The Bottom Line on Health Reform

This is it. In Washington the compromises are coming fast and furious. Here's where reformers must stand firm—and where we ought to deal

BY JON MEACHAM AND TED MARMOR

All the elements are in place for a classic Washington minuet on health care: Mitchell and Foley shuttling between the White House and Capitol Hill; Moynihan expounding on the Sunday morning shows; Clinton cajoling lawmakers; then, in the end, C-Span televising the vote on the Health Security Act of 1994. The president will hail the achievement in the Rose Garden, and the congressional satraps will then run home to campaign.

First, the setting: The Democrats want to pass a health care bill this year—*any* bill. After George Mitchell led a Colonial Williamsburg retreat of Senate Democrats in late spring, he came back saying, "There was no discussion of timing, except we intend to get it done this year." On the plane back to Washington from Nixon's funeral in California, Bob Dole organized an all-night health care talkathon.

But the terrifying likelihood is that what emerges will fall far short of the reform the country needs. This is especially true if the legislative winner is a limited bill that merely takes care of the two things the middle class thinks will solve its insurance worries: eliminating denial of coverage if you have a preexisting condition and guaranteeing you won't lose insurance if you switch jobs. It this happens, then the constituency for major health reform could become like that for deficit reduction or for aid to the poor—the pious and the concerned, and history tells us they don't often make up a working majority.

Instead, we will go on spending nearly $1 trillion annually, billions more than any other industrialized democracy, on a health care system that, unlike any other democracy, leaves millions uninsured and still millions more worried that they cannot pay medical bills, insured or not—in sum, a confused and angry public spending too much money and not getting what it wants in return.

But insurance reform, while important and no doubt politically appealing, won't be enough. In Washington the temptation is growing to do whatever it takes to get a bill, even one that could prove inadequate. "There is a sense that this is closing in—all the years of meetings and all the studies and all the speeches," says Jay Rockefeller.

On May 4, for example, Democrats Bob Kerrey

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and David Boren endorsed Republican John Chafee's bill, which has no reliable mechanism for controlling overall costs, creates new bureaucracies, and delays universal coverage until the 21st century. Nevertheless, the step was hailed by Washington voices with a stake in keeping reform to a minimum.

"This is the most significant breakthrough all year in moving Congress toward action," said Bill Gradison, head of the Health Insurance Association of America. Well, yes, if you consider firmly entrenching private insurers at the heart of an already-complicated health care system and delaying universal coverage for a decade "action." But the tom-toms are beating: A *Washington Post* headline declared: "Chafee Bill: A Dose of Compromise." A Democratic campaign strategist told *The Washington Times*, "Democrats cannot afford to let this go on until the bitter end. We have to have health care in hand to take home to the voters." Apparently so: On May 10, Ted Kennedy, long a backer of major health reform, proposed eliminating the critical Clinton health purchasing alliances in order to get a bill out of his Senate Labor and Human Resources Committee. And the president summoned the Democratic leadership to a May 24 White House meeting to see what has to be done to make a deal this year.

But history is unmistakable on this point: Legislative rush jobs near an election often produce near-fatal to fatal compromises. (Exceptions are the historic Congresses of Roosevelt in 1933-36 and of Johnson in 1964-66.) Frequently what appear to be reasonable concessions—in this case, just reforming insurance, for example—are in truth fatal flaws. The 1986 Tax Reform Act, for instance, despite its announced aims, neither radically simplified the nation's tax system nor made it fairer by dramatically increasing the amount of income subject to federal tax. Likewise, the promised total welfare reform of the Family Support Act of 1988—Daniel Patrick Moynihan warned then that "we put the next century at risk" if the bill didn't pass—failed to match its ambitions and here the nation is again debating how to end welfare "as we know it."

To be sure, we wish the Clintons had used a Canadian-style single payer system as a working model for health reform. Contrary to the popular impression that single payer is some kind of horrifically statist enterprise, it is in fact the most attractive and least disruptive of the reform plans that are on Washington's table. How? Because single payer largely eliminates the key villain that makes most people unhappy with or nervous about their health coverage: costly insurers. It also covers everyone at equal levels of decent care, controls costs, guarantees doctor choice, and is mainly financed by income and sales taxes, not a potentially burdensome employer mandate or a hopelessly complicated individual one.

