

Inadequate living conditions, extreme poverty and socio-economic factors affect the health of mothers and newborns. However, effective health systems can greatly limit the number of infant deaths, particularly by addressing life-threatening issues during the neonatal period. Around two-thirds of deaths during the first year of life occur before an infant reaches 28 days (neonatal mortality), primarily from congenital anomalies, prematurity and other conditions arising during pregnancy. For deaths beyond these first critical weeks (post-neonatal mortality), there tends to be a greater range of causes – the most common being sudden infant death syndrome, birth defects, infections and accidents. Child mortality rates – referring to deaths among children before the age of five – have fallen dramatically in recent decades, with the majority of deaths among children occurring during infancy.

Infant mortality rates are low in most OECD countries, although seven member countries reported at least five deaths per 1 000 live births: the Slovak Republic, the United States, Chile, Costa Rica, Turkey, Mexico and Colombia (Figure 3.17). Within OECD member countries, however, infant mortality rates are often higher among indigenous populations, ethnic minority populations and other vulnerable groups – as observed in Australia, Canada, New Zealand and the United States (Smylie et al., 2010[16]). In OECD partner countries, infant mortality remains above 20 deaths per 1 000 live births in Indonesia, South Africa and India, and above ten deaths in Brazil. Infant mortality rates have fallen in all OECD member and partner countries since 2000, with reductions generally largest in countries with the highest rates historically. Despite this progress in reducing infant deaths, an increasing number of low-birthweight infants presents a concern in some OECD countries. Low-birthweight infants have a greater risk of poor health or death, require a longer period of hospitalisation after birth, and are more likely to develop significant disabilities later in life.

The rise in risk factors for chronic disease among children and adolescents – including low physical activity, poor nutrition and smoking – can negatively affect health behaviours and outcomes in adulthood. For a significant number of children, however, poor health begins even earlier than adulthood. Mental health problems, for example, represent the biggest burden of disease for young people, with a prevalence at least as high among children as among adults, and half of all mental illnesses developing by the age of 14 (OECD, 2018[17]). Intervening early is critical to mitigate the development of poor health and its impact on the development and long-term health of young people.

Across 27 OECD countries, an average of 28% of 11-year-olds and 41% of 15-year-olds reported multiple health complaints – including symptoms of both poor physical and mental health – more than once a week (Figure 3.18). In Norway, Slovenia and Spain, fewer than one in five 11-year-olds reported having

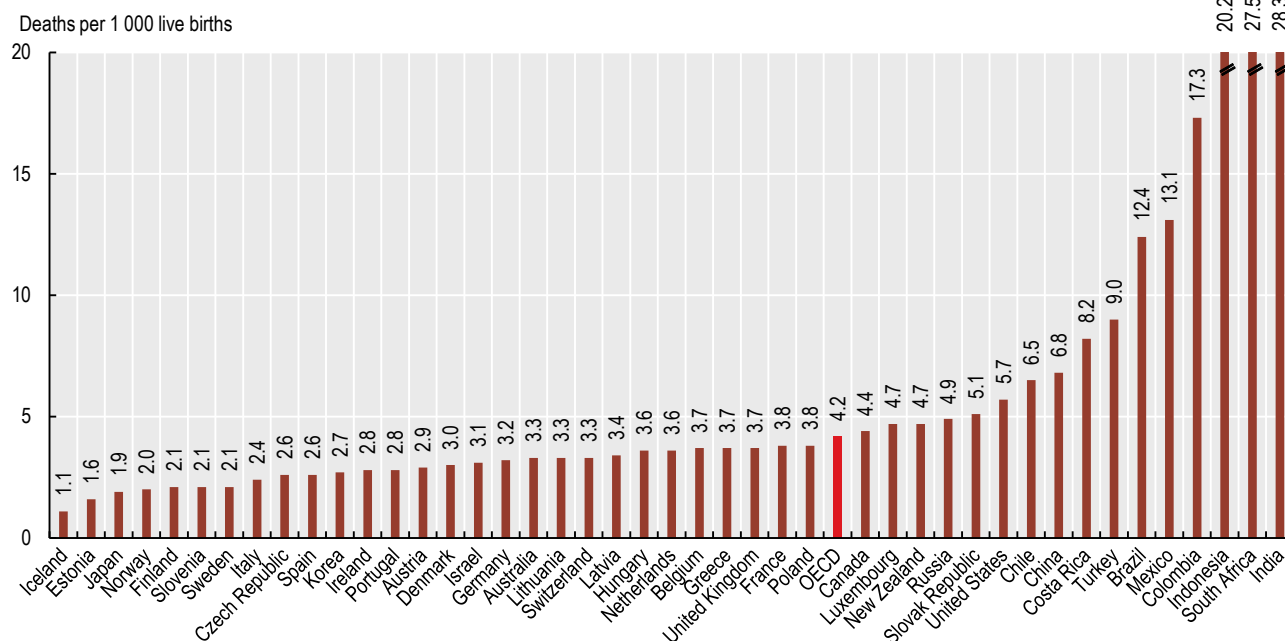
multiple health complaints more than once a week. By age 15, at least three in ten adolescents reported having multiple health complaints more than once a week, even among the best-performing countries of Spain, Germany and the Netherlands. Multiple health complaints were reported by 36% of 11-year-olds in the Slovak Republic, France and Sweden, and by 45% of 11-year-olds in Italy. By age 15, nearly or more than half of adolescents reported multiple health complaints in Sweden, Poland, Greece and Italy, including three in five 15-year-olds in Italy. At both ages and across all OECD countries with available data, girls were more likely to report living with multiple health complaints more than once a week than boys.

