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Metacritique of Influential Studies Purporting COVID-19 Vaccine Successes: Part 3 — Meslé et al., Liu et al., Lin et al., and Datta et al.

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Abstract

In this third and final part of the metacritique, I evaluate four influential studies focused on Europe and Oceania: the European study by Meslé et al., Liu et al., and Lin et al. from Australia, and Datta et al. from New Zealand. These regional studies have significantly shaped public health messaging and vaccine policy. As in Parts 1 and 2, I identify recurring issues that call their conclusions into question—namely, problematic counting windows, inadequate accounting for adverse events, assumptions that exaggerate vaccine effectiveness, and potential conflicts of interest. Several studies also overlook waning or negative effectiveness and exclude safety signals, such as myocarditis. Collectively, these issues raise serious concerns about the reliability of models used to justify mass vaccination policies. A brief synthesis of all six studies is included to assess whether the prevailing narrative of universal COVID-19 vaccine benefit holds up under critical scrutiny.

Keywords: COVID-19, COVID-19 vaccines, counting windows, risk-benefit analysis, negative effectiveness

Introduction

Parts 1 and 2 of this metacritique examined two of the most influential modeling studies supporting widespread COVID-19 vaccination. Part 1 focused on Watson et al., who claimed that over 14 million lives were saved globally. Part 2 evaluated Kitano et al., a U.S.-based study that used quality-adjusted life years (QALYs) to argue that mRNA vaccines were beneficial across all demographics. Both studies suffered from serious methodological flaws, including improper counting windows, exaggerated assumptions, limited safety data, and potential conflicts of interest.

In this third and final part, I turn to four additional studies—the European study by Meslé et al., Liu et al., and Lin et al. from Australia, and Datta et al. from New Zealand. These regional studies have also shaped public health messaging and vaccination policies and share many of the same recurring problems noted in Parts 1 and 2. These include questionable assumptions about vaccine effectiveness, poor accounting for adverse events, failure to consider waning or negative effectiveness, and funding or institutional affiliations that may compromise objectivity.

This section builds on my previous critiques by expanding and updating the analysis of these four studies. It also includes a synthesis of all six evaluations presented in this series to reexamine the strength of the prevailing narrative that COVID-19 vaccines delivered universal benefit.

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Meslé et al. — Europe

Another major study, recently conducted by the World Health Organization (WHO) and the European Respiratory Surveillance Network (Meslé et al.), focused on the WHO's European Region, which includes not only the expected European countries but also Russia, the United Kingdom, and Israel. After *The BMJ* reported on the preprint version, I submitted a critique there as a rapid response. (1,2) The expanded version below includes content that was excised from the original submission due to word count limits.

The authors claim that COVID-19 vaccines saved over a million lives in Europe and emphasized the importance of boosters. (3) There are a few issues with the paper; one of them is the issue of waning vaccine effectiveness. While Meslé et al. thankfully did not make the mistake of assuming a static vaccine effectiveness, they assume only "that vaccine effectiveness declined by 0·25% every week since vaccination, regardless of dose." This decline in effectiveness is far too low, given the multitude of studies on waning effectiveness. While we earlier discussed evidence revealing that vaccine effectiveness drops to zero—and even below—within months, Meslé et al. apparently chose to factor in only a VE decline of around 13% over a year, making a mockery of the published science and even their own constant exhortations to receive booster shots. They further acknowledge that they "were also not able to differentiate the extent of waning immunity after vaccination disaggregated by dose."

Another important issue concerns the estimates of expected mortality. Greater clarity is needed regarding what these estimates represent, how confounding variables influence them, and how they are justified. While the earlier version's supplementary material section on expected mortality, containing multiple instances of "Error! Reference source not found," has been improved, questions remain.

Another issue is that Meslé et al. strongly encourage ongoing vaccinations despite evaluating only the benefits of COVID-19 vaccines, without considering the risks. Refer again to Fraiman et al., Benn et al., Thacker, and the alarming findings of Raethke et al., who reported that the rate of serious adverse effects could be as high as 1 in 400.

It is also the case that WHO is partly funded by the Bill & Melinda Gates Foundation (BMGF), which has heavily invested in COVID-19 vaccines, and that many of the paper's authors have ties to the government. The paper itself was "supported by a US Centers for Disease Control and Prevention cooperative agreement." Meslé et al. could plausibly be influenced by financial and political conflicts of interest. I had intended to raise this point in my original submission to *The BMJ*, but the word count precluded it. While I have identified several critical problems with these studies, it is worth noting that additional issues could be uncovered and explored if constraints such as word count limits and funding were not a barrier.

