6 years of COVID-19

Long COVID and the concealment of pandemic harm

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29 December 2025

The United States has now entered the seventh year of the COVID-19 pandemic, and the country is moving through what the Pandemic Mitigation Collaborative (PMC) characterizes as the 12th major wave. What makes the present period politically decisive is not only the level of transmission, but the systematic degradation of surveillance, the frontal assault on public health institutions, and the deliberate normalization of mass infection—conditions that for good reason undermine public trust in the official figures posted on the Centers for Disease Control and Prevention (CDC) website.

Within this context, the PMC at Tulane University has stepped in to fill the void in public health information. According to the PMC's December 22, 2025 national estimate of the scale of transmission in the United States, based on wastewater surveillance, around 732,000 people are being infected daily. In the current year, there have been a total of 232,000,000 infections. The same dashboard estimates that one in 67 people (1.5 percent of the population) is actively infectious on a given day, and that cumulative infections per person since the start of the pandemic have reached 4.86, a clear reflection of the official policy of repeated exposure.

This is not an abstract curve. The PMC estimates that new infections are generating 224,000 to 890,000 Long COVID cases per week. Even under conditions of lowered acute fatality risk compared to the first two years of the pandemic, the PMC estimates 220 to 360 excess deaths per day from new infections and 1,300 to 2,200 excess deaths per week from new infections. These are deaths "in excess" of expected baselines, and are frequently not recorded as "COVID deaths" in routine tallies.

At the same time, the very wastewater-driven heat map that the PMC draws on highlights how fragmented and incomplete US surveillance has become. Large sections of the country are marked as having "limited data," while the map itself warns that the data are "lagged" and levels are "worse than shown." This is a practical expression of the political assault on public health: society is being led through an ongoing mass-disabling event with the instruments for measuring it intentionally blunted.

Observed deaths versus attributable deaths—or how the pandemic is rendered invisible

The CDC's provisional mortality surveillance for January 4 through December 13, 2025 lists approximately 21,380 deaths with COVID-19 coded as the underlying cause of death. But if one makes an annual estimate of COVID-related excess deaths based on the PMC's figure for the week of December 22, 2025, a relatively low number according to the PMC, this translates to between 67,600 and 114,400 excess COVID-related deaths. The question then arises as to how to resolve this discrepancy? One answer stems from the CDC report that estimates annualized observed deaths from influenza, COVID and pneumonia, a questionable lumping of the data as it conceals a clear examination of the implication of respiratory illnesses. Nevertheless, over the period January 4 through December 13, 2025, the CDC reports 196,283 deaths in the combined category.

These numbers are not contradictory. They expose the method by which pandemic mortality is obscured.

"Observed COVID deaths" typically refers to death certificates where COVID-19 is listed as the single underlying cause. This narrow category depends on access to testing, physician attribution and coding practices that have deteriorated sharply since the end of the federal public health emergency. In contrast, the combined flu–COVID–pneumonia category captures deaths where any of these conditions appear on the death certificate, whether as underlying or contributing causes.

The overwhelming majority of deaths in this combined category are now coded as pneumonia, a non-specific terminal diagnosis that frequently represents the final pathway of fatal viral illness. COVID-19 is a multi-organ vascular disease that increases the risk of respiratory failure, thrombosis, cardiac events, stroke, renal failure and immune dysregulation. When the initiating viral infection is not documented—perhaps because it is politically inconvenient to do so—it disappears from the record, replaced by downstream diagnoses such as pneumonia, heart disease, or metabolic decompensation.

This is why epidemiologists distinguish between COVID-coded deaths and COVID-attributable deaths. The latter includes deaths where SARS-CoV-2 plausibly initiated the causal chain, even if it is not listed as the underlying cause. Excess mortality analysis—used by EuroMOMO in Europe and the UK Office for National Statistics—consistently shows that total deaths remain elevated well above pre-pandemic baselines, even as official COVID death tallies decline.

