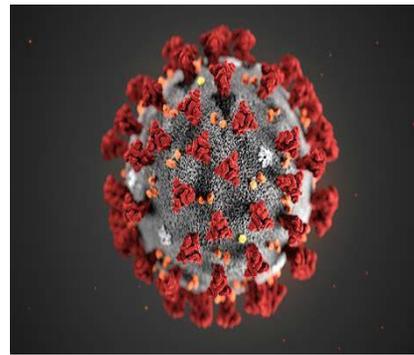


# THE CANADIAN RESPONSE TO THE COVID-19 PANDEMIC

## FACTS AND ISSUES



by Robert Lyman  
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## EXECUTIVE SUMMARY

The purpose of this note is to provide essential background information concerning the health and economic impact on Canada of actions taken by federal and provincial governments to address the Covid-19 pandemic, in order better to inform decisions by businesses and individuals as to the public policy actions they should consider supporting in future.

Public Health organizations have responded with varying degrees of urgency and effectiveness to the pandemic. They have focused largely on seeking to ensure that the public takes adequate measures to limit the transmission of the virus, imposing restrictions on public activity, and increasing the capacity of hospitals to deal with cases requiring intensive care. The restrictions on people's movement and lockdowns in turn have sharply increased unemployment and business losses and reduced incomes, to which governments have partially responded with unprecedented levels of expenditures, funded by increased public indebtedness.

As of January 14, 2021, over 14,870,942 people have been tested for Covid-19 in Canada. This corresponds to a test rate of 395,617 per one million people. Of all the people tested, 4.4% have been found to be positive. Of the 4%, almost all of them (i.e. 99%) are either asymptomatic or experiencing mild to moderate flu symptoms. The cumulative number of Covid-19 cases in Canada is 686,786, or 1.8% of the Canadian population of 37.8 million people. 584,652 (86%) of the people who have been shown by testing to have Covid-19 have recovered. The total deaths have been 17,383, or 2.5% of the cases, and 0.05% of the population. Both the hospitalizations and the deaths resulting from Covid-19 primarily affect people 50 years of age and older. Indeed, 89.2% of the people who have died from Covid-19 in Canada were 70 years of age or over. At the other end of the age spectrum, people under 40 years of age constitute only 17% of those hospitalized due to covid-19 and 0.4% of those who have died.

The Canadian Institute for Health Information published a report in November, 2020 describing Covid-19's effect on hospital care services. Notably, it found that:

- The initial response of the health care system was to prepare for the worst-case scenario. It based its modelling primarily on the experiences in Italy and Wuhan, China, which saw extreme levels of Covid-19 in their populations.
- In March 2020 many hospitals cancelled planned surgeries to ensure enough hospital resources (beds, staff and equipment) would be available for Covid-19 patients.
- Consequently, from March to June, 2020 overall surgery numbers fell 47% compared with 2019, representing 335,000 fewer surgeries. The cancellations varied according to urgency, but even life-saving and urgent surgeries declined by 17% to 21%, while those for disc surgery declined 42% and hernia repair 53%.
- By taking these actions, hospitals were able to free up more acute care and ICU beds. In January, 2020 Canadian hospitals had 3,170 beds capable of invasive ventilation.

Approximately US \$15 trillion worth of world productivity has been lost due to governments' response to Covid-19.<sup>1</sup> Billions of lives have been negatively affected by lockdowns, loss of income, loss of businesses in many sectors, massively increased poverty, health effects from Covid-19 and the “neglected” diseases (heart health, cancer and other screenings missed, medical care unavailable). This was not the direct result of the virus; it was the consequence of political choices.

In Canada, we have not yet had a full accounting of the economic or financial costs of the Covid-19 policies. In Canada and in most other countries, no government has undertaken even the most rudimentary analysis of the benefits and costs of the measures taken. There has been remarkably little transparency as to the reasons for the decisions taken, and frequently little or no consultation or even advance notice with the most affected stakeholders. The most basic standards of good public policy and democratic decision-making have been swept aside in what can only be described as a panic.

It is difficult to avoid the conclusion that federal and provincial governments have seriously failed the Canadian public in the ways that they have managed the public health and broader economic and societal policies before and during the onset of Covid-19. Along with the mass media, they have operated within, and arguably encouraged, an atmosphere of fear among the public, and belittled and sometimes suppressed dissenting voices.

