

superimposed with districts where more COVID-19 cases were observed (Fig. 2)"; c) As correlações apresentadas (Fig.s 3 e 4 do artigo de Nogueira PJ *et al*) são fortes (R e Rho , 0,98/ 0,78/ 0,45/ 0,52) e significativas ($p < 0,001/ < 0,001/ < 0,06/ < 0,028$). Usando dados do INE,² verifica-se que tanto a subida em março, o cume no início de abril e a descida posterior dos novos casos COVID-19 como o excesso de mortalidade foram simultâneas. Estes dados, juntamente com os dados do relatório nº 55 da DGS reforçam a importância já denotada do factor COVID-19: a) as mortes por COVID-19 explicarão a esmagadora maioria

das mortes em excesso verificadas, b) a grande maioria de ambas verificaram-se nas idades acima de 84 anos; recorda-se que 40% das mortes por COVID-19 foram em lares de idosos (DGS), que se desconhecem as causas de muitas mortes nos lares ou em instituições de cuidados continuados,³ e que os dados são de auto-preenchimento por parte dos lares.⁴ O grupo mortalidade nos com mais de 74 anos é demasiado grande e heterogéneo, pelo que seria benéfica a análise de subgrupos. As mesmas razões para análise separada por sexos.

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We are grateful for the interest and comments¹ of our recently published study on excess mortality estimation during the COVID-19 pandemic in Portugal.²

The aim of our investigation was essentially to be factual about the observed excess all-cause mortality. Therefore, in our paper we separate excess mortality calculations from possible contributory explanations, where several could be acting simultaneously. From our perspective, usual estimates are performed by comparing with homologous period in recent years, assuming 'normal conditions'. We found it important to highlight that such procedure might not be correct in the real lockdown period. Our scenarios are intended to promote discussion and to demonstrate that the observed excess mortality is higher than what has been discussed. There is nothing alarming about assuming at least 2400 to 4000 deaths as the estimations are explained and supported by both science and data.

We hypothesize that the observed reduction in access to health care should have had its impact on the death toll. It is important to clarify that our estimate for access to healthcare during the study period was done independently and it is not included in any of our all-cause excess mortality estimations. It rather represents an academic exercise to potentially explain part of the observed excess mortality. Therefore, the imputation of potential deaths due to the increased non-attendance of emergency care, while using 2008 study mortality risk estimators according to severity level, is not relevant to the observed excess mortality, as it is not part of its calculation. Furthermore, one can argue that the mortality risk in those not attending the emergency department while actually needing to do so will supposedly be higher than the mortality observed in those who attend, regardless of any improvement in healthcare services since 2008. Additional hypotheses for the observed excess overall mortality also includes deaths with identified COVID-19 infection and deaths with unidentified COVID-19 infection. Moreover, our study did not aim to calculate unidentified COVID-19 deaths.

Finally, several studies have been consistently pointing towards excess mortality quite above the number of deaths in those infected with COVID-19, both in Portugal³ and in other countries.⁴⁻⁶ We acknowledge that further research is necessary to integrate the different estimates in our main calculation, and we hope that such studies will be performed.

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