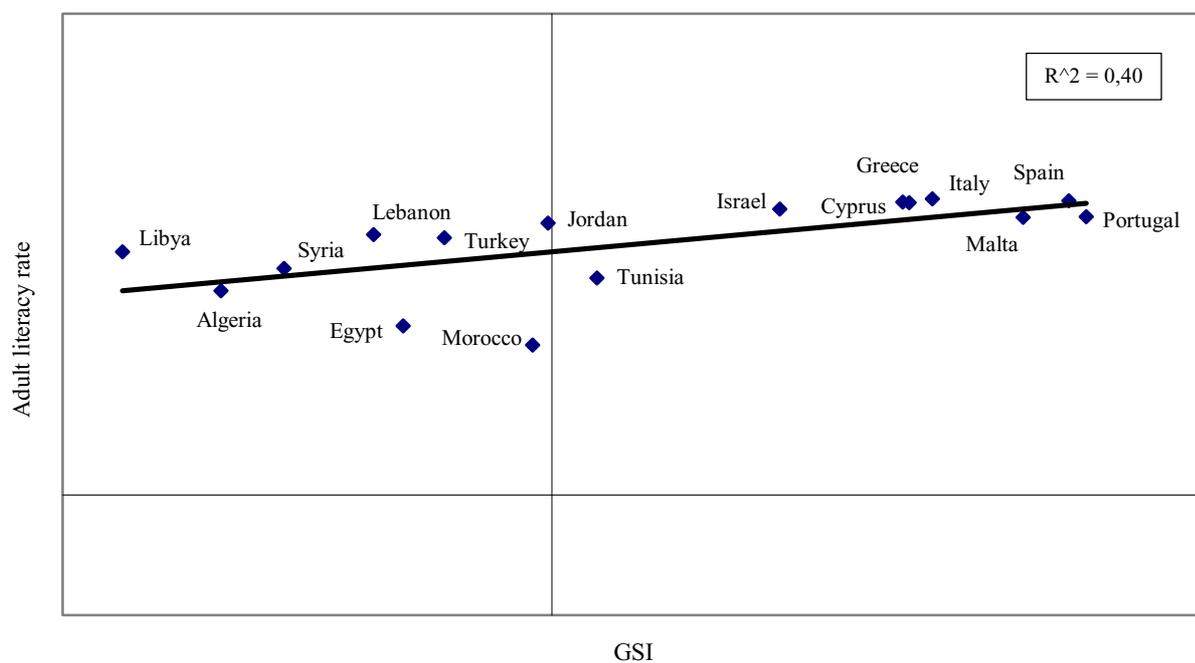
Source: Data from World Bank, World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

Fig. 22 – Analysis of correlations between the Governance and Security Index (GSI) and the gross enrolment rate



Source: Data from World Bank, United Nations Development Programme and UNESCO, 2003, elaborated by Censis

Fig. 23 – Analysis of correlations between the Governance and Security Index (GSI) and the Adult literacy rate



Source: Data from World Bank, World Health Organization and United Nations Development Programme, 2003, elaborated by Censis

RESEARCH SYNOPSIS

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 poverty⁵;*
- *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*

⁵ See the introduction of the World Development Report 2004 of the World Bank, also on-line at: www.worldbank.org/data/databytopic/databytopic.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 considered⁶.

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

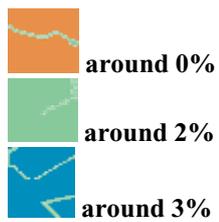
Annual population growth ranges from 0.1% in southern European countries like Italy, Portugal and Spain, to rates around 3% in the Middle East, especially in Jordan (3.9%), in Israel (2.9%), and in Syria (2.7%).

⁶ 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:

- a) countries where infant mortality is significantly lower than the average (all the European countries as well as Israel, Cyprus and Malta);
- b) countries where infant mortality is close to or just below average, like Jordan, Lebanon, Libya, Syria and Tunisia;
- c) 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

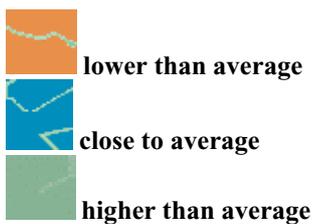
In the Mediterranean area the Millennium Goal relative to the development of employment opportunities for the young⁷ seems a long way from being reached. The lack of data on the incidence of youth unemployment upon most of the countries on the southern shores implies a big delay not only in the attainment 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.

⁷ 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:

- a) Countries whose health investment is less than 2% of their GDP (in order of increasing percentage: Morocco, Syria, Libya and Egypt);
- b) 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);
- c) Countries whose health investment exceeds 5% of their GDP (in order of increasing percentage; Spain, Portugal, Italy, Malta, France).

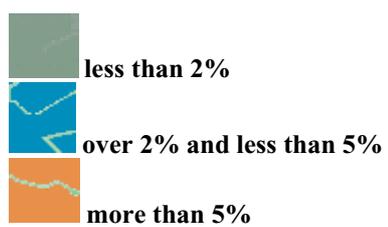
However, this is not a static situation. Data for 1995-2000 reveals an overall lack of homogeneity during the course of time:

- a) 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;
- b) 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);
- c) 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;
- and) *political stability* registers particularly positive values in Malta, Portugal and Greece.

