

Figure 4.1b Percentage of young people (age 11, 13 and 15) living in stepfamilies

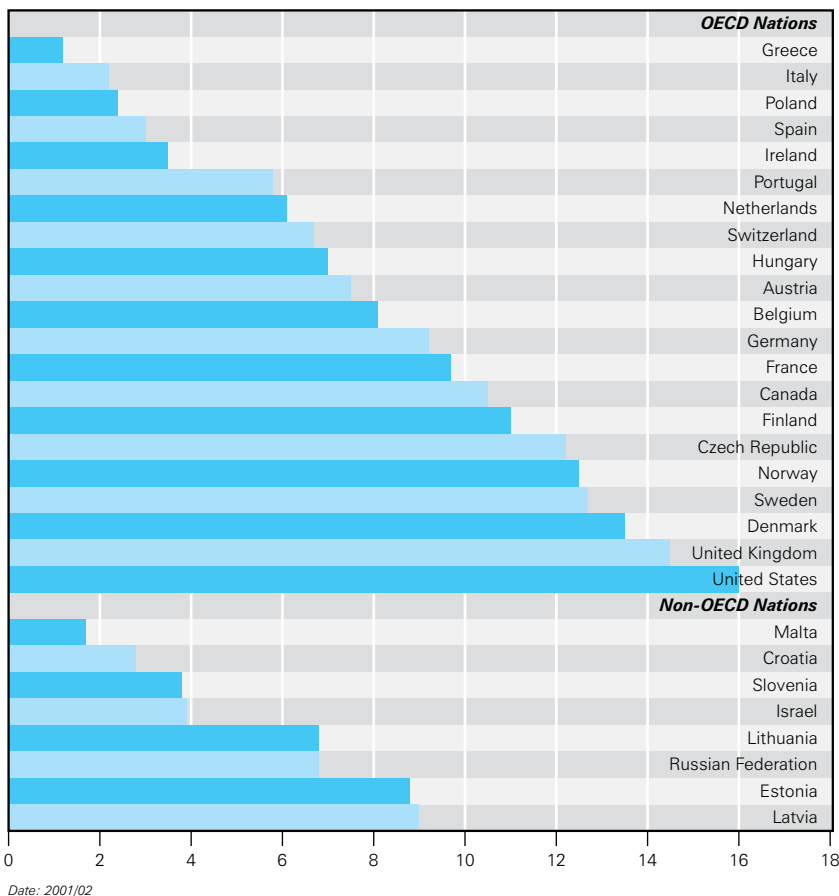
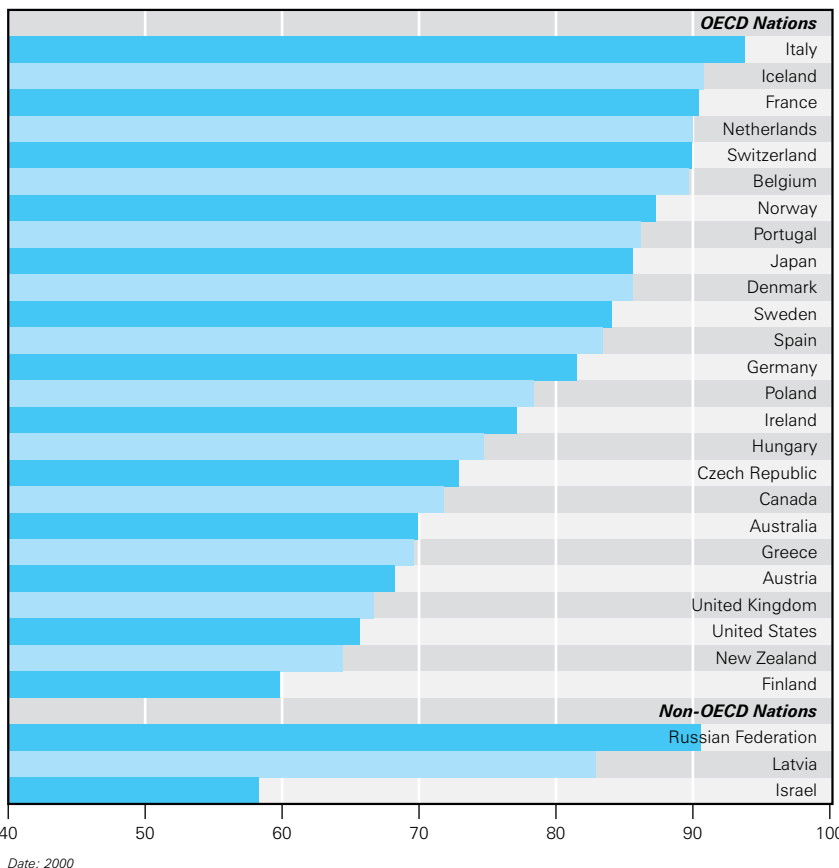


Figure 4.2a Percentage of 15 year-olds who eat the main meal of the day with their parents 'several times per week'



children. The data in these two tables draw on the previously mentioned *Programme of International Student Assessment (PISA)* which, in addition to testing for educational achievement, also asks a variety of questions about the home lives of the students who take part in the survey.

Among those questions:

- In general, how often do your parents eat the main meal with you around a table?
- In general, how often do your parents spend time just talking to you?

Figures 4.2a and 4.2b show what percentage of young people in each country answered these questions by checking the box marked 'several times a week'.

Even in the lowest ranked countries, almost two-thirds of children still regularly eat the main meal of the day with their families, with France and Italy maintaining the tradition more tenaciously. But there are significant differences between the two tables. A much smaller number of children report *talking regularly* with their parents, with the proportion falling towards 50% in Germany, Iceland and Canada. The United Kingdom and the United States are to be found in the top half of the 'talking regularly' table. Italy is the only OECD country to feature in the top level of both tables.

Other data on this topic are available from the World Health Organization's study *Health Behaviour in School-aged Children (HBSC)*. Among its findings are that young people, and especially girls, find it easier to talk to their mothers than to their fathers and that difficulty in communicating with parents rises significantly between the ages of 11 and 15.

Relationships with friends

Relationships outside the family assume ever greater importance as

children grow up. According to the World Health Organization 'Being liked and accepted by peers' is 'crucial to young people's health and development, and those who are not socially integrated are far more likely to exhibit difficulties with their physical and emotional health.' An attempt has therefore also been made to incorporate into this overview an indicator of children's relationships with friends and contemporaries.

Figure 4.3, drawing on the HBSC study, shows the results of surveying 11, 13 and 15 year-olds in more than 30 countries with the question 'do you find your peers generally kind and helpful?'. More than half were able to answer 'yes' in every OECD country except the Czech Republic and the United Kingdom. Switzerland and Portugal top the table with scores of around 80%.

These different sets of data attempt to represent a dimension of child well-being that is difficult to define, measure, and compare across nations. In some individual OECD countries, however, more revealing information is becoming available. The United Kingdom's *National Family and Parenting Institute*, for example, has conducted surveys to estimate the number of children who could answer 'yes' to questions such as:

- my parent/s are always there for me when I need them (76%)
- my parent/s make me feel loved and cared for (65%)
- I can talk to my parent/s about any problem which I may have (56%)
- my parent/s and I argue a lot (20%)
- my parent/s do not give me the attention I need (11%)
- my parent/s make me feel bad about myself (7%)

In the absence of such detailed data for other OECD countries, this attempt to include 'relationships' in the overview of child well-being should be regarded as an initial step towards monitoring this dimension of child well-being.

Figure 4.2b Percentage of 15 year-olds whose parents spend time 'just talking to them' several times per week

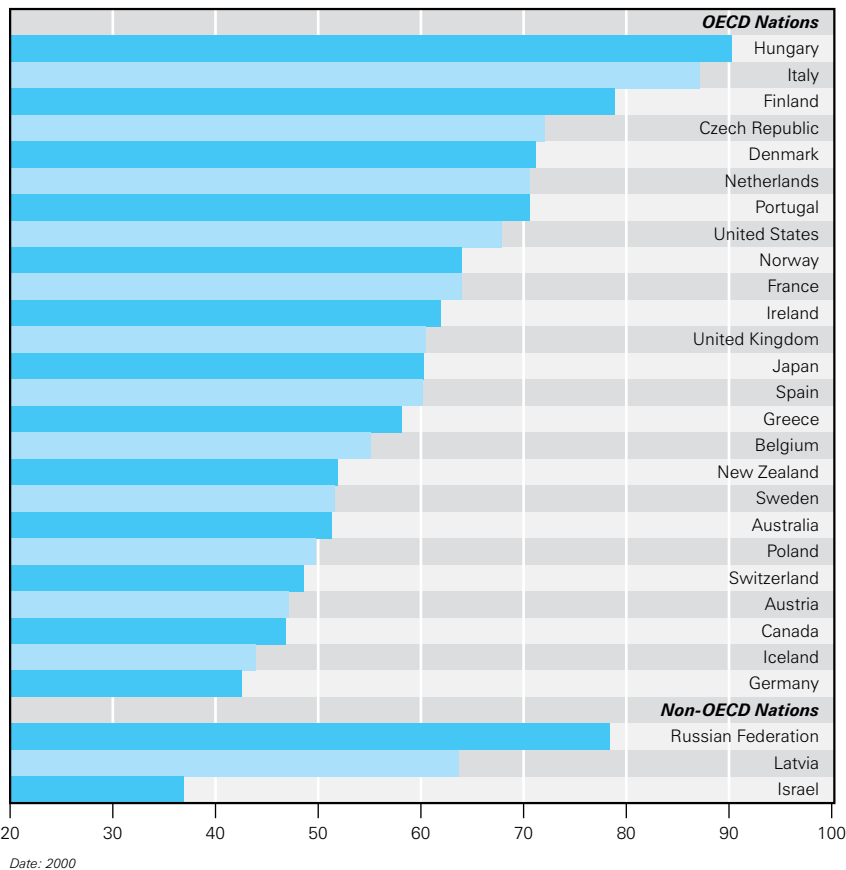
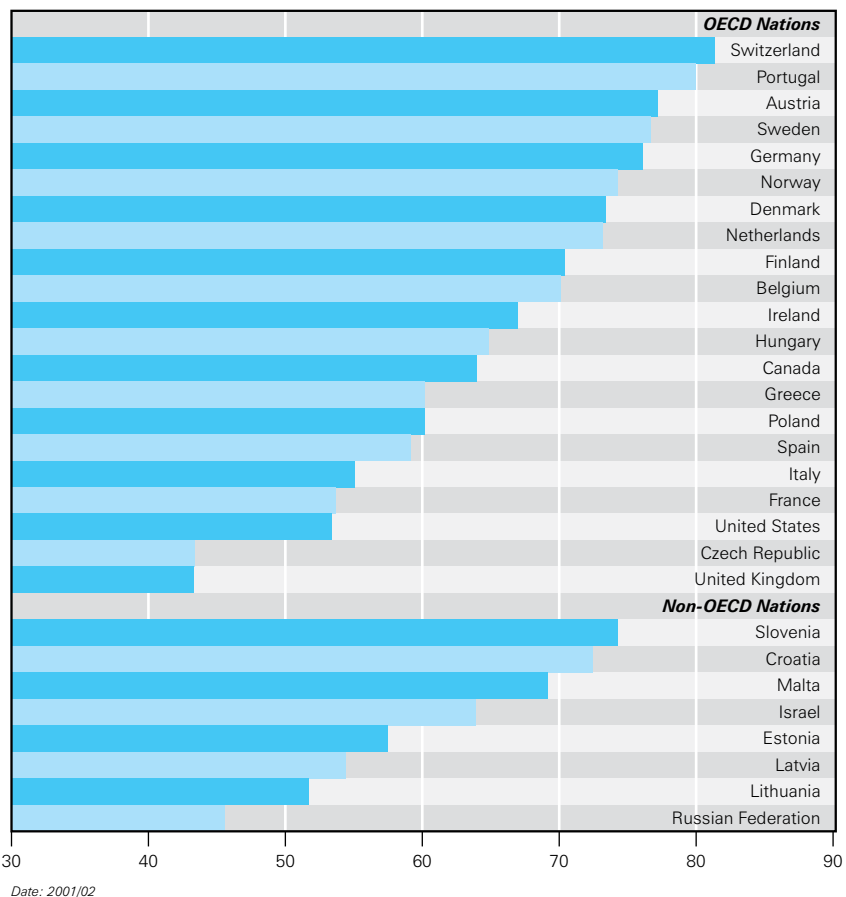


Figure 4.3 Percentage of young people age 11, 13 and 15 who find their peers 'kind and helpful'



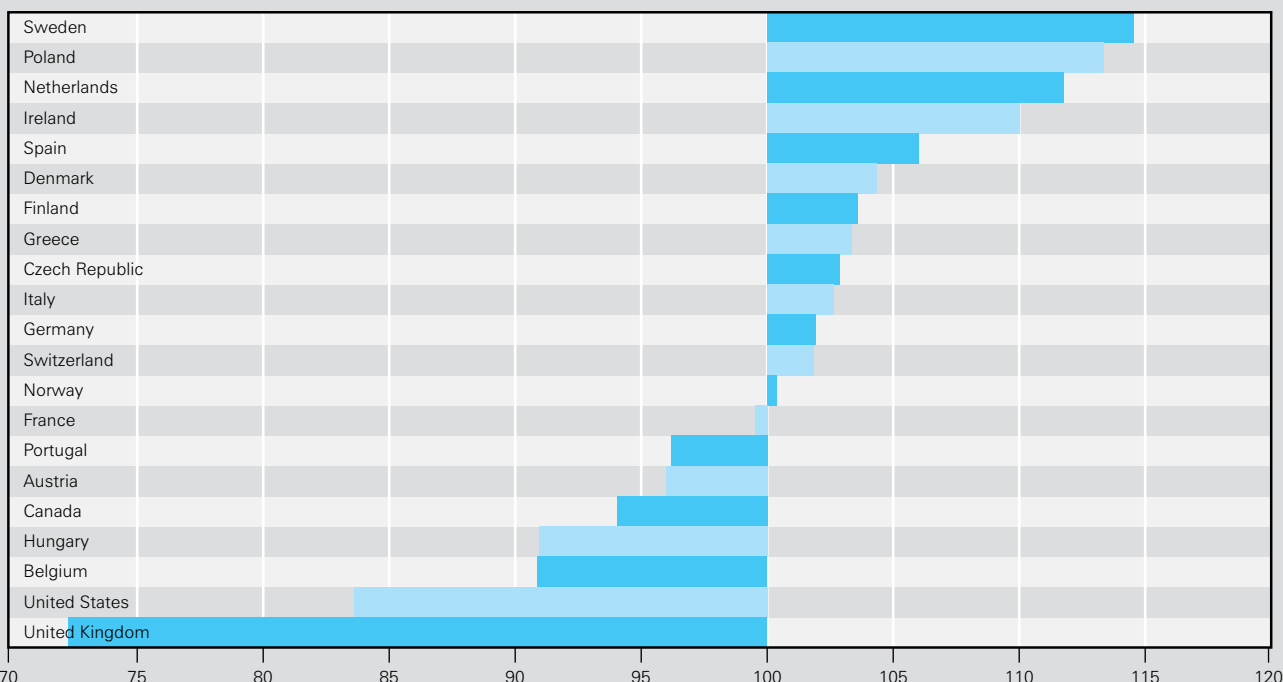
Dimension 5

BEHAVIOURS AND RISKS

Figure 5.0 Behaviours and risk-taking of young people, an OECD overview

Any overview of children's well-being must attempt to incorporate aspects of behaviour which are of concern to both young people themselves and to the society in which they live. This section therefore brings together the available OECD data on such topics as obesity, substance abuse, violence, and sexual risk-taking.