Nevertheless, perhaps the most significant issue with the study again centers on the assumed values for vaccine effectiveness. As detailed in an unofficial four-part series published in the *Journal of Evaluation in Clinical Practice* (JECP4), authored by researchers including Peter Doshi and myself, serious concerns have emerged that inadequate counting windows for COVID-19 infections and adverse effects likely resulted in highly exaggerated estimates of vaccine effectiveness and safety—both in clinical trials and subsequent observational studies. Central to this exaggeration is the failure to account for what occurs during the "partially vaccinated" period, which can last from weeks to months. The distortion is further compounded when these individuals are not only excluded but also misclassified as unvaccinated.

Buried deep within the supplementary material (Supplementary Table 2)—which is significantly longer than the article itself—are the studies used to estimate vaccine effectiveness. These include several that employ inadequate counting windows, such as those by Andrews et al., Arbel et al., and Monge et al. Potentially exacerbating the issue is the recurring problem of perceived negative effectiveness. Another paper by Monge, published in *The BMJ*, acknowledged this phenomenon and hypothesized that it may result from selection bias. (4) In response, I noted that such a hypothesis is insufficient and cited additional evidence of COVID-19 vaccine negative effectiveness (as well as rapid waning), with respect to infections, hospitalizations, and even deaths. (5) As previously discussed, the plausibility of negative effectiveness is further supported by findings in JECP4. Notably, some of the most recent evidence for negative vaccine effectiveness comes from another study conducted by the WHO, with CDC involvement.

Katz et al. found: "VE was 60% (95% Confidence Interval (CI) 12–82) for last vaccine received 7–89 days before symptom onset, 59% (95% CI 31–76) for 90–179 days, 7% (95% CI -29–33) for 180–269 days, and -6% (95% CI -44-22) for 270–365 days." And: "When we limited our analysis to SARI patients ≥ 60 years old, annual VE was 44% (95% CI

-33–77) for last dose received up to 89 days before onset, 50% (95% CI 7–73) at 90–179 days, -3% (95% CI -51–30) at 180–[269] days, and -14% (95% CI -67–22) for those with a last dose 270–364 days before symptom onset." Before we hear again the revised narrative that the vaccines are only meant to prevent or at least reduce severe COVID-19, the authors note that vaccine effectiveness for severe disease was worse still: "66% (95% CI 15-87) for a last dose received 14–179 days prior, 23% (95% CI -60–63) at 180–269 days, and -40% (95% CI -156–23) at 270–364 days prior." (6) Somehow, none of this is factored into the Meslé et al. model.

These concerns remain unaddressed since the original version of this critique was posted as a rapid response on *The BMJ* website. Unfortunately, now that the article has been formally published, we are still left with little confidence in the claimed number of European lives, both total and net, saved by the COVID-19 vaccines.

Liu et al. — Australia

An article concerning Australia concluded that "COVID-19 vaccination is highly effective against COVID-19 mortality among older adults, although effectiveness wanes with time since the last dose" and emphasized "the importance of continuing to administer booster doses." (7) Like the other studies, however, Liu et al. is subject to the same type of counting window issues highlighted in JECP4—issues that likely led to substantial exaggerations in vaccine effectiveness and safety, while potentially masking negative effectiveness.

Their classifications for vaccination status—"8–90, 91–180, >180 days"—are based on intervals from Feiken et al., with no further justification. That study clearly stated it only included "vaccine efficacy or effectiveness estimates for time intervals during which a person could have been fully vaccinated, considered as having received the complete primary vaccine schedule followed by enough time to develop immunological protection." (8) Given that vaccination could initially lead to an immunocompromised state and that partial vaccination is an inevitable part of becoming fully vaccinated, what occurs in the partially vaccinated is relevant and must be accounted for. Liu et al. claim that "the 0–7-day interval was included in analyses but not shown due to small numbers," but without access to these "small numbers," the claim remains unverifiable. Does this mysterious "inclusion" mean that the partially vaccinated were counted as unvaccinated? These ambiguities warrant reanalysis and further clarification. Additionally, it remains unclear whether similar counting window issues apply to adverse effects, which would impact their recommendations regarding booster doses. Ignoring adverse events in the partially vaccinated would be even more egregious.

