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

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31 July 2026

This is part two of a two-part series. Part one can be accessed here.

Who died: age, class, occupation and race

The official narrative constructed by the political establishment relied heavily on raw COVID-19 death counts to minimize working class mortality. Because absolute death counts are naturally dominated by the elderly, politicians and media commentators deployed these figures rhetorically to dismiss the virus as harmless to the working-age population. However, age-adjusted rates and relative mortality increases are the epidemiologically correct metrics for measuring the pandemic's disproportionate impact on society.

When presented alongside the age-specific rate data, this stacked bar chart exposes the absolute versus relative misrepresentation. While the 75 year and older age band dominates the raw numbers, the 45 to 74 working-age band carries a massive absolute toll, consistently representing a substantial portion of annual COVID-19 deaths during 2020 and 2021. Absolute counts favor the elderly simply because there are more elderly people dying naturally and their baseline death rates are higher. Yet, the relative increases prove that working-age adults experienced proportionally far larger mortality shocks. The political misuse of absolute count data to minimize working class death was a deliberate framing choice used to justify sending workers back into unsafe environments.

This forced exposure ensured that the virus did not travel randomly through the population but strictly followed the geography of class. A CDC analysis of 81 communities in Los Angeles County from March 2020 to September 2021 documented this profound geographic divide. During the summer 2020 wave, COVID-19 incidence rates were nearly seven times higher in communities at the 10th income percentile, with a median income of $48,944, compared to communities at the 90th percentile, where the median income was $133,286. By January 2021, the lowest-income communities recorded 835 cases per 100,000 residents, while the wealthiest recorded only 198 per 100,000.

This multi-wave line chart provides the central visual argument for class-determined exposure. The solid black line representing the poorest 10th percentile communities detaches from the light dashed line representing the wealthiest 90th percentile communities. This divergence means that in working class neighborhoods, the virus raged out of control, while affluent areas remained largely shielded. The virus did not discriminate by zip code randomly. It discriminated precisely by who was required to work in person, who lived in overcrowded housing, who lacked paid sick leave and who could not afford to isolate.

This massive disparity in exposure translated directly into a national class mortality crisis. In 2022, researchers led by Dr. Elizabeth Pathak analyzed the joint effects of socioeconomic position on COVID-19 mortality among working-age adults. They found that the disease was five times more lethal among low socioeconomic position working-age adults, recording 72.2 deaths per 100,000, compared to just 14.6 deaths per 100,000 for high-income adults. This represents a staggering relative risk of 4.94 for the working class. The occupational data definitively proves why this occurred, revealing that 68 percent of all COVID-19 deaths in 2020 among adults aged 25 to 64 occurred among workers holding labor, service and retail jobs. These jobs universally required on-site attendance and prolonged close contact, denying these workers the protective shield of remote work.

The gradient is unbroken. At every step down the socioeconomic ladder the age-adjusted COVID-19 death rate climbs, the signature of a disease whose lethality tracked the class position of those infected rather than any property of the virus itself.

That gradient was produced by the unequal distribution of remote work. The same study mapped the occupational composition of each socioeconomic, racial and gender group, and the pattern is unambiguous. Low socioeconomic position workers, and within every tier the non-white among them, were concentrated in blue-collar, service, and retail jobs that could never be performed from home, while high-socioeconomic position white workers were overwhelmingly in white-collar positions where remote work was feasible. The share of each group employed in never-remote work explained 72 percent of the variance in COVID-19 death rates. Race tracked mortality because race tracked exposure.

The class structure of exposure is laid bare. The groups doing the most never-remote work are precisely those that died at the highest rates, confirming that the racial and gender gaps in mortality were, at root, gaps in who was compelled to keep working in person.

