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How Should We Reopen? Round 3 – The Health ID Card

Your blogger (YB) does not typically go on rants. They are strenuous, and generally unproductive. The loud voice scares people away. It is better to try to persuade … softly. This afternoon, an excellent interview of Paul Romer by Russ Roberts (https://www.econtalk.org/paul-romer-on-the-covid-19-pandemic/) led to the discussion that if people had the right information (about COVID-19) "most" of them would do the right thing. That is, if they were well, they would go out, and if they were sick, they would stay home. Ignoring the BIG question of what "most" means in this case, it brings us back to the question of how we know whether we (and they) are safe.

In a previous blog (http://allengoodman.wayne.edu/Blog/Reopen2.pdf), YB wrote about the adult film industry with their ID cards that had to be presented when appearing for work. These cards certified that the actors did not have sexually transmitted infections. No card, no work.

Here comes the "mini-rant". Over the last several years YB has had contact with at least five different health care organizations. EVERY TIME he goes somewhere new, he must fill out a new form, generally on paper, and almost always, it is transcribed with inaccuracies. This exchange happened within the last couple of years.

> Nurse: "We see here that you have arthritis, psoriasis, high blood pressure, diabetes, and skin cancer."
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> YB: "I don't have diabetes.:
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> Nurse: "It says here you have diabetes."
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> YB: "That information is inaccurate."

YB has NO card other than his Medicare card and his insurance ID. He has several credit cards with which he can move thousands of dollars securely. He carries all of his referrals and records on a flash drive. Recently, he asked if he could insert the drive into the doctor's laptop. That was fine with the doctor. No one had ever asked him to do this.

Why has our medical records system been so bad? In short, the doctors liked it that way. They claimed that they had to protect patient confidentiality. They claimed that the records systems did not allow them to share records. They claimed that there was not a standardized system. They claimed the HIPAA required it. YB has believed for at least thirty years that the EMR (electronic record system) was and is bad because a transparent system makes it easier to monitor bad (and good) work. If Clinic A, or Insurer B cannot readily access the data from Hospital C, then Hospital C faces less oversight. Along with that, there

is the very real probability (indeed the almost certainty) that there will be mistakes in transmitting data from Hospital C to the clinic or to the insurer, and vice versa.

The time is long overdue for a national health ID Card with insurance coverage, medical conditions, prescription drugs, COVID-19 tests and everything else. As YB said in his April 18 blog, card readers could be provided to workplaces, restaurants, libraries, University lecture halls, even arenas and stadiums. Put your card in the slot, test negative, you get to work, you go to the restaurant, or to the lecture. You don't want to get tested … you don't get in.

Isn't it time?

Allen C. Goodman
Professor of Economics