

Definition and measurement

Measures of subjective well-being are a useful complement to objective measures of living standards in comparing quality of life across countries (EFILWC, 2003). These data provide a measure of the subjective evaluation of an individual's health, education, income, personal fulfilment and social conditions. The indicators shown here are based on survey responses to two standard questions: first, how satisfied are respondents with their own life as a whole; and second, how happy do they feel. The indicators of subjective well-being presented here – as well as those on social isolation and group membership presented later in this volume – use data from the *World Values Surveys* of 1999-2002. In these surveys, respondents rate life satisfaction on an increasing scale of 1 to 10, and the indicator shown refers to the proportion of respondents indicating a score of 7 or above. Feelings of happiness are scored according to four categories (“very happy”, “quite happy”, “not very happy” and “not at all happy”), and the indicator shown refers to the proportion of respondents reporting that they feel quite or very happy.

The *World Values Surveys* cover over 80 countries containing 85% of the world's population. The use of a common questionnaire allows for a comparison of beliefs and values on a broad range of aspects such as perceptions of life, work, family, the environment, politics and religion. Previous waves of these surveys were conducted in 1981-82, 1990-91 and 1995-96. Although the questionnaires used in each country have a similar structure, the exact wording may change as questions asked are sometimes adjusted to reflect individual country characteristics. Sample sizes for most OECD countries are of around 1 000 (but higher for larger countries, e.g. Turkey).

Life satisfaction and feelings of happiness for any individual can depend on the fulfilment of personal goals in a broad range of areas such as family life, work, cultural and leisure activities. Chart CO1.1 ranks OECD countries by values of a simple average of the proportions of satisfied and happy respondents around the year 2000.

In several OECD countries, more than 80% of respondents report being satisfied with their life, with this proportion exceeding 85% in the Netherlands, Iceland, Ireland, Denmark and Switzerland. These same countries also feature some of the highest happiness rates, at or above 95%. The proportion of respondents indicating that they are happy with their life is 90% or more in a majority of OECD countries. Countries at the bottom of the ranking in Chart CO1.1 have significantly lower proportions of “satisfied” or “happy” respondents. These include Eastern European countries as well as Turkey. Japan and Korea combine relatively low rates of life satisfaction and relative high rates of happiness. Across countries, these two measures of subjective well-being are highly correlated and this correlation has increased from 0.74 in 1990-91 to 0.85 in 1999-2002. Over time, there is strong persistence in country rankings according to mean life-satisfaction and happiness throughout the four waves of the surveys.

While subjective well-being may be expected to be related to several dimensions of material well-being, of special interest is whether higher incomes lead to higher life satisfaction. The first panel of

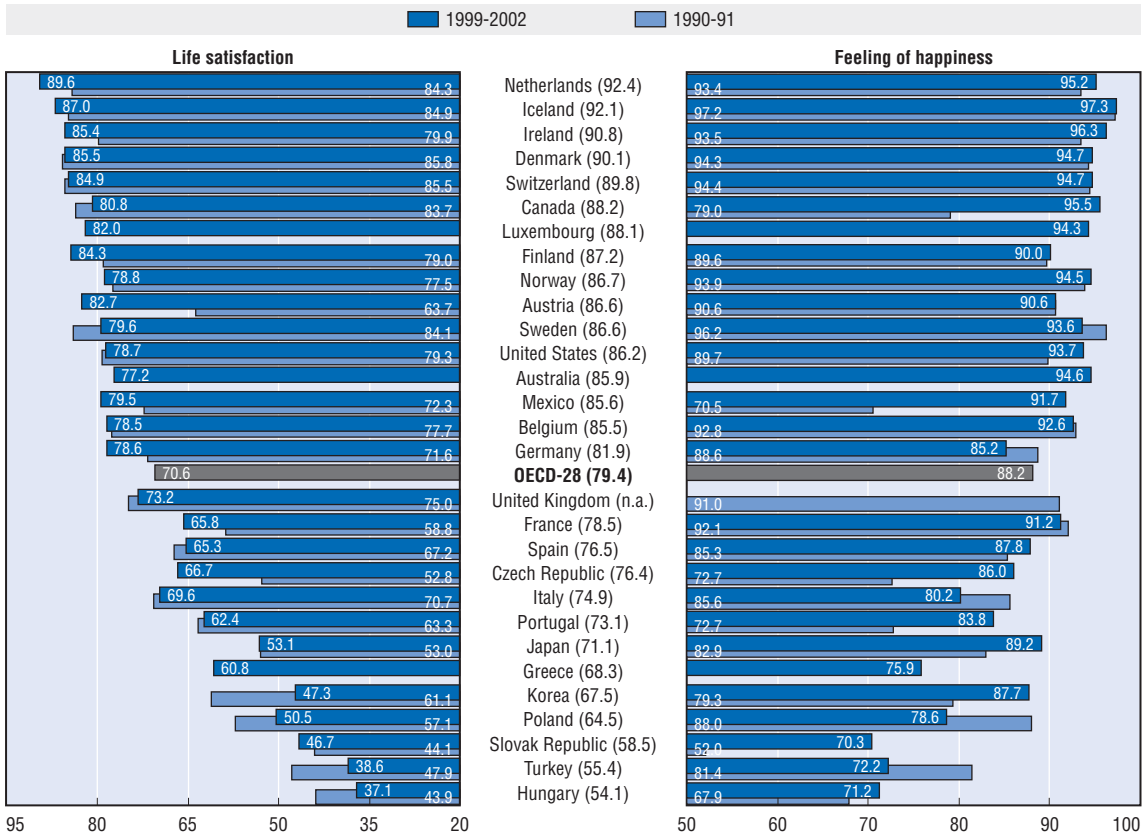
Chart CO1.2 compares the average level of the satisfaction response for each country to its per capita income (in PPP rates). Average life satisfaction tends to increase with higher per capita incomes. There is also much diversity across countries in average life satisfaction for a given level of per capita income: at per capita incomes of around USD 30 000, average satisfaction varies from 6.5 in Japan to 8.3 in Denmark. Similarly, Turkey and Mexico – the two OECD countries with the lowest per capita income – record large differences in average life satisfaction.

There is also evidence of an inverse relationship between the variance of satisfaction responses across individuals in each country and average GDP per capita (2nd panel of Chart CO1.2). The largest within-country variation of responses is observed in Turkey and the lowest in the Netherlands. In other words, as average per-capita income increases, there tends to be less and less diversity in responses to the life satisfaction question. Although this suggests that higher per capita incomes translate into lower inequalities in life satisfaction, this may also relate to the tendency for income inequality to be lower in countries with higher per capita income.

