Who died and why: COVID-19, class and mass death in the United States

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Introduction: An accounting no one wants to conduct

The COVID-19 pandemic triggered a historic and devastating rupture in the conduct of science and public health. When the virus first emerged, the capitalist ruling class faced a stark choice: mobilizing the vast resources of global society to eliminate the pathogen and save millions of lives or protect the financial markets and corporate profits. Across the world, and most aggressively in the United States, capitalist governments chose the latter. The policies set forth in those early months of the global outbreak did not merely result in a temporary public health failure. They laid the cornerstone for the complete teardown and politicization of the entire scientific community.

To justify the abandonment of life-saving public health measures, the Trump administration weaponized anti-science propaganda, peddling the homicidal strategy of "herd immunity" and demanded a rapid return to work to keep the wheels of profit turning. The Biden administration then codified this approach into a permanent policy of "forever COVID," dismantling pandemic surveillance, dropping isolation guidelines, and systematically normalizing mass death and debilitation.

This deliberate subordination of human survival to economic demands fundamentally transformed public health institutions. Agencies once tasked with disease prevention were hollowed out and converted into instruments of political enforcement. Decades of scientific advancement were discarded to accommodate a social order willing to accept millions of preventable deaths as the mere cost of doing business.

Today, the American scientific enterprise faces an existential crisis. The ruling class is no longer just ignoring science; it is actively attacking it. The elevation of anti-vaccine figures like Robert F. Kennedy Jr. to lead the Department of Health and Human Services exemplifies this descent into barbarism. The assault on public health infrastructure, the slashing of biomedical research funding, and the suppression of evidence-based medicine is not accidental. They are the direct continuation of a class-based political project that began in early 2020. A scientific establishment that tells the truth about airborne pathogens, chronic disease, and mass mortality is intolerable to a ruling elite determined to extract endless labor from the working class.

The present moment: Science under siege

On June 5, 2026, Louisiana State Police and event security escorted five leading diabetes scientists out of the American Diabetes Association (ADA) annual conference in New Orleans. Their offense was distributing copies of a peer-reviewed editorial from their own journal, *Diabetes Care*, documenting the Trump administration's destruction of the United States biomedical research infrastructure. Dr. Aaron Kelly filmed the scene and stated flatly, "Censorship is real." The incident occurred moments before National Institutes of Health (NIH) Director Jay Bhattacharya was scheduled to deliver the keynote address. After Bhattacharya canceled, senior NIH adviser Richard Woychik replaced him and opened with an endorsement of the Make America Healthy Again (MAHA) agenda, proudly telling the crowd, "I could have written the MAHA agenda."

The ADA initially told Dr. Steven Kahn, editor in chief of *Diabetes Care*, that his behavior violated the conference code of conduct. His actual transgression was distributing peer-reviewed science critical of the administration. Following intense public backlash, ADA Chief Executive Officer Chuck Henderson released a video apologizing to Kahn and the other researchers, stating that trust "must be earned back through actions and not just words." However, the ADA had already quietly added disclaimers to the editorial to distance the society from its own editors. Kahn rightly described this bureaucratic capitulation as an attempt to appease the Trump administration.

The ADA incident is not an aberration. It is an indication of the systematic dismantling of public health infrastructure in the United States. The Trump administration is firing tens of thousands of federal health workers, gutting the Centers for Disease Control and Prevention (CDC) and the NIH, defunding disease surveillance, rewriting vaccine recommendations by executive fiat, and withdrawing the US from the World Health Organization (WHO).

Former NIH Director Dr. Francis Collins described the logic of this purge in March 2026: "Mix politics and science, you get politics. You kind of lose everything else." It would have been more correct to say, "Mix capitalist politics and science, you get capitalist politics." It is the profit system that acts as the universal solvent, reducing every aspect of science, including the historic gains in public health, to what can be monetized for the possessing class.

