Dear David Staples,

As you know, the Strategic COVID-19 Pandemic Committee argued in the Edmonton Journal on Feb 17 that the pandemic response should be based on facts. We agree. In this rebuttal we address the Committee's misleading assertions made in response to our pandemic plan.

First, our arguments were misrepresented, creating easy Straw Man arguments for the Committee to defeat without engaging with the evidence. Here we can address only a few.

1. We implied the lives of those over 60 are not as "worthy of protection" as younger patients.

In fact, we are trying to save seniors. Based on the evidence, we stated that people over 60 are the high-risk group that demands better protection, having markedly higher infection fatality rate than other age-groups [ref 1]. For example, our plan would have protected seniors in long-term care homes, preventing over 70% of deaths from COVID-19. Prolonged quarantine of our entire society, including those in long-term care, is what has occurred now; we instead proposed quarantine of long-term care homes, and visitation of quarantined seniors with appropriate facilities for protection provided.

2. We ignored illness in younger patients, with "9 [fatalities of Albertans] in their 20s," and "10-15% [of whom] will have 'Long-COVID' with… profound tiredness, heart problems…."

In fact, we acknowledge that younger patients get infection and sometimes require ICU care; that is why we stressed the need for surge capacity, more achievable if people over 60 were adequately protected. The incidence, severity, and duration of "Long-COVID" compared to contemporaneous cohorts of people suffering loneliness and depression from lockdowns are not known, and should not be exaggerated. The 9 COVID-19 deaths in people aged 20-29 are indeed tragic; yet the infection fatality rate at this age is 0.01%, lower than for influenza every year.

3. We claimed that "a relaxed, 'Swedish' approach to COVID results in fewer deaths than other countries that instituted lockdowns."

In fact, we stated that Sweden had lower deaths/capita than Quebec. The death rate in Sweden almost exactly tracks that of the average in the European Union [including countries with harsh lockdowns]. Different from our plan, Sweden failed to protect their long-term care populations.

Second, there were factual inaccuracies exaggerating the threat from COVID-19 and minimizing the harms from lockdowns. Here we can address only a few.

1. If 40% of Albertans were infected there would be "10-20,000 more deaths."

In fact, this calculation is inaccurate and exaggerated. If 40% of high-contact Albertans under age 60 were infected, with infection fatality rate being 0.05%, there would be up to 766 deaths, accounting for 7.3% of deaths in people under 60 occurring in Alberta over two years. Several studies show herd immunity can be obtained at natural infection rates of under 40% of the population.

2. We offered "no evidence" of infringement on Charter Freedoms.

In fact, there are many charter freedoms being infringed, including freedoms of association, peaceful assembly, mobility and travel, liberty, security of the person [e.g., access to healthcare, future funding for healthcare and other government programs, ability to earn a living], conscience and religion. These

freedoms are constitutionally guaranteed, “subject only to such reasonable limits… as can be demonstrably justified in a free and democratic society,” thus requiring a cost-benefit analysis [ref 2].

3. There is “no evidence” that lockdowns cause “more harm to population wellbeing and deaths in the long-term.”

In fact, there is ample evidence [ref 3]. Lockdowns on balance cause far more harm than benefit, as shown in cost-benefit analyses. Harms include loneliness and unemployment, which are among the strongest risk factors for shortened lifespan, early morality, and many chronic diseases. Harms include the recession which will, in the long-term, result in reduced government spending on many social determinants of health that in turn will reduce population wellbeing and lifespan. Major collateral harms also include those from disrupted healthcare, intimate partner violence, deteriorating mental health, and school closures. The efficacy of lockdowns in reducing COVID-19 cases has likely been highly exaggerated, as several analyses find no difference between case rates among countries with varying stringencies of lockdown [ref 4].

4. In the second wave the “number of patients requiring hospital and ICU care was over 900 patients.”

Indeed, at the second wave peak, 797 people were hospitalized with COVID-19, and 154 in ICU. Yet, AHS has 8515 acute care beds, and (based on outdated data from 2010 being used by the Committee) 292 ICU beds “capable of invasive ventilation” (with recent surge plans to 1081 ICU beds if necessary).

We proposed an Emergency Management response to the pandemic, with 3 priorities: protect concentrations of high-risk seniors; enact surge capacity in hospitals; and replace fear with confidence. We strongly advocate for vaccines, being highly effective to protect people from developing COVID-19. We recommend this plan start now.

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David Redman, Lieutenant Colonel (Retired), Former Head of Emergency Management Alberta.

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