

SEP Summer School 2021 Lecture

The historical background and initial stages of the COVID-19 pandemic

Benjamin Mateus
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The 1918 Influenza has been described as the mother of all pandemics. The COVID pandemic is certainly challenging that long-held characterization.

It has been estimated that at least one-third of the world's population (or approximately 500 million people) were clinically infected during the Spanish flu more than a hundred years ago.

The case fatality rate for the 1918 Influenza pandemic has been estimated to be greater than 2.5 percent, as compared to a typical flu that has a less than 0.1 percent lethality. Worldwide, total deaths were estimated at 50 million and arguably as high as 100 million.

Placing this into context, World War I itself caused far less loss of life, with 20 million deaths. There were 9.7 million military personnel that died and about 10 million civilians. Both sides saw an essentially equal number of combat casualties.

Many comrades have been following the epidemiological graphs of the current pandemic and are now familiar with them. The accompanying graphs that describe the death rates over time show how different social distancing and mitigation measures employed in various cities across the US led to different mortality outcomes. They proved that rapid and sustained social distancing and mitigation measures saved lives.

In Philadelphia, as the deadly wave of influenza was just beginning to surge, city officials went ahead and hosted the Philadelphia Liberty Loans Parade in which more than 200,000 people were in attendance. The city oversaw raising \$259 million for war-time efforts. That was on September 19, 1918. Twenty-four hours later, 118 Philadelphians were coming down with the mysterious deadly influenza. On the third day after the parade, every bed in Philadelphia's 31 hospitals was filled. A week later, 4,500 were dead and 47,000 infected. The outbreak was so bad, by October 3, the city essentially shut down.

The US suffered 675,000 excess deaths during the 1918 Influenza pandemic. Using today's population size, this would translate to approximately 2.16 million deaths. Placing the COVID pandemic into context, though reported deaths are now at 625,000, recent estimates have found that there have been approximately 185,000 additional unrecognized COVID-related deaths, putting the figure closer to 800,000. Additionally, the IHME (Institute for Health Metrics and Evaluation) modeling placed the figure of excess deaths closer to 900,000 back in the spring.

So, we are speaking about a pandemic that is in the same ballpark as the death caused by the Spanish flu in the US despite all the added innovations and technological capacity we now possess. We have ICUs. We can ventilate and provide oxygen in high concentrations. We have

medications to blunt the immune response. We have even been able to develop very effective vaccines with unprecedented speed. What we have been unable to do is place the appropriate priority on the well-being of the population.

The descendants of the Spanish flu

Yet, the impact of the Spanish flu was not limited to the period 1918–1919.

All influenza A pandemics since that time, and indeed almost all cases of influenza worldwide have been caused by descendants of the 1918 virus. For instance, the H2N2 pandemic of 1957–1958 that originated in Southern China killed between one and four million worldwide. It was a descendent of the 1918 influenza virus, as was the 1968–1969 flu pandemic caused by H3N2, which also killed another one to four million people globally.

It took another 80 years when a scientific team led by Dr. Jeffery K. Taubenberger was able to completely sequence the genome of one virus and partial sequence four others.

And in 2011, Drs. Watanabe and Kawaoka, using advancements in reverse genetics, were able to re-create the 1918 virus entirely from complementary DNA. With an artificially resurrected and intact virus bearing all eight RNA segments, molecular analysis into the unusual virulence of the 1918 pandemic was now possible.

These studies showed that the re-created 1918 virus from the second wave could replicate efficiently in the lungs of infected ferrets and non-human primates, inducing the type of fatal pneumonia encountered in the 1918–1919 pandemic.

Though the first wave caused extensive infection, it was not highly lethal as compared to the second and third waves. It is not known whether the virus in the first wave was the same as in the second wave or if it underwent a genetic shift or reassorted with another flu virus that made it so lethal. There is evidence that suggests those who developed the flu in the first wave had protection against the second wave.

Various theories exist as to the origin of this novel Influenza A virus, though many have noted the emergence of the illness in March of 1918 in Kansas, which quickly spread throughout the Eastern seaboard in recruit camps and cities and then to Europe and globally thereafter.