The league table below ranks each OECD country according to its average 'behaviours and risks' score (being the average of its scores for the three components selected to represent this dimension of young people's well-being – see box below). The table is scaled to show each country's distance above or below the OECD average of 100.



Assessing behaviours and risks

The table on the right shows how the index of children's behaviours has been constructed. The choice of individual indicators reflects the availability of internationally comparable data.

For each indicator, countries have been given a score which reveals how far that country stands above or below the OECD average. Where more than one indicator has been used, scores have been averaged. In the same way, the three component scores have been averaged to arrive at each country's overall rating for children's behaviours and risks (see box on page 5).

| | COMPONENTS | INDICATORS |
|---------------------|------------------------|--|
| Behaviours and risk | health behaviours | <ul style="list-style-type: none"> – percentage of children who eat breakfast – percentage who eat fruit daily – percentage physically active – percentage overweight |
| | risk behaviours | <ul style="list-style-type: none"> – percentage of 15 year-olds who smoke – percentage who have been drunk more than twice – percentage who use cannabis – percentage having sex by age 15 – percentage who use condoms – teenage fertility rate |
| | experience of violence | <ul style="list-style-type: none"> – percentage of 11, 13 and 15 year-olds involved in fighting in last 12 months – percentage reporting being bullied in last 2 months |

Young people’s behaviours and risks

The behaviours and risks discussed in this section are presented not as a catalogue of social problems but as an attempt to measure an important and elusive dimension of child well-being. There may be many reasons why children and young people abuse drugs, or live unhealthy lifestyles, or become pregnant at too early an age; but those reasons often reflect circumstances, pressures, and self-perceptions that undermine well-being. In ways that are not fully understood, they indicate problems and pressures facing a significant proportion of young people in the countries under review. The outcomes, shown in the following tables, reflect in some degree their unpreparedness and inability to cope with such pressures.

Through the *PISA* and *HBSC* studies already cited, several behavioural and risk-taking indicators have become available for most OECD countries. Figure 5.0 brings 12 of these indicators together into the three components selected to represent this dimension of child well-being – health behaviours, risk behaviours, and experience of violence.

Health behaviours

Like several of the measures in this review, eating habits in childhood and adolescence are indicators of both present and future well-being. Those who eat unhealthily during the early years of life are more likely to continue the pattern into adulthood and to be at increased risk from health problems including diabetes, heart disease, and cancer.

Figures 5.1a and 5.1b bring together data on the two indicators that have been chosen to represent ‘healthy eating’. Figure 5.1a shows the percentage of young people age 11, 13 and 15 who regularly eat breakfast. Its value as an indicator rests on the finding that skipping breakfast is associated with mid-morning fatigue, reduced concentration, and a greater likelihood of high-fat, low-fibre snacking during the day. Differentiation by age and gender shows that boys are more likely to eat breakfast than girls.

Figure 5.1b shows the percentage of young people who report eating fruit every day. Overall, only about a third of young people eat fruit daily (in the 35 countries surveyed). An even smaller proportion report eating vegetables every day.

Figures 5.1c and 5.1d approach ‘health behaviours’ from a different angle by focusing on physical activity and obesity.

Guidelines drawn up by an international panel under the direction of the World Health Organization recommend that all young people should participate in physical activity of at least moderate intensity for an hour a day (‘moderate intensity’ being defined as the ‘leaving the participant feeling warm and slightly out of breath’). Figure 5.1c shows how many 11, 13 and 15 year-olds measure up to this standard. And again the answer is ‘not many’. In the OECD countries as a whole, only about a third of young people exercise for an hour or more on five or more days a week. Young people take most exercise in Ireland, Canada and the United States, and least exercise in Belgium and France.

Figure 5.1 Children’s health behaviour, an overview of Figures 5.1a to 5.1d

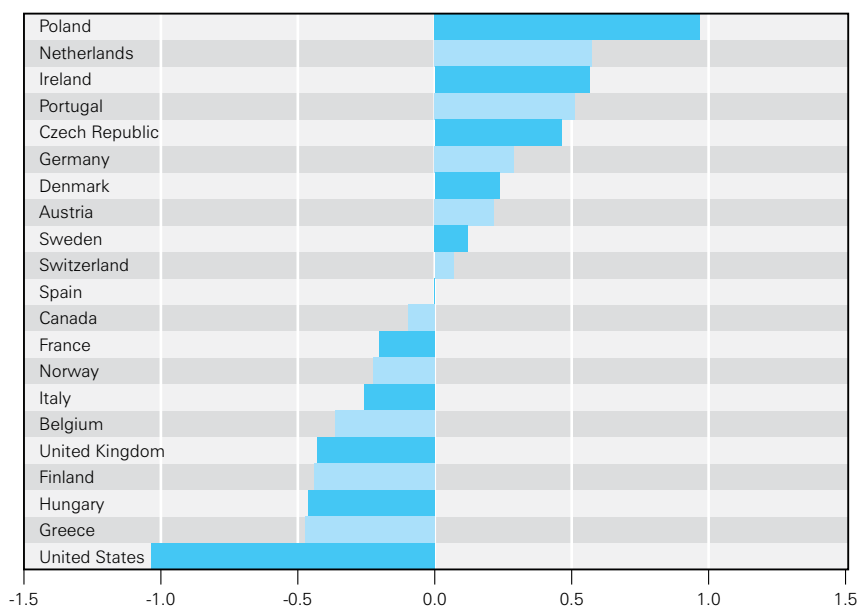


Figure 5.1a Percentage of young people age 11, 13 and 15 who report eating breakfast every school day

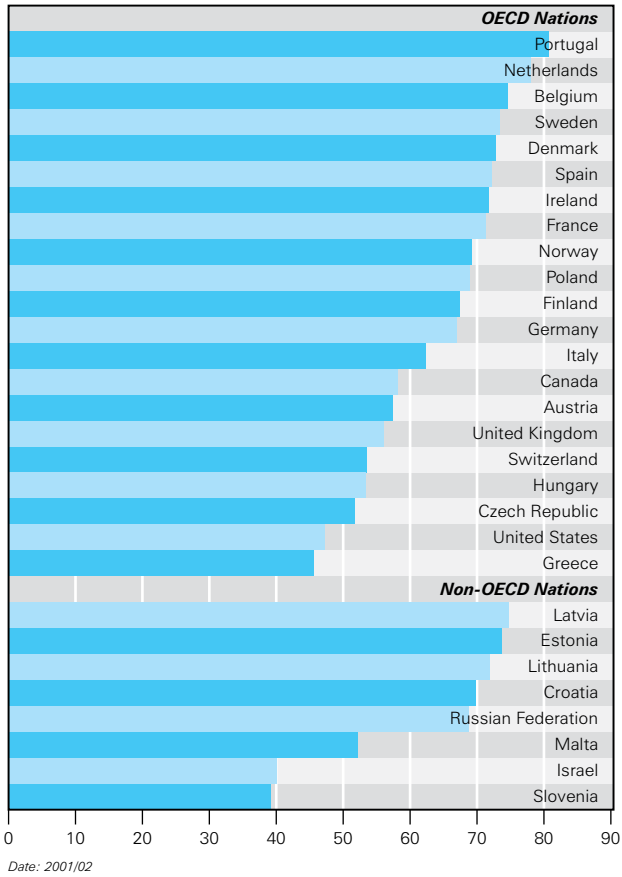


Figure 5.1b Percentage of young people age 11, 13 and 15 who report eating fruit every day

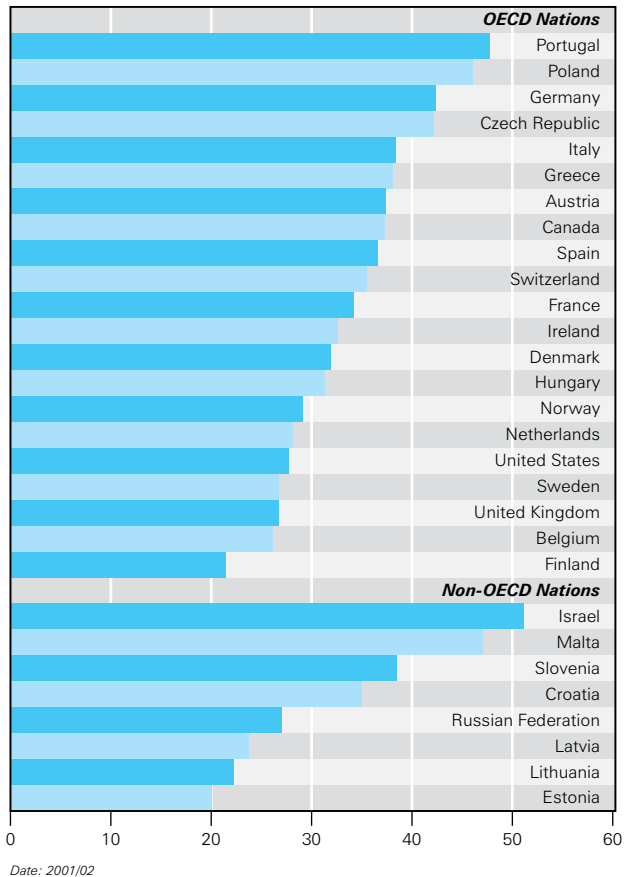
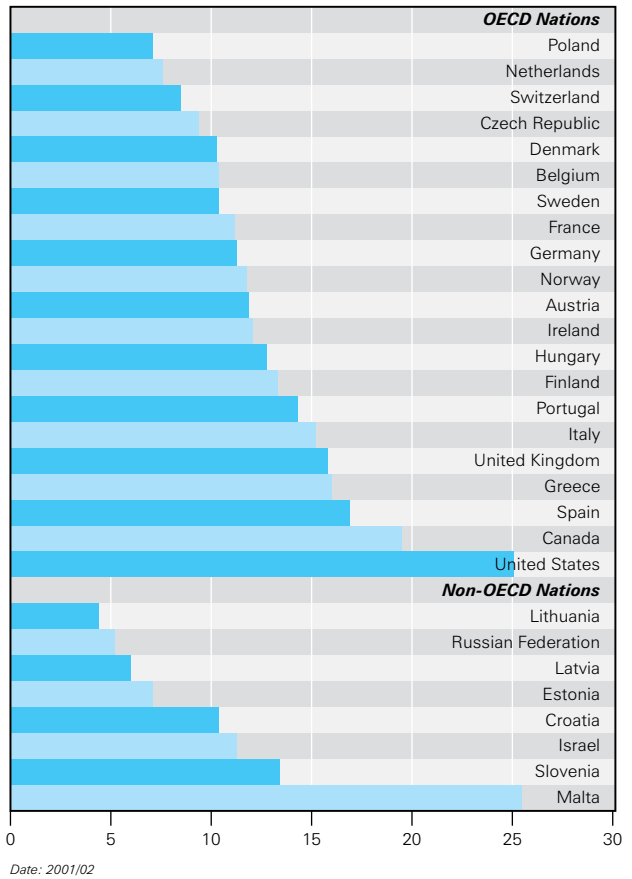
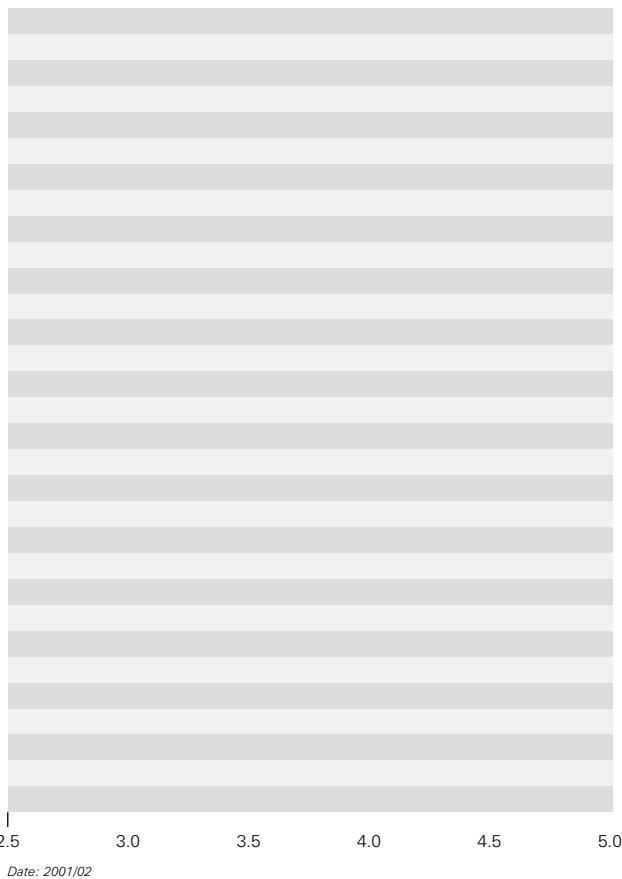


Figure 5.1d Percentage of young people age 13 and 15 who report being overweight



In all countries and all age groups surveyed, boys are more likely to be physically active than girls.