The editorial these scientists tried to distribute ended with a call to act. A few brushes of a pen, its authors warned, are rapidly destroying what generations built. For carrying those words into a scientific conference, police removed them. This report is in solidarity with that refusal to submit. But the ADA incident is not the story. It is the present chapter of a story that began six years ago. And as this report will demonstrate, the social murder carried out against the working class in the US and internationally during the COVID pandemic is a crime of capitalism.

Six years of managed silence

The United States has recorded over 1.2 million confirmed COVID-19 deaths, accounting for 16 percent of the global toll despite the country having only 4 percent of the world's population. Excess mortality

analyses indicate the true domestic toll is approaching 1.5 million, while *The Economist*'s excess-mortality model puts the true global toll at more than 27 million, nearly four times the official count. Yet the sixth anniversary of the pandemic declaration passed in March 2026 without a single acknowledgment from any major bourgeois publication.

The pandemic has not ended. According to the Pandemic Mitigation Collaborative (2026), there were approximately 240 million COVID-19 infections in the United States in 2025 alone. A massive 12th wave swept the country late last year, and weekly excess deaths remained near 2,000 as of early 2026. The absolute media and political silence surrounding these deaths is not negligence. It is a deliberate policy of concealment, and as the police action in New Orleans demonstrated, the capitalist state is now using force to maintain this silence.

The political establishment attempts to justify this erasure by pointing to an illusory "recovery." In 2024, the CDC reported a nominal all-time-high life expectancy of roughly 79 years, using this aggregate figure to declare the health crisis resolved. However, this headline number conceals a profound and widening class divide. Research by economists Anne Case and Angus Deaton (*Brookings Papers on Economic Activity*, 2023) documented the hard baseline of this disparity: in 2020 alone, life expectancy for Americans without a four-year college degree fell 3.25 years, compared to a drop of only 1.09 years for degree holders (using college education as a proxy for class). Furthermore, COVID-19 age-adjusted mortality ran at 165 per 100,000 for those without a bachelor's degree, versus 57 per 100,000 for degree holders, representing a nearly threefold higher death rate for the working class.

The interpretation of this differential is damning. The aggregate life expectancy rebound to 79 years is the statistical effect of the wealthy living longer and pulling the national average upward. The working class fell the furthest and has not recovered the ground it lost, leaving a permanent, class-based mortality gap hidden beneath a narrative of national recovery.

What was possible, and why it wasn't done

The entire ideological apparatus of the capitalist response rests on the claim that mass death was unavoidable. The epidemiological record firmly refutes this assertion. A comprehensive WHO excess mortality assessment , co-authored by Ariel Karlinsky, creator of the World Mortality Dataset (Msemburi et al., *Nature*, 2023), found that suppression measures produced results consistent with large numbers of lives saved. This aligns exactly with the strategy of global elimination and eradication advanced by the *World Socialist Web Site* from the outset of the crisis.

This figure exposes the vast gap between the official count and the true scale of global mortality. The cumulative excess death toll climbs to roughly 14.8 million by January 2022, while confirmed COVID-19 deaths reach only about 5.4 million over the same period, meaning official tallies captured barely a third of the dead worldwide. In the opening months of 2020, the excess line briefly falls below zero, reflecting the temporary drop in non-COVID deaths such as road traffic fatalities during the initial lockdowns. The companion panel shows the monthly excess death rate sharply and consistently outrunning the reported rate from mid-2020 onward, with the widest divergence during the Delta wave. This staggering toll is the measure of what a coordinated elimination strategy could have prevented.

The counterfactual is not hypothetical. Where coordinated elimination strategies were implemented seriously, they worked, and the populations that adopted them recorded fewer deaths during the pandemic than they would have in an ordinary year. A death toll on this global scale was the product of political decisions about whose lives could be spent, and the regional data examined further on shows exactly where those decisions diverged.

