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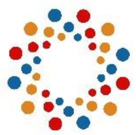

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RESEARCH ARTICLE

Curing the Cancer in Healthcare

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ABSTRACT

Cancer occurs when an organ in the body or a part of a system goes rogue and grows without limit, eventually killing the host. Healthcare systems worldwide are critically ill with cancer. Patients are experiencing death-by-queue. Systems thinking exposes the cancer in healthcare, its mechanism of action, and how to cure it.

Manifestations of healthcare cancer include shortages, especially of physicians; dollar inefficient, over-spending by most nations, particularly the U.S.; medical care itself unaffordable for most people; and accessibility to care so limited that people are dying waiting in line for care.

Effects of malignancy in healthcare include flouting the law; taking away medical autonomy; asserting a right to health care that is incompatible with freedom; elimination of the fiduciary relationship; and imposition of medical tyranny.

The cancer imposes its will on healthcare systems by controlling its financing and thereby controlling medical decision-making. The cure involves restoring decision-making authority – both financial and medical – to the patients, taking it away from the cancer. Details of this "cure" are discussed including impacts on patients, providers, and finances.

Patient-controlled health care is the only way to achieve timely, compassionate, quality, affordable care to We the Patients.

Introduction

It might seem offensive hubris for a non-oncologist to instruct oncologists on how to diagnose and treat cancer. However, cancer is not limited to biologic organisms – it can occur in non-biologic entities like organizations and even whole industries such as healthcare. For non-biologic cancer, systems thinkers are the necessary healers.

For semantic clarity, there are two forms of *healthcare*. As one word, healthcare refers to a massive system employing tens of millions of individuals, involving dozens of federal agencies and millions of regulations, and costing the U.S. $4.5 trillion in 2023.

As two words, health...care refers to confidential, legally protected, fiduciary, contractual relationship between two individuals: patient and care provider. The provider exchanges his/her personal service or work product for the patient's financial compensation.

The fiduciary connection between patient and doctor is unique. The patient gives up personal agency (individual freedom) temporarily to the provider knowing that provider will use that power solely for the benefit of the patient. The classic fiduciary example is the patient rendered unconscious by general anesthesia where a surgeon opens and operates inside a body cavity. The same scenario done by someone who is not the patient's chosen fiduciary is attempted murder.

This analysis, while focused on the United States, applies to any country where the central government controls the healthcare system, i.e., single payer systems such as in the United Kingdom and Canada. [1]

Good medicine = systems thinking

Practicing good medicine is the only way to cure a sick person. Systems analysis is the only way to restore a dysfunctional system to permanent *good health*. Good medical practice and systems thinking are nearly identical, both founded on two fundamental principles.

First, good health in a person or optimal function of a system depends on the interactions of the body or system parts. Looking at any one part in isolation without considering its interactions with the other parts leads to error. For instance, optimizing the operating room (OR) budget without considering impacts on other divisions in the hospital can lead to closure of the OR! [2]

A good physician would never treat kidney disease without considering the potential impacts of treatment on other body parts like the liver or the heart. In a failing (sick) system, one would not change the workforce of one department without looking at the upstream and downstream effects on other departments.

Second, to cure, not merely palliate, a sick patient, whether person or system, requires knowledge of doctors call etiology of sickness and what systems thinkers call the root cause. Without knowing the cause, one can only treat symptoms and make the patient better, but never *cure* the person or permanently *fix* the system.

The mechanics of practicing good medicine and systems analysis are remarkably similar. Where the physician would take a history, do physical exam, and review patient's records including prior test results, the systems thinker would do problem identification. The doctor who studies the medical literature and the systems thinker who evaluates prior evidence are both seeking a provisional diagnosis. Both then perform additional studies like blood tests and imaging or forensic accounting and value chain analysis seeking the true etiology or root cause (same thing.) Both use that knowledge to devise a treatment plan aimed at *curing* the human or "dissolving"[3] the root cause of healthcare's cancer so as to *permanently fix* the system.

What is cancer?

Cancer starts as a normal, healthy body cell or part of a non-biologic system that goes rogue. It ceases to participate in homeostasis and goes out of control. In rare cases of human cancer, the root cause is a virus in Kaposi's sarcoma and human papillomavirus. In most human cancers the precise, subcellular initiating event is not known. Treatment must therefore be aimed at the cancerous cells themselves rather than the illusive underlying root cause.

Consider a gastrointestinal columnar epithelial cell. The normal cell is programmed by its DNA/RNA to absorb ingested food, break it down to small enough packets to transport to the liver for further metabolism. The cell absorbs just enough energy to do its work. After 18-24 hours, the cell obeys its programmed apoptosis (cell death) to be replaced by a new cell in situ that behaves just like the old cell.

When a cell becomes cancerous, it is reprogrammed and no longer follows original instructions. The cell ceases all normal functions, grabs all the energy it can find, and uses that energy for one purpose: to grow and spread, sometimes locally like glioblastoma and other times

to distant locations, viz., breast or pancreatic metastases.

