

The Social Consequences of the Global Expansion of the COVID-19 Pandemic

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Abstract: Based on a class analysis, the article shows the failure of the commercialized health care system in the Global North and South to address the COVID-19 pandemic. To this end, the article investigates the dynamics, consequences, and prospects of the struggle by developed countries to overcome the coronavirus crisis, revealing the extremely low effectiveness and class limitations of the measures taken. The stumbling block in the way of curbing the pandemic on a global scale has been the refusal by developed countries to help developing countries vaccinate their populations. The brunt of the COVID-19 problem has been shifted by the capitalist state and monopolies onto the working class, leading to increased exploitation, excess mortality, and widening inequality. On the basis of an analysis of the health crisis in the capitalist world, the article concludes that global civilization must move toward a more just and democratic world order that is able to put the health of workers before monopoly profits, and to guarantee everyone the right to live with dignity.

Key words: neoliberalism; COVID-19; health care; inequality; working class

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Introduction

Since 2020 the term “COVID-19 pandemic,” which is the key word in our article, has been widely used in socio-economic publications. There are currently more than 2,500,000,000 references to “COVID-19 pandemic” on Google, which shows the

enormous attention paid in the world political-economic and economic-sociological discourse to COVID-19 as a social disease. By the admission of many scientists, the measures taken against the pandemic by the authorities in the Global North have failed to achieve their goals, resulting in mass infections, the impoverishment of millions of people, increased inequality, and the trampling of justice on all continents as a result of the inability of global capitalism to withstand the coronavirus onslaught.

As interpreted by the British sociologist Christian Fuchs, the COVID-19 pandemic struck the world economy at a time when authoritarian traits were expanding within capitalism as a consequence of a deep economic crisis and of decades of neoliberal policies that had reinforced social inequality and encouraged the spread of far-right ideology. As a result, the global community had grown more fragile and prone to violence, war, and fascism; it had become ill-prepared to deal with a global pandemic, and finished up paying an excessively high price to overcome it (Fuchs 2021, 264). The authors of this article share the opinion of those scholars who argue that the failure of the countries of the Global North in their fight against COVID-19 has been a consequence of the intensification of the general crisis of global capitalism in the first decades of the 21st century.

World civilization has experienced more than 20 pandemics in the last 200 years, and has faced severe shocks from viral diseases. It should suffice to recall that in 1918–1920 the “Spanish flu” claimed more than 50 million lives (Taylor 2022). However, the current spread of COVID-19 is the first pandemic in the history of humanity to have struck almost the entire world at the same time. In an extremely short period, the disease swept across the entire global space and affected all major aspects of human security (Robles 2022). All nations needed to implement solidarity actions in order to minimize the irrevocable human losses caused by the virus. This did not happen, and as a result, academic scholarship is faced with the question: “Why?”

One well-researched and reasoned answer to this question is provided by the distinguished American professors Noam Chomsky and Marvin Waterstone:

COVID-19 has revealed glaring failures and monstrous brutalities in the current capitalist system. It represents both a crisis and an opportunity. Contests for controlling the narratives around the meaning of this pandemic will be the terrain of struggle for either a new, more humane common sense and society or a return to the status quo ante. The outcome of those contests is uncertain; everything depends on the actions that people take into their own hands. (Chomsky and Waterstone 2021, 344)

In the capitalist world, the lack of adequate action by both states and mass social movements to prevent and overcome the pandemic has resulted in COVID-19 reaping an abundant “harvest of death” on all continents. According to the Johns

Hopkins University Center for Systems Science and Engineering, as of November 11, 2022, the world had seen 634,588,209 cases of COVID-19 and 6,608,713 deaths due to infection by the virus (Johns Hopkins University 2022). The latter figure exceeds the irretrievable losses of any country in armed conflicts since World War II (Worldometers 2022a).

The latest World Health Organization (WHO) data show that between January 1, 2020, and December 31, 2021, the total number of deaths related to the pandemic (“excess deaths”) was nearly three times greater than the official COVID-19 mortality statistics, amounting to approximately 14.9 million. “Excess mortality” refers to deaths attributable directly (due to disease) or indirectly (due to the impact of the pandemic on the functioning of the health care system and society) to COVID-19 (WHO 2022). The World Health Organization estimates that by far the greatest number of excess deaths (84%) occurred in Southeast Asia, Europe, and the Americas. Over the two-year period, middle-income countries accounted for 81% of the 14.9 million excess deaths (53% in lower-middle-income and 28% in upper-middle-income countries), while high- and low-income countries accounted for 15% and 4% of excess deaths, respectively (WHO 2022). “These sobering data not only point to the impact of the pandemic but also to the need for all countries to invest in more resilient health systems that can sustain essential health services during crises, including stronger health information systems,” said WHO Director-General Dr. Tedros Ghebreyesus (WHO 2022). Further research on the issue has shown that the social and human costs of the global expansion of COVID-19 have been much higher even than the WHO data would indicate.

An international team of 96 researchers who analyzed global excess mortality rates as part of an initiative by the British medical journal *The Lancet* estimated that 18.2 million people died worldwide between January 1, 2020, and December 31, 2021, because of the COVID-19 pandemic. The global excess mortality rate for all age groups due to COVID-19 was 120.3 deaths per 100,000 population. In 21 countries the excess death rate was more than 300 deaths per 100,000 people. The number of excess deaths caused by COVID-19 was highest in the regions of South Asia, North Africa, the Middle East, and Eastern Europe. At the individual country level, the highest numbers of cumulative excess deaths caused by COVID-19 were reported in India—4.07 million, the United States—1.13 million, and Russia—1.07 million (COVID-19 Excess Mortality Collaborators 2022, 1513). The UN Department of Economic and Social Affairs estimates that between 2019 and 2021 the pandemic resulted globally in a 1.7-year decrease in life expectancy at birth (United Nations 2022, 21).

Many researchers are now paying particular attention to the excess mortality rates in the US, where medical science is highly advanced, and which advertises its achievements in telemedicine in every possible way. American health care still

serves as a model for the ruling elites in many developing and post-socialist countries. The pandemic, however, has highlighted both sides of the “US health care” coin, and has revealed the existence of two systems of health care delivery in the center of digital capitalism: one for capital and the rich, the other for labor and the poor (United Nations 2022, 21).

Overall, the global outbreak of COVID-19 has convincingly demonstrated the anti-popular nature of world capitalism and its widespread failure to treat coronavirus infection. The pandemic has also shown the incompatibility of commercialized health care with guaranteeing human beings the right to life. The COVID-19 ordeal has resulted in the agonizing loss of numerous lives due to a lack of access to basic health services both in the affluent countries of the Global North and in the poor countries of the Global South. All this confirms the conclusions of the American author Jathan Sadowski: “Capitalism’s trajectory has been on a path toward increasingly higher rates of social inequity, economic instability, and existential insecurity. The digital turn in capitalism has not disrupted these trends; if anything, it has amplified and accelerated them” (Sadowski 2020, 193).

Methodological Approaches to Analysis of the COVID-19 Pandemic

Today, the ruling elites in the “golden billion” countries present COVID-19 as an “exogenous shock” that has figured as the main cause dragging global capitalism into another economic crisis. Through this maneuver apologists for the modern model of capitalism seek to hide their responsibility for failures in domestic and foreign policy, aiming to divert the attention of the peoples of the world from the latest stage in the general crisis of capitalism, and to include them in a global “viral battle” under the bourgeois slogan “We are all in this together!” (Alexiou 2021, 286). This “humane” appeal, however, does not prevent these people from ignoring the problems of the Third World and of the “transitional economies,” or of their own working and unemployed poor who need vaccination and treatment for COVID-19. In reality, the pandemic is not the root cause of the problems, but a direct legacy of the devastating impact of the current crisis of global capitalism on the health sector, and a catalyst for dragging the global economy into another economic recession. The global capitalist economy has not yet managed to cope with the consequences of the first-ever global financial and economic crisis of 2008–2009. The pandemic has further limited the ability of global capitalism to avoid entering into a new economic crisis, threatening a repeat of the Great Depression of 1929–1933 (Arseienko 2021). Worth noting in this context is the conclusion of Mexican political economist Arturo Guillén that blaming the coronavirus for the crisis is an ideological construct of the hegemonic sectors of the financial

oligarchy and of the mass media serving them, a construct that seeks to hide the contradictions of capitalism and to confuse the population (Guillén 2020, 358). Meanwhile, the significantly lower losses recorded by the People's Republic of China (PRC) and other socialist countries in the fight against COVID-19 demonstrate the advantages of their health care systems.

