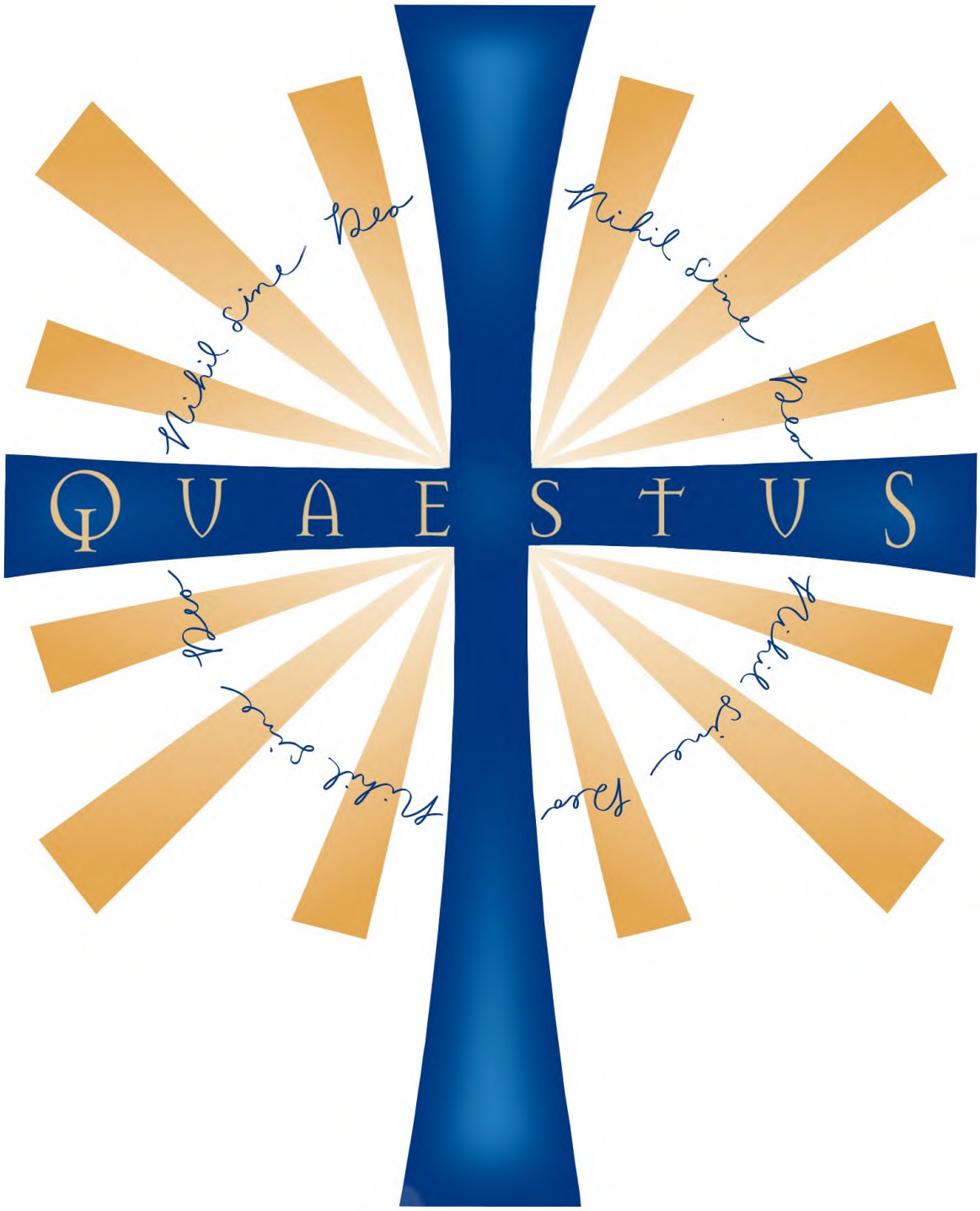
2021 Volume II



A Student-Led Liberty and Economics Journal

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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

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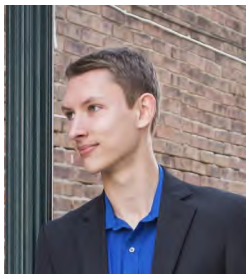

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Civil Discourse and Rights of Conscience

Transcribed from a lecture given at Concordia University Wisconsin by Dr. Robert George, professor at Princeton University, with questions fielded by Dr. Sam Greg, research director at the Acton Institute.

Robert George: The theme we've been assigned is freedom of speech and thought and their necessity for truth seeking. We don't want to think that freedom of speech or other basic civil liberties simply fall down out of the heavens. We don't think that they are implications of pure logical propositions. They are to be affirmed as true because they protect a central goods. There is no way that the truth can be honestly and fruitfully sought without freedom of thought and freedom of expression and freedom of discussion. That's why it's essential that we honor and respect freedom of thought, freedom of speech, freedom of discussion, freedom of inquiry. There are many truths we don't know. And truths that we know are to be explored more deeply. Freedom is required to engage our students in ways that will make them truth. That doesn't presuppose relativism, moral or otherwise. In fact, it's incompatible with it. It's not because there is no truth to be attained that we need to honor freedom of thought and speech. It's precisely because the truth is so important that we must honor those things. The same considerations apply when we consider republican democracy and self-government. Government, as Lincoln said, "of the people" which of course all government is, "for the people," which all good government is even if it's the government of a benign despot, but government also "by the people" that is, republican government. That same unsettling process by which we challenge, for the sake of truth, also needs to be in place and its conditions need to be in place if we are to conduct good government. We cannot make good decisions if we are not free to poke and prod and question and challenge in radical ways. If we do not as a republic make good decisions, then we will not succeed as a republic. It goes without saying that today, these conditions of truth seeking and of republican government are precarious. They're under assault from various sides and perspectives. We see it in the universities and the cancel culture. We see it in the streets. We see it in the unwillingness of people who have power, political economic, cultural, to stay their hands, to permit dissent, to permit challenges. If that continues to be the case, then the loss of civic friendship will continue. This is another thing that cannot be lost if we are to sustain republican government. Government by the people requires that the people treat each other as fellow citizens and civic friends, not as enemies. Yet we look around ourselves today and we see people regarding each other and treating each other not as fellow citizens with whom we disagree, but as people who are to be destroyed because they are impossible to maintain civil friendship with. Good examples need to be set by people of standing and influence across the culture, not just the politicians, but also in business, in law, in the health professions. Religious leaders could certainly do more than they are doing. We need people who will exemplify the virtues that are necessary to sustain the truth seeking process. And with that, Sam, I am delighted to hand it over to you.

Sam Greg: The first thing I'd like to ask you, concerns the whole way in which civility is perceived by so many significant segments of American opinion. Many people will say that since all language is a type of imposition of power, rules of civility simply restrains the weak. Therefore, the argument goes, those who are oppressed should effectively reject civility and embrace a type of activism that encapsulates what they often call absolute moral clarity. You find this type of language used in groups ranging from philosophers like Herbert Marcuse to the Black Lives Matter movement. So how would you respond to that type of critique?

Robert George: I want to address the very question of what civility is. Civility is not merely politeness. Civility is not reducible to the idea that I will sit there quietly and not talk while you talk, and you sit there quietly and not talk when I talk. But that's not civility. You're only engaged in a civil discussion and civil discourse when you engage on the basis of having 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

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.

Sam Greg: 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?

Robert George: 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.

Sam Greg: 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?

Robert George: 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.

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

Robert George: 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.

Sam Greg: 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?

Robert George: I don't have any limits. I think that the proper currency of intellectual discourse consists of reasons, evidence, and arguments. I am prepared to engage anybody putting forward any point of view, including points of view that I believe are appalling, who's prepared to defend that perspective in the proper currency. I don't think that I have to argue with a lunatic or someone who has not given the issue

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I have publicly defended my colleague at Princeton, Peter Singer's right to advocate infanticide or even sex between humans and animals. I don't share his views of those things. And yet, because Peter does business in the currency of intellectual discourse, he challenges me, he allows me to challenge him. Every few years disability rights groups protest Peter's being here because of his views about infanticide of cognitively disabled children. And I defend him. I'm not defending his views; I'm defending his rights. The proper understanding of rights is not as abstract rights but as goods. So what good is Peter Singer doing by advocating horrible things? In making his defense of infanticide, he challenges me to think more deeply and more clearly about what grounds we have for honoring equally the dignity of all human beings.