The CDC's 2020 occupational data for working-age decedents across 46 states provides the specific empirical evidence of this slaughter. Protective service workers, including police and security guards, faced the highest age-adjusted death rate at 60.3 deaths per 100,000. Workers in food preparation and serving suffered roughly 35 to 40 deaths per 100,000. Measuring the proportionate mortality ratio, which evaluates the proportion of COVID-19 deaths relative to all causes, reveals a similar devastation in public-facing jobs. The proportionate mortality ratio stood at 158.5 for community and social services, 119.3 for transportation and warehousing, 118.7 for healthcare and social assistance and 118.3 for administrative and support services. For male community and social service workers, the ratio reached a staggering 194.7, the highest of any male occupational group. These victims held overwhelmingly non-remote, public-facing, working-class jobs. They were systematically denied employer-provided sick leave, lacked adequate health insurance and were given no option to work from home, forcing them to exchange their survival for paychecks.

The institutions where this exposure was concentrated were themselves engines of transmission. Hospitals, kept chronically understaffed and stripped of adequate protective equipment, became sites of nosocomial

(hospital-acquired) spread that fell hardest not on physicians but on the lower-paid nurses, aides, orderlies and cleaners drawn overwhelmingly from the working class. Schools, reopened under the official insistence that children neither suffered from nor transmitted the disease, functioned as community superspreader sites that seeded infection into the crowded, multigenerational households where working class families live, while teachers and school staff were ordered back into those rooms with the same indifference shown to meatpackers and warehouse workers. Children themselves were cast in the dominant narrative as invulnerable bystanders, yet they served as both vectors and victims, carrying the virus into their homes and suffering Long COVID, multisystem inflammatory syndrome and lasting developmental disruption. The official insistence that schools were safe was never grounded in the epidemiology. It served one overriding function, returning working parents to their jobs as rapidly as possible.

The mortality record in these cases is equally unsparing. In the single year from August 2021 to July 2022, COVID-19 killed 821 children and young people aged zero to nineteen in the United States and stood as a leading cause of death in that age group, eighth among all causes and first among every infectious and respiratory disease, ahead of influenza and pneumonia combined; across the pandemic it has claimed on the order of 1,500 young lives. It killed more children than any vaccine-preventable disease did in the years before a vaccine for it existed, a fact the present administration answers by stripping those same children of access to the vaccine. The toll fell heaviest on those who cared for and taught them. The WHO estimates that between 80,000 and 180,000 health and care workers died worldwide by mid-2021; in the United States the Lost on the Frontline investigation counted more than 3,600 healthcare worker deaths in the first year alone, and a tally of educators documented more than 1,300 teachers and school staff dead by the end of 2022. It was the price of ordering the young into unmitigated classrooms and the workers who cared for them into wards without protection.

Racial disparities in the United States are real and must be considered, yet the health impact is substantially explained by class position. A 2025 analysis of mortality data by Abidin and colleagues documented this reality. The non-Hispanic American Indian and Alaska Native population suffered the highest cumulative age-adjusted mortality rate at 154.0 per 100,000, which was 2.82 times higher than the Asian American reference group. They were followed by Native Hawaiian and Pacific Islanders at 124.2, African Americans at 123.9 and Hispanics at 123.2 deaths per 100,000. White Americans recorded 81.5 deaths per 100,000, while Asian Americans recorded 54.7.

Among Hispanic individuals, COVID-19 accounted for roughly 23 percent of all deaths in 2020 and 2021, nearly eliminating the long-documented Hispanic Mortality Paradox where this demographic traditionally experienced longer life expectancies than white Americans. The COVID disparities are largely driven by overrepresentation of Hispanics in low-income, never-remote occupational categories. Race amplifies class vulnerability and interacts lethally with historical discrimination, but it does not replace class as the primary explanatory variable for who lived and who died.

The working class ultimately faced a double burden, as the populations carrying the highest occupational exposure documented above were also the last to receive protection. The vaccination gradient ran inversely to occupational risk, perfectly tracking income and education in the opposite direction from death. Exposure and protection moved along the exact same class line in opposite directions, compounding rather than offsetting each other. Those who were forced to face the highest risk of infection on the front lines of the capitalist economy were structurally denied the resources to protect themselves.