Yet from early in the pandemic, capitalist governments deliberately imposed a policy of mass infection. China's Zero-COVID policy successfully held deaths near zero for roughly two years across a population four times the size of the United States, demonstrating at scale that suppression was achievable. The Chinese Communist Party abandoned this life-saving policy in December 2022 under immense pressure from international finance capital demanding the restoration of corporate supply chains. This capitulation produced precisely the catastrophe that elimination had prevented for three years. Because the government reported only 121,000 COVID-19 deaths through May 2023, a Stanford analysis reconstructed the true scale from the obituaries of more than 10,000 Chinese officials and academics, estimating that between 1.44 million and 2.56 million excess deaths occurred in the few weeks following the reopening. Even so, because Zero-COVID had suppressed the earlier and more lethal waves, China's cumulative pandemic mortality remained well below that of comparable nations, with India's running between 42 and 162 percent higher.

A coordinated international effort could have contained and ended the pandemic. Its absence was not a failure of science or logistics. It was a failure of political will by a capitalist class whose interests lay in the uninterrupted extraction of profit from a workforce that could not be permitted to stop working.

The argument is not merely that the capitalist class chose profit over human life, although financial oligarchy did so at every turn. The suppression of public health as a social function serves a definite political and economic logic. A genuine elimination strategy would have required subordinating production to human need, providing guaranteed income to all workers and collectively mobilizing global resources. Such an effort would have demonstrated in practice that the global economy can be fundamentally reorganized around social need, serving as a powerful political education in socialism. That is one of the fundamental reasons why the ruling class refused to implement it. In this very concrete sense, the campaign against public health was a campaign against socialism.

The Make America Healthy Again (MAHA) movement of Robert F. Kennedy Jr. and the ongoing demolition of the public health infrastructure must be understood within this framework. These policies function not only to dismantle preparation for the next pandemic but to deliberately suppress working-class longevity as a mechanism of social control. The ruling elites rely on rising retirement ages and the normalization of working until death to extract maximum surplus value. A working-class person who is sick, exhausted, or dead before retirement cannot organize, strike, or build political alternatives, nor simply tap into his retirement funds, live his or her life with a semblance of any dignity or consideration that they provided something to better this world. Indeed, these early deaths were a boon to the financial oligarchs on social security outlays. As the NBER paper noted, "The pandemic resulted in approximately 1.4 million excess deaths among individuals aged 25 and older between 2020 and 2023. These premature deaths mostly reduced future retirement benefits, which increased the Social Security fund by [$156 billion, revised down from $219 billion by the authors]. Future disability benefit payments were reduced by $6 billion."

The life expectancy data forms the operational record of that reactionary project. The 8.5-year educational divide, the nine-year wealth gap for the elderly, and the excess mortality heavily concentrated in essential labor prove that death followed rigid class lines. The empirical evidence documented in the following sections serves as the foundation for a damning political verdict. This mass death was not a natural disaster. It was an organized social outcome requiring an organized social response.

To fully grasp the magnitude of the current social catastrophe and the

political motives driving the destruction of public health, it is necessary to examine the historical baseline of American mortality. The COVID-19 pandemic did not strike a healthy, thriving society. It collided with a population already suffering from the profound, class-based health inequities. However, this contemporary mortality crisis emerged only after the capitalist class deliberately halted and reversed a long era of historic, collective improvements in human longevity.

A century of gains and what produced them

Between 1900 and 1980, the United States recorded dramatic, sustained gains in life expectancy across every single state. These profound improvements in human survival were not the automatic byproduct of free market economic growth or individual consumer choices. They were the direct result of deliberate, collective public health interventions. Massive public investments in sanitation, clean water infrastructure, and comprehensive vaccination programs fundamentally transformed the lived experience of the population, effectively ending the childhood mortality gap that plagued earlier generations.

The staggering efficacy of these public health measures is a matter of historical and statistical record. As documented by Dr. Theodore Holford and colleagues in *JAMA Network Open* (2025) and analyzed by the *World Socialist Web Site*, routine childhood vaccinations for children born in the United States between 1994 and 2023 alone prevented an estimated 1.1 million deaths. These same routine immunizations prevented 32 million hospitalizations and 508 million illnesses, producing approximately $3.7 trillion in overall societal cost savings. The global eradication of smallpox and the near elimination of polio stand as enduring monuments to the power of collective public health investment and coordinated scientific action.