Such a malign process can occur in human beings as well as non-biologic systems. In humans, the cancer locus can start anywhere such as skin, breast, lung, pancreas, or intestines. (Almost never in the heart brags this cardiologist author.) In non-biologic entities – companies, agencies, whole industries – cancer can begin in accounting, R&D, HR, engineering, production, marketing, sales, or subdivisions.

For example, suppose a sales department becomes cancerous. It refuses to stay within budget, takes more and more of company money (energy). The other divisions can no longer function: HR can't hire, production cannot produce, and marketing cannot advertise. Eventually, the company closes its doors – in medical terms, the patient dies.

HOW DOES THIS TRANSLATE TO HEALTHCARE?
Healthcare has all the symptoms and manifestations of cancer. One part of the system – the Washington bureaucracy – is consuming all the energy starving all the other parts. Bureaucracy's (cancer's) rules and regulations are confusing, contradictory, and constantly changing making it impossible for the various other parts of the system to interact effectively and consistently. Growth of the cancer has made it increasingly difficult for the consumers or end-users called patients to acquire what they need: care. Patients' inability to get proper care in a timely manner leads to the ultimate healthcare system failure: death-by-queue, patients dying while waiting in line for technically possible medical care. [4, 5]

Manifestations of healthcare cancer

There are three primary manifestations – signs and symptoms in medical terms – of cancer in government healthcare: unaffordability, inaccessibility, and shortages.

SHORTAGES
The U.S. has critical shortages of physicians, nurses, mental health specialists and dentists. [6-9] These shortages create medically dangerous wait times for care. [10, 11] As increasing numbers of physicians cannot afford to see Medicaid patients, many of these patients have no provider at all and must use an emergency room for any care at all.

The United Kingdom's National Health Service, the paradigm single payer system, is having an ominous mass "exodus" of senior physicians. [12] Not only is this problematic for current patients but without them, who will train future generations of physicians?

The reasons for provider shortages are cultural – inherent in government-run healthcare systems. Most doctors, nurses, and therapists become care providers for the psychic reward. [13] They seek to satisfy the highest of Maslow's Hierarchy of Needs, self-actualization, confirmation of self-worth. As a nurse wistfully recounted one day at lunch, "When my babies [her patients] do well, it feeds my soul." [14] When an external force such as government or insurance tells the provider what he or she can and cannot do for the patient, they take away decision-making capability and deny the provider a psychic reward. Without that, why should the trauma surgeon get out of a warm bed at 2AM and plunge hands into an abdomen full of blood that may put his/her own life at risk? In fact, without the psychic reward, why should anyone go through the long years, sometimes decades, of expensive schooling, sleep-deprived training, and limited family life?
Care providers feel devalued by government-dominated healthcare not only because of lack of psychic reward but because of compensation. Other professionals like lawyers and accountants determine their prices based on market value and get paid what they charge. For everyone except physicians, price, charge, and payment are the same amount. Not so for physicians – their charges (or prices) are mostly irrelevant. Government "allowable reimbursement schedules" dictate what providers will be paid, usually a small fraction of the actual charge.

As a pediatric cardiologist, this author did cardiac catheterizations in critically ill neonates. The average charge ranged between $1500 to as much as $9000 if an implantable device was required. Regardless of the charge, Medicaid paid its maximum allowable reimbursement, $387.

Medical providers repeatedly experience "cosmology episodes" [15] that eventually drive them out of clinical care. Every human has a set of presumptions, usually below conscious level, that give order to our lives. The sun rises in the east and sets in the west. If you throw a ball up into the air, it comes down. But what if the ball never came down or the sun came up in the north? That makes no sense – it destroys our fundamental understanding of how the cosmos works: that is a cosmology episode.

Care providers experience cosmology episodes every day at work. They believe they are doing what people want and need. Some would call it God's work. Naturally, care providers expect the system to help them do their noble deeds and to value them highly when they provide compassionate care to the sick or dying. Instead, the system

harasses providers, places a mountain of bureaucratic and regulatory obstacles in their way, immediately blames them when outcomes are adverse. Government enacts policies unabashedly aimed at protecting patients from their own care providers!

Every job has two components: work content and work environment. [16] Care providers *love* what they do – the content – and *hate* (not hyperbole) the environment in which they must do it. For them, getting up to go to work is a painful cosmology episode. After a while, they can't take it anymore. They quit.

Increasing shortages become inevitable. Despite recent media hype, artificial intelligence (AI) cannot substitute for the judgment and humanity of an experienced nurse or physician. [17] AI has no "healing hands."

Looking to Washington to fix provider shortages is like asking the arsonist to put out the fire [18] or expecting cancer to cure itself.

UNAFFORDABILITY

For American taxpayers, both health care as well as the healthcare system are impossibly expensive.

In 2023, the U.S. spent $4.5 trillion just on healthcare. This amount is greater than the entire GDP of the fourth most productive nation on earth, Germany. U.S. healthcare spending was 16.5 percent of GDP. In 1960, five years before the cancer started Medicare and Medicaid, the U.S. expended 4.8 percent of GDP on healthcare. [19]

In 2023, a typical American family expended $31,065 [20] on healthcare costs. In the same year, average median household income was $67,521. Of the $31,065, at least 77 percent ($23,968 [21]) was compensation the employer did not give to the employee but rather the employer sent that money to an insurance company as "employer-supported health insurance."