Definition and comparability

The infant mortality rate is the number of deaths of children under one year of age per 1 000 live births. Some of the international variation in infant mortality rates may be due to variations in registering practices for very premature infants. While some countries register all live births including very small babies with low odds of survival, several countries apply a minimum threshold of a gestation period of 22 weeks (or a birthweight threshold of 500g) for babies to be registered as live births (Euro-Peristat Project, 2018[18]). To remove this data comparability limitation, data presented in this section are based on a minimum threshold of 22 weeks' gestation (or 500g birthweight) for a majority of OECD countries that have provided these data. However, data for ten countries (Australia, Canada, Greece, Ireland, Italy, Lithuania, Luxembourg, Mexico, Norway and Portugal) continue to be based on all registered live births (with no minimum threshold of gestation period or birthweight), resulting in potential overestimation.

Data come from the Health Behaviour in School-aged Children (HBSC) surveys of 2013-14 and 2017-18. Data are drawn from school-based samples of 1 500 in each age group (11-, 13- and 15-year-olds) in most countries. Participants were asked whether and how often they had experienced different health conditions (headache, stomach ache, backache, feeling low, feeling irritable or bad tempered, feeling nervous, difficulties in getting to sleep and feeling dizzy) over the previous six months. Children who reported more than one health complaint more than once per week over the previous six months were considered to have reported multiple health complaints. The comparability of data is limited by the fact that the indicator is derived from self-reported data, which can be affected by people's subjective assessment of their health and by social and cultural factors.

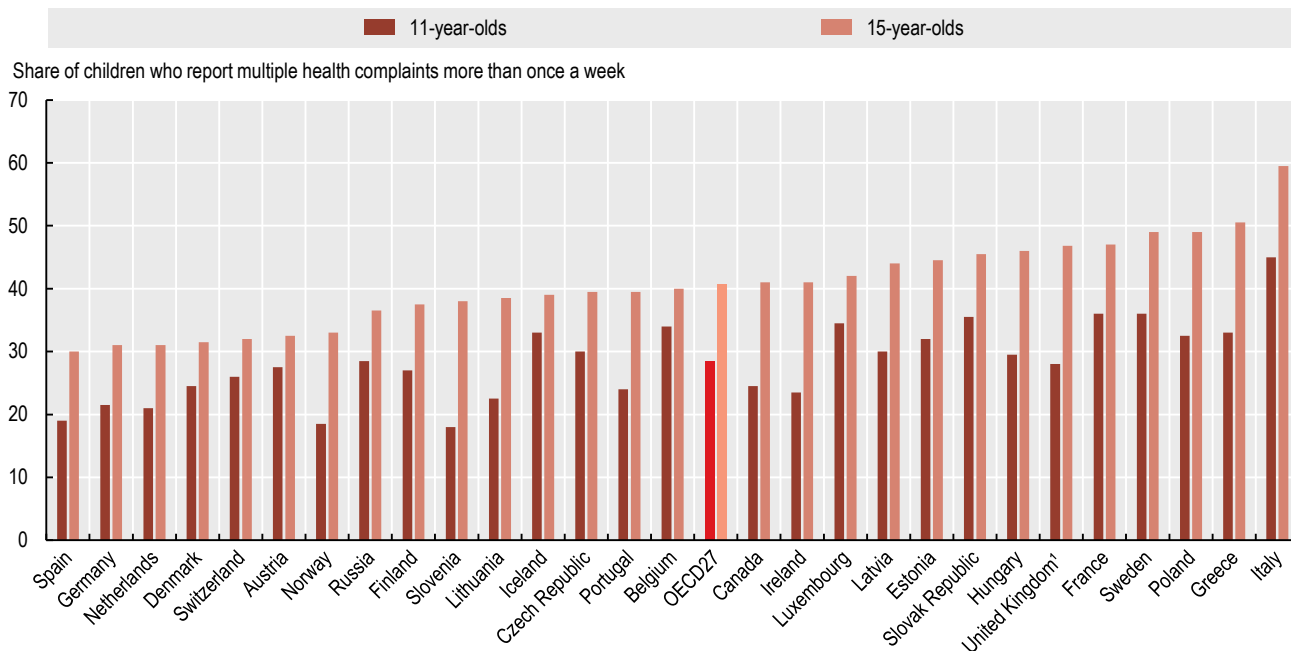
Figure 3.17. Infant mortality, 2019 (or nearest year)



Source: OECD Health Statistics 2021.

StatLink <https://stat.link/xgbwi1>

Figure 3.18. Share of 11- and 15-year-olds reporting multiple health complaints, 2018



1. The United Kingdom includes data from England, Scotland and Wales.

Source: HBSC survey, 2018.

StatLink <https://stat.link/zh9onx>



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