We have this in common. I cannot say for all the wickedness of his views, that Peter's not a truth seeker. I think he's got it all wrong, but he's trying to get at the truth. The evidence I have for that is his willingness to engage me and listen to me. If he wasn't a truth seeker, he wouldn't have to do that. And that's why I'm willing to let him challenge me. My answer to the question is I think we should be Socratic. Socrates wouldn't put anything out of bounds.

Sam Greg: In the end, the fundamental foundation for taking civility seriously, even with people that you would radically disagree about any number of questions, it's the good of truth and reason itself that's at stake.

Robert George: Even if what you believe is true, by engaging an intelligent critic, that process will result in your more deeply understanding the truth you hold. It's one thing to that something is the case. It's something deeper and more important to know why it's the case or how it could be the case.

Samuel Greg

Robert George

Transcribed by:
Grace Hemmeke

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 days.

What's interesting is it's seventy, eighty years later, and for the most part we're still having the same debates. We're still having the same discussion. If you listen to the political rhetoric in the United States, many people say, [well], look around the world, and the US is the only country without. Without a universal safety net, without universal insurance, or without care being provided for everybody. Without price controls, without supply controls. And that's right. The question I've been asking is does that mean the United States is behind or the United States is ahead?

Something interesting happened to healthcare between the time the NHS was founded in Britain in the late forties and today. Healthcare became something that was primarily episodic, to something that is overwhelmingly chronic. In the US somewhere around eighty percent of spending on healthcare is on conditions that last more than a year. That would have been unthought of when we established our first efforts and safety nets and national health systems. The percentage of GDP spent on healthcare, particularly on disposable income, all around the world makes it one of the one or two top industries. [And] of course, the third thing, [the thing] that has changed absolutely everything in the economy, is the information balance between seller and buyer has changed because of the internet.

Health Affairs published just this month yet another appreciation of Kenneth Arrow's article, which made the key argument calling for governments, for insurers, or strong central authorities to act as the consumer in healthcare. And that argument is "we can't be consumers of healthcare." Why? We just don't know enough. We're in a situation, to use in economist terms, where a seller could say to us, "buy my stuff or you'll die." That's a very strong pitch. And Arrow's point was that there was no way for consumers to evaluate that claim to push back against it. And that the amount of emotional anxiety and lack of information and superior knowledge that the seller had, meant relying on normal consumer markets in healthcare was impossible.

That is the most influential article in health economics. It's justified a lot of what had already occurred in other developed countries and what was going to occur today, and people refer to it today still as an intellectually foundational argument for what we do in healthcare.

Here's the problem: That piece is sixty years old. And in any other industry, if Arrow had written about almost anything else, any other industry, we would say "yeah, but a lot has changed." Only in 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

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 mini-computer was sold by a company called Digital Equipment Corp., DEC, and the price of the very first mini-computer… 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.

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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. Well, has that worked? Even before something like the ACA's extraordinarily poorly thought-out provision that essentially said to sharers "you get paid fifteen percent of what you spend," there's never been a ton of incentive in private insurance to keep down the cost of spending because what are you doing? You're [just] marking it up, that's what your job is as an insurer. There's very little true risk in the health insurance business, which is why as the cost of care has exploded, their profits have exploded.

One of the things that makes America unique though, is that we don't have one single type of intermediary, we have several. We don't just have insurance; we [also] have CMS governing Medicare and Medicaid. And I want to talk about Medicare for just a moment, because I think it's important to understand that an intermediary is not a neutral customer…

One of the big assumptions in healthcare economics is that intermediaries are just neutral, that their policies don't drive care. And much of what I've written about is [how] that's the exact opposite of what's true, that an intermediary's economic incentives drive how healthcare is delivered. CMS is a great example of this. [So] if you're CMS you're an organization responsible to Congress, and what do you want to show Congress? That you pay the lowest possible prices for things. And that seniors get all the care they could possibly need. So when you compare Medicare to private insurance, what do you see? You see that visible prices are much lower, but you also see an extraordinary problem of overtreatment. You see massive amounts of uncoordinated care. The statistics on just the number of seniors who are taking contraindicated drugs is extraordinary. You see an enormous amount of accidental death and death from error. You see literally no governance of the system. All the time I hear from supporters of Medicare For All that Medicare is really cheap to run. I've never been, until recently, in the healthcare business… and you recognize… that [it] comes from a nonprofit perspective: "our foundation has only 5% expenses and the other 95% is given out to the poor." That is not what you want in a business. You can always run a bank without security guards.... It's not good for business though. We don't judge businesses [just] by their cost of administration; we judge them by their efficiency. The fact that Medicare only costs two or three percent of beneficiary spending to administer, isn't necessarily a good thing. If it fails to actually govern the healthcare system, fails to reign in excess, fails to protect its beneficiaries.

So private insurers who pay a much higher price per care have a different set of incentives. They need to show their customer, which is primarily companies, that they're sensible in how they administer. But because they're also marking up the cost of care, they have more of an incentive to allow less care at higher prices. CMS has more of an incentive to have a lot of care at really low prices. Neither are neutrals.

Where do we go? How do we get out of the traps we're in? You know, as I've mentioned, a big part of the trap is intellectual. And if we look at what that's about, it's about understanding healthcare the way we did sixty and seventy years ago as if it hasn't changed, understand the role of the patient as if it hasn't changed, and the doctor as if it hasn't changed. The first thing we do is to get out of that trap and understand that 21st century healthcare is likely to have a lot of care spending for which consumers can consider what they want, what's best for them, how they need, and that we want to encourage sellers to reach them and innovate on that basis. That's the first step. I would argue the second step is to abolish healthcare all together, by which I don't mean care itself. But I mean this idea that this thing with… tens of thousands of skews is a thing that needs to be solved as a thing. Nobody argues that making sure that our least well-off citizens don't starve is the same issue as how we regulate hygiene at restaurants. And yet, calling all of this healthcare in a way limits us intellectually. What we need is a 21st century economy of healthcare. What does that mean? That means we do want a safety net, because I think most of us believe that we would like to make sure that every one of our fellow citizens has

citizens don't starve is the same issue as how we regulate hygiene at restaurants. And yet, calling all of this healthcare in a way limits us intellectually. What we need is a 21st century economy of healthcare. What does that mean? That means we do want a safety net, because I think most of us believe that we would like to make sure that every one of our fellow citizens has access to essential care. We want to use that safety net for those things though, those things that we know people must have to lead healthy lives.

The second thing is we probably need some insurance because there are some things that are truly unexpected in the way that your home burning down is unexpected. Some of these are congenital, some of these are accidents, some of these will affect you for the rest of your life. So the idea of an insurance system like the one we have today based on your employment or your status in life probably doesn't work. There probably needs to be some insurance that follows you over your entire life, whether that needs to be government-provisioned isn't clear to me. But it's also clear that the less we cover by insurance, the less healthcare is going to cost. The more we can expose to a genuine market, the better a chance we have of keeping the cost of healthcare down, of reducing the amount of unnecessary care, and of creating—in terms of information, technology, customer service—the type of information a consumer's going to need to make the choices they're required to make anyway.

The last element, which a lot of market people don't talk about, but I do, is we need the government to be the government. One of the difficulties I see in the patient safety movement is that the government is compromised: it's the partner of the healthcare industry, it can't be anything other, it spends almost half the money spent in healthcare, it's the partner of the hospitals. My interest in healthcare started with my father's death from a medical error in a hospital. In part because I like to think of what I and others wrote, this became an issue that the Obama administration started paying attention to, started attaching penalties to those types of errors, and that's terrific. But the reality is that there's only so much that CMS can penalize the hospital—it's got to keep the hospitals in business, it's their business partner. And part of the reason that you don't see the type of effective regulation in something like healthcare that we see in aviation, is that in aviation the government's role is strictly as a regulator. In healthcare it must be a business partner. And I think those of us who believe in markets need to talk about how compromised the government is in that role when we expect it also to be the provider of care. We're not going to get there quickly, and I think a lot of the things that we hope to accomplish through policy are less likely to work than we think. Let me give an example: many of us—and I include myself—believe strongly in high deductible plans, and in HSAs, and the logic there is that it does sort of what I said, it takes some of your care away from the insurance system into what could be a market. But that hasn't worked, and the WHY it hasn't worked really is interesting. [So] if you have a high deductible insurance plan, what you've probably noticed is that your insurer keeps the same in-network and out-of-network rules, and approval rules for spending your own money as they do for spending their money. So how does that create any competition? How does that create any need for you to shop around? Or hope that providers will come to you with innovative and interesting offerings? [So] if your concern is diabetes and some entrepreneurial provider says, "I've got a great pre-diabetes package to help you avoid diabetes even though it's in your family history," you can't spend your money on that and have it count against your deductible. It's not in your insurance plan. If you want telemedicine, you have to use telemedicine that your insurance agreed to, even though you're paying for it out of pocket. So the system—and I don't necessarily want to accuse insurers of doing this on purpose—but the whole high deductible system has been hijacked by keeping network and insurance design in place and making, as a result, sort of the worst of both worlds. Now you have a high deductible, you have to spend a high amount of money out of pocket. And your insurer won't recognize it against your deductible if you spend it on anything other than the exact same structure we have today.