The hidden toll: cardiovascular deaths, drug overdoses and the downstream mortality of crisis

The massive loss of life documented in the official pandemic statistics captures only a portion of the catastrophe. A profound hidden toll exists beneath the confirmed counts, manifesting primarily as a cardiovascular crisis. Before the pandemic, cardiovascular disease deaths in the United States sat at a baseline of approximately 874,569 in 2019. In 2020, this figure surged to 928,713. The death toll climbed further to 931,552 in 2021 and 941,621 in 2022. This represents a staggering excess of 55,000 to 67,000 cardiovascular deaths per year above the historical baseline, a lethal trend that has persisted continuously through 2025.

These fatalities do not appear on COVID-19 death certificates and are entirely excluded from the 1.2 million confirmed pandemic death count. The 45 to 74 working-age band consistently accounts for 34 to 36 percent of all cardiovascular deaths. This means that tens of thousands of excess cardiovascular deaths are concentrated specifically among working-age adults every single year.

This stacked bar chart makes the hidden toll argument concrete. It tracks annual deaths from circulatory and heart disease by age cohort from 2010 to 2026. The blue shaded area representing the baseline period of 2013 to 2019 allows for direct comparison of pandemic-era cardiovascular deaths against the pre-pandemic trend. The data clearly show total cardiovascular deaths remaining elevated above the pre-pandemic trend line through the entire 2020 to 2025 period with no return to baseline. These deaths are not officially counted as COVID-19 deaths, and they are not what the political establishment refers to when discussing the pandemic death toll. Instead, they represent the downstream cardiovascular consequences of COVID-19 infection, the cardiac effects of Long COVID and the fatal results of delayed or foregone medical care when hospital systems were overwhelmed.

The explanation for this cardiovascular surge is now definitively established in scientific literature. A 2025 University of California, Los Angeles meta-analysis of 155 studies led by Dr. Kosuke Kawai quantified this exact viral danger. The researchers found that acute SARS-CoV-2 infection triggers up to a fourfold increase in myocardial infarction risk and a fivefold increase in stroke risk within the first month after infection.

Furthermore, the pathology of Long COVID extends these severe cardiovascular risks across years, with long-term follow-up indicating a 74 percent higher risk of coronary heart disease and a 69 percent higher risk of stroke among those previously infected. The authors concluded that viral infections represent underrecognized and potentially preventable contributors to the global cardiovascular disease burden. This biological reality explains the excess cardiovascular deaths visualized in the actuarial data. The virus inflicts profound downstream cardiac damage, triggering inflammatory and vascular injury long after the acute respiratory phase has passed.

However, biology alone does not explain who actually died. This cardiovascular catastrophe was fundamentally amplified by class. The American working class arrived at the pandemic already carrying the highest cardiovascular disease burden, a direct product of decades of widening socioeconomic inequality and systematic disinvestment in public health.

COVID-19 functioned as a biological accelerant in precisely those populations least equipped to absorb the shock. The victims of this hidden toll were people who had never received adequate preventive care, who labored in highly stressful and physically demanding conditions and who simply could not afford to stop working and rest after becoming infected. Moreover, these workers were structurally locked out of the advanced medical therapies, specialized cardiovascular care and comprehensive rehabilitation routinely available to the wealthy elite. The tens of

thousands of excess cardiovascular deaths recorded annually from 2020 to 2025 cannot be separated from the pre-existing conditions that American capitalism had already imposed upon the working class. The ruling class decision to allow endless viral transmission subjected the most vulnerable layers of society to a massive, ongoing cardiovascular stress test.

A common thread connects the cardiovascular deaths and opioid-related deaths. The same overwhelmed health system that left cardiac patients without timely care also let addiction treatment programs lapse, and the pandemic drove a massive surge in deaths of despair from drugs and alcohol. In 2019, drug and alcohol overdose deaths stood at approximately 64,560. By 2020, this figure spiked to 86,305, and then soared to 100,886 in 2021 and 101,931 in 2022, remaining devastatingly elevated through 2025. The victims are overwhelmingly working adults. The 18 to 44 and 45 to 74 age bands carry massive shares of this mortality. It is the mortality of profound economic precarity, disrupted addiction treatment programs and intense social devastation concentrated entirely within the working class. This crisis was already underway before COVID-19, driven by deindustrialization and wage stagnation, but the pandemic accelerated it into absolute slaughter.

