A Student-Led Liberty and

Economics Journ Student

Mission

Quaestus is a student-led journal presenting ideas about Liberty, Faith and Economics, from a Christian perspective, to promote human flourishing.

Vision

Our vision is to inspire the next generation of Christian thought leaders by addressing global issues with sound economic and moral principles.

"And God blessed them, saying, 'be fruitful and multiply, fill the earth and subdue it; have dominion over the fish of the sea, over the birds of the air, and over every living thing that moves on earth'."

Genesis 1:22

Editorial Board

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The theme we ve been as-

ing considered the strength of the argument put forwards by your interlocutor with a willingness to be persuade if the truth is on the other side. Civility begins with a genuine recognition of our own fallibility. In practice we tend to treat ourselves as infallible. When it comes to our deepest, most cherished identity forming beliefs, it s emotionally difficult to allow yourself to be challenged in a way that you are open to the possibility of being wrong. But it seems to me that s what we have to do if we re to have genuine civility. The underlying problem here is that we human beings tend to wrap our emotions tightly around our convictions. That s in itself not bad. If we were not emotionally committed to our beliefs, we wouldn t effectively act on them. The problem comes when we wrap our emotions so tightly around our convictions that we become dogmatists. When we wrap our emotions that tightly around our convictions and become dogmatic, we re not open to learning.

So civil conversation requires virtues like intellectual humility. I ll conclude in answering this question by saying that even if critical theorists are committed to their ideology which is incompatible with free speech, those of us that are not must nevertheless recognize their free speech and their right to make their case even as we resolutely oppose it.

You mentioned in your opening remarks that you think religious leaders need to do more in terms of prospering civility. Could you elaborate on what you mean by that?

I ll give you a very good example: Rabbi Jonathan Sacks is a religious leader of a very small community in England. But he has set such a good example of civility, of learning and teaching by getting together and laying aside points of difference to see how we can cooperate together. He doesn t pretend that the things that make us different don t matter. He s a committed Jew. He draws on the resources of his tradition to go outward and engage with others and I think set a very good example. I d like to see more of that amongst our religious leaders.

: Why do you think there are religious leaders who don t seem to be stepping into the role of modeling this type of behavior as much as you or I would like?

: One problem that I find in religious leaders generally is fear. Often if they are to be authentic witnesses for their faith, they will have to speak on issues where their faith differs from the established religions of the culture. The prospect of speaking out especially when it comes to those issues, is scary. It s hard to stand up and take the heat, especially from those who have cultural power. Religious leaders have very little cultural power. But Hollywood s got plenty of it. Journalism s got plenty of it. Corporate America has a ton of it. Academia s got it s share of it. For my own tradition of faith, for Catholics, the scandals in the priesthood have damaged the moral capital of the church. Those scandals weaken the witness. The saddest thing to me is that just at this moment of cultural crisis when the moral witness of the catholic church is needed the most, the Catholic church is off the battlefield due to self inflicted wounds.

: Where do you see signs of hope for a recovery of genuine civility in the United States?

: I am hugely impressed with young conservative intellectuals. These are extraordinary young men and women who have genuinely open minds. They ve got commitments, they ve got convictions, but they re genuine independent thinkers who are profoundly learned, committed to civility, truth seeking, maintenance of republican order. But they ve also got one thing above all that gives me hope: courage. They stand up and speak out and they don t fear the slings and arrows that will come.

: Where are the limits to civility? When do we say, OK now a person have moved beyond the pale? and a different type of response is required?

: I don t have any limits. I think that the proper currency of intellectual discourse consists of reasons, evidence, and arguments. I am

The Catastrophic Care Approach to Healthcare Delivery

Transcribed from a lecture given at Concordia University by David Goldhill, Author of Catastrophic Care

The problems I ve been looking at in healthcare are in great part, frankly, intellectual. Which is, we have this view of healthcare that it is fundamentally different than everything else, and in some ways that s right. Healthcare is one of the small handful of services for which we have a direct safety net. It s something where intervention in markets has been assumed to be the correct policy for a very, very long time. It is something with [certain] unique characteristics obviously. There s not much you can do being a customer when you re unconscious and you have something that s a genuine emergency. Many people are born with things that will assure that their entire lives are unhealthy lives. Societies have tried to address that in a variety of ways. But one of the things that s most interesting to me is that the debates about healthcare fundamentally have not changed since the mid twentieth century. That s fascinating if you think about it, because everything else has.