Figure 5.1d shows the prevalence of obesity among 13 and 15 year-olds in 21 OECD countries and is based on asking young people to give their weights and heights (a question which yielded low response rates, possibly indicating that the figures are underestimates). Poland and the Netherlands have the smallest proportion of overweight young people. The highest levels of obesity are to be found in the four Southern European countries (Spain, Greece, Italy and Portugal) plus the United States, Canada, and United Kingdom. Countries at the foot of this league table can expect problems in the future; as the EU Health Commissioner has said: *“Today’s overweight teenagers are tomorrow’s heart attack victims”*.

Figure 5.1 brings all of these factors together and shows that in most countries young people’s health behaviours do not deviate very far from the average for the OECD as a whole. The exceptions are Poland, where children’s health behaviours are considerably better than average, and the United States whose overall ranking suffers because of high levels of obesity.

Risk behaviours

The second component chosen to represent this dimension is the prevalence of risk-taking among young people – including smoking, drug and alcohol abuse, hazardous sexual activity, and becoming pregnant at too early an age.

Figure 5.2 combines the available data on all of these risks into an overall OECD league table of young people’s risk behaviours. Three of the bottom five places in the league table are

occupied by English-speaking countries and the United Kingdom finds itself at the foot of the rankings by a considerable distance.

Figure 5.2a presents data on smoking, well-known as the leading cause of premature illness and death in the rich world. Overall, it shows that 10% or more of young people in OECD countries are smoking at least once a week by the age of 15. The HBSC survey from which the data is drawn puts the result more positively: *“84% of young people report that they do not smoke. About one third of the 16% who smoke do so less than once a week.”* The same survey reports that in 23 out of 35 countries girls are more likely to smoke than boys.

Alcohol, cannabis, sexual relations

Figure 5.2b shows the percentage of young people aged 11, 13 and 15 who, answered ‘two or more times’ when asked ‘how often have you had so much alcohol that you were really drunk?’. In the majority of OECD countries, fewer than 15% of young people report being drunk on two or more occasions. In the Netherlands, the figure rises to over a quarter and in the UK to almost a third.

The percentage of 15 year-olds who have used cannabis (Figure 5.2c) also appears to vary widely across the OECD countries – from fewer than 5% in Greece and Sweden to over 30% in Canada, Spain, Switzerland, the United States and the United Kingdom. Canada is the only country with a cannabis use rate of over 40% among 15 year-olds. Regular cannabis use is associated with depression, physical ill health, problems at school, and with other forms of risk-taking. It may also trigger psychoses, especially in young people already prone to such conditions.

There is rather less but still significant variation in the percentage of young people who have had sexual intercourse by the age of 15 (Figure 5.2d). For 16 of the 17 OECD countries with available data, the proportion is between 15% and 28%; for the United Kingdom it is almost 40%. Most countries have made efforts to educate young people about the dangers of HIV/AIDS and sexually-transmitted disease and this is reflected in the rate of condom use. Among 15 year-olds who have had sex, the great majority (between 65% and 90%) used a condom (Figure 5.2e).

Figure 5.2 Young people’s risk behaviour, an overview of tables 5.2a to 5.2f

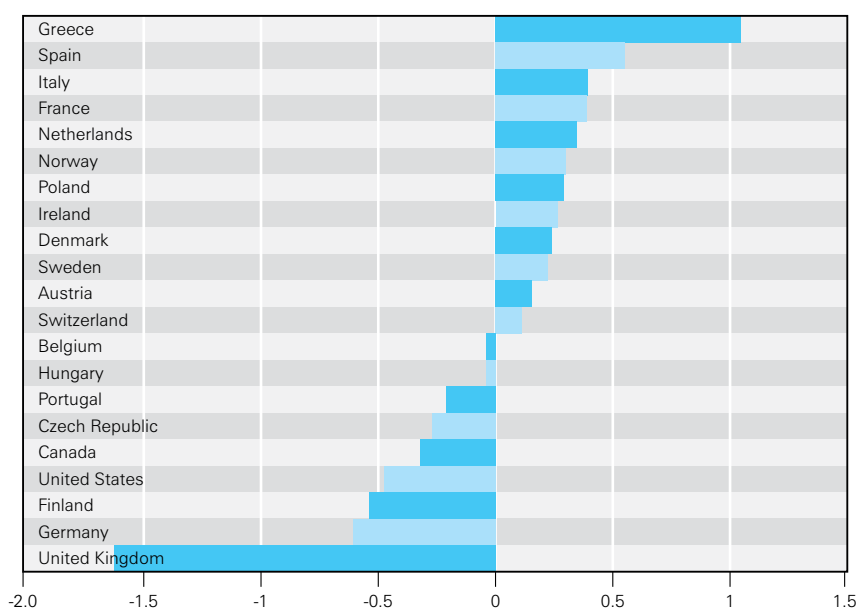


Figure 5.2a Percentage of students age 11, 13 and 15 who smoke cigarettes at least once a week

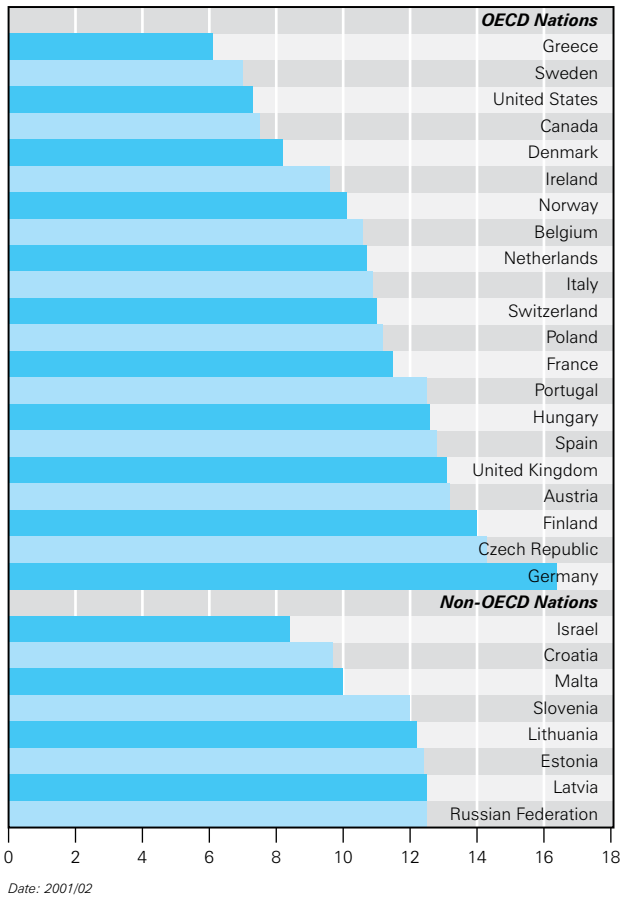


Figure 5.2c Percentage of students age 11, 13 and 15 who report having used cannabis in the last 12 months

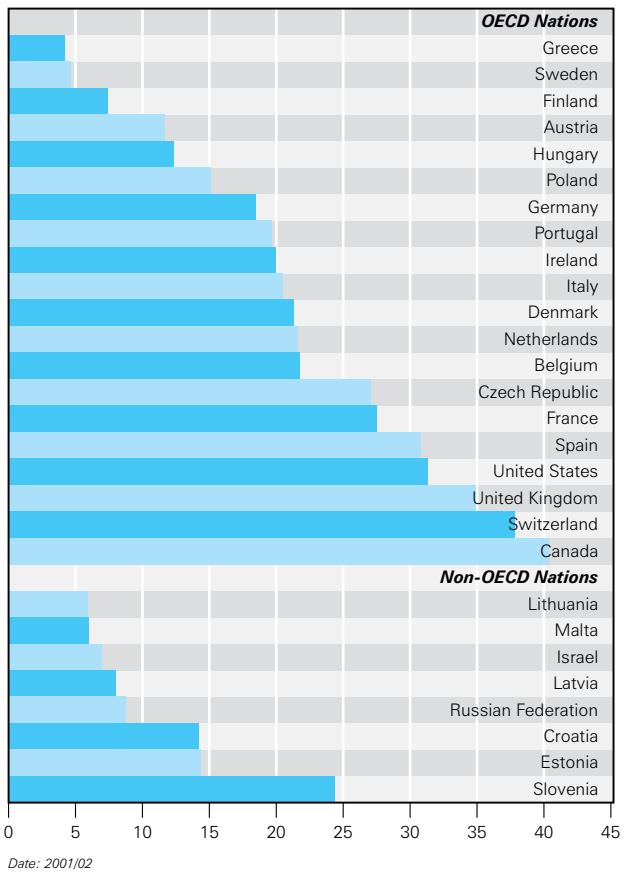


Figure 5.2b Percentage of students age 11, 13 and 15 who report having been drunk two or more times

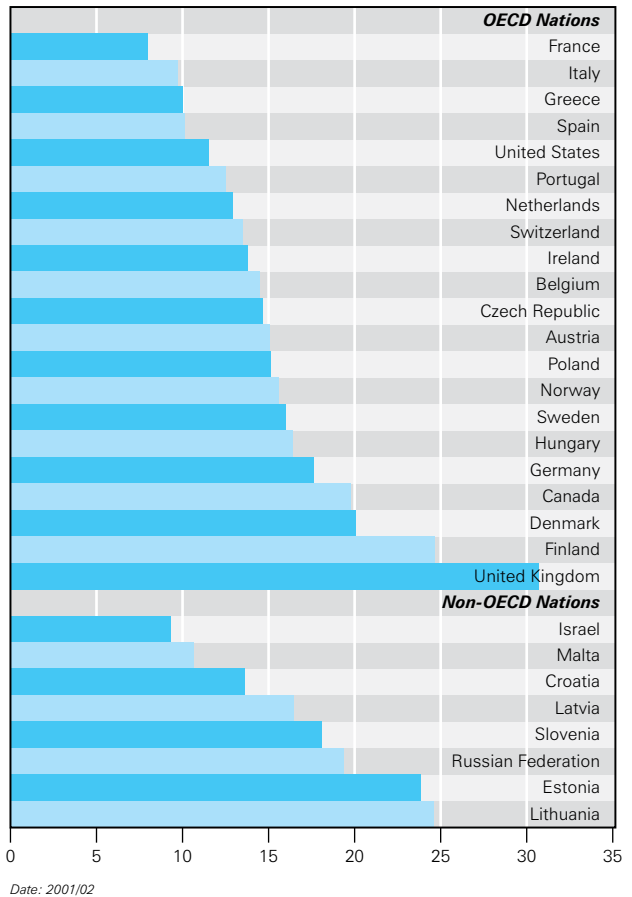
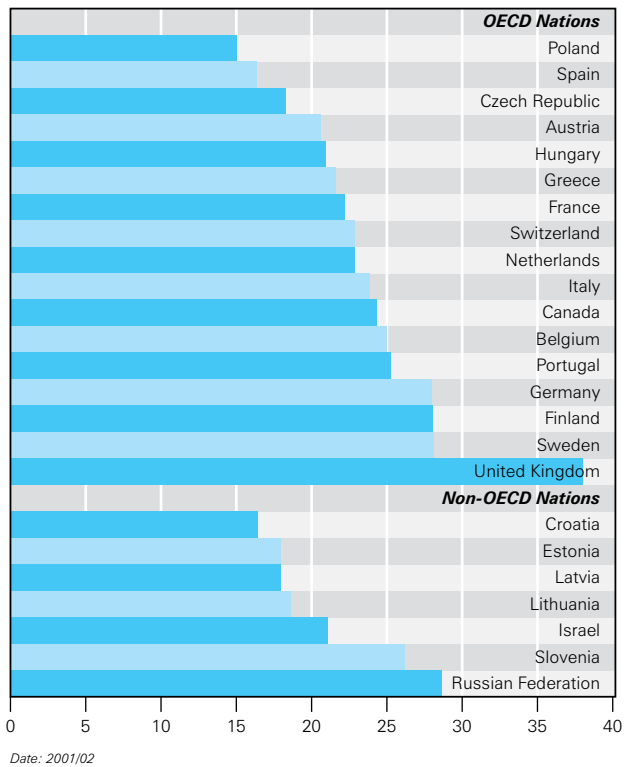


Figure 5.2d Percentage of 15 year-olds who report having had sexual intercourse



Many of the risk behaviours featured in these tables are related or people who smoke cigarettes, for example, are approximately three times more likely to use alcohol regularly and eight times more likely to use cannabis.

Teenage births

Teenage fertility rates in OECD countries (Figure 5.2f) also vary considerably – from as few as 5 to as many as 45 births for every 1,000 girls aged 15 to 19.

For most girls growing up in an OECD country, the norm today is an extended education, a career, a two-income household, delayed

as always, association is not the same as cause. Many girls who give birth in their teens have themselves grown up with the kind of poverty and disadvantage that would be likely to have negative consequences whether or not they wait until they are in their twenties before having children. Becoming pregnant while still a teenager may make these problems worse, but not becoming pregnant will not make them go away.

having a baby to love and be loved by, with a small income from benefits and a home of her own, may seem a more attractive option than the alternatives. A teenager doing well at school and looking forward to an interesting and well-paid career, and who is surrounded by family and friends who have similarly high expectations, is likely to feel that giving birth would de-rail both present well-being and future hopes.

shadow the lives of many young people, making the time of life that adults like to think of as happy and carefree into a time of anxiety and misery. In particular, exposure to violence in the home – both directly through child abuse and indirectly through witnessing aggression and violence between adults – can be a cause of enduring distress and damage to children of all ages.¹⁴

Unfortunately, exposure to violence is difficult to define and the available indicators are inadequate to the task of reflecting either present misery or future consequence. Figures 5.3a and 5.3b bring together the few data on what children themselves have to say about this issue.

In 18 of the 21 countries surveyed, the proportion of those involved in fighting in the previous 12 months (Figure 5.3a) was over one third, ranging from fewer than 30% in Finland and Germany to more than 45% in the Czech Republic and Hungary. Overall, about 40% of all young people in countries surveyed reported involvement in at least one physical fight during the previous year.