I got frustrated after a decade of writing about these things, and so in the last year and a half I've started a company called Sesame, which really in some ways after a beta test in Kansas City last year, just opened for telemedicine nationally and for physical medicine in New York and Houston three weeks ago. What Ses-

other than the exact same structure we have today.

I got frustrated after a decade of writing about these things, and so in the last year and a half I've started a company called Sesame, which really in some ways after a beta test in Kansas City last year, just opened for telemedicine nationally and for physical medicine in New York and Houston three weeks ago. What Sesame is the simplest idea in the internet, but incredibly complex in healthcare. It's a cash-based marketplace for care. Doctors, nurse practitioners, clinics, surgical centers, list cash prices, and you can lock-in the cash price by pre-paying. You basically buy your appointment, you buy your service, and what we've seen is extraordinary interest from a wide range of providers in doing that, and utterly massive discounts. Discounts well below the prices that you can achieve through your insurer's discount. We really designed Sesame for people who were either uninsured or high deductible and had figured it out. What I mean by figured it out is that in any given year around 15% of American families bust through their deductible. Most of those families know they're going to bust through their deductible on January 1st because there's a serious chronic issue, for example diabetes, which you know you're going to spend more than your deductible. The percentage of families who don't know they're going to bust through their deductible and do in any given year is small single digits. Which means if you've got a five-thousand-dollar deductible, you are a self-paid patient with catastrophic insurance. you actually have the type of plan I wish we would adopt on a national basis, but you may not know it yet. So for people like this, if they're told they need an MRI, and they have a five-thousand-dollar deductible, they can… go to a hospital, and any hospital can quote them $2100, $2200 for an MRI, and your insurance discount may bring that down to $1100 or 1000, sometimes 900, 950. On Sesame I don't think we've ever sold an MRI for more than $450. You literally save 4, 5, 600 dollars off the insurance price. Most primary care appointments are in the 40-50-dollar range for physical appointments, 20-35-dollar range for virtual appointments. We have everything. I heard Dan mention Keith Smith: Keith lists his surgeries on Sesame; we've actually sold a couple in just our three weeks of business.

The idea of a marketplace is not just about price. And this is where I want to part a little with those who claim that just price transparency is the answer. So in one of the first industries to have effective marketplaces was travel, and I served on the board of Expedia in… early 2000, I think until 2007. And one of the things we saw happen in the travel marketplace was really interesting. Airlines became fully price transparent to the customer. They also became fully transparent to each other. Which meant that no airline anymore ever offers a genuine special by which they're offering a price less than other airlines are. The reason—and some of it relates to the fact that there's no longer much competition in [the airline] business—is I know if I cut the price from Newark to LA… Delta and American are going to match my price immediately. I literally won't have more than a few seconds of price advantage, so I don't do it. There are different prices on those flights, the redeye is priced differently from the first price in the morning, etc.… but truly direct competition doesn't exist. If you are flying out of Newark in coach in the morning flight, and you both booked on the same day, you're both paying the same price regardless of what airline you go on. And that is because, in a noncompetitive industry, price transparency sets a floor; it doesn't actually drop competition. There was much more price competition in the airline business before marketplaces. But on the hotel side, what it created was massive differentiation as a way of competition. Let me give you an example. So you're going to LA on this flight, and one of you is going for a romantic weekend so you want a small hotel somewhere in a fun part of town, someone else… just cares about a great gym, someone just cares about night life… there's literally dozens and dozens of different forms of demand and so there is price competition because I have to charge correctly for each of those categories or somebody will say, "You know what, I can 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

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 cash market. There's some corporate benefit stuff that's come up recently that I can talk about; but fundamentally, in healthcare, unlike any other industry, we say innovation on packaging, innovation on quality, innovation on price needs to come from the customer i.e.: the insurer, CMS, not the provider. And in doing so we've killed all the potential entrepreneurial energy that's driven change in other industries.

And that's where I'll finish. What our goal is in Sesame is to create low-cost healthcare reflecting low marginal cost across the broad spectrum, for those people who are very value-conscious. Either the uninsured, or people with high deductibles, who really have to think about each dollar. In doing so, though, in that small corner of healthcare—that small corner of healthcare by the way which, like every small corner of healthcare, is about 250 billion dollars a year in spending—in that small corner of healthcare, we think we can create something normal that starts to create normal market dynamics. To circle around to what I said at the end, that's what we need to think differently about healthcare. Some corner of healthcare in which we see markets are actually working so we can carve back insurance, we can carve back the safety net, to what works best. I wrote a piece in Forbes about three weeks ago about telemedicine that I think illustrates this really well. Telemedicine is… technology that grandparents have been using to talk to their grandkids for twelve, thirteen years now. The innovation was getting third party payers to reimburse it. But let's look at what that's done. Teladoc, which is the largest telemedicine company in the United States, and the only one public… did four million telemedicine visits in 2019. They paid the doctors roughly 25 dollars a visit: that's 100 million dollars. They had 533 million dollars of revenue from the companies and insurers who subscribe to Teladoc. So do the math, their revenues were about 130 dollars an appointment and they paid the doctors about 25 dollars an appointment, and they lost money. Why did they lose money? Because that's the cost of servicing third party payment. The difference between the 25 dollars you pay doctors and the 135 dollars they charge customers all goes to servicing third party payment systems. If you look at the national medical accounts, the entire 533 million is treated as medical service. But it's not. The bulk of it is admin cost and sales and marketing and all the clerical work you need to do to get something reimbursed. On Sesame a typical doctor lists their telemedicine cervices for 25 or 30 bucks, and that's what the patient pays. And fundamentally the more parts of 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 works for

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 works for 21st century needs.

David Goldhill

Transcribed by: Isaiah Mudge

The Empathy Deficit By: Senior Editor Benjamin Dubke

On January 6, 2021, a mob attacked the United States Capitol in an attempt to prevent the certification of the 2020 election results, breaching the Capitol for the first time since the British invasion in the War of 1812 (Holpuch, 2021). It was disappointing and discouraging, especially because many Americans recognized that the attack was not an isolated incident, but a reflection of our country's decaying political health. Why does our country suffer from violent political extremists? Why do our presidential debates devolve into insults and name-calling? Why can we not just get along? Why do we hate each other? One central problem is a shortage of civil discourse. We fail to see others' perspectives and enter political conversations to win battles rather than seek the truth. We need a renewal of empathy. If we truly recognized other points of view, we would not be so quick to vilify and demonize, and we could sincerely work together toward a more perfect union.

The Pew Research Center published a landmark report in 2017 addressing political polarization. The main headline was that the partisan gap in political values has widened greatly since 1994. Republicans had become more conservative and Democrats had become more liberal, as measured by responses to several policy questions (p. 1). This phenomenon is known as *ideological polarization*. Some degree of ideological polarization can actually enhance civil discourse because ideological diversity encourages civil engagement and innovative solutions (Barberá, 2020, p. 47). More worryingly, the Pew report also found an increase in *affective polarization*, feelings of distrust and dislike for members of the opposing perspective:

> As Republicans and Democrats have moved further apart on political values and issues, there has been an accompanying increase in the level of negative sentiment that they direct toward the opposing party… Among members of both parties, the shares with *very* unfavorable opinions of the other party have more than doubled since 1994. (Pew Research Center, 2017, p. 65)

Not only do Americans hold more disparate political perspectives, but many disagreements also produce visceral emotional reactions against those who hold the opposite view. Affective polarization impairs civil discourse because angry, impulsive responses keep us from thoughtful debate.

Many people think social media is a significant part of the problem. The theory is that social media users are siloed into online echo chambers where they only digest information that reinforces their viewpoint, never being exposed to arguments supporting the alternative. The observed effects of social media on political interactions are more complex, however. Pablo Barberá, a computational political scientist at USC, analyzed the existing research on social media and political interactions, and he found that the evidence challenges the idea that echo chambers restrict people to hearing a single political perspective (2020). He summarizes, "The review of the literature on social media and 'echo chambers' has shown that, rather counterintuitively, there is convincing empirical evidence demonstrating that social networking sites increase the range of political views to which individuals are exposed" (p. 44). One study even indicates that a social media user's political opinions could become more extreme when exposed to views outside his usual echo chamber, contrary to what would be expected if lack of exposure were causing ideological polarization (Bail et al., 2018). It appears that echo chambers are not as worrisome as many claim, but social media does tend to encourage sensationalist and inflammatory content, which seems to increase affective polarization, and, in turn, prevents civil discourse (Barberá, 2020, p. 46-47).

