

UK- Australia COVID-19 Deaths, Deprivation Deaths in Developing Countries, Indigenous Avoidable Deaths

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Global Research, April 08, 2020

Region: [Europe](#), [Oceania](#)

Theme: [Intelligence](#), [Poverty & Social Inequality](#), [Science and Medicine](#)

We are all shocked by the Covid-19-related carnage in Western Europe and the US in particular and fervently hope for an early end to the disaster. However it is timely to note huge avoidable deaths from deprivation in the Developing World (minus China) prior to the coronavirus pandemic. Best-case Covid-19 Suppression scenarios for the rich UK and rich Australia predict “annual Covid-19-related deaths as a percentage of population” of about 0.03% pa. In contrast, “annual avoidable deaths from deprivation as a percentage of population” is already a shocking 0.30% pa for the Developing World (minus China), 0.60% pa for indigenous Australians, and variously about 0.1% pa – 0.4% pa for Developing Countries that have been popular holiday destinations for relatively rich British and Australian tourists.

(1) Covid-19 Case Fatality Rate (CFR), Infection Fatality Rate (IFR), and age-specific risk

The Case Fatality Rate (CFR) measures the deaths as a percentage of diagnosed cases per unit time. However there are shortcomings in Covid-19 testing, sampling, diagnosis and other matters. A better quantification is Infection Fatality Rate (IFR) which measures deaths as a percentage of all those with infection i.e. those with detected disease (Cases) plus those with an undetected disease (asymptomatic and not tested people) [1, 2]. Thus the IFR is always lower than the CFR. However the media typically report each day on the number of deaths and the numbers of Cases detected, this allowing calculation of the Case Fatality Rate (CFR).

Indeed the Centre for Evidence Based Medicine (CEBM) sets out a very useful critique of its own CFR reportage:

“It sets out the current Case Fatality Rate (CFR) estimates, the country-specific issues affecting the CFR, and provides a current best estimate of the CFR, and more importantly, the Infection Fatality Rate (IFR)... What is affecting the case fatality rate? The number of cases detected by testing will vary considerably by country; Selection bias can mean those with severe disease are preferentially tested; There may be delays between symptoms onset and deaths which can lead to underestimation of the CFR; There may be factors that account for increased death rates such as coinfection, poorer healthcare, patient demographics (i.e., older patients might be more prevalent in countries such as Italy); There may be increased rates of smoking or comorbidities amongst the fatalities; Differences in how deaths are attributed to Coronavirus: dying with the disease (association) is not the same as dying from the disease (causation)... In China, CFR was higher in the early stages of the outbreak

(17% for cases from 1 to 10 January) and reduced to 0.7% for patients with symptom onset after 1 February” [1].

While deaths are accurately reported, the total number of symptomatic and asymptomatic infections is difficult to determine for a whole population (although one supposes that this would be possible through very large, sophisticated, inclusive and expert sampling of populations). Nevertheless the CEBM provides useful CFR-based data for all countries and in particular the following useful CFR-based estimates for China (21 March 2020):

“The CFR was 2.3% (1023 deaths/44 672 confirmed cases). Reported CFRs by age were ≤ 9 years, 0%; 10 to 19 years, 0.18%; 20 to 49 years, 0.32%; 50 to 59 years, 1.3%; 60 to 69 years, 3.6%; 70 to 79 years, 8.0%; ≥ 80 years, 14.8%... Patients with comorbid conditions [multiple illnesses] had much higher CFR rates. Those with no comorbidities had a CFR of 0.9%. Critical cases had a CFR of 49%, no deaths occurred among those with mild or even severe symptoms” [1].

As a 75-year old I am in a high risk group but, ever the optimist, I take some comfort from these CFR statistics because I am in reasonable health and am self-isolating at home, washing my hands, coughing into my elbow, and only going out to buy food and other necessities while strictly maintaining social distancing orders (1.5 metres between people outside and 4 square metres of personal space inside).

(2) Annual avoidable mortality from deprivation

The Second Law of Thermodynamics dictates that people grow old and eventually die. Consequently in rich countries that can afford top quality medical services there is an increasingly older population with an increased overall death rate because of this demographic imbalance. Thus annual mortality in Australia as a percentage of age-based sub-group population is 0.15% (0-4 years), 0.02% (5-9), 0.02% (10-14), 0.06% (15-19), 0.08% (20-24), 0.09% (25-29), 0.12% (30-34), 0.17% (35-39), 0.24% (40-44), 0.36% (45-49), 0.52% (50-54), 0.78% (55-59), 1.18% (60-64), 1.85% (65-69), 3.05% (70-74), 5.38% (75-79), 10.00% (80-84), 27.12% (80+) [3]. These age-specific mortality statistics for Australians parallel the Covid-19 age-specific statistics for China set out above in section 1 i.e. the annual probability of dying increases with age after infancy, and the annual probability of dying from Covid-19 increases with age [1].