Status indicators: Income inequality (EQ2), Employment (SS1), Educational attainment (SS7), Health-adjusted life expectancy (HE2), Social isolation (CO2), Suicides (CO6).

CO1.1. Life satisfaction and feeling of happiness, 1999-2002 and 1990-91

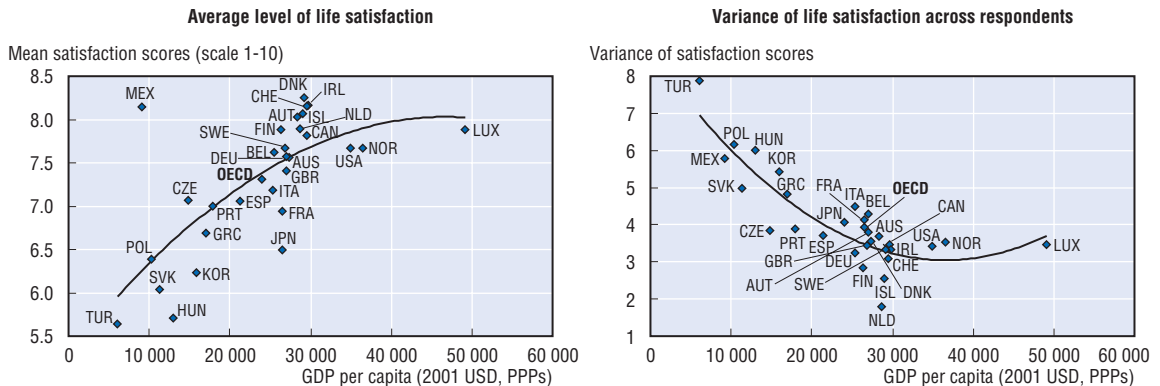
Percentage of total respondents



n.a. = Not available.

Note: Data for Germany in 1990-91 refer to West Germany only. Data for the United Kingdom refer to Great Britain only. The countries are ranked in decreasing order of the average of satisfaction and happiness levels in 1999-2002, which are shown in parentheses. Values shown at the top and bottom of each bar refer to 1990-91 and 1999-2002 responses, respectively.

CO1.2. Higher incomes lead to higher satisfaction on average, and lower differences within each country



Source: Estimates based on Inglehart, R. et al. (2004), "Human Beliefs and Values: A Cross-cultural Sourcebook", based on the 1999-2002 Values Surveys, Siglo XXI Editores, México.

StatLink: <http://Dx.doi.org/10.1787/236488100807>

Further reading: ■ EFILWC (2003), *Quality of Life in Europe: an illustrative report*, European Foundation for the Improvement of Living and Working Conditions, Dublin. ■ Diener E. and E. M. Suh (1999), "National Differences in Subjective Well-Being", in D. Kahneman, E. Deiner and Schwartz (eds.), *Well-Being – The Foundations of Hedonic Psychology*, Russel Sage Foundation, New York.

Definition and measurement

Social isolation is characterised by the lack of contact with other people in normal daily living. Social contact occurs in variety of settings – in the workplace, in social activities and within families – and can be assessed through data measuring the frequency of contacts reported by individuals.

Most of the data reported in this section are from the *World Values Surveys* of 1999-2002. Questions about the frequency of contacts with other persons ask respondents how often they spend their time socialising with family members, friends and colleagues from work; with other people in churches, mosques or synagogues; or in sports and cultural associations. Responses in each of these categories distinguish among contacts that occur: i) weekly; ii) once or twice a month; iii) rarely; and iv) never. The indicators of social isolation reported in this section measure the proportion of respondents who report spending time socialising with others only rarely or not at all. As data concerning contact with family members are only available for a limited number of countries, this category of contacts is excluded in the composite indicator shown below. People who are living alone, particularly if they are not active professionally or if they have no children at home, are exposed to special risks of social isolation: to assess the size of this group, this section presents information about the share of adults who are living alone and have no children, as available from household income surveys of member countries.

Social isolation is both a symptom and a cause of social distress. Experiences of social isolation may follow family breakdown, the loss of a job, illness or financial difficulties. Once socially isolated, individuals may face greater difficulties not only reintegrating society as a contributing member, but also fulfilling personal aspirations with respect to work, family and friends. Social isolation can be a downward spiral: feelings of exclusion affect morale, and lack of contacts with other people may reduce both social and economic opportunities.

There are significant differences across OECD countries in the proportion of respondents at risk of social isolation (Chart CO2.1). The share of respondents who report socialising with others only rarely ranges from around 15% in Japan and Mexico to less than 3% in the Netherlands and Ireland. The proportion of respondents who report never socialising with others is substantially smaller, ranging from 0.2% in Greece and Iceland to 4.7% in Mexico. In almost all countries, both these shares are lower for people in the (self-reported) high-income group than for those in the low- and middle-income groups. Those in the oldest group (50 and over) are more likely to have infrequent contacts than prime working-age (30-49 years) and young (15-29 years) respondents.

Table CO2.2 distinguishes different types of social contacts. In all countries, the proportion of people who report having infrequent contact (i.e. rarely or never) with friends is lower than those reporting lack of contacts with either colleagues or people in social

groups. In some countries, it is more common for respondents never to spend time socialising with colleagues from work than it is to see them socially only infrequently. In most countries, a majority of people rarely or never spend time with people from church, sports or cultural groups.