Our lack of civil discourse has several disturbing effects on society and government. Clearly, it undermines the goal of political discourse, the shared pursuit of truth. Instead of all participants working together to discover the truth, each one only tries to win the argument by making the opponent look foolish with ad hominem attacks and straw man arguments. This also makes the political sphere unattractive to outsiders. A 2017 study revealed that 75% of Americans believe that incivility causes less political engagement, and 59% believe it discourages people from pursuing public service (Weber Shandwick, 2017, p. 11). Every person has a valuable contribution to make to our civil discourse, but many people hear the vitriol and outrage and are justifiably put off.

Our landscape of tribalism also encourages substandard leaders to rise to the top. When many of the moderating voices become disillusioned and leave the political conversation, candidates with more extreme, polarizing views become more prevalent. Winning 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 extreme ideology and more hardball methods to exert any remaining political power, a process documented in the United Kingdom following Brexit and the United States after the 2016 election (Maher, 2018). This

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 extreme ideology and more hardball methods to exert any remaining political power, a process documented in the United Kingdom following Brexit and the United States after the 2016 election (Maher, 2018). This situation is exactly what James Madison warned against in Federalist 10:

> A zeal for different opinions concerning religion, concerning government, and many other points, as well of speculation as of practice; an attachment to different leaders ambitiously contending for pre-eminence and power; or to persons of other descriptions whose fortunes have been interesting to the human passions, have, in turn, divided mankind into parties, inflamed them with mutual animosity, and rendered them much more disposed to vex and oppress each other than to co-operate for their common good. (Madison, 1961, p. 79)

We are entrenched in our political factions, and whichever faction happens to gain power can enact a tyranny of the majority over the other. This is why we experience a pendulum swing of policy shifts when a new party gains control, and why so much governing is accomplished through executive action instead of legislation. A failure of civil discourse is a direct threat to our freedom as a society.

Faced with such a bleak picture, some might be tempted to abandon the political conversation altogether, but the solution to uncivil discourse is civil discourse, not no discourse at all. We need to rediscover the virtue of empathy and make a habit of exercising it in our political conversation. This means we must honestly consider the other point of view, and always argue against the idea, not the person who holds it. Stephen L. Carter explains, "Civility requires that we listen to others with knowledge of the possibility that they are right and we are wrong" (1998, p. 139). To develop this habit, there are many models we can learn from, such as the great former Supreme Court justices Antonin Scalia and Ruth Bader Ginsburg. Although they disagreed vehemently on many issues, they were close friends because they knew they were working together toward the common goals of justice and liberty. Like Justices Scalia and Ginsburg, we can resist the impulse toward enmity and replace it with empathy.

Christians have some special advantages when it comes to empathy. When we encounter any person, we know with confidence that they are created in God's image, that Jesus paid for them by his blood, and that God wants them in heaven forever.

These facts, not our political differences, should define our perception of others. Carter frames empathy as a sacrifice: "The project of constructing civility will also require all of us to surrender some of our desires … For civility *is* sacrifice" (1998, p. 103).

For the sake of civility, we must sacrifice the words we would rather say, the insults we would rather hurl, and the outrage we would rather experience. When we love our political neighbor in this way, we follow our Lord's sacrificial example.

On the one hand, the solution to our civil discourse crisis is incredibly simple. We need to listen to each other honestly, learn from other perspectives, and approach political discussions with willingness to have our minds changed. Our loyalty to the truth and the greater good must win out over our pride and stubbornness that our way is always right. On the other hand, the problem is immense, and these principles are difficult to implement in practice. It seems like some people will always refuse to sincerely engage in civil discourse, and that we need to stoop to their level to make any difference. But to rebuild an empathetic culture of civil discourse, someone must humble himself and make the first move. Christians are well-equipped by Christ's sacrificial example and specifically called to make this contribution. The civil discourse crisis should not discourage us or press us to cynicism. Rather, this moment presents an opportunity to heal our political divisions, restore confidence in American institutions, and demonstrate the transformative love of Christ.

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The Value of Free Markets and Competition in the Delivery of Affordable Healthcare

By: Senior Editor Dr. Anthony Glavey

Introduction

The United States economy is primarily composed of free market transactions where the price for goods and services are established by supply and demand with little or no government control. However, the Healthcare delivery system in the U.S. is unlike most free markets. The means of providing medical services to patients all across America is certainly a subject of intense political / social debate, as noted by McCkalip (2016), and not an easy task. Arguments for healthcare are centered around the concept of what constitutes the best economic model for delivery of care that achieves improved; access, quality, and affordability for each and every American (McCkalip 2016). The history of the American Insurance model has moved from third-party payer toward a free-market model of care. As noted by, (McCkalip 2016) "Patients, physicians, and citizens continue to express concern that the current delivery models are not delivering on promises and may be causing harm (p.1)." One can certainly argue that the U.S. focus on healthcare is to pay for procedures rather than the value of our healthcare. The goal of this essay is to discuss the uniqueness of the affordable healthcare delivery systems in a free market highlighting three various perspectives, concluding with principles and insights, describing solutions to the accumulated problems and challenges.

Perspective 1: Consumerism

Meaningful consumerism in health care starts with patients requiring them to be active participants throughout the journey, from research through the patient care delivery (Carman et al. 2020). The US healthcare system does not always present consumers and providers the same information to make informed decisions that in other markets can lead to increased competition. Arming consumers and providers with the same information enables consumers to engage the healthcare system with their informed voice, rather than with just their dollars (Carman et al. 2020). Consumerism has certainly improved the U.S. healthcare industry and has bettered patient outcomes. One example is the advent of the Patient Protection and the Affordable Care Acts. Over this last decade in fact, patients have started to gain an increasing opportunity to act more like informed consumers. Allowing patients, the ability to choose their own healthcare path determining which providers they want to see. In this model the consumer has more 'say' in the types of procedures and services that are performed. These changes have allowed patients to sometimes increase their care while decreasing their costs. However, these changes have also left some consumers with very large deductibles that can put pressure on patients to find the best solutions to hopefully improve outcomes.

> Consumerism has reached a tipping point, becoming pervasive enough that the healthcare industry must develop better ways to respond…Providers are going to be getting more and more questions around cost and quality and they really need to have good answers (Massey 2019).

Furthermore, as noted by (Qunicy 2019), there is little evidence to suggest that these high-deductible plan designs even work. While the ability to make decisions based on quality information may move the market in a desirable direction, the main reason to provide this information, is because it is just and fair (Carman et al. 2020). To control spending and bring better value to our healthcare system one could argue that Americans need a new vision for what the consumer's role should be.

Perspective 2: Competition

The healthcare industry is comprised of patients, buyers, employers, and providers all who play a role in competition and the direction of healthcare. In fact, the competition in the healthcare market is highly profitable to consumers as it can help to reduce the cost while also improving the quality of patient care. Some would even suggest that because of that innovation and focus on clarity that cost can also encourage and improve innovation and patient outcomes. Certainly, competition compels companies to deliver increasing value for better patient outcomes but is cost always lowered, are outcomes always improved?

> The fundamental driver of this continuous quality improvement and cost reduction is innovation. Without incentives to sustain innovation in health care, short-term cost savings will soon be overwhelmed by the desire to widen access, the growing health needs of an aging population, and the unwillingness of Americans to settle for anything less than the best treatments available. Inevitably, the failure to promote innovation will lead to lower quality or more rationing of care—two equally
>
> undesirable results (Teisberg et. al. 1994)

Unfortunately, this competition has been enormously

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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).

Perspective 3: Government regulation

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 items and services available for patients. The goal of these changes is to provide a full transparency across the industry for the consumer to make the best choice for their healthcare. One could certainly argue that these additional changes could help the consumer choose the best direction for their own needs.

The U.S. is certainly not a free market or capitalist system, as various regulations at the state and federal levels, influence the operation of the healthcare market. The government sector spending, Medicaid, and Medicare for example, are similar to or greater than the same measure in most other OECD countries; Germany, Belgium, Austrian, New Zealand, and others (McMaken 2017). According to the World Health Organization, U.S. per capita spending on health care is the fourth highest in the world. As noted by Grimm (2014),

Unfortunately, new regulations have made the healthcare system less efficient while also failing to improve the quality, which was opposite of the original goal.