In other words, COVID has not stopped killing. It has been administratively erased.

Long COVID and the structural mechanisms of ongoing harm

Six years after the emergence of SARS-CoV-2, the most consequential and enduring dimension of the pandemic is Long COVID, which provides the clearest explanation for the persistence of excess disease, disability and mortality worldwide despite repeated claims of normalization.

First, Long COVID represents a massive global burden of disease. A

growing body of high-impact research converges on the finding that approximately 6 to 10 percent of all SARS-CoV-2 infections result in symptoms lasting at least three months, with prevalence rising substantially after severe or repeated infections (Ballering et al., 2022; Davis et al., 2023; Global Burden of Disease Long COVID Collaborators, 2022). A large multinational cross-sectional study spanning 33 countries found persistent post-COVID symptoms across all regions and income levels, with fatigue, cognitive impairment, cardiopulmonary symptoms and autonomic dysfunction among the most frequently reported manifestations (Amin-Chowdhury et al., 2025). Taken together, these findings indicate that hundreds of millions of people globally are now living with Long COVID, establishing it as a population-scale chronic health condition rather than a marginal post-viral syndrome.

Longitudinal cohort studies further underscore the seriousness of this burden. Three-year follow-up data from the US Veterans Health Administration, published in *Nature Medicine*, demonstrate sustained excess risk of death and multisystem disease extending into the third year after infection, including cardiovascular disease, thromboembolic events, neurological disorders, kidney disease and metabolic dysfunction (Xie, Choi, and Al-Aly, 2024). Importantly, risk did not return to baseline even after several years, confirming that the health effects of SARS-CoV-2 are durable and cumulative, not transient.

Second, reinfection substantially amplifies the risk of Long COVID, including among children and adolescents. Analysis from the RECOVER-EHR program during the Omicron era found that the incidence of Long COVID approximately doubled following reinfection, with cases encompassing autonomic dysfunction, fatigue syndromes, cardiovascular symptoms and neurocognitive impairment (RECOVER Initiative, 2024). These findings directly contradict claims that repeated SARS-CoV-2 infections are benign, particularly in younger populations.

Third, routine healthcare data captures only a fraction of Long COVID cases, leading to systematic underestimation of prevalence. A 2025 population-based study from the Barcelona Integral Healthcare Consortium, using primary-care electronic health records, initially identified Long COVID in 2.4 per 1,000 individuals. After correcting for under-ascertainment related to missed diagnoses, delayed presentation and inconsistent coding, prevalence increased by more than 25 percent, with a clear dose-response relationship: prevalence rose steadily with each additional infection (Català et al., 2025). The critical implication is not the precise percentage, but the structural limitation of health system data, which detects only a subset of cases—particularly among working-age adults who remain partially functional while chronically ill.

Taken together, these studies establish Long COVID as the primary mechanism through which hyperendemic SARS-CoV-2 transmission translates into cumulative social harm. In the context of repeated infection waves, each surge generates new cohorts of chronically ill individuals while worsening outcomes for those already affected. Long COVID therefore reveals that the pandemic has not ended but has entered a protracted phase of population-level morbidity, largely obscured by weakened surveillance, yet increasingly evident in healthcare strain, labor force attrition and excess mortality.

Finland as a high-resolution case study

Finland provides a rare, high-resolution view of these dynamics—not because it is biologically unique, but because it still maintains relatively comprehensive national health registries and wastewater surveillance.

Much of the most accessible synthesis of this data has been produced by Ilkka Rauvola, an equity research analyst by profession, who publishes independent analyses under the handle @jukka235 and in a Substack newsletter (“Ilkka’s Newsletter”). Rauvola is not a clinician or epidemiologist. His contribution lies in applying rigorous time-series analysis to public data released by Finland’s health authorities.

Central to his work is Avohilmo, Finland’s national primary healthcare register, maintained by the Finnish Institute for Health and Welfare (THL). The registry captures diagnoses and encounters across the public healthcare system and allows longitudinal tracking of disease burden by age group and medical diagnosis. While no registry is perfect, Avohilmo’s national scope and continuity make it far more informative than the fragmented and delayed datasets now available in the United States.