In present circumstances, Canadians have no choice but to try to observe the restrictions under which they have been placed for at least some additional period of time. Canadian business has generally been excluded from the decision-making process but it has a responsibility to its employees, customers and shareholders to continue acting responsibly.

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<sup>1</sup> <http://reliefweb.int/report/worldpandemic-countries-humanitarian-crises-what-s-happened-so-far-and-what-s-coming-next>

## THE CANADIAN RESPONSE TO THE COVID-19 PANDEMIC – FACTS AND ISSUES

### Purpose

The purpose of this note is to provide essential background information concerning the health and economic impact on Canada of actions taken by federal and provincial governments to address the Covid-19 pandemic, in order better to inform decisions by businesses and individuals as to the public policy actions they should consider supporting in future. While the main focus of the note will be on the situation in Canada, it will use the results of reports by the Auditor General of Ontario to draw special attention to the experience there.

### Background

Covid-19 moved quickly across the world after its first outbreak in Wuhan, China in December, 2019. The first case of Covid-19 in Canada was confirmed on January 27, 2020 in Toronto. The incidence of the virus spread rapidly and reached an early peak in April, 2020, then gradually subsided over the warm weather months before re-emerging in a more aggressive form in the fall of 2020, and increasing to much higher levels in December and January 2021. Public Health organizations have responded with varying degrees of urgency and effectiveness and have focused largely on seeking to ensure that the public takes adequate measures to limit the transmission of the virus, imposing restrictions on public activity, and increasing the capacity of hospitals to deal with cases requiring intensive care. The restrictions on people's movement and lockdowns in turn have sharply increased unemployment and business losses and reduced incomes, to which governments have partially responded with unprecedented levels of expenditures, funded by increased public indebtedness. As of January 14, 2021, there remains considerable uncertainty as to how long the high levels of virus transmission will last, and therefore concerning the duration and severity of government response measures. In the hope that current mitigation measures will succeed in lowering the number of cases and hospitalizations, attention is increasingly focusing on the efforts that may be needed to accelerate the inoculation of the public with anti-Covid-19 vaccines.

### Statistical Summary of the Pandemic So Far

As of January 14, 2021, over 14,870,942 people have been tested for Covid-19 in Canada. This corresponds to a test rate of 395,617 per one million people. Of all the people tested, 4.4% have been found to be positive. Of the 4%, almost all of them (i.e. 99%) are either asymptomatic or experiencing mild to moderate flu symptoms. This means that, out of 37.8 million Canadians, 6,868 had severe symptoms

The cumulative number of Covid-19 cases in Canada is 686,786, or 1.8% of the Canadian population of 37.8 million people. 584,652 (86%) of the people who have been shown by testing to have Covid-19 have recovered. The total deaths have been 17,383, or 2.5% of the cases, and 0.05% of the population. Why the discrepancy between the 6,868 people who

experienced severe symptoms and the 17, 383 officially recorded as having died from Covid-19? It may be that this difference can be explained by the practice of counting any person who died within 28 days of taking a positive test as a Covid-19 death, even though the death might have been caused by co-morbidities or other reasons.

The number of cases and deaths by province and territory is indicated in Table 1.

Table 1

Cumulative Covid-19 Cases and Deaths by Jurisdiction in Canada

| <u>Jurisdiction</u>   | <u>Cases</u> | <u>Deaths</u> |
|-----------------------|--------------|---------------|
| British Columbia      | 59,072       | 1,031         |
| Ontario               | 228,310      | 5,189         |
| Quebec                | 236,827      | 8,878         |
| Alberta               | 113,618      | 1,368         |
| Manitoba              | 26,695       | 753           |
| Saskatchewan          | 19,017       | 206           |
| Nova Scotia           | 1,542        | 65            |
| New Brunswick         | 836          | 12            |
| Newfoundland          | 393          | 4             |
| Prince Edward Island  | 103          | 0             |
| Nunavut               | 266          | 1             |
| Yukon                 | 70           | 1             |
| Northwest Territories | 24           | 0             |

Thus, Ontario, Quebec and Alberta account for 84% of the cases and 89% of the deaths related to Covid-19. This is not surprising, given that these three provinces contain 73% of Canada's population as well as many of the most densely-populated areas.

A better understanding of the demographic consequences of the virus can be gained by reviewing the numbers of people in Canada that have been hospitalized and have died as a result. Table 2 indicates the cumulative figures as of January 13, 2021.