We had a debate about how healthcare should be properly financed and governed and managed at a time when most care was episodic, when most of the expensive care was major and unanticipated. And one could argue that the systems we set up all around the developed world, fundamentally insurance-based, reactive, and with central authorities acting not just as financiers of care, but essentially as the customer of care, might have made sense in those d e. It is somethi tmed k Ñust Ī ! thi th century. Tth

healthcare, and I think it says more about the field of health economics than [it does] about healthcare itself, do people still refer to something that people wrote pre-internet, as if it is the final word on the relationship between sellers and buyers. And again if you live in the world of health economists, nobody says what I just said, which is things change. But things really change. Let s look at the conventional wisdom in healthcare. One is, without insurance very few people can afford care. It s almost impossible to afford.

Who do we think is paying for that insurance? When Ezekiel Emmanuel wrote his book about the Affordable Care Act, he started as every single healthcare writer does, with a story. And his story was about a single mom in her early forties, who develops breast cancer, and thank God she has insurance because the cost of her treatment was seventy-five thousand dollars. Well, Zeke s a responsible academic so of course he s got footnotes, and if you go to the footnotes what you find is that this woman was paying fifteen thousand dollars a year for health insurance, with a five-thousand-dollar deductible. Which basically means every five years she pays for the cost of breast cancer treatment. Now try to imagine if you own a home, if your homeowner s insurance policy was priced in such a way so that every five years you paid for the price of the house, that s not insurance. And again, this is somebody who desperately needed insurance at the time. And the mistake in that, and it s a very common mistake, was that all that matters is what happens at the point of purchase. The fact that this woman is going to shell out a hundred fifty thousand dollars out of pocket over ten years so that she gets reimbursed seventy-five thousand dollars once, in any other industry would obviously be bad math and bad consumer math. It s not in healthcare. I m going to come back to that.

Another part of the conventional wisdom is that technology pushes up the cost for care, and I like to joke that that line is written on an eight-hundred-dollar laptop. You know if you look at healthcare in 1965 when Medicare was passed, the average cost of healthcare... per American was somewhere around two-hundred and fifty bucks

In 1965 the very first commercial minicomputer was sold by a company called Digital Equipment Corp., DEC, and the price of the very first minicomputer was eighteen thousand dollars. So in 1965 the lowest level information technology was roughly eighty times the annual cost of healthcare.

So fast-forward fifty-five years later, and I think we all know where we are, which is that phone that you re all on is somewhere between three hundred dollars and a thousand dollars. And the average spending on healthcare is something closer to twelve thousand dollars. And to argue that it is technology that has pushed up the cost of care, sometimes I think is intended to be irony, but it s not. One of the key arguments that Arrow made and a key part of the conventional wisdom, is that patients can t possibly have enough knowledge to be medical consumers. What s interesting about that is again that pre-internet understanding. Any doctor will tell you that the average patient shows up with the diagnosis that they ve come up with online, and a variety of treatments. And for most doctors that s annoying because the patient s often wrong, but it doesn t matter. It s completely changed. And what s more important, even if you get away from patients [trying to be] their own doctors and trying to tell doctors how to be doctors, [is] the nature of care has changed. We went from a sort of auto-mechanic idea of change—you had a heart attack we need to fix you—to chronic care. Even for cancer now, almost invariably a patient has to make a choice as to the type of treatment, and a doctor is an advisor as to alternatives. That is not in the traditional model of care. If patients are required to make these kinds of decisions—and they are—then how is it we don t have a healthcare economy which is designed to assure greater patient understanding? How do we have [at] the foundation of the economy [the idea] that patients don t have enough knowledge, when] the reality of care in the 21st century [is] patients needing to make decisions?

The conventional wisdom argues that only big intermediaries have enough expertise, enough market power, to drive prices, quality, and appropriateness. And I understand having that point of view when Arrow wrote in the early sixties. I don t understand retaining it today. We have sixty years of experience in which we ve seen the very different ways in which

The conventional wisdom argues that only big intermediaries have enough expertise, enough market power, to drive prices, quality, and appropriateness. And I understand having that point of view when Arrow wrote in the early sixties. I don t understand retaining it today. We have sixty years of experience in which we ve seen the very different ways in which CMS, state Medicaid organizations, and private insurers do the opposite, do a very poor job of driving prices and value, do a horrific job of driving appropriateness, and of course, as far as quality and safety goes we still have somewhere between 175,000 and 250,000 deaths a year from medical errors. And by errors we don t mean incorrect diagnoses or incorrect treatments, we mean literally mistakes. I don t think one can fairly argue that quality has been well-driven in this system.

