Public health collapsing as COVID pandemic enters its 7th year

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15 January 2026

Soon after the emergence of COVID-19, the International Committee of the Fourth International made the correct analysis that the pandemic had to be understood as a trigger event in world history. It did not create a crisis in public health, but rather exposed and accelerated longstanding processes: the erosion of life expectancy, the dismantling of scientific institutions, and the subordination of human life to the profit requirements and military-strategic interests of the financial oligarchy.

The world has now entered the seventh year of the COVID pandemic, with the United States facing the 12th major wave of infections. Conservative estimates place cumulative COVID deaths in the United States at over 1.2 million, while excess-mortality analyses indicate a substantially higher toll. Globally, excess-mortality modeling places the true pandemic death toll in the tens of millions, with central estimates near 27 million worldwide, far exceeding official counts. Transmission continues at high rates—presently at roughly 1 million infections per day, with more than 240 million infections recorded in 2025 alone. Reinfections are widespread, and Long COVID remains a mass disabling condition affecting millions.

What has ended is not the pandemic, but any acknowledgement by the political and media establishment that COVID-19 remains a major threat. There is zero political commitment to even the meager combination of mitigation, surveillance and data-gathering. This was not and is not an oversight. It is a decision to conceal the ongoing harm that is affecting the entire global population.

As has been repeatedly demonstrated, the COVID pandemic has exposed an intensifying attack on the working class. The consequences of the public health collapse, combined with the broader assault on material living conditions, have produced a stark divergence in life expectancy between the bourgeoisie and the working class. Research by economists Angus Deaton and Anne Case demonstrated that life expectancy in the United States began to diverge sharply along class lines around the turn of the millennium. This divergence accelerated after the financial crisis of 2008, when life expectancy among working class layers declined for the first time in decades, and it was dramatically intensified by the pandemic.

A long-term comparative analysis of US mortality trends from 1980 to 2023 estimates approximately 14.7 million excess deaths in the United States relative to other high-income countries. These deaths were not the result of a single event but of accumulated structural disadvantages—inequality, underinvestment in public health and unequal access to care—that were sharply exacerbated by the pandemic. Each excess death represents a life cut short, families destabilized and human potential permanently lost.

Class differences in the impact of COVID-19

During the earliest phase of the ongoing COVID pandemic, life expectancy fell far more sharply among poorer and working class layers than among the wealthiest. Exposure risk, access to care, the ability to isolate and the burden of long-term disability followed class lines.

Now, barely six years later—a brief period in historical terms—international evidence confirms the devastation wrought by the COVID pandemic and how it continues to sicken population health.

In Finland, one of the most detailed pictures of the cumulative health impact of COVID has emerged through analysis of national healthcare data. Ilkka Rauvola, an equity research analyst, examined data from Avohilmo, Finland's national primary healthcare registry maintained by the Finnish Institute for Health and Welfare.

Using time-series analysis, Rauvola showed that since 2019, the cumulative share of the population diagnosed with illness has risen sharply across nearly every major disease category. By 2025, diagnoses involving mental and behavioral disorders, immune and blood disorders, nervous system diseases and metabolic conditions had increased to roughly one and a half to nearly two times pre-pandemic levels. He correlated these findings with wastewater surveillance showing sustained SARS-CoV-2 circulation at levels comparable to early Omicron peaks. This indicates that COVID persists at a hyper-intense endemic state, with temporary lulls driven only by massive infection waves that briefly suppress transmission before the next surge.

Rauvola warned that this trajectory—the impact on health systems from a mass disabling event—represents a structural sustainability crisis. Even a well-resourced welfare state cannot absorb a continuously rising disease burden driven by repeated infection and long-term impairment. If COVID alone is eroding population health under such conditions, the implications for countries actively dismantling public health infrastructure are grave.

To understand why this raises such a profound alarm, it is necessary to situate the present crisis in the historical context of what public health has achieved—and what is now being reversed.

In the course of the 20th century, public health interventions—vaccination, clean water systems, sanitation, community water fluoridation and disease surveillance—produced some of the most dramatic gains in human longevity ever recorded. Vaccination alone is estimated to have saved tens of millions of lives globally over the past 50 years. In the United States, routine childhood immunization reduced infant and child mortality to a fraction of early-20th-century levels.

It is precisely these historic gains—achieved through collective action, scientific rigor and public investment—that are now under direct and conscious attack.

On January 5, 2026, Robert F. Kennedy Jr. unilaterally preempted the established scientific review process and imposed sweeping changes to the US vaccine schedule.

2026: The year of vaccine reduction

On that day, federal health authorities revised the US childhood immunization schedule, reducing the number of diseases with routine universal recommendation from 17 to 11. Six vaccines—including influenza, COVID-19, rotavirus, hepatitis A, hepatitis B and certain meningococcal vaccines—were removed from routine universal recommendation and reclassified for high-risk groups or shared clinical decision-making. This action did not emerge suddenly. It followed earlier interventions, including changes to the hepatitis B vaccine, which served as a preliminary signal of the direction being prepared.

Taken together, these actions represent a deliberate rupture with evidence-based public health governance. In this sense, January 5 marks a "Welcome to 2026" moment for public health, just as the January 3 criminal attack on Venezuela was for American imperialist foreign policy and the January 7 murder of Renee Nicole Good was for Trump's plans for dictatorship.