Table 2

Cumulative Hospitalizations and Deaths Due to Covid-19

| <u>Age Group</u> | <u>Hospitalizations</u> | <u>%</u> | <u>Deaths</u> | <u>%</u> |
|------------------|-------------------------|----------|---------------|----------|
| 0-19             | 538                     | 1.5      | 3             | 0.0      |
| 20-29            | 1,091                   | 3.1      | 24            | 0.1      |
| 30-39            | 1,800                   | 5.1      | 47            | 0.3      |
| 40-49            | 2,506                   | 7.1      | 118           | 0.7      |
| 50-59            | 4,259                   | 12.1     | 392           | 2.4      |
| 60-69            | 5,817                   | 16.5     | 1,187         | 7.2      |
| 70-79            | 7,371                   | 21.0     | 3,063         | 18.6     |
| 80+              | 11,772                  | 33.5     | 11,601        | 70.6     |

From this data, one can see that both the hospitalizations and the deaths resulting from Covid-19 primarily affect people 50 years of age and older. Indeed, 89.2% of the people who have died from Covid-19 in Canada were 70 years of age or over. The disease most seriously affects the elderly. At the other end of the age spectrum, people under 40 years of age constitute only 17% of those hospitalized due to covid-19 and 0.4% of those who have died. Further, an extremely large share of those who have been hospitalized or died have co-morbidities that might have been the main cause of illness.

## Questions concerning the Reliability of the Testing

The vast majority of the testing to determine whether an individual is “infected” or not uses an RT-PCR (reverse transcriptase polymerase chain reaction) test. As a layman, I do not pretend to understand the merits of this testing procedure, which essentially involves drawing fluid from a person’s nasal cavity and seeking to determine whether this fluid contains particles that are evidence of Covid-19. Several questions have been raised about the reliability of this testing, such as:

- The PCR test was not designed as a diagnostic tool for confirming infections; the present usage yields 99% of positives where fragments of virus mRNA are detected but where the patient is not infected or only mildly so. How can such a test be trusted without detailed follow-up and medical diagnosis?
- If someone tests positive who is asymptomatic, are they infectious, and if so, how infectious? If someone tests positive who is symptomatic, same question.
- False negative and false positive rates on current Covid-19 tests have been reported in 2 to 33% of the cases, and even up to 99% in one case. Why then is everyone who is tested positive considered not only to be a “Covid case”, but also to be infectious to others?
- Why have the questions (and answers) surrounding the testing not been made public and clearly explained?

## Sources of Transmission/Exposure

A great deal of controversy surrounds the topic of how the Covid-19 virus is spread within the population. The public health authorities claim to have detailed case report data for 632,312 cases, but exposure history was only available for 418,379 (66.2%) cases. The “probable” exposure setting of these reported cases are:

- Domestic acquisition (defined as any exposure that occurred in Canada): 401,402 (95.9%)
  - From contact with a Covid case: 243,398 (58.2%)
  - From contact with a traveller: 4,239 (1.0%)
  - From an unknown source: 153,765 (36.8%)
- Currently unknown: 10,616 (2.5%)
- Travelled outside Canada: 6,361 (1.5%)

These are quite extraordinary figures from a number of perspectives. It is remarkable that:

- Officials have no exposure data on fully one third of the cases
- There is no breakdown indicating whether transmission was at home, at work, in recreation, or in other settings. There is also no breakdown that indicates whether transmission of the virus probably occurred indoors or outdoors.
- The percentage of exposure from contact with a traveller or from having travelled outside Canada is 2.5%. This is striking, given the enormous controversy that has surrounded instances of travels by people abroad.

There also are some notable gaps in the information. For example, approximately 200,000 people immigrated to Canada in 2020. There were tens of thousands of migrant workers who entered Canada temporarily during the harvest season. No data has been published as to how many of them brought Covid-19 with them, and it seems very difficult to believe that none of them did.

It is possible that health agencies have more detailed information than is being published and made available to the public. If so, this is unfortunate, as it leaves the public without the information it needs to form an objective view of the decisions that are being made, especially with respect to curtailments of people's mobility and lockdowns of businesses.