Liu et al.'s central findings focus on vaccine effectiveness against COVID-19 and all-cause mortality. Yet the study fails to clarify what happened to those who received only one dose of vaccine or two doses but were still not considered "fully vaccinated"—a concern that also applies to those who received additional doses. Are such individuals excluded from the analysis—or worse, counted as unvaccinated? Once again, it is difficult to validate the results without access to the underlying data.

Another major concern with how the results are reported is that in Figure 1, several vaccinated groups appear to have higher mortality rates than unvaccinated groups, yet positive vaccine effectiveness (VE) is still reported. For example, one triple-dosed group shows a mortality rate of 1.139, compared with 0.929 for the unvaccinated, yet a moderately high VE of 63.4% is reported. The VE figures appear to have been adjusted, but how they were derived from the raw figures is unclear.

Additionally, while Figure 3 appears to suggest that the vaccines reduce mortality, some double-dosed individuals may be more likely to die from COVID-19, with confidence intervals including negative VEs. This inclusion reflects perceived negative effectiveness, as previously discussed. Various groups—particularly those who received two doses—also appear more likely to die from all causes. Why? Could the vaccines be causing more adverse effects than expected? Will the triple- and quadruple-dosed suffer similar patterns in the near future?

And while the vaccines would be expected to make death from COVID-19 less likely, why do the majority of groups also appear less likely to die from non-COVID-19 causes? Could survivor bias or the healthy vaccinee effect help explain this apparent panacea? Indeed, the latter was compellingly supported in a Czech study, which found that all-cause mortality was "consistently much lower in freshly vaccinated groups even outside COVID waves." (9) This interpretation is supported by the soon-to-be-discussed Lin et al., which reveals an uncharacteristically high unvaccinated rate among elderly Australian aged care residents. It is worth noting that Liu et al. offered an astonishingly naïve possible explanation for the vaccines' apparent ability to protect

against, well, everything: "COVID-19 may increase the risk of death from other causes, such as cardiovascular and respiratory disease, and thus vaccination provides some protection against these outcomes."

These and other issues are more evident—and even amplified—in their Supplementary Figure 3, which, for some reason, is barely discussed in the main article. First, based on the raw numbers, the figure clearly shows that COVID-19 mortality is less of a concern than deaths from cardiovascular disease, dementia, respiratory disease, and cancer. Second, deaths with COVID-19 listed as either the underlying or contributing cause are combined. These categories should be separated to determine how effective the vaccines are at preventing deaths primarily caused by COVID-19. Both Australians and Americans have been made aware, through mainstream news outlets, of accidental deaths attributed to COVID-19 solely because the decedent had tested positive in the weeks prior. In fact, while this meta-critique was in publication, an important study was released that provides a reference point to help determine the extent of the "with COVID/from COVID" problem. Basoulis et al. offer evidence indicating that around half of "deaths with COVID" may not actually be "deaths from COVID." (10) Third, although the vaccines appear to protect most groups against COVID-19 and non-COVID-19 deaths, the figures reveal that there are numerous groups in which vaccinated individuals are—or may be— dying at higher rates from cardiovascular disease, dementia, respiratory illness, and cancer.

Without the data, it is again difficult to make sense of this. Why would the vaccines cause fewer cardiovascular deaths? Why would they cause more? The same applies to dementia and possibly cancer, and more. And why would the vaccines appear to cause both fewer and more deaths at the same time, depending on how many doses vaccinees have received and how much time has passed since their last dose? These gross inconsistencies suggest underlying issues with the (as yet undisclosed) data, the authors' methods, or both. Perhaps very different types of people are receiving different vaccines, different doses, and at different times. With such shoddy work, it is hard to know.

The authors did acknowledge the potential for a healthy vaccinee bias, but only addressed it by restricting "analyses to individuals who received an influenza vaccination in 2021," as though that single variable could eliminate all the possible confounders. It is also plausible—and a transparent presentation of the data could clarify—that the potentially increased risk of these other causes of death, which contribute far more overall mortality in Australia (as the authors themselves acknowledge), may outweigh the COVID-19 deaths apparently prevented by the vaccines. I therefore strongly encourage Liu et al. to not only recalculate where appropriate, but also to be transparent by releasing their data. Notably, Liu et al. acknowledged "that VE for all-cause mortality was negative for some of the dose two intervals examined," offering a hypothesis but no substantive explanation. They speculated that these individuals "may have serious health conditions." Perhaps—but proper argumentation is preferable to mere speculation, and could these health conditions, hypothesized by the authors as preexisting, have been caused by the vaccine?

