



# Austria

**The Child Safety Profile 2007 for Austria highlights the burden of child and adolescent injury and examines socio-demographic determinants to provide a starting point for interpreting the results of Austria's Child Safety Report Card 2007 and for measuring progress toward and setting targets for reducing child and adolescent injury-related death and disability.**

Injury is the leading cause of death in children and adolescents aged 0-19 years in Austria. When compared to the 18 countries participating in the Child Safety Action Plan, Austria's child and adolescent mortality rates rank 8th highest for males and 6th highest for females using the most recent years for which data are available. Deaths in 2001 represented over 27,055 potential years of life lost – years where children and adolescents won't be growing, learning and eventually contributing to society (Table 1). Child and adolescent injuries were responsible for over 33% of all child and adolescent deaths, more than all other causes combined. Although injury death rates have fallen in Austria since the early 1980s, compared to Sweden (the safest country in Europe) they remain unacceptably high, particularly for males (Figure A). A look at specific causes indicates that road traffic accidents continue to take the greatest toll, however other causes types of accidents typically seen in and around the home also contribute significantly to injury deaths (Table 2).

Table 1. Select measures of child and adolescent injury mortality

	Austria	EU-25
Injury death rate children and adolescents 0-19 years/100 000 (2001)	18.56	13.17
Potential years of life lost (PYLL) as a result of injury deaths to children and adolescents 0-19 years (2001)	27,055	—
Contribution of unintentional injuries to all child and adolescent mortality (2003)	24.05%	20.67%
Contribution of intentional injuries to all child and adolescent mortality (2003)	8.61%	6.63%

Figure A. Child and adolescent injury deaths in Austria and Sweden  
3-year moving averages, children and adolescents 0-19 years

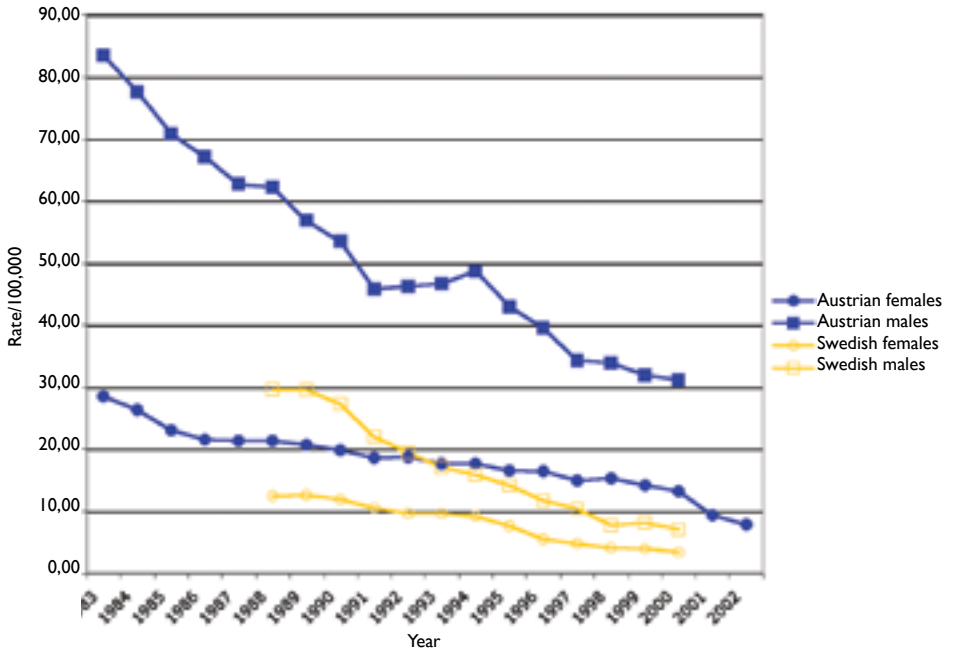


Table 2. Age standardised unintentional injury-related deaths by specific cause in children and adolescents 0-19 years, 2-year average 2002-2003

Injury death rate /100,000, 0-19 years

	Males	Females
Motor vehicle driver/passenger	0.71	0.69
Motorcycle driver	0.34	0.00
Pedestrian	0.70	0.73
Cyclist (traffic and non-traffic)	0.20	0.15
Drowning	0.95	0.21
Falls	1.25	0.26
Fires	0.29	0.09
Poisoning	0.25	0.11
Choking/strangulation	0.17	0.34

Injuries disproportionately affect the most vulnerable children and adolescents in society and in many ways health relates to the wealth of the individual as well as the country.\* More children and adolescents are injured when families are of lower income, have less education and are less literate, live in more crowded conditions and when adequate funding is not provided for public health as part of healthcare. In addition the continued loss of children and adolescents to injury is a critical demographic and economic issue.