> The primary reason for health care regulation is to ensure that the care being provided by health care industries is safe and effective.

Conclusion

Health plans, insurance companies, providers, drug and device manufacturers, regulators and, policymakers must all work together to lower the underlying cost of healthcare. It cannot be done by only one group performing better or by simply allowing more 'visibility' to the consumer. As noted by (Goldhill 2009), the U.S. needs to reduce the role of insurance companies and move to focus programs on, "protecting the poor, cover us against true catastrophe, enforce safety standards, and ensure provider competition" (Goldhill 2009). These changes can help the U.S to, "overcome our addiction to Ponzi-scheme financing, hidden subsidies, manipulated prices, and undisclosed results" (Goldhill 2009). Changes like these will help the consumer to rely more on their own choices driving to more, "reasonable prices, and sensible trade-offs between health-care spending and spending on all the other good things money can buy" (Goldhill 2009).

Is it vital to understand that even the Institute of Medicine estimates that one third of what the U.S. spends is wasted and certainly does not result in better health outcomes. What we are doing now simply does not work as that additional wasted cost stresses that consumers are paying too much. The U.S. consumer and each and every patient should not settle for high, 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.

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.

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COVID-19 Interviews, Research, and Analysis – Life and Liberty

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

"The political liberty of the subject is a tranquility of mind arising from the opinion each person has of his safety. In order to have this liberty, it is requisite the government be so constituted as one man need not be afraid of another. When the legislative and executive powers are united in the same person, or in the same body of magistrates, there can be no liberty; because apprehensions may arise, lest the same monarch or senate should enact tyrannical laws, to execute them in a tyrannical manner."
Baron de La Brède et de Montesquieu

"If Men were Angels no Government would be necessary."
James Madison

"Remember all men would be tyrants if they could." ***Abigail Madison***

"Men are partial to themselves." ***John Locke***

Introduction

Certainly, many of us have been impacted by the pathology and challenges of COVID-19. In a March 30, 2021 news release, Director-General Dr. Tedros Adhanom Ghebreyesus called for further studies as to the origin of the pathogen. The statement called for the WHO "to identify the zoonotic source of the virus and the route of introduction to the human population, including the possible role of intermediate hosts, including through efforts such as scientific and collaborative field missions." While we do not know where this virus originated, we know it is real. Unfortunately, the statements and arguments surrounding COVID-19 are both confusing and often divisive. This article is an attempt to address several of the questions that show up in countless articles, news networks, and opinion pieces. By conducting original interviews and reviewing legitimate literature, this author hopes to uncover some of the common myths surrounding COVID-19. To further seek clarity, questions will also be addressed from the perspective of liberty concerns – based in part on interviews of Dr. Angus Menuge, chair of Philosophy at Concordia University and an accomplished scholar.

For this article five interviewees were chosen from everyday Americans. The objective was to get the perspective from U.S. citizens to see how they were feeling. Then an interview with Dr. Ramarao Yeleti, Executive Vice President, Community Health Network in Indianapolis took place discussing each of the chosen responses; and, finally, the perspective of Dr. Menuge was considered.

INTERVIEW 1: Chuck, 44 year old male remarked***: "If you notice there are no deaths of the common flu anymore what happened to all those people? Are the numbers simply inflated that could also include common flu deaths?***

In researching the question comparing COVID-19 deaths to flu deaths, many articles and arguments came up. On May 14, 2020 Dr. Jeremy Samuel Faust and Dr. Carlos del Rio in their JAMA article *Assessment of Deaths From COVID-19 and From Seasonal Influenza,* discussed this very notion. Their article stressed concerns with the public and officials that "continue to draw comparisons between seasonal influenza and SARS-CoV-2 mortality, often in an attempt to minimize the effects of the unfolding pandemic."

> The root of such incorrect comparisons may be a knowledge gap regarding how seasonal influenza and COVID-19 data are publicly reported. The CDC…presents seasonal influenza morbidity and mortality not as raw counts but as calculated estimates based on submitted International Classification of Diseases codes (Faust & del Rio 2020).

(Armitas 2020, Faust & del Rio 2020) described that the first thing we need to realize is that deaths due to COVID-19 and the flu are not counted in the same way. This means comparing the numbers is not as straightforward as we would like.

> The CDC estimates* that, from **October 1, 2019**, through **April 4, 2020**, there have been: **39,000,000 – 56,000,000** flu **illnesses / 18,000,000 – 26,000,000** flu **medical visits / 410,000 – 740,000** flu **hospitalizations / 24,000 – 62,000** flu **deaths** (2019-2020 U.S.).

As you can see the numbers are simply not as straightforward or counted the same way as they have been with COVID-19. For example, Dr. Yeleti (2021) commented that there is a delay in tracking the common flu and that more data about the deaths and impacts will show up in about a year.

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).***

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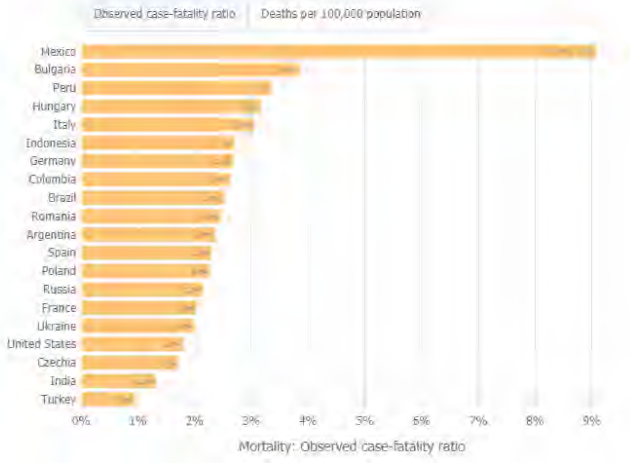

Tables 1&2: Mortality: Observed case-fatality ratio 4/1/2021 – (Mortality analyses 2021) & Table 2: Mortality: Deaths per 100,000 population 4/1/2021 – (Mortality analyses 2021)

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 get COVID-19 relative to the common flu.

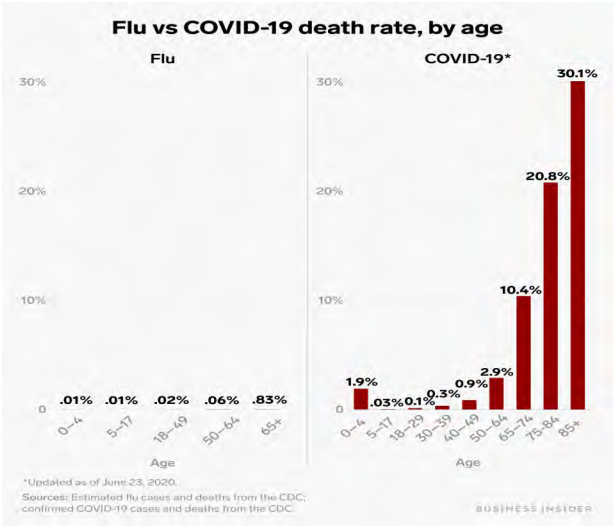

Table 3: Flu vs. COVID-19 death rate by age (Secon, 2020)

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-19 tests, especially early on in the testing. But, the bigger liberty issues pertain to what actions to take based on the data, and to ensure that all reliable scientific studies get discussed, without selectively limiting speech of respected scientists.

INTERVIEW 2: Chris (41) commented that, "***Many who die of COVID actually died from something else, but they are just listed as a COVID death to make it look worse than it really is."***
According to (Overberg et al. 2021) the actual recorded death count from of COVID-19 neared 3 million worldwide. The true extent is actually far worse according to the article and each passing day the number continually grows.

> 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

> 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).

Figure 1. Immediate cause, intermediate cause, and underlying cause of death in Part I of the cause-of-death section

CAUSE OF DEATH

Part I. Enter the chain of events—diseases, injuries, or complications—that directly caused the death. Do not enter terminal events such as cardiac arrest or respiratory arrest. Do not use abbreviations.

Approximate interval between onset and death

Immediate Cause (Final disease or condition resulting in death)

a. Immediate cause

Sequentially list conditions, if any, leading to the cause listed on line a. Enter the **Underlying Cause** (disease or injury that initiated the events resulting in death) last.

b. Intermediate cause

c. Underlying cause

d.

Part II. Enter other significant conditions contributing to death, but not resulting in the underlying cause given in Part I.