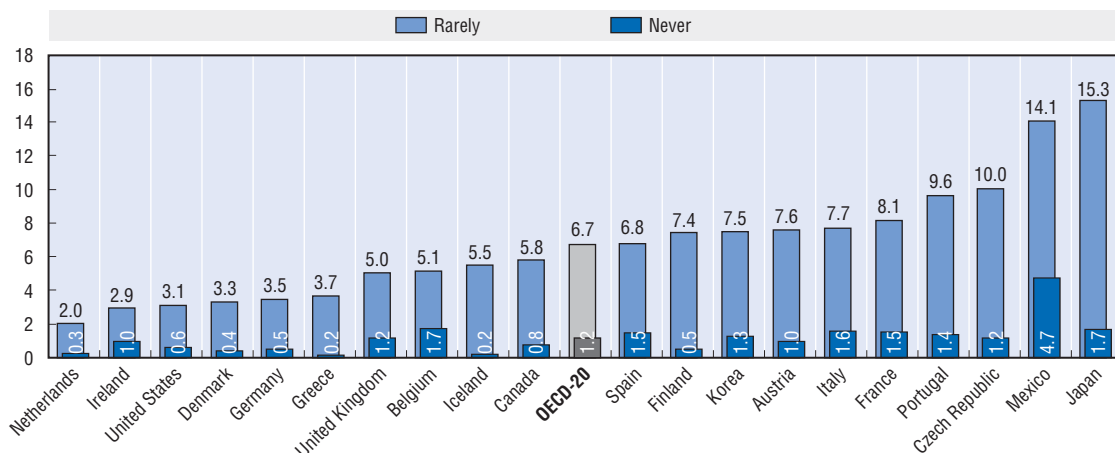
Contact with family members is, in general, far more common, although information on this is available for only a few OECD countries. The proportions of respondents indicating that they never have contacts with other family members are generally less than 5%. In Japan and Korea, however, more than one respondent in four reports rarely or never spending time with family members.

While living alone does not always imply less frequent contacts with other persons, the risks of social isolation are especially high for persons lacking social interaction within the home. The proportion of individuals living alone ranges from less than 2% in Mexico, to more than 25% in Belgium and Sweden. In all OECD countries, the probability of living alone is especially high among older people, with more than one in four in such situation on average: this proportion is above 40% in all Nordic countries, while is below 6% in Mexico and Turkey.

Status indicators: Unemployment (SS2), Jobless households (SS3), Youth inactivity (SS9), Subjective well-being (CO1), Group membership (CO3), Suicides (CO6).
Response indicators: Public social spending (EQ5).

CO2.1. Proportion of respondents who rarely or never spend time with friends, colleagues, or others in social groups

Percentages, 1999-2002



Note: The proportion “Rarely” includes those who respond either “rarely” or “never” to all of the categories of contacts (friends, colleagues or others in social groups). The proportion “Never” includes those who respond “never” to all of the categories.

CO2.2. Frequency of contacts with others in various settings

Percentages of respondents who rarely or never spend time with others, 1999-2002

	Contacts with friends		Contacts with colleagues from work		Contacts with people in social groups		Contacts with family members		Percentage of respondents living alone ¹
	Rarely	Never	Rarely	Never	Rarely	Never	Rarely	Never	
Austria	9.9	2.0	26.5	37.4	45.9	25.8	..	..	11.7
Belgium	13.6	5.2	34.3	31.2	29.1	20.2	..	..	26.0
Canada	8.1	1.8	28.2	30.3	46.0	24.4	17.5	4.2	10.0
Czech Republic	15.3	3.9	33.3	26.2	49.5	32.0	..	..	9.7
Denmark	7.5	1.8	40.0	23.0	35.1	17.7	..	..	17.9
Finland	10.9	1.0	33.8	19.1	45.7	24.8	..	..	17.6
France	11.0	2.5	24.0	44.7	57.5	43.3	..	..	11.5
Germany	12.3	1.7	39.9	21.8	24.5	12.8	..	..	17.8
United Kingdom ²	5.2	2.1	26.8	30.4	46.1	32.2	..	..	12.0
Greece	6.9	1.2	26.0	17.7	44.9	26.0	..	..	6.7
Hungary	22.0	11.8	..	..	..	..	..	..	8.9
Iceland	10.1	0.5	44.7	15.7	54.8	27.0	..	..	..
Ireland	5.2	1.6	20.4	27.1	28.1	16.7	..	..	7.5
Italy	13.3	4.6	26.4	35.0	47.5	30.6	..	..	7.4
Japan	30.1	3.7	32.3	21.3	62.2	45.0	26.7	1.5	6.8
Korea	18.1	3.7	18.6	17.8	51.1	30.3	23.3	2.2	..
Luxembourg	9.8	2.7	..	..	..	..	..	..	..
Mexico	19.8	16.1	19.5	35.9	36.7	19.3	11.0	4.4	1.8
Netherlands	6.7	1.3	35.7	18.9	30.8	20.0	..	..	16.2
Poland	22.9	9.9	..	..	..	..	..	..	3.8
Portugal	16.3	5.6	16.5	30.2	36.4	16.2	..	..	5.0
Slovak Republic	17.4	2.8	..	..	..	..	..	..	..
Spain	9.7	4.1	15.9	37.5	50.6	30.9	8.7	3.3	4.1
Sweden	5.0	0.3	37.0	9.3	23.0	14.4	..	..	25.2
Turkey	4.2	4.0	5.4	40.0	..	0.1	13.5	4.4	6.3
United States	6.3	1.5	26.6	19.5	30.0	13.8	15.9	1.9	10.2
OECD-22	11.2	3.2	27.8	26.8	41.7	23.8	..	..	..

1. Percentage of respondents living alone does not include lone parents and uses 1995 data for Belgium and Spain.

2. Data for the United Kingdom refer to Great Britain only.

Source: Estimates based on Inglehart, R. et al. (2004), “Human Beliefs and Values: A Cross-cultural Sourcebook”, based on the 1999-2002 Values Surveys, Siglo XXI Editores, México.

StatLink: <http://Dx.doi.org10.1787/847811387032>

Further reading: ■ Gallie D. and S. Paugman (2004), “Unemployment, Poverty and Social Isolation: An assessment of the current State of Social Exclusion Theory”, in D. Gallie (ed.), *Resisting Marginalisation, Unemployment Experience and Social Policy in the European Union*, Oxford.

Definition and measurement

The extent to which people participate in formal and informal groups in society is an important dimension of social cohesion. While the importance of informal networks is more difficult to quantify, the indicators presented in this section focus on membership of formal groups and associations. Even when concentrating on formal groups, it is difficult to distinguish between active and inactive membership. To assess how actively individuals are engaged in the groups to which they belong, information is also presented on the extent of volunteer work that individuals perform in each of them.

The data on group membership in this section come from the *World Values Surveys*. Data for most countries rely on the 1999-2002 wave, although for some countries data come from the 1995-96 wave. In the most recent survey, respondents were asked whether they belonged to groups of a particular type, whereas in the previous waves they were also asked whether they consider themselves to be an “active” or “inactive” member. Respondents in the most recent survey were also asked for which groups, if any, they were currently doing unpaid voluntary work. The indicator on the density of group membership is defined as the average number of groups of which respondents are members. The proportion of respondents doing unpaid work for at least one group is also shown. The groups covered in this survey include a variety of organisations and advocacy groups. These are separated into four categories: groups based on religious affiliation; sports and cultural associations; organisations with a political orientation, including labour unions; and other groups including single issue movements and specific causes (Inglehart *et al.*, 2004).