And then there are the classic things that people say against consumer healthcare, which is that when you have a heart attack, you can t shop around. That s true but so what. When you have a tire blow out on a highway you can t shop around, but it doesn t mean that when the tow truck comes you can ask for your net worth statement. We have markets not because they work in every circumstance, but because they work in many circumstances. And what I talk about the intellectual trap that we re in in healthcare, it s this either-or assumption. It s that because markets can t work in every situation, they can t work in many. The reality is that the way healthcare has changed, becoming much, much more integrated in the day-to-day life of many people, mostly about chronic conditions requiring patient decision-making. We must have market mechanisms in order to have the type of... care that is going to work in the 21st century. What we re really arguing about is a state of healthcare that existed in the mid 20th century, not where we re likely to go in the 21st century. And so as a result I do argue that most of the systems are designed to fail, because as care needs and technology become ever more targeted, ever more individual, ever more long-term, systems that are based on financing as if it s a car wreck are designed to fail not just here.

Why should you care? Well, we talk a lot about cost in healthcare, but I think we talk about it in very abstract terms. When I first started looking at healthcare—the first thing I did— I] was running a 500-person entertainment business in the U.S. And I looked at what somebody starting with us would contribute to the healthcare system over her lifetime. Now I should warn you, these numbers I first calculated in 2009, so they re out of date. But at the time if you looked at a young woman starting work at say $30,000 a year, and having the sort of normal three-percent growth in her income every year, and having a normal life, getting married at 30, having a couple kids, retiring at 65, going on Medicare. I actually [had] her divorcing at 65 because it made the math easier. But what was interesting is when you added up everything we took out of this woman s paycheck and everything she spent on healthcare, just how large that number is.

So what I did is I said, let s look at insurance premiums, our share [and] her share, because our share of costs is just our cost of employing her, it just affects the wages we pay her. But everything, what percent of her federal taxes funds healthcare, her Part A tax, her deductibles and out-of-pocket, the Medicare premiums she ll pay, the very large percent of her state income taxes that fund Medicaid. What I discovered is, assuming a zero-percent increase in the cost of healthcare over her lifetime, this working woman would put 1.2 million dollars into the healthcare system over her life. And I want to pause on that for a second because these are big abstract numbers, but of course this makes sense. If we re spending ten thousand dollars a person per year on healthcare, who do we think is ultimately paying for it? Where do we think it s coming from? And if only two-thirds of the population at any one time contributes, they re going to put in way more than their share. What s interesting is when you ask people how much they worry about spending on healthcare over their life, they worry that they re going to run up the bills to a hundred thousand, a hundred fifty thousand, two hundred thousand. If you [then] said to them do you understand that you ll put into the system five or six times that over your life? I suspect we would no longer have this system.

Why is it so expensive? Well I think a major part of this, which we don t really appreciate is that intermediaries massively increase the cost of care. The theory—and this is another one of those theories [that] I think is way out of date—is that they have market power, so they should be able to drive down that gap.

citizens don t starve is the same issue as how we regu-

other than the exact same structure we have today.

I got frustrated after a decade of writing about

skip the gym for the night, the one hotel with a great gym is too expensive. And that s what was really interesting about price transparency in other industries. If you were in a competitive marketplace, you were likely to see real price competition persist but without competition you just created floors. And my fear in healthcare is that without creating genuine competition for the consumer dollar, all price transparency will do is create floors. When I had my second child, I was uninsured. I walked into a hospital; I negotiated a deal. In a price transparent noncompetitive world, I m not sure that deal is available. A lot of what we do on Sesame is those deals. It s a hospital chain that is losing out to the big merge chain that dominates its market, that s willing to try something innovative. It s a doctor who just so happened to have a cancellation the next hour that she wants to fill. But it s also innovation. When we launch Sesame one of the very first things that happened is a pediatrician in our beta market of Kansas City started listing late night hours at a two-times premium to her daytime hours. Now you might think to yourself, I just said that this would drive prices down, here s someone charging a premium, but for those of us who have been parents, we know that with a newborn something happens at ten o clock at night, your choice is the emergency room. And at two times, that pediatrician is about an 80% discount from the emergency room. More importantly, there is no way for that pediatrician to sell a premium [service] in the reimbursement market. Why? Because from an insurance perspective from CMS perspective, 10 at night and 10 in the morning is the same use of resources; they should be reimbursed the same. There s no one selling the pre-diabetes package, etc.... except in the

