Health at a Glance: Europe 2020
State of Health in the EU
DOI: https://doi.org/10.1787/82129230-en

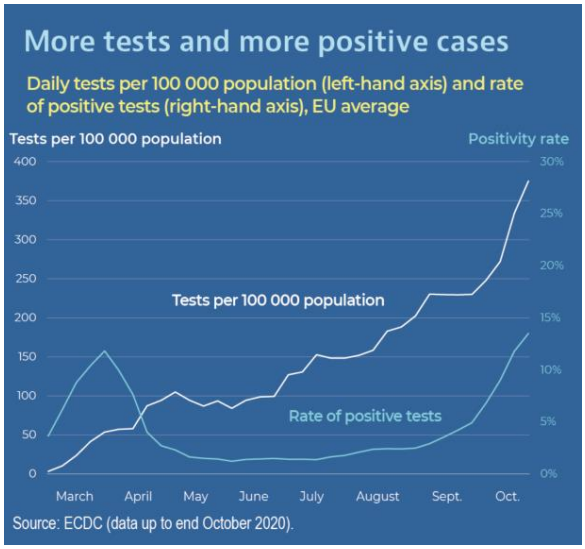
OECD
ISBN 978-92-64-58562-1 (print)
ISBN 978-92-64-49456-5 (PDF)
ISBN 978-92-64-54097-2 (EPUB)
ISBN 978-92-64-67755-5 (HTML)

European Union
ISBN 978-92-76-25153-8 (PDF)
ISBN 978-92-76-25152-1 (print)
Catalogue number: EW-01-20-701-EN-N (PDF)
Catalogue number: EW-01-20-701-EN-C (print)

Corrigendum

Page 17

The infographic was revised and now reads as follows:



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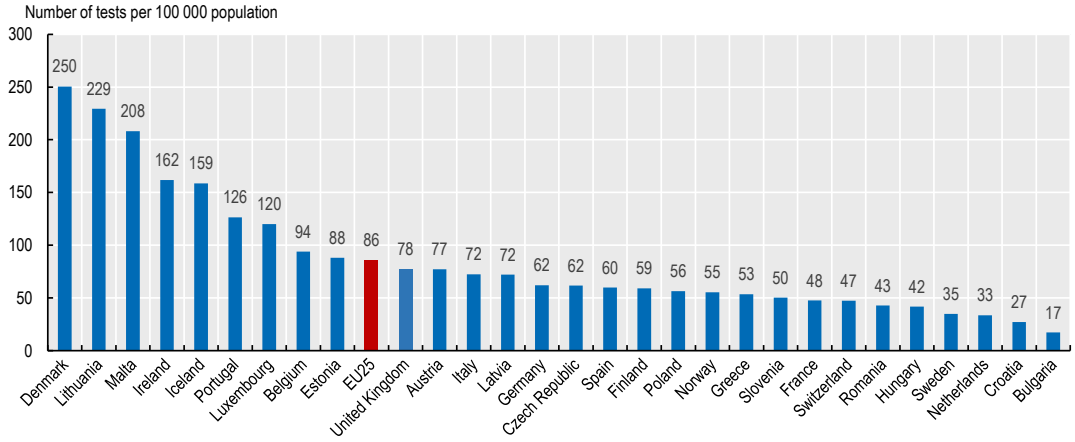
Paragraph 3 was revised to reflect changes in Figure 1.8 and now reads as follows:

One way to estimate the initial COVID-19 testing capacity of countries is to look at the number of daily tests performed at the beginning of the outbreak. Figure 1.8 reports the daily number of tests per 100 000 population by country, 30 days after each country reached a mortality rate of ten deaths per million population.[4] Denmark reported the highest number of daily tests performed, with 250 tests per 100 000 population, followed by Lithuania, Malta, Ireland and Iceland (between 150-230 tests).

Figure 1.8 was revised to correct a miscalculation and now reads as follows:

Figure 1.8. Daily number of tests per 100 000 population 30 days after the country recorded 10 deaths per million population (averaged over a week)



Note: The EU average is unweighted. In order to mitigate daily fluctuations in reporting, values displayed correspond to an average of the daily number of tests performed on the week of analysis. The analysis covers the period between February and June 2020.
Source: Roser et al. (2020[20]), "Our World in Data", https://ourworldindata.org/coronavirus, accessed 6 July 2020.