This stacked bar chart captures the pre-pandemic opioid crisis baseline and the sharp pandemic-era surge. The key visual argument is the sustained elevated plateau. The surge from roughly 64,560 to over 100,000 between 2019 and 2021 represents a staggering 56 percent increase in drug and alcohol deaths in just two years. This visualizes the severe acceleration of a pre-existing working class mortality crisis, demonstrating that the victims of these overdoses are working-age adults dying from the social consequences of capitalism.

Against this explosion of overdose fatalities, the data on suicide provides a crucial analytical counter-narrative. Throughout the pandemic, right-wing politicians and the corporate media relentlessly deployed the argument that lockdowns and public health measures caused mental health crises and suicide surges, using it to justify forcing workers back into infected facilities. The empirical record does not merely fail to support this claim, it refutes it. In 2020, the year of the most stringent restrictions, suicides did not rise but fell, dropping from roughly 47,500 deaths in 2019 to about 45,980, before creeping back upward to approximately 49,470 by 2023, a trajectory that stayed within the pre-pandemic trend and never approached the explosive growth in overdose deaths. The two curves answer to different mechanisms. Overdose mortality surged in large part because the treatment infrastructure that vulnerable users depended upon, the clinics and programs and emergency departments, buckled under a deliberately overwhelmed health system even as the illicit supply turned more lethal. Suicide, which does not hinge in the same way on that collapsing medical scaffolding, registered no comparable shock.

This chart is the empirical refutation of the lockdown-suicide myth. Suicides fell in 2020 and returned only gradually to their pre-pandemic trend, while overdose deaths nearly doubled. That divergence locates the overdose crisis in economic devastation and the collapse of treatment, not in public health measures as such. Where isolation did add to the toll, through people using alone with no one to reverse an overdose and through addiction programs left to lapse, the cause was the ruling class refusal to build any social support. The mitigation measures did not kill; the dismantled safety net did.

Finally, cancer mortality serves as the essential analytical control that makes the entire excess mortality argument comprehensible. Cancer deaths remained relatively stable across the crisis, inching upward from approximately 615,179 in 2019 to roughly 624,400 in 2022 and 636,115 in 2024. These modest increases are consistent with pre-existing trends and an aging population, rather than representing a pandemic-specific shock. This stability is analytically crucial because it proves that excess mortality is not randomly distributed across all cause-of-death categories. Instead, mass death is concentrated precisely in conditions directly linked to the pathological effects of COVID-19, such as cardiovascular disease, and the social devastation of the working class, such as drug overdoses, as well as the collapse of overwhelmed healthcare systems. The catastrophe did not meaningfully elevate conditions with longer, more independent natural histories like cancer.

The relative stability of cancer deaths in this chart serves as an indicator that the excess non-COVID mortality of the pandemic years is not demographic noise or coincidence. It is the specific, targeted signature of COVID-19's downstream pathological effects and the deliberate social abandonment of a working class population already pushed to the breaking point.

Variants, vaccines and the unequal distribution of protections

The scientific development and initial rollout of COVID-19 vaccines represented a monumental triumph of global scientific collaboration. The vaccines worked. Three consecutive modeling publications from the Commonwealth Fund establish the cumulative case for this quantified counterfactual.

Through November 2021, the first year of the vaccination campaign, the vaccines prevented an estimated 1,087,191 deaths and 10,319,961 hospitalizations, primarily by blunting the catastrophic impact of the Delta variant. By March 2022, those figures had expanded to more than two million deaths and 17 million hospitalizations prevented, saving roughly $900 billion in healthcare costs. By November 2022, marking two years of the vaccination program, the Commonwealth Fund estimated that the vaccines had prevented 3.2 million deaths and 18.5 million hospitalizations while saving $1.15 trillion in medical costs. Without this life-saving intervention, the United States would have experienced 4.1 times more deaths.

