With more than 1 million dead, who have been the victims of the coronavirus pandemic?

Part one

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This is the first of a two part series.

Ten months into the COVID-19 pandemic, every major news outlet has called attention to the sobering figure of 1 million deaths. Even more startling are the projections that by the end of the year, that figure might far exceed 2 million as the Northern Hemisphere is bracing for the winter season. The Institute of Health and Metrics Evaluation's most recent projection has placed this figure at 2,343,648 by January 1.

Such a massive rapid loss of life is unprecedented in recent history. It was only eight months ago that the first 1,000 deaths were tallied, and practically all took place in China. There are now 1,039,332 deaths, spanning all the world's continents except for Antarctica, and by most scientific and public health sources, that figure represents a considerable underestimate. COVID-19-related deaths already exceed annual deaths from HIV and malaria and may surpass tuberculosis. There is more death forthcoming.

Scenes of devastation

The harrowing and eerie images of empty city streets in Wuhan city in Hubei province evoked disbelief. The corpses being whisked away in trucks from hospitals in Bergamo, Italy, in the dead of night counterposed to the melancholic faceless voices singing in unison from balconies left the world heartbroken.

Bulldozers digging massive graves and men in protective gears piling coffins into the ground at Hart Island in New York City were a chilling reminder of the deadliness of the coronavirus. Health care workers protesting in garbage bags in front of their hospitals, decrying the dangers they face on the front lines, provoked anger and resentment that a country with such vast riches could allow such a situation exist.

The miles of cars waiting in lines at food banks across the nation have been a stark reminder of the fragile state of affairs for the working class, who have been left destitute by the millions. The massive international protests against police violence and brutality have indelibly imprinted the multiracial and global character of the class struggle erupting into the open.

Despite these critical developments and events, the global economy's rapid reopening continues to see from one month to the next deaths remaining at a staggering level averaging more than 160,000 a month, indicating that the current half-hearted efforts to stem the impact of the pandemic have only steadied the assault. As schools face the prospect of resuming in-class instruction so that parents can reenter the workplace in full force, it will only begin accelerating the pandemic into a third surge.

Many early deaths in the US from COVID-19 occurred at Lifecare Center of Kirkland, Washington, which became the pandemic's first epicenter in this country. However, no urgent call was placed to protect the vulnerable population living in nursing homes and extended care facilities. Instead, in many states, elderly people in the final stages of COVID-19 were sent back to nursing homes to die and ended up infecting large numbers of residents and staff.

By mid-June, the *Wall Street Journal* had reported that nursing home fatalities associated with COVID-19 had topped 50,000 out of the 116,700 deaths that had taken place by then. The number of cases in nursing homes had reached more than 250,000, which was most likely an undercount representing over 10 percent of those infected at the time though they made up less than 1 percent of the US population.

A report released in June by the Canadian Institute for Health Information comparing mortality associated with COVID-19 in long-term homes, globally, as a percentage of total deaths, found the following statistics:

Canada, 81 percent of all COVID deaths; United States, 31 percent; Ireland, 56 percent; the UK, 27 percent; Germany, 34 percent; France, 48 percent; Spain, 66 percent; Belgium, 50 percent; Norway, 57 percent; Israel, 58 percent; and Australia, 33 percent. More recently, for the United States, the Centers for Medicare and Medicaid Services reported that as of September 20, there had been 238,283 total confirmed cases, 138,783 suspected cases, and 57,008 deaths at such facilities.

The impact of the pandemic on front-line health care workers has been nothing short of criminal negligence. With personal protective equipment (PPE) and respirators in short supply, no cohesive international or national efforts were undertaken to bring the entire globe's capacity and resources to contain and eradicate the virus. Instead, health care workers were forced to care for and treat their patients while left defenseless, turning to an assortment

of ad hoc means to protect themselves from falling victim.

In September, the director of Pan American Health Organization, Carissa F. Etienne, reported at a press conference that nearly 570,000 health workers across the hemisphere had fallen ill, and more than 2,500 had perished. She added, "in the US and Mexico—which have the highest case counts in the world—health workers represent one in every seventh case, and these two countries account for nearly 85 percent of all COVID deaths among health workers in our region."