Employer-supported health insurance is an obsolete, dollar inefficient holdover from World War II that should have been terminated long ago. From 1939 to 1945, wage freezes were necessary so that government could spend huge sums of money prosecuting the war. To reward workers while complying with wage freezes, Washington passed legislation allowing companies to pay for health insurance for employees and account these expenses as "cost of doing business," i.e., tax advantaged.

When the war over and wage freezes were discontinued, Washington should have repealed the employer tax advantage clause and given that money to employees. Cancerous Washington did not do this. Monies that should be employees' property to was paid insurance parties. Thus, the third-party payment control mechanism was born, taking away financial decision-making from the people who earned that money.

With control of money came control of care. What, where, when, by whom and even if care is provided is now decided by a third party for everyone who cannot pay the exorbitant cost of care out of pocket, i.e., more than 90 percent of the population.

Studies show that 31 percent to more than 50 percent of all U.S. healthcare spending goes to BARRCOME – bureaucracy, administration, rules, regulations, compliance, oversight, mandates, and enforcement. [14, 22] That means $1.4 trillion to $2.25 trillion of U.S. healthcare spending *produces no care.*

Cancer's insatiable appetite for energy (money) took $1,400,000,000,000 to $2,250,000,000,000 worth of care away from the American public. [23]

Other countries spend much less on healthcare than the U.S. (18.8 percent GDP), such as Germany (12.8 percent), United Kingdom (11.9 percent), Canada, France (12.2 percent), and Spain (10.4).

With respect to dollar efficiency, one report [22] from 1999 showed that Canada then expended 16.7 percent of GDP on BARRCOME while the U.S. spent 31 percent. However, the 1999 study did not include several elements of BARRCOME expenses and thus underestimated Canadian spending. Additionally, that study was done more than 20 years ago. Since then, the number of healthcare regulations and the consequent BARRCOME spending have increased considerably not just in the U.S. but in other nations as well. In terms of national affordability, the cancer is winning, and the people are losing.

As healthcare, the system, is unaffordable for nations, the same is true for the cost to families of health care, the service. In the U.S., average household spending on healthcare in 2001 was $8,414 (20 percent of median household income). In 2023, it had climbed to $31,065 (42 percent of household income). [20, 24]

While health care is unaffordable out of pocket for individual Americans, this is not true for residents of single payer nations where all healthcare is paid

through taxes. In the U.S., highest personal tax rate is 37 percent. In single payers, United Kingdom and France, maximum tax rate is 45 percent.

INACCESSIBILITY

Paying for BARRCOME comes first, before paying for care. What is left after paying accountants, administrators, agents, billers and coders, compliance officers, consultants, enforcement agents, lawyers, managers, regulators, rule writers, etc., can be used to pay doctors, nurses, pharmacists, hospitals, those who provide patient care.

The limitation on money for care combined with the shortages of personnel and facilities, especially in rural areas, creates medically injurious delays in access to care. Even a four-week delay in diagnosis of human cancer increases the mortality. [25] Consider the effect of the average maximum wait time to see a primary care physician of four months! [10]

Despite President Obama's assurance that his namesake legislation, the ACA or Obamacare, would provide "all the care that Americans deserve," maximum wait time for care increased from 99 days before the ACA to 122 days after implementation. [10]

Inability to access care due to the provider shortage is exacerbated by the increasing reluctance of physicians still practicing to provide care for new Medicaid patients, with at least one third of doctors nationally saying, "Sorry, but my practice is full." In Texas, more than half of all doctors refuse to see government insured patients for two reasons: massive regulatory burden and low payment ("reimbursement") schedules, often below their cost of doing business. [26]

The Obama and Biden administrations claim one of their great successes the reduction in the uninsured rate mostly by expansion of Medicaid enrollment, which reached a peak of 95 million Americans two years ago and currently insures at least 85 million (25 percent of U.S. population.) This number is likely to swell greatly as states such as California and Oregon have begun to offer Medicaid benefits to illegal immigrants. [27]

Healthcare cancer produces an unintended adverse impact called the seesaw effect. [5, 28] As the number of people with government health insurance increases, and the number of doctors available to care for them decreases, wait times for care get longer and longer. The more people government insures, the less access to care they have.

As more people look for their promised care (after all they now *have* insurance!) and don't get it, the disingenuous conflation of insurance with care becomes glaringly obvious. Government insurance *does not* equal medical care. In fact, government insurance equals death-by-queue: a line of people waiting for care that doesn't come in time to save them. [4, 5, 9]

Diagnosis of cancer

The characteristic features of human cancer are apparent in the federal healthcare bureaucracy as follows:

- Cessation of normal function, i.e., no longer facilitating access to medical care
- Consumption of increasing amounts of energy (money taken from care)
- Unlimited growth in size, scope, and reach
- Spread to other parts of system where it does not belong
- Cancer harms other parts of the system rather than facilitating them
- Control by the cancer takes away freedom [2]

Congress has created and abetted in the development of a malignant healthcare bureaucracy harms people in the following ways.

CANCER FLOUTS CONSTITUTION AND LAW (U.S.)