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Paragraph 5 was revised to reflect changes in Figure 1.9 and now reads as follows:

As shown in Figure 1.9, containment and mitigation strategies have had a substantial impact on people's mobility. All countries reported a reduction in the mobility of their populations over the studied period, ranging from -22% in Sweden to over -60% in Spain and Italy. In the first weeks following the enforcement of these policy options, the mobility of the population in certain countries was almost total, with reductions of -85% or more in Spain, Italy or France. Differences in the measures adopted can explain some of the variation observed across countries. For example, places with formal stay-at-home orders had an average reduction of -50% compared to -37% for those without. Overall, it appears that general lockdowns and closures of public spaces reached their intended objective to limit people's mobility and as a result their potential interactions.

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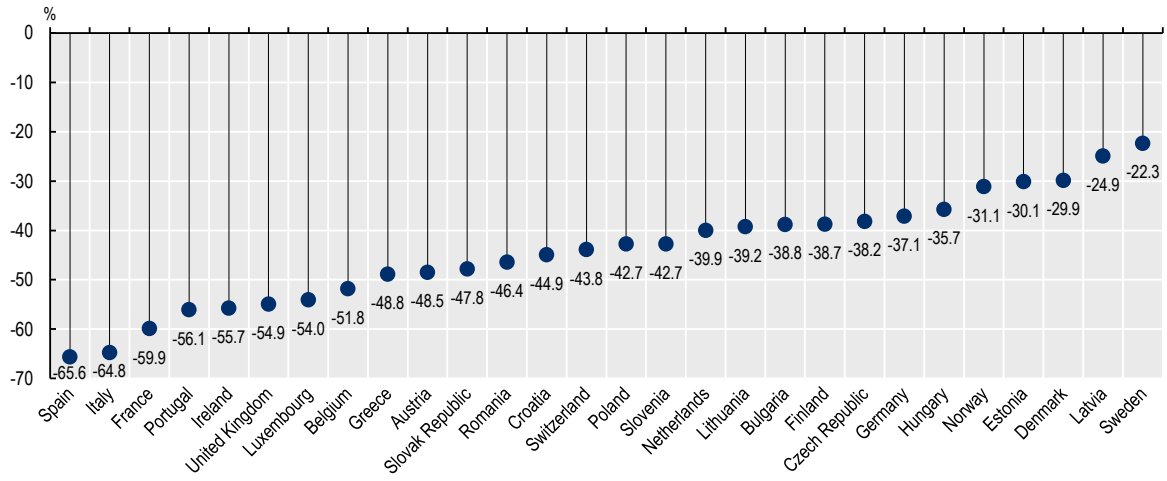
Figure 1.9 was revised to correct a miscalculation and now reads as follows:

Figure 1.9. Reduction in populations' mobility over the March-May 2020 period, compared to baseline



Note: This figure represents an average of the reduction in mobility of populations over a three-month period (March to May 2020). It combines reductions in public transport and leisure activities. The baseline reference was defined as the median value from the 5-week period 3 Jan to 6 Feb 2020.
Source: Google LLC (2020[28]), "Google COVID-19 Community Mobility Reports", https://www.google.com/covid19/mobility.

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Paragraph 3 was updated and now reads as follows:

The health sector was naturally among the first recipients of additional financial resources. Amongst European countries with comparable data, central government budgetary commitments to health system responses to COVID-19 ranged from almost EUR 450 per person in the United Kingdom, and around EUR 300 per person in Germany and Ireland, to under EUR 50 per person in Latvia, Iceland and the Netherlands, adjusted for purchasing power parity (Figure 1.12).