The prevalence of bullying (Figure 5.3b) varies more widely, with about 15% of children reporting being bullied in Sweden and the Czech Republic as opposed to more than 40% in Switzerland, Austria, and Portugal. About a third of young people in the countries surveyed report being bullied at least once during the two months prior to the survey. A similar proportion reported bullying others.

Both of these tables need to be treated with caution. The fact that the children of the Czech Republic simultaneously appear at the top of the ‘fighting’ table and at the bottom of the ‘bullying’ league, for example, is not necessarily inconsistent. The distinction between bullying and fighting is, at the margins, an issue of perception, and the subtleties of the distinction may occasionally be eroded in translation. The definition used by the survey quoted, and submitted to interviewees as a preliminary to the question on bullying, illustrates the difficulty: *“We say a student is being bullied when another student, or group of students, says or does nasty and unpleasant things to him or her. It is*

also bullying when a student is teased repeatedly in a way he or she doesn't like, or when he or she is deliberately left out of things. But it is not bullying when two students of about the same strength quarrel or fight. It is also not bullying when the teasing is done in a friendly and playful way.”

Figure 5.3 brings both ‘fighting’ and ‘bullying’ indicators into a composite table, but remains an inadequate representation of young people’s experience of violence in the countries concerned. What is needed is more information on children’s exposure to violence of all kinds in the home. National studies show that children who often witness violence between others in the home are also most likely to be victims of violence themselves, and both forms of exposure represent incalculable levels of current misery and long-term damage to the development and well-being of many millions of children. *Report Card 5* (September 2003) concluded that in some industrialized nations today as many as one child in every 15 is the victim of serious maltreatment and that this is an issue which needs to be dragged out from the shadows of national life and into the daylight of public and political scrutiny.

Figure 5.3 Young people who report not being involved in fighting, or being bullied, an overview of tables 5.3a and 5.3b

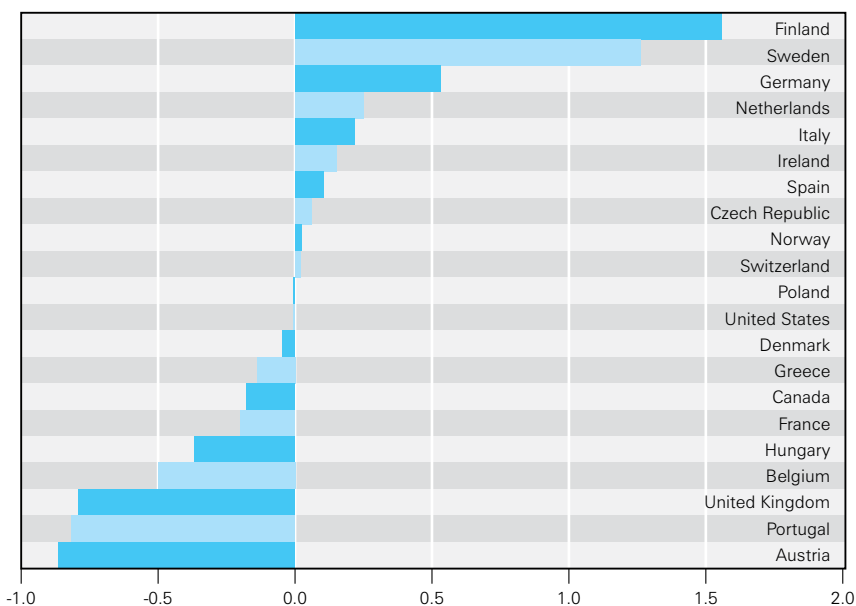
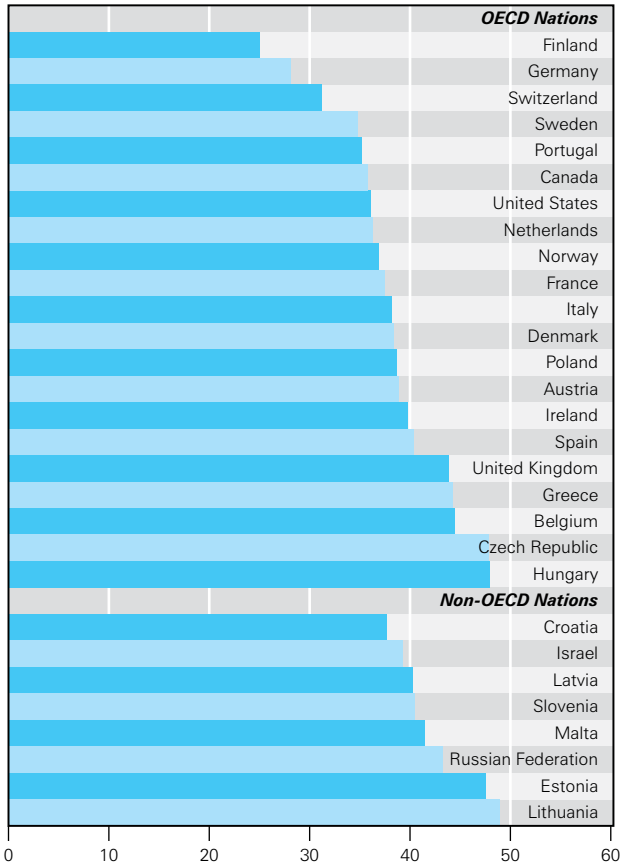
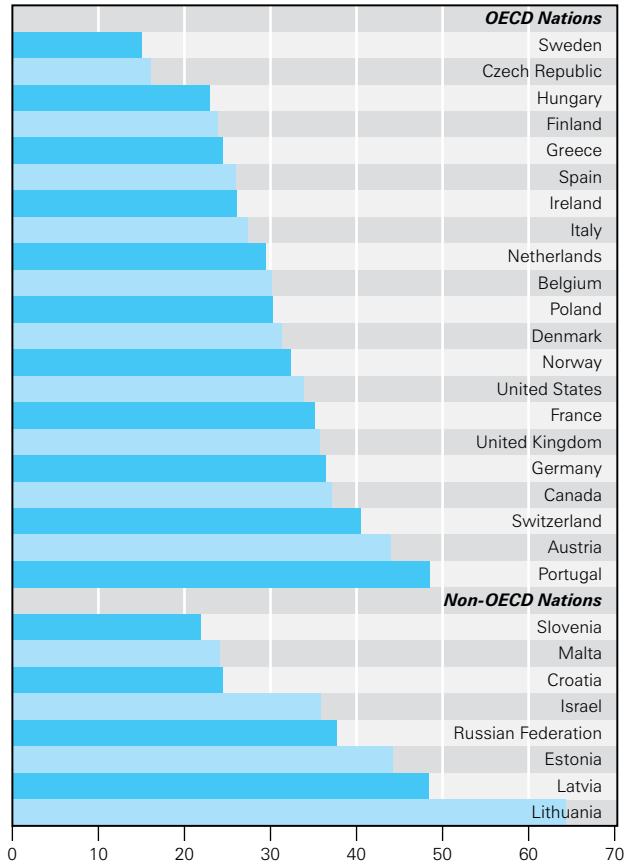


Figure 5.3a Percentage of young people age 11, 13 and 15 who report having been involved in fighting in the previous 12 months



Date: 2001/02

Figure 5.3b Percentage of young people age 11, 13 and 15 who report being bullied in the previous 2 months



Date: 2001/02

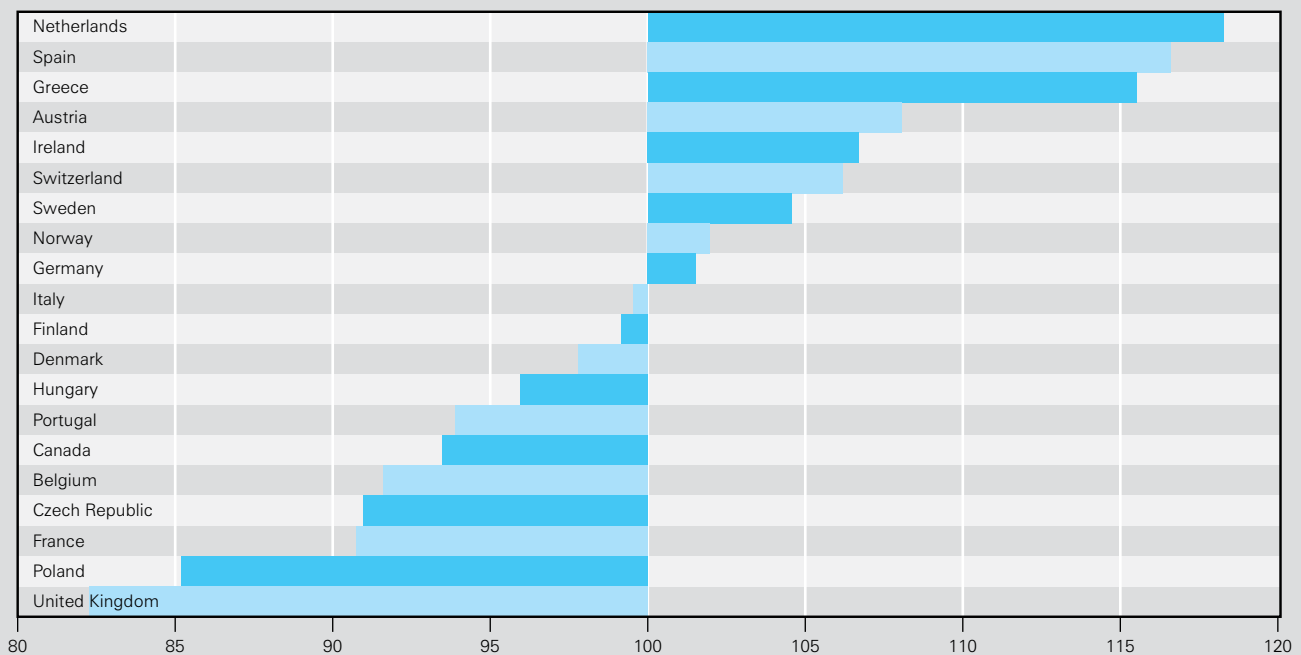
Dimension 6

SUBJECTIVE WELL-BEING

Figure 6.0 Subjective well-being of young people, an OECD overview

This section attempts to give depth to this overview of child well-being by taking into account children’s own perceptions, drawing on international surveys of children’s and young people’s opinions. The table below brings the results into a composite overview of children’s own subjective sense of well-being.

The table is scaled to show each country’s distance above or below the OECD average of 100 and shows each country’s standing in relation to the average for the OECD as a whole.



Subjective well-being

The box on the right shows how the index of children’s subjective well-being has been constructed. The choice of individual indicators reflects the availability of internationally comparable data.

For each indicator, countries have been given a score which reveals how far that country stands above or below the average for the OECD countries under review. Where more than one indicator has been used, scores have been averaged. In the same way, the three component scores have been averaged to arrive at each country’s overall rating for children’s subjective well-being (see box on page 5).

| Subjective well-being | COMPONENTS | INDICATORS |
|-----------------------|---------------------|--|
| | health | – percentage of young people rating their own health no more than ‘fair’ or ‘poor’ |
| | school life | – percentage of young people ‘liking school a lot’ |
| | personal well-being | – percentage of children rating themselves above the mid-point of a ‘Life Satisfaction Scale’ – percentage of children reporting negatively about personal well-being |

Young people’s subjective assessments of well-being

Various elements in this overview of child well-being have attempted to reflect children’s own views and voices – for example the surveys of reported family affluence, experience of bullying, or the frequency of communication with parents. The inclusion of ‘subjective well-being’, as a distinct dimension, represents an attempt to focus more directly on children’s perceptions of their own well-being.

Three components have been selected to represent this dimension – the proportion of young people rating their own health no more than ‘fair’ or ‘poor’, the proportion who report ‘liking school a lot’, and a measure of children’s overall satisfaction with their own lives.

Bringing the available data together (Figure 6.0) shows that children’s subjective sense of well-being appears to be markedly higher in the Netherlands, Spain, and Greece and markedly lower in Poland and the United Kingdom. Unfortunately insufficient data are available for the United States which therefore could not be included in this section.

Perceptions of health

Surveys of young people’s own perception of their own health show that, in virtually all OECD countries for which data are available, girls report lower levels of health than boys and that this difference gradually increases with age. This finding does not appear to vary a great deal across different national social and cultural contexts and it therefore seems likely

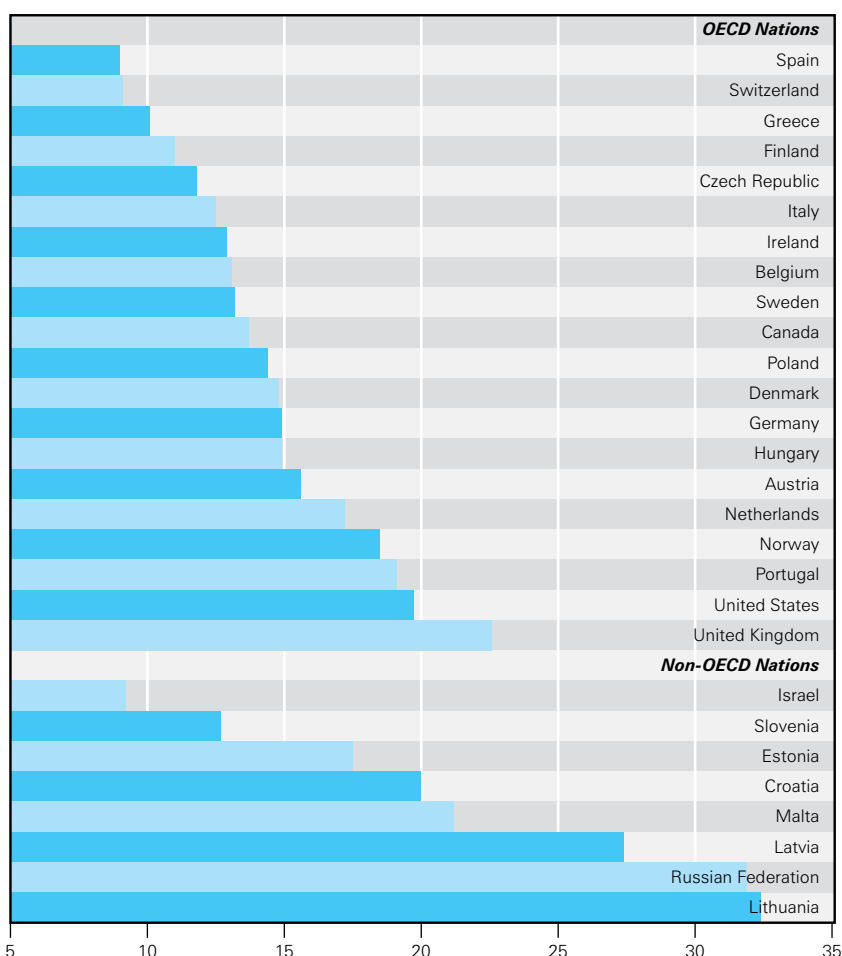
| Subjective assessment of health percentage of young people rating their own health as ‘fair or poor’ | | | |
|---|--------------|--------------|--------------|
| | 11 year-olds | 13 year-olds | 15 year-olds |
| Girls | 15.7 | 20.8 | 27.2 |
| Boys | 12.1 | 13.6 | 16.1 |