The most vivid counterfactual emerges from the daily mortality rates. Without the vaccination program, projected daily COVID-19 deaths could have reached approximately 21,000 per day. This staggering figure is nearly 5.2 times the actual record peak of roughly 4,000 deaths per day recorded in January 2021.

This dual-line chart makes the vaccine efficacy argument visually undeniable. The green line represents the model projection with the actual vaccination program, showing exactly what happened. The red line represents the counterfactual scenario without vaccination, showing what would have happened. The gray shaded area between them during the Delta wave in the autumn of 2021 represents the massive number of lives saved by collective public health intervention. During the Delta wave peak, the gap translated to approximately 18,000 additional United States deaths prevented per day above what was occurring. The vaccination program was one of the most consequential collective public health interventions in American history, which makes its subsequent abandonment and political demolition even more indicting.

The chronological evolution of the variants further exposes the lethal consequences of the government's policy decisions. During the Delta wave, from July to mid-December 2021, the United States recorded 201,580 confirmed COVID-19 deaths. This period produced a 25 percent excess mortality ratio, the highest of any variant era. This massive death toll occurred precisely because it coincided with an incomplete vaccine rollout and the deliberate abandonment of masking and ventilation guidance by federal and state health agencies.

The same variant-period table [see Figure 6, part one] reveals a devastating truth that directly refutes the "mild Omicron" narrative perpetuated by the political establishment and the corporate media. From mid December 2021 to mid-June 2024, the Omicron era generated the

largest cumulative COVID-19 death count of any period, with 387,820 confirmed deaths. This slaughter occurred because all remaining public health protections were stripped away as the highly transmissible variant spread. Despite lower individual fatality rate initially, the extraordinary transmissibility of Omicron produced more total deaths than Delta when the full era is considered. Furthermore, case fatality rates rose exponentially through successive subvariants, from 0.32 percent for BA.1, to 0.41 percent for BA.5, up to 0.86 percent for XBB.1.5, approaching Delta-level pathogenicity. The mortality data shatters the homicidal framing that society could safely "live with COVID."

Furthermore, the benefits of these lifesaving vaccines were distributed along rigid class lines. A survival analysis of CDC Behavioral Risk Factor Surveillance System data across 29 states from December 2020 to December 2022 documented profound socioeconomic stratification in uptake. By early 2021, 76 percent of college graduates were vaccinated or intended to be, compared to just 53 percent of those without a degree, representing a massive 23-point relative gap. During the critical early rollout phase, 29 percent of graduate degree holders secured vaccination, compared to only 9 percent of those with a high school education or less. Similarly, 24 percent of individuals in the highest income quartile were vaccinated early, compared to a mere 9 percent in the lowest income quartile.

This chart visualizes the progression of primary series vaccination coverage by community income decile in Los Angeles County from January to September 2021. By September, the poorest 10th percentile communities had reached only 59.4 percent coverage, while the wealthiest 90th percentile communities had achieved 71.5 percent. This gap directly compounded the occupational exposure inequality established earlier. The working class faced a deadly double burden. Those who were most exposed to the virus on the front lines of the economy were pushed to the back of the line for protection from it.

The Biden administration's "vaccine only" strategy deliberately abandoned masking, ventilation, testing, and other transmission reduction measures, leaving unvaccinated and under vaccinated workers fully exposed to the virus. This capitulation was rapidly followed by the withdrawal of booster recommendations, the defunding of vaccine infrastructure and the appointment of prominent vaccine skeptics to public health leadership. This reactionary campaign reached a new stage in January 2026, when Health and Human Services Secretary Robert F. Kennedy Jr. unilaterally revised the United States childhood immunization schedule, removing routine universal recommendations for six fundamental vaccines. The consequences of this ideological assault are already materializing. In 2025, the United States recorded more than 2,000 measles infections, the highest case count in more than three decades, placing the nation's measles elimination status, achieved in 2000, in imminent jeopardy. The dismantling of the vaccination program is not an isolated policy error. It is the direct continuation of the same murderous political project.

