

Spatiotemporal Variation of Excess All-cause Mortality in the World (125 countries) During the COVID Period 2020-2023 Regarding Socio-Economic Factors and Public Health and Medical Interventions

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Theme: [Science and Medicine](#)

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Summary

We studied all-cause mortality in 125 countries with available all-cause mortality data by time (week or month), starting several years prior to the declared pandemic, and for up to and more than three years of the Covid period (2020-2023). The studied countries are on six continents and comprise approximately 35 % of the global population (2.70 billion of 7.76 billion, in 2019).

The overall excess all-cause mortality rate in the 93 countries with sufficient data in the 3-year period 2020-2022 is 0.392 ± 0.002 % of 2021 population, which is comparable to the historic rate of approximately 0.97 % of population over the course of the 1918 “Spanish Flu” pandemic.

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By comparison, India (which is not included in the present study) had an April-July 2021 peak in excess all-cause mortality of 3.7 million deaths for its 2021 population of approximately 1.41 billion, which corresponds to an excess death rate of 0.26 % for 2021 alone (Rancourt, 2022).

Our calculated excess mortality rate (0.392 ± 0.002 %) corresponds to 30.9 ± 0.2 million excess deaths projected to have occurred globally for the 3-year period 2020-2022, from all causes of excess mortality during this period.

We also calculate the population-wide risk of death per injection (vDFR) by dose number (1st dose, 2nd dose, boosters) (actually, by time period), and by age (in a subset of European countries). Using the median value of all-ages vDFR for 2021-2022 for the 78 countries with sufficient data gives an estimated projected global all-ages excess mortality associated with the COVID-19 vaccine rollouts up to 30 December 2022: 16.9 million COVID-19-vaccine-associated deaths.

Large differences in excess all-cause mortality rate (by population) and in age-and-health-

status-adjusted (P-score) mortality are incompatible with a viral pandemic spread hypothesis and are strongly associated with the combination (product) of share of population that is elderly (60+ years) and share of population living in poverty.

There are large North-South (Canada-USA-Mexico) differences in North America, and large East-West differences in Europe, which are due to large national jurisdictional differences, or discontinuities in socio-economic and institutional conditions. Such systematic differences in mortality and underlying structure are captured by hierarchical cluster analysis using a panel of (yearly) time series, including to some extent the likelihood of persistent excess all-cause mortality into 2023.

Excluding borderline cases, 28 countries (of 79 countries with sufficient data, 35 % of countries) have a high statistical certainty of persistent and significant excess all-cause mortality into 2023, compared to the extrapolated pre-Covid historic trend, excluding excess all-cause mortality from peak residuals extending out from 2022, and excluding accidentally large values: Australia, Austria, Belgium, Brazil, Canada, Denmark, Ecuador, Egypt, Finland, Germany, Ireland, Israel, Italy, Japan, Lithuania, Netherlands, Norway, Portugal, Puerto Rico, Qatar, Singapore, South Korea, Spain, Sweden, Taiwan, Thailand, United Kingdom, and USA. More research is needed to elucidate this phenomenon.

The spatiotemporal variations in national excess all-cause mortality rates allow us to conclude that the Covid-period (2020-2023) excess all-cause mortality in the world is incompatible with a pandemic viral respiratory disease as a primary cause of death. This hypothesis, although believed to be supported by testing campaigns, should be abandoned.

Inconsistencies that disprove the hypothesis of a viral respiratory pandemic to explain excess all-cause mortality during the Covid period are seen on a global scale and include the following.

- Near-synchronicity of onset, across several continents, of surges in excess mortality occurring immediately when a pandemic is declared by the WHO (11 March 2020), and never prior to pandemic announcement in any country
- Excessively large country-to-country heterogeneity of the age-and-health-status-adjusted (P-score) mortality during the Covid period, including across shared borders between adjacent countries, and including in all time periods down to half years
- Highly time variable age-and-health-status-adjusted (P-score) mortality in individual countries during and after the Covid period, including more-than-year-long periods of zero excess mortality, long-duration plateaus or regimes of high excess mortality, single peaks versus many recurring peaks, and persistent high excess mortality after a pandemic is declared to have ended (5 May 2023)
- Strong correlations (all-country scatter plots) between excess all-cause mortality rates and socio-economic factors (esp. measures of poverty) change with time (by year and half year) during the Covid period, between diametrically opposite values (near-zero, large and positive, large and negative) of the Pearson correlation coefficient (e.g., Figure 29, first half of 2020 to first half of 2023)

One might tentatively add:

- No evidence of the large vaccine rollouts ever being associated with reductions

in excess all-cause mortality, in any country (and see Rancourt and Hickey, 2023)

- Exponential increases with age in excess all-cause mortality rate (by population), consistent with age-dominant frailty rather than infection in the limit of high virulence

We describe plausible mechanisms and argue that the three primary causes of death associated with the excess all-cause mortality during (and after) the Covid period are:

1. Biological (including psychological) stress from mandates such as lockdowns and associated socio-economic structural changes
2. Non-COVID-19-vaccine medical interventions such as mechanical ventilators and drugs (including denial of treatment with antibiotics)
3. COVID-19 vaccine injection rollouts, including repeated rollouts on the same populations

In all cases — for all three identified primary causes of death — a proximal or clinical cause of death associated (such as on death certificates) with the quantified excess all-cause mortality is respiratory condition or infection. Therefore, we distinguish (and define) true primary causes of death from the pervasive and accompanying proximal or clinical cause of death as respiratory.

We understand the Covid-period mortality catastrophe to be precisely what happens when governments cause global disruptions and assaults against populations. We emphasize the importance of biological stress from sudden and profound structural societal changes and of medical assaults (including denial of treatment for bacterial pneumonias, repeated vaccine injections, etc.). We estimate that such a campaign of disruptions and assaults in a modern world will produce a global all-ages mortality rate of >0.1 % of population per year, as was also the case in the 1918 mortality catastrophe.

Introduction

All-cause mortality by time and by administrative jurisdiction is arguably the most reliable data for detecting and epidemiologically characterizing events causing death, and for gauging the population-level impact of any surge or collapse in deaths from any cause. Such data can be collected by national or state jurisdiction or subdivision, by age, by sex, by location of death, and so on. It is not susceptible to reporting bias or to any bias in attributing causes of death in the mortality itself (see many references in Rancourt et al., 2023a).

Rancourt and collaborators have studied all-cause mortality for many jurisdictions, while developing the analytic approaches:

- several, esp. USA (Rancourt, 2020);
- France (Rancourt et al., 2020);
- India (Rancourt, 2022);
- USA (Rancourt et al., 2021a, 2022b);
- Canada (Rancourt et al., 2021b, 2022c);
- Australia (Rancourt et al., 2022a, 2023b);
- 17 countries in the Southern Hemisphere (Rancourt et al., 2023a);
- Israel (Rancourt et al., 2023b);

- world, with respect to COVID-19 vaccine efficacy (Rancourt and Hickey, 2023).

Researchers at [CORRELATION](#) and collaborators continue to be engaged in a broad research program of all-cause mortality and its associations with various factors.

Here we study all-cause mortality in 125 countries with available all-cause mortality data by time (week or month). The studied countries are on six continents and comprise approximately 35 % of the global population (2.70 billion of 7.76 billion, in 2019).

Large countries which are notably excluded for lack of available data include China (1.41 billion in 2019), India (1.38 billion in 2029), Indonesia, Pakistan, and most countries in Africa, although India has previously been studied (Rancourt, 2022; and references therein).

See the Summary for an overview.

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Report |
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