Taking into account 1) the global nature of the COVID-19 pandemic and its dire consequences for humanity; 2) the inability of the ruling elites of the Global North to deal with the coronavirus crisis at home, and their failure to show solidarity with underdeveloped countries in overcoming it; 3) the desire of capital worldwide to shift the main burden of COVID-19 onto the working masses; and 4) the positive experience of socialist countries in preventing and coping with viral pandemics, it follows that conducting scientific research on these problems and achievements has great importance, not only academic but also practical. It is important today to employ the methods of political economy and economic sociology to analyze the dynamics and social consequences of the global COVID-19 pandemic; to identify the reasons for the poor performance of capitalist countries in confronting COVID-19; to generalize and popularize positive experiences in the fight against COVID-19; and to develop recommendations for the prevention and treatment of this grave and insidious disease. This article aims to contribute to the discourse in global political economy and economic sociology on this topical issue, which now occupies an important place in many socio-economic journals and other publications (Alexiou 2021; Lohmeyer and Taylor 2020; Lust 2021; Paulsson and Koglin 2022; Robinson 2020; Saad-Filho 2020; Sen, Qadeer, and Missoni 2022; Stevano et al. 2021; Suwandi and Foster 2022; Wei and Chen 2020; etc.). In the countries of the Global North and South, the social organization of health care and the efforts to deal with the COVID-19 problem have been the subjects of much academic work by political economists and economic sociologists. The work of researchers who adopt a critical approach in studying the causes and consequences of the spread of the pandemic deserves special attention. Many of these works were used in the preparation of this article (Bambra, Lynch, and Smith 2021; Cahill and Konnings 2017; Chomsky and Waterstone 2021; Feher 2018; Gaase 2020; Horton 2020; National Academies of Sciences, Engineering, and Medicine 2022; Robinson 2022; Sadowski 2020; Washington 2006; Winant 2021; etc.).

Scientific analysis of the social consequences of the global spread of COVID-19 indicates that in the 21st century, humanity is facing an unprecedented challenge to the socio-economic viability of global society. The authors believe that in the context of the threat facing the world, the most appropriate approach to the study of this problem is an interdisciplinary one. A synthesis of economic science and sociology; of the history of economic studies and historical sociology; of political economy and economic sociology; and of medical economics and the sociology of medicine offers the

greatest scope for an objective and comprehensive analysis of this complex topic. We use an interdisciplinary approach, since none of the mainstream economic theories employed by the various neoclassical schools can manage a scientific analysis of the social consequences of the global COVID-19 outbreak, or an analysis of the impact of the current crisis of global capitalism on the pandemic and vice versa. Nor are these theories able to provide an adequate response to the global challenges and risks of our time, which are leading humanity into a historical stalemate with unpredictable consequences. This is a result of the refusal of adherents of the neoclassical schools to apply the sociological method to economic research, and the economic method to sociological research, in order to avoid the accusation of having a materialist understanding of society. As a result, the adherents of these schools fail to study the reasons why humanity's natural harmony is violated under capitalism, resulting in an aggravation of the contradictions between workers' labor and their spiritual and intellectual foundations. These contradictions have a negative impact on the workers' physical health and moral condition. As the renowned Greek liberal economist and politician Xenophon Zolotas noted, "Mental stress, fear, aggressiveness and social apathy have become the main features of life in the 'society of abundance'" (Zolotas 1985, 129).

With the new century, attempts to overcome the limitations of traditional approaches to the study of "sick" Western society within the framework of the "new political economy" and the "new economic sociology" intensified in both the Old and New Worlds. In the context of these attempts, some Western economists and sociologists who have nothing in common with Marxism have resorted increasingly to Marxist terms in order to explain the crisis trends and processes in the modern capitalist economy and society. An example is the following passage from an article by one of the most famous founders of the "new economic sociology," Cornell University Professor of Sociology, Richard Swedberg. Entitled "The Tool Kit of Economic Sociology," the article was published in *The Oxford Handbook of Political Economy*. Swedberg notes:

All in all economic sociology, while lacking a cohesive theoretical core of the type that mainstream economics has, nonetheless has at its disposal a number of concepts that help untangle the impact of social relations and social structures. In particular, as argued here, these concepts can be used to approach the interactions between the political and the economic spheres in modern society. What is primarily needed to advance economic sociology beyond its current state is to make room for the concept of interest, to make it easier to get at the forces that drive the economic actions of individual actors. (Swedberg 2006, 948)

As they say in Argentina, it takes two to tango; the successful promotion and implementation of sociological concepts in socio-economic theory and practice

requires establishing a dialogue between sociologists and economists. Swedberg notes that “this enterprise would be much more successful if there were interest on both sides—now, alas, economic sociologists pay far more attention to the work of economists than economists do to the work of economic sociologists.” At the same time, he believes that “sociologists should undoubtedly follow the economic literature, since most topics in the study of economy (if not all topics) were once analyzed by economists” (Swedberg 2005, 11). To be fair, a number of the concepts put forward in the West as part of the new economic sociology have made some contribution to the development of critical sociology. However, these concepts have not and cannot become mainstream in the socio-economic sciences that serve the interests of the powerful and of those in power. This is due to the banishing from the methodological foundations of economic sociology of the methods of economic science itself, and especially, of classical political economy. This is because it is “economic science that in one way or another subsumes social processes to economics and thereby objectively confirms the materialistic approach” (Elmeev 2007, 23). In general, however, as American sociologist Mark Granovetter admits, the fundamental shortcoming of contemporary sociological theory in capitalist countries is that it cannot satisfactorily connect micro-level interactions with macro-level structures (Granovetter 2014, 71). To overcome such problems in political economy and economic sociology, it is not enough for sociologists to do as Swedberg urges and to follow the economic literature more closely, and for economists to follow the sociological literature. To overcome the problems, both the former and the latter need to move beyond accepting the system of continued exploitation of wage labor, and to realize that “only Marxism has prepared the scientific means of guiding social progress toward overcoming capitalist tendencies and working constructively for the communist future of humanity” (Elmeev et al. 2009, 68).

In its time, the active use of an interdisciplinary approach to the study of the emergence of industrial capitalism greatly expanded the research and analytical potential of Marxism. This allowed the founders of Marxism to comprehensively reveal the essence of the contradictions that exist under capitalism, and the antagonism within capitalism of the productive forces and production relations. The scientific achievements of Karl Marx and Friedrich Engels in this field have not lost their relevance today. Almost 170 years ago Marx emphasized:

In our days, everything seems pregnant with its contrary: Machinery, gifted with the wonderful power of shortening and fructifying human labour, we behold starving and overworking it; The newfangled sources of wealth, by some strange weird spell, are turned into sources of want; . . . This antagonism between modern industry and science on the one hand, modern misery and dissolution on the

other hand; this antagonism between the productive powers and the social relations of our epoch is a fact, palpable, overwhelming, and not to be controverted. (Marx 1958, 4)

All these characteristics of the old system were clearly evident when the system collided with the viral pandemic, and are of direct relevance to the scientific identification of the causes and social consequences of the COVID-19 pandemic. Proceeding from this, we consider it important to use the historical experience of the application by the Marxist classics of an interdisciplinary approach to contemporary problems, in order to provide a comprehensive class analysis of the social problems caused to workers by the COVID-19 pandemic in the countries of global capitalism, and to show the fundamental difference in the methods and results of the struggle against the same viral disease in socialist countries.