healthcare economy we can do that in, the more confidence we as a society will have carving insurance back to where it is genuinely pulling risk and providing value, and not just adding massive costs to every single episode of healthcare we need. And when we can do that, when we can see that that s a possibility, we can start to build a healthcare system that really

ning elections today is not accomplished by persuading voters from the other side, but rather by feeding the flames of outrage to energize the existing base. Whichever side loses often turns to an even more ex-

References:

Bail, C. A., Argyle, L. P., Brown, T. W., Bumpus, J. P., Chen H., Hunzaker, M. B. F., Lee, J., Mann, M., Merhout, F., & Volfovsky, A. (2018). Exposure to opposing views on social media can increase poli

> or more rationing of care—two equally undesirable results (Teisberg et. al. 1994)

Unfortunately, this competition has been enormously successful at producing quality-enhancing innovation but has failed to reduce the needed cost (Teisberg et. al. 1994). Prices still remain high and the technology has remained just as expensive if not more so.

Another essential condition of a properly functioning free market competition is that there is adequate competition among businesses (Brill 2015). This rarely exists in today s consolidated hospital and insurance markets. Consolidation appears to be accelerating as health care looks to achieve greater scale to address a dizzying array of market and government pressures (Wirtz 2015). Prices are often the result of market power with minimal input from consumers. Successful reform must begin with a clear understanding of how the current system creates incentives for unproductive competition (Teisberg et. al. 1994).

Government controls, and the influential stakeholders, largely disagree on both desired priorities and the impact of various healthcare policies. In fact, an extremely broad range of regulatory bodies and programs can effect various aspects of the healthcare industry. For example, health care regulations can be developed and enforced by all levels of government including; federal, state, local, while also including private organizations. Each with their own influence and direction, with no real coordination or communication with one another.

> Federal, State, and local regulatory agencies often establish rules and regulations for the health care industry Some other agencies require voluntary participation but are still important because they provide rankings or certification of quality and serve as additional oversight, ensuring that health care organizations promote and provide quality care (Grimm 2014).

On November 15, 2019 the U.S. Federal Government issued two new rules focused on; Price transparency for hospitals along with providing a full listing of

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rising premiums and the increasing burden of out-of-pocket costs because there are many other promising approaches available. Consumers should not have to bear the brunt of poorly functioning healthcare markets that don t deliver value.

By. Senior Editor Dr. Anthony Binford Glavey
April 27, 2021

Acknowledgements: Dr. Ramarao Yeleti & Dr. Angus Menuge interviews
Interview with Dr. Menuge by Dr. Daniel Sem

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Another alarming figure is the case mortality analyses (2021) of COVID-19 in the US is 1.8%. That is 552,072 dead from the 30,460,342 cases. Certainly not one of the highest ratios like Mexico that is over 9% but the numbers are still very scary as you can see from the two below ***Tables (1 & 2) : Observed Case-fatality ratio & Deaths per 100,000 Population (Mortality Analysis 2021).***

Tables 1&2: Mortality: Observed case-fatality ratio 4/1/2021 – (Mortality analyses 2021) & Table 2: Mortality: Deaths per 100,000 population 4/1/2021 – (Mortality analyses 2021)

But what about the common flu? That seems to be the question we keep hearing over and over from politicians and even Chuck above. The Second (2020) article title, *The US Death Rate From The Coronavirus Is 52 Times Higher Than The Flu*, provides the fact-based conclusion. To answer the question for Chuck even more clearly, the below ***Table 3: Flu vs. COVID-19 death rate by age (Secon, 2020)*** provides a breakdown by age. The common flu still kills but the percentages are dramatically different from COVID-19, with much higher mortality for older populations that at COVID-19 relative to the common flu.