Rauvola’s analyses show that since 2019, the cumulative share of the population recorded with disease diagnoses has risen across nearly every major ICD-10 category. By 2025, compared with 2019 levels, Finland has seen:

- Mental and behavioral disorders rise to 1.73 times baseline
- Blood and immune disorders to 1.68
- Diseases of the nervous system to 1.64
- Genitourinary diseases to 1.56
- Endocrine and metabolic diseases to 1.48
- Total disease burden across categories to 1.35

Age-stratified analyses using 2020 as the baseline show increases across all age groups by 2025, including 1.39 times baseline among ages 25–49, 1.47 among ages 50–74, 1.61 among those over 85, and 1.62 among infants.

As Rauvola recently noted on his social media post: “In fact, we’re seeing exponential growth in patient numbers across all disease and age groups in Finland. The trend is strikingly linear on a log scale, with no sign of any slowdown since 2020. No health system can take this for long. It’s just a matter of time.”

His wastewater analyses are particularly revealing. Finnish SARS-CoV-2 wastewater levels in late 2025 reached comparable magnitudes to the first Omicron peak in early 2022, despite the absence of emergency declarations or mass testing. This pattern defines the current hyperendemic phase of the pandemic: SARS-CoV-2 maintains a high baseline level of circulation, punctuated by repeated waves that continuously seed new cases of long COVID and downstream complications. The United States shows the same structure, but with far poorer visibility. The PMC’s estimate of 732,000 daily infections and climbing aligns closely with this interpretation.

It must be stated: hyperendemic does not mean stable or benign. It means persistent high transmission with recurrent surges, ensuring a steady accumulation of chronic disease.

Conclusion: The COVID pandemic is a class event

Six years into the COVID-19 pandemic, the evidence is no longer ambiguous. The continued spread of SARS-CoV-2, the mass emergence of Long COVID, and the steady accumulation of chronic disease and excess death expose a social order that has treated mass infection as an acceptable cost of doing business. The pandemic was never merely a medical emergency. It has always been a class event, shaped by decisions that subordinate human life to profit, market stability, and geopolitical agendas.

As David North has stated, *“The pandemic revealed, with terrible clarity, the incompatibility of capitalism with the most basic requirements of public health.”*

That incompatibility now defines the present phase of the crisis.

Governments have dismantled surveillance, narrowed definitions of COVID death and promoted the fiction of a post-pandemic “normal,” even as millions remain chronically ill and excess mortality persists. This is not a failure of knowledge, but of political will.

The social distribution of harm makes this unmistakable. COVID infections, deaths and long-term disability have fallen disproportionately on the working class, while the wealthy insulated themselves through remote work, private healthcare and the ability to avoid exposure. Life expectancy losses, elevated mortality from cardiovascular and respiratory disease and the burden of Long COVID have tracked closely with income, occupation and access to care. The virus exploited pre-existing inequality, and policy amplified it.

The decay of public health institutions must be understood in this light. The erosion of data systems, the undercounting of COVID-related deaths through misattribution to pneumonia and cardiac causes, and the abandonment of mitigation are not technical errors awaiting correction. They are expressions of a social system that no longer even pretends to place collective well-being above private accumulation. Where data remain robust, as in Finland, the scale of ongoing harm becomes visible. Where they do not, it is merely concealed.

The lessons of the pandemic point inexorably toward the need for an independent response by the working class. The defense and reconstruction of public health—universal access to care, clean air, paid sick leave, transparent surveillance and sustained scientific investment—cannot be entrusted to institutions that have already demonstrated their allegiance to profit over life. A socialist reorganization of society is not an abstraction, but a practical necessity if humanity is to confront a pandemic that has not ended but been politically obscured. The fight for public health is inseparable from the fight for social equality, and it must be taken up consciously and internationally.