The mission of the WHO, founded in 1948, is to achieve the highest possible level of health for all peoples (UN Department of Public Information 2005, 66). As defined by the WHO, it is “the United Nations agency that connects nations, partners and people to promote health, keep the world safe and serve the vulnerable—so everyone, everywhere can attain the highest level of health” (WHO 2023). However, the noble goals that were proclaimed by the WHO more than 70 years ago have not yet been realized in the capitalist world, precisely because the leading economic interest of the bourgeoisie in all areas, including health care, is the unbridled pursuit of profit.

Speaking at the 13th World Health Summit (October 16–18, 2022, Berlin), WHO Director-General Tedros Ghebreyesus acknowledged the failure of medical structures in the capitalist world to deal with coronavirus infection. He argued:

Taking global health to a new level means we need a new global agreement based on a common vision, a new global health architecture that is coherent and inclusive, and a new global approach that prioritizes promoting health and preventing disease, rather than only treating the sick. (Banerji 2022)

Addressing the meeting from the rostrum, Ghebreyesus also said that “health is a fundamental human right, not a luxury” (Paudal 2022). To make this right a reality, he called on world leaders to take action to eliminate health inequalities between rich and poor countries. This call, however, cannot be realized without a fundamental reorganization of the current world order on the basis of social justice.

In this context, the publication of the United Nations Research Institute for Social Development *Crises of Inequality* notes that COVID-19 has revealed unequal structures in society, while reinforcing existing inequalities between rich and poor people and between social groups. It has driven the more vulnerable

segments of the population further backward, plunging millions of people into poverty. All six of the major global epidemics/pandemics that have occurred on our planet since the beginning of the 21st century have brought dramatic increases in income inequality (UNRISD 2022, 112–113). As the American sociologist William Robinson writes, the social consequences of the pandemic are not limited to rising inequalities. They have to be seen in the context of a capitalist society that is driven by the inexorable logic of accumulation. The pandemic, it should be remembered, is not a purely biomedical phenomenon, but has a social as well as an economic, political and ecological character. The COVID-19 outbreak has revealed the class character of the public health emergency, since it is the poor and working classes who are least able to protect themselves from infection, and their living conditions put them at greater risk (Robinson 2022).

Social Problems in Overcoming the Planetary Diffusion of COVID-19

The conversion of the capitalist economy to market fundamentalism has led to the establishment of a neoliberal welfare state, completely subordinated to the demands of corporate profitability and to the interests of greedy employers. Within the framework of the welfare state enormous elements of social services, including health care, have been left to “free entrepreneurs.” These act in accordance with the core neoliberal principle of “laissez faire” (“let them do what they want”), which give them the right to determine their own behavior. The marketization of health services has allowed their maximum exploitation for the enrichment of the ruling plutocracy. As the management of public health care has grown more chaotic, and neoliberal reforms since the late 1970s have permitted capital to satisfy its lust for profit, health care has steadily been degraded (Cahill and Konnings 2017, 83–92; Feher 2018, 130–131). As a result, the political machinery of monopoly dictatorship has been unable to resist the global expansion of the COVID-19 pandemic, with tragic social consequences.

As humanity has entered the new millennium, viral epidemics and pandemics have repeatedly set alarm bells ringing, with the possibility of diseases appearing in new and dangerous forms. According to the journal *Emerging Infectious Diseases*, more than 40 new pathogens (mostly viruses) have been added since 1975 to the ever-growing list of infectious diseases (Smil 2012, 72). The likelihood of the global spread of viral infections has brought urgent calls for effective measures to prevent new virus outbreaks and to minimize human suffering and loss. Nevertheless, capitalist health systems, including those in economically developed countries, have persistently ignored the global threat to human populations. As a result, important areas of potential defense against viral infections have not been prepared to deal with

coronavirus outbreaks. The global spread of COVID-19 has led to enormous loss of life and to a planetary medical crisis with unpredictable consequences for all of the Earth's inhabitants. In this context, the cynical assessments of the prospects for defeating COVID-19 made by the newfangled theorists of "inclusive" capitalism are particularly noteworthy. These theorists in the past have devoted great efforts to creating "exclusive" capitalism, and would now like to prolong the existence of the old system by carrying out cosmetic repairs. Among the theorists are the founder and executive chairman of the World Economic Forum Klaus Schwab and his co-author Thierry Malleret, who in their book *Covid-19: The Great Reset* state: "Many of us are pondering when things will return to normal. The short response is: never" (Schwab and Malleret 2020, 12).

Researchers at McKinsey & Company, the world's largest consulting firm, believe that the public health crisis set off by the COVID-19 pandemic has highlighted major public health vulnerabilities that predate the tragedy. In their view, successful management of infectious outbreaks requires the following measures: threat identification and surveillance; emergency preparedness and response operations; emergency manufacturing, procurement and supply chain management in emergency situations; and access to innovation. Implementation of these measures must be supported by a specific set of public governance enablers that are tailored to preparing for a viral pandemic. This involves technology and data, public communication, budgets and finances, scientific, clinical and operational talent, organizational structure and partnerships. According to McKinsey & Company experts, pandemic preparedness requires a highly functional health care system to which the population has equal access, and also effective emergency management (B-Lajoie et al. 2022, 3). The above list of antiviral forms and tools goes far beyond the range of measures required to deal with a coronavirus outbreak. But these have not been implemented even in the countries of the world's "golden billion."

The failure of the health systems in most capitalist countries to address the COVID-19 pandemic has had a number of complex class-related causes. The most crucial of these, inequality of access to health care based on a person's socio-economic status, has posed an insurmountable barrier to getting rid of COVID-19 for many of the "working poor" and other disadvantaged people in all countries of the capitalist world. In the context of the social revenge of the bourgeoisie since the dismantling of the global socialist system, the transfer to private business of many health care functions affecting working people has brought a deterioration of conditions for the working class in countries both of the Global North and Global South. This has substantially limited the ability of many millions of workers to use health services even for the reproduction of the labor force, and has placed on the agenda an intensification of the fight against the global health policies of zealous adherents of the ideology and practice of market fundamentalism.

In the 20th century, four main models of health care evolved around the world. Despite the anti-popular neoliberal adjustments made to them since the turn of the century, these models still prevail in the Western world and are now being implemented in the former socialist countries. The differences between them center on the degree of state involvement in the regulation of health care. The free-market model is applied in states that limit their intervention in health matters to the most necessary involvement. An example in this regard is the US, where only Medicaid (for the poor) and Medicare (for the elderly) are the responsibility of the state. Private insurance fills part of the resulting gap. However, a large proportion of the US population is not insured for health care costs or loss of income due to illness and disability. In the second model, the social insurance system, patients pay insurance premiums to a health insurance fund, which contracts with first-line (therapist) and second-line (hospital and specialist) health care providers. The role of the state in this system is limited to determining the general terms and conditions of contracts between patients, providers and insurers. First applied in Germany, this system still exists in a modified form in Germany, the Netherlands, Belgium, France, Austria, Switzerland, Luxembourg, and Japan. The third model of health care is based on taxes. An example is the National Health Service model, first introduced in Great Britain in 1948. It is financed by taxes, and the state is responsible for providing medical care in health care facilities (hospitals). This model is currently used in Great Britain, Ireland, Denmark, Norway, Sweden, Finland, Iceland, Spain, Italy, Portugal, Greece, Australia, and New Zealand. The fourth, most centralized variant of the health care system is the Soviet model, which dates back to 1920. Under the Soviet model the state guarantees full free access to health care for everyone. This model functions with funding from the state budget, covers the whole country geographically, and guarantees the provision of care and services to the entire population. Among the countries that previously had a health care system based on the Soviet model were the republics of the former USSR and some Central and Eastern European states (Stevens and van der Zee 2011, 280).