In wealthy countries there is a high life expectancy because of top medical services and in many cases universal health care for everyone. However in poor Developing Countries deprivation through war or hegemony can have a big impact on mortality rate. Avoidable mortality from deprivation (avoidable death, excess death, excess mortality, premature death, untimely death, death that should have happened) can be defined as the difference between the actual deaths in a country and the deaths expected for a peaceful, decently-run country with the same demographics (i.e. birth rate and percentage of children). Using UN Population Division data it is possible to estimate avoidable mortality for all countries (for a detailed account of the methodology as applied to Developing Countries or Developed Countries see Chapter 2 [4]).

The “annual avoidable mortality from deprivation” can be expressed as a percentage of the population and has been estimated as follows for various parts of Humanity (2003): 0.0% (Overseas Europe), 0.01% (East Asia), 0.03% (Latin America and Caribbean), 0.05%

(Western Europe), 0.25% (Arab North Africa and Middle East), 0.26% (Central Asia, Iran and Turkey), 0.26% (South East Asia), 0.31% (Eastern Europe), 0.38% (South Asia), 0.39% (Pacific), and 0.97% (Non-Arab Africa).

The “annual avoidable mortality from deprivation as a percentage of the population” is effectively about 0% for Overseas Europe (US, Canada, Australia, New Zealand and Apartheid Israel), China, Japan, South Korea, Singapore, Taiwan, the wealthy Arab Gulf States and Cuba. In contrast, this parameter is 0.35% for India (2003 data) [4]. Assuming a baseline mortality of 4 deaths per 1,000 of population per year one can calculate from current UN data that presently each year 15.2 million people die avoidably from deprivation in the Developing World (minus China), this representing $15.2 \text{ million} \times 100 / 5,050.2 \text{ million} = 0.30\% \text{ pa}$ [4]. Annual avoidable deaths from deprivation presently total 4.55 million for capitalist ostensible democracy India i.e. 0.33% pa. In contrast annual avoidable death from deprivation as a percentage of population is 0.0% pa for pluralist and One Party State China (2020) and 0.04% pa for the UK (2003 data).

Covid-19 is theoretically largely preventable with rapid total lockdown, testing, contact tracing, and the very best medical intervention. The following section compares expertly predicted Covid-19 deaths in the UK in various scenarios with pre-Covid-19 avoidable mortality in the UK and other regions.

(3) UK annual Covid-19 death rate (as percentage of population per year) versus “annual avoidable mortality from deprivation as a percentage of the population”

On 16 March 2020 eminent epidemiologist Professor Neil Ferguson and his colleagues at Imperial College, London, released an important research document entitled “Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and health care demand” [3]. This research paper has compelled the UK Government to take drastic action to suppress the COVID-19 epidemic via a “Suppression” scenario involving hygiene and social distancing, case detection and isolation, household quarantine, and the closing of schools and universities. This “Suppression” strategy is modelled to result in much fewer Covid-19-related UK deaths over 2 years (circa 40,000) as compared to a less stringent “Mitigation” strategy not involving school and university closure (210,000 deaths) or Inaction (510,000 deaths) [5-7].

Assuming that everyone eventually gets the Covid-19 disease then the 1-year deaths per 1,000 of population for the UK are predicted to be (1) about $0.02 \text{ million} \times 1,000 / 67.5 \text{ million} = 0.30 \text{ per thousand}$ (0.03% pa; aggressive Suppression), (2) $0.105 \text{ million} \times 1,000 / 67.5 \text{ million} = 1.56 \text{ per thousand}$ (0.16%; less aggressive Mitigation), and (3) $0.255 \text{ million} \times 1,000 / 67.5 \text{ million} = 3.78 \text{ per thousand}$ of population. (0.38%, Inaction).

It has been estimated that annual avoidable deaths from deprivation per 100 of population were 0.04% pa(UK), 0.05% pa (Western Europe), 0.36% pa (South Asia) and 0.97% pa (Non-Arab Africa) (2003 data) [4]. Presently in 2020 annual avoidable deaths from deprivation per 100 of population are 0.11% pa (Morocco), 0.30% pa (Developing World minus China) and 0.33% pa (India).