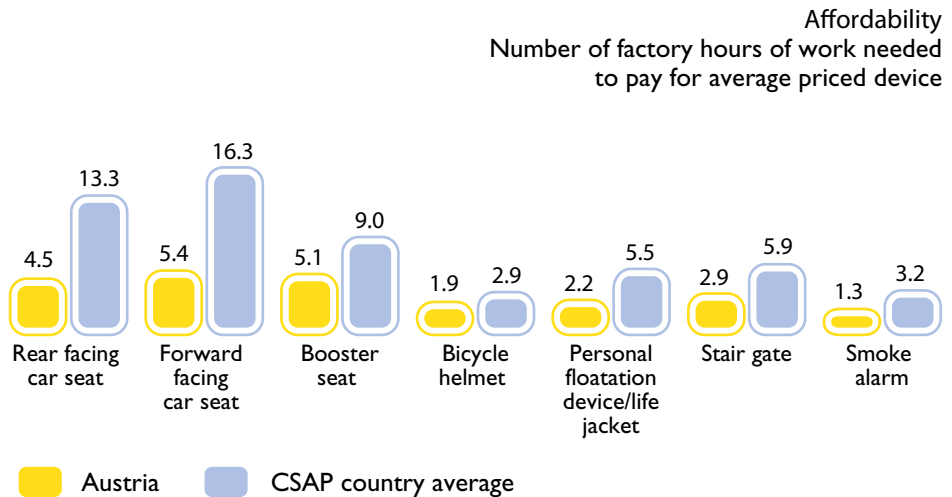
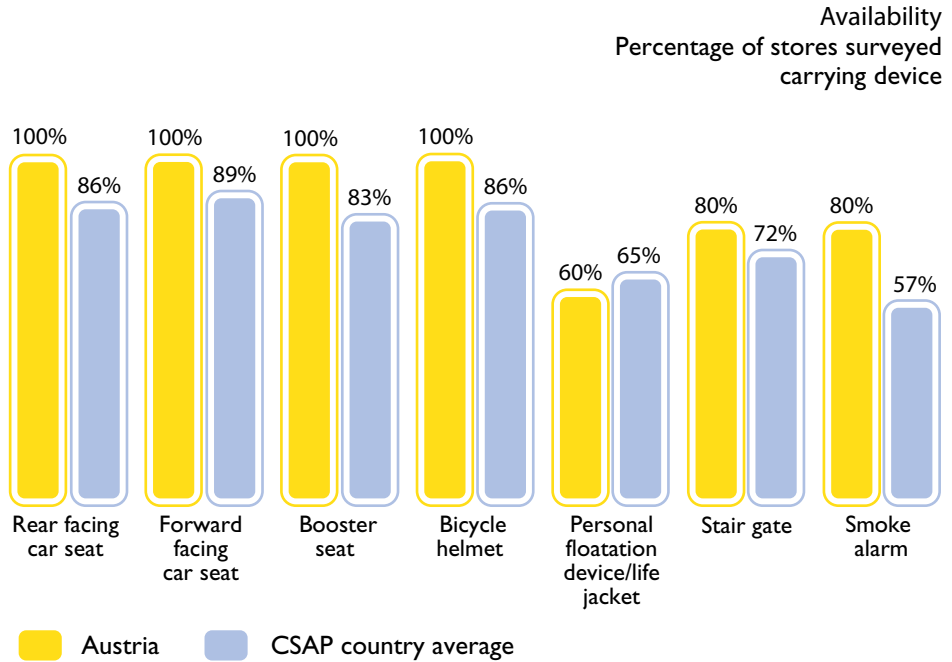
It is important to look at these factors to help interpret Austria's response to the child and adolescent injury problem and Table 3 provides information on select socio-demographic measures and determinants of injury. Figure B provides a comparison of the availability and affordability of safety devices whose use is recommended to reduce the risk of child and adolescent injury. Austria needs to work to ensure that every child born is provided with a safe environment to live, learn and play to ensure they grow up to be contributing members to society. This will require that inequalities, including availability and affordability of recommended safety equipment, are addressed in injury prevention policies and programming.

Table 3. Select socio-demographic measures and determinants of injury

	Austria	EU-25
Total population (2006)	8,265,900	463,523,400
Average population density (population/square kilometre, 2006)	99.1	118
Percent urbanised (2004)	68%	78.3%
Percent population under 14 years of age (2004)	16.1%	—
Natural population change (annual live births – annual deaths, 2005)	3,000	381,300
Adult illiteracy rate (% ages 15 and older, 2003)	1%	1.5%
Gross Domestic Product (GDP) per capita PPS (index EU-25=100, 2005)	123	100
Total health expenditure as percent of GDP (WHO estimates, 2004)	7.5%	8.87%
Percent at-risk-of-poverty rate (after social transfers, 2003)	13%	15%
Percent children and adolescents aged 0-17 years living in jobless households (2006)	7.2%	9.5%
Human Development Index (HDI, 2004)	0.944	—
HDI Ranking in European Economic Area (2004)	9/29	—
GINI index (1997)	30.0	—
GINI index ranking in European Economic Area	9/27	—