Source: *Young People’s Health in Context*, Health Behaviour in School-age Children (HBSC) study: international report from the 2001/2002 survey, WHO, 2004, p. 57

that gender differences in self-reported health status are related to the different physiological and psychological pressures brought by the onset of puberty. Girls, for example, may be under greater pressure to

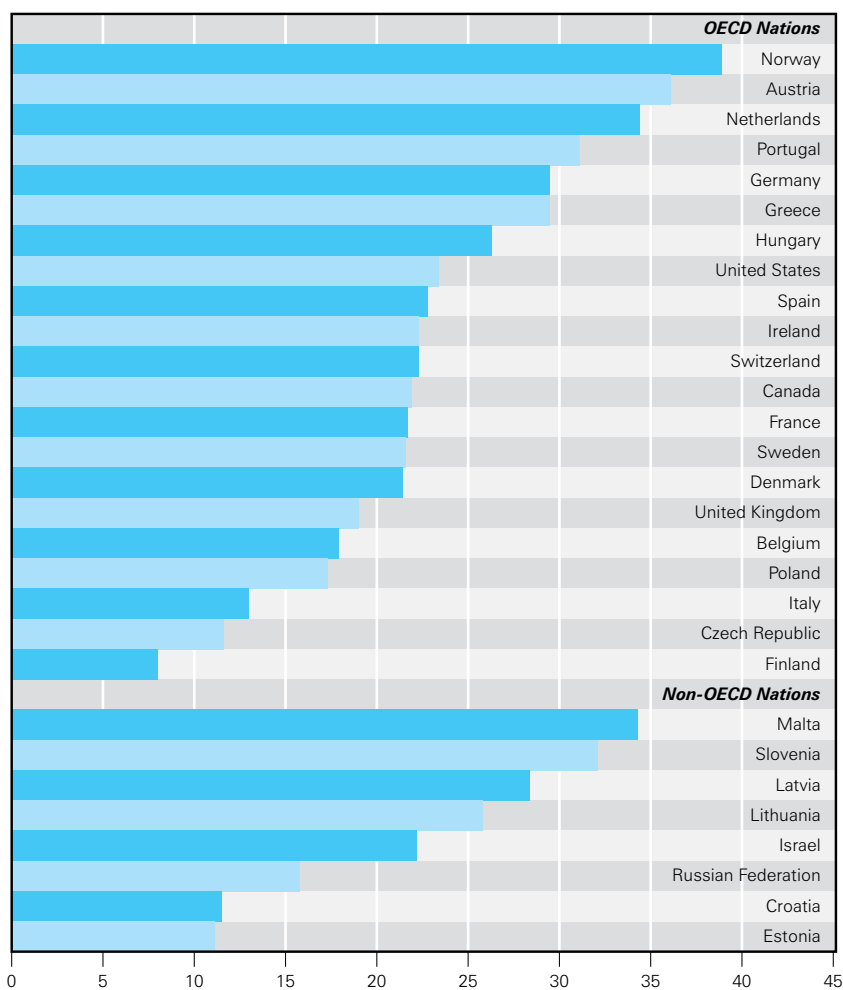
worry about body image and to be more aware of and/or sensitive to their own physical and emotional state (and therefore, perhaps, to have a lower threshold for self reported poor health).

Figure 6.1 Percentage of young people age 11, 13 and 15 who rate their health as ‘fair or poor’



Date: 2001/02

Figure 6.2 Percentage of students age 11, 13 and 15 who report 'liking school a lot'



Date: 2001/02

Figure 6.1 shows the percentage of 11, 13 and 15 year-olds in each country who replied 'fair' or 'poor' when asked the question 'Would you say that your health is excellent, good, fair, or poor?'. Overall, approximately 80% of young people consider their health to be good or excellent in every OECD country except the United Kingdom.

School

A broad measure of how happy young people are during their schooldays is provided by the HBSC survey which questioned representative groups of children in 35 countries about their attitudes to the time spent in school. Specifically, it asked children aged 11, 13, and 15 to tick one of four possible attitudes to school – 'I like it a lot, I like it a bit, I don't like it very much, or I don't like it at all'.

Figure 6.2 shows how many answered – 'I like it a lot'. And the answer is 'not many'.

Better data for EU countries

Since 2004, the 25 countries of the European Union (EU) have been developing a new statistical data source, known as *Community Statistics on Income and Living Conditions (EU-SILC)*.

EU-SILC aims to become the reference source of comparative statistics on income distribution and living conditions within the EU. A primary purpose of EU-SILC is to monitor the common indicators (the so-called *Laeken Indicators*) by which the EU has agreed to measure its progress towards reducing poverty and social exclusion.

EU-SILC therefore replaces the *European Community Household Panel (ECHP)* which was the main source of such data from 1994 until 2001 (for the then 15 Member States of the EU). Designed to fill some of the acknowledged gaps and weaknesses of the ECHP, EU-SILC collects every year comparable and up-to-date cross-sectional data on income, poverty, social exclusion and other aspects of living conditions – as well as longitudinal data on income

and on a limited set of non-monetary indicators of social exclusion.

The first EU-SILC data for all 25 Member States of the current EU, plus Norway and Iceland, should be available by the end of 2006. The first 4-year longitudinal data on 'those at-persistent-risk-of-poverty' will be available by the beginning of 2010.

In addition to populating these core indicators, each round of EU-SILC also gathers data on one particular theme – beginning in 2005 with data on the inter-generational transmission of poverty.

For more information on EU-SILC and the EU Laeken indicators, as well as an in-depth analysis of the major challenges facing the EU *Social Inclusion Process*, see E. Marlier, A.B. Atkinson, B. Cantillon and B. Nolan (2006), *The EU and social inclusion: Facing the challenges*, Policy Press, Bristol

See also: Bradshaw, J., Hoelscher, P. and Richardson, D. (2007) *An index of child well-being in the European Union*, Journal of Social Indicators Research. 1, 2007

The Netherlands and Norway, along with Austria, again find themselves at the head of the table with over a third of their schoolchildren admitting to 'liking school a lot'. The proportion drops below 15% in Finland, the Czech Republic, and Italy.

Once again this is an overview which masks gender and age differences, with girls tending to like school more than boys and older children tending to like school less than younger.

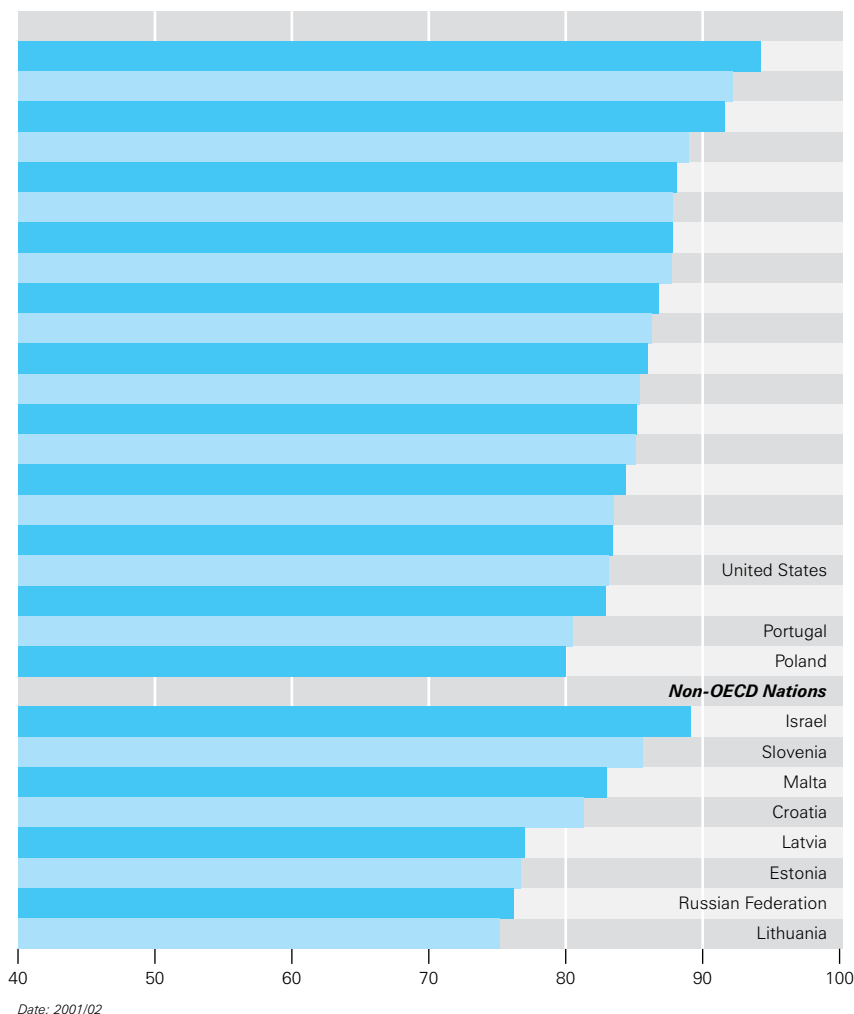
With some exceptions, such as Finland, there appears to be a positive relationship between liking school and educational achievement. A self-reinforcing relationship between the two seems likely, with young people who do well tending to like school and those who like school tending to do well.

Life satisfaction

Figures 6.3a and 6.3b attempt to gauge children's overall satisfaction with themselves and their lives.

The first (Figure 6.3a) is based on putting the following question to children aged 11, 13, and 15:

'Here is a picture of a ladder. The top of the ladder, 10, is the best possible life for you and the bottom, 0, is the worst possible life for you. In general, where on the ladder do you feel you stand at the moment? Tick the box next to the number that best describes where you stand.'



A score of 6 or more was treated as a positive level of life satisfaction and Figure 6.3a clearly shows that the great majority of young people growing up in all OECD countries score themselves above this midpoint on the 'life satisfaction ladder'.

In the OECD countries as a whole, there is a slight trend towards decreasing life satisfaction between the ages of 11 and 15, particularly for girls.

Out of place

Figure 6.3b attempts to explore psychological and social aspects of subjective well-being, such as feelings of awkwardness, loneliness, and 'being an outsider' – perceptions of social exclusion that can significantly affect the quality of young people's lives. The table brings together the results of asking young people to agree or disagree with three statements about themselves:

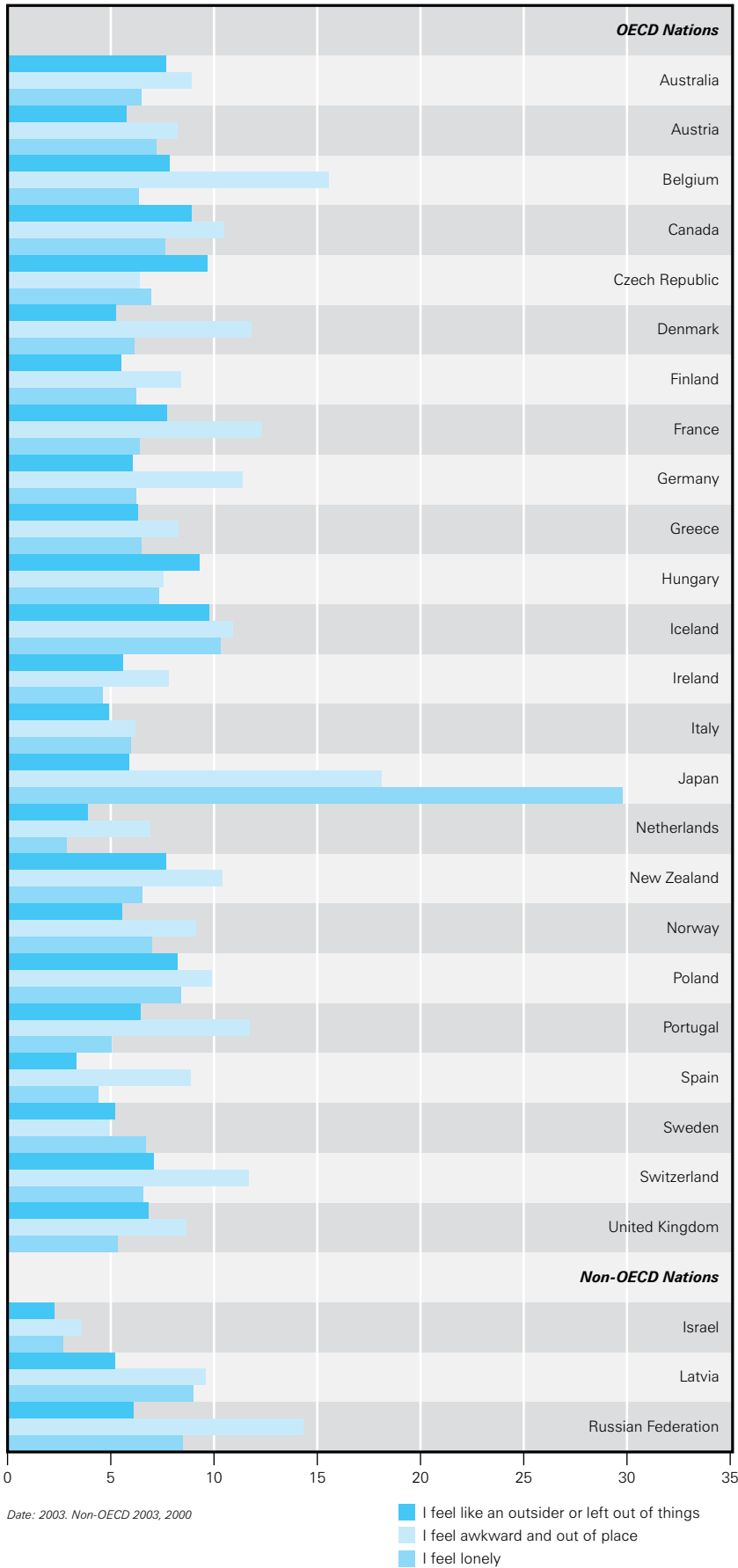
- I feel like an outsider or left out of things
- I feel awkward and out of place
- I feel lonely

Overall, the responses reveal a remarkable consistency across most of the OECD countries and a high level of life satisfaction among its young

| 'Life Satisfaction Ladder' | | | |
|--|--------------|--------------|--------------|
| percentage of young people rating themselves above the mid-point | | | |
| | 11 year-olds | 13 year-olds | 15 year-olds |
| Girls | 87.1 | 82.5 | 77.4 |
| Boys | 88.1 | 86.9 | 84.5 |

Source: *Young People's Health in Context*, Health Behaviour in School-age Children (HBSC) study: international report from the 2001/2002 survey, WHO, 2004, p. 57 (note: the table draws not only on data from OECD countries but from all 35 countries surveyed under the HBSC programme).