I suspect that such phenomena occur partly because this is not a randomized controlled trial (RCT), which would have been designed to eliminate confounding variables. However, even for the Pfizer and Moderna RCTs, JECP4 found that estimates for vaccine efficacy/effectiveness and safety were exaggerated, generally due to inappropriate counting windows. Other analyses of the trials have found, in the vaccinated groups, no statistically significant decrease in COVID-19 deaths, a statistically significant increase in serious adverse events of special interest, and a non-statistically significant increase in total deaths. These trials also addressed what were arguably the deadliest strains, so it would be reasonable for subsequent researchers, such as Liu et al., to expect more modest benefits from the vaccines.

It is also curious that the analysis from Liu et al. differs from the situation in the United Kingdom, where Office for National Statistics (ONS) data consistently showed that later in the pandemic, the unvaccinated (those who received precisely zero doses) fared better than the "ever vaccinated" (those receiving at least one dose) in terms of both COVID-19 and non-COVID-19 deaths. (11) Somewhat similar data emerged in Australia, where New South Wales (NSW) Health reports consistently showed the unvaccinated outperforming the vaccinated with respect to COVID-19 hospitalizations and ICU admissions—and sometimes even COVID-19 deaths—through to December 2022, although NSW Health abruptly stopped reporting serious COVID-19 outcomes stratified by vaccination status. (12)

Several other issues also merit attention. Equivocal language is used throughout, raising concerns about the validity of the conclusions. For example, the authors state, "Incomplete adjustment for serious

comorbidities could also bias our findings" and "These factors may counterbalance the healthy vaccinee effect." Clarification regarding the magnitude of these potential biases would be helpful. And are we to simply accept whichever statistical bias is most advantageous at any given moment—much like how Kitano et al. utilized non-U.S. data to support vaccine effectiveness while disregarding non-U.S. data related to adverse effects?

Liu et al. also "excluded people who received a fifth vaccine dose before baseline," apparently being "individuals with significant immuno-compromising conditions." Would it not be better to see the data for these 2000+ individuals? And, as noted previously, could these conditions have been caused by the earlier doses of the vaccines, particularly given that Australian doctors are now recognizing that the vaccines "might cause immune dysfunction" and that "long COVID" might be "long jab," often seen in vaccinated individuals who have never had COVID-19? (13)

They also "estimated COVID-19 mortality rates by vaccine status by using the rate in the unvaccinated population and multiplying this by the adjusted hazard ratios to derive adjusted rates." Are these estimates controlled for other comorbidities? Why are they estimating—was the actual mortality data not sufficient or available? Why aren't we shown the adjusted hazard ratios? So many questions remain unanswered in this widely publicized and widely cited study.

Furthermore, the terms "high effectiveness" and "wanes significantly" appear to be strange bedfellows. Given the findings presented in JECP4, it is plausible that one reason for the rapid waning of effectiveness is that the vaccines were not particularly effective to begin with; inappropriate counting windows may have led to exaggerated estimates of effectiveness.

Liu et al. also note, "The focus on deaths limited our ability to measure the overall health impacts of vaccines." This is a crucial point. If the vaccines lead to increased cancer rates, for example—as their own data suggest may be possible for many of the double-dosed—the true impact on mortality may be forthcoming. This underscores the importance of long-term safety surveillance, which the authors of JECP4 noted was lacking in both the clinical trials and many observational studies. Related to this, a serious discussion of deaths potentially caused by COVID-19 vaccines, which is necessary for a proper risk-benefit analysis, is sadly lacking. Another concern is the misclassification of the unvaccinated, which "could have resulted in underestimated VE." However, such misclassification could just as easily have resulted in overestimated VE, as demonstrated in JECP4.