NOTE: The figure is a representation of a cause-of-death section in a typical electronic death registry system based on the 2003 U.S. Standard Certificate of Death.
SOURCE: National Center for Health Statistics, National Vital Statistics System, Mortality.

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

The reality is the numbers we are seeing from COVID -19 do not seem to be "staged" or "inflated." There is certainly a difference in how the numbers are tracked but when you lay it all out side by side the numbers point to the primary cause of death as COVID-19.

Dr. Menuge (2021) mentioned that this issue is one of probabilities, and that since deaths are typically associated with comorbidities, COVID-19 likely increased the probability of dying in many cases. Many of these people may have died anyhow, perhaps in a slightly different timeframe. But again, the main liberty issues pertain to what to do based on knowing COVID-19 increases likelihood of death, to whatever extent.

INTERVIEW 3: Loretta (74) stressed, ***"I would rather me and my son live doing what we want to do, get COVID, take the chance, versus being trapped at home, not living"***

The Pew Research Center performed a survey of Americans over the last year with their reactions to COVID-19 from Kessel et al. (2021) on this very subject.

> The vast majority of Americans (89%) mentioned at least one negative change in their own lives, while a smaller share (though still a 73% majority) mentioned at least one unexpected upside. Most have experienced these negative impacts and silver linings simultaneously: Two-thirds (67%) of Americans mentioned at least one negative and at least one positive change since the pandemic began (Kessel et al. 2021).

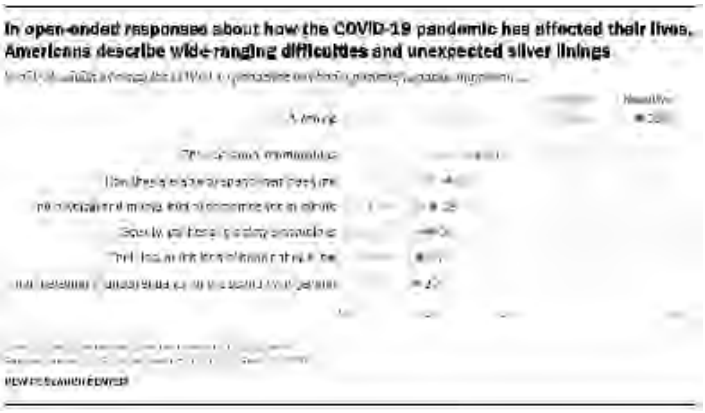

Table 5: PEW Research Survey (Kessel et al. 2021)

We know suicide rates have increased, people have a new way of life, and many are worried if life will ever get back to normal. If you are feeling trapped, worried or concerned be sure to reach out to your local networks as you are not alone. To address Loretta's point, Flaherty & Haslett (2021) described this dichotomy the best:

> It's the million-dollar question everyone is asking about COVID-19: When will life return to normal? And will school be open this fall? The answers are all over the map -- from Texas and Mississippi governors declaring their 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

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.

Dr. Menuge (2021) had more to say regarding Loretta's comment, as strong Liberty issues apply here. He noted that there is more to being human than biological health and that focusing only on COVID-19 ignores the impact of social deprivation (especially for example those in nursing homes), increasing teen suicide rates, and general increases in anxiety and depression that can impact other health outcomes as well. He would like to see side-by-side studies that weigh these impacts against those of COVID-19 directly. He wonders if such studies are deprioritized because people do not want to know the answer. He also worries about the constraint on Liberties due to lockdowns that have removed freedom of movement and gathering (i.e. religious), questioning their effectiveness since the spread seems as bad in states that have taken extreme lockdown measures.

INTERVIEW 4: Jeremy (61) ***"If there was such a concern why aren't vaccines available for kids?"***

The good news is, according to Mascarenhas (2021) updated March 31, 2021, "Clinical trial results of Pfizer/BioNTech's Covid-19 vaccine showed its efficacy is 100% and it is well tolerated in youths ages 12 to 15." Pfizer/BioNTech will obviously be submitting the data to the US Food and Drug Administration for expanded emergency use authorization of the two-dose vaccine. The Oxford-AstraZeneca and Johnson & Johnson vaccines are also due to start trials in children soon. The reason that shots are not available for kids is boiled down into four key answers according to Norgrady (2021).

Children are not yet priorities for vaccination is that they are much less affected by SARS-CoV-2 infection than adults.

There is also the possibility that children have fewer ACE2 receptors in the cells that line nasal passages, which are the doorways the SARS-CoV-2 viruses uses to gain entry to host cells and infect them.

Children's apparent resilience to covid-19 makes them a lower priority for vaccination, especially when demand for vaccines far outstrips supply.

Children also are a challenge in vaccine development—and in any kind of drug development—because they are considered a vulnerable population.

(Table 5) Created using (Norgrady 2021)

The point is that children are not as high a risk to get serious reactions to COVID-19. But further research, especially after the reopening of schools, universities, and colleges, suggests that infection rates are particularly high in young adults (Norgrady 2021).

Dr. Yeleti (2021) stressed that the reduction of deaths was, and still is, the primary focus versus the focus on getting kids back to school. Another thing to consider, as observed by Dr. Yeleti, is that kids are not the ones that are dying. The risk to people under 16 is not the serious concern as compared to reducing deaths especially in older populations. "This may seem harsh, but it is the reality and the focus is about saving lives, not getting kids to school" (Yeleti 2021). What would really help getting kids back to school, and getting back to normal, is getting teachers and more of the population vaccinated as described by Dr. Yeleti.

Dr. Menuge (2021) reiterated the relatively lower risk of COVID-19 for children, and again asks us to be allowed to weigh the benefits and risks – in this case of giving a vaccine that has had little testing on children (so is experimental), to a population that has low risk of harm from COVID-19. Furthermore, the decision not to attend school to protect against harm from COVID-19 must be balanced against the likely harm on children's education and social development – the impacts of which could be felt for years to come. This especially impacts poor and at-risk populations where the home environment is sometimes not as conducive to learning. He would like us to consider input from 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/].

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INTERVIEW 5: 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 resolved the infection rates dropped dramatically. As to the notion that masks do not work and civil liberties are somehow being damaged, Dr.Yeleti asked "Why do people cover their face when they sneeze? Does a person do that to protect themselves or others?" Another example he mentioned was drinking. If a person does that at home that is completely fine. If they get in their car it is a different story. We have laws against that because of the *risk it presents to others*. Wearing a mask is the same concept as covering your mouth when you sneeze, or not drinking and driving.

Dr. Menuge (2021) focused less on whether masks worked or not, and more on the Liberty issues of demanding rather than requesting compliance with lockdowns and mask-wearing. He claims the mandates "infantilize people – treat them as if they can't make informed decisions" – and he points us in the direction of a book entitled *The Price of Panic* (Richards et al. 2020). That book begins with a perhaps relevant quote from renowned economist Thomas Sowell:

> *What can we be certain of in history? That human beings have been wrong innumerable times, by vast amounts, and with catastrophic results. Yet today there are still people who think that anyone who disagrees with them must be either bad or not know what he is talking about*.

Conclusion

The current pandemic has created not only a medical crisis, but one might argue, a moral crisis in our nation. The focus of *Quaestus* is about presenting ideas about *Liberty, Virtue and Economics*, from a Christian perspective, to promote human flourishing. Most relevant for this essay is the interface of public health risks presented by the pandemic, supported by science, and the equally human concerns of liberty. Should there ever be constraints on liberty, and if so when and how? Liberty is the state of being free within society from oppressive restrictions imposed by authority on one's way of life, behavior, or political views. It is well known and accepted that in our country, we are blessed to have many liberties. However, what is sometimes overlooked is the responsibility that accompanies freedom.

Dr. Menuge (2021) does not dispute that COVID-19 is causing significant deaths, but he asks us to, consider the Liberty issues associated with mandates, and for individuals to be allowed to weigh benefits and risks of actions such as lockdowns, including the effects of social deprivation and the impact on children who have been kept out of school. Clearly, in the end, we must balance the desire to protect Life with the need to protect individual Liberty, and perhaps trust that individuals will behave in ways that are compassionate to others. This "compassion" to our neighbor could be forced by an autocratic government, as in China. This could also happen voluntarily if we have a virtuous society, founded in (for example) Christian values, that is also free and allows individuals to flourish.

