An assessment of the ongoing toll of the COVID-19 pandemic

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As the United States enters the seventh year of the COVID-19 pandemic, the nation's public health infrastructure has been systematically dismantled through a deliberate campaign of ideological negligence. One year into the tenure of Health and Human Services (HHS) Secretary Robert F. Kennedy Jr., this dismantling has taken concrete form in the removal of scientific oversight and the erosion of evidence-based policy, most notably through the dismissal of the entire Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP). The replacement of public health expertise with anti-vaccine ideology has severed the United States from established global safety standards and created conditions for the resurgence of preventable infectious diseases.

The consequences of these policy decisions are already measurable across the full spectrum of infectious disease. The United States is amid its twelfth major COVID-19 wave, with transmission largely unchecked as the cumulative infection baseline approaches five infections per person.

According to estimates from the Pandemic Mitigation Collaborative (PMC), the United States experienced approximately 260 million SARS-CoV-2 infections in 2025, equivalent to 76 percent of the population. This unchecked transmission generated between 13-52 million new Long COVID cases and produced a level of excess mortality comparable to the nation's leading causes of death.

In response to inquiries from the *World Socialist Web Site*, Michael Hoerger, who directs modeling for the PMC, estimated that COVID-19 was responsible for 81,000 to 175,000 excess deaths in 2025 alone, based on conservative assumptions that incorporate wastewater surveillance, actuarial projections and known undercounting of COVID-related mortality. Even at the lower bound, this death toll rivals or exceeds the annual mortality burden of chronic kidney disease (53,597), influenza and pneumonia (51,537) and diabetes (103,294), effectively placing COVID-19 as the seventh or eighth leading cause of death in the United States.

This ongoing, immense scale of death is now entirely covered up by the powers-that-be, with an ever-growing disparity between reality and public perception. During the 2025–26 influenza season, influenza has caused approximately 10,000 deaths through mid-January, drawing sustained media and public attention. By contrast, COVID-19's annualized excess mortality surpasses that figure more than tenfold, demonstrating how the normalization of the pandemic has rendered socially acceptable a level of disease and death far greater than that posed by recognized endemic threats. This silence reflects the collapse of public health strategy, which has allowed the virus to circulate freely, disable millions and sustain a permanently elevated baseline of mortality.

Although the twelfth major COVID-19 wave peaked on January 3, 2026, with daily infections exceeding one million, the most dangerous epidemiological trend is not the wave itself but the relentless linear rise in cumulative infections. By early 2026, the average American had accumulated more than five lifetime SARS-CoV-2 infections, up from 4.57 infections per person in September 2025, confirming that population-level immunity is not stabilizing but steadily eroding.

This trajectory is being reinforced by the collapse of vaccination uptake. During the 2025–26 respiratory season, only 17.3 percent of adults reported receiving the updated COVID-19 booster as of early January 2026. Pediatric coverage remains even lower, with just 7.6 percent of children considered up to date with the current formulation. By late December 2025, approximately 20.6 million doses had been administered through pharmacies and physician offices, representing well under 10 percent of the US population at that point in the season.

Under these conditions, reinfection has become the dominant driver of transmission. With annual infections affecting nearly three-quarters of the population, millions of Americans are now surviving their fifth, sixth, or seventh COVID-19 infection, accumulating compounding immune dysfunction and organ damage with each exposure. What is being presented as an "endemic" phase is, in reality, an accelerating cycle of mass infection and premature death, driven not by viral inevitability but by deliberate policy decisions that have abandoned even the most basic principles of public health prevention.

At the same time, the collapse of vaccination policy has fueled a broader resurgence of preventable diseases. A severe influenza season, driven by the A(H3N2) subclade K variant, has produced widespread hospitalizations and pediatric deaths amid declining immunization rates. Even more stark is the return of measles at levels not seen since the early 1990s, alongside a sustained surge in pertussis claiming infant lives.

While COVID-19 mortality continues to eclipse that of influenza, with annual excess deaths exceeding flu-related deaths by more than tenfold, the 2025–26 influenza season has nonetheless imposed a severe and concurrent strain on the US health care system. Driven by the rapid emergence of the influenza A(H3N2) subclade K variant, which accounts for more than 90 percent of characterized viruses, the season has produced an estimated 18 million to 19 million illnesses and up to 250,000 hospitalizations through mid-January 2026.

The dominance of this antigenically drifted variant has significantly weakened population immunity. Preliminary data indicate that vaccine effectiveness against subclade K has fallen to between 32 percent and 39 percent in adults, contributing to hospitalization rates that have reached their second-highest level since the 2010–11 season. The heaviest burden has fallen on adults over 65 and infants under one year, groups most dependent on robust vaccination coverage and preventive care.

The consequences are most stark in pediatric mortality. As of mid-January 2026, 44 influenza-associated pediatric deaths have been reported, continuing a deadly trend that followed a record 289 pediatric deaths during the 2024–25 season. Public health data shows that 90 percent of these recent pediatric fatalities occurred in children who were not fully vaccinated against influenza. This outcome underscores the lethal consequences of the administration's shift away from universal vaccination recommendations toward so-called "shared clinical decision-

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making," a policy that has widened immunization gaps and left the most vulnerable children exposed to predictable and preventable death.

The erosion of public health authority has produced a historic reversal in the control of vaccine-preventable disease, most clearly demonstrated by the resurgence of measles. In 2025, the United States recorded 2,255 measles cases, the highest annual total since 1992. Transmission has accelerated further in the new year, with 607 confirmed cases so far in January 2026 alone.