The Tenth Amendment to the U.S. Constitution reads as follows: "The powers not delegated to the United States [referring to federal government] by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." Such delegated are specified in the Constitution.

Article I, Section 8 of the U.S. Constitution specifies 18 "powers," the limits of Washington's authority, such as: establish post offices and post roads; coin and borrow money; constitute Tribunals inferior to Supreme Court; raise and support armies and a navy; and regulate commerce with foreign nations.

The Constitution specifically *did not delegate* health authority to Washington. Furthermore, by the Tenth Amendment, the federal government is prohibited from having power or control over both healthcare and health care, which are strictly "reserved to the states respectively, or to the people."

The charge of unconstitutionality applies to the United States but not to single-payer nations such as Spain, Great Britain, and Canada.

According to Article 43 of the Spanish Constitution of 1978, all Spaniards are entitled to "equal, efficient health care assistance of the highest

possible quality" with the government responsible for providing such care. [29]

In both Great Britain and Canada, the government, not the patient, takes primary responsibility for medical decision making. [30-32] Great Britain does allow the private practice of medicine outside government controlled National Health Service. Canada does not – it takes sole and exclusive control of health care services with prohibitive penalties for engaging in private practice.

In the U.S., cancerous control of healthcare abrogates its own federal law. Washington controls the administrative, financial, and medical aspects of Medicaid, a system supposedly run by the states. The Medicaid law itself prohibits any federal involvement. Section 1801 of Public Law 89-97 (1963) reads as follows: "Nothing in this title shall be construed to authorise any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." [33]

When Washington illegally supervises, controls, or administers state Medicaid programs, it acts in direct contravention of its own law. This is another example of a cancerous bureaucracy that has gone rogue.

CANCER TAKES AWAY MEDICAL AUTONOMY

Federal bureaucrats may assert that they never deny American patients their freedom or medical autonomy. They say patients are free to choose whatever provider, hospital, medication, or treatment they want. Individuals would simply have to pay for their choices out of their earnings. This argument is specious and disingenuous.

According to government records, the 2023 median gross income for a family of four was $74,580. After paying taxes, rent, food, energy, insurances, etc. (all at inflationary prices), paying for medical care out of pocket is simply impossible, with medical prices like $1000/vial of insulin, $2500 or more for an MRI or an echocardiogram; $35,000 for hip replacement and six figures (at least) for heart surgery or cancer treatments.

The cancer of government healthcare takes Americans' money in high taxes and costly insurance premiums. Then it drives up the cost of care by generating BARRCOME. Finally, the malignant bureaucracy controls provision of care through insurance regulations and pre-authorization processes.

The cancer takes away patients right to choose how to spend their healthcare dollars, ceding decision-making over money *and care* to third parties. Thereby, the cancer takes away medical autonomy. [34, 35]

RIGHT TO HEALTH CARE

The malign bureaucracy advances the concept that health care is "a right for every single American" (2020 Democrat Party Platform [36].) Such a *right* denies the freedom, not of patients, but of providers.

Health (more properly, medical) care is the professional work product of a doctor, nurse, or therapist. There is an implicit service contract between patient and doctor, just like a lawyer, although theirs are always carefully worded and explicit. Physician provides his or her work product in exchange for financial compensation by the patient.

However, one does not pay for a right, such as free speech, assembly, or religious liberty. Merely by living in a constitutional republic, one automatically has rights specified in its Constitution. You do not pay for any such rights. There are no rights that involve the work product of another person. One has a right to religious freedom but not a right to the services of a religious leader or teacher. People are entitled to assemble but have no *right* to the services of an Uber driver.

If, as the cancer asserts, a care provider's personal *service* were a patient's right, the patient could demand service where, when, and what the patient desires and the provider could not refuse. The provider would have to serve the patient, which takes away the provider's right to choose, denies her or his freedom. [37, 38] That is called slavery.

Health care cannot be a right in any nation that supports personal liberty.

CANCER AS MEDICAL TYRANT

The cancer of government healthcare has become tyrannical using the following as justification: a putative right to health care, adverse medical outcomes, health inequities, [39, 40] and exorbitant prices for care.

Federal so-called advisories, guidelines, clinical algorithms, pronouncements, and prohibitions are really commandments, strictly enforced directly or

by proxy. [41] A physician who fails to comply or simply refuses to abide by government practices is censured, cancelled, and may lose hospital privileges or licensure. When the FDA unscientifically and improperly disapproved the use of Ivermectin during CoViD, pharmacies refused to fill prescriptions for the drug even though physicians and families wanted this potentially life-saving treatment for patients. [42]

The CoViD scam exposed the medical tyranny imposed by cancer. [34, 37] Governments throughout the world mandated and then forced injection of a poorly tested, inferior quality *experimental* never-before-used mRNA gene therapy, the so-called *vaccine* or the "jab," on hundreds of millions of individuals. This was done despite adverse outcomes data that successfully escaped censorship and suppression by cancer. [43-46]

In the rush to mandate mRNA shots, Washington's malpractice included skipping preclinical testing for oncogenesis induced by coding mRNA for non-human pathologic target protein. The jab has been recently shown to promote development and aggressiveness of various cancers probably by immune dysregulation. [47]

Practicing, (real) physicians were powerless to stop the malpractice *on their patients* imposed by the cancer's tyrannical, anti-scientific bureaucrat/non-practicing MDs.