The testing practices and the data reporting based on it varied considerably across Canada. For example, according to the Auditor General of Ontario, due to its delay in expanding lab capacity Ontario took one month longer than Alberta and three weeks longer than British Columbia to allow anyone with Covid-19 symptoms to be tested. As a result of this delay, as of August 31, 2020 the Auditor General estimated that about 119,000 Ontarians contracted Covid-19 and were not tested for it.

#### The Public Health System Response to Covid-19

The Public Health System response to Covid-19 has consisted of several different parts. These have included testing, tracking cases, changing hospital practices, adding capacity to hospitals where possible, imposing special requirements on long-term care facilities, and many others. The Government of Canada has also much expanded its information services for Canadians, as indicated by the following website:

<https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/prevention-risks/measures-reduce-community.html>

The Canadian Institute for Health Information published a report in November, 2020 describing Covid-19's effect on hospital care services. Notably, it found that:

- The initial response of the health care system was to prepare for the worst-case scenario. It based its modelling primarily on the experiences in Italy and Wuhan, China, which saw extreme levels of Covid-19 in their populations.
- In March 2020 many hospitals cancelled planned surgeries to ensure enough hospital resources (beds, staff and equipment) would be available for Covid-19 patients.
- Consequently, from March to June, 2020 overall surgery numbers fell 47% compared with 2019, representing 335,000 fewer surgeries. The cancellations varied according to urgency, but even life-saving and urgent surgeries declined by 17% to 21%, while those for disc surgery declined 42% and hernia repair 53%.
- Twenty-two per cent fewer people were admitted to intensive care units (ICU) than in the comparable period of 2019, with much fewer admissions for cardiac conditions, strokes or pneumonia.
- By taking these actions, hospitals were able to free up more acute care and ICU beds. In January, 2020 Canadian hospitals had 3,170 beds capable of invasive ventilation.

The Financial Accountability Office of Ontario, in its *Preliminary Review of the Impact of the Covid-19 Outbreak on Hospital Capacity*, began by noting that in 2019-20, Ontario hospitals had 34,700 beds, of which 22,400 were acute care beds and 2,012 beds configured for critical care. The average occupancy rate was 96 %. Ontario's rate of total hospital beds per 1,000 people was among the lowest in the Organization for Economic Cooperation and Development (OECD), and its occupancy rate was the highest. In other words, at the beginning of the outbreak, Ontario hospitals had virtually no spare capacity to deal with a pandemic. By April 14, the Province and Ontario hospitals had taken measures (i.e. essentially, reducing services to other patients) that made available 9,349 acute care beds, 2,077 critical care beds, and 2,075 critical care beds with ventilators. The Province expanded capacity by spending \$300 million for new beds and taking other actions.

### How Ontario Managed the Pandemic

Every province has faced a major challenge in terms of how it managed the Covid-19 outbreak, and there has been some variation across Canada in terms of how well each jurisdiction has done in testing, tracking the spread of the virus, using the resources of the public health system to deal with confirmed cases and applying lockdown measures. With respect to how they have managed the health Care system, only Ontario has had a thorough review of its performance, carried out by the Office of the Auditor General (AG) of Ontario. The Ontario AG, Bonnie Lysyk, released a series of reports in late 2020 that examined outbreak planning and decision-making.

The reports were generally critical of Ontario's response. The AG found that it was slower and more reactive than those of other provinces, the command system was overly cumbersome, and the Chief Medical Officer of Health did not lead the province's response, nor did he fully exercise his powers under the *Health Protection and Promotion Act* to ensure that public health units responded consistently to the pandemic. Stakeholders were not always told about decisions that impacted them before the decisions were publicly announced. Stopping non-

essential hospital services resulted in significant backlogs of elective surgeries. According to a study in the Canadian Medical Association Journal, between March 15 and June 13, Ontario had an estimated backlog of over 148,000 surgeries, which would take 84 weeks to clear.