Thus in terms of UK Covid-19 deaths as a percentage of total population per year, (1) aggressive Suppression would yield an awful 0.03% pa (similar to the 0.04% pa avoidable mortality in the UK in 2003), (2) less aggressive Mitigation would yield a disastrous 0.16% pa (as compared to the 0.11% pa present avoidable mortality in cheap British holiday

destination Morocco), and (3) Inaction would yield 0.38% pa avoidable mortality (as compared to the 0.33% pa present avoidable mortality for impoverished India, a nation that is still recovering from 2 centuries of genocidally exploitative British rule [8-14]).

Thus aggressive Suppression of Covid-19 in rich First World UK (per capita GDP \$42,491 [15]) would yield a death rate (0.03% pa) similar in magnitude to the existing very low avoidable mortality rate occurring in the UK (0.04% pa) (2003 data). However mere Mitigation of Covid-19 would yield a Covid-19-related death rate in the UK of 0.16% pa, about 50% higher than the avoidable death rate of 0.11% pa in relatively poor Morocco (per capita GDP \$3,238 [15]). Inaction would yield a catastrophic Covid-19-related death rate in the UK of 0.38% pa, comparable to the present avoidable death rate of 0.33% pa in impoverished ostensible democracy but corrupt plutocracy India (per capita GDP \$2,016 [15])

The Covid-19 pandemic has been spread throughout the world by international travel and specifically largely by air travel. The irony of the present catastrophe is that while aggressive Suppression will yield a death rate comparable to the 2003 avoidable death rate in the UK, insufficient Mitigation will yield a UK death rate 50% higher than the pre-Covid-19 avoidable death rate in the cheap UK tourist destination of Morocco. Inaction (a policy initially contemplated by a sangfroid UK Tory Government) would yield an even higher death rate similar to the present huge avoidable death rate in the distant UK tourist destination of impoverished India.

In our new Coronavirus World the adage that “You are what you eat” is in danger of becoming “You are who you visit” for rich, tourism-mad European countries.

(4) Australia, Indigenous Australians and tourism contribution to Covid-19 deaths

Australia (population 25 million, per capita GDP \$51,663) is culturally and politically similar to the UK (population, per capita GDP \$42,491) [15], and it would be reasonable in the absence of other data to assume much the same epidemic outcomes of Covid-19-related death rates as a percentage of population of 0.03% pa (aggressive Suppression), 0.16% pa (less aggressive Mitigation) and 0.38% pa (Inaction). Prior to the Covid-19 pandemic, on a global comparative basis the overall Australian avoidable death rate was about 0.02% pa but the Indigenous Australian avoidable death rate was a shocking 0.6% pa, this lying between that in impoverished India (0.33% pa) and that in Non-Arab Africa (1.0% pa) [4] but occurring in one of the richest countries on earth [15]. Thus the Indigenous Australian avoidable death rate (0.6% pa) (for detailed analysis see [16]) is already 50% bigger than the overall Australian Covid-19-related death rate expected in the absence of any emergency action (0.38% pa) and 30 times greater than that for Australia as a whole (0.02% pa). In addition to this huge avoidable mortality disparity, overcrowded housing and other huge socio-economic and health deficits [16] already put Indigenous Australians at a much higher risk from Covid-19 than non-Indigenous Australians.

The Australian Government reports (7 April 2020):

“As at 6:00am on 7 April 2020, there have been 5,844 confirmed cases of COVID-19 in Australia. There have been 100 new cases since 6:00am yesterday. Of the 5,844 confirmed cases in Australia, 42 have died from COVID-19. More than 304,000 tests have been conducted across Australia” [17].

Australians love travelling notwithstanding the inherent expense, inconvenience and pointlessness of the pursuit. Covid-19 infections in Australia have primarily derived from plane-borne or boat-borne travellers from overseas. Calla Wahlquist of the Guardian reports (31 March 2020):

“The age group most represented in Australian statistics for confirmed cases of Covid-19 are people in their 20s, because they are the group most likely to travel or party with returned travellers, experts have said. Data updated daily by the federal health department shows that 11.3% of confirmed cases of the coronavirus in Australia are among people aged 25 to 29, followed by 9.5% in those aged 60 to 65 – the cruise ship cohort – and 9.3% in those aged 20 to 25. People aged 80 and older account for just 2.7% of the confirmed cases of Covid-19 but 47% of the deaths” [18].