But the Clintons—and enough congressional Democrats—instead embraced the untested and more complex theory of managed competition. (Congressman Sam Gibbons summed up Washington's attitude toward single payer: "It just won't fly.") Managed competition enhances the role of multiple private insurers, allows the affluent to buy better care, cannot reliably control costs, limits doctor choice unless you can pay more, and depends—for both financing and administration—on an employer or individual mandate.

What reformers must do, then, is make one last push for a single payer, single plan for the nation.

This is hardly a lost cause: The Paul Wellstone-Jim McDermott bill has 92 co-sponsors in the House and five in the Senate, more than Jim Cooper's alternative, and California has put single payer on its November ballot. (But even Wellstone-McDermott relies on employer financing, which could cost jobs.) If single payer fails, we should intelligently draw lines in the sand to fight for what's essential. This means provisions that you can't be denied coverage; that you won't lose your insurance if you change jobs (called "portability"); that small businesses be able to ally with other businesses in order to gain bargaining power with insurers; and every American ought to have the right to buy the same plan that covers federal employees and members of Congress.

These are clearly doable reforms. More important but infinitely more contentious are universal coverage in the near future; cost control; comprehensive, equal benefits for every American; standardized paperwork and rules to determine what's covered; sensible financing; patient choice of doctor; and doctor liberty within budget limits. And we *can* make sure states have the means to set up their own single payer plans, a provision that's in the Clinton bill. Cooper, however, actively opposes the option, meaning the provision could fall through the cracks if advocates of sensible, large-scale change don't pay attention.

Up to now the trappings of the debate—the ever-extended buildup of Hillary Clinton's semi-secret task force, presidential speeches and town meetings, Harry and Louise ads and counter-ads—have been just that: trappings. This is the time reformers must decide when to stand firm and when to make realistic compromises. Although the Clinton legislation is complicated—perhaps the most complicated legislation in a generation—the criteria to judge the final product are not so incomprehensible.

● ***Universal, equal coverage by 1998.***

Universal coverage is the one thing Clinton insisted on in his 1994 State of the Union speech. But there is still enormous wiggle room on the deadline the bill sets for full coverage. Clinton wants it by 1998; Chafee, the most moderate GOP alternative, waits until 2005; Cooper doesn't have it at all. The instinct on the Hill is to split the difference between 2005 and 1998 and go with, say, 2003. But a deadline after 1998 is unacceptable.

Why? First, the pocketbook argument. While it may appear that universality is just another damn giveaway program, it is actually the linchpin of sensible health insurance. Universality gets rid of the free riders who take advantage of the current system of cost-shifting. This currently lets hospitals and doctors charge people who can pay—well-insured patients and the government, through Medicare and Medicaid—for services it provides free to people who can't.

Universal coverage under equal terms and conditions—the Canadian model—puts everyone in the same pool and prevents hospitals and doctors from playing different payers against each other, thereby controlling medical inflation. In a universal system like the one Clinton proposes, the insured would not have to worry that he's getting ripped off by the uninsured guy who shows up in an emergency room after a careless motorcycle accident. If you have insurance now, you are already paying—to the tune of scores of billions of dollars in total premiums—for people who don't.

Republicans and Democrats like Cooper, however, would at most like to guarantee the right of every American simply to buy coverage—which is no reform at all, because all Americans, if they have enough money, can do that now. As Senator Tom Daschle, a Clinton supporter, rightly says, "That's like saying everyone has access to a Mercedes. Sure, you can walk into a showroom and test drive one, but not everyone can afford to *buy* one."