Notably, the Province failed to benefit from the lessons of past pandemics. To quote from the AG report:

*“We found that key lessons identified in the aftermath of the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003 had not been implemented by the time Covid-19 hit Ontario, and were not followed during Ontario’s Covid-19 response.*

*International best practices indicate that there are three critical things that must be done to control the virus – timely testing, managing positive cases, and contact tracing... Laboratory testing, case management and contact tracing are still not being performed in Ontario in a timely enough manner to contain the spread of the virus. If there were no delays in completing these activities, an infected person’s potential to transmit Covid-19 to others can be reduced by 80%.*

*The need for properly resourced public health labs in Ontario and better information systems had been pointed out by experts and others, including our office, with little or no action taken until the onset of the Covid-19 pandemic. If these longstanding concerns had been addressed earlier, the Ministry would have better information to enable it to adjust testing eligibility criteria to the highest-risk Ontarians and probable cases, and Ontario could have responded to Covid-19 more quickly, more effectively and more efficiently.”*

We know that some other provinces have had similar problems but have not yet seen the comprehensive analysis that was done for Ontario. All jurisdictions were admittedly dealing with an unanticipated and fast-developing public health challenge.

### The “Flattening the Curve” Issue

In the early months of the pandemic, health authorities and political leaders repeatedly emphasized that the restrictions that were being imposed were temporary, as the modelling done by health officials indicated that, without such measures, the number of people requiring hospitalization and/or intensive care might exceed the capacity of the hospitals.

According to published sources, prior to the outbreak of Covid-19, Canada had 3,170 ICU beds capable of invasive ventilation, and 4,982 ventilators capable of invasive ventilation. The provincial breakdown of these facilities is indicated in Table 3.

Table 3  
Pre-Covid ICU and Ventilation Capacity by Province

| <u>Province</u>      | <u>ICU Beds With Ventilation</u> | <u>Ventilators</u> |
|----------------------|----------------------------------|--------------------|
| Newfoundland         | 98                               | 124                |
| Nova Scotia          | 141                              | 191                |
| Prince Edward Island | 18                               | 22                 |
| New Brunswick        | 103                              | 113                |
| Quebec               | 885                              | 1,197              |
| Ontario              | 1,122                            | 2,101              |
| Manitoba             | 93                               | 151                |
| Saskatchewan         | 108                              | 235                |
| Alberta              | 292                              | 373                |
| British Columbia     | 304                              | 460                |
| Territories          | 3                                | 15                 |
| Canada               | 3,170                            | 4,982              |

Canada has far fewer ICU beds per capita than the United States, but similar numbers of ICU beds to those in many Western European countries. The actual numbers of Covid-19 patients in ICU beds has never come anywhere close to the capacity in place before the pandemic, and certainly not to the increased capacity that has been added in provinces like Ontario. For example, on January 14, 2021, which marks a peak in the demand for Covid-19-related hospital services in most provinces, the number of Covid-19 patients in ICU in Ontario was 387, 34% of the pre-Covid ICU capacity, and only 19% of the increased capacity in place after April 2020. In

Quebec has been one of the hardest-hit provinces; with only 23% of Canada's population, Quebec has had 34% of the Covid-19 cases and 50% of the Covid-19-related deaths. The number of Covid-19 patients in ICU on January 14 2021 was 136, 15% of the pre-Covid 19 capacity. The public explanation that has been given is that the constraint is not the number of ICU beds but the number of qualified nurses to administer them.

Thus, it appears that the need to "flatten the curve" has been considerably exaggerated. Most Canadian provinces, on average, have come nowhere close to exhausting physical capacity. The shortage of nurses is a different problem, and one that has been publicized for years. It may have something to do with the incomes available to nurses, an issue that deserves a great deal of attention in the post-Covid 19 period.

### The Indirect Effects of Covid-19 on Mental Health and Social Wellbeing

In early 2020, the World Health Organization Department of Mental Health and Substance Use expressed concerns about the potential effects of Covid-19 on mental health and wellbeing. It listed the emerging mental health issues related to the pandemic as related not only to fears about the direct effects of contracting the virus but also the "psychosocial stressors" such as the use of isolation and quarantine. They expressed special concern about the impacts on children who were isolated or quarantined as they were more likely to develop acute stress disorder, adjustment disorder, and grief. Studies at the time indicated that 30% of the children who were isolated or quarantined met the clinical criteria for posttraumatic stress disorder.