As a person aged 75 and thus in one of the higher risk groups I am modestly indignant that people such as myself who travel rarely are now at high risk because of this pointless national obsession with overseas travel in rich but “culturally cringing” Australia. The disastrous world-wide coronavirus epidemic illustrates the dangers of the modern mass travel obsession in rich countries like Australia with international or intranational travel for travelling’s sake. Australian Literature Nobel laureate Patrick White condemned this pointless and indulgent mass movement in a 1988 speech at La Trobe University on the occasion of national celebrations of the 200th anniversary of the genocidal British invasion of Australia in 1788: “They are flogging camels from East to West and from West to East, and running from the City to Surf and from the Surf to City. Why don’t they just stay home, cook themselves a nice meal and curl up with a good book?” [19].

Resolutely ignored are the deadly consequences of this endless travelling. Thus 9 million people die annually from air pollution, about 50% from indoor pollution (cooking and heating) and 50% from outside pollution (electrical energy and transport). About 10,000 Australians die annually from air pollution and a further 75,000 people die annually around the world from the long-term effects of toxic pollutants from the burning of Australia’s world-leading coal exports [20]. However now we have the mounting death toll in Australia from Covid-19 infection brought to island continent Australia by Australian and non-Australian travellers. Notwithstanding being an atheist, I tell my travelling friends and relatives: “You can’t escape your immortal soul ... stay home and read a good book”.

Remote Indigenous communities are at risk from Covid-19 spread by endless touring Australian retirees (“Grey Nomads”) from the cities, just as Australia as a whole has been impacted by hundreds of thousands of returning Australian travellers. These “grey nomads” obsessively touring remote parts of “outback” Australia with their caravans and campervans have been given the descriptive SAD (“See Australia and Die”), most memorably in Tim Winton’s novel “Dirt Music” [21]. Indigenous Australian’s have a life expectancy about 10 years less than that for non-Indigenous Australians and have a disproportionately greater burden of chronic disease [16].

On a global comparative scale the “annual avoidable mortality as a .percentage of population” is 0.6% pa for Indigenous Australians as compared to about 0.0% pa for non-Indigenous Australians, 0.02% pa for Australians as a whole, 0.26% for neighbouring Indonesia (a major tourist destination for Australians), 0.33% pa for impoverished India (an exotic tourist destination for Australians), and 0.44% pa for Fiji (another major tourist destination for Australians). One notes by way of comparison that the “annual Covid-19

deaths as a percentage of population” if they are the same for Australia and the UK – 0.03% pa (aggressive Suppression), 0.16% (less aggressive Mitigation) and 0.38% (Inaction). On this basis, as observed with the UK, Australia’s “best case” Covid-19 action Suppression scenario” yields a death rate similar to the avoidable death rate for Australia, Mitigation yields a death rate similar to the avoidable death rate of tourist destination Indonesia, and the worst case of Inaction yields a death rate similar to the avoidable death rate of Indigenous Australians, and of popular tourist destination Fiji.

Look-the-other-way Australians are happy to holiday in remote Australia, Indonesia and Fiji but ignore the huge differential avoidable mortality in these places (just as the findings of this analysis will be censored by the mendacious Mainstream journalist, politician, academic and commentariat presstitutes as coming from an Australian scholar rendered “invisible” by the Establishment and its presstitute lackeys). Australians have no formal legal obligations towards its neighbours Indonesia and Fiji but it does have a legal and moral responsibility for its Indigenous subjects, noting that a Treaty has never been signed between the European invaders and the First Peoples of Australia. Articles 55 and 56 of the Geneva Convention relative to the Protection of Civilian Persons in Time of War unequivocally state that an Occupier must provide its conquered Subjects with life-sustaining food and medical requisites “to the fullest extent of the means available to it” [22].

Indigenous Australians from the arid region of northern South Australia want to remove their Elders to safety from the extreme threat from Covid-19 infection to the city of Adelaide, but their urgent request has been denied by the Coalition South Australian government . Thus Stephanie Boltje of the ABC (Australia’s equivalent of the UK BBC) reports (31 March 2020):

“Vulnerable Indigenous elders wishing to leave the remote South Australian Anangu Pitjantjatjara Yankunytjatjara (APY) Lands to self-isolate amid the coronavirus pandemic have been denied support from SA Health.” [23]. Ellen Fanning of the ABC reported (19 March 2020): “Indigenous health leaders are urging the Federal Government to declare special isolation zones patrolled by the police or the army in a radical move to prevent COVID-19 devastating remote Indigenous communities” [24].

