Corrigendum

Page 17

The infographic was revised and now reads as follows:

![Infographic]

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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. 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)**

![Graph showing daily number of tests per 100,000 population](image)

**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.


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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.

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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).

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)

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

Corrigendum: Health at a Glance: Europe 2020
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.


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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.