What was unusual about these deaths was that they cut down young adults in the prime of their lives. The W-shaped death curve was a unique finding that suggested the older population may have had partial immune protection from a possible exposure to a then-circulating virus circa 1889.

Perhaps most sobering is what Dr. David Morens, Office of the Director at the NIAID, wrote about the influenza pandemic in April of 2019.

“As deadly as the 1918 pandemic was, US mortality data, adjusted for population growth, suggest that over the past century about three times as many deaths have been caused by descendants of the 1918 pandemic virus than by the pandemic virus itself.” These have considerable relevance to the generations that will be forced to live with the SARS-CoV-2 virus.

Woodrow Wilson’s response to the flu pandemic

As the 1918 flu pandemic was killing hundreds of thousands of Americans, it is worth reviewing President Woodrow Wilson and the White House’s response to the pandemic, which have perhaps interesting parallels to the COVID pandemic.

Focusing his attention completely on the war effort, Wilson never uttered a single public statement about the 1918–1919 flu epidemic. Historian John M. Barry, author of *The Great Influenza: The Story of the Deadliest Pandemic in History*, noted, “In terms of managing a federal response to the pandemic, there was no leadership or guidance of any kind from the White House. Wilson wanted the focus to remain on the war effort. Anything negative was viewed as hurting morale and hurting the war effort.”

Tevi Troy who wrote *Shall We Wake the President: Two Centuries of Disaster Management from the Oval Office*, ranked Wilson as the worst president. “The federal response to the influenza outbreak in 1918 can best be described as neglectful. Hundreds of thousands of Americans died without President Wilson saying anything or mobilizing nonmilitary components of the U.S. government to help the civilian population.” He also faulted Wilson for contributing to the massive spread of the disease by continuing troop mobilizations “even as World War I was winding to a close.”

Barry notes that Wilson was quite aware of how serious the disease was. He heard and read reports on the way the illness would strike young and healthy soldiers in the barracks or on troop transports that were sailing across the Atlantic Ocean. Though the US lost almost 54,000 soldiers in combat during the war, another 45,000 (a number in equal magnitude to combat deaths) perished from influenza and related pneumonia by the end of 1918.

In fact, White House staffers were falling ill left and right. A Secret Service agent, the White House usher and a stenographer fell ill before Wilson left for France. When in Paris to negotiate the Treaty of Versailles after the World War I armistice, a young American aide in the peace delegation, Donald Frary, fell ill and died. He was only 25.

Wilson too fell ill at Versailles during the peace delegations, developing a fever as high as 103 degrees Fahrenheit. The *New Yorker* wrote, “Wilson, sequestered during his recovery in the Hôtel du Prince Murat, an elegant town house in the Eighth Arrondissement, soon appeared changed by his bout with flu. He became obsessed with ‘funny things,’ as an aide put it. He grew fixated on the furniture in the house and came to believe that he was surrounded by French spies. ‘We could but surmise that something queer was happening in his mind,’ Irwin Hoover, the President’s chief usher, said. ‘One thing is certain: he was never the same after this little spell of sickness.’”

Providing the necessary political analysis for understanding the response to the pandemic then, the ICFI wrote on the occasion of the centenary of Armistice Day:

The war was waged for markets, profits, resources and spheres

of influence. But this conflict itself did not simply arise from the political outlook of the various imperialist politicians. It had deeper roots in the very development of the capitalist economy. As Leon Trotsky explained, in words that ring out even more powerfully in today’s era of globalized production, the foundations of the war were to be found in the objective contradiction between the development of world economy and the division of the world into rival capitalist nation-states and imperialist great powers.

Each of the imperialist powers sought to resolve this contradiction through a bloody struggle to decide which of them would become the hegemonic world power. That conflict was to finally result—after three decades of barbarism, involving economic devastation, fascism, the Holocaust of European Jewry, and the mass slaughter of World War II—in the domination of US imperialism.

But the contradictions of world capitalism were not overcome. They were only temporarily subsumed under the domination of the United States. The disease which had gripped the global capitalist system was not cured, it only went into a period of remission. This period has now ended.