The first case of Covid-19 in China may have been on 17 November 2019 but the Chinese Government notified the WHO that the first confirmed case had been diagnosed on 8 December 2020, and notified the world about human-to-human transmission of coronavirus on 21 January 2020 [25]. The first cases were detected in the UK in January 2020 but were predicted because of regular flights to the UK from Wuhan that had been noted as a Covid-19 disease cluster by 31 December 2019. The UK Government adopted stringent controls after mid-March 2020 and UK schools were closed from 20 March 2020 [26]. The first case of Covid-19 in Australia was detected on 25 January 2020, 6 weeks ago [27]. However the incompetent, anti-science and neoliberal Coalition Government adopted an “evolving” response and has still declined to close schools in the face of mounting concern from numerous medical experts [7]. If island continent Australia had acted in January 2020 to ban all foreign entries and to quarantine and test all Australian entries then Australia today would have zero cases of Covid-19. Such “ifs” aside, it is clear that action should ideally have been maximal and as early as possible given human-to-human transmission and exponential growth of infection that threatens to overwhelm medical services.

Final comments

One fervently hopes that the stringent Suppression approach belatedly adopted by the UK Government on about 20 March 2020 will restrict annual Covid-19 deaths to the 0.03% pa of the UK population as predicted by expert epidemiologists, a death rate commensurate with the 0.04% pa of avoidable deaths from deprivation in 2003. However the less aggressive Mitigation approach would yield a disastrous 0.16% pa deaths (as compared to the 0.11% pa present avoidable mortality in cheap British holiday destination Morocco), and Inaction would yield 0.38% pa deaths (as compared to the 0.33% pa present avoidable mortality from deprivation for impoverished India). While Westerners are rightly concerned about potentially huge death rates from Covid-19 in European countries, there is no practical concern for high, pre-Covid-19 avoidable death rates from deprivation in the Developing World. Indeed Westerners are happy to holiday in poor countries such as Morocco and India suffering huge, pre-Covid-19 rates of annual avoidable deaths from poverty of 0.11% pa and 0.33% pa, respectively.

European countries have closed down their economies and committed trillions of dollars to contain Covid-19 deaths but have effectively ignored the horrendous, continuing reality that 15 million people die avoidably from deprivation each year on Spaceship Earth with the rich First World in charge of the flight deck [4]. It was estimated in 2014 that an annual Global Wealth Tax of 4% would lift all countries to the modest, circa world average per capita GDP enjoyed by China and Cuba, countries for which avoidable mortality is zero [29, 30]. When this pandemic is over, rich European countries will no doubt renounce the current flood of Keynesian economic humanitarianism, attempt to restore their economies along neoliberal lines, consign immense government debt to future generations already saddled with \$200-250 trillion of inescapable Carbon Debt [28], and even more assiduously ignore horrendous avoidable death rates from deprivation in the Developing World (minus China) as exemplified by 0.4% of population pa in South Asia and 1.0% of population pa in non-Arab Africa.

Australia under an anti-science, effective climate change denialist, neoliberal and Trumpist Coalition Government has adopted a strengthening “Mitigation” approach to the Covid-19 pandemic that balances “lives” versus “livelihoods” and excludes variously medical expert-advocated and UK-adopted school closure as a policy [7]. Nevertheless belated but stringent border control measures may mean that Continent Australia will escape the carnage happening in Western Europe. However in an extraordinary bungle Australian officials allowed 2,700 passengers to freely disembark in Sydney on 19 March from the “Ruby Princess” cruise ship despite passengers on board showing signs of respiratory illness – at least 662 people linked to this cruise ship have been diagnosed with Covid-19 throughout Australia, more than 10% of Australia’s total detected cases, and about 5 have died [31, 32].

As an Australian I fervently hope that Australia’s unique island Continent nature and presently strong social distancing measures will save us from high Covid-19 death rates comparable to the pre-Covid-19 avoidable death rates from deprivation in neighbouring countries like Indonesia and Fiji in which look-the-other-way Australians happily holiday. However the pre-Covid-19 avoidable death rate from deprivation of 0.6% pa for Indigenous Australians means about 4,000 Indigenous avoidable deaths from deprivation each year and a continuing life expectancy “gap” of about 10 years between Indigenous and non-Indigenous Australians. Successive Liberal Party-National Party Coalition and Labor Party (aka Lib-Lab) Governments have been unable or unwilling to close “the gap”. Covid-19 disproportionately threatens Indigenous Australians who disproportionately suffer from huge

comparative health deficits and socio-economic deficits (notably crowded and substandard housing in remote communities). Australia must act immediately to protect Indigenous Australians from the Covid-19 threat – the world is watching.

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