Figure 6.3b Percentage of 15 year-olds agreeing with specific negative statements about personal well-being



people. In most nations, the proportion of young people agreeing with the statements is at the lower end of the 5% to 10% range. A higher proportion of children agreed with the statement *'I feel awkward and out of place'* but even here the proportion answering 'yes' exceeded 10% in only 8 out of 24 OECD countries. The most striking individual result is the 30% of young people in Japan who agreed with the statement *'I feel lonely'* – almost three times higher than the next highest-scoring country. Either this reflects a difficulty of translating the question into a different language and culture, or a problem meriting further investigation, or both. ■

CONCLUSION

Taken together, the six dimensions of child well-being assessed in these pages represent a significant step forward in measuring and comparing children's well-being across the countries of the OECD.

There are significant relationships between some of the dimensions chosen. Poverty, for example, affects many aspects of child well-being in many well-documented ways: particularly when prolonged, poverty has been shown to be likely to have an effect on children's health, cognitive development, achievement at school, aspirations, self-perceptions, relationships, risk behaviours and employment prospects. Equally clearly, economic poverty alone is revealed as an inadequate measure of children's overall well-being. A multi-dimensional approach to well-being is necessary to improve understanding, monitoring, and policy effectiveness.

It is tempting to take the process one stage further and combine the scores of all countries under all dimensions into an overall OECD league table of child well-being. Other than listing countries according to their average ranking (page 2), this temptation has been resisted. In part this is to maintain opacity and avoid leaning too hard on limited data; composite indicators, of which this report has made plentiful use, need to be as transparent as possible both to keep the process open to debate and to

avoid elevating the data to heights of authority that their foundations can not sustain. But in part, also, reducing the overview to a single score or number would undermine the emphasis on children's well-being as a multi-dimensional issue requiring a wide range of policy responses. Sometimes the whole can be less than the sum of the parts.

This first multi-dimensional overview is best regarded as a work in progress, in need of improved definitions and better data. But in the process it is easy to become ensnared in the data and to lose sight of what it is that we are trying to capture. When we attempt to measure children's well-being what we really seek to know is whether children are adequately clothed and housed and fed and protected, whether their circumstances are such that they are likely to become all that they are capable of becoming, or whether they are disadvantaged in ways that make it difficult or impossible for them to participate fully in the life and opportunities of the world around them. Above all we seek to know whether children feel loved, cherished, special and supported, within the family and community, and whether the family and community are being supported in this task by public policy and resources.

The measures used in this report fall short of such nuanced knowledge.

Findings that have been recorded and averaged may create an impression of precision but are in reality the equivalent of trying to reproduce a vast and complex mountain range in relatively simple geometric shapes. In addition, the process of international comparison can never be freed from questions of translation, culture, and custom.

But a start has been made.

All families in OECD countries today are aware that childhood is being re-shaped by forces whose mainspring is not necessarily the best interests of the child. At the same time, a wide public in the OECD countries is becoming ever more aware that many of the corrosive social problems affecting the quality of life have their genesis in the changing ecology of childhood. Many therefore feel that it is time to attempt to re-gain a degree of understanding, control and direction over what is happening to our children in their most vital, vulnerable years.

That process begins with measurement and monitoring. And it is as a contribution to that process that the *Innocenti Research Centre* has published this initial attempt at a multi-dimensional overview of child well-being in the countries of the OECD. ■

The choice of indicators for this assessment of child well-being in OECD countries is heavily circumscribed by the limited availability of internationally comparable data. But the selection and deployment of the data that are available reflects a concept of child well-being which needs to be spelt out.

Its starting point is the *Convention on the Rights of the Child* that has been agreed on by virtually all countries.

Although universal in status, the *Convention* acknowledges that child economic, social and cultural rights must be implemented progressively taking into account the specific context of each nation. The right to '*an adequate standard of living*' (Article 27) or to '*the highest attainable standard of health care*' (Article 24), for example, calls for national definitions and is dependent on the resources and commitment of the society in which the child lives.

By concentrating on the well-being of children in a group of the world's economically developed countries, this *Report Card* is able to give some degree of practical expression to this ideal: a country cannot be said to be securing for its children the '*highest attainable standard of health care*' or investing in its children '*to the maximum extent of available resources*' if children have no priority on the national agenda and if other countries at a similar stage of economic development are demonstrably achieving higher standards of health care and investing more resources in children.

Unfortunately, a lack of internationally comparable data has prevented the report from adequately addressing some important dimensions of children's lives. By and large, internationally comparable data tend to depict the situation of children who are living at home and in mainstream education, whereas the *Convention* requires that particular attention be devoted to excluded and disadvantaged children such as those living with disabilities, those who are refugees, those from ethnic minorities, those from immigrant families, and those being cared for in institutions.

In other respects, the report is able to shadow the *Convention*

Material goods and leisure activities were not, in general, seen as top priority by children. Relationships with family were seen as the most important determinant of well-being, followed by friends, school, and pets (the fact that 'health and safety' did not feature highly in children's priorities shows that there is still a place for adult input in the selection of indicators).

Efforts to develop multi-dimensional indicators are also underway in Austria, in France, and in Germany (where indicators are based on the concept of *Lebenslage* – defining child well-being by the scope given for the development of each child's interests and capabilities). UNICEF has also supported efforts to develop multi-dimensional indicators of child well-being not only in the world's poorest countries but in Ecuador, Argentina and Mexico (an OECD country which would have been included in this *Report Card* had internationally comparable data been available).

International measurement

The monitoring and comparison of child well-being faces even greater data problems when the focus shifts, as in this report, to international comparison. But this is slowly changing. The HBSC and PISA surveys quoted extensively in this report (see box) have added enormously to our knowledge of children's well-being and of what, in practice, constitutes '*the highest available standard*' in such fields as health care and education.

In addition to these efforts, an international expert group drawn from different academic disciplines launched the *Multi-National Project for Monitoring and Measuring Children's Well-Being* (<http://multinational-indicators.chapinhall.org>). This initiative arose partly in response to UNICEF's own *Progress of Nations* report which attempted to monitor the well-being of children in developing countries using basic yardsticks such as rates of malnutrition, immunization, and primary school enrolment. Such measures were found to be of limited relevance in countries where the most basic of physical needs are met for the great majority, and this sparked a search for ways and means of monitoring progress 'beyond the basics'. After initial discussions in the late 1990s, a second stage of the work has

concentrated on a scientific protocol for collecting data on child well-being and on building a network of researchers to collaborate on collecting and disseminating the necessary data. The participants in this project agreed on some 50 indicators, grouped under five domains – safety and physical status, personal life, civic life, children's economic resources and contributions, and children's activities. After more than a decade of work, the project has eventually led, in 2006, to the establishment of an *International Society for Child Indicators (ISCI)*. The aim of the society is to develop a network dedicated to improving measurement, data collection, analysis, and the dissemination of information about the status of children. ISCI further seeks to enhance the capacity of countries in the initial stages of producing child well-being indicators, and to strengthen links between measurement, analysis and policy.

Six dimensions

The overview of child well-being set out in this *Report Card* has drawn upon and learnt from all of these efforts (which clearly share much common ground).

In practice, data for 'ideal indicators' of the different aspects of child well-being were often unavailable (or not available on an internationally comparable basis). In such cases, it was decided to press ahead using the best data available for the countries under review.

The result is an overview which, despite the acknowledged gaps and inadequacies, represents a significant improvement on any international assessment of overall child well-being currently unavailable.

The *Report Card* aims to make as transparent as possible the method by which each dimension has been assessed. Further information and background papers, including reference to the raw data used, are available via the web site of UNICEF's Innocenti Centre at www.unicef.org/irc

*Bradshaw, J. and Mayhew, E. (eds.) (2005) *The well-being of children in the UK*, Save the Children, London.

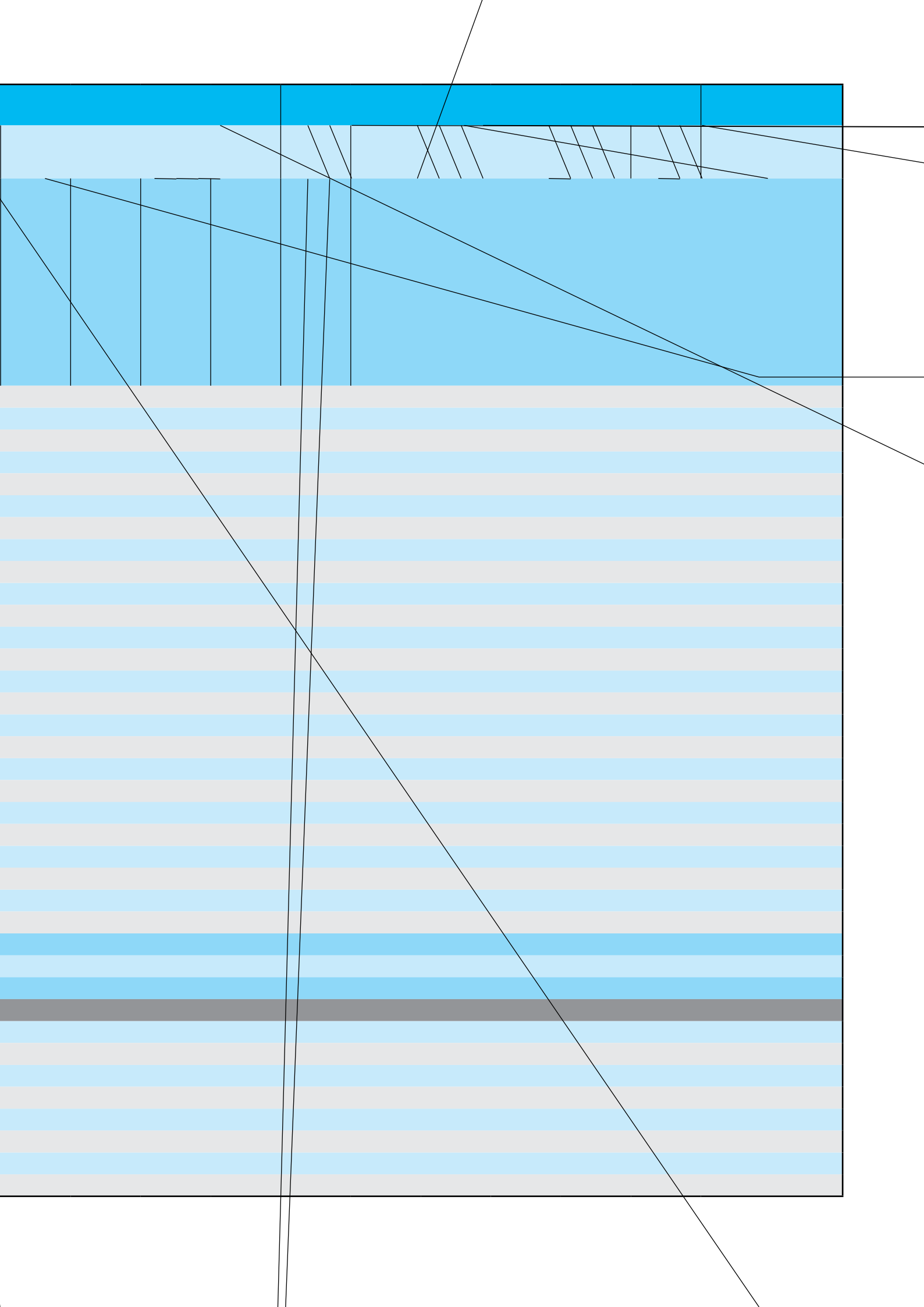
| Dimensions | Material well-being | | | | | Health and safety | | | | |
|------------------------|---|--|---|---|---|---|---|---|---|--|
| Components | Child income poverty | Deprivation | | | Work | Health at birth | | Immunization | | |
| Indicators / Countries | Percentage of children (0-17) in households with equivalent income less than 50 per cent of the median: most recent data. | Percentage of children reporting low family affluence, aged 11, 13 and 15: 2001. | Percentage of children aged 15 reporting less than six educational possessions: 2003. | Percentage of children aged 15 reporting less than ten books in the home: 2003. | Percentage of working-age households with children without an employed parent OECD: most recent data. | Infant mortality rate (per 1000 live births): most recent data. | Low birth rate (% births less than 2500g): most recent data | Measles: % children immunized aged 12-23 months: 2003 | DPT3: % children immunized aged 12-23 months: 2002. | Polio 3: % children immunized aged 12-23 months: 2002. |
| Australia | 11.6 | | 16.4 | 4.9 | 9.5 | 4.8 | 6.4 | 93 | 93 | 93 |
| Austria | 13.3 | 16.8 | 16.7 | 9.3 | 2.1 | 4.5 | 7.1 | 79 | 83 | 82 |
| Belgium | 6.7 | 16.9 | 21.0 | 11.7 | 4.0 | 4.3 | 6.5 | 75 | 90 | 95 |
| Canada | 13.6 | 10.7 | 21.9 | 6.4 | 3.0 | 5.4 | 5.8 | 95 | 91 | 89 |
| Czech Republic | 7.2 | 40.2 | 27.8 | 1.9 | 7.2 | 3.9 | 6.6 | 99 | 98 | 97 |
| Denmark | 2.4 | 13.5 | 27.2 | 7.4 | 4.1 | 4.4 | 5.5 | 96 | 98 | 98 |
| Finland | 3.4 | 17.8 | 20.5 | 5.1 | 3.1 | 3.1 | 4.1 | 97 | 98 | 95 |
| France | 7.3 | 16.1 | 25.4 | 9.1 | 6.2 | 3.9 | 6.6 | 86 | 97 | 98 |
| Germany | 10.9 | 16.4 | 17.6 | 6.9 | 8.8 | 4.2 | 6.8 | 92 | 89 | 95 |
| Greece | 12.4 | 28.7 | 61.8 | 7.2 | 2.4 | 4.8 | 8.3 | 88 | 88 | 87 |
| Hungary | 13.1 | 38.7 | 44.1 | 4.1 | 11.3 | 7.3 | 8.7 | 99 | 99 | 99 |
| Iceland | | | 8.4 | 3.3 | | 2.4 | 3.1 | 93 | 95 | 91 |
| Ireland | 15.7 | 20.7 | 31.0 | 10.4 | 6.9 | 5.1 | 4.9 | 78 | 85 | 84 |
| Italy | 15.7 | | 25.8 | 9.0 | 3.8 | 4.3 | 6.5 | 83 | 96 | 96 |
| Japan | 14.3 | | 53.3 | 9.8 | 0.4 | 3.0 | 9.1 | 99 | 96 | 81 |
| Netherlands | 9.0 | 9.0 | 18.3 | 12.6 | 5.7 | 4.8 | 5.4 | 96 | 98 | 98 |
| New Zealand | 14.6 | | 21.9 | 6.1 | 7.1 | 5.6 | 6.1 | 85 | 90 | 82 |
| Norway | 3.6 | 5.8 | 11.9 | 4.6 | 4.6 | 3.4 | 4.9 | 84 | 91 | 91 |
| Poland | 14.5 | 43.1 | 42.5 | 8.4 | 9.3 | 7.0 | 5.9 | 97 | 99 | 98 |
| Portugal | 15.6 | 28.9 | 33.9 | 12.9 | 1.7 | 4.1 | 7.4 | 96 | 98 | 96 |
| Spain | 15.6 | 22.4 | 24.7 | 4.4 | 4.2 | 4.1 | 6.8 | 97 | 96 | 96 |
| Sweden | 3.6 | 9.2 | 18.2 | 4.5 | 2.7 | 3.1 | 4.5 | 94 | 98 | 99 |
| Switzerland | 6.8 | 13.1 | 22.7 | 10.9 | 1.8 | 4.3 | 6.5 | 82 | 95 | 94 |
| United Kingdom | 16.2 | 15.3 | 20.1 | 9.4 | 7.9 | 5.3 | 7.6 | 80 | 91 | 91 |
| United States | 21.7 | 13.1 | 24.2 | 12.2 | 2.3 | 7.0 | 7.9 | 93 | 94 | 90 |
| Mean | 11.2 | 19.8 | 27.0 | 7.9 | 5.0 | 4.6 | 6.4 | 90 | 94 | 93 |
| Standard Dev | 5.1 | 10.7 | 12.2 | 3.1 | 2.9 | 1.2 | 1.4 | 8 | 5 | 6 |
| REVERSED | YES | YES | YES | YES | YES | YES | YES | NO | NO | NO |
| Non-OECD Countries | | | | | | | | | | |
| Croatia | | 43.5 | | | | 6.0 | 6.0 | 95 | 95 | 95 |
| Estonia | | 40.1 | | | | 8.0 | 4.0 | 95 | 97 | 98 |
| Israel | | 27.5 | 13.1 | 8.8 | 5.0 | 5.0 | 8.0 | 95 | 97 | 93 |
| Latvia | | 55.9 | 58.4 | 3.3 | | 10.0 | 5.0 | 99 | 97 | 98 |
| Lithuania | | 53.1 | | | | 8.0 | 4.0 | 98 | 95 | 97 |
| Malta | | 43.1 | | | | 5.0 | 6.0 | 90 | 95 | 95 |
| Russian Federation | | 58.3 | 72.7 | 4.4 | | 16.0 | 6.0 | 96 | 96 | 97 |
| Slovenia | | 20.5 | | | | 4.0 | 6.0 | 94 | 92 | 93 |