Density of associational activity is to a large measure determined by historical and cultural factors, particularly with respect to the types of groups of which people are members. In societies where membership of a single group can affect various aspects of societal life, or where the role of informal networks is relatively strong, individuals have fewer reasons to belong to different groups at the same time. Traditionally, civil society involvement in public life is strongest in Nordic countries, the Netherlands, Canada and the United States.

Chart CO3.1 shows that the mean number of groups to which respondents belong is above three in the United States, Sweden and the Netherlands, while it is below one in some southern and eastern European countries. The proportion of people who report doing voluntary work for the groups to which they belong is closely related to average membership: it is highest (at 50% or above) in the three countries mentioned above (as well as in Canada, Korea and the Slovak Republic) and lowest (at less than 10%) in Spain, Hungary, Portugal and Turkey. There is a wide variation in both group membership and volunteer work across the OECD. On average, in the OECD area, respondents are members of 1.5 groups.

Chart CO3.2 shows significant diversity across countries with respect to the types of groups in which most individuals belong. In Sweden and Iceland, high membership rates are found in both church groups and those of a political orientation, with close to 75% of respondents purporting to be members of groups

in each of the categories. In the Netherlands and Australia, roughly two out of three respondents are members of sports clubs or cultural associations.

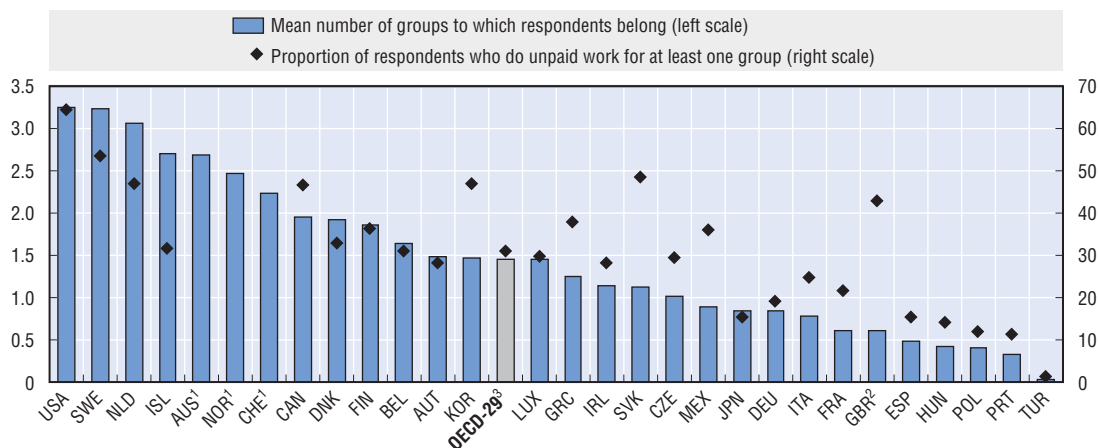
Within countries, membership depends strongly on the type of group activity. For example, Denmark shows a high proportion of members in political groups and professional associations, and a relatively low proportion in groups based on religious affiliation. Conversely, in Korea, membership in the latter groups is much higher than in the former.

Membership of organisations that can advance or protect individual's economic and employment-related interests (*e.g.* trade unions, professional associations and political parties) is more common among the prime working-age (30-49 years) population than among those younger (15-29 years) or older (50 and over). Indeed, throughout the OECD, prime-age persons belong to more groups on average and are more likely to do volunteer work for groups than younger people. A positive relationship also exists between income level and group membership: in all OECD countries, the mean number of groups to which respondents belong and the proportion of volunteers both increase with income.

Status indicators: Employment (SS1), Social isolation (CO2).

CO3.1. Wide gap between countries with highest and lowest group activity

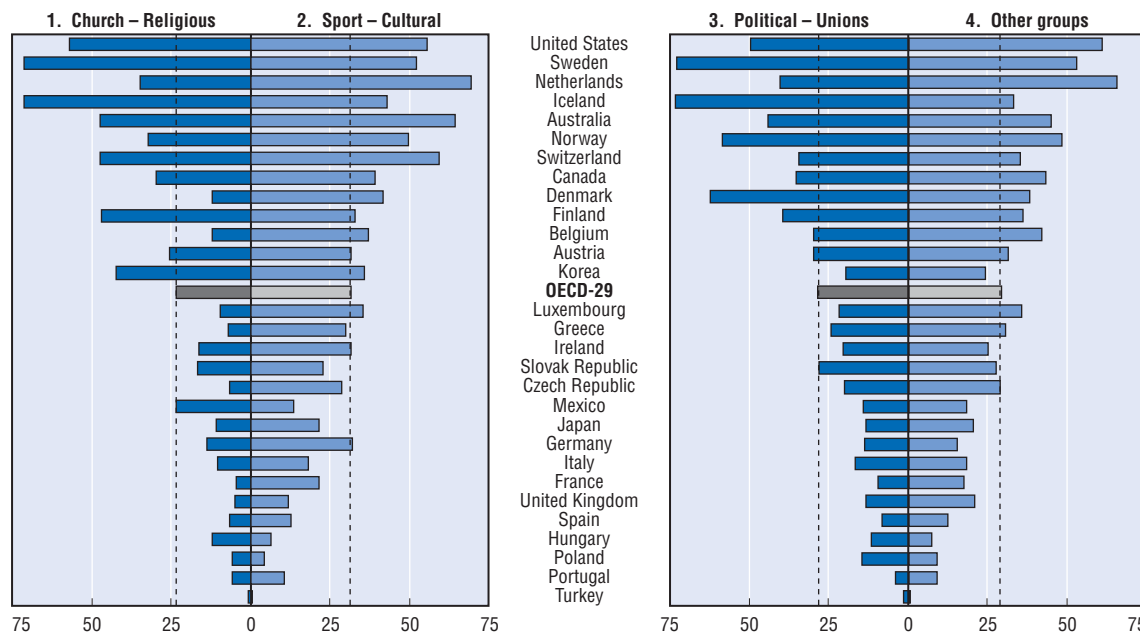
Density of associational activity, 1999-2002



1. Data for Australia, Norway and Switzerland refer to 1995-96. Unpaid work data for these countries are missing.
2. Data for the United Kingdom refer to Great Britain only.
3. The OECD average excludes New Zealand.