\* UNICEF Innocenti Research Centre. A league table of child death by injury in rich nations. UNICEF; 2001. Report Card No. 2. Florence. Available from: <http://www.unicef-icdc.org/publications/pdf/repcard2e.pdf>

Figure B. Availability and affordability of select safety devices



# Methods to prepare child safety profile

- The Child Safety Profile was developed by the Child Safety Action Plan Project (CSAP), a European initiative led by the European Child Safety Alliance of EuroSafe with co-funding and partnership from the European Commission, the Health and Environment Alliance (HEAL), UNICEF Innocenti Research Centre and WHO Regional Office for Europe. One of the objectives of the CSAP initiative was to establish a set of indicators and standardised data collection tools focussing on child and adolescent injury to identify a baseline level of injury burden and action in the participating countries to support planning and provide a means of benchmarking and evaluating progress in reducing injury as countries move from planning to implementation.
- The purpose of the Child Safety Profile is to provide a starting point for interpreting the results of the Child Safety Report Card 2007 for Austria and for measuring progress toward and setting targets for reducing injury-related death and disability amongst Austrian children and adolescents. The Profile highlights the burden of child and adolescent injury in Austria and examines socio-demographic determinants of child and adolescent injury that may impact both burden and prevention efforts.
- Measures for the Profile were selected in conjunction with an expert advisory group made up of members from HEAL, UNICEF Innocenti Research Centre, WHO Regional Office for Europe and experts on indicators and childhood injury prevention from the Universities of Keele and the West of England, respectively.

Data on injury deaths and socio-demographic determinants were obtained from existing databases managed by UNICEF, WHO, Eurostat and the United Nations Development Programme during 2005-2007 and mortality indicators were calculated at the Institute of Hygiene and Epidemiology at the University of Udine, Italy.

Data presented are for the most recent year(s) available from data sources at the time of data collection. Mortality data are for ages 0-19 as data for ages 0-17 are not available.

Data on safety device availability and affordability were collected by country partners in the 18 participating countries in 2006 and indicators were calculated at the European Child Safety Alliance.

Ranking for child and adolescent injury death rates by gender was done using 3-year averages of the most recent years available.

Ranking for the Human Development Index (HDI) and GINI Index was done using data from UN Human Development Report 2004, which uses most recent year of data available to calculate HDI and GINI index for a country; HDI ranking of 29/31 countries in European Economic Area (EEA) for which data were available (data unavailable for Iceland and Liechtenstein); GINI ranking of 27/31 of countries in EEA for which data were available (data unavailable for Cyprus, Liechtenstein, Malta and Iceland).

## Definitions and terms

**At-risk-of-poverty rate after social transfers** – the share of persons with an equivalised disposable income below the risk-of-poverty threshold, which is set at 60 % of the national median equivalised disposable income (after social transfers). (Eurostat)

**Children and adolescents aged 0-17 living in jobless households** – the share of children and adolescents aged 0-17 who are living in households where no one is working. Both the numerators and the denominators come from the EU Labour force survey. (Eurostat)

**Gini index** – a quantitative index measuring inequality over the entire distribution of income or consumption. A value of 0 represents perfect equality, and a value of 100 perfect inequality, thus the higher the coefficient, the higher the inequality of the income distribution

**Gross domestic product (GDP)** – a measure of economic activity; the value of all goods and services produced less the value of any goods or services used in their creation. The volume index of GDP per capita in Purchasing Power Standards (PPS) is expressed in relation to the European Union (EU-25) average set to equal 100. If the index of a country is higher than 100 this country's level of GDP per head is higher than the EU average and vice versa. (Eurostat)

**Human Development Index** – a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development: 1) A long and healthy life, as measured by life expectancy at birth; 2) Knowledge, as measured by the adult literacy rate (with two-thirds weight) and the combined primary, secondary and tertiary gross enrolment ratio (with one-third weight) and 3) a decent standard of living, as measured by GDP per capita in purchasing power parity (PPP) terms in US dollars. (United Nations Human Development Project)

**Natural population change** – the difference between the number of live births and the number of deaths during the year. A negative number means the number of deaths exceeds the number of births (EuroStat)

**Potential Years of Life Lost (PYLL)** – an indicator of premature mortality representing the total number of years NOT lived by an individual who died before average life expectancy at birth. For this report card ages 78 and 83 were used for males and females, respectively.

*More information at:*  
[www.childsafetyeurope.org](http://www.childsafetyeurope.org)

The findings and views expressed are those of the authors and do not necessarily reflect the views of the partner organisations.

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