**Paper**: The Solution Comes from Understanding the Problem

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**Topic**: Western society has been conditioned to believe that childhood sickness and chronic “disease” is somehow “normal”. This same conditioning, that has been intensified since the early 1980’s, is now being promoted by such things as “strokes and heart conditions being normal” for children.

The current & obvious (for anyone who wishes to pay attention) elimination of younger people is an extension of the 54.1% ‘childhood chronic ‘disease’ rate’\*, that society has accepted as ‘normal’.

Is a 54.1% Childhood Chronic “Disease” Rate\* Normal?

The simple answer is **NO**.

Thanks to the emerging Truth that has been accentuated during the past 21 months, the facts behind the claim “NO”, are well in place. This can be briefly summarised by the following 2 points:

1. Genes as a cause – Bruce Lipton and his ground-breaking work in Epigenetics, 15 years ago, has eliminated genes as being a scapegoat for “disease”. Epigenetics = “control over genetics”. Bruce has clearly explained how genes function for the ‘average’ individual/layman.
2. Infectious, exogenous, pathogenic ‘microbes’ as a cause – Again, emerging evidence during the past 21 months has fully illustrated the details behind the “baseless guess” of “germ theory”, as being *total falsehood*. This reveal was first and completely logged (The French Academy of Sciences & Medicine) by the detailed scientific evidence of Professors Antoine Bechamp & Alfred Estor, during the latter half of the 19th century. Several scientists have replicated Bechamp & Estor’s work since that time.

If NO is the Answer, then What is the Question?

So, if it can now be easily demonstrated that the childhood disease rate is NOT normal then there must be some other contributing factor to this seemingly “odd” condition. The question then becomes, “What is the cause of the massive amount of human suffering, in spite of the most heavily funded medical ‘healthcare’ system in the world & history?”

The complete answer to this question is contained in the research & documentation of our Truth Centre, Keremeos, British Columbia and online ([www.oneeyedbudgie.com](http://www.oneeyedbudgie.com) – 6 Tabs).

The purpose of this Paper is not to answer this question, but rather to stimulate individuals to **ask the right question**!

Conclusion

When a situation and/or a realization becomes so drastic and horrendous (culling of children), it ***should*** stimulate an equally impactful ***question***.

A question of this kind of magnitude requires a *broadening of the consciousness* to capture principles and procedures necessary to supply the satisfactory answer (of equal magnitude).

This answer must be founded in complete Truth, which has the Power to disintegrate any falsehoods that lay in its path.

It is at this point of realization that will bring both Peace & Freedom to the individual and an **imminent** condition for planet Earth, known as being “Settled in Light & Life”.

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1. \*Document – 54.1% Childhood Chronic ‘Disease’ Rate (following – page 1)

Found here: https://www.academicpedsjnl.net/article/S1876-2859(10)00250-0/pdf

Note: If you read these 4 books, then you will never use the word “disease” again.

Actually, book 1) will do the job alone!

This document can be printed here: [www.oneeyedbudgie.com/the-truth-centre](http://www.oneeyedbudgie.com/the-truth-centre) (5 tabs)

Videos related to this Paper & the Truth Centre, Keremeos, B.C. – BitChute, search name “davesheers”

For those who know that something is not right, and do not know where to turn, they can find community & Truth on our Saturday evening Zoom sessions @ 6pm PST – email ds7715990@gmail.com for invite/link.

ARTICLES–STATE PROFILES, DURATION OF COVERAGE, AVAILABILITY

OF SERVICES, QUALITY MEASURES, MEASURING FAMILY EXPERIENCES

OF CARE, STATE QUALITY MEASURE NEEDS, REPORTING QUALITY

A National and State Profile of Leading Health Problems and Health Care Quality for US Children: Key Insurance Disparities and Across-State Variations

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ABSTRACT

BACKGROUND: Parent/consumer–reported data is valuable and necessary for population-based assessment of many key child health and health care quality measures relevant to both the Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and the Patient Protection and Affordable Care Act of 2010 (ACA).

OBJECTIVES: The aim of this study was to evaluate national and state prevalence of health problems and special health care needs in US children; to estimate health care quality related to adequacy and consistency of insurance coverage, access to specialist, mental health and preventive medical and dental care, developmental screening, and whether children meet criteria for having a medical home, including care coordination and family centeredness; and to assess differences in health and health care quality for children by insurance type, special health care needs status, race/ethnicity, and/or state of residence. METHODS: National and state level estimates were derived from the 2007 National Survey of Children’s Health (N ¼ 91 642; children aged 0–17 years). Variations between children with public versus private sector health insurance, special health care needs, specific conditions, race/ethnicity, and across states were evaluated using multivariate logistic regression and/or standardized statistical tests.

RESULTS: An estimated 43% of US children (32 million) currently have at least 1 of 20 chronic health conditions assessed, increasing to 54.1% when overweight, obesity, or being at risk for developmental delays are included; 19.2% (14.2 million) have conditions resulting in a special health care need, a 1.6 point increase since 2003. Compared with privately insured children, the prevalence, complexity, and severity of health problems were systematically greater for the 29.1% of all children who are publicly insured children after adjusting for variations in demographic and socioeconomic factors. Forty-five percent of all children in the United States scored positively on a minimal quality composite measure: 1) adequate insurance, 2) preventive care visit, and 3) medical home. A 22.2 point difference existed across states and there were wide variations by health condition (autism, 22.8, to asthma, 39.4). After adjustment for demographic and health status differences, quality of care varied between children with public versus private health insurance on all but the following 3 measures: not receiving needed mental health services, care coordination, and performance on the minimal quality composite. A 4.60 fold (gaps in insurance) to 1.27 fold (preventive dental and medical care visits) difference in quality scores was observed across states. Notable disparities were observed among publicly insured children according to race/ethnicity and across all children by special needs status and household income. CONCLUSIONS: Findings emphasize the importance of health care insurance duration and adequacy, health care access, chronic condition management, and other quality of care goals reflected in the 2009 CHIPRA legislation and the ACA. Despite disparities, similarities for public and privately insured children speak to the pervasive nature of availability, coverage, and access issues for mental health services in the United States, as well as the system-wide problem of care coordination and accessing specialist care for all children. Variations across states in key areas amenable to state policy and program management support cross-state learning and improvement efforts. KEYWORDS: children’s health insurance; children’s health services; chronic conditions in childhood; CSHCN medical home;nationalsurveyofchildren’shealth(NSCH);qualityofcare…