The influenza pandemic could not be allowed to interfere with this redivision of the world, and, in a matter of speaking, the Influenza pandemic had been a byproduct of these contradictions and bloody struggles. And the reemergence of another deadly scourge, COVID-19, was not only unsurprising, but it was also long predicted had been foreseen.

Warnings of a new pandemic

In a report published more than a decade ago, titled, “Global trends in emerging infectious diseases,” the authors noted these events have been rising significantly over time, impacting global health and economies. A significant majority are derived from diseases that are transmitted from animals to humans. They also found that there has been a “substantial risk of wildlife zoonotic and vector borne EIDs originating at lower latitudes where there is little reporting.” Also, of concern are (antibiotic resistant) bacterial pathogens.

Peter Daszak, the disease ecologist, noted: “Pandemics are on the rise, and we need to contain the process that drives them, not just the individual diseases: Plagues are not only part of our culture—*they are caused by it*. ... Pandemics usually begin as viruses in animals that jump to people when we make contact with them. These spillovers are increasing exponentially as our ecological footprint brings us closer to wildlife in remote areas and the wildlife trade brings these animals into urban centers. Unprecedented road-building, deforestation, land clearing and agricultural development, as well as globalized travel and trade, make us supremely susceptible to pathogens like coronaviruses.”

In early February 2018, the World Health Organization held an informal consultation in Geneva, Switzerland, to review the list of priority diseases with a focus on severe emerging infectious diseases (EID) with potential to generate a public health emergency, and for which insufficient or no preventive and curative solutions exist. The review determined that given their potential to cause a public health emergency and the absence of efficacious drugs and/or vaccines, there is an urgent need for accelerated research and development for disease like Ebola, Lassa Fever, Zika, MERS and SARS, and Disease X, a term for an as-of-yet-unknown and

unnamed pathogen.

The WHO said: “Disease X represents the knowledge that a serious international epidemic could be caused by a pathogen currently unknown to cause human disease.”

John-Arne Rottingen, Special Adviser to the WHO said: “History tells us that it is likely the next big outbreak will be something we have not seen before. It may seem strange to be adding an ‘X’ but the point is to make sure we prepare and plan flexibly in terms of vaccines and diagnostic tests. We want to see ‘plug and play’ platforms developed which will work for any, or a wide number of diseases; systems that will allow us to create countermeasures at speed.”

However, despite these warnings, little funding and effort has been placed in fully developing this critical infrastructure nor coordinating these on an international basis.

The outbreak in Wuhan, China

The first hint to the world of the outbreak of a novel coronavirus in Wuhan was received on December 30 by way of an international memo sent out by Wuhan’s health administration warning of an unusual viral pneumonia.

Dr. Marjorie Pollack, a graduate of the CDC’s Epidemic Intelligence Services, who is a volunteer at ProMED, a program run by the International Society for Infectious diseases, and resides in Brooklyn, was checking her emails after dinner on that day when she received an alert from a colleague about clusters of seriously ill patients in China. Four hours later, an AI system run by Boston Children’s Hospital sent out a brief alert about unidentified pneumonia cases in Wuhan.

During an interview on March 5, 2020, she explained, “I got an alert from a colleague who keeps a finger on the pulse of Weibo, the Chinese social media platform. The alert gave me some tweets about stuff that was going on in Wuhan—a cluster of four cases, then 27 cases—along with a picture theoretically of a document sent out by the Wuhan public health commission stating something about pneumonia cases that seemed to be associated with a seafood and wildlife market. Having lived through and worked through the SARS outbreak, it just rang a bell. This was a *déjà vu*.”

ProMED-mail was founded in 1994. Originally envisioned as a direct scientist-to-scientist network, ProMED rapidly grew into a prototype outbreak reporting and discussion list, especially after the 1995 Ebola outbreak. They also played a crucial role in identifying the SARS outbreak early in 2003.

As to a question regarding China’s response, during the same interview Dr. Pollack added, “I think this go around, China has been completely transparent. SARS was a lesson on the need for transparency. I’ve been very impressed with them. They’ve been putting out data whenever they’ve had it. I think in Wuhan, what happened was they were just overwhelmed. And they were very honest. They admitted that they basically didn’t have the surge capacity to handle the volume, which is why they ended up building two hospitals in less than a week.”