A report from Amnesty International (AI) last month found that at least 7,000 health workers have died worldwide. At least 1,320 of these are confirmed to have succumbed to the infection in Mexico. Though the Centers for Disease Control and Prevention (CDC) places US health worker deaths at close to 700 and AI at 1,077, a recent report released by the National Nurses United last week estimated 1,718 US health care workers had died from COVID-19 complications.

A report released by the *Lancet* last month found that among health care workers in the US and the UK, front-line workers had at least a threefold higher risk of reporting a positive COVID-19 test or suspected infection. The reuse of PPE and inadequate PPE were associated with an increased risk of COVID-19.

Still, more than seven months into the US pandemic, nurses continue to face challenges in accessing proper PPE and N95 masks. Last month, nurses at HCA hospitals in Florida, Kansas, Missouri, and Nevada held public actions to bring attention to the reuse of single-use N95. A survey by Healio found that among nurses who reported reusing N95 masks, 58 percent reused masks for five days or more.

The survey noted that 51 percent had treated COVID-19 or suspected positive cases in the last two weeks among respondents. PPE shortages remained commonplace, with 42 percent experiencing widespread or intermittent inadequacy. Some 37 percent said that N95 masks were in short supply. The reuse of N95 remains commonplace and strongly encouraged by hospital and medical facility administrators.

Who else has died?

In the US, those aged 65 and older represent 16 percent of the population but have accounted for 80 percent of COVID-19 deaths, while people under 35 account for approximately 3 percent of COVID-19 deaths. A disproportionate number of these occurred in the long-term facilities, as mentioned above.

Data from July 22 found that out of 31,688 deaths in New York, 24,304 were 65 or older, accounting for 77 percent. For New Jersey, it was 79 percent; Massachusetts, 91 percent; and Pennsylvania, 87 percent. Though sunbelt states had a younger mean age for infections, the elderly made up for the lion's share of deaths. One-third of COVID-19 deaths occurred in people who were at least 85 years of age.

During the spring months, those more than 60 years of age represented 30 to 40 percent of COVID-19 cases, while those under 40 came in at 30 percent. Presently, the curves have shifted with under 40, making up more than half the cases with under 20 representing approximately 16 percent. Those who are 60 or older now make up only 17 percent of newly infected individuals.

Additionally, several studies from China, Europe, and the US have investigated non-communicable illnesses such as high blood pressure, diabetes, and cardiac disease as contributing factors for developing severe or fatal COVID-19 infection. A study using data on 72,314 cases from the Chinese Center for Disease Control and Prevention published in the *Journal of the American Medical Association* (*JAMA)* on April 7 found that the overall case-fatality rate (CFR) was 2.3 percent. However, those with cardiovascular disease had a 10.5 percent mortality risk, 7.3 percent for diabetes, 6.3 percent for chronic respiratory disease, 6.0 percent for hypertension, and 5.6 percent for cancer.

There are two estimates to calculate COVID-19 deaths. CFRs are based on using only known cases, while infection-fatality rates (IFRs) use the more extensive estimates of how many people have likely had infections. Thought the global CFR stands just under 3 percent, the often-quoted IFR is about 0.6 percent, about six times deadlier than the seasonal flu.

However, the bulk of the entire population of the planet has no natural immunity to this novel virus and is at considerable risk. Given COVID-19's ability to infect large clusters of people, it is considered highly virulent. It is also known to cause a constellation of symptoms ranging from respiratory, cardiac, blood clotting, kidney and neurologic ailments with convalescence times measured in weeks by symptomatic people who have recovered. A small percentage of patients known as long-haulers have developed persistent headaches, difficulty in concentration, intermittent fevers, and an array of neurologic and psychiatric issues. The long-term complications remain unknown.

According to the International Severe Acute Respiratory and Emerging Infection Consortium, the global survival rate for people hospitalized for COVID-19 has increased from 66 percent in March to 84 percent in August. There is debate over whether the decline seen in death rates is due to improved therapeutics and clinical care for COVID-19 or to a byproduct of a shift in the demographics. But all agree that should hospitals become inundated again as they had been in the spring, mortality will climb.

To be continued