Table 3: Flu vs. COVID-19 death rate by age (Secon, 2020)

Dr. Yeleti (2021) commented that another way to look at it is by understanding how we prevent the common flu; social distancing, hand washing, and staying home. These are the same preventions that are used for preventing the spread of COVID-19. A great example Dr. Yeleti discussed was on another hospital-acquired infection called Clostridium difficile (C. Diff). Dr. Yeleti noted that this infection has seen a dramatic dip simply because staff are washing their hands and using personal protection equipment between patients. In other words, the precautions that we are taking for COVID-19 are making dramatic impacts in other areas.

Dr. Menuge (2021) stated that it is reasonable to believe there were likely false positives for COVID-

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> Less than two-thirds of that surge has been attributed directly to Covid-19. Public-health experts believe that many of the additional deaths were directly linked to the disease, particularly early in the pandemic when testing was sparse. Some of those excess deaths came from indirect fallout, from health-care disruptions, people avoiding the hospital and other issues (Overberg et al.)

The COVID-19 virus caused approximately 375,000 deaths and was the third leading cause of death in 2020, after heart disease and cancer. COVID-19 deaths in the U.S. now top 550,000 since the start of the pandemic (Johnson 2021).

Dr. Yeleti (2021) gave an example of a patient that had lung cancer that is in a hospital yet dies from a heart attack. Is the cause of death cancer or heart attack? The attending physician is required to list how the patient dies as the most "immediate" or "recent" event that leads to death is listed. The other conditions are then listed sequentially. The last and most remote condition leading to death is listed as the underlying cause of death as seen in (Table 4) below instructions for the cause of death from the National Vital Statistics Reports (2021).

Table 4: National Vital Statistics Reports (2021) – utilized from the CDC

The reality is the numbers we are seeing from COVID -

> states already open and lifting mask mandates, to health experts warning the virus will always linger (Flaherty & Haslett 2021).

The answer falls somewhere in the middle. Many infectious disease experts agree at least 70-85% of the country needs to become immune to starve the virus (Flaherty & Haslett 2021).

Dr. Yeleti (2021) explained that the question really is about short-term gain over long-term pain. Dr. Yeleti also stressed that somewhere between 10-35% of COVID-19 patients are having severe long-term complications. These are 20 to 40-year old s. The question to Loretta and others is this: do you mind having short**-**term restrictions versus having long**-**term complications that are very serious and potentially life long? Dr. Yeleti further commented that in his opinion once you get both vaccines you should have no major issues getting back to a more normal life, and that is just around the corner.

development psychologists and the clear recommendation of the American Academy of Pediatrics, which strongly advocates that all policy considerations for school COVID-19 plans should start with a goal of having students physically present in school [https://services.aap.org/en/pages/2019-novel-coronavirus-covid-19-infections/clinical-guidance/covid-19-planning-considerations-return-to-in-person-education-in-schools/].

Jennifer (38) ***Masks don t work***

Many articles, including peer-reviewed science, has shown that masks work, but, the issue of requiring masks remains contentious. McKelvey (2020) in her article *Coronavirus: Why are Americans so angry about masks?* really said it best.

> In the midst of the pandemic, a small piece of cloth has incited a nationwide feud about public health, civil liberties, and personal freedom. Some Americans refuse to wear a facial covering out of principle. Others in this country are enraged by the way that people flout the mask mandates (McKelvey 2020).

Many Americans act like their civil liberties are being violated. As stated by McKelvey (2020), the wearing of a mask has been more about political conflict than science.

> The dispute over masks embodies the political dynamics of the campaign. It also reflects a classic American struggle between those who defend public safety and those who believe just as deeply in personal liberty (McKelvey 2020).

As Fox (2020) described the limitations on movement, commerce, and fashion (referring to mask mandates) have been utilized to fight Covid-19,

> have been decried in some quarters as unprecedented and unconstitutional affronts to liberty there s nothing unprecedented about restricting freedom in the name of fighting infectious disease. There s nothing unconstitutional either (Fox 2020).