After the collapse of the USSR, various Western, mostly American health care systems began to be imposed in the post-Soviet space. How the “free-market” model works can be judged by the results of the “grinding down” of the Soviet model in Ukraine over 30 years. During the years when the “free-market” model has functioned the country’s population has decreased from 52 million in 1992 to 41 million in 2022. From the ending of World War II in 1945, there was not a single year in which the mortality rate in the Ukrainian SSR exceeded the birth rate. In the modern Ukraine since 1994 there has not been a single year when the birth rate has exceeded the death rate (Minfin 2022).

The Soviet experience of health care has influenced the organization and improvement of socialized medicine internationally. It is still used today in

socialist countries. As acknowledged by American sociologists, centralized systems of health care delivery provide the best mechanisms of cost control, while in the US the absence of such state intervention has been shown to be counterproductive (Stevens and van der Zee 2011, 280). Soviet medicine became the prototype for socialist medicine. The term is used to refer to health care systems that provide preventive, diagnostic, clinical, rehabilitative, educational and custodial services to patients free of charge (Field 2011, 587). The fundamental difference between socialist medicine and capitalist medicine is that the former is proactive in that it focuses mainly on the prevention of disease and is provided to the entire population free of charge, while the latter is reactive in that it reacts mainly to requests for help and provides patient treatment on a commercial basis for profit. The advantages of socialist medicine are clearly illustrated by comparing it with health care in the US, the only country in the Western world and the OECD countries that does not have universal access to health care. Life expectancy in China and Cuba has been higher than in the US in recent years (Table 1). The difference in approach to health care provision under socialism and capitalism has been clearly evident during the COVID-19 pandemic.

Table 1. Life Expectancy Comparisons

<i>Years</i>	<i>US</i>	<i>China</i>	<i>Cuba</i>
2021	76.1	78.2	78.98
2020	77.0	77.9	79
2019	78.8	77	79
2018	78.7	77	79
2017	78.6	76	79
2016	78.7	76	79
2015	78.7	76	79
2010	78.7	74	78
2005	77.6	73	78
2000	76.8	71	77
1995	75.8	70	75
1990	75.4	69	75
1980	73.7	67	74
1970	70.8	59	70
1960	69.7	44	64
1950	68.2	43	57.6

Source: <https://peoplesworld.org/article/socialism-makes-the-difference-cuba-and-china-exceed-u-s-in-life-expectancy/>.

The privatization, commodification, and financialization of health services within the framework of neoliberalism have substantially exacerbated the social problems that have existed under all three bourgeois models of health care. This has manifested itself above all in a general worsening of the conditions and situation of work, in an intensification of the wear and tear on the labor force, and in an increased need for the reproduction of physically fit wage workers. At the same time, the “captains of industry” and the moguls of the financial world have bet on minimizing expenditure on the health care of working people. *The Concise Encyclopedia of Sociology* points out that class, race, and other social variables influence the relationship between workers’ health and their use of health services (Clair and Wasserman 2011, 279). This is contrary to the *International Covenant on Economic, Social and Cultural Rights*, which states that parties to this covenant “recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (Shestakov 1986, 36). An editorial in the *Journal of Medical Economics* notes that a good health care system should be based on solidarity, which means that two people who go to a health care facility with the same problems or needs should receive the same quality of attention and care (Anneman 2019, 499). But none of this is or can be the case in societies where class, race and other social variables influence the receipt of health services.

The quality of health and health care in the world today is significantly differentiated between countries and regions along these lines. The poorest countries of the Global South, exhausted by long years of colonial domination, are in the worst situation. Their populations now suffer from poor nutrition, unsafe drinking water, inadequate sanitation, multiple diseases, and inadequate and poor-quality health services. Although sub-Saharan Africa (SSA) accounted for 25% of the global burden of disease at the end of the first decade of the 21st century, it had just 750,000 health workers for a population of 682 million. This represented just 1.3% of the global health workforce, 15 times fewer than in the OECD countries. A minimum of 2.5 health workers is needed to adequately serve 1,000 people. In SSA, the average at the time specified was less than a third of the minimum standard of 0.8 health workers per 1,000 people. One million health workers are needed to achieve the minimum staffing level required in this region (Washington 2006, 393). The population of SSA is projected to double from 1 billion to 2 billion by about 2050 (Selassie 2021, 59). Understandably, bringing the number of health workers up to international standards in this deprived region will not be feasible in the foreseeable future.

In the developing countries of Asia, Africa, and Latin America, the populations are struggling today to free health care from the heavy legacy of colonial rule. Researchers investigating the political economy of health financing in the Global

South have noted that the former metropolitan countries exert considerable influence over political and economic policies in these regions. Market-based economic policies are being introduced in most countries of the South, while new global health policies are being enacted for the benefit of the countries of the Global North (Jakovljevic et al. 2021, 30). In response, the peoples of the Third World are advocating the “decolonization” of global health as part of a movement against the new global health policy. In reality, this latter policy is an old refrain intended to reincarnate colonialism with the prefix “neo” (Sen, Qadeer, and Missoni 2022). The main content of the “decolonization” movement is clearly articulated in *The Lancet*:

To decolonize global health is to remove all forms of supremacy within all spaces of global health practice, within countries, between countries, and at the global level . . . Supremacy is there in persisting colonial and imperialist (European and otherwise) attitudes, in stark and disguised racism, White supremacy, White saviorism, and displays of class, caste, religious, and ethnic superiority. (Abimbola and Pai 2020, 1627)

The coronavirus outbreak in 2020 struck all countries without exception—capitalist and socialist, rich and poor. Where a “free-market” model of health care has led the American empire will be discussed later. Nor have the adherents of the second and third health care models in the European Union (EU) achieved notable success in the battle against COVID-19. As the following data (Table 2) reveal, more than half of the deaths (3,502,260) due to the COVID-19 pandemic have occurred in Europe and North America. The rest of the world (Asia, South America, Africa and Oceania), which has a few remaining socialist countries but is dominated by developing, underdeveloped and “transitional” states, accounts for fewer than half of all coronavirus deaths (3,103,937 cases).

Table 2. COVID-19: Reported Cases and Deaths (November 7, 2022)

<i>Country</i>	<i>Total cases</i>	<i>Total deaths</i>
Europe	235,126,439	1,946,767
North America	118,104,951	1,555,493
Asia	194,771,989	1,490,838
South America	64,506,444	1,333,416
Africa	12,681,128	257,935
Oceania	12,682,368	21,748

Source: www.worldometers.info/coronavirus/#countries.

The excess death rate in Europe and North America relative to the rest of the world is almost half a million (398,323 cases), which belies the bourgeois myths about the Western health system being the world's best. Europe's current entry into the third wave of the virus shows that its lauded socialized health care system is in a prolonged and severe crisis. In each of the last three years, the mortality rate from COVID-19 and its mutations in Europe has remained unchanged. The invention of vaccines has not been a panacea and has not reduced infection and mortality in Europe. In the first 12 months of the pandemic, some 845,000 people in European countries lost their lives to COVID-19. Then between March 1, 2021, and March 1, 2022, a total of 905,000 Europeans fell victim to the disease. Since March 1, 2022, some 220,000 people have died, and after the coming winter morbidity spike, the mortality rate in Europe is predicted to increase (Tissot 2022).

Unlike capitalist medicine, socialist medicine works to prevent disease. In China, strict quarantines and other methods of counteracting COVID-19 have been applied in order to minimize human losses. Particular attention has been given to improving practices in the area of identifying and treating carriers. The PRC government's policy of preventing the spread of the coronavirus has been complemented by a "dynamic zero" policy. This has consisted of recognizing the possibility of COVID-19 entering the country (e.g., through illegal border crossing) and has required a rapid response by health authorities in order to quickly and effectively reduce the number of cases to zero. Local health departments play a key role in the implementation of dynamic zero policy. If even one case of the disease appears in a city, the health authorities set out immediately to identify all close contacts of the sick person, to test them, and as quickly as possible to check the places they have visited. The central government requires local health departments to test cities with fewer than 5 million inhabitants in two days, and those with more than 5 million inhabitants in three to five days. Mobile testing laboratories are usually dispatched to regions with active COVID-19 outbreaks to speed up screening of the population. These laboratories actively assist local health departments. During the Delta outbreak in Guangzhou 18 million residents were tested in three days in June 2021, resulting in complete elimination of the disease in less than a month (Defend Democracy Press 2021). Unfortunately, it is impossible within the scope of a journal article to describe more fully the positive experiences of China and other socialist countries in overcoming COVID-19.