Second, the moral case. The affluent should not have the right—as they will under Clinton—to buy more doctor choice. Congress and the federal bureaucracy have reserved themselves the right to buy out of the basic plan, which would cover 80 percent of the population. A two-tiered system, one for the well off, the other for those who can't afford to buy more, is not the way health care should be run—it's like saying the police or fire departments shouldn't answer calls in poor neighborhoods. And if we are all in the same boat, we will care about the cost for all of us instead of just our own plans.

Delay could also keep future Congresses and administrations from finishing the job. It is the nature of our politics, after all, to lurch from crisis to crisis. Massachusetts, for example, has taken the marvelous step of *legislating* universal coverage but has never gotten around to *funding* it. It's unlikely that a federal plan would pass without at least a "target date" for universality; the phrase to

watch for is "date certain." Without that, Clinton should make good on his threat and veto whatever comes out of Congress.

● ***Cost control.***

The U.S. spends more than 14 percent of GDP, over $900 billion, on health care. If current trends hold, the figure will hit 16 percent by the end of 1994 and 18 percent by 1998. Per capita, we spend a third more than Canada, the next highest-spending country in the world.

How to control costs? The Clintons already compromised on serious cost control by not mandating global budgets (set amounts a state or set of providers can spend, a feature of most other successful health systems and of single payer). Instead, they fall back on limiting the growth of premiums and pray that competition between different health plans will produce savings, or at least slow the rate of medical inflation.

This is weak tea for people who had hoped for reliable cost control, but it is what most in Congress are at best prepared to put in their cups. Move right from Clinton—in other words, look at any plan except for single payer—and there are neither premium limits nor global budgets. There's no attempt to control costs except through the unreliable promise that competition, which has not worked yet, will do so now.

We know that the market does not work in medicine in the way it does, for example, for washing machines. That's because when people are sick and walk into a doctor's office or an emergency room, they aren't thinking about price or comparative shopping; they want to get well, and the human instinct is to pay whatever is asked to do that. Also, visiting a doctor is not like shopping at Sam's or Price Club, where you know precisely what you want and how much you're willing to pay for it. With medical care, patients depend on physicians to tell them what they need, and if doctors tend to sell a lot of services, more money gets spent. When you're in the examining room, worried, you aren't thinking like an ordinary shopper. Hence a willingness to pay whatever is asked, and hence soaring medical costs.

So while overall budget limits are what would really work, a realistic compromise is to fight for the Clintons' premium caps. Why lose blood over an already-compromised measure? Because the alternative—the chimera of competition—is worse.

What else can control costs nationally? Reform of specialization, doctor training, and malpractice

can play an important role over time. One of the most readily identifiable causes of higher medical spending is the overspecialization of physicians. A look at their salaries tells part of the story: In 1991, according to the American Medical Association, anesthesiologists and surgeons made $221,000 and $233,800 respectively; pediatricians and family-practice physicians took in $119,300 and $111,500. More important is how inclined specialists are to order expensive, high-tech tests. A 1992 New England Medical Center Health Institute study found that specialists order more tests, perform more procedures, and hospitalize patients much more often than general practitioners or family doctors.

At the moment, in all other developed countries, 50 to 75 percent of doctors are GPs; in the U.S., only 29 percent are, and even that number is eroding rapidly. Only 14 percent of current medical students are choosing primary care, which is less than half the rate (36 percent) in 1982.

Health care costs will never be slowed if we don't reverse this trend. Another 1990 study says that a 50-50 mix of primary care doctors to specialists would generate a 39 percent cut in total money spent on doctor services. If true, getting to that even mix should be one of the highest priorities of health reform.

Consider: No other part of the health care world gets *increased* funding in the Clinton bill *except* medical educators. In exchange for an increase in grants—from $5 billion now to $10 billion by the year 2000—Clinton would require medical schools to train specialists and primary care doctors in a 50-50 ratio by 1998 instead of the current 70-30 mix. But by lobbying lawmakers from major urban areas (where teaching hospitals are especially important), groups like the Greater New York Hospital Association have successfully made their case to legislators who have tacitly agreed to back the schools' increased funding but not the ratio.