Dr. Yeleti (2021) remarked that one of the big issues that he saw about masks was that in the beginning he and his staff simply did not have enough. They were recycling and doing what they could but many of the front line were getting sick. Once that issue was resolvethap" φ l M þ as re-

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2019-2020 U.S. Flu Season: Preliminary In-Season Burden Estimates

Overberg, P., Kamp, J., Michaels, D., & Huth, L. (2021, January 14). The COVID-19 death toll is even worse than it looks. Retrieved from https://www.wsj.com/articles/the-covid-19-death-toll-is-even-worse-than-it-looks-11610636840

Press release WHO - https://www.who.int/news/item/30-03-2021-who-ca, ŭ ɣ a, - e

Throughout all of history empires have risen and fallen. Some have gained great success with their citizens, others have expanded to the edge of the world. No matter what form of government one uses,

A society s freedom is one of the most important things it can have. Civil discourse and rights of conscience in particular, contribute a tremendous amount to the culture of humanity. They benefit both society as a whole and the individuals who live under it. For all these reasons, civil discourse and the right of conscience are extremely important to a free and virtuous society.

Shahram Jafarzade, (2012). Importance of freedom in humanities developing. Retrieved from https://www.sciencedirect.com/science/article/pii/S1877042811029910

Wencong Fa, (2019). Remembering why free speech is important. Retrieved from https://pacificlegal.org/remembering-why-free-speech-is-important/\

Benjamin Franklin, (July 1722). Silence Dogood No. 8,9. Retrieved from https://founders.archives.gov/documents/Franklin/01-01-02-0015

When I thank God for all that He s given to me lately, I can t help but let out a bit of a sigh when I arrive at my unfettered access to the Internet. Please do not be mistaken; I think it is a wonderful tool for gathering knowledge, staying in touch with people around the globe, and talking intelligently about how to better the world around us. Yet in spite of this amazing potential for good, I see far too often how instead it is used as a weapon, tearing down people, families, and even entire organizations in this phe-

ask why, the desire to search and be human, and the ability to flourish with one another. After all, even if the state found a way to dictate conversation by silencing some voices and glorifying others, this manufactured conversation cannot be virtuous, and the free, flourishing society will have been hopelessly lost.

Though these consequences are dire, the power of civil discourse is still greater, for its regular use calls attention to that which is the key to preventing this world of imprisoned thought: a greater appreciation for the intrinsic value of individual ideas. We are all unique from the inside out, down to the genetic coding in our smallest cells and up to the ideas in our minds; this fact cannot be disputed. Why then, are many of us so quick to assume we are so learned, justified, or otherwise charged to think that we have nothing to learn from those outside of our own head? Instead of allowing this pride to seep into our minds and conversations, we should hold our distinct, God-given gifts of reason and empathy to the highest degree. Thus, extensive care and respect for unique and unrestricted thinking must fuel the heart of the free and virtuous society. In this environment, great thinkers wring out each idea for its juiciest, most valuable qualities and distill them down into their most concentrated forms of usable knowledge. With these informed discoveries, we must move beyond the tribal divides of cancel culture and preserve the pursuit of virtue. After all, The key to reconstructing civility, I shall argue, is for all of us to learn anew the virtue of acting with love towards our neighbors (p. 18) as Stephen Carter (1999) has remarked. At the end of the day, the back-and-forth banter between people whose respect runs much deeper than labels or appearances will bear delicious fruit. We just need to give it the chance and time to work wonders in our lives.

Carter, S. L. (1999). Civility: manners, morals, and the etiquette of democracy. Harper Perennial.

George, R. P. (2016). Conscience and its enemies: Confronting the dogmas of liberal secularism. Ignatius.

Operating under the guise of the free market, current United States medical practice proves replete with convoluted insurance, governmental regulations, and administrative restrictions. Gone are the Norman Rockwell days of small private healthcare practices, in which doctors knew their patients cases intimately and made frequent patient-home visits. Massive healthcare conglomerates, hurried along by benevolent yet error-prone interventionism, comprise the vast backdrop of current medical practice. Yet in the middle of this brave new world of modern medicine, the Dickensian voice questions, could free markets produce a tangibly better outcome? Could rivalrous competition result in the delivery of more affordable healthcare? Politicians and health policy specialists alike attest that a system as staggeringly complex as modern healthcare demands an equally complex, expert-driven solution; however, only the free market—with certain fundamental assumptions about human nature—offers the tools by which society can m q rs ḏ ʿ κ ô

rather a discovery process with a non-linear trajectory; it speeds along by individuals unhindered, un-coerced pursuit of what Adam Smith would call self-interest. Instead of optimization, the fundamental issue becomes one of knowledge, specifically re-

Hayek, F. A. (1973). Chapter 2: Cosmos and Taxis. (pp. 35-54). *Law, Legislation, and Liberty*. (Vol. 1: Rules and Order). The University of Chicago Press.