Canada's experience as to how Covid-19 has affected mental health has been documented in three surveys conducted by Mental Health Research Canada (MHRC), the most recent of which was published in November 2020. The following are the major findings:

- The Covid-19 outbreak and restrictions led to an increase in both anxiety and depressions and, as time continues, this has not lessened.
- Compared to the situation before the outbreak, the proportion of Canadians reporting high levels of anxiety quadrupled, while those with depression doubled. One in four Canadians have dealt with a personal or family diagnosis of anxiety or depression.
- More than half the Canadians who report high levels of anxiety or depression are likely to be classified as moderate to severe.
- The highest proportions of people likely to be diagnosed with anxiety or depression are females, younger people (aged 18 to 34), people living alone, and front-line healthcare workers.
- Two-thirds of those who have received a personal or family mental health diagnosis are taking action to treat it, with prescription medication being the most common, and one quarter talking to a therapist.
- The highest sources of mental health stress related to Covid-19 relate to recent job loss or the possibility of job loss or reduced working hours.

In a paper<sup>2</sup> recently published in the Canadian Medical Association Journal, researchers assessed the “indirect” effects of Covid-19 on the health of children and young people. They noted that, while hospitalizations have been relatively low, *“pandemic-related service closures have resulted in limited access to primary and secondary health care, parental fear of seeking health care, closures of daycares and schools, and employment and financial instability.”* They warned that *“adverse childhood experiences, including family violence, nonaccidental trauma and mental illness are expected to increase during lockdown and worsen during the anticipated economic recession. Existing economic and health inequities are likely to worsen.”*

Public Health Ontario carried out a review<sup>3</sup> of the negative effects of public health measures during a pandemic based on evidence over several years. It found that the effects of the Covid-19 response so far have been decreased vaccination coverage, decreased movement behavior, impacts on nutrition (e.g. low physical activity, poor diet, increased screen time, and sedentary behavior), and on children’s mental health. In particular, the reduction in outdoor activities, free play and social interactions may be associated with an increase in children’s depression, anxiety, irritability, and stress.

Ana Fostik of the Vanier Institute of the Family has offered an interesting analysis<sup>4</sup> of the effects of Covid-19 on family life across Canada. In it, she notes that the lockdowns implemented in early 2020 presented unique circumstances and increased pressures on couples. Many of them found themselves together 24/7 – sometimes with children- while quickly adapting their homes into shared workspaces and/or learning environments. Some had to deal with the financial pressures resulting from unemployment. There was clearly the potential for both positive and negative outcomes. Couples who previously had little time to share with one another might have greatly improved their relationships.

For others, tensions that existed in the marriage and were previously masked by minimal contact might become worse. In almost every country that has instituted lockdowns in response to Covid-19, there have been increases in intimate partner violence ranging from 20 to 30 per cent, according to Dr. Patricia O’Campo, who holds the Canada Research Chair in Population Health Intervention Research at the University of Toronto. Higher contact levels between unhappy couples might increase the possibility that couples would consider separation or divorce. The academic research shows, ironically, that in difficult economic times when unemployment is high, the divorce rates actually decline – possibly due in part to the cost of divorce or related aspects of ending a couple relationship. In contrast, studies in the United States show that between 1979 and 2009 as incomes increased, the incidence of divorce also increased.

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<sup>2</sup> Neil Chanchlani, Francine Buchanon and Peter Gill. Addressing the indirect effects of Covid-19 on the health of children and young people. CMAJ, August 10 2020

<sup>3</sup> <https://www.publichealthontario.ca/-/media/documents/ncov/cong/2020/06/covid-19-negative-impacts-public-health-pandemic-families.pdf>

<sup>4</sup> <https://vanierinstitute.ca/covid-19-impacts-couple-relationships-in-canada/>

## The Economic Costs of the Governmental Response

Approximately US \$15 trillion worth of world productivity has been lost due to governments' response to Covid-19.<sup>5</sup> Billions of human lives have been negatively affected by lockdowns, loss of income, loss of businesses in many sectors, massively increased poverty, health effects from Covid and the "neglected" diseases (heart health, cancer and other screenings missed, medical care unavailable). This was not the direct result of the virus; it was the consequence of political choices.

In Canada, we have not yet had a full accounting of the economic or financial costs of the Covid-19 policies. The Parliamentary Budget Office in June 2020 prepared an analysis of the costs of the federal government special measures that had been introduced to that point in time. As illustrations, the Canada Emergency Wage Subsidy was projected to cost \$74 billion in 2020-21, the Canada Emergency Response Benefit \$66 billion, the Canada Recovery Benefit \$13 billion, and the Canada Emergency Business Account \$9 billion. The federal government's budget deficit for the year is likely to exceed \$400 billion, and there have been no estimates provided of the collective expenditures, or increased indebtedness, of the provincial and territorial governments.