Moreover, the weakness of the current reform strategy is that it attacks the problem only from the medical school perspective (and, as you can see, it's getting outmaneuvered there). A more immediate, inexpensive reform would be to have the government make the annual student loan payment for interns and residents who become GPs *and* even for specialists who are already practicing but who decide to switch to general medicine. Unlike other reforms, this one won't cost an enormous amount because Washington doesn't have to take on the total loan, only the yearly payments for as long as the doctor stays in general practice. And if doctors later bugged out and specialized, the payments would stop and we could force them to pay back everything the government had ponied up on their behalf.

This is a curious political fight, because the enemies of change aren't run-of-the-mill flacks for, say, cigarette companies or the gun lobby. They are the cream of research medicine, the deans of famous medical schools, who are fighting to preserve their departmental structures and their federal funding. Because medical school departments are now built around specialties, the chairmen of those departments, and their deans, have an understandable obsession with preserving their specialties' contributions to medicine. But we can't let them get away with acting out that obsession by attracting so many available physicians into specialties at everyone else's ultimate expense.

There are two other forces which seem to contribute to physicians' justifiable self-pity: Harsh internships and residencies and the high cost of malpractice insurance. Hospitals and medical schools must stop exhausting young doctors who, in the heat of 36-hour shifts, forge a lasting sense of entitlement that expresses itself in choosing high-priced specialties or, in some cases, in resisting reform that would affect their incomes. What we have to correct is the insanity of the medical culture's abuse of its young. (In fact, this magazine once proposed giving every medical intern a Jaguar so that, when they came out dazed and exhausted from long shifts and saw the *older* physicians' fancy cars parked in the lot, young doctors would have less reason to store up grievances.) In order to help make medical education more bearable, older doctors could be required to do occasional night duty as part of their privileges to admit patients to hospitals.

The other problem generating self-pity is malpractice worries. At the moment, fearing ruinous lawsuits, doctors are practicing defensive medicine, ordering up every test imaginable to cover themselves. Childbirth is a good example. Caesarian sections are twice as expensive as regular births—$10,000 as opposed to $5,000—but are now considered the safest way to prevent a lawsuit if something goes wrong. In 1993 the Centers for Disease Control found that doctors

had performed 349,000 unnecessary C-sections, at a cost of an extra $1 billion. Why? "When the malpractice issue became a huge one," Dr. Kaighn Smith of Philadelphia's Lankenau Hospital told the *Philadelphia Inquirer*, "we began to do things in the hope of preventing a malpractice action against us. Those things became habit." But the point is many C-sections are unnecessary, and if doctors had less reason to fear malpractice suits, the rate of the procedures would drop, saving money and sparing new mothers the trauma of being cut open when there's no medical need for it.

Yet right now there is no cap on the damages a jury is entitled to assess in malpractice suits and no limit on lawyers' fees. This is one case where Chafee's Republican bill goes further than Clinton, and reformers ought to back Chafee. He would limit pain-and-suffering damages to $250,000, cap lawyers' fees at 25 percent, and make losers pay lawyer and court fees. This would still pay for a malpractice victim's medical trauma and whatever money he loses because he can't work. But it would finally bring the infinitely inflatable pain-and-suffering damages under control. Potentially fatal obstacles: There are 66 lawyers in the Senate, and the House is reluctant, too. When a Ways and Means subcommittee passed a $350,000 limit on non-economic damages—in other words, pain-and-suffering—Congressman Jack Brooks of Texas, head of the Judiciary Committee, wrote Dan Rostenkowski a letter warning Ways and Means off his committee's turf. Rosty told his colleague not to worry. "That won't get out of the full committee," Rostenkowski reportedly said.

But encouraging doctors to generalize, freeing them from insurance company oversight, and curbing malpractice lawsuit excesses should go some way toward reminding physicians why many of them went into medicine in the first place. The image of the decent, hardworking doctor is a powerful figure in American life and is what attracts many young people to the profession.

The fact is, physicians are themselves increasingly terrified of having their lives turned upside down by making private insurers even more important than they are now—which will result from anything less than a single payer plan.