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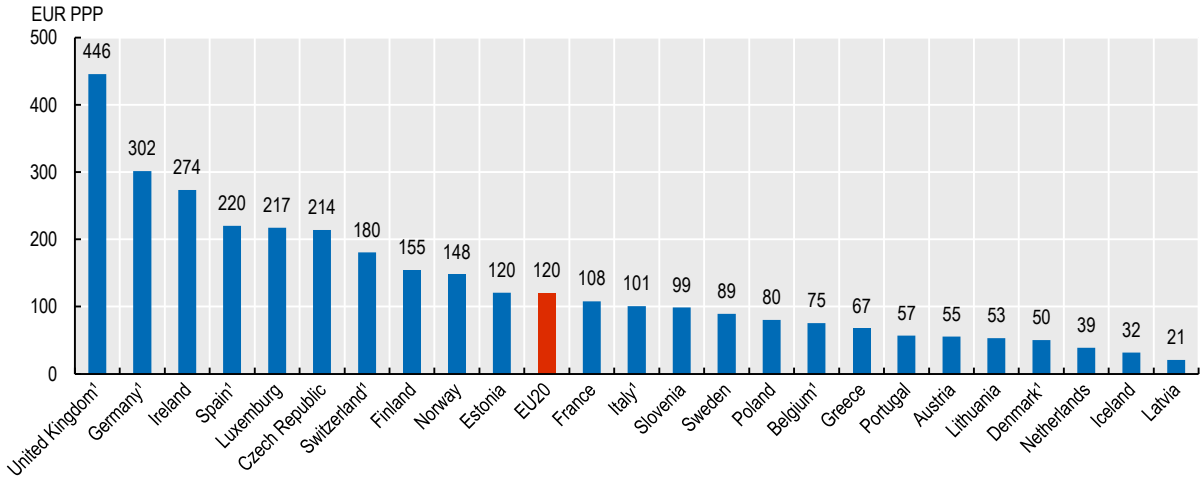
Figure 1.12 was revised to correct the data for Greece and to update the EU average and now reads as follows:

Figure 1.12. Central government additional COVID-19 health spending commitments per capita, 2020 (between March and September 2020)



Note: The EU average is unweighted. These figures represent estimates from official announcements of spending measures against COVID-19. They are commitments rather than actual expenditures. Figures reflect central government spending commitments only, excluding commitments by subnational governments, external donors or private donations. Cross-country comparability is limited by differences in the date of the latest available official announcement. See Table 1.3 for details on the exact timing of official announcements across countries.
1. Denotes countries with a significant budgetary response at the subnational level.
Source: OECD member country governments (typically from ministries of finance or parliamentary reports).

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Table 1.3 was revised to correct the data for Greece and now reads as follows:

Table 1.3. Additional central government COVID-19 health expenditure commitments, 2020 (latest available official announcement)

Country	Additional commitment (millions, national currency)	Additional commitment (per capita, Euro PPPs)	Main expenditure areas	Date of latest available official announcement
Austria	579	55	Purchase of PPE and medical equipment, research	6 May
Belgium[1]	1000	75	Purchase of medical equipment and PPE	20 April
Czech Republic	40 300	214	Health insurance payments, salaries, PPE, medical devices, hospital debt relief	7 May
Denmark[1]	3 100	50	Procurement of PPE	29 May
Estonia	213	120	Transfer to Estonian Health Insurance Fund	2 April
Finland	1 087	155	Additional health costs, testing, PPE and medical equipment, research on diagnosis and vaccines	24 September
France	8 000	108	Extraordinary health care expenses including equipment and masks, staff remuneration	10 June
Germany[1]	26 790	302	Central procurement of PPE, vaccine development and treatment measures	18 September
Greece	610	67	Purchase and distribution of PPE and medical goods, hiring additional health workforce, enhance laboratory capacities	21 September
Iceland	2 500	32	Hospital services, testing capacities, mental health services, health workforce bonuses	21 April
Ireland	1 800	274	Expand hospital capacity, develop primary and community-based responses, procurement of medical equipment	12 May
Italy[1]	6 312	101	Hiring of medical and nursing personnel, expanded private hospital capacity, purchase of medical equipment	17 March

Country	Additional commitment (millions, national currency)	Additional commitment (per capita, Euro PPPs)	Main expenditure areas	Date of latest available official announcement
Latvia	59	21	Health personnel expenditures, procurement of PPE, testing equipment, ventilators, surveillance, laboratory network	4 September
Lithuania	249	53	Purchase PPE, equipment, bonuses and social guarantees for health care workers	1 July
Luxembourg	194	217	Medical equipment and health infrastructure, testing capacities	4 April
Netherlands	800	39	Purchase, distribution and sale of medical devices, contribution to vaccine research, training additional health care personnel	24 April
Norway	12 160	148	Expenses for medicines and medical equipment, laboratory expenses, vaccination development	12 May
Poland	7 500	80	Creating and equipping infection hospitals, medical transport, additional health care services, purchasing PPE	1 April
Portugal	504	57	Health personnel expenditures, acquisition of medical equipment	18 June
Slovenia	247	99	Purchase of medical, protective equipment	30 August
Spain[1]	10 030	220	Ministry of Health support, transfer to regions, research on drugs and vaccine development	12 July
Sweden	12 366	89	Public Health Agency, National Board of Health and Welfare, Swedish Medical Produce agency, transfers to municipalities and regions for costs associated with testing and tracking	21 September
Switzerland[1]	2 910	180	Procurement of PPE, tests, medical supplies, medicines, funds for Coalition for Emergency Preparedness and Innovations	12 August
United Kingdom [1]	32 000	446	PPE; Test, Trace, Contain and Enable programme, procurement of additional ventilators	8 July