The timeline speaks for itself: As cases began to accumulate, physicians in the Wuhan City hospitals began to note an unusual pneumonia-like illness that was afflicting patients. At first, they were concerned this was the emergence of the SARS virus. By the following week (the first week in January) four independent labs in China had sequenced the novel coronavirus.

Internal communications at the time also reflect that the National Health Commission was notified that the new virus was potentially contagious through respiratory passage and recommended taking preventative

measures in public areas. The US CDC even advised a travel watch advisory for Wuhan City. We know now that every major institution in the US—FDA, CDC, White House, Congress—had been notified of these developments.

On January 11, Dr. Zhang Yongzhen of Shanghai Public Health Clinic Centre, out of frustrations with delays by authorities, published the sequence on virological.org, finally providing the world the first glimpse of the genetic blueprint for SARS-CoV-2. Thai researchers, who had isolated and partially sequenced the virus from an ill Chinese traveler discovered at the airport on January 9, issued findings on January 13 that the virus was identical to Dr. Zhang’s sequence.

The crux of the criticism against China’s delay lies in the fact that more than two weeks had passed since the partial sequence had been decoded and more than a week since three other labs had full sequences before the sequences were finally published on GISAID, platform for scientists to share genomic sequences. Yet, the issue of human-to-human transmission had not been resolved.

By mid-January, Beijing was quickly forced into damage-control mode, launching a nationwide public health emergency plan.

Peter Daszak, president of Eco Health Alliances, a scientist who has spent his career hunting dangerous viruses, explained: “The pressure is intense in an outbreak to make sure you’re right. It’s actually worse to go out to the public with a story that’s wrong because the public completely lose confidence in the public health response.”

Only after a renowned infectious disease and pulmonologist specialist, Dr. Zhong Nanshan, declared on January 20 that the new virus was being transmitted between people, did the Chinese President Xi Jinping call for the “timely publication of epidemic information and deepening of international cooperation.”

The response of the WHO

On January 22, the WHO convened an independent committee to address if there was a need to declare a global health emergency. A week later, on January 30, a Public Health Emergency of International Concern (PHEIC) was declared when there were just over 10,000 COVID-19 cases, of which 80 had been detected outside of mainland China.

To be clear, the four weeks to the PHEIC was the objective recognition of the scope of the global crisis and the call to action. The five to six weeks that followed became a recognition that there lacked the political will by the ruling elites to stem the rapid pace of global transmission. In short, the declaration of the pandemic was a declaration of defeat by the WHO, a declaration that little would be done to impede the course of the pandemic.

Offering a searing criticism of the global response, the WHO’s independent oversight and advisory committee wrote on May 21, 2020, “There has been a palpable lack of global solidarity and common purpose. That is a recipe for extending and worsening the global outbreak, leaving all countries less secure. A successful pandemic response hinges on interconnected global systems and networks: of scientific expertise, medical supply, trade, innovation, and production. The rising politicization of pandemic response is a material impediment to defeating the virus, while it aggravates other health, social and economic impacts.”

Meanwhile, the ICFI, who had been following these events closely very early in the course of the crisis, analyzing the developments almost from moment to moment, recognized the dangers posed by the virus to global inaction and irresponsibility.

On February 28, 2020, the ICFI issued the statement, “For a globally coordinated emergency response to the coronavirus pandemic,” at a time

when the number of COVID infections were approaching 100,000 and there were only 3,000 deaths, the majority of them in mainland China, stating in no uncertain terms that the danger could not be overstated.

The consequences of “herd immunity”

Since the declaration of the pandemic, the ruling elites across the globe have used every means in their powers to enrich themselves while forcing the populations to accommodate themselves to the virus through policies that can best be described as malign neglect and social murder. The attempts to insist that the “cure can’t be worse than the disease,” or implement a Swedish model that advocated a “herd immunity” strategy that supposedly protected the elderly while allowing the younger population to become infected, formally adopted as The Great Barrington Declaration, have proven to be not only a bankrupt, but quite deadly, policy.