Understanding the monumental scale of what the working class and the scientific community built over the past century is essential to understanding the catastrophic costs of its current dismantling. The capitalist state is not merely trimming budgets. The ruling class is systematically destroying the very infrastructure that doubled human life expectancy, threatening to plunge society back into an era of unchecked, preventable disease.

The historic gains in American life expectancy generated by a century of public health investment ground to a halt after 2010. Yet this stagnation was not a universal phenomenon. As researchers Leah Abrams, Mikko Myrskylä, and Neil Mehta documented in *PNAS* (2023), the United States entered a period of “double jeopardy,” where mortality improvements stalled simultaneously for both working-age adults and those of retirement age. The scale of the crisis at older ages is staggering. If retirement-age mortality had simply continued to decline at the pace set between 2000 and 2009, women would have gained an additional 0.9 years and men 1.3 years of life expectancy between 2010 and 2019. Instead, progress flatlined. As a result, 81 percent of excess female deaths and 76 percent of excess male deaths in 2019 occurred among those aged 65 and older.

This stalling of life expectancy gains was not distributed equally across society. The declines in life expectancy observed since 2010 have been overwhelmingly confined to the working class, specifically the roughly two-thirds of Americans who do not hold a four-year college degree. Extensive research by economists Case and Deaton utilized educational attainment as a proxy for socioeconomic class to expose the lethal consequences of this divide. They found that by 2021, the life expectancy gap between the classes had exploded to a devastating 8.5 years. Adults possessing a bachelor’s degree could expect to live to 83.31 years of age, while those without a degree would see their lives end, on average, at 74.82 years. This chasm represents a massive acceleration of social inequality, more than tripling from a 2.5-year gap in 1992.

The data reveals a fundamental shift in the social geography of American mortality. The findings from Case and Deaton demonstrate that educational and class divides now exceed racial divides in determining survival. A Black American with a bachelor’s degree is now closer in life expectancy to a white American with a bachelor’s degree than to a Black American without one. This stark reality confirms that economic class and education, rather than race per se, are the primary sorting mechanisms determining mortality in capitalist America.

The divergence in survival based on educational attainment reflects a broader, decades-long widening of the socioeconomic mortality gradient. In a February 2022 report for the Society of Actuaries Research Institute, researcher Dr. Magali Barbieri documented this accelerating chasm. Between 1982 and 2019, the life expectancy gap between the lowest and highest socioeconomic deciles widened from 3.7 to 7.2 years for men and from 1.6 to 5.7 years for women. The rate of mortality improvement itself became a function of class. Across all adults between the ages of 50 and 80, those in the wealthiest quintile saw their mortality improve at 1.5 to 2 times the rate of those in the poorest quintile. The ultimate finding of the report is a devastating indictment of American capitalism: Only the top 10 percent of Americans live as long as the *average* citizen of other Organisation for Economic Co-operation and Development nations (OECD). Every other segment of the US working class was already dying earlier than their international peers well before the pandemic arrived.

This chart provides long-term visual context for actuarial data, showing the relative all-cause mortality trends and the stark divergence between socioeconomic groups from 1982 to 2019. The data reveals this divergence accelerating rapidly after approximately 2010, with the lower socioeconomic deciles exhibiting flat or worsening relative mortality while the higher deciles continue to improve. When we state that the COVID-19 pandemic exposed and accelerated a pre-existing crisis, this chart is exactly what that crisis looked like. The pandemic did not create the gap. It struck a population in which the mortality gap between the most and least advantaged Americans had already been widening for 40 years.

This lethal inequality compounds over a lifetime, producing a massive wealth gap in survival at older ages. A 2025 analysis by the National Council on Aging and the LeadingAge LTSS Center demonstrated that low-income older adults die on average nine years earlier than their wealthiest peers. The study measured two-year mortality rates within the cohort by income group: older adults earning $20,000 or less annually had mortality rates of 17 to 21 percent—nearly double the 10.5 to 11 percent rate among those earning $120,000 or more. This shortened lifespan is driven by profound economic precarity, as 80 percent of older United States households, representing approximately 34 million people, cannot withstand a major financial shock. Commenting on these findings, Dr. Marc Cohen of the University of Massachusetts Boston stated, “When you know that your fellow citizens, people who have worked their entire lives, are likely to live almost a decade less simply because of their economic position, that should trouble all of us.”