Recently, a hematologist at Yale simply blurted out that the current world of managed care is "ruining the practice of medicine." A psychiatrist, his eyes glistening, reports how unbelievable are the demands of distant reviewers who tell him what

his suicidal patients do and don't need. Another shrink reports a case where a Minnesota case manager was unwilling to agree to pay for extra hospital days for a 23-year-old woman who was suicidal, had lost her therapist, and was diagnosed with Huntington's chorea (a deadly neurological affliction that kills all its victims, like Lou Gehrig's disease). The hospital staff was horrified, the woman was distraught, and medical care was being handled as if a collection agency was in charge.

Indeed, if most physicians understood the trajectory of managed care, as some do, they would be clamoring for reform, like single payer, that rearranges the way care is *paid* for and leaves them the freedom (as doctors have in single payer systems) to practice as they wish, protected from the medical judgment of quasi-accountants. That's why the 60,000-member American College of Surgeons, for example, has endorsed a Canadian system, even though its members have the most personal income at stake if the growth of fees is capped.

● ***Financing.***

Much has been made of the small business lobbies' campaign against mandating that employers pay for some percentage of their workers' insurance. But even Senator John Breaux, Cooper's key co-sponsor, suggested in mid-May that mandates are very much on the table. The essential point, however, is not whether mandates are good or bad politics but why they are bad policy. Employer mandates attempt, as Yale Professors Jerry Mashaw and Michael Graetz noted recently in *Domestic Affairs*, to arrest the rapid unravelling of employment-based health insurance that now leaves as many as 60 million Americans without coverage at some point every year. In fact, it is the decline in the percentage of the employed who are insured through their workplace—not unemployment or a decline in support for public programs—that has resulted in a smaller percentage of Americans being covered now than in 1980. But mandating the repair of this crumbling edifice does not equal sensible policy choice.

First, employer mandates are perverse forms of taxation, with undesirable economic effects. Small employers, collectively the largest source of job creation, can least afford hefty benefits. And efforts to subsidize small employers—as the Democrats are trying to do—are endlessly complex (as, of course, are subsidies to individuals). For example: If generous, subsidies could induce large firms to subdivide into smaller corporate units in order to attract subsidy dollars. Bar association meetings already contemplate the extra legal business that such subsidies would prompt—one New York bar session called any health bill that included an employer mandate "a full employment act for lawyers."

Any mandate makes independent contractors or temporary workers more attractive than regular employees, and the IRS already finds monitoring independent contractors enormously difficult. New mandates would come at the worst possible economic time: Though the recovery from the 1990-91 recession is fairly strong, there are still 10 million unemployed and 6.2 million people who have taken part-time work but want a full-time job. Tying benefits to employment also extends the problems of administering portability—the ability to change jobs without losing or impairing insurance coverage—and this can be solved only by further mandates and regulation. Finally, employer mandates do nothing for the unemployed, who would have to be covered separately.

In sum, the appeal of employer mandates is truly illusory. They are an indirect form of taxation, one that masks the tax and perversely redistributes income. They are justified as "building on the present system." But the present system is like sand—porous and unstable. Arguments about whether employers should pay 50 or 80 percent of mandated premiums are misleading. Except for minimum wage workers, employers may write the checks, but workers pay the costs. Proportional taxes on individual wages, more appealing in principle, have the unavoidable defect of making permanent employees more expensive than other business costs.

The new kid on the mandate block is Chafee's *individual* mandates, which would require every person to buy insurance and, if the person were too poor, would subsidize him to make it affordable. This would require the same bureaucracy that the Clinton employer mandates depend on, but more important, universal coverage is delayed for 11 years and costs would still be as uncontrollable as they are now.

Canadian-style single payer, however, has the virtue of funding national health insurance mainly with income and sales taxes, a fact that reduces the direct burden on employment. For reformers, the realistic compromise is to walk with Rostenkowski,

who understands that a broader tax is necessary. Two ideas present themselves which might together raise enough money to pay for a reformed system (but remember that this is a *substitute* for what the country now pays in insurance premiums, not an additional financial burden): A well-implemented national value-added tax on consumption—championed in theory by people as diverse as Sam Nunn and Jerry Brown—could bring in enough to help avoid the subsidy trap. Another option would be a tax on corporate profits if the IRS can figure out a way to make sure companies can't pull con games and hide profits.