The political economy of mass death: a continuum

The six years of the COVID-19 pandemic in the United States were not a natural disaster that befell an unprepared society. The pandemic was a preventable catastrophe whose severity was determined in advance by deliberate policy choices. The empirical data converges on a single, documented chain of causation. Decades of labor market degradation produced profound income insecurity, which forced working class families into poor housing and inadequate nutrition.

This economic precarity guaranteed frontline occupational exposure. Combined with inadequate healthcare access, this exposure led inevitably to COVID-19 infection. Lacking employer-provided sick leave, infected workers were forced to continue working, resulting in severe disease, Long COVID and earlier death. Each link in this deadly chain can be quantified. Essential workers experienced proportionate mortality ratios 19 to 59 percent above the occupational average. At the community level, every $10 per capita increase in local health spending reduced peak COVID-19 deaths by 1.2 per 100,000 residents. Yet the United States, which spends a staggering $14,570 per person on healthcare annually, allocates less than 3 percent of those funds to public health and prevention, resulting in the lowest life expectancy among peer nations.

Within this political economy of mass death, the concept of the "essential worker" requires demystification. During the spring of 2020, capitalist politicians and the corporate media celebrated "essential workers" with performative gratitude. Yet this designation functioned purely as ideological cover for a policy of organized, lethal exposure. In practice, the term "essential" simply meant that a worker's labor was necessary for the uninterrupted functioning of the capitalist economy, and therefore, their life was entirely expendable.

The occupational mortality data definitively names who these workers were. They were protective service workers, food preparation and serving staff, transportation and material moving workers, healthcare support staff, community and social service workers and production workers. They were forced into infected facilities without adequate protection, denied paid sick leave and left to face the virus alone. The class composition of COVID-19 mortality is precisely the class composition of "essential" labor. This overlap was not a tragic coincidence, but the fundamental structure of the American economy made lethal, confirming that the pandemic death toll was driven by the ruthless subordination of working class survival to the accumulation of corporate profit.

The Trump administration established this lethal template early in 2020. Despite possessing clear scientific knowledge of the virus's extreme lethality in January of that year, the administration explicitly prioritized economic activity, demanding that the country be back to work by Easter. Guided by the ruling class mantra that the cure cannot be worse (for the economy, i.e., profits) than the disease, the government funneled trillions of dollars to the financial elite through the CARES Act while launching a homicidal back-to-work campaign in March and April 2020. This campaign forced millions of workers into unsafe environments devoid of protective equipment, adequate testing infrastructure and paid sick leave. The occupational mortality data documented in previous sections is the direct record of the slaughter that followed. This conscious prioritization of capital over human survival became the template followed by all subsequent administrations.

The Biden administration did not reverse this course, but rather consolidated and expanded it. By September 2022, President Biden declared on national television that the pandemic was over, a policy statement made while more than 400 Americans were still dying from the virus every single day. Under immense pressure from the United States and other major capitalist powers, the WHO ended its global health emergency declaration in May 2023, providing the political cover to dismantle remaining domestic protections. Masking guidance was gutted, wastewater surveillance was systematically defunded and the burden of public health was shifted entirely onto individuals. The capitulation was absolute by March 2024, when the CDC issued revised guidelines urging COVID-19-positive individuals to return to schools and workplaces while actively infectious.

Ultimately, far more people died of COVID-19 under the Biden administration than under Trump. As the *World Socialist Web Site* has consistently documented throughout the crisis, this was not a product of ignorance or a failure of science, but a calculated political decision to codify a "forever COVID" policy and normalize mass death in the pursuit

of uninterrupted economic production.