CO3.2. Membership varies according to the type of groups

Proportion of respondents who are active or inactive group members, by type of group



Note: Countries are ranked in decreasing order of the average number of groups to which respondents belong. The category “Sports – Cultural” includes recreational activities. The category “Political – Unions” includes political parties, local political groups, labour unions and professional associations. The “Other” category includes youth work, welfare service for the elderly, conservation and ecological groups and single issue movements such as health, peace, human rights and women groups.

The vertical bars represent OECD averages (which exclude New Zealand). Data for Australia, Norway and Switzerland are from the 1995-96 waves of the World Values Survey. Data for the United Kingdom refer to Great Britain only.

Source: Estimates based on Inglehart, R. et al. (2004), “Human Beliefs and Values: A Cross-cultural Sourcebook”, based on the 1999-2002 Values Surveys, Siglo XXI Editores, México.

StatLink: <http://Dx.doi.org/10.1787/418783833417>

Further reading: ■ OECD (2001), *The Well-Being of Nations: The role of Human and Social Capital*, OECD, Paris.

Definition and measurement

Teenage births rates are here defined as the number of (live) births to mothers aged 15 to 19, expressed per 1 000 teenagers (i.e. the 15 to 19 age specific fertility rate). The data are based on population registers of member countries, as collected by Council of Europe and the International Data Base at the US Census Bureau, Population Division.

Teenage births are often seen as a problem for policy because they are strongly associated with a wide range of disadvantages for mothers, children and society in general. Teenage mothers are more likely to drop out of education, hold low-paid jobs and live on welfare. Their babies may encounter health problems such as low birth weight. Children from teenage mothers may also be more likely to become victims of neglect and to be less successful in school.

Teenage birth rates have declined sharply during the past 20 years, from around 34 births for 1 000 teenagers in 1980 to 16 births in early 2000s on average (Chart CO4.1). The decline has affected all OECD countries with the exception of Japan and the United Kingdom.

Cross-country differences in the level of teenage birth rates are large (Chart CO4.2). In 2002, teenage birth rates were lowest in Korea, Japan and Switzerland and highest in the United States, Turkey and Mexico – where they exceed the OECD average by a factor of three or more. In the United States, high teenage births mainly reflect high rates among younger girls (aged between 15 to 17), as well as some ethnic groups (in 2003, birth rates of Hispanic and black teenagers exceeded those of white Americans by around 50% and 80%; Census Bureau, 2003). Research in the United States indicates that teenage mothers are less likely to have received prenatal care, and more likely to have experience health problems during pregnancy.

The situation of teenage mothers is very heterogeneous across countries. Teenage pregnancy is rarely intended in most of countries, and mainly results from inappropriate use of contraception. While some of the factors contributing to teenage births are common across countries – e.g. age at first sexual experience is falling in most OECD countries (UNICEF, 2001) – different policies exist in the various countries to influence teenage childbirth (family planning). In Continental Europe – where levels of

teenage births are lower than in the United States and declines over the past thirty years have been larger and more consistent – the Dutch and Scandinavian experience are often identified as providing evidence of the impact of open attitudes towards sex and provision of contraception in limiting the socio-economic consequences of teenage births for both mothers and children. In addition, teenage births rates are highest in poorer and more deprived groups of society. Households headed by teenage lone mothers are among the poorest in both the United Kingdom and the United States, and often depend on government benefits as their unique or major source of income. The debate on teenage births in these two countries has mainly focused on welfare as a cause of their rise. However, prior experience of poverty, school drop-out and educational failures are also important predictors of teenage childbearing.

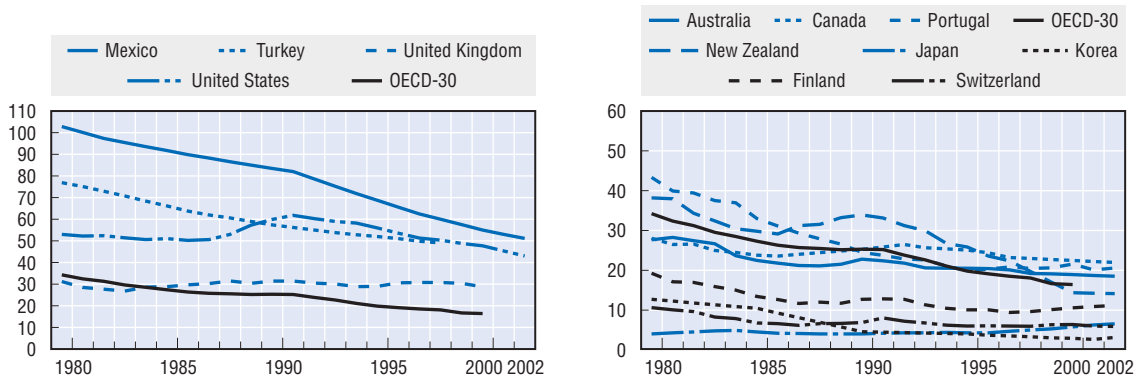
Enabling young women to choose when to become a mother – so as to provide children with a favourable family environment and the necessary care they need – is an important justification for policy intervention in this field.

Status indicators: Relative poverty (EQ1), Income inequality (EQ2), Drug use and related deaths (CO5).

Response indicators: Educational attainment (SS7), Public social expenditure (EQ5), Total health care expenditure (HE4).