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As it stands today we can watch the world clock of COVID-19 outbreaks, deaths, recoveries throughout the entire world on: https://www.worldometers.info/coronavirus/. As the numbers visibly grow, citizens debate whether they have to wear masks, whether their family can go into a restaurant or gym, or why all students should be in school. While we all enjoy the individual freedom, or the liberty, to hold our chosen beliefs or opinions, we still have a responsibility to all the other citizens who have the exact same rights. Is it possible that we, as Americans, in the attempt to protect our individual rights, have allowed our politics to cloud our responsibility, and ultimately our behavior towards others?

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A Society's Freedom

By: Ambrose Shaltanis

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, or how large or small it is, the goal should remain the same. This goal is the welfare of the people. In order to have a strong body of people, certain rights must be given to those participating. Among these are freedom of speech and civil discourse. These two rights are essential in creating an environment suitable for the people.

One of the defining characteristics of a functioning, virtuous, well ordered society is the right of freedom given to the people. A quote from Shahram Jafarzadeh in a journal in ScienceDirect says, "Human development is the most important factor of welfare improvement where the freedom is an essential instrument to achieve it." The most basic human right is the freedom for people to speak without being censored. This freedom is a staple in all successful nations, but is sadly being oppressed more and more throughout time, as seen with countries like China, which censors the citizens from speaking ill about the government and establishment. According to Wencong Fa from the Pacific Legal Foundation, "Free speech is inextricably linked to prosperity. After all, prosperity comes from ideas, and new ideas can thrive only in a society in which they are free from suppression."

Two important elements related to free speech are the right of conscience, and the right to have civil discourse. There are three main reasons why these are instrumental in a well ordered, virtuous society. First, the rights allow for discussion amongst the people, creating bonds and allowing for a mingling. Second, they promote morality and the value of freedom to those who benefit from it. Finally, with these discussions it develops the nation by encouraging qualitative dialogues and critical thinking.

Civil discourse, according to the Oxford dictionary, is defined as: "A long and serious treatment or discussion of a subject in speech or writing." Allowing members of society to debate and learn from each other is extremely important for the long term effects of a society's stability. Without people contesting and challenging each other, the nation could become a massive echo-chamber, that is to say having everyone in the same mind, destroying any thought deemed harmful. By having everyone converse with each other, the whole society benefits from the exchange of ideas and differentiation between all those inside it. There will be clashing conflicts, which are necessary for a civilization to thrive, as the issues must be worked out. This can be seen with compromises that politicians make, finding ways to help both sides, such as a government stimulus. It is also, in many circumstances, best to allow people to sort out their thoughts and emotions amongst themselves, rather than having an authority force their opinion over both, ending the quarrel.

Another reason it is extremely important to have the rights of civil discourse and rights of conscience is the instillation of morality and freedom set upon the people. When everyone has the right to discuss and affirm their conscience, it helps everyone reinforce each other's same belief. While there will be differing opinions, everyone will be united by the right to speak. This is something that everyone will have in common, and it is only possible if the country allows all speech and discourse.

Possibly the best benefit of allowing rights of conscience is the development of critical thinking and morality to all. Hard moral decisions that arise amongst the population will occur, and when they do, and there is no correct answer according to the law, they will be forced to think critically and examine all sides and options. Benjamin Franklin himself puts his say in the matter, "Without Freedom of Thought, there can be no such thing as Wisdom; and no such thing as public liberty, without Freedom of Speech." This means that freedom and wisdom both enforce each other up, as freedom allows the opportunity for wisdom to increase, and the wise comes to the natural conclusion that freedom is important to further wisdom. This is not a circular argument, but rather shows two virtues building upon each other to grow, just as America was founded with many men building off of each other, rather than one being used as an authority on the matter.

This is extremely beneficial for two reasons. First, it will most often result in a correct answer being unearthed, as it can always be reached through logic and proper reasoning. Second, the skill of critical thinking itself is immensely important. This practice will become more common and will help the community learn and grow by actively participating. Even if a true answer is not concluded, the participants will still have gained much from their examining of all sides.

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.

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Cancel Culture: A Blight on Our Rights of Conscience

By: Harrison Hulse

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 phenomenon dubbed "cancel culture," wherein an individual can be excommunicated from society for simply stating what they believe if it is not 'acceptable' in the public eye. Often, this attack lands squarely on the rights of conscience we hold in the United States, and to my continual horror, the "cancelers" constantly aim to have these taken away from us in the name of "social justice." Our rights of conscience are inexorably linked to a free and virtuous society, for they grant people the opportunity to sharpen their minds and beliefs with one another through a platform on which they can respect each other as individuals.

In the Biblical book of Proverbs, King Solomon writes that "As iron sharpens iron, so one person sharpens another." Although written over two thousand years ago, this statement describes modern civil discourse strikingly well. In response to the inevitable revelation of ideas, one may find stronger ways to express beliefs or even subscribe to the opposing view. As a result, that person is much better off than the man who shuts down foreign ideas at first sight and dismisses them as invalid on superficial or even inaccurate assumptions all before even learning the other's name. For instance, I, a born-and-raised Lutheran, have a Catholic friend with whom I debate on the matter of Christian doctrine regularly. This discourse grants me the opportunity to see into the methodology of her thinking while also sharpening my own beliefs, forcing me to have evidence for my claims and think through them logically so that I may explain them to her. Our discussions never devolve into shouting matches or worse still, playground-level insult contests, and as a result, our civility creates the perfect environment for us to mold one another into wiser people.

Granted, it is difficult to converse when one lacks a point of disagreement. To that end, just as fine kindling and logs make for a roaring blaze, the rights of conscience we so often take for granted are the perfect logs that fuel our necessary fires of civil discourse. While searching for a firm definition of these rights, I uncovered Robert P. George's (2016) concluding analysis of John Henry Newman's perspective: "The right of conscience is a right to do what one judges oneself to be under obligation to do, whether one welcomes the obligation or must overcome strong aversion to fulfill it" (p. 117-18). Having the autonomy to select for ourselves whether or not we choose to hold specific and varying beliefs is a beautiful thing on its own, but even more importantly, grants that there will be a difference of opinion on what the right course of action is to take within these options. Often times, it is unclear what that proper course might be, so individuals will take a stance on an issue based on their worldview. Inevitably, someone will hold a view contrary to another's belief, and thus, discourse can commence. It is precisely because individuals are allowed to choose what they believe about the world that they might be able to discuss the merits of the issue at hand. Had worldviews been decided for them in advance, there would have been no disagreement and therefore nothing to discuss. Choice produces disagreement that can burn and destroy, but like a campfire, disagreement handled carefully provides warmth, camaraderie, and life-sustaining food for thought .

Moreover, this disagreement that allows individuals to sharpen themselves and each another also grows in them a singular respect for each other; even if they come to no agreement, civil discourse naturally lends itself to the creation of mutual, high regard among the parties involved. Through the process of clear articulation, thoughtful counterargument and cordial banter, people are bound to come to see each other as thinkers who know themselves well enough to admit that they may be wrong. On a macroscopic scale, a society of such people can only hope to move forwards in more meaningful discourse as opposed to less. The person who holds another in high esteem in spite of their different perspectives will be enabled to search for grounds of agreement. As Stephen L. Carter (1999) highlights in *Civility*, "We must come into the presence of our fellow human beings with a sense of gratitude" (p. 281). Take away the choices found in disagreement and you tear from individuals the will to 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.

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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.

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The Case for Free Markets in Healthcare: An Austrian Approach

By: Senior Editor Catherine Bodnar

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 acceptably solve the perennial healthcare problem.

But what exactly are free markets, and what are their implications for society and healthcare? In his seminal work *Human Action*, Austrian economist and 20th century classical liberal Ludwig von Mises begins answering these questions with a simple axiom: man acts. Seemingly obvious yet incredibly profound, this statement regarding purposeful individual human action sets the foundation for the entire free market framework. For it is man, and not collective entities, governments or organizations, who deliberates and chooses among alternatives in the face of a scarcity of time, resources, and knowledge. At a fundamental level, man receives information, modifies his plans in light of this new information, and then coordinates his plans to fit within the meshwork of the unknown plans of others. Together, all these individual actions merge to create what Austrian economist and philosopher Friedrich Hayek calls a "spontaneous order," a dynamic market system. Such is the tenet of methodological individualism: social aggregates become more than the sum of their individual parts. Any market system must be seen in light of the myriad individual actions that merge to create a dynamic whole.
Healthcare is no different: individuals recognize deficits in their own health and seek appropriate care. In doing so, they coordinate with others—whether multidisciplinary teams or individuals from other entities—to fulfill their plans for better health. A system emerges from the confluence of many such interactions.