As a result of this extreme stratification, the working class arrived at the pandemic carrying the highest burden of cardiovascular disease. This burden was not a natural phenomenon but the direct biological product of occupational stress, inadequate preventive care, and the decades-long socioeconomic gradient. This pre-existing cardiovascular damage formed the biological terrain upon which COVID-19 would amplify class mortality. A 2025 University of California, Los Angeles meta-analysis of 155 studies, published by Dr. K. Kawai and colleagues in the *Journal of the American Heart Association*, quantified this viral impact. The researchers found that acute SARS-CoV-2 infection is linked to a fourfold increase in heart attack risk and a fivefold increase in stroke risk within

the first month after infection. The pre-existing cardiovascular burden of the working class was therefore not incidental context. It was the specific vulnerability that capitalist governments exploited when they dismantled public health measures and forced workers back into infected facilities to sustain corporate profits.

The missing Americans: US mortality vs. peer nations

To comprehend the true scale of the social crime perpetrated against the American working class, one must look at the international data. A 2025 study published by Dr. Jacob Bor and colleagues in *JAMA Health Forum* quantified this catastrophe, revealing that between 1980 and 2023, the United States suffered an estimated 14.7 million excess deaths relative to 21 other high-income countries. The pandemic did not create the American mortality crisis; it exposed and accelerated a structural failure four decades in the making. Long before the virus emerged, the capitalist state had already condemned millions to early graves. In 2019, United States mortality was already 28 percent higher than its international peers. During the acute pandemic years of 2020 and 2021, the ruling class response drove this gap to a staggering 46 percent above peer nations. This lethal trend continues unabated. Even in 2023, excess United States deaths accounted for 22.9 percent of all fatalities, including 46 percent of all deaths among people under the age of 65.

The single most damning indicator in the *JAMA Health Forum* report focuses specifically on the working-age population. In 2023, United States adults between the ages of 25 and 44 experienced a mortality rate 2.6 times higher than their counterparts in peer high-income nations. These victims are workers in the prime of their lives, not the elderly. This massive disparity provides the starkest possible evidence of a systemic social failure predating COVID-19. It definitively refutes any ideological claim by the political establishment that American mortality outcomes simply reflect natural variation or demographic circumstance.

The international data from Bor and colleagues perfectly confirms the grim reality exposed by the Society of Actuaries Research Institute: only the wealthiest 10 percent of Americans live as long as the average citizen of other OECD nations. For the American working class, the survival gap with peer nations has been expanding for forty years, precisely tracking the decades-long corporate offensive against living standards and social infrastructure. The emergence of SARS-CoV-2 did not create this divergence. Instead, capitalist governments utilized the pandemic to accelerate this inequality with lethal force, exposing the fundamental antagonism between private profit and human life in the most concrete terms possible: a mountain of working-class bodies.

The scale of deaths: confirmed, excess, and the measurement of catastrophe

The official accounting of the pandemic presents a staggering, yet deliberately incomplete, record of mass death. According to the CDC's Center for Health Statistics (2024), the confirmed COVID-19 death toll stood at approximately 384,000 in 2020. The deadliest year followed in 2021, driven by the Delta variant, with roughly 462,000 deaths. As successive waves swept the population, the official toll reached approximately 245,000 in 2022 and 76,000 in 2023. Between 2020 and 2023 alone, the United States recorded roughly 1,167,000 confirmed COVID-19 deaths. Estimates for 2024 project approximately 50,000 deaths, and for 2025, over 40,000 deaths, even as capitalist governments systematically curtailed disease surveillance meaning these figures were undercounting the ongoing real toll. Despite possessing only 4 percent of the world's population, the United States accounts for roughly 16 percent of all global confirmed COVID-19 deaths.