Hayek, F. A. (1945). The Use of Knowledge in Society. *The American Economic Review, 35*(4), 519-530. https://www.jstor.org/stable/1809376?seq=1

Mises, L. V. (1996). *Human Action: A Treatise on Economics* (4th ed.). Mises Institute. https://mises.org/library/human-action-0/html

Smith, A. (1852). Book IV Chapter II: Of Restraints upon the Importation from Foreign Countries, of such Goods as can be produced at Home. *An Inquiry into the Nature and Causes of the Wealth of Nations.* (pp. 183-191). Project Gutenberg. https://www.gutenberg.org/files/38194/38194-h/38194-h.htm

Although it is the position of both this periodical and our nation s constitution that uninhibited speech be held sacrosanct, the issue of free discourse becomes more complex within a private institution. Recently, for instance, at Concordia University Wisconsin some students have begun expressing caution that the University may be becoming too willing to support non-Lutheran ideas. Thus, the specific question is this: How ought non-Lutheran ideas, ideas that may even be antithetical to the Lutheran ideology, be treated in a university system which proclaims itself to be distinctly Lutheran? Furthermore, how does freedom of speech and discourse apply to students who may hold these antithetical beliefs while attending said university? Finally, how ought a Lutheran university relate to its Lutheran students? The purpose of this editorial is to allow a more concise and beneficial conversation regarding these questions, for the furthering of civil discourse in our universities.

To begin, it is necessary to outline the central affiliation of the Concordia System, and most specifically, Concordia University Wisconsin, where these issues seem to have become a focal point. CUW is a *Lutheran* institution. It is a part of a system which is governed by the Lutheran Church—Missouri Synod. Its move to its current campus was approved by the LCMS, funded by the LCMS, and its transition to a four-year college was allowed by the LCMS. The President and all senior administration must be LCMS members in good standing, and the same is required for members of the board of regents. All of this is reflected in CUW s mission statement to be a Lutheran higher education community committed to helping students develop in mind, body, and spirit for service to Christ in the Church and in the world. And on its website CUW advertises its very reason for existence to be as a place of Lutheran Christian higher education. All of the Schools, programs and initiatives of the University are guided by shared fidelity to this central purpose.

Thus, CUW has a strong, evident, and self-advertised Lutheran identity which it is obligated to uphold, acting as a primary facility for training future LCMS pastors, church workers, and theologians. This is for the dual purpose that it exists due to LCMS influence and because this Lutheran identity is a primary reason why many students attend the university to begin with. To refrain from promoting the Lutheran values which it proclaims to hold dear would be both dishonesty as an institution and a betrayal of the students who attend for those values, which are specifically the teachings of the LCMS.

A second unequivocal fact of CUW is that it is a *university*. Although coupled with the idea of Lutheran identity, CUW does promise rigorous and diverse academic programs, with the goal of campuses, facilities, human and financial resources, and infrastructure which support a robust student experience in a welcoming environment that results in the professional, social, academic and spiritual formation of all. While faith is a central focus of CUW, academic prowess is as well. Thus, CUW as an institution, its teachers and its administration, all have a responsibility to ensure the proper academic education of those students attending. To fail in this duty would also be to betray a promise which CUW makes to all students who attend.

Concordia has two identities, one as a Lutheran institution and one as a university, and each of these identities denote obligations that must simultaneously be maintained, although they may sometimes be in conflict. For instance, the LCMS takes a strong stance upon supernatural creation as the origin of the universe, but modern biological theory orients towards a purely naturalistic evolutionary origin. With respect to its Lutheran identity, CUW has an obligation to support the biblical account of creation. However, regarding its identity as a university, CUW also has an obligation to ensure that its students are m

(LCMS bylaw 3.10.6.7.2). Thus it seems that, at least in this circumstance and circumstances like it, Concordia does have an obligation to allow ideas which are antithetical to Lutheranism to be expressed for the sake of promoting Christian education. In other words, teaching a belief is intrinsic to teaching how it is false.

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