In the fight against COVID-19, the Third World countries that are still captive to the medical mission of the "white man" have been severely tested. Against the backdrop of China's success in the battle against COVID-19, the fight against the disease in India has been a failure. According to the Indian Federal Ministry of Health, the number of deaths in the country from COVID-19 at the beginning of February 2022 exceeded 500,000, while the total number of infections reached

41,952,712 (*Xinhua* 2022). The half-million mark on the Indian list of victims has prompted myriad accusations against the authorities. Chief among them has been the lack of adequate health care in the country. As of November 11, 2022, the total number of COVID-19 cases had reached 44,664,810, and the number of COVID-19 deaths was 530,520 (Worldometers 2022b). The scale of the social tragedy that has resulted from the rampant spread of COVID-19 in a country of 1.4 billion people is deeply disturbing. Most people in India do not have adequate access to SOTA, which is advertised as “universal and equitable” surgical, obstetric, trauma and anesthetic care, and the level of SOTA assistance available from the state is in any case low. In assessments of its health system, India lags behind more than a dozen low and middle-income countries. The COVID-19 pandemic has exacerbated the existing epidemic of mental health problems in India. To implement the Indian Mental Health Act, 2017, the government needs to spend Rs 940 billion (up from the current expenditure of Rs 10 billion). Access to health care for India’s tribal population, who live mostly in remote areas, is sadly deficient. Some 110 million people live in the parts of the country concerned, and have been socially marginalized for generations (Zadey and Dubey 2022, 1587). Overcoming both COVID-19 and its long-term consequences depends on solving these problems.

Analysis of the social consequences of the spread of COVID-19 in all of the “three worlds” of global capitalism leaves no doubt that it is the global working class that suffers most from coronavirus infection. There are a number of reasons for this. Workers tend to be more exposed to the virus as a result of inequalities in working conditions. Lower-paid workers, especially those in the service sector, have to go to work every day even during lockdown, and use public transport more often. Those in low-skilled jobs are less likely to be able to work from home. Inequalities in social conditions contribute to workers having poorer health, and can result in their acquiring a range of diseases that increase their vulnerability to COVID-19 and the likelihood that they will develop severe cases, with potentially fatal consequences. People from disadvantaged communities are more vulnerable to COVID-19 infection as a result of chronic stress caused by long-term exposure to unfavorable living conditions and environments (Franklin 2022, 57). The way in which the impacts of the COVID-19 pandemic are shifted onto the working class makes nonsense of the globalist claim that when it comes to the coronavirus, we are all in the same boat.

In the course of 2022 humanity did not witness the expected victory over the “plague of the XXI century,” but it was nevertheless able to gauge the worth of different approaches to combating COVID-19 in the countries of capitalism and socialism. These results emerge from a comparative analysis of the fight against the pandemic in the US and in the People’s Republic of China. At the beginning of May 2022, the number of deaths in the US due to COVID-19 exceeded

1 million. As of June 19, 2022, the number of deaths from the virus in mainland China since the beginning of the epidemic in January 2020 was 5,226. There had been 3,042 deaths per million population in the US and 3.7 deaths in the PRC. In these two polar worlds, the different approaches taken to the right to life of human beings had thus seen 822 times as many deaths from COVID-19 in the US as in China. Things in this respect were no better in the member states of the EU. During the entire pandemic period, until June 19, 2022, there were 2,434 COVID-19 deaths per million population in the EU, which was almost 658 times more than in the PRC (Walsh 2022).

During its unsuccessful fight against the pandemic, the US ranked first in the Western world in the spread of COVID-19 and first among the world's wealthy nations in terms of deaths from the virus (Wallis and Zhuo 2020, 155; Johnson 2022a). The first three months of the coronavirus spread cost the US more deaths than the entire Vietnam War (1965–1973) (Horton 2020, 47). While total US deaths from COVID-19 had reached 300,000 by the end of 2020, as of December that year there had been a total of 35 deaths in socialist Vietnam (Stevano et al. 2021, 3). This serves as further evidence of the advantages of socialist medicine over medicine in the capitalist world. The latter is not based on guaranteeing “the right of every human being to the highest attainable standard of physical and mental health” (Shestakov 1986, 36), but on the need for capital to maximize its profits at the expense of human health and well-being.

The Lost Battle with COVID-19 in the Epicenter of Global Capitalism

Both the rich countries of the Global North and the poor countries of the Global South are in the planetary grip of the COVID-19 pandemic. The COVID-19 “plague” has not bypassed the epicenter of global capitalism, the US, and among OECD countries, it is there that the proportion of pandemic victims is at its highest. The more than 1 million US residents who have died from the coronavirus number more than twice the total US military dead during World War II—407,316 (The National WWII Museum 2022). Since December 1, 2021, when the first case of the Omicron variant was recorded in the US, the proportion of Americans dying from the coronavirus was 63% higher than in other large and wealthy countries. More recently, Americans have been dying from COVID-19 at nearly twice the rate of Britons and four times the rate of Germans. The only large European countries that have exceeded the US COVID-19 mortality rate are Russia, Ukraine, Poland, Greece, and the Czech Republic. One of the main reasons for the high COVID-19 mortality rate in the US is lower vaccination rates than in other large and wealthy countries, despite the US having one of the most powerful arsenals of

vaccines in the world. The US lags behind many European countries in vaccination rates for the elderly. Some 12% of Americans aged 65 and over have not been fully vaccinated, while 43% of the same age group have not received a booster shot (Mueller and Lutz 2022).

The defeat suffered by the US in the war on the coronavirus results largely from the fact that the US has two systems of health care and health services—one for the rich, and one for the poor. The first system has flourished, while the second has been marginalized. As a result of the structure of health care, new inequalities have been entrenched in both hospital beds and staffing levels. The marginal status of the nursing staff who attend to “mere mortals” in the US is evident both in their low wages and benefits and in other aspects of their work (Winant 2021, 219).

The implementation in the US of neoliberal programs over the last 50 years has dealt the worst blow to public health. American health professionals have calculated that mortality rates from various diseases fall by 1.1% to 6.9% for every 10% increase in local health spending. Increases in funding for significant and sustained improvements in health must also be accompanied by improvements in health care practices (Mays and Smith 2011, 1585). After half a century in the procrustean bed of neoliberalism, however, the US health care system is underfunded and deprived of opportunities to improve its functioning. Overall spending by the states for these purposes has been steadily decreasing.

The budget of the Centers for Disease Control and Prevention (CDC) in fiscal year 2017 was \$7.15 billion, or \$21.95 per head of population (Segal and Martín 2018, 6). The Public Health Emergency Preparedness Cooperative Agreement Program is the only federal program in the US that supports state and local health departments in preparing for and responding to all types of emergencies, including infectious disease outbreaks. Prior to the pandemic, core funding for emergency preparedness was reduced from \$940 million in fiscal year 2002 to \$667 million in fiscal year 2017 (Segal and Martín 2018, 8). From fiscal year 2015–2016 through fiscal year 2016–2017, public health spending decreased in 31 US states (Segal and Martín 2018, 14). In addition, within ten years of the end of the Global Financial Crisis, local health departments had cut the number of their employees by 55,000 (Wallace 2022).

The situation of ordinary Americans during the COVID-19 pandemic has been complicated by the fact that about 44 million of them have no health insurance and 38 million have “inadequate” policies. Consequently, millions of people suffering from COVID-19 symptoms but without the means to treat them are forced to abstain from testing and hospitalization to avoid poverty. As a result, the uninsured or underinsured pariahs of American society are the sources of the spread of COVID-19 throughout the population. The lack of uniform and accessible health care for all in the US has meant that even citizens who can afford prevention, screening, and treatment are vulnerable to infectious diseases (Segal and Wasserman 2020). This is a

consequence of the exclusion of many citizens from health care. In a survey of 5,000 Americans in the fall of 2021 more than a third identified access to affordable health care as the largest barrier to their well-being (Bulcho et al. 2021).