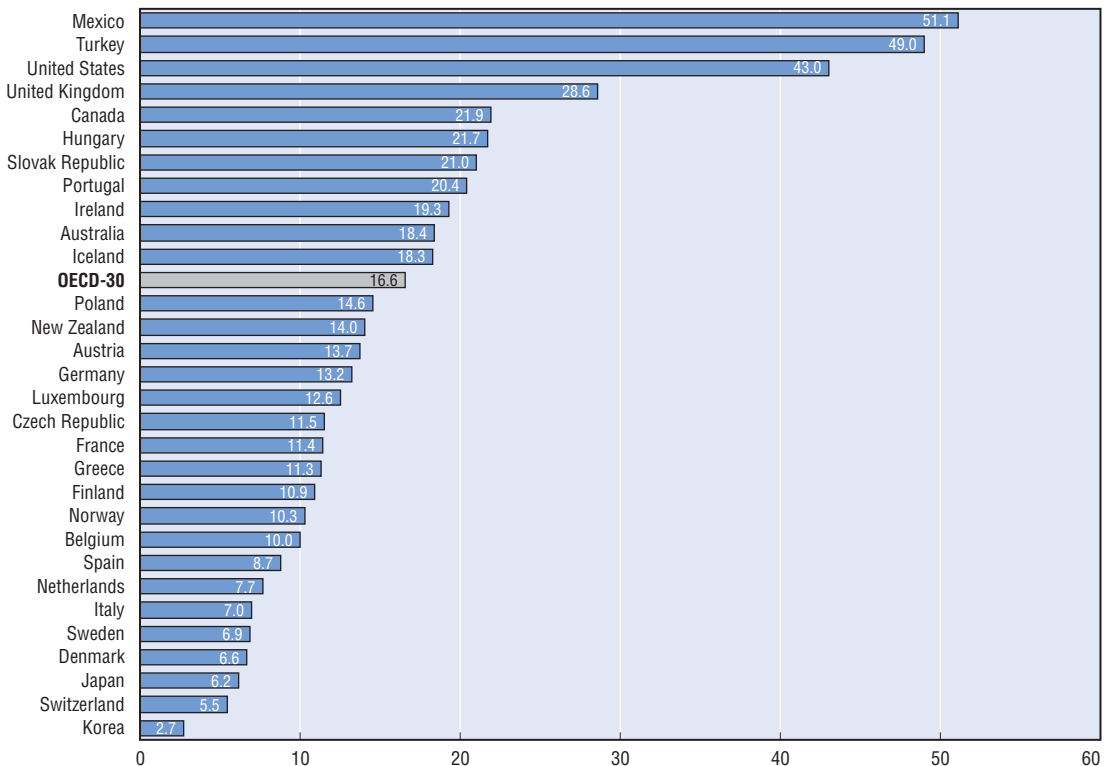
CO4.1. Overall decline in teenage births

Births to mothers aged 15-19 per 1 000 women (aged 15-19), 1980-2002



CO4.2. Large cross-country differences in teenage birth rates

Births to mothers aged 15-19 per 1 000 women (aged 15-19), 2002¹



1. 2001 for France, Germany and Ireland; 2000 for Italy, Spain, Turkey and the United Kingdom; 1999 for Greece; 1998 for Turkey; 1997 for Belgium. Source: Council of Europe (2003), Recent Demographic Developments in Europe; US Bureau of the Census, International Data Base www.census.gov/ipc/www/idbprd.html; Japan: Ministry of Health and Welfare, Vital Statistics of Japan; United States: DHHS, National Vital Statistics.

StatLink: <http://Dx.doi.org/10.1787/228334614167>

Further reading: ■ Census Bureau (2003), "Fertility of American Women: June 2002", *Current Population Reports*, Washington DC. (see also www.teenpregnancy.org). ■ UNICEF (2001), "A League Table of Teenage Births in Rich Nations", Innocenti Research Centre, Florence.

Definition and measurement

Drug use is both a symptom and a cause of social problems. Efforts to escape or avoid the stresses and responsibilities of everyday life can lead to drug addiction. This, in turn, reduces the chances of having a decent job, maintaining family relationships and realising personal goals. Illicit drug use is also linked with crime. These problems often concern a relatively small group of “problem users” that face a multitude of social problems including homelessness.

The first indicator used here refers to the number of people who report having consumed an illicit drug at least once in the last twelve months prior to the survey, as percentage of the population aged 15 to 64. These data come from confidential surveys amongst people, and are may be subject to considerable response bias. In addition they may be affected by differences across countries in the definition of drug use, the frequency and comprehensiveness of surveys, and other differences in research methodologies. Drug-related deaths (the second indicator presented here) are a cause of grave social concern. Information is presented on the number of drug-related deaths per 1 million persons. In the EU countries, statistics on drug-related deaths generally refer to deaths occurring shortly after drug use (because of acute intoxication, overdose, poisoning or drug-induced deaths), while longer time-periods can be used in other countries. Direct comparisons between national statistics are difficult because of the variety of reporting systems and definitions. Bearing this in mind, drug-related deaths can highlight trends for severe forms of drug use.

Available information about the prevalence of drug use covers a variety of substances such as cannabis, amphetamines, opiates, ecstasy, and cocaine. Cannabis continues to be, by far, the most widely consumed drug in most OECD countries. Prevalence of “self-reported” cannabis use appears to be higher in Australia, New Zealand and the United States, and lower in Japan and Korea (Table CO5.1), although these variations may reflect methodological differences. Significant proportions of the adult population (between 2 and 4%) also report use of ecstasy (in particular in Australia, the Czech Republic and Ireland) and amphetamines (in Australia and New Zealand).

Information on trends in drug use is more sparse. Cannabis consumption appears to be rising in Europe except for Ireland and the United Kingdom (EMCDDA, 2003).

The risk of drug-related death varies with the substance and the pattern of use. Trends in drug-related deaths also differ from country to country because of differences changes in recording procedures. Despite these limitations, Chart CO5.2

suggests that the number of drug-related deaths increased in most countries until the mid-1990s. Since that date, national trends have become more diverse. In many countries, the number of drug-related deaths has stabilised (*e.g.* Denmark and the United Kingdom) or even decreased (*e.g.* France and Italy).

In a few countries, the trend is still upwards. This is especially the case in those countries where opiate use appears to have increased in recent years (Greece, Ireland and Portugal). In other countries, the stabilisation in drug-related deaths may be explained by changes in patterns of use (such as a decrease in injecting) or to the effects of policy interventions (such as the spread of opiate substitution programmes).

Status indicators: Life expectancy (HE1), Suicides (CO6).
Response indicators: Total health care expenditure (HE4).