There are also concerns regarding financial and political conflicts of interest. Liu et al. encourage ongoing booster doses, while the last listed author—typically the senior or supervisory researcher—declares funding from the Wellcome Trust, as well as from WHO and Gavi, the Vaccine Alliance, both of which receive large donations from BMGF, a major investor in COVID-19 vaccines. Although it was acknowledged that Kristine Macartney also received "payment as an expert witness on COVID-19 for state governments," it was not disclosed that she also serves on the Advisory Committee on Vaccines of the Therapeutic Goods Administration, the organization in Australia that approved the COVID-19 vaccines— information noted on her University of Sydney webpage. (14) Also disclosed is her position at the Children's Hospital at Westmead, an organization that terminated multiple staff members for not being vaccinated against COVID-19, including myself, despite working entirely from home at the time (related legal proceedings have thus far ruled in my favor). (15) More directly, Liu et al. acknowledge that the study was funded by the Australian government, which approved, promoted, and mandated COVID-19 vaccines. (16)

Due to these numerous problems, the conclusions from Liu et al.—that the COVID-19 vaccines are "highly effective against COVID-19 mortality," and that boosters are to be encouraged—are highly questionable. Of critical concern is why their data indicate that some groups of double-dosed vaccinees could be dying at a greater rate than the unvaccinated from cardiovascular disease, dementia, respiratory disease, cancer, and even COVID-19. It is also concerning that the data for the partially vaccinated have not been released, since it is plausible that some of them may have died due to the vaccine, which would explain why significant numbers of Australians stopped at one dose, when two doses would grant "full protection" and all the associated freedoms. More research is needed in this area and into the related issue of excess mortality persisting beyond the COVID-19 pandemic, which was the subject of a recent Australian Senate inquiry. (17)

Lin et al. — Australia

Another Australian article worth discussing is Lin et al., which received widespread media coverage for its sweeping claims, such as: "Unvaccinated indi-

viduals had a 7.7-fold greater mortality rate than those who were fully vaccinated among people aged 50+, which rose to 11.2-fold in those who had received a booster dose." (18) The article was published in *PLOS One*, one of the largest and most prestigious open-access journals in science and medicine. Because the journal does not typically publish responses and its comments section (formerly allowing *BMJ*-style rapid responses) is currently inactive, I contacted the editorial team. In May 2024, a helpful publications assistant assured me that they would be happy to post the comment on my behalf. One year and numerous emails later, the comment still has not appeared—predictably. Fortunately, some journals remain open to academic debate, so please enjoy this expanded version of my contrarian commentary.

Lin et al., again centered around a model, display similar issues to the other studies. Recall the revelations in JECP4—not only that suboptimal counting windows likely led to inaccurate estimates of vaccine effectiveness and safety, but also that negative effectiveness is plausible and may be obscured by such data manipulations. Intriguingly, as with Watson et al., Lin et al.'s Figure 1 shows that COVID-19 cases accelerated once nearly the entire Australian population had been vaccinated. Nevertheless, they state: "We assumed that any vaccine dose required 2 weeks to provide protective immunity, which we implement by shifting vaccination coverage (1st dose, 2nd and 3rd dose) two weeks later." They add in their supplementary material, "Cases reported as no effective dose received their first dose of a vaccination course less than 21 days prior to known exposure to COVID-19 or have not received any vaccine dose." It would appear that if a vaccinee died from COVID-19 or some other cause, and perhaps even due to the vaccine itself (by increasing the chance of COVID-19 or some other adverse effect)—within a few weeks of receiving the vaccine, the individual was classified as unvaccinated. That vaccine-caused deaths could be occurring in the "unvaccinated" group bodes ill for the state of science today.

As seems to be the norm for these sorts of papers, "rates of mortality of 50+ individuals were first estimated." Why are estimates necessary, again? Shouldn't they already have this information? Readers will recall that during the height of the pandemic, COVID-19 death figures were reported daily—even as they were dwarfed by total deaths, cardiovascular deaths, cancer deaths, tobacco-related deaths, and so on. Not estimates, but discrete numbers. Likely exaggerated—if only due to the "with COVID/from COVID" issue—but discrete numbers nonetheless.

As for waning vaccine effectiveness, much like the Europe-focused Meslé et al., Lin et al. assume an unreasonably modest decline. In their supplementary material, they state: "The effectiveness of two doses of the vaccine in reducing death rate is assumed to decline by 0.5% per week." That equates to only about 26% in 1 year, whereas studies have shown a decline of 100%—and even into negative effectiveness—within months. And once again, the healthy vaccinee effect is not properly accounted for, which is especially relevant given that their "primary focus was on individuals aged 50 and above." This, in itself, raises concerns, as clarity is needed on whether the vaccines—and the mandates—are suitable for all. Yet this possibility is not even acknowledged. And this, despite their own data apparently indicating it to be present, since they note that "a higher proportion of unvaccinated people . . . about 7% and 9% of aged care residents in NSW and VIC, respectively, had not received any vaccine, compared with only 1.4% of people aged 70+ in NSW." There is little benefit to be had in people close to death becoming vaccinated, especially if that could be what tips them over the edge. And there are no further comments from Lin et al. on other possible biases and confounding variables.