Malign tyranny extended to restoring "quarantine camps" in Australia for those who refused the jab, [48] reminiscent of Japanese internment camps in the U.S. or Nazi-era concentration camps in Poland. In the U.S., the state of Washington considered (but did not pass) a bill emulating Australia's unlawful incarceration nullifying the Fourth and 14th Amendments to the U.S. Constitution for its 7.8 million residents. [49]

Engaging in medical malpractice such as forcibly injecting patients with a dangerous even deadly drug would cause any real-world clinical physician to lose his or her license and possibly jail time. Bureaucrat-MD Anthony Fauci, the chief spokesman for the mal-practicing cancer, was rewarded with the highest salary of any U.S. government employee ($480,654) as well as royalties from Big Pharma. He and his wife experienced an overall net worth gain during CoViD of more than $5 million. [50-53] Meanwhile, on Fauci's orders, millions of Americans lost their jobs and their incomes.

Medical tyranny extended beyond egregious vaccine mandates. The cancer literally abrogated First Amendment rights such as freedom of speech, right of assembly, and religious liberty by mandating and enforcing lockdowns. More than 200,000 small U.S. businesses were forced to close. [54] Millions of people were forced to stop work and thus stopped receiving paychecks. Education of children was severely impaired with cessation of in-person teaching. This was especially damaging to lower income individuals as many are without home computers and/or internet access and therefore could not participate in online education.

ONE SIZE DOES NOT FIT ALL

Federal cancer controls healthcare with a very broad brush, using a one-size-fits-all approach that does not work. Medicaid regulations and standards, clinical guidelines, advisories, prohibitions are the same throughout the entire U.S. despite dramatic differences among the states.

Montana and Rhode Island have virtually the same number of residents, one million. Montana has 1100 physicians to cover patients spread out over 145,000 square miles. The nearest Level One trauma center to Helena, the capital of Montana, is in Salt Lake City, Utah, eight hours' drive when the roads are passable. Rhode Island has 5500 doctors within 1212 square miles with three world-famous trauma centers less than 45 minutes' drive away in Boston. To apply the same healthcare requirements and standards to these two states is ludicrous. Yet, that is what cancer does.

CANCER TAKES AWAY FIDUCIARY RELATIONSHIP

The connection between buyer (patient) and seller (provider) in health care is different from other forms of commerce. Patient and physician are supposed to have an intimate, confidential, legally protected *fiduciary* relationship. [55, 56]

The patient chooses a specific physician as his or her fiduciary and gives up (temporarily) his or her freedom and personal agency to that provider, who is obligated morally, ethically, and legally to use that agency or power exclusively for the patient's benefit. Of necessity, a fiduciary physician is responsible since he or she is making medical decisions for the patient. Such august responsibility requires requisite, august authority.

When government, through its regulatory power, takes away physicians' decision-making capability, the cancer nullifies the patient-physician fiduciary relationship, turning a highly personal and frankly intimate connection into a totally impersonal one. By taking authority away from the physician, the cancer takes upon itself the role of decision-maker and thus should accept responsibility for the

patient's outcome. Logically, the physician should no longer be held responsible. And yet, he or she is.

Curing cancer in healthcare

START WITH ETIOLOGY (ROOT CAUSE)

When cancer develops in a biologic organism, the first event is a reprogramming of the cell. Other than the infrequent viral vector, most of the time what causes reprograming is unknown. After the healthy programming is altered, the cell follows its new instructions, and all the consequences described above result.

The initiating event or proximate cause for the government to become cancerous in healthcare is also unclear. It could simply be human nature – the desire for power, a need to control. However, that is pure speculation. Whatever the proximate root cause, the mechanism of action and effects are well known and subject to adjustment.

The combination of regulatory authority and third-party control of spending gives the cancer of government healthcare control of patients, providers, and one sixth of the total economy. Congress passes legislation that establishes healthcare policies and grants authority to federal agencies to formulate rules and regulations that dictate and limit actions of the public.

Federal regulations empower the Medicare Trust to tax all working Americans supposedly to pay for senior care. [57] Federal regulations empower insurance companies to take the public's money – taxes and premiums – and spend as they choose. Thereby, insurance – both government and private – makes financial as well as medical decisions instead of those who should – patients.

Physicians too are prevented from deciding both financial and medical matters. Decisions are made by the cancer. A physician's charges are irrelevant: doctors are paid what central government dictates, not what they charge. Doctors' judgment in patient care is also subsumed by federal medical dictates. Physicians do what Washington says or else. The cancer censors and suppresses data it doesn't like labelling it misinformation. The cancer even fires physicians who try to do what they know is best for their patients when that does not comport with the federal narrative. The CoViD experience provides ample proof. [58-64]

In single payer systems, cancer's control of healthcare is overt and direct. Doctors in Great Britain's NHS work for the government, not for the patients.

In the U.S., control by cancer is either direct or indirect but always total. For 186,300,000 Americans (56 percent of population) Washington directly controls their care through Medicaid/CHIP, Medicare, Tricare, and EMTALA (for the uninsured). Approximately 147,000,000 have private insurance. Their care is determined by their insurance carrier or health plan, who in turn must comply with federal insurance regulations and clinical pronouncements.