The return of Donald Trump to the White House marked a transition from the abandonment of public health to its active demolition. This was not mere negligence but a deliberate institutional assault. The record of this destruction is staggering. On February 14, 2025, the Trump administration fired thousands of Department of Health and Human Services employees in a single day, eliminating 1,300 scientists and staff from the CDC, which amounted to roughly 10 percent of its workforce, and about 1,500 from the NIH. By October 2025, approximately 24 percent of all CDC employees had been eliminated, and the overall HHS workforce was slashed from roughly 80,000 to 60,000. These cuts left critical agencies decimated, prompting experts like virologist Dr. Angela Rasmussen to describe the CDC as "not functional."

The scientific infrastructure was systematically dismantled. More than 1,700 NIH research grants were terminated. The entire CDC maternal mortality monitoring team was eliminated, and funding was cut for vital public health journals including *Emerging Infectious Diseases* and *Preventing Chronic Disease*. The 2026 budget included a devastating 44 percent cut to the NIH, the outright elimination of the National Institute on Minority Health and Health Disparities, the National Institute of Nursing Research and the Fogarty International Center. Furthermore, the proposed 2027 budget seeks an additional $5 billion reduction. Commenting on this trajectory, Dr. Georges Benjamin of the American Public Health Association warned that these cuts "will totally destroy the nation's public health infrastructure."

Simultaneously, the administration waged an ideological war on science. The childhood vaccine schedule was revised by executive fiat, stripping routine recommendations for six fundamental childhood vaccines. The result was immediate and lethal. In 2025, measles cases exceeded 2,000, reaching the highest level in three decades and threatening the nation's elimination status achieved in 2000. The administration formally withdrew the United States from the WHO on January 22, 2026. Official federal resources like COVID.gov were replaced with lab-leak propaganda, wastewater disease surveillance was defunded and the National Center for Health Statistics data infrastructure was dismantled.

This destruction is occurring at the most dangerous possible moment. A 2022 Georgetown University study published in *PNAS* by Dr. Colin Carlson and colleagues documented that climate change will trigger thousands of new cross-species viral transmission events in the coming decades. The United States is withdrawing its surveillance capacity and gutting its public health system at the precise moment that science predicts that new pandemic threats are rapidly accelerating.

The silence and what it means

The empirical evidence demands an uncompromising verdict. Over the course of six years, the United States recorded more than 1.2 million confirmed COVID-19 deaths. Yet, when all uncounted casualties are tallied, the true toll of excess mortality approaches 1.5 million lives lost. Against the official media narrative that the virus primarily threatened the elderly and the frail, the actuarial data proves definitively that working-age adults absorbed the largest relative mortality shocks. Geographic tracking demonstrates that in major metropolitan areas, low-income communities suffered infection rates nearly seven times higher than their wealthiest neighbors. The occupational data is even more damning, revealing that 68 percent of all working-age COVID-19 fatalities occurred among laborers, service industry employees and retail workers forced to remain on the front lines. Furthermore, this acute viral slaughter triggered a chronic secondary crisis, generating 55,000 to 67,000 excess cardiovascular deaths above the historical baseline every single year since 2020. And the people who died were overwhelmingly working class, dying in staggering numbers because the capitalist political and economic order is organized entirely around the uninterrupted extraction of their labor, not the preservation of their lives.

Recently, the CDC reported that aggregate United States life expectancy reached a nominal all-time high in 2024. This figure was immediately seized upon by the political establishment to declare the pandemic crisis permanently resolved. But the evidence requires that this headline figure be read critically. The foundation of the American mortality crisis remains a profound, widening class divide. The sourced data establishes the absolute floor of this catastrophe. In 2020, adults without a four-year college degree lost 3.25 years of life expectancy, compared to a drop of just 1.09 years for those holding a degree. During that same period, the COVID-19 age-adjusted mortality rate stood at 165 per 100,000 for the non-college educated, nearly three times higher than the 57 per 100,000 rates for college graduates. Today, the devastating nine-year survival gap based on wealth at older ages and the 8.5-year educational gap in adult life expectancy have not narrowed.