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 countries⁸ 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

⁸ 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

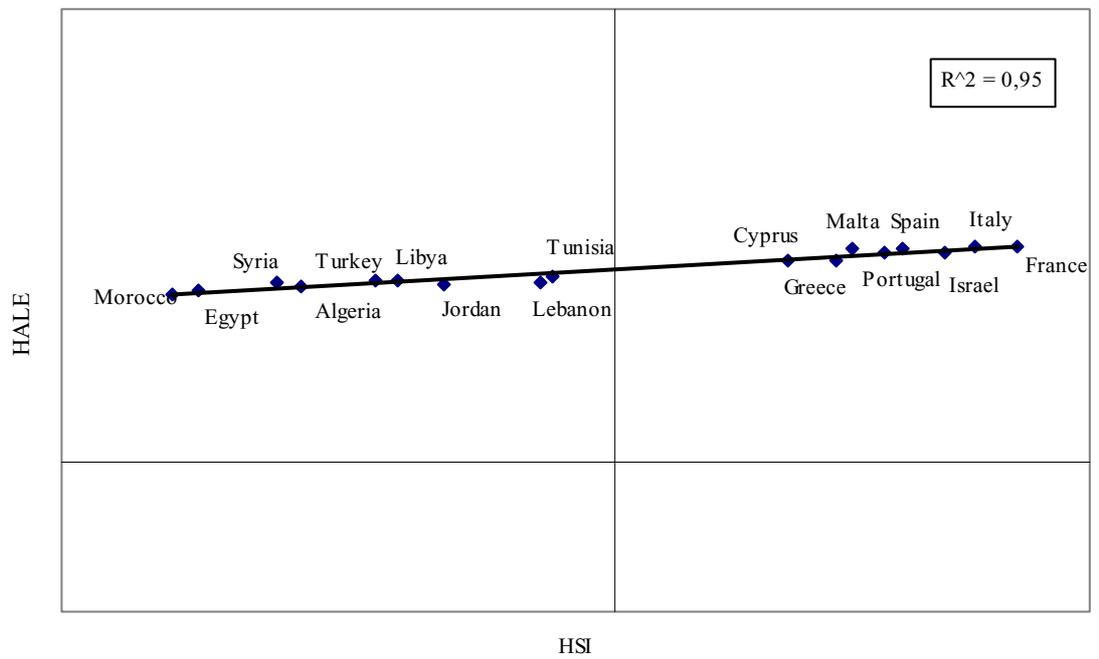
Source: Censis processing of 2003 World Bank data

Rank of correlation

The correlation study 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.

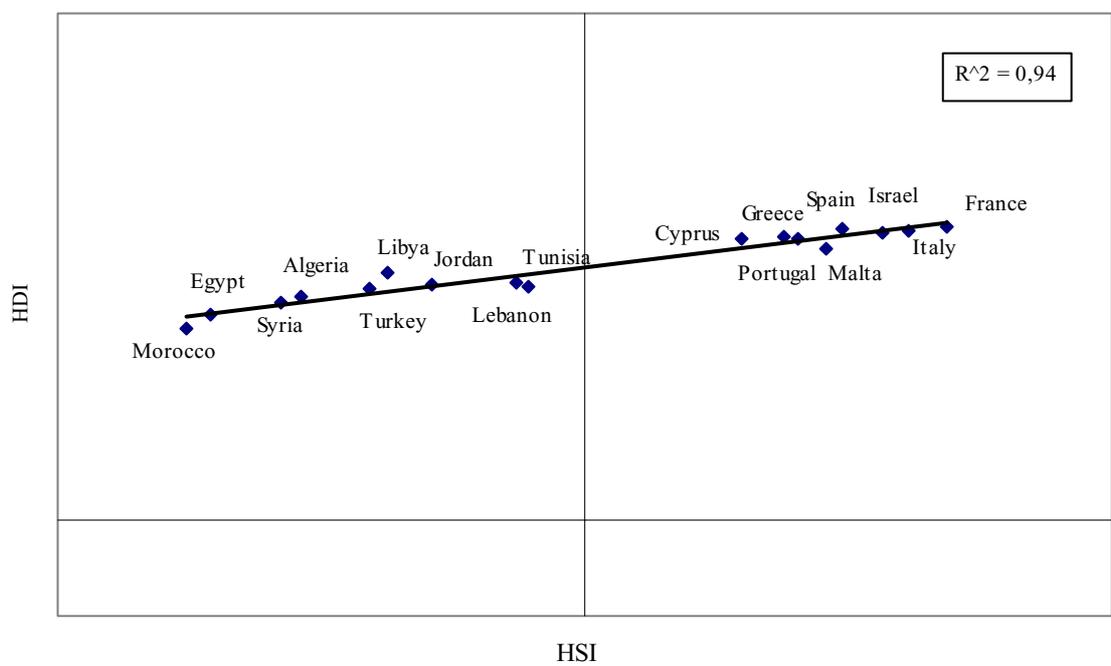
The weak correlations are also of particular interest. The Poverty and Access Index (PAI), for example, has a weak correlation with human resources for health, and in particular with the number of doctors per 100,000 inhabitants, showing that it is the health system overall that affects poverty rather 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
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 THE 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.

Italy

- 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, according to Istat data, 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 high and unquestionable correlation between wealth and health expenditure of Italian families 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.

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.