A recently released report by the Kaiser Family Foundation, based on a nationally representative survey conducted from February 25 to March 20, 2022, has generated considerable public outcry in working in America. This study surveyed 2,375 adults, including 1,292 adults with current medical debt, and found that 41% of US adults (or about 100 million people) currently had such debts. These ranged from less than \$500 (16%) to \$10,000 or more (12%). Medical debt significantly limits the ability of many people in the US to access needed medical or dental care. One in seven adults with medical debt indicated that a provider had denied them care because of unpaid bills (Lopes et al. 2022).

Gabriel Winant in his book on the degradation of the American health care system notes that the pandemic has revealed those who are valued and those who are ignored in American society. The thousands of people left to die in nursing homes and prisons have been among those who in the terms of capital are regarded as socially useless. In these conditions, the finest human and professional qualities have been shown by health workers who have carried on serving in risk areas despite inadequate protective equipment, staff shortages, insufficient training, and, often, denial of payment for working in hazardous conditions. Continuing to work out of a sense of duty or for lack of other choice, thousands of health workers have fallen ill and died. Former patients have expressed admiration for the actions of medical staff by placing banners in hospital windows thanking the “frontline heroes” (Winant 2021, 264–265). But the selfless work of these health staff has gone unnoticed by the ruling elite.

During the coronavirus crisis, older Americans who are forced to spend their final years in nursing homes have suffered a difficult fate. The pandemic has exposed new and reinforced old deficiencies in nursing homes: inadequate staffing levels, poor infection control, lapses in oversight and regulation, and other flaws that have caused real harm to patients. These failings include ageism, which manifests itself in an undervaluation of the lives of the elderly. As a result, nursing home residents have reported disproportionately high rates of morbidity, hospitalization, and death compared to the general population. Despite making up less than 0.5% of the US population, nursing home residents as of October 2021 accounted for about 19% of all COVID-19 deaths in the US. By February 2022, more than 149,000 nursing home residents and more than 2,200 staff had died from COVID-19 (National Academies of Sciences, Engineering, and Medicine 2022, 2).

In response to the skyrocketing death rate in shelters in New York and many other US states, laws were hastily passed that exempted officials in shelters from judicial liability (Katch 2022). According to US media reports, nursing home

workers at the epicenter of the earliest and deadliest COVID-19 outbreaks quit their jobs en masse, in part because low pay forced them to work in multiple locations, inadvertently accelerating the spread of the virus. As a result, some 425,000 jobs have been lost in nursing homes since the pandemic began (Press 2022).

In the lead-up to the COVID-19 outbreak, members of the “Lancet Journal Commission on Public Policy and Health Care in the Age of Trump” noted: “The US health-care system is in crisis . . . Vast sums collected from taxpayers on the Constitutional promise to ‘promote the general welfare’ are diverted to boost the profits of corporations” (Himmelstein et al. 2018, 993). Washington’s anti-infection measures failed to stop mass deaths among COVID-19 patients, and required the urgent implementation of a structural overhaul of the entire system of medical services to the population. Neither the administration of Donald Trump, however, nor that of Joe Biden has done anything in this regard.

As a result, the White House’s strategy and tactics in the fight against COVID-19 have so far been limited to the implementing of emergency measures. These have not been able to halt the rapid expansion of COVID-19, nor to act as a reliable barrier against it, able to forestall a “harvest of deaths.” The Biden team’s bet on total vaccination of the population served the interests of the giant pharmaceutical corporations, but was not the promised panacea. From Biden’s inauguration until early May 2022, some 575,000 people in the United States died from the coronavirus. Meanwhile, in January and February 2022 (the initial period of the seventh wave of COVID-19 expansion), 52,000 fully vaccinated people in the US fell victim to the infection (Mateus 2022).

As the Lancet Journal Commission of 33 medical experts testified,

The suffering and dislocation inflicted by COVID-19 has exposed the fragility of the US social and medical order, and the interconnectedness of society. A new politics is needed, whose appeal rests on a vision of shared prosperity and a kind society. (Woolhandler et al. 2021, 744)

This conclusion is supported by a study of COVID-19 published on June 13, 2022, in the *Proceedings of the National Academy of Sciences*. The study notes that in the face of the pandemic, the introduction of universal health care and universal health insurance in the US is imperative. Advocates of health care reform in the US have pressed for this goal to be realized through the passage of the Medicare for All Act. This would open the door for millions of Americans to receive health care services not currently available even to many nominally insured individuals. According to the participants in this study, solving this problem would have prevented 338,594 deaths from COVID-19 in the US from the start of the emergency through mid-March 2022 (Galvani et al. 2022). In this context Chomsky and

Waterstone note: “Both in terms of the etiology and spread of the pandemic, and in the very uneven response to it, we can see the inexorable workings of the cruel logic of neoliberal, late-stage, globalized capitalism” (Chomsky and Waterstone 2021, 335). Therefore, the battle against the global expansion of COVID-19 must be an integral part of the overall struggle against neoliberal global capitalism.

The Metamorphosis of Labor and Capital during the COVID-19 Pandemic

In the early months of 2020 advances in the digitization of labor, production, and services were seen as a good basis for expanding the use of information and communications technology (ICT) to help overcome the pandemic. As responses are mounted to the challenges of COVID-19, the contribution of ICT to different sectors of the global economy and global health has increased significantly, notably through the use of remote working and of telemedicine. But the shift by numerous wage earners to “online” work affected mainly office workers, and was hardly applicable to the industrial proletariat or to many categories of service-sector labor. The expansion of remote work has helped to stabilize the world economy to a degree, but has failed to prevent it from stagnating, and will not save it from sinking into another crisis. Telemedicine has also failed to live up to expectations, as it is inaccessible to those sectors of the population who lack the possibility of being treated in a hospital setting. An important driver of the digitization of labor has been the desire of digital providers to increase their capital through the exploitation of new labor markets, products, and services that have arisen as a result of the COVID-19 pandemic. This is being achieved through creating new structures of capital accumulation at the cost of labor, especially in non-standard employment. Here it is appropriate to note the conclusion of the Russian sociologist Konstantin Gaase:

Until recently, it seemed that there was simply no place on the planet for a new wave of the extensive growth of capitalism. Thanks to the pandemic, that place now exists—our places of residence, our habitats, homes and flats, which are gradually being colonized by state and corporate disciplinary practices. (Gaase 2020, 302)

Owners of both traditional and digital businesses have exploited, for their own enrichment, the opportunities created by the pandemic. Enterprises of both categories have significantly increased their profits as a result of the spreading digitization of the economy. At the same time, the financial hardship of wage earners has increased still further. Since the COVID-19 pandemic began, a new billionaire has

appeared in the camp of global capitalism every 26 hours. The world's ten richest people, eight of whom made their fortunes in the digital industry, have doubled their wealth during this period and now hold more wealth than the 3.1 billion people at the bottom of the global social pyramid (Oxfam 2022, 10). Nowadays, there are more than 1.43 million people in the US alone with a fortune in excess of \$5 million. There are more than 740 billionaires with a total wealth of \$5.1 trillion, about \$2 trillion more than at the start of the COVID-19 pandemic in March 2020 (Johnson 2022b). According to former US Secretary of Labor Robert Reich, wealth inequality is now devouring America. As in the late 19th century, a handful of "robber barons" monopolize the economy, stifle wage growth and bribe lawmakers (Reich 2021).

For the last four years, annual US Gross Domestic Product (GDP) has exceeded \$20 trillion. Nevertheless, the well-being, health and lives of American working people are not so much determined by the amount of GDP as by the way it is distributed. For years imperialist propaganda has indoctrinated people with the message that the larger the "economic pie" created through the combined efforts of labor and capital, the larger the portion of it that will go to the labor force. During the pandemic, however, millions of working people have had to draw in their belts even tighter to pay for medical treatment. This has dispelled the bourgeois myths about the supposed "flow of wealth from the top down." In fact, in capitalist countries the opposite is happening: the poor are growing poorer and the rich are growing richer through the "flow of wealth from the bottom up." This leads to steadily widening socio-economic inequality, and deprives millions of workers of basic health insurance.