1. Denotes countries with a significant budgetary response at the subnational level.
Source: OECD member country governments (typically from ministries of finance or parliamentary reports).

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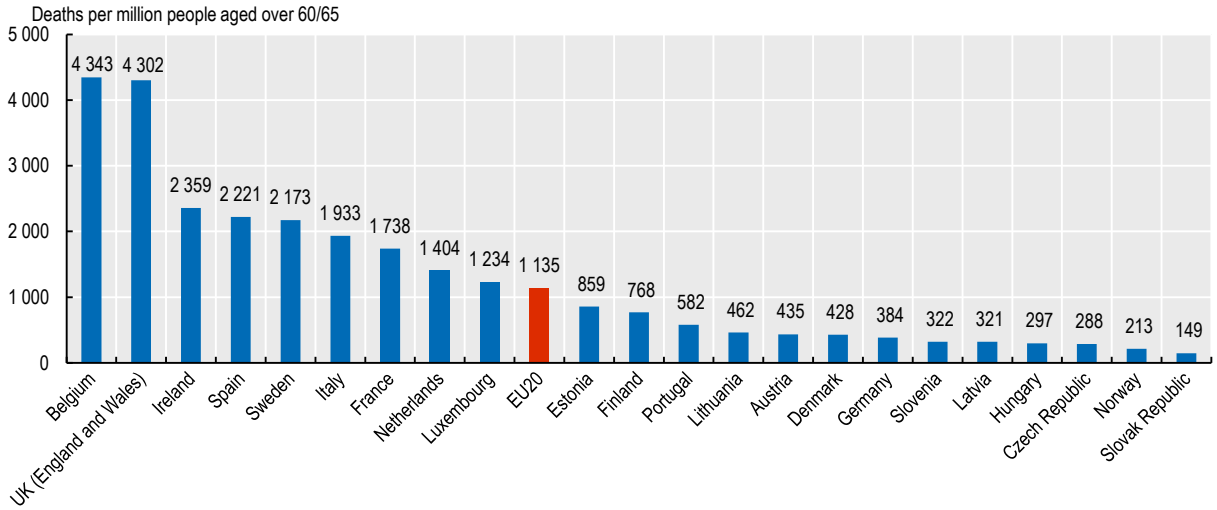
Figure 1.17 was revised to correct the data for Finland and now reads as follows:

Figure 1.17. Reported COVID-19 deaths per million people aged over 60/65, up to early October 2020 (or latest data available)



Note: Data on cumulative deaths up to mid-September/early October 2020, except for Portugal (August), Ireland and Luxembourg (July) and Spain (May). Data are not fully comparable due to different testing, reporting and coding procedures. In Belgium and Ireland, data include confirmed and suspected COVID-19 deaths. Data refer to people aged 60 and over in Denmark, France, Germany, Italy, Hungary, Netherlands, Norway, Portugal, Spain and Sweden. In France and Spain, as data disaggregated by age excluded deaths in long-term care (LTC) facilities, data on deaths in LTC facilities were added to the count of deaths.
Source: Institut National d'Etudes Démographiques, https://dc-covid.site.ined.fr, Eurostat Database, national epidemiological summaries and European Centre for Disease Prevention and Control (ECDC).

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Paragraph 2 was revised to reflect changes in Figure 1.8 and now reads as follows:

For testing, rapid scale-up of testing capacities, effective public health messages and population screening policies are key. Outside Europe, these factors largely explain Korea's excellent results in the early stages of the outbreak with relatively few tests, based on a swift and targeted approach that included innovative policies such as drive-through and phone booth testing centres, and strong public private partnerships. New Zealand has been another successful example. Within Europe, Denmark reported the highest number of daily tests in the early stages of the pandemic. Iceland was also able to rapidly scale-up testing, its success built on voluntary self-referrals and effective public information to encourage people to come forward.