CO5.1. Variation across countries in drugs consumption

Annual prevalence of use of cannabis, amphetamines and ecstasy, latest year, percentage of the population aged 15-64¹

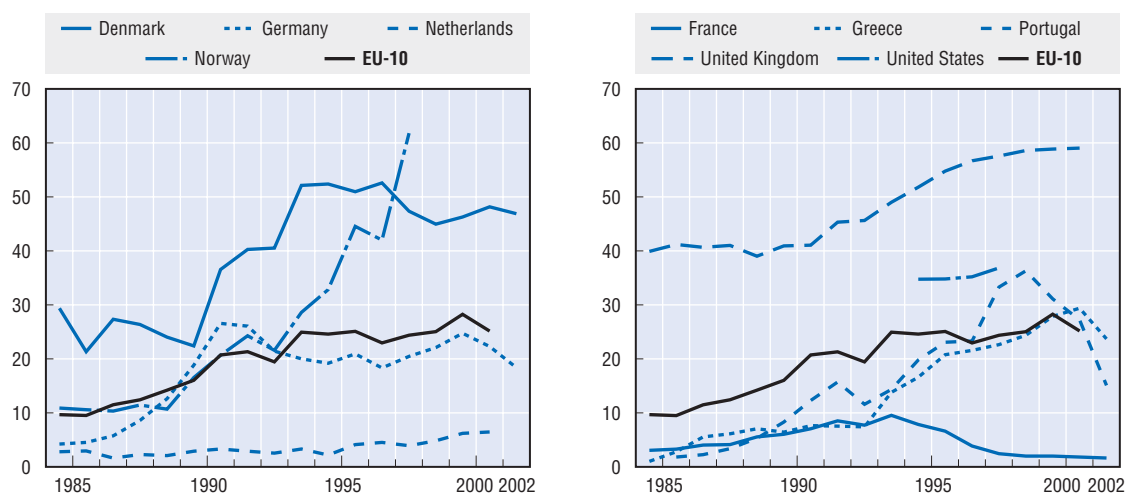
		Cannabis	Amphetamines	Ecstasy
Australia	2001	15.0	4.0	3.4
Austria	2002	5.6	0.3	0.6
Belgium	2001	6.1	0.6	0.9
Canada (Ontario)	2000	10.8	1.0	1.8
Czech Republic	2002	10.9	1.1	2.5
Denmark	2000	6.9	1.3	0.5
Finland	2002	2.9	0.5	0.5
France	2002	9.8	0.2	0.3
Germany	2000	6.0	0.6	0.7
Greece	1998	4.4	0.1	0.1
Hungary	2001	2.2	0.7	1.0
Iceland	2000	5.0	0.6	0.9
Ireland	2002	9.0	1.6	3.4
Italy	2002	6.2	0.1	0.2
Japan	2001	0.1	0.3	–
Korea	late 90s	0.1	0.2	–
Luxembourg	1999	4.0	0.4	0.4
Mexico	2002	0.6	0.1	0.0
Netherlands	2001	6.1	0.6	1.5
New Zealand	2001	13.4	3.4	2.2
Norway	1999	4.5	1.0	0.6
Poland	2000	2.4	0.6	0.2
Portugal	2001	3.3	0.1	0.4
Slovak Republic	1999	3.6	0.4	0.8
Spain	2001	9.7	1.2	1.8
Sweden	2000	1.0	0.1	0.2
Switzerland	1999	7.0	0.2	0.4
Turkey	2003	1.8	0.2	0.3
United Kingdom	2003	10.6	1.6	2.0
United States	2002	11.0	1.4	1.3
OECD-30		6.0	0.8	1.0

1. Persons aged 15 to 64 except 16-64 in Denmark, 18-64 in Germany, 18-65 in Hungary, 18 and older in Ireland, 15-44 in Italy, 15-99 in Japan, 12-65 in Mexico, 15-75 in Sweden, 16-59 in United Kingdom and 12 and older in the United States.

Source: UNODC (2004), *World Drug Report*, United Nations Office on Drug and Crime (www.unodc.org/unodc/en/world_drug_report.html).

CO5.2. Drug-related deaths have stabilised since the mid-1990s

Acute drug-related deaths per 1 000 000 persons, 1985 to 2002



Source: EMCDDA (2003), *Annual Report 2003: the State of the Drugs Problem in European Union and Norway*, European Monitoring Centre for Drugs and Drug Addiction, Lisbon (www.emcdda.eu.int); United States: Office of Applied Studies, Substance Abuse and Mental Health Services Association (SAMHSA), Drug Abuse Network 1998 (www.samsha.gov).

StatLink: <http://Dx.doi.org/10.1787/184760004607>

Further reading: ■ UNODC (2004), *World Drug Report*, United Nations Office on Drug and Crime (www.unodc.org/unodc/en/world_drug_report.html).

Definition and measurement

The intentional killing of oneself is evidence not only of personal breakdown, but also about the social context in which individuals live. Although mental disorders are involved in 90% of all suicide cases, especially as a consequence of depression or substance abuse, this does not imply that all persons committing suicides are “mentally ill”, and only few people who commit suicide have been under psychiatric observation or treatment. Suicide results from many different social and cultural factors: it is more likely to occur during crisis periods associated to economic, family or individual events, for example the breakdown of a relationship, drinking, drug use, and unemployment.

Data on suicides shown below are based on official registers of “causes of death”, expressed per 100 000 individuals. As great stigma surrounds suicide in many countries, those recording deaths may come under pressure from surviving family and friends to record deaths from suicide as being due to other causes. As administrative records are the only source of information on suicide rates, this inevitably reduces data comparability across countries. That said, the large differences shown below presumably do reflect real differences in the frequency of suicides across countries, although they are also affected by the small number of cases in some countries (*e.g.* Iceland) and by differences across countries in the proportion of deaths from unreported causes.

Over the twenty years to 2000, the average suicide rate has been declining moderately, though steadily, since the peaks of the late 1980s (Chart CO6.1, left-hand panel). Such progress can be observed for both sexes, although suicide remains a predominantly male phenomenon. Indeed, men are twice as likely to kill themselves as women. The frequency of suicides also rises with the age of individual (Chart CO6.1, right-hand panel), although these age differences have declined over the past two decades. Suicide rates among the elderly (persons aged 65 and over) have declined significantly over the past two decades, reflecting higher well-being of the elderly in today’s society. However, almost no progress has been observed for younger cohorts.

Average suicides rates – across 23 OECD countries – hide large cross-country differences. Suicide rates range from below 5 per 100 000 persons in most Mediterranean countries to above 20 per 100 000 persons in Hungary, Japan, Belgium or Finland (Chart CO6.2). People aged under 25 seems to be more prone to commit suicide in Finland, New Zealand, Ireland and in Iceland, and these rates seems to have increased dramatically since 1980 in the latter three countries. In contrast, Southern

European countries together with Mexico have among the lowest suicide rates among youths.