With evidence confirming the harm cancer inflicts on the public and knowledge of how the cancer works, one can construct a cure. Systems analysis assures us this cure will work to provide timely, compassionate, affordable care to the most individuals at the lowest cost. This cure is easy to understand and supremely difficult to implement as the cancer will resist, vigorously.

The cure for healthcare cancer is excision: cut out the government. This is called *patient-controlled health care*. By eliminating government and third-party decision-making, control will naturally return where it belongs – in patients' hands. [65]

RESTORE FINANCIAL CONTROL

Repeal the obsolete, World War II holdover of tax-advantaged employer-supported insurance benefit and give that money, averaging $23,968 in the U.S., [21] to employees as compensation. The employee can then contribute these funds to the new *Family HSA* (described below) as a tax credit, not merely a tax deduction.

Families can shop and pay for medical care out of the Family HSA. The vast majority of medical needs, from checkups to diarrhea and broken bones, cost much less than the tens of thousands of dollars in Family HSAs.

Providers as well as medical facilities will compete for consumers' dollars by advertising both charges and results. Those who refuse to do so will quickly have empty waiting rooms. Those care givers who do not make their results and charges readily understandable to the public will also have no patients. Providers who exaggerate their medical successes will soon find themselves in court.

In the U.S., repeal Medicaid, CHIP, TriCare, and EMTALA. Stop taxing Americans for these programs and cease mandating how the states should handle their medically vulnerable. Allow the states, singly or in regional groups, to develop medical safety nets that best serve the states' unique needs and resources. Models have been described for such safety nets that are much cheaper and provide

better, more timely care than Medicaid. [14] This approach is called StatesCare, to emphasize who designs and implements the safety nets – states, not the federal government. In Canada, one might call this ProvinceCare. In the U.K., the Trusts should individually decide how to care for their medically vulnerable populations.

Repeal and pay out the Medicare Trust to all those who paid in. Allow them to put this money and additional personal funds into Family HSAs. Do this before Medicare becomes insolvent in 2028. [57, 66, 67]

Repeal federal restrictions on insurance policies so that the market, i.e., millions of consumers not Washington, can decide what to purchase, including very high deductible, full-payment-of-charge policies, which are likely to be highly desirable in patient-controlled health care. If people want what Biden calls "junk" insurance, that too should be available rather than prohibited. [68]

With patients now as shoppers who spend their own money, free market forces will return. Buyers will have a strong incentive to economize, and sellers will compete on price and quality, driving the former down and the latter up. The results will be affordable, timely, quality, compassionate care.

With patients controlling their money, almost all the malign federal regulatory machinery becomes unnecessary eliminating nearly all spending on BARRCOME. Two trillion dollars annually could be recouped in the U.S. to reduce the tax burden and/or spend more money for patient care and other social programs. A similar effect would occur in other countries.

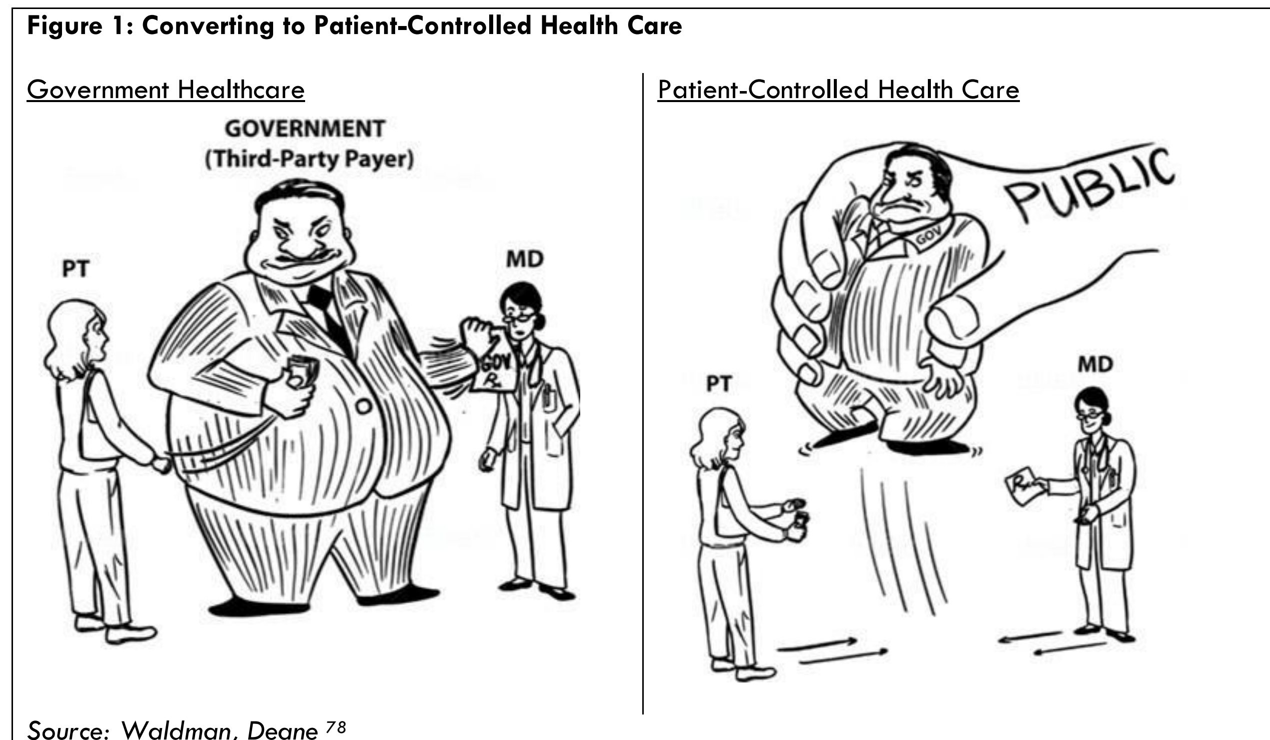
With the elimination of most BARRCOME, federal agencies such as FDA, NIH, CDC, and particularly CMS can be drastically downsized. Those who remain should be culturally reprogrammed. By their actions and pronouncements during CoViD, these agencies (and others) have destroyed public confidence in their objectivity and reliability. [69-71] With the creation of patient-controlled healthcare, the agencies' top priority in the new, consumer dominated environment should be to regain the trust of the public as well as the practicing medical community.