The number of reported COVID infections globally has now passed 200 million. But this is a massive undercounting, as many countries do not have the testing capacity to track infections. This is the same number of people that have been thrown into extreme poverty because of the response to the pandemic. And still, a significant majority of the globe’s population remains immunologically vulnerable and have yet to receive even a single dose of the vaccines.

There is also a severe underestimate in the reported global COVID death toll, which stands at 4.2 million. But like many devastating events, the initial figures are far lower than they really are. Only after the dust has settled, the bodies have been pulled out of the rubble and a proper accounting has been made, do we begin to recognize the scale of death that the ruling elites have failed to properly chronicle during this pandemic which, as we have insisted, was foreseeable and stoppable.

In a recent report in the *Economist*, published on May 15, 2021, when the death toll was at 3.2 million, they estimated that worldwide there had been 7 million to 13 million excess deaths during the pandemic, with a central estimated of 10.2 million, or more than three times the reported figures. COVID deaths now account for the third leading cause of death during the pandemic across the globe.

Excess deaths include those that died from COVID but had not been accounted for as such and those that perished not necessarily due to COVID-related complications, but by the social crisis that may have led to inability to access health care and other factors that could have been averted had the pandemic been brought under control quickly and had an elimination strategy been globally adopted.

For instance, in South Africa there had been 55,000 COVID deaths since the beginning of the pandemic. During the same time, the country had recorded 158,499 excess deaths, of which the public health officials felt confident that 85 to 95 percent were caused by SARS-CoV-2. The point being made is that in poorer countries, where there are delays in officially documenting deaths and the cause of these deaths, we fail to appreciate the real impact of the present global crisis caused by the pandemic.

Summarizing their findings by geographic region:

There were between 2.4 million and 7.1 million excess deaths in Asia, while official COVID-19 reported deaths stood at 0.6 million. Since then, the torrential surge of infections, with the Delta variant throughout India and Indonesia, these estimates will now have to be revised upwards.

In Latin America and the Caribbean, 1.5 million to 1.8 million excess deaths have been estimated while there were 0.6 million reported COVID deaths. In Africa, excess deaths have been estimated as high as 2.1 million while only 0.1 million had been reported, speaking to the low level of

testing and reporting. In Europe, 1.5 million to 1.6 million excess deaths versus 1 million reported deaths. In the US and Canada, 0.7 million versus 0.6 million.

More recently, an estimate of unrecognized deaths in the US found that there had been 185,000 uncounted, placing the total COVID-related deaths in the US at 775,000 at the end of May 2021.

In the US, one in 12 in long-term care facilities and one in 10 in nursing homes died from COVID-19. According to the American Association of Retired Persons Nursing Home COVID-19 dashboard, as of July 15, 2021, more than 184,000 residents and staff of nursing homes and other long-term care facilities have died.

We should also highlight that more than 115,000 health care workers have died from COVID-19 across the globe.

We are fast approaching the point that the COVID-19 pandemic is the singularly most deadly event in American history, even above the death wrought by the Civil War. And this despite the COVID vaccines and every means to bring the pandemic to an end. The Biden administration, like the Trump administration, has squandered every opportunity to end the pandemic, even suppressing critical information that highlighted the dangers of the variant even among those that are vaccinated. And now we are facing a resurgence of a deadly turn with a much more transmissible virus that continues to evolve and pose a significant existential threat to the world’s population.

At our Sixth National Congress last year this time when we met for the first time online under extraordinary conditions, we wrote, “The COVID-19 pandemic is a trigger event in world history that is accelerating the already far-advanced economic, social, and political crisis of the world capitalist system. It is creating conditions for an immense intensification of the class struggle on an international scale.”

I would like to end my report by reading a quote from Damir Huremovic, from a chapter titled “The Brief History of Pandemics.”

He says, “Very few phenomena throughout human history have shaped our societies and cultures the way outbreaks of infectious diseases have; yet, remarkably little attention has been given to these phenomena in behavioral social science and in branches of medicine that are, at least in part, founded in social studies. In a long succession throughout history, pandemic outbreaks have decimated societies, determined outcomes of wars, wiped out entire populations, but also, paradoxically, cleared the way for innovations and advances in sciences (including medicine and public health), economy, and political systems.”



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