➤ ***Scope of benefits.***

What's essential to control costs and cover everyone equally is to ensure we avoid the troubles Medicare and Medicaid have run into: paying too little for preventive care and too much for fancy treatments. What is not sensible is trying to control costs by excluding certain benefits, which is the way managed care works now.

The real problems have to do with how many services—like MRIs or C-sections—are used, how often, and at what prices, not what benefits are covered. In the right kind of scheme, hospitals get a global budget and decide there, on the ground with doctors and administrators, how to spend the money. And smart systems don't say you can only admit people to the hospital, for example, with three symptoms, because close calls would produce a windfall for lawyers and litigation. Decisions should be made on who needs what treatment, within reason, not ability to pay or definitional tidiness.

One benefit that's disappearing in the current system and which managed competition will make worse is free patient choice of providers. Most Americans want the freedom to choose their doctors and other professionals without interference, whether from HMOs, insurance firms, or government agencies. Moreover, American doctors understandably want freedom to provide care without intrusive second-guessing or distracting oversight. Single payer eliminates that worry.

Another bureaucratic nightmare waiting to happen in managed competition is administering a multi-tiered system. If the affluent are going to be able to buy different, better coverage than others, that automatically entails a different set of forms and rules, increasing the administrative complexity. Think of your own internist's office. Remember the days when it seemed there was just a nurse and a receptionist handling all the paperwork? These days the space behind the reception counter is more likely to resemble a data-processing center at IBM, with people buried in files and forms. Managed competition, with different tiers and continuing multiple insurers, guarantees the problem will stay the same. The lesson is clear: Once you get intricate subsidies or separate tiers of coverage, mind-boggling complexity results.

● ***Administration.***

Because Clinton failed to go to a single payer system in which the government, in negotiation with doctors and hospitals, would set budget limits and cap costs, he had to come up with another way to run his railroad. Alliances, or purchasing cooperatives of employers and individuals, were his solution. Quickly, however, a dismissive conventional wisdom took over. As early as March, Moynihan, on "Face the Nation," said alliances were "too big, too much government," essentially agreeing with Phil Gramm, who was saying much the same thing at the same hour on "This Week with David Brinkley."

But no one outside the single payer camp has come up with another way to accomplish the alliances' goals. Clintonian alliances, as Paul Starr has pointed out in *The New York Times*, seek to enhance personal choice of physician by removing the choice of insurance coverage from employers and giving employees the power to select competing plans through the alliance. Nevertheless, even ardent Clinton supporters acknowledge that the word "alliance" is, as one Senate Democrat put it, "toxic."

Rockefeller recently circulated a memo on alliances to the members of the Senate Finance Committee pointing out that if you take any alternative to an alliance—individual mandates, voluntary participation, whatever—you are embarking on a more burdensome and regulatory plan. Chafee, for example, sticks the burden of administering his plan on Washington and the state governments, not the alliances. If states that opt for managed competition don't have alliances, they will essentially have the status quo. And voluntary alliances make about as much sense as voluntary speed limits: The public good depends on bringing health costs into line so that everyone will be covered and the country won't go bankrupt. Nothing should be "voluntary" about that.

The problem with whatever bill is likely to emerge is that it will exacerbate an already terrible situation when a simple, effective alternative—single payer—was sitting right in front of Washington's face, only to be ignored. At the moment, 70 percent of Americans with health insurance are in some form of managed care. This means doctors are harassed by insurance overseers, patients are denied access to the physicians they want, and more and more people—new mothers, for example—are being sent home after 24 hours to clear the bed. This is the status quo; single payer or its equivalent would reverse it, not make it worse. This is the point Americans must begin to see.

Proposals that would adapt Canada's system to the United States could, contrary to the conventional wisdom, be considered conservative. After all, they require little change in how