With almost unimaginable amounts of money at stake, one would have thought that each and every assumption that underlay the responses would have been broken down, intensely scrutinized, tested, discussed publicly, and shared. Instead, in Canada and in most other countries, no government has undertaken even the most rudimentary analysis of the benefits and costs of the measures taken. There has been remarkably little transparency as to the reasons for the decisions taken, and frequently little or no consultation or even advance notice with the most affected stakeholders. The most basic standards of good public policy and democratic decision-making have been swept aside in what can only be described as a panic.

It would take a much longer and more rigorous analysis to understand why this has happened. One point that should be obvious is that governments, driven by political considerations, accepted the demands of the media and certain groups that reducing the number of Covid-19 deaths was a public policy objective that over-rode all others – and especially made economic considerations (often referred to as "crass commercial considerations") of low priority, and often the object of ridicule.

## The Great Barrington Declaration and the John Snow Memorandum

On October 5, 2020, a group of prominent infectious disease epidemiologists and public health scientists published a declaration stating their "grave" concerns about the damaging physical and mental health impacts of the prevailing Covid-19 policies and recommended an approach

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<sup>5</sup> <http://reliefweb.int/report/worldpandemic-countries-humanitarian-crises-what-s-happened-so-far-and-what-s-coming-next>

that they called “Focused Protection”. Thousands of physicians and scientists have subsequently signed the declaration.

The physicians and scientists stated that:

*“Current lockdown policies are producing devastating effects on short and long-term public health. The results (to name a few) include lower childhood vaccination rates, worsening cardiovascular disease outcomes, fewer cancer screenings and deteriorating mental health – leading to greater excess mortality in years to come, with the working class and younger members of society carrying the heaviest burden. Keeping students out of school is a grave injustice.”*

The FAQ (i.e. frequently asked questions) concerning the Great Barrington Declaration can be found here:

<https://gbdeclaration.org/frequently-asked-questions/>

Within weeks, an opposing group of experts, also numbering in the thousands, had put their names to the John Snow Memorandum. The document defended the restrictions to slow the spread of SARS-CoV-2 as “essential to reduce mortality, prevent health-care services from being overwhelmed, and buy time to set up pandemic response systems to suppress transmission”. It described focused protection as “a dangerous fallacy unsupported by scientific evidence” and warned that “uncontrolled transmission in younger people risks significant morbidity and mortality across the whole population”. The memorandum concluded by asserting that “controlling community spread of COVID-19 is the best way to protect our societies and economies until safe and effective vaccines and therapeutics arrive within the coming months”.

The drafters of the Great Barrington Declaration stress that they are not suggesting people behave recklessly. Basic precautions, such as handwashing and self-isolation, when necessary, should be maintained. But the priority, in their view, is to dismantle many of the constraints that have been imposed all over the world over the past year. The declaration advocates the resumption of sports and cultural events and the re-opening of restaurants and other businesses. It advises young, low-risk adults to discontinue working from home.

The sponsors of the Great Barrington Declaration reckon a focused protection approach would lead to herd immunity some time between 3 and 6 months, after which the vulnerable could return to normal life. The sponsors of the John Snow Memorandum reply that the herd immunity point has not been established, nor is it clear how stable this immunity would be. They noted that the 11 million infections and 250 000 deaths from COVID-19 that have been documented in the USA only constitute a small fraction of the total population. They insist that people wait for herd immunity to be conferred by a vaccine. Most experts believe the earliest this could happen would be the second half of 2021. The debate over what to do in the interim looks set to continue.

Unfortunately, as is so often the case, the debate among epidemiologists has been politicized, with many in the U.S. media condemning the Great Barrington Declaration as a product of “Trump-like thinking”.

### Conclusion

It is difficult to avoid the conclusion that federal and provincial governments have seriously failed the Canadian public in the ways that they have managed the public health and broader economic and societal policies before and during the onset of Covid-19. Along with the mass media, they have operated within, and arguably encouraged, an atmosphere of fear among the public, and belittled and sometimes suppressed dissenting voices.

In present circumstances, Canadians have no choice but to try to observe the restrictions under which they have been placed for at least some additional period of time. Canadian business has generally been excluded from the decision-making process but it has a responsibility to its employees, customers and shareholders to continue acting responsibly.

I hope that the information in this note will help to inform a discussion about the future.