Italics indicates data that have not been used in the corresponding league table because other data relevant to that component were unavailable.

| | Educational well-being | | | | | | Peer and family relationships | | | Dimensions |
|---|--|--|--|---|--|---|--|--|---|------------------------|
| Child mortality | Achievement | | | Participation | Aspirations | | Family structure | | Family relations | Components |
| Deaths from accidents and injuries per 100,000 under 19 years, average of latest three years available. | Reading literacy achievement aged 15: 2003 | Mathematics literacy achievement aged 15: 2003 | Science literacy achievement aged 15: 2003 | Full-time and part-time students in public and private educational institutions aged 15-19 as a percentage of the population of 15-19 year-olds: 2003 | Percentage of 15-19 year-olds not in education or employment: 2003 | Percentage of pupils aged 15 years aspiring to low skilled work: 2003 | Percentage of young people living in single-parent family structures, aged 11, 13 and 15: 2001 | Percentage of young people living in step family structure, aged 11, 13 and 15: 2001 | Percentage of students whose parents eat their main meal with them around a table several times a week, aged 15: 2000 | Indicators / Countries |
| 15.1 | 525 | 524 | 525 | 82.1 | 6.8 | 24.6 | | | 69.9 | Australia |
| 15.0 | 491 | 506 | 491 | 77.3 | 10.2 | 33.1 | 12.5 | 7.5 | 68.2 | Austria |
| 15.1 | 507 | 529 | 509 | 93.9 | 7.1 | 19.1 | 9.2 | 8.1 | 89.7 | Belgium |
| 14.8 | 528 | 532 | 519 | | 6.7 | 22.0 | 14.6 | 10.5 | 71.8 | Canada |
| 18.7 | 489 | 516 | 523 | 90.1 | 5.8 | 39.3 | 13.4 | 12.2 | 72.9 | Czech Republic |
| | 492 | 514 | 475 | 84.7 | 3.0 | 21.9 | 16.5 | 13.5 | 85.6 | Denmark |
| 14.9 | 543 | 544 | 548 | 86.0 | 9.8 | 27.3 | 14.6 | 11.0 | 59.8 | Finland |
| 12.5 | 496 | 511 | 511 | 87.2 | 14.0 | 41.2 | 11.0 | 9.7 | 90.4 | France |
| 13.4 | 491 | 503 | 502 | 89.0 | 4.7 | 34.1 | 12.8 | 9.2 | 81.5 | Germany |
| 13.5 | 472 | 445 | 481 | 82.6 | 9.3 | 18.3 | 7.5 | 1.2 | 69.6 | Greece |
| 16.1 | 482 | 490 | 503 | 83.4 | 6.8 | 30.7 | 13.4 | 7.0 | 74.7 | Hungary |
| 11.6 | 492 | 515 | 495 | 83.0 | 4.3 | 32.9 | | | 90.8 | Iceland |
| 15.0 | 515 | 503 | 505 | 84.4 | 5.2 | 24.2 | 10.3 | 3.5 | 77.1 | Ireland |
| 9.2 | 476 | 466 | 486 | 77.8 | 10.5 | 25.1 | 7.0 | 2.2 | 93.8 | Italy |
| 12.8 | 498 | 534 | 548 | | | 50.3 | | | 85.6 | Japan |
| 9.0 | 513 | 538 | 524 | 84.9 | 4.6 | 34.0 | 10.7 | 6.1 | 90.0 | Netherlands |
| 23.1 | 522 | 523 | 521 | 67.0 | | 24.5 | | | 64.4 | New Zealand |
| 13.0 | 500 | 495 | 484 | 85.3 | 2.7 | 29.8 | 16.2 | 12.5 | 87.3 | Norway |
| 18.3 | 497 | 490 | 498 | 88.2 | 3.3 | 17.1 | 10.2 | 2.4 | 78.4 | Poland |
| 19.9 | 478 | 466 | 468 | 70.9 | 8.8 | 18.5 | 9.8 | 5.8 | 86.2 | Portugal |
| 12.1 | 481 | 485 | 487 | 78.5 | 7.3 | 25.3 | 9.1 | 3.0 | 83.4 | Spain |
| 7.6 | 514 | 509 | 506 | 86.8 | 4.2 | 28.7 | 16.8 | 12.7 | 84.1 | Sweden |
| 12.3 | 499 | 527 | 513 | 83.1 | 8.0 | 39.7 | 12.5 | 6.7 | 89.9 | Switzerland |
| 8.4 | 507 | 508 | 518 | 75.9 | 9.4 | 35.3 | 16.9 | 14.5 | 66.7 | United Kingdom |
| 22.9 | 495 | 483 | 491 | 75.4 | 7.0 | 14.4 | 20.8 | 16.0 | 65.7 | United States |
| 14.3 | 500 | 505 | 504 | 82.5 | 6.9 | 27.5 | 12.7 | 8.3 | 79.4 | Mean |
| 4.1 | 18 | 24 | 19 | 6.3 | 2.8 | 7.6 | 3.5 | 4.4 | 9.8 | Standard Dev |
| YES | NO | NO | NO | NO | YES | YES | YES | YES | NO | REVERSED |
| | | | | | | | | | | Non-OECD Countries |
| 17.7 | | | | | | | 7.4 | 2.8 | | Croatia |
| 39.4 | | | | | | | 17.7 | 8.8 | | Estonia |
| 60.0 | 452 | 433 | 434 | 65.6 | 25.2 | 35.2 | 9.3 | 3.9 | 58.3 | Israel |
| 43.3 | 491 | 483 | 489 | | | 23.5 | 18.6 | 9.0 | 82.9 | Latvia |
| 31.7 | | | | | | | 13.5 | 6.8 | | Lithuania |
| 7.3 | | | | | | | 4.8 | 1.7 | | Malta |
| 56.1 | 442 | 468 | 489 | 29.3 | | 30.5 | 16.9 | 6.8 | 90.6 | Russian Federation |
| 23.3 | | | | | | | 8.7 | 3.8 | | Slovenia |

| Dimensions | Peer and family relationships | | Behaviours and risks | | | | | | | |
|------------------------|--|---|---|---|--|--|---|--|---|---|
| | Family relations | Peer relations | Risk behaviour | | | | | | Experiences of violence | |
| Components | | | | | | | | | | |
| Indicators / Countries | Percentage of students whose parents spend time just talking to them several times per week, aged 15: 2000 | Percentage of young people finding their peers 'kind and helpful', aged 11, 13 and 15: 2001 | Percentage smoking cigarettes at least once per week, aged 11, 13, 15: 2001 | Percentage of young people who have been drunk two or more times, aged 11, 13, 15: 2001 | Percentage of young people who have used cannabis in the last 12 months, aged 15: 2001 | Adolescent fertility rate, births per 1000 women aged 15-19: 2003. | Percentage of young people who have had sexual intercourse, aged 15: 2001 | Percentage of young people who used a condom during their last sexual intercourse, aged 15: 2001 | Percentage of young people involved in physical fighting in previous 12 months, aged 11, 13, 15: 2001 | Percentage of young people who were bullied at least once in the last 2 months, aged 11, 13, 15: 2001 |
| Australia | 51.3 | | | | | 18.0 | | | | |
| Austria | 47.1 | 77.2 | 13.2 | 15.1 | 11.7 | 22.0 | 20.6 | 81.9 | 38.9 | 44.0 |
| Belgium | 55.1 | 70.1 | 10.6 | 14.5 | 21.8 | 11.0 | 25.0 | 70.5 | 44.5 | 30.1 |
| Canada | 46.9 | 64.0 | 7.5 | 19.8 | 40.4 | 20.0 | 24.4 | 75.8 | 35.8 | 37.2 |
| Czech Republic | 72.0 | 43.4 | 14.3 | 14.7 | 27.1 | 23.0 | 18.3 | | 47.9 | 16.1 |
| Denmark | 71.2 | 73.4 | 8.2 | 20.1 | 21.3 | 8.0 | | | 38.4 | 31.3 |
| Finland | 78.8 | 70.4 | 14.0 | 24.7 | 7.5 | 10.0 | 28.1 | 65.6 | 25.1 | 23.9 |
| France | 63.9 | 53.7 | 11.5 | 8.0 | 27.5 | 10.0 | 22.2 | 82.0 | 37.5 | 35.1 |
| Germany | 42.5 | 76.1 | 16.4 | 17.7 | 18.5 | 14.0 | 28.0 | 70.0 | 28.1 | 36.5 |
| Greece | 58.1 | 60.2 | 6.1 | 10.0 | 4.2 | 17.0 | 21.6 | 86.9 | 44.3 | 24.5 |
| Hungary | 90.2 | 64.9 | 12.6 | 16.4 | 12.4 | 27.0 | 21.0 | 78.2 | 48.0 | 23.0 |
| Iceland | 43.9 | | | | | | | | | |
| Ireland | 62.0 | 67.0 | 9.6 | 13.8 | 20.0 | 15.0 | | | 39.8 | 26.1 |
| Italy | 87.2 | 55.1 | 10.9 | 9.7 | 20.5 | 8.0 | 23.9 | | 38.2 | 27.3 |
| Japan | 60.2 | | | | | 4.0 | | | | |
| Netherlands | 70.6 | 73.2 | 10.7 | 12.9 | 21.6 | 5.0 | 22.9 | 77.9 | 36.3 | 29.4 |
| New Zealand | 51.9 | | | | | 30.0 | | | | |
| Norway | 64.0 | 74.3 | 10.1 | 15.6 | | 10.0 | | | 36.9 | 32.3 |
| Poland | 49.7 | 60.2 | 11.2 | 15.2 | 15.1 | 16.0 | 15.1 | 73.0 | 38.7 | 30.2 |
| Portugal | 70.6 | 80.0 | 12.5 | 12.6 | 19.7 | 23.0 | 25.3 | 73.2 | 35.2 | 48.5 |
| Spain | 60.2 | 59.2 | 12.8 | 10.2 | 30.8 | 9.0 | 16.4 | 89.1 | 40.4 | 26.0 |
| Sweden | 51.6 | 76.7 | 7.0 | 16.1 | 4.7 | 9.0 | 28.1 | 65.3 | 34.8 | 15.0 |
| Switzerland | 48.6 | 81.4 | 11.0 | 13.6 | 37.8 | 5.0 | 22.9 | 80.7 | 31.2 | 40.5 |
| United Kingdom | 60.5 | 43.3 | 13.1 | 30.8 | 34.9 | 28.0 | 38.1 | 70.2 | 43.9 | 35.8 |
| United States | 67.9 | 53.4 | 7.3 | 11.6 | 31.4 | 46.0 | | | 36.1 | 33.9 |
| Mean | 62.8 | 65.6 | 11.0 | 15.4 | 21.4 | 16.0 | 23.6 | 76.0 | 38.1 | 31.0 |
| Standard Dev | 13.1 | 11.3 | 2.7 | 5.2 | 10.4 | 9.8 | 5.3 | 7.2 | 5.8 | 8.2 |
| REVERSED | NO | NO | YES | YES | YES | YES | YES | NO | YES | YES |
| Non-OECD Countries | | | | | | | | | | |
| Croatia | | 72.5 | 9.7 | 13.6 | 14.3 | 18.0 | 16.5 | 74.2 | 37.7 | 24.5 |
| Estonia | | 57.5 | 12.4 | 23.9 | 14.4 | 28.0 | 18.0 | 73.2 | 47.6 | 44.2 |
| Israel | 36.9 | 63.9 | 8.4 | 9.3 | 7.0 | 23.0 | 21.1 | 81.5 | 39.3 | 35.8 |
| Latvia | 63.7 | 54.4 | 12.5 | 16.5 | 8.0 | 32.0 | 18.0 | 79.2 | 40.3 | 48.4 |
| Lithuania | | 51.7 | 12.2 | 24.7 | 6.0 | 33.0 | 18.6 | 76.3 | 49.0 | 64.3 |
| Malta | | 69.2 | 10.0 | 10.7 | 6.0 | | | | 41.5 | 24.1 |
| Russian Federation | 78.4 | 45.6 | 12.5 | 19.4 | 8.8 | 46.0 | 28.7 | | 43.3 | 37.7 |
| Slovenia | | 74.3 | 12.0 | 18.2 | 24.4 | 9.0 | 26.2 | 74.0 | 40.5 | 21.9 |