The perceived national recovery is an illusion. It is the statistical signature of a deeply unequal class society. The affluent living longer pulls the national average upward, while the working class continues to carry the massive mortality disadvantage it absorbed during the pandemic and continues to die much earlier. Using this distorted aggregate figure to declare the public health crisis over is not a valid epidemiological observation, but a deliberate political act. It is as much a political act as replacing official government resources like COVID.gov with right-wing lab-leak propaganda or utilizing police to escort scientists away from a national diabetes conference simply for attempting to discuss the ongoing viral threat. The working class has not recovered from the pandemic. Its ongoing suffering has simply been erased from the official record, in order to protect corporate profits.

The alarm over the systematic destruction of public health is now sounding from within the scientific establishment itself. In June 2026, the editors of the journal *Diabetes Care* published a searing editorial calling on citizens to demand an immediate halt to what they described as the spiraling fall of the United States of America's status as the foremost nation in healthcare innovation. Their peer-reviewed findings document the deliberate demolition of the American scientific infrastructure. They report an 89 percent reduction in NIH funding opportunities, with only 84 issued compared to 787 the prior year. Grant awards have been slashed by 66 percent, resulting in a 54 percent reduction in research funding to investigators, plummeting from just over $1.3 billion down to $600 million. Furthermore, the authors expose a new multiyear forward funding mechanism specifically designed to rapidly deplete congressional appropriations, a bureaucratic maneuver that will reduce fundable grants by an estimated 40 percent per year which will eviscerate the whole edifice of scientific inquiry and research.

When these prominent scientists attempted to distribute copies of their evidence-based editorial at the American Diabetes Association's annual scientific conference in New Orleans, Louisiana State Police and security guards physically removed them from the building. Pediatric obesity researcher Aaron Kelly filmed the expulsion and correctly declared that censorship is real. The target of this censorship is not merely a single medical editorial, a professional conference, or even this specific report. The ultimate target is the capacity of the working class to know exactly what the ruling class is doing to it.

The capitalist war on public health is fundamentally a war on socialism. The suppression of working class longevity is not an accidental byproduct of greed but a coherent and lethal political project. Every major decision in this continuum has served the exact same function. Donald Trump's homicidal back-to-work campaigns in 2020, the Biden administration's

total abandonment of mitigation measures, the bipartisan normalization of mass death and the current active demolition of the health agencies all share a singular goal. That goal is to restore the extraction of labor and profit from the working class as rapidly as possible, regardless of the staggering cost in working class lives.

The MAHA movement now advances this longer-term project. The administration seeks to permanently normalize elevated working class mortality, destroy life-saving vaccination programs, eliminate comprehensive disease surveillance and deliberately suppress any research documenting health disparities. They are waging a relentless ideological campaign against the very concept of collective public health action. The objective of the financial oligarchy is to engineer a working class that works until it dies, expects no state protection of its health and lacks the institutional and scientific infrastructure to even measure its own mortality.

Had the COVID-19 pandemic been fought seriously on a global scale, it would have required the subordination of private profit to human need. It would have served as a profound political education in the benefits of collective social action for the international working class. That it was not fought seriously was a deliberate political choice by the capitalist class. The mountain of data assembled here stands as the historical record of what that choice cost.

Conclusion: the way forward

The millions of individuals documented here are not mere statistics. They were the essential workers who kept society functioning, the elderly poor who could not afford life-saving medications and the construction and food service employees who had no option to work from home. They belonged to communities whose profound poverty reflected social inequality accumulated across generations. Their premature deaths were never inevitable. Rather, their lives were the price exacted by a social order organized entirely around the accumulation of corporate profit.

The defense of public health is fundamentally a class question and a political question. This crisis cannot be resolved by better data or improved scientific communication alone, even as both are currently being actively destroyed. Ending this nightmare requires a mass political movement of the international working class that consciously understands the profound connection between its own longevity and the economic organization of society. This movement must treat public health infrastructure as an inalienable collective right and demand its complete rebuilding on a scientific and internationalist basis. Furthermore, it must resolutely refuse to accept the normalization of mass preventable death as the acceptable cost of doing business under capitalism. There has never been a more urgent moment for a profound societal reckoning, nor a more critical time to build the revolutionary political movement that this unprecedented crisis demands.

Concluded