Just as the criminal attack on Venezuela has functioned as a harbinger of the abandonment of international law in favor of the openly stated law of force, the preemption of the vaccine schedule marks the abandonment of scientific truth and public health norms in favor of ideological rule. Peer review, evidence and population-level risk assessment are no longer constraints on policy.

Public health and vaccine experts such as Paul Offit and Peter Hotez warned immediately that removing vaccines from routine universal recommendation would have predictable and harmful consequences. Epidemiologists emphasized that universal schedules are the foundation of high coverage, clear clinical practice and public trust. Pediatric infectious disease specialists cautioned that shifting vaccines to "shared clinical decision-making" would delay vaccination, reduce uptake and disproportionately harm working class and underserved populations.

Former public health officials stressed that population-level protection depends on clarity and universality, not individualized risk calculations. They warned that the changes would undermine herd immunity, weaken outbreak response and accelerate the resurgence of vaccine-preventable disease.

The consequences of inadequate prevention were already visible during the 2024–2025 influenza season, when more than 280 children died from influenza in the United States. Pediatric flu deaths are a recognized sentinel indicator of failure in vaccination and prevention systems.

Although these deaths occurred before the most recent changes to the vaccine schedule, they demonstrate the inherent danger of influenza under existing social conditions and provide a clear warning as the country enters another severe flu season.

Influenza is now well understood to be primarily an airborne disease, transmitted through aerosols in the indoor air. Despite this knowledge, no systematic airborne precautions—such as ventilation standards, air filtration or masking during surges—are being implemented. In this context, vaccination remains the only broadly available population-level measure shown to reduce severe illness, hospitalization and death from influenza. Under these conditions, the public health consequences are not uncertain or speculative; they are well understood in advance.

Decades of epidemiological modeling demonstrate that even modest declines in vaccination coverage lead to sharp increases in outbreaks, hospitalizations and deaths. These outcomes are foreseeable and preventable—and they will be the consequences of the policies now being implemented.

The same dynamic is evident with measles. In 2025, the United States recorded its highest number of measles cases in more than three decades, with over two thousand confirmed infections.

The United States was declared to have eliminated measles in 2000, a designation dependent on the absence of continuous indigenous transmission for 12 months. That status is now at serious risk. If sustained transmission continues into 2026, the United States could lose its measles elimination status, marking a historic regression in public health.

This crisis cannot be attributed to any single administration. The Trump administration initiated the abandonment of pandemic mitigation, dismantling federal coordination and promoting mass infection in the name of economic reopening. The Biden administration did not reverse this course. Instead, it consolidated and normalized these policies despite vastly greater scientific understanding of the nature of the SARS-CoV-2 virus.

Under Biden, emergency measures were dismantled while excess deaths continued. Masking guidance was withdrawn, surveillance was curtailed and responsibility for protection was shifted onto individuals and families. As a result, far more people died of COVID under Biden than under Trump. This was not ignorance. It was a political decision.

Public health and class society

The assault on public health must be understood within the broader framework of class rule under capitalism. From the outset of the COVID-19 pandemic, the decisive priority of governments was not the preservation of life, but the protection of profit, financial markets and corporate interests. This orientation was articulated openly in calls to "reopen the economy" even as mass death unfolded.

In this context, the staggering death toll among the elderly and medically vulnerable was not an unintended consequence, but an outcome that was politically accepted and normalized. Sections of the population deemed no longer "productive" were treated as expendable. The refusal to suppress transmission, the dismantling of mitigation measures and the abandonment of population-level protection functioned to reduce life expectancy along class lines.

This process has not ended. The dismantling of public health institutions, the erosion of vaccination programs and the normalization of mass infection continue to operate in the same direction. The well-off retain access to private health care, early treatment and protection. The working class is left exposed—to infection, long-term disability and premature death. Disease itself becomes a mechanism through which social inequality is enforced.

The policies now being advanced under Robert F. Kennedy Jr. must be understood in this light. The attack on vaccination, disease surveillance and scientific authority does not represent a defense of individual freedom, but a further degradation of collective protection. These policies function to weaponize disease against the population, particularly against those with the least capacity to shield themselves.

Central to this project is an ideological assault on science itself. By promoting the claim that scientists are corrupt agents of corporate interests, and that medical knowledge is inherently suspect, these forces cultivate distrust, fear and confusion. This anti-scientific outlook has a paralyzing political effect. It undermines rational understanding, fragments social consciousness and obstructs the development of a clear, class-based response to the crisis.

From a Marxist standpoint, this represents the antithesis of what is required. The working class cannot defend its interests without access to truth, scientific knowledge and a clear understanding of the social forces shaping its conditions of life. The defense of public health is therefore inseparable from the defense of scientific integrity and the political education of the working class.

The erosion of public health is inseparable from broader social policy.

The expiration of Affordable Care Act subsidies threatens millions of working people with loss of coverage, delayed treatment and increased mortality. Health access, like disease exposure, follows class lines.

In sum, public health is a class question. The assault on vaccines, science and population-level prevention is part of a broader attack on the social gains secured by the working class over the 20th century. The COVID pandemic exposed these priorities with devastating clarity. What is unfolding now is the conscious continuation of that trajectory. The task before us is to make this reality understood and to orient the working class internationally to the defense of science, public health and human life itself.