Italics indicates data that have not been used in the corresponding league table because other data relevant to that component were unavailable.



NOTES

1 The overall ranking for the United States is determined by its average rank over five of the six indicators, insufficient data being available for the 'Subjective well-being' category.

2 But see *Report Card 5*, September, 2003, which attempted to address this issue.

3 This is the same measure used in *Report Card 6*: Child Poverty in Rich Countries. (Sources may differ as the data has here been updated.)

4 It is notable that over 90% of young people in Northern and Western Europe have their own bedrooms.

5 Countries with systematic ante-natal screening for serious disability, and the option of abortion, tend to have lower infant mortality rates. National efforts to

combat Sudden Infant Death Syndrome may also lower IMRs.

6 There are some limitations to the validity of low birth weight as an indicator of infant and child health in different societies. It is more common, for example, in some ethnic groups and in multiple births (often associated with in vitro fertilization).

7 Misleading publicity linking the MMR vaccine to autism may affect measles immunization levels as an indicator of health service comprehensiveness, as lower levels of take-up in some countries may reflect the extent of parental alarm rather than inadequacies in outreach.

8 *Innocenti Report Card 2* (2001) page 2

9 *Innocenti Report Card 2* (2001) page 2

10 *Innocenti Report Card 2* (2001)

11 Using Purchasing Power Parities.

12 *Innocenti Report Card 4*, November 2002, ref 3, p. 6.

13 HBSC. p 28

14 *Innocenti Report Card 5*, September 2003

15 In the HBSC survey Belgian data were collected separately from both French and Flemish speaking regions. For the purposes of international comparison the Flemish data (the largest sample) has been used in this *Report Card*. In the case of the United Kingdom, data were collected separately for England, Scotland and Wales; data for England (the largest sample) has been used here. In Germany data was collected using a regional sample (Berlin, Hessen, North Rhine-Westphalia and Saxony).

SOURCES AND BACKGROUND INFORMATION

Material deprivation

The data for Figure 1.1 are from Förster, M. and D'Ercole, M. (2005) 'Income Distribution and Poverty in OECD Countries in the Second Half of the 1990s', OECD Social, Employment and Migration Working Papers: Paris France, OECD. Belgian data come from the Luxembourg Income Study (LIS), accessed at <http://www.lisproject.org/keyfigures.htm> on May 30th 2006. In both cases the poverty threshold is set at 50 per cent of the median disposable income of the total population.

Figure 1.2 uses data from the OECD Income Distribution questionnaires for the various years. Assistance with the access to these data was provided by Anna D'Addio at the Directorate for Employment, Labour and Social Affairs at the OECD. Israeli data was provided by Asher Ben-Arieh from The Paul Baerwald School of Social Work and Social Welfare, The Hebrew University of Jerusalem.

Sources drawn upon extensively in this *Report Card* include the OECD *Programme for International Student*

Assessment (PISA); and the World Health Organization's survey of *Health Behaviour in School-age Children (HBSC) 2001*, reported in Currie, C., et al (eds) (2004) 'Young People's Health in Context. Health Behaviour in School-age Children Study' (HBSC): International report from the 2001/2002 study, WHO Regional Office for Europe. Figures 1.3a through 1.3c are derived from these sources.

Figure 1.3a reports results from the Family Affluence Scale (FAS) which identifies the percentage of children from each country who self report low levels of wealth based upon 'family item' ownership of a car, van or truck, whether they have their own bedroom, the number of family holidays in the last twelve months, and the number of computers owned by the family. With positive answers adding to a possible score of eight, the percentage of children in each nation scoring three points or below on the FAS scale is used as the indicator of deprivation (Currie et al., 2004: 15). For all of the HBSC data in this *Report Card*, German data are from a regional sample of four lander; Flemish data are used for Belgium. and English data for the UK.¹⁵

Figures 1.3 b and c are sourced from the OECD PISA survey (2003). A copy of the international dataset was downloaded at http://pisaweb.acer.edu.au/oeecd_2003/oeecd_pisa_data.html in August 2005. As with all 2003 OECD PISA data for the UK in this *Report Card*, results are to be treated with caution due to low initial sample response rates and low replacement rates for the English sub-sample. A sampling problem is also found for the Netherlands data for OECD PISA 2000. The indicator for Figure 1.3b identifies the percentage of children aged 15 in each country with less than six (the OECD median) educational items (out of eight). The eight items include: a desk to study at, a quiet place to study, a computer for school work, educational software, an internet connection, a calculator, a dictionary, and school text books. Israeli data for Figures 1.3b and 1.3c are taken from comparable questions in the OECD PISA survey 2000. A copy of the international dataset for OECD PISA 2000 was downloaded at http://pisaweb.acer.edu.au/oeecd/oeecd_pisa_data.html in August 2005.

Health and safety

OECD health data for 2005 were used to populate Figures 2.1a and 2.1b accessed at the Source OECD website <http://www.sourceoecd.org/database/healthdata> in January 2006. Figure 2.2 is made up of immunization rates for Measles, DPT3 and POL3. The figures for the latter two measures were accessed using the World Bank's Health Nutrition and Population Database at <http://devdata.worldbank.org/hnpstats/query/default.html> in August 2005, and in each case represent the final dose in a series of immunizations that can prevent diphtheria, pertussis, tetanus, and poliomyelitis. Measles data were taken from the World Development Indicators 2005 accessed at <http://www.worldbank.org/data/wdi2005/index.html> in August 2005.

Child mortality data are the average of the latest three years available, and taken from the World Health Organization's Mortality Database, a version of which was downloaded from <http://www3.who.int/whosis/menu.cfm?path=whosis,mort&language=english> in August 2005. Data were combined for all kinds of accidental deaths – murder, suicide and deaths with undetermined cause – into one variable. For Switzerland and the Russian Federation data are based on the new ICD10 classification. All other countries use ICD9 classifications. Interpretation and analysis of the WHO Mortality data is that of the authors and not of the World Health Organization. Israeli data were provided by Asher Ben-Arieh from The Paul Baerwald School of Social Work and Social Welfare, The Hebrew University of Jerusalem.

Education

Figure 3.1 provides a standardized composite for literacy data taken from the OECD PISA (2003) survey for measures of reading literacy, mathematics literacy and science literacy. UK results are to be treated with caution (see above).

The data for Figures 3.2 and 3.3a are sourced from the OECD's 'Education at a Glance Report 2005', accessed at <http://www.oecd.org/edu/eag2005> in April 2006. The data for Figure 3.3b are taken from 'Education at a Glance 2004' accessed in August 2005 at <http://www.oecd.org/edu/eag2004>. The data used for Figure 3.3b are generated using responses given in the OECD PISA survey (2000); for this reason, data for the Netherlands are to be treated with caution.

Children's relationships

The majority of the data for Children's relationships were taken from Currie, C., et al (eds) (2004) 'Young People's Health in Context. Health Behaviour in School-age Children Study' (HBSC): International report from the 2001/2002 Study, WHO Regional Office for Europe. Figures 4.1a, 4.1b and 4.3 are all derived from this report. The data for single and step parent proportions are living condition data as opposed to outcome data, and as such are applicable for all age groups who live with an individual of the sample age group. Furthermore the impact of growing up with a single-parent on children's well-being might differ across countries. Some countries (for example the Nordic group) have much higher rates of single-parent families than, for example, the countries of Southern Europe. Cross-national differences in public acceptance of single-parenthood, in legislation and practice concerning custody and the extent to which policies cater for the needs of single-parents (e.g. benefits, child care, flexible employment arrangements) might be reflected in children's well-being.

Data for Figures 4.2a and 4.2b are taken from OECD PISA (2000), downloaded at http://pisaweb.acer.edu.au/oecd/oecd_pisa_data.html in August 2005.

Behaviour and lifestyles

This dimension is made up entirely of data derived from Currie, C., et al (eds) (2004) 'Young People's Health in Context. Health Behaviour in School-age Children Study' (HBSC): International report from the 2001/2002 Study, WHO Regional Office for Europe, with the exception of Figure 5.2f which used the World Development Indicators data accessed at <http://www.worldbank.org/data/wdi2005/index.html> in August 2005.

For Figures 5.1a to 5.1c cross-national differences may influence final standings. For Figure 5.1a differences across countries might be influenced by cultural differences regarding eating habits. For 5.1b country variation might be influenced by the availability and prices of fruit across countries. The authors of the HBSC report also point to seasonal differences in the timing of fieldwork that may have impacted on the results. For Figure 5.1c a range of factors might influence children's physical activity within and across countries, including the amount and organization of physical education at school, children's mode of travel to

school, and the availability and accessibility of leisure facilities. For Figure 5.1d data response rates were particularly low; this led to data for 11 year-olds being omitted. As the Body Mass Index data were calculated using self-reported weight and height, this meant children were required to know (and be willing to report) their height and weight. An analysis of cases with missing data showed that young people who did not report their height and weight were less likely to come from higher socio-economic groups, less likely to be physically active and to consume fruit, vegetables and sweets and in many countries more likely to be dieting or to feel the need to lose weight. It is therefore likely that the prevalence of overweight is underestimated (Currie et al., 2004).

For Figure 5.2e, identifying condom use in the countries of study, there is a relatively high number of missing countries as not all countries that participated in HBSC included questions on sexual behaviour. This question was only answered by the sub-sample that already had sexual relationships so that sample sizes are reduced for each country to 15 to 38 per cent of the original sample.

Subjective well-being

Data for the figures presented in the final dimension were also taken in the majority from Currie, C., et al (eds) (2004) 'Young People's Health in Context. Health Behaviour in School-age Children Study' (HBSC): International report from the 2001/2002 study, WHO Regional Office for Europe. Figures 6.1, 6.2 and 6.3a are all derived from this source, and as such UK and Belgian results are to be treated with caution (See note on Figure 1.3a). For Figure 6.3a, which reports levels of life satisfaction, children aged 11, 13 and 15 were asked to score their lives at present on a scale (ladder) of one to ten in terms of satisfaction (the Cantril self-anchoring life satisfaction Ladder); the results presented are the proportions of each country's sample reporting six or over (best possible life at the top, worst possible life at the bottom).

Figure 6.3b is sourced from the OECD PISA survey 2003 accessed at http://pisaweb.acer.edu.au/oecd_2003/oecd_pisa_data.html in August 2005. UK results should be treated with caution. The United States did not provide responses to these items.

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UNICEF Innocenti Research Centre advisors

Marta Santos Pais
Director

David Parker
Deputy Director

Eva Jespersen
Social and Economic Policies Unit

External advisors

Jonathan Bradshaw
Professor of Social Policy
Department of Social Policy
and Social Work
University of York
United Kingdom

Dominic Richardson
Research Fellow
Social Policy Research Unit
Department of Social Policy
and Social Work
University of York
United Kingdom

Petra Hoelscher
Research Fellow
University of Stirling
Scotland

Asher Ben-Arieh
Associate Director for Research
and Development
Israel National Council for the Child
Paul Baerwald School of Social Work
The Hebrew University of Jerusalem
Israel

Anna Cristina D'Addio
ELS/Social Policy
Directorate of Employment, Labour
and Social Affairs
OECD
Paris
France

Mike Lewis
Director
Children in Wales
Cardiff
UK

Eric Marlier
International Senior Advisor
CEPS/INSTEAD Research Institute
Luxembourg

Brian Nolan
Research Professor
Social Policy Research
Economic and Social
Research Institute (ESRI)
Dublin
Ireland

Sue Richardson
Director
National Institute of Labour Studies
Flinders University
Adelaide
Australia

Hirokazu Yoshikawa
Associate Professor of Psychology
and Public Policy
Department of Psychology
New York University
New York, NY 10003

Additional comments were provided by:

Gordon Alexander
UNICEF Regional Office for CEE/CIS
Geneva

Patrice Engle
UNICEF, New York

Alberto Miniujn
Consultant

Yuko Nonoyama
UNICEF, New York

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and Angela Bartlett of mccddesign.

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Also available from the UNICEF
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