These outbreaks, driven largely by major clusters in South Carolina and Utah, have placed the nation's measles elimination status, maintained since 2000, in imminent jeopardy. The scale of the regression was dismissed by the CDC's Principal Deputy Director Ralph Abraham, who characterized the loss of measles control as merely the "cost of doing business," underscoring the extent to which preventable disease has been normalized under Kennedy.

A similar collapse is unfolding with pertussis, or whooping cough, a highly contagious bacterial infection that poses a particular danger to infants. After reaching a decade-high level in 2024, pertussis cases remained elevated in 2025, with 28,783 reported infections and at least 13 deaths, primarily among unvaccinated infants under one year of age. This resurgence closely tracks declining immunization coverage. Diphtheria, Tetanus and Pertussis (DTaP) vaccination rates have fallen in more than 75 percent of US counties, leaving some states, including Oregon, facing levels of disease not seen since the 1950s.

The breakdown of coordinated disease prevention extends beyond childhood vaccination. Respiratory syncytial virus (RSV) activity remains elevated, particularly in the South and Mid-Atlantic, threatening infants and older adults despite the availability of immunization products. At the same time, norovirus outbreaks are rising, with wastewater surveillance showing high viral levels across the Midwest and Northeast, driving widespread gastrointestinal illness and disrupting schools and health care facilities.

Together, these overlapping outbreaks expose a public health system that has been deliberately weakened. The dismantling of vaccination policy and disease surveillance has transformed preventable infections into recurring crises, replacing population-level protection with acceptance of mass illness as routine.

The Trump-Kennedy administration's policy of sustained mass infection has accelerated a severe degradation of population-level immunity, a process now documented in mechanistic detail by research emerging from the National Institutes of Health RECOVER Initiative.

Studies published in *Nature Immunology* in January 2026 show that Long COVID is driven by persistent immune activation and marked T-cell exhaustion, including the chronic upregulation of inflammatory pathways and the depletion of regulatory immune cells critical for antiviral defense. These findings demonstrate that Long COVID is not a transient post-viral condition but a lasting alteration of immune function. The data further establishes a dose-dependent risk: Individuals with three or more SARS-CoV-2 infections face a three- to ten-fold increase in the likelihood of developing Long COVID. With the average American now having experienced nearly five infections, the population is sustaining cumulative immune injury that undermines its ability to respond effectively to future pathogens.

This immune dysfunction is already manifesting through the reemergence of opportunistic and latent infections, which serve as potential biological indicators of widespread immunocompromise. Clinical reports and cohort studies document the reactivation of latent tuberculosis and Epstein-Barr virus following COVID-19, linked to impaired white blood cell function that normally suppresses these infections.

A similar pattern is evident in the rising incidence of herpes zoster, or shingles, long recognized as a marker of declining immune surveillance. Patients who develop shingles after COVID-19 face sharply increased risks of serious secondary infections, major adverse kidney events and autoimmune conditions such as systemic lupus erythematosus. COVID-19 pneumonia has also been shown to heighten susceptibility to severe secondary bacterial infections, creating a synergistic effect that significantly increases mortality risk. Together, these findings confirm that repeated SARS-CoV-2 infections are dismantling immune defenses that once protected the population from long-controlled diseases.

This biological erosion of immunity is now colliding with the deliberate dismantling of preventive health policy, producing conditions in which heightened vulnerability is met not with protection, but with continued exposure.

Following Kennedy's dismissal of the Advisory Committee on Immunization Practices and the January 2026 overhaul of the childhood immunization schedule, which reduced universally recommended vaccines from 17 to 11, pediatric protection has sharply deteriorated. As of January 10, 2026, only 7.6 percent of children were up-to-date on the current COVID-19 vaccine, leaving the vast majority of the pediatric population exposed during an active wave of transmission. Influenza vaccination, which historically reached 55-65 percent of children, is now threatened by its reclassification under "shared clinical decision-making," despite evidence that 90 percent of the 44 pediatric influenza deaths reported this season occurred in unvaccinated children.

The erosion extends to core childhood immunity. MMR coverage has fallen to 92.5 percent, below the herd immunity threshold in 39 states, while DTaP coverage has declined in more than 75 percent of US counties. These declines are directly driving the resurgence of measles and pertussis, reversing decades of public health progress and exposing children to diseases long understood to be preventable through universal vaccination.

Beyond the immediate human toll, the economic consequences of mass infection and disability are profound. Modeling by Bartsch and colleagues estimates that a single case of Long COVID generates annual costs ranging from $5,084 to $11,646, with more than 90 percent of the burden arising from lost productivity due to absenteeism and workforce exit. Even conservative estimates place the current societal cost of Long COVID at $2.01 to $6.56 billion per year, a figure that is certain to rise as cumulative infections increase. At current transmission levels, the economic burden of chronic post-COVID illness is approaching that of major diseases such as diabetes and cardiovascular disease, representing a permanent and growing drag on the US economy.

This outcome is not accidental. The systematic dismantling of public health infrastructure constitutes a direct threat to the right to life, subordinating human survival to profit and political expediency. The consequences fall most heavily on the working class, accelerating declines in life expectancy that were already underway due to inequality and untreated disease. As basic protections are stripped away, the defense of public health emerges as a class question. Preventing further destruction requires the independent political mobilization of the working class to restore public health institutions on a scientific basis, ensuring they serve the collective needs of society rather than private and political interests.

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