Complexity necessarily defines such a market system. Rather than existing as static, man-made orders, the healthcare system (and a good many other social systems) are dynamic and humanly unplanned. As Hayek describes in *Law, Legislation, and Liberty,* "[these systems'] degree of complexity is not limited to what a human mind can master" (p. 38). Certainly, we are aware of these systems' existence and understand very well our own microcosm within that vast "*kosmos*" (p. 37), but to claim understanding of the spontaneous order in its totality is both hubris and folly. No single individual possesses the full knowledge of the healthcare system's workings; thus no individual is qualified to control this system. Healthcare, like other spontaneous orders, is not so much a calculated game of chess—in which each move is carefully orchestrated—as it is an ever-changing, unpredictable kaleidoscope. As participants in this intricate array of human action, we each see our own minute facet but cannot fully comprehend the whole. And since the inner workings of the entire spontaneous order cannot be concentrated into a single mind, top-down social planning for such a system proves utterly impossible.

Too often, both mainstream economics and society lose sight of this complexity, focusing instead on the problem of allocation: will there be enough surgical suites for unexpected cardiac emergencies? Will enough individuals train in endocrinology fellowships to assist the growing population with diabetes? Will hospitals maintain enough beds to care for the critically ill? Emphasizing scarcity, such questions ignore the fundamental axiom of human action by pretending that humans are not actors but merely passive reactors—optimizing functions and maximizing utility given certain objective ends, constraints, and scarce means. Hayek argues instead that society's central economic problem lies not in allocation but in knowledge itself. In "The Use of Knowledge in Society," he attests that the totality of all human knowledge is fragmented and scattered across countless individuals. Each actor within the market system wields a minute splinter of knowledge specific to time, place, circumstance, and experience. Each actor in turn employs this limited knowledge to service his plans—and in doing so, reveals his knowledge to others. Market itself, therefore, is not an equilibrating machine but 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 regarding how to promote the greatest exchange of information and ideas in society.

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Problems naturally arise within this complex system of the market process, and in turn, solutions are discovered. Individuals most keenly aware of the problem and its salient details instinctively step up to the challenge of tackling the issue, incentivized by the boon that comes from attaining a resolution. Herein lies the case for liberty: administrators rarely—if ever—have enough knowledge of the market process to solve a particular societal problem. Liberty to act allows individuals to make use of their unique fragments of knowledge to piece together solutions unimagined by any single wise ruler or expert panel. Indeed, reliance on the competitive process of the free-market system allows society to taste the fruits of a much greater collection of individual knowledge than any one government healthcare task-force or health policy committee—operating blindly and in isolation—could ever dare hope to achieve. Liberty leaves room for the unpredictable and flings acute and chronic societal ills alike into Adam Smith's steady and sure "Invisible Hand," in whose embrace solutions emerge from a constant exchange of ideas.

Within the arena of the healthcare system, free enterprise allows individuals to act as they know best, wielding their own fragments of knowledge in ways that both align with their own health self-interests and elegantly dovetail with the plans of others. This interaction, in turn, translates into a healthcare system characterized by the true market process: patients are empowered to make informed medical decisions unimpeded by the disruptive rules and regulations of disinterested and uninformed third parties. Physicians also are free to act, enabled to practice medicine without government dictating which protocols to follow and procedures to perform. In essence, both parties—patients and physicians—are free to interact within the healthcare market process in a way that ultimately strengthens the patient-doctor relationship by removing third party interference. Moreover, instead of government forcing simplistic sub-par "solutions" upon society top-down, those intimately acquainted with local healthcare problems are at liberty to develop local organic solutions specifically furnished to meet the identified deficits. Ultimately, knowledge abounds in the process, leading to solutions and innovations no health policy expert could have ever fathomed.

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Silence of the Students: How Free Speech Relates to Contrary Ideologies in a Lutheran University

By Senior Editor: Isaiah Mudge

Introduction

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.

Concordia's Identity as Lutheran

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.

Concordia's Identity as a University

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.

When Identities Collide

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 thoroughly educated in modern science, regardless of its relation to LCMS Teachings. To remove evolutionary theory from the curriculum would be to ignore this duty and to graduate students who are unprepared to engage in full scientific discourse. CUW's solution to these conflicting roles has been to teach ideas which stand against Lutheran teaching for the sake of students becoming well-rounded and well-informed, but simply not to teach these ideas as absolute truth

(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.

Freedom of Speech within the Student Body of Non-Lutherans

A similar conflict pertains to non-Christian, or even just non-Lutheran members of the Concordia student body, as their freedom of expression, which ought to be granted in a university atmosphere, may come into conflict with LCMS teaching. Certainly, both must be maintained. To resolve this tension, let us draw a distinction between CUW *allowing expression* and *giving support to it.* When CUW is allowing expression, it is not preventing the expression of thoughts *intellectually* between students or within the classroom, even if these thoughts are antithetical to Lutheranism. This allowance is not a violation of CUW's Lutheran identity so long as CUW does not stray into giving support, that is, actively increasing the power of organizations or other entities which support antithetical ideologies. In other words, CUW's responsibility as a Lutheran organization is to keep the ideas as ideas, and not allow them to be expressed in methods which allow them greater influence beyond the ideological. For instance, the LCMS takes a strong pro-life stance, which is reflected in CUW's statement of principles. According to its Lutheran identity, CUW has an obligation to uphold these principles. As such, while Concordia both may and should allow the expression of pro-choice thought amongst students, CUW would have an obligation to prevent a pro-choice rally, a fund-raising event for an abortion clinic, or any other event which lends power to an antithetical idea beyond the ideological. In this manner, CUW allows for its Lutheran students to engage with antithetical teachings in a manner which is beneficial to their Christian education, while allowing non-Lutheran and non-Christian students to express their thoughts without repression, and without corrupting its identity as a Lutheran institution which supports Lutheran thought.

The Responsibility of the Student Body of Lutherans

Perhaps a clearer method by which to view the role of CUW in the lives of Lutheran students is as a guardian of their rights to express the Lutheran ideas which they believe. It is not in violation of CUW's Lutheran identity for it to allow antithetical ideas to be spoken, so long as the university staff, faculty, and administration champion the rights of Lutheran ideology and treat expression of its teachings as sacrosanct. CUW exists as a haven for Lutheran thought in a world where even other private institutions may have begun abandoning the Christian identity upon which they once made claim. Ingrained in its identity as a Lutheran institution is an obligation to stay that way.

Now, while CUW has a responsibility to ensure the *capacity, safety,* and *opportunity* for Lutheran students to speak, it is not obligated to make it easy. It may, and almost certainly will, be difficult to respond to non-Lutheran ideas during a seminar class, or to represent Lutheran ideas well in a debate with another student. In these cases, it is the responsibility of Lutheran students to be capable of having these conversations, and not to mistake their own discomfort with antithetical ideology as danger or as a lack of administrative support. So long as representation of Lutheran ideas is upheld with a sanctity that reflects CUW's foundational responsibility, Concordia is upholding its role.

When Things Go Wrong

With all this said, it is certainly the role of the student population to ensure that CUW is upholding the responsibilities which its dual identities endow. This is not synonymous with reprimanding those deemed deserving of punishment. Pecuniary responsibilities are held by the CUW administration, not the students, and punishment ought to be delivered dispassionately and with specific and preordained measures. Aristotle once cautioned that "anybody can become angry[…] but to be angry with the right person and to the right degree and at the right time and for the right purpose, and in the right way." These characteristics require restraint and control to exhibit, and while an administrator may hold them, a crowd almost certainly does not. The purpose of the students is simply to understand Concordia's dual nature and to call attention to violations of the responsibilities which these natures endow as outlined in the LCMS bylaws. Specifically for Lutheran students, it is our responsibility, for I am,

to ensure that CUW maintains an atmosphere protective of Lutheran discourse. Should CUW, its faculty, its staff or its administration fail in these duties, we as students must be hard-headed about how we proceed. It is easy for us to become upset and to feel victimized. It is difficult to construct a cogent and level-headed argument. However, construction of that argument is how we know we are correct. We must not attack CUW for faults against us unless we can provide the exact rule that was broken and evidence of its being broken, according to LCMS bylaws. We must be able to give specific examples and to demonstrate exactly how these examples resulted from CUW lapsing in its responsibilities. Should we be unable to do that, we must ask carefully whether an affront was truly made. Finally, throughout this we must be careful to ensure that non-Lutheran voices do not see our care in protecting our rights to speak as a desire to quell theirs. The cornerstone of free speech is that truth will reveal itself in contest with falsehood. Should the Lutheran beliefs which we hold dear be true, they will hold their own. They simply need the opportunity, and the skill on our part, to be shared.

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