The severe consequences of the COVID-19 pandemic are now being experienced by all of the world's workers, whether engaged in digital or physical labor. People employed in the former, however, mainly work online from home, which significantly reduces their risk of becoming infected. Based on surveys of workers in almost 1,000 professions, US economists estimate that 37% of US jobs can be completely relocated in this way. These jobs generally pay better than those that cannot be done from home, and account for 46% of all wages in the US. Applying a similar occupational classification to 85 other countries shows that lower-income countries have a lower share of jobs that could be shifted to the home. Developing and emerging economies with GDP per capita below 1/3 of that of the US may have half as many jobs that can be carried out in a domestic setting (Dingel and Neiman 2020, 2).

The second category of workers (those engaged in physical labor) is responsible for the provision of vital services to the population and for the functioning of infrastructure. In Europe, about 41% of workers are in interactive services. They typically work for low wages, endure relatively poor working conditions, have a high prevalence of atypical forms of employment, and have few career prospects.

The multiple disadvantages, during the pandemic, of workers in systemically important sectors of the economy have three sources: the system of labor regulation, the sociodemographic characteristics of the workforce, and the inherent nature of their work. Employers in retail, logistics and other vital sectors are increasingly refusing to engage in collective bargaining, on the pretext of needing to reduce labor standards in order to keep their services competitive. In doing so, business owners are defiantly challenging trade unions and the institution of collective bargaining. Workers who perform essential services are subject to stringent regulations that aim to cut wages and degrade working conditions. As a result, precarious and part-time work is everywhere becoming more widespread. Agency-based employment and student work are now common in retail and logistics, as is voluntary work in nursing. The combination of low wages with the spread of precarious employment in these sectors is increasing the numbers of “working poor,” and in the long term promises mass poverty among older people (Dörflinger 2020).

IMF calculations indicate that over the first two years of the COVID-19 pandemic the rate of infection among people in poor households was about five times higher than among those in rich households (more than 50% and just over 10%, respectively), and that people in poor households were four times more likely to die. The poor have been more exposed to the coronavirus for the following reasons: 1) many of them are engaged in vital service work (selling or delivering food and goods), for which they receive low incomes; 2) many of them live in poor areas with high population density, which increases the likelihood of infection; and 3) many of them are self-employed and lack sufficient savings to be able to reduce their working hours and lower their risk of infection. More affluent people can reduce this risk by cutting their working hours and spending less time away from home. The heaviest impact of COVID-19 is thus borne currently by people living in poor households (Dizioli, Andrle, and Bluedorn 2020).

The results of the Household Pulse Survey conducted in the US in late 2021 and early 2022 confirm a striking disparity in the impacts of COVID-19 depending on income. Working-age Americans whose income in 2019 was less than \$25,000 were 3.5 times more likely to suffer from COVID-19 than those earning \$100,000 or more (Raifman, Skinner, and Sojourner 2022). In December 2021 the CDC reduced the isolation period for people infected with COVID-19 from ten days to five. This decision benefited employers, but was detrimental to workers, many of whom were forced to return to their workplaces despite the obvious health risks (Udavant 2022). In March 2021 paid sick leave was available to 79% of civilian workers, but these included 95% of those whose average hourly wage was in the top 10% for civilian workers and only 35% of those whose average hourly wage was in the bottom 10% (Bureau of Labor Statistics 2021). The deaths induced by COVID-19 in the US also have a distinct ethnic face, with African-Americans

dying at the highest rate compared to all other national groups. The racial footprint also appears in the composition of the reserve army of labor. The unemployment rate in the US for blacks rose from 6.5% in November 2021 to 7.1% in December, with the figure for black women increasing during the same period from 4.9% to 6.2% (Broady and Barr 2022).

Economies and major labor market indicators in all regions of the world are not yet back to pre-pandemic levels, and according to International Labour Organization projections, full recovery within the next two years is unlikely (International Labour Organization 2022, 12). Nor do the prospects for overcoming the COVID-19 pandemic appear promising. Conclusions concerning the end of the pandemic are premature and unfounded; when such conclusions were voiced recently, some 11,000 people worldwide were still dying each week from COVID-19, including about 3,000 in the US. The time to talk about winning the battle against COVID-19 has not yet come. In response to US President J. Biden's claim in September 2022 that the COVID-19 pandemic was over, WHO senior adviser B. Aylward said that if rich countries agreed with this view, they should do all they could to help low-income countries achieve this as well, by making vaccines available for everyone, everywhere (Stancil 2022). The need to help developing and underdeveloped countries achieve full vaccination has been evident for three years now, but is still present . . . To the world's existing inequalities, new vaccine and digital inequalities have thus been added.

New Inequalities in the Capitalist World during the Digital Age

A serious impediment to combating the pandemic has been the entrenched inequalities in developed and underdeveloped capitalist countries. These inequalities, which have intensified in recent years, result from various forms of exclusion, marginalization and vulnerability among and within populations (Zheng and Walsham 2021, 2). The organization and functioning of health care in the modern capitalist world has exposed the pernicious effects of two new types of inequalities, vaccine and digital, which have become serious barriers to resolving the coronavirus problem.

In recent years, vaccine inequity has played a devastating role in the livelihoods of the majority of the world's population. It has become infamous in the form of the "vaccine apartheid" suffered by the Third World, a manifestation of the selfishness of ruling elites and of the social injustice of the current world order. Despite repeated calls for a more equitable distribution of vaccines among all countries to stem the problem of the coronavirus (WHO 2021; IMF 2021), the goal of universal vaccine availability remains elusive. The map of vaccine availability and coverage closely mirrors the map of economic inequalities (Our World in

Data 2022). As of early February 2022, only 4% of people in low-income countries were fully vaccinated. In high-income countries, the rate has exceeded 70% (IMF 2022). A November 2021 WHO study of 25 African countries found that only 27% of health workers in these countries were fully vaccinated, compared to 80% in 22 high-income countries (Ajeigbe et al. 2022, e1090).

While millions of people in poorer countries die because vaccines are unavailable, and while vaccinated citizens in richer countries are at risk from new strains due to low vaccination coverage in the global dimension, giant pharmaceutical monopolies make super-profits (ActionAid International 2021; Kender 2022; Oxfam 2022, 16), and are unwilling to share vaccine production technology. The most successful vaccine manufacturers—Pfizer, BioNTech, and Moderna—make a combined profit of \$65,000 every minute, approximately \$1,000/second (Oxfam 2021a). During 2022, Pfizer said it was projecting record revenues for the year of \$32 billion from its publicly funded coronavirus vaccine. While making huge profits, this pharmaceutical giant is refusing to share its technology with other countries, leaving billions of people without access to a lifeline amid the rising tide of a new pandemic. As many other Western vaccine manufacturers follow Pfizer's lead, the coronavirus pandemic remains a deadly force around the world, killing an average of 10,600 people every day. This is a direct result of the fact that in low-income countries only 10.4% of people received at least one dose of the coronavirus vaccine during the first two years of the pandemic (Johnson 2022c).

Not only do many governments in the Global North fail to promote the elimination of vaccine apartheid and thus reduce the tragic death toll in the Global South, but they actually stand by the Agreement on Trade-Related Aspects of Intellectual Property Rights, which is used by the pharmaceutical business to protect its patent rights. When the governments of the Republic of South Africa and India were able to secure White House support for the cancellation of patents on COVID-19 vaccines for developing countries, this was opposed by the UK, Germany, and a number of other EU member states. Although some countries in the Global South have been able to establish their own vaccine production, reduce the seven-day infection rate and make progress toward vaccine sovereignty, the coronavirus "harvest of death" in many countries in Asia, Africa and Latin America continues (Blanke, Kolbitz, and Dickson 2022). Severe vaccine shortages have acted as an additional factor in increasing human losses primarily in developing countries, and increasing and perpetuating cross-country inequalities (World Inequality Lab 2021, 47).