MOVING TO PATIENT-CONTROLLED HEALTH CARE

The conversion from government healthcare (cancer) to patient-controlled health care was recently summarized pictorially. [72]

With current government-controlled, third-party payment structure (Figure 1, left side), patient and physician are separated by the third-party decision maker who takes the patient's money, tells the physician what to do medically, and pays the doctor what the third party decides. Both financial and medical decisions are made by BARRCOME. Patient and doctor do not interact directly. There is no fiduciary, no one with authority whose sole focus is that specific patient's well-being.

Figure 1: Converting to Patient-Controlled Health Care



Source: Waldman, Deane [78]

As federal government will never voluntarily yield financial and medical authority back to the public, We the Patients must force this change using the power of the ballot box. When the third-party/government is no longer the decision-maker, patients and physicians can interact directly (Figure 1, right side), re-establishing fiduciary relationship. Patient chooses doctor. Doctor advises treatment. Patient decides what treatment and pays doctor for treatment. There is no BARRCOME.

(NEW) FAMILY HSA

At present, HSAs are strictly limited by complex federal regulations. All restrictions should be repealed. The new "Family HSA" should allow unlimited contributions, which are accounted as a credit against federal income taxes. There should be no time limit, i.e., no use-it-or-lose-it. The Family HSA can be passed on from one generation to the next without taxation. Funds in the Family HSA can be used for any legitimate medical expense, where "legitimate" is defined by the patient not by the government. If a patient wants to pay for cosmetic surgery, that is certainly medical; a new 98" TV screen is not. Paying for medical insurance from the HSA is permissible. The government should not decide what is "junk" versus good insurance. [68, 73]

If a family wishes to pay for someone else's medical expenses, such as a close friend or neighbor, that too is allowed.

Most healthy families would spend considerably less than the $23, 968 they put in each year, even paying the cost of high-deductible, catastrophic insurance. Thus, after a few years, families would have very large sums of money they can afford to spend on health care.

RESTORE MEDICAL AUTHORITY

Though the financing of healthcare receives the most attention, *care* is (or should be) the highest priority for healthcare, not saving money or the number of people with insurance. [74]

By making medical care decisions for the people, including rationing (limiting) care, [75-80] the cancer of government healthcare claims to know what is best for patients, better than they do themselves. Federal bureaucrats relieve individuals of the responsibility for making life-and-death decisions, *in their best interests of course*!

This is patently false, as shown by the CoViD nightmare and the absurdity of one size fits all. The patient knows what is best for himself/herself, better than any nameless, faceless, unaccountable bureaucrat sitting in a numbered cubicle in Washington, Ottawa, Brussels, or Canberra.

There is something more valuable than money and even more important than good medical care: FREEDOM, the right to choose, personal independence from government control. The British initiated this concept in 1215 with the *Magna Carta Libertatum* (Great Charter of Freedoms.)

Americans made the individual-to-government relationship unambiguous with the Declaration of Independence of 1776. That document did more than declare the colonies' independence from King George's rule. It said individuals were independent from government rule, except in those specific areas ("powers) that the individuals granted to the government, and that they could take away whenever they decided.

Individual independence is the highest value in most constitutionally governed countries. In the U.S., medical autonomy – the patient's right to make all personal medical decisions free from coercion – is both legally and constitutionally enshrined.

Cancer nullifies medical autonomy by controlling access to care through regulations and control of money flow. When control of their money returns to patients, medical autonomy is automatically restored. With the ability to decide spending, patients can once again make their own medical decisions.