Yet these confirmed counts do not capture the true scale of the catastrophe. The all-cause mortality data reveal a historical rupture. Before the pandemic, total United States deaths hovered at a baseline of approximately 2.85 million per year. In 2020, total deaths surged to 3.38 million, followed by an even greater toll of 3.46 million in 2021. This staggering loss of life represents the largest single-year mortality increase since World War II.

This stacked bar chart acts as the establishing shot for the scale of the catastrophe. It displays total annual United States deaths by age cohort from 2010 to 2026, with the pre pandemic baseline period of 2013 to 2019 clearly shaded in blue. The visual contrast is stark. Total deaths rise from the baseline of 2.85 million in 2019 to 3.46 million in 2021, representing an increase of over half a million deaths in a single year. The dark red band representing working age adults between 45 and 74 years old is visually prominent, accounting for 37 to 41 percent of all deaths during the pandemic years. Before any discussion of specific variants or occupational data, this chart shows the reader in the simplest possible visual terms that an unprecedented and massive shock struck the American working class.

When we compare the historical all-cause mortality baseline to the confirmed COVID-19 death toll, the true, hidden cost of the pandemic becomes visible. By May 2026, the central excess mortality estimate reached approximately 1.45 million United States deaths, compared to the roughly 1.22 million confirmed COVID-19 deaths recorded by that point. This leaves a massive gap of 200,000 to 400,000 uncounted dead. These are people who died because of the pandemic, but whose deaths were never officially attributed to it. This gap is not a methodological artifact. It is the direct product of deliberate policy choices by the political establishment, including the refusal to fund adequate testing, the catastrophic overwhelming of hospitals, the resulting foregone medical care, and the systematic narrowing of death certification criteria.

This time series line chart makes the political argument about undercounting visible. It tracks cumulative excess deaths in the United States from January 2020 to May 2026, comparing the total confirmed COVID-19 deaths against the central excess mortality estimate and its uncertainty bounds. The confirmed deaths line reaches roughly 1.22 million by May 2026, while the central excess mortality estimate reaches 1.45 million, with an upper bound approaching 1.6 million. The widening gap between what the government officially acknowledged and what happened represents 200,000 to 400,000 people whose deaths were caused by the pandemic but never counted in its official toll. The lines diverge most sharply during the winter surges of 2020 to 2021 and 2021 to 2022, exactly when overwhelmed hospital systems were least able to accurately attribute causes of death.

The same WHO mortality assessment globalizes the undercounting argument [see Figure 1]. By January 2022, cumulative reported COVID-19 deaths worldwide reached roughly 5.4 million, while the true toll of cumulative excess deaths reached roughly 14.8 million, a gap of some 9.4 million uncounted deaths and a true toll about 2.7 times the official one. The monthly death rate tells the same story: the reported rate never rose above roughly 5 per 100,000, while the excess rate spiked to about 13 per 100,000 in the winter of 2020 to 2021 and about 22 per 100,000 in the spring of 2021, the latter driven by the uncontrolled Delta wave in Southeast Asia. Official tallies captured barely a third of true mortality worldwide. This widening gap is not statistical noise but the unmistakable signature of systematically uncounted death resulting from the refusal of capitalist governments to implement lifesaving mitigation

policies.

The cumulative signal of this crisis reveals a catastrophe that the political establishment simply decided to ignore. When examining excess mortality as a percentage above expected baseline trends, the data show that excess deaths ran 11 to 17 percent above normal levels through the entire period ending in December 2023. This trajectory was marked by two distinct and devastating peaks during the winter of 2020 to 2021 and the winter of 2021 to 2022.

This single line chart displays the cumulative percentage difference between observed United States deaths and projected deaths based on pre-pandemic trends from January 2020 to December 2023. The line starts briefly below zero in early January 2020, then rises sharply from March onward, peaking at approximately 17 to 18 percent above baseline in the winter of 2020 to 2021. After a slight dip, it peaks again at roughly 17 percent in the winter of 2021 to 2022, then gradually declines but remains firmly elevated at 11 to 12 percent above baseline through the end of 2023.