Another of the main barriers to the use of new technological developments in preventing and treating COVID-19, and in working and learning in a pandemic context, is the digital divide. The number of internet users worldwide has now exceeded 5 billion (about 66% of the world's population). However, the distribution of those who have access to the World Wide Web across the various

continents is highly uneven. The highest level of internet users is in the countries of North America (93.9%), and the lowest is in African countries (43.2%). Internet penetration remains a problem in both developed and developing countries (Watts 2020, 396). In 2021, a third of the world's population did not have access to the World Wide Web (Internet World Stats 2021). The digital divide occurs not only in the developing countries of the poor Global South, but also in many Old and New World countries that are part of the rich Global North.

The inaccessibility or limited use of ICTs, especially the internet, by many members of poor families in capitalist society has become a serious obstacle to their accessing medical care and services at a distance. Telemedicine involves virtual visits to health care facilities through communication between the health care provider's PC screen and the patient's PC screen, or through the use of smartphones or laptops. In the COVID-19 era, telemedicine has made huge strides, making it much easier and faster to share information between doctor and patient. For this, patients need to have access to adequate and inexpensive broadband. The "digital zoning" of the living arrangements of poor and low-income people results in unequal access to the internet. This is either because these people cannot afford internet access, or because internet services are unavailable or of poor quality in the places where the poor live.

As a result, poor families even in the US have far fewer opportunities to use the World Wide Web to communicate with family physicians than do rich families. Up to half of the lowest-income Americans, even those with internet access, cannot use it for video conferencing because their internet speeds are insufficient for this purpose. According to Louise McCarthy, President of the Community Clinic Association of Los Angeles County (an organization serving 1.7 million patients), about a third of its members in 2021 said they had Wi-Fi and broadband issues that prevented them from using telemedicine. Both low-income patients and the clinics serving them, she noted, are located in the same areas that are underserved by internet service providers (Buhl 2022).

Affecting poor and rich countries alike under digital capitalism, the digital divide has not failed to make an impact on the birthplace of the internet—the US. The COVID-19 pandemic has shown that both health care and digital innovations are inaccessible to millions of ordinary Americans. In the initial period of the pandemic more than 21 million people in the US, mainly those living in rural areas, were without access to modern internet services. As a consequence, many millions of Americans faced the challenge not only of being unable to work and study remotely, but also of being unable to use ICT to obtain the information and advice they needed to treat COVID-19 (Merrefield 2020). Two years later, the number of Americans without access to high-speed internet service was estimated at 24 million. The main reasons why millions of ordinary people in the US cannot connect to the

World Wide Web are lack of computer literacy and the high cost of securing internet services. As a rule, the people affected are low-income families, the elderly, residents of rural areas and members of historically marginalized communities (Hinton et al. 2022).

In European countries some 80 million people suffer from a lack of digital “inclusion.” Many of them have never used the internet, because they do not have computers or because the cost of internet services is too high (European Commission 2021). In the UK, for example, official figures suggest that there are 5.3 million “non-users” of the internet (10% of the adult population) (Watts 2020, 395). To date, millions of people in numerous countries either lack access to the internet, or cannot afford modern broadband internet service due to the high cost. As a result, calls by authorities in capitalist countries for people to make greater use of the World Wide Web to obtain information on how to avoid being infected with COVID-19, or on how to treat it at home, have not been implemented among people who are “digitally excluded.”

The significant digital divide between and within First and Third World countries (Watts 2020, 396) is a very serious obstacle to the digitization of labor and to the use of ICT for coping with the COVID-19 pandemic.

The intensification of “old” and the emergence of “new” inequalities in the pandemic context provides evidence of the low social efficiency of the current neoliberal model of growth and development, and of the slowing of humanity’s recovery from the current crisis. These phenomena confirm the conclusion of the famous Egyptian economist Samir Amin that modern capitalism “can produce nothing but greater inequalities between peoples (global polarization) and within peoples themselves (Global South and North)” (Amin 2007, 41). Undoubtedly, the pandemic has become a significant factor accelerating and reinforcing inequality, perpetuating disparities in social and economic development in the world of capital, and preserving the underdevelopment of many peoples, countries and regions for decades to come. It has rightly been called the “pandemic of inequality” (Etienne 2022; Oxfam 2021b; The World Bank 2021).

The exacerbation of old and the appearance of new inequalities in the world of capital during the pandemic exposes the cynical nature of the bourgeois slogan “We are all in this together!” This is in fact a modification, in the context of economic globalization, of the earlier Western myth that “We are all in the same boat!” As interpreted by the globalists, the waves of economic globalization will eventually bring all the boats of the world economy to the cherished shore of happiness, where the planet’s inhabitants are supposedly waiting for “golden mountains and rivers full of wine.” In reality, both globalization during its rise and the COVID-19 pandemic during deglobalization have demonstrated that these and similar mythologies are developed and introduced into popular consciousness

with one single purpose—to provide an ideological cover for the anti-people and anti-working-class policies of those in power, and to sow ideological destruction in the heads of ordinary people.

Nevertheless, the attempts by the globalizers to present the COVID-19 pandemic as the Great Equalizer, reconciling the interests of rich and poor within the framework of digital society, have not been successful. This is a conclusion now being voiced by a growing number of Western scholars. All this speaks to the need for a radical transformation of health care and other social systems in the capitalist world so that they serve the entire population, not just the “club of a select few.” This places on the agenda of working people the question of mobilizing all the forces and means of progressive social organizations and movements, and of intensifying the class struggle so as to ensure the basic human right to a decent life, through the establishment of a new world order in which the free development of each will be the guarantee of the free development of all.

Conclusions

The efforts by the world of capital to manage the COVID-19 pandemic have failed to achieve their goals. The main reason for the failure of the ruling elites in the Global North to deal with the coronavirus crisis is that with the transition of developed countries from Keynesianism to neoliberalism, many social structures of the “welfare state” in Anglo-Saxon countries and of the “social state” in European countries have been dismantled. The commercialization of health services has made them inaccessible to many working people. With few exceptions, the fight against COVID-19 in the Old and New Worlds has met with comprehensive defeat, leading to stagnating economies, increased exploitation of workers, rampant disease and excess deaths. This demonstrates the failure of global capitalism to respond adequately to the challenges of the multi-faceted coronavirus infection, to establish universal access to health care for all vulnerable social strata, to provide solidarity assistance to developing countries in order to overcome the pandemic, and to use the positive experience of socialist medicine so as to prevent and treat viral infections and to ensure people’s right to a decent life.

Digital and pharmaceutical companies have made the most of the critical COVID-19 situation to enrich themselves, with the result that old inequalities have increased and new types of inequality—vaccine and digital—have emerged and been reinforced. This has dealt a heavy blow above all to peripheral and semi-peripheral countries, most of which are unable to produce their own vaccines due to the refusal of big business in the “golden billion” countries to remove restrictions on patent rights. As a result, only a small fraction of the population in developing countries has received any degree of vaccination, casting doubt on the prospects of achieving

collective immunity as a condition for overcoming the pandemic on a planetary scale in the foreseeable future. Advanced digital technology remains inaccessible to many working people in both the developed and developing worlds, depriving them of the chance to use modern telemedicine to rid themselves of COVID-19. In both the Global North and South, ruling elites have failed to learn the lessons from the defeats suffered by their countries in the battle against COVID-19, and this threatens to derail preparations to repel further potential coronavirus attacks.

The need to employ all available synergies so as to improve the social effectiveness of health care and the economy thus signifies that abandoning the anti-popular and anti-working-class practice of neoliberalizing and commercializing social infrastructure has become part of the global agenda of our time. Achieving this goal will require civilization to make the transition to a new world order, one in which the lives and rights of human beings will take precedence over the economic interest of the capitalist state and big business in multiplying corporate profits.

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