The infection fatality rates (IFRs) and case fatality rates (CFRs) used are again very high, with the supplementary material revealing an astonishingly elevated CFR of 4.45%—a figure that serves to exaggerate the harms of COVID-19 and, by extension, the potential benefits of vaccination. It is insufficient to simply cite values from studies that align with the authors' aims; such figures must be explicitly justified. Given the substantial disagreement over the true IFRs and CFRs, far more work is needed to support the authors' numbers.

To their credit, and unlike many other studies, there do not appear to be direct links between Lin et al. and pharmaceutical companies or governments that approved, encouraged, and mandated COVID-19 vaccines. However, a deeper look reveals several potential financial and political conflicts of interest. For example, although the authors state they received "no specific funding for this work," they also indicate that coauthor Haydar Demirhan was responsible for funding acquisition. One of the authors, James Trauer, is affiliated with Monash University, which received millions from COVID-19 vaccine manufacturer Moderna and is set to host the "world's first mRNA production facility to be located on a university campus." (19) Monash Univer-

sity also received millions in government funding for mRNA medicine manufacturing (20) and tens of millions in grants from the BMGF in recent years. (21) Trauer has also worked with WHO, (22) which is partly funded by BMGF, and served as a chief investigator for the PROPHECY project, which received support from organizations including the Murdoch Children's Research Institute. (23) This institute also received substantial funding from BMGF. (24) Other coauthors are affiliated with RMIT University, which has also received financial support from both the Australian government (25,26) and, once again, from BMGF. (27)

Finally, as is typical for such studies, there is no mention of vaccine-related injuries or deaths, meaning that a risk-benefit analysis is not provided, and is therefore untenable. This omission is especially concerning, given that the long-term effects of the vaccines are, by definition, still unknown. Lin et al. should have refrained from making strong claims such as, "Mortality would have been far higher if not for vigorous efforts to rapidly vaccinate the entire population." To be taken seriously, they must address these issues thoroughly before it can be reasonably concluded that Australia's vaccination program was so successful.

Datta et al. — New Zealand

Another study based on a model, Datta et al., claims that in New Zealand, the COVID-19 "vaccines saved 6650 (95% credible interval [4424, 10180]) lives" between January 2022 and June 2023. (28) The study suffers from several critical problems, the first being that their model "uses robust estimates for the effectiveness of the Pfizer vaccine against infection, severe disease and death caused by Omicron variants," which relies on the usual problematic counting windows that begin at least 7 days after the second dose, as in the cited Cromer et al. Also relevant is that the positive estimates used for vaccine effectiveness against death conflict with the findings from the initial clinical trials: The RCTs for the mRNA COVID-19 vaccines showed no statistically significant reduction in COVID-19 deaths among the vaccinated groups and even an increase (though not statistically significant) in total deaths.

The issue of waning vaccine effectiveness also warrants scrutiny. Datta et al. refer to a "waning rate," but defer details to their supplementary material, leaving readers of the main article uncertain as to whether their estimates are reasonable. In that supplementary material, clear figures are difficult to identify, though the authors do state: "We also assumed that immunity against hospitalisation and death never wanes below $e_{sev,min} = 0.5$." This assumption is inappropriate and, by itself, undermines the model's validity, as substantial evidence demonstrates that waning occurs rapidly—such that vaccine effectiveness, including for mortality, declines to 0 and even into negative effectiveness within mere months. As previously discussed, several published articles now either directly report or incidentally reveal some form of perceived negative effectiveness—yet Datta et al. appear unaware of this literature. They also seem to overlook potential confounding variables, such as the healthy vaccinee bias, which is well-documented to exaggerate effectiveness estimates.

It also appears that the estimates of COVID-19-related deaths used by Datta et al. are inflated. Echoing the long-standing "with COVID/from COVID" issue, the authors define deaths as those in which the cause was classified as "COVID underlying" or "COVID contributory." IFRs and CFRs are also widely recognized as highly contested, yet they substantially influence modeling outcomes. Estimates for COVID-19 IFRs have ranged from less than 0.01% to 2.3%.