This chart supports the central argument against the official claims that the crisis has ended. The cumulative excess signal running above zero through December 2023 provides visual proof that the pandemic's mortality impact persisted continuously from March 2020 through the entire study period. The pandemic was not over; it was declared over. The line never returned to zero. Even in late 2023, long after the introduction of vaccines and the politically motivated declarations of victory, the United States was still recording roughly 11 percent more deaths than pre-pandemic trends would have predicted. The gradual decline in the line from 2022 onward reflects the combined effect of vaccines, prior immunity, and the biological shift to less lethal Omicron subvariants, rather than the product of any successful policy intervention.

This persistent undercounting was not merely an artifact of the chaotic early months of the outbreak. It was a structural feature of how the pandemic toll was measured and reported across every single phase of viral evolution. (Note on methodology: *the variant period data discussed below rely on an author-constructed table utilizing variant-period death summaries from Wikipedia cross-referenced against Our World in Data cumulative COVID-19 death and excess mortality time series. Period endpoints are aligned to variant dominance dates. These are close approximations, and readers should consult CDC WONDER for authoritative figures.*)

This four-row table covers the major SARS-CoV-2 variant eras from January 2020 through mid-June 2024, detailing the variant name, date range, interval COVID-19 deaths, cumulative COVID-19 deaths, cumulative excess deaths, and the percentage of excess mortality. The data show that the Wuhan and D614G era from January 2020 to February 2021 produced 508,300 interval COVID-19 deaths and 621,200 cumulative excess deaths, resulting in a 22 percent excess mortality ratio. The Alpha period from March to June 2021 recorded 92,300 interval COVID-19 deaths and a 13 percent excess. The Delta wave from July to mid-December 2021 drove 201,580 interval COVID-19 deaths and 999,970 cumulative excess deaths, producing a 25 percent excess. Finally, the Omicron era from mid-December 2021 to mid-June 2024 saw 387,820 COVID-19 deaths and 1.47 million cumulative excess deaths, yielding a 24 percent excess.

This table establishes the undercounting argument definitively. The key pattern is undeniable. Excess mortality ran 13 to 25 percent above confirmed COVID-19 deaths in every variant period without exception. Official counts systematically undercounted the true toll throughout the crisis. The highest ratio of any variant period occurred during the Delta wave, and despite media narratives minimizing its danger, the Omicron era produced the largest cumulative COVID-19 death count in absolute terms. The massive gap between confirmed and excess deaths persisted across all variants, proving that the concealment of the pandemic's true cost was a permanent feature of the capitalist response.

Regional variation as policy variation: where suppression worked

Excess mortality was not distributed evenly across the world. The stark geographic variation in survival tracks the political policies imposed by regional governments, not the inherent lethality of the virus. When measured using the P-score, which calculates excess deaths as a percentage above the expected baseline, the contrast between WHO regions for 2020 and 2021 is unmistakable.

The Region of the Americas sustained 30 to 50 percent excess mortality through late 2020, illustrating the deadly consequences of the United States and Latin American mitigation approach. The European region followed a similarly grim trajectory, climbing toward 35 to 40 percent excess mortality across 2021. Meanwhile, the South-East Asian region experienced a catastrophic spike to roughly 120 percent excess mortality in the spring of 2021. This surge, driven by India's uncontrolled Delta variant catastrophe, remains the clearest single image of the homicidal "let it rip" policy in action. Against all these soaring death rates, the Western Pacific region held its excess mortality near zero across the entire two-year period. This region encompasses China, together with New Zealand, Australia, South Korea, Taiwan, Vietnam and Japan, all states with elimination and strong suppression policies.