FIDUCIARY ONCE MORE

When the cancer of government healthcare is excised, and decision-making is returned to patients, patient-controlled health care restores the cancer-severed fiduciary relationship. Without a third party in between them, the patient and his or her chosen physician can re-establish "microeconomic, fiduciary connection." [81]

There is often a good reason why a physician's charges may seem excessive for a 30- or 45-minute in-person visit. Before recommending a new drug or advising a new procedure, physicians will study data on others' experience, particularly safety and efficacy, before using or doing something not yet well established. Who pays for time spent *on* but not *with* the patient? The person who benefits, i.e., the patient, should pay.

One lesson obvious from the CoViD experience is that real docs, practicing clinical physicians, cannot indeed must not accept government practice mandates, viz., mRNA injections, simply because some government official or federal agency pronounces it, "safe, effective, and doctor approved," which the mRNA shots most certainly were *not*! [37, 43-47]

Conclusion

Patient-controlled health care will have impacts on everyone. Most of its effects are salutary. Some will be painful.

The general population will experience affordable, timely, quality, and compassionate medical care. Medically vulnerable populations will receive similar care because states will create effective safety nets using free market forces.

The public, who are all patients in the sense they all need periodic care, will also have more money in their pockets, money they, not third parties, control. Most valuable of all, patients will regain medical autonomy, their freedom.

The impacts on providers of care will be equally salutary but initially, they may not believe so. Competing in a true free market will be a great culture shock to institutions, facilities, and especially to physicians. Initially, doctors are likely to resist or refuse. They are not used to marketing themselves and competing with other physicians. Those who embrace competition, who can demonstrate good outcomes in ways understandable to the public, and who can keep prices low, will be successful financially. Oklahoma Center for Surgery [82] and numerous direct-pay (concierge) practices prove that doctors can practice good medicine and do well financially in a competitive environment.

Furthermore, freed from the cancer's regulatory burden and insurance administrative hassle, care providers will be immensely more satisfied in their practices. Without exception, direct-pay (free market) physicians say they are happier, have more time with the patients, and know them as people not numbers. They can again be true fiduciaries, not government-employed, cancer-controlled drudges.

Physicians and nurses work primarily for the psychic reward, what Maslow called the highest of human needs, self-actualization. [83] Reconnecting patient and doctor *directly* (no third party in between) with physician as fiduciary re-establishes the doctor's psychic reward for healing the patient.

An unintended but likely benefit from resumption of fiduciary relationship is restoration of trust in medical professionals, which was destroyed by government's handling of CoViD. Evidence is now incontrovertible that government healthcare authorities in the U.S., Canada, United Kingdom, and Australia plus others distorted scientific data, censored studies that refuted federal CoViD response plans, repeatedly lied to the public, and accepted "royalties" from pharmaceutical companies while forcing populations to accept an experimental, ineffective, and medically harmful therapy, mRNA injections. [37, 41, 43, 44, 46, 47, 59, 60, 84-91]

The public has lost all faith in federal medical agencies and their spokespersons to release objective, medically reliable truth. [92-94] They repeatedly duped us for political and financial gain during CoViD. For similar reasons, clinical physicians know *not* to trust or depend on official releases from the CDC, FDA, NIH, or CMS.

Individual doctors need to gather all the facts, even (especially) contradictory reports, analyze the data themselves, and base their recommendations to patients on their best judgment. Doing this will strengthen the fiduciary bond and regain patients' trust, not in bureaucrats with MDs but in their chosen personal healers.

Another likely benefit of patient-controlled health care is easing the physician shortage. With restoration of fiduciary connection and the psychic reward; with elimination of cancer's obstacles to practicing medicine; and with higher pay for physicians, fewer are likely to take early retirement. More young people are likely to choose a career in health care.

The impact on taxpayers can be dramatic. Implementation of patient-controlled health care will drastically reduce federal spending on BARRCOME and should translate into reduced federal tax burden for all. Voters should make sure this happens.

Patient-controlled health care eliminates most of Washington's BARRCOME. This means that millions of federal and state BARRCOME workers will lose their jobs. While this is unfortunate for them, taxpayers will be relieved as they are no longer forced to fund – through their taxes – $2 trillion of healthcare spending that provides no value, no care, for them.

As contributions to Family HSAs will be tax credits, there will be a small reduction in federal tax revenue. This will be more than offset in reduced federal spending.

At present, Medicaid programs are jointly funded by federal and state governments. [95] By repealing Medicaid, federal payments to the states will cease as will the costs of complying with federal BARRCOME. State taxes to Washington should be reduced by what was paid in to their Medicaid programs. As noted previously, state-designed medical safety nets can be both better and cheaper

than complying with federal Medicaid standards and requirements.

The impact on sellers of health insurance is hard to predict other than industry profitably is likely to decrease. By repealing insurance regulations, the government can no longer dictate what insurance companies must sell and what people are allowed to buy. With patient-controlled health care, millions of consumers, not the cancer, decide what they will buy and what they won't. Most individuals will want some form of insurance. Insurance companies that can offer policies the public wants will do very well. The most popular could be a very high deductible policy, viz., $10,000, that pays the provider's full charges. The company that can offer such a policy at a price buyers find attractive could well be profitable.

There is one final, intangible but infinitely valuable benefit of patient-controlled health care from which all will benefit. Freedom is restored. In the end, what people want even more than timely, quality health care is freedom, the right to choose. With it, as Eleanor Roosevelt reminded us, "comes responsibility."

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