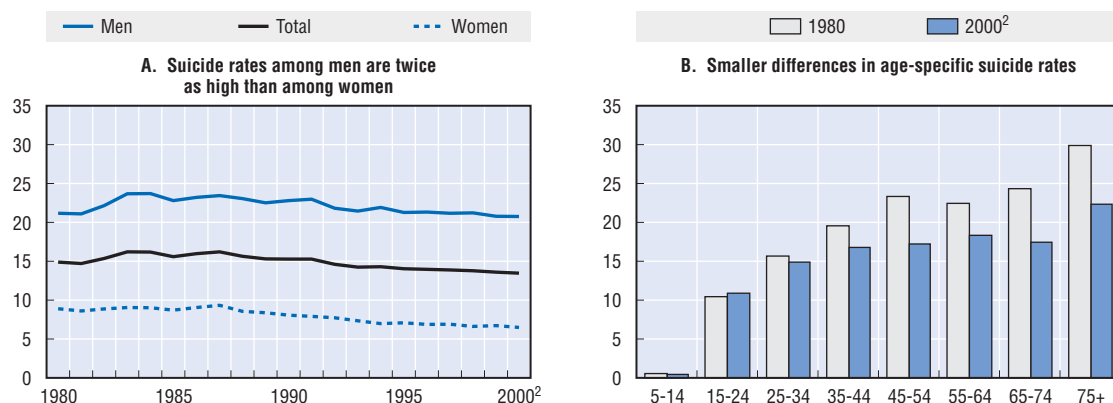
While drug addiction, prolonged unemployment and social isolation often characterise the lives of those who commit suicide, their underlying causes are complex and cannot be reduced to a single factor. External pressures from the social and family environments, combined with difficulties in making the transition from childhood into adulthood may also bring young people consider toward extreme responses. Attempted suicides are even more common than fatal outcomes. Prevention needs to start before the act, and address a wide range of aspects related to health conditions and the educational and socialisation process during adolescence (Ruzicka and Choi, 1999).

Status indicators: Unemployment (SS2), Social isolation (CO2), Drug use and related deaths (CO5).

Response indicators: Public social spending (EQ5), Total health care expenditure (HE4).

CO6.1. Declining suicide rates in the last two decades

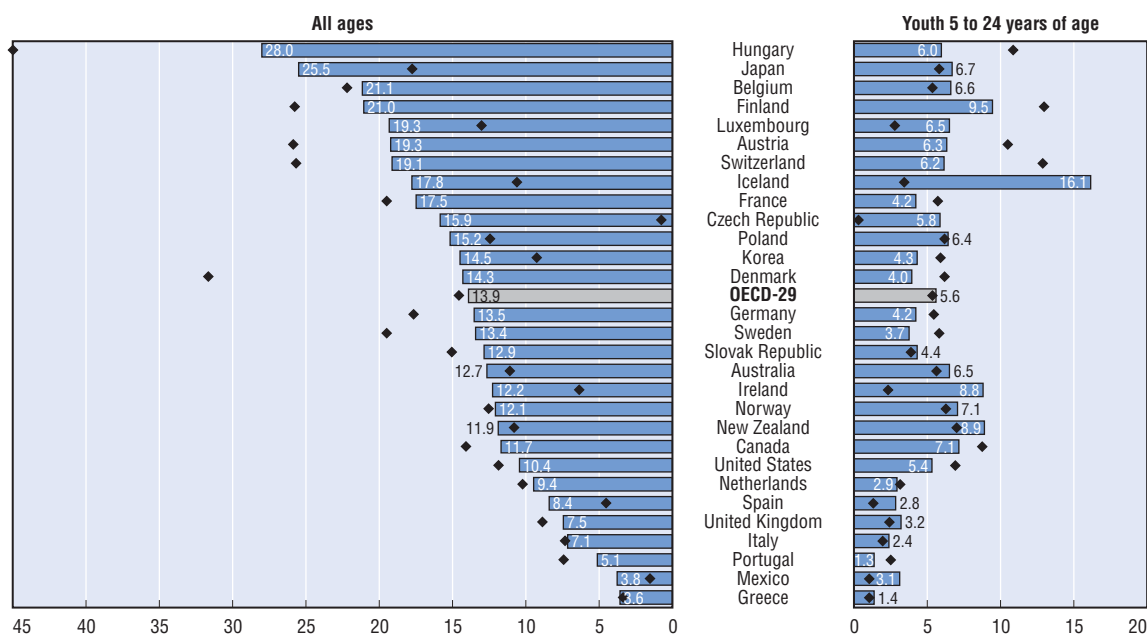
Suicides per 100 000 persons, by gender and age, average of 23¹ OECD countries



1. Excludes Belgium, Czech Republic, Germany, Korea, Poland, Slovak Republic and Turkey.
2. 1999 for Denmark, France, Greece and the United Kingdom.

CO6.2. Variation in suicide rates across OECD countries¹

Suicides per 100 000 persons, latest year¹ (bars) and 1980² (diamond markers)



1. 1997 for Belgium; 1999 for Denmark, France, Greece and the United Kingdom; 2000 for Canada, Iceland, Ireland, Italy, Japan, Netherlands, New Zealand, Portugal, Spain, Switzerland and the United States; 2001 for Australia, Czech Republic, Germany, Korea, Mexico, Norway, Poland, Slovak Republic, Sweden; 2002 for Austria, Finland, Hungary and Luxembourg; 2003 for Japan.
2. 1983 for Poland; 1985 for the Czech Republic; 1990 for Germany; 1992 for the Slovak Republic.

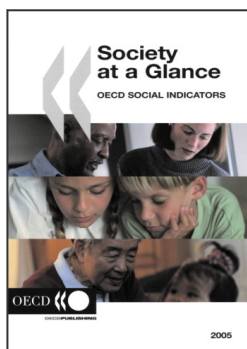
Source: World Health Organisation, "Live your Life", Mental Health Project on Suicide prevention (www.who.int/mental_health); Japan: Ministry of Health and Welfare, Vital Statistics of Japan.

StatLink: <http://Dx.doi.org/10.1787/431364466722>

Further reading: ■ OECD (2003), *Health at a Glance: OECD Indicators 2003*, OECD, Paris; OECD (2004), *OECD Health Data*, OECD, Paris (see also www.oecd.org/health/healthdata). ■ Ruzicka, L. and C.Y. Choi (1999), "Youth Suicide in Australia", Working Papers in Demography, No. 78, The Australian National University.

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