Datta et al. also neglect to account for hospitalizations and deaths caused by the vaccines, rendering a risk-benefit analysis impossible—something they effectively acknowledge: "We have not attempted a formal risk-benefit analysis here." Nevertheless, this omission is especially striking given the mounting evidence of adverse effects, negative effectiveness, and their own admission that COVID-19 infections and deaths increased after "77% of the population (90% of those aged over 12 years) had received at least two doses of the Pfizer/BioNTech BNT162b2 vaccine and 27% of the population (35% of adults) had received a third dose." As noted earlier, evidence of negative effectiveness and adverse effects continues to grow. One of the more alarming recent studies, by Raethke et al., reported a serious adverse drug reaction rate of approximately 1 in 400.

While Datta et al. is clearly not robust enough to determine whether the vaccines were overall beneficial in New Zealand, the authors did make one intriguing revelation: "Relative differences among scenarios in the number of infections were smaller (25% above baseline in all scenarios). This shows that, over the 18-month time period considered, the primary benefit of vaccination in the model was to reduce the risk of severe disease and death rather than to prevent transmission." This provides some evidence against the long-held belief that vaccina-

tion mandates—such as those imposed by the New Zealand government—were necessary to "stop the spread." Notably, the U.S. government has already accepted (among other things) that "vaccine mandates were not supported by science and caused more harm than good." (29) Regarding funding, Datta et al. appear to have no direct financial ties to the vaccine manufacturers or their investors. They did, however, receive funding from the New Zealand government, which approved, encouraged, and even mandated COVID-19 vaccines. (30) In late 2021, the last listed author, Michael Plank, received an award for helping shape New Zealand's response to the pandemic—echoing the situation with Ferguson, WHO, and Macartney, mentioned above. (31) We continue to find—perhaps unsurprisingly—that individuals involved in enforcing lockdowns and facilitating access to COVID-19 vaccines, including through mandates that arguably violated fundamental human rights (the Australian Human Rights Commission now appears to concur), (32) later participate in research that seems to justify their past and future actions. A cynic may wonder if it was truly possible that they could have found otherwise.

The Datta et al. study is beset with problems. Vaccine effectiveness is exaggerated, while waning effectiveness is not adequately addressed—nor is the increasing evidence of perceived negative effectiveness. The deadliness of COVID-19 appears to be overstated, and no substantive mention is made of the risks associated with COVID-19 vaccination, rendering a risk-benefit analysis impossible. As such, the study in its current form is not helpful in determining whether the vaccines have been particularly beneficial for the people of New Zealand.

Conclusion

This third and final part of the metacritique examined the remaining four studies—from Europe, Australia, and New Zealand—that join the globally relevant Watson et al. (Part 1) and U.S.-focused Kitano et al. (Part 2) in making sweeping claims about the benefits of COVID-19 vaccination. As with the earlier studies, these analyses rely on models built on flawed assumptions and incomplete data, while failing to adequately account for critical confounders and potential harms.

Across all six studies, the same core problems recur: exaggerated vaccine effectiveness, typically due to delayed case-counting windows; overstated safety due to truncated adverse event tracking; underappreciated or ignored waning of effectiveness; and no recognition of increasingly observed negative effectiveness. Confounding variables—especially the healthy vaccinee effect—are rarely addressed. In many cases, key assumptions such as IFRs and CFRs are unjustified or inflated. Most studies also lack meaningful discussion of vaccine risks, making valid risk-benefit analyses impossible. These issues are further compounded by financial and political conflicts of interest, including ties to vaccine manufacturers, their funders, and the very governments that approved, promoted, and often mandated the vaccines.

Did the COVID-19 vaccines really save more than 14 million lives worldwide? Based on these flawed models and limited data, we cannot say for certain—but the claim appears highly doubtful, especially in light of the findings in JECP4, reanalyses of the pivotal clinical trials, and the growing evidence of serious adverse effects, negative effectiveness, and persistent excess mortality.

To properly determine whether COVID-19 vaccines were ultimately net beneficial or harmful—particularly for low-risk populations—long-term studies comparing health outcomes in vaccinated and unvaccinated groups are urgently needed. At present, the evidence suggests that for the young and healthy, these vaccines may have done more harm than good. Until such evidence is thoroughly explored, broad recommendations based on these compromised studies should be approached with great caution.

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