This small-multiple figure from the WHO mortality assessment shows monthly P-scores, representing excess deaths as a percentage above the expected baseline, for the world and the six WHO regions from January 2020 to December 2021. A P-score of 40 percent means 40 percent more deaths occurred than would be expected in normal times; a P-score near zero means no net excess mortality. The regional contrast is striking. The Region of the Americas sustained 30 to 50 percent excess through late 2020, the European region climbed toward 35 to 40 percent across 2021, and the South-East Asian region spiked to roughly 120 percent in spring 2021 during India's Delta wave.

Against all of these, the Western Pacific region held its P-score close to zero across the whole period, rarely exceeding 10 percent and at times dipping below it. This single panel is an empirical demonstration that policy, not the virus, determined the death toll. The flat Western Pacific line beside the surging Americas, European, and South-East Asian lines is the visual proof of what a coordinated international elimination strategy could have achieved everywhere, representing lives gained at a large scale wherever suppression was implemented.

Apologists for the policy of mass infection frequently attempt to dismiss the Western Pacific data by claiming it relies on unreliable Chinese reporting. This objection fails on two distinct fronts. First, the WHO methodology estimates excess all-cause mortality precisely to bypass the reported COVID-19 death problems and political manipulation that affect every country's official tally, not only China's. Second, the regional result does not depend solely on China. Nations such as New Zealand, Australia, South Korea, and Taiwan recorded near-zero or negative excess mortality across the exact same period in multiple independent datasets. The elimination result remains remarkably robust regardless of whether a reader trusts the figures originating from Beijing.

This data represents the empirical fulfillment of the thesis stated at the outset. Where suppression and elimination were implemented, excess mortality approached zero. Where capitalist governments deliberately chose to "live with the virus," excess deaths ran tens of percent above baseline. The lives gained through elimination were on the scale of entire populations, proving definitively that mass death was never an inevitability but a deliberate political choice.

Collapse of life expectancy

The COVID-19 pandemic erased two decades of life expectancy gains in the United States. In 2019, life expectancy stood at 78.8 years, but by 2021, it had fallen to a low of 76.4 years. The analytical point here is not the overall trajectory but the sheer scale of the collapse. This 2.4-year fall across 2019 and 2021 represents the largest two-year decline since the period of 1921 to 1923, plunging the US to its lowest life expectancy level since 1996. It is a reversal on the scale of the 1918 influenza aftermath, compressed into just 24 months.

By 2024, the CDC reported that aggregate life expectancy had climbed to roughly 79 years. However, this headline number is not evidence of a national recovery. Instead, it is an average artifact that conceals the precise mechanism of a widening class divide. A population-mean rises whenever its longest-lived members live longer, irrespective of what happens beneath them. As established previously, the massive differential in life expectancy drops and mortality rates between those with and without a college degree dictates this outcome. The 2024 aggregate is exactly this statistical effect. The wealthy living longer pulls the national average upward while the working class continues to carry the mortality disadvantage it absorbed during the pandemic. The headline number is therefore evidence of divergence, effectively erasing the class gap on which it is built.

The political establishment deployed the narrative that the virus “only kills the elderly” throughout the pandemic to justify returning workers to unsafe environments. By analyzing relative mortality increases, the exact opposite holds true. Working-age adults absorbed proportionally far larger mortality shocks than the elderly, and the absolute-count framing is precisely what inverted this reality to minimize working-class deaths.

This table provides the statistical refutation of the narrative that COVID-19 exclusively threatened the elderly. It shows that the 35 to 44 age cohort experienced a 44.5 percent rise in death rates in 2021 over 2019, the single largest relative increase of any age group. Similarly, those aged 25 to 34 saw a 40.4 percent increase, and those aged 45 to 54 saw a 36.9 percent increase. By contrast, those 85 and older experienced only an 11.4 to 13.1 percent relative increase. Indeed, working-age adults saw an increase in death rates far greater than for the elderly, by a factor of nearly four. This data was available throughout the pandemic. The decision to characterize the disease as primarily threatening the elderly was not ignorance but a deliberate framing choice serving the interests of those demanding workers returning to production.

This working-age mortality elevation was not confined to 2020 and 2021 but persisted through the study period, driven in part by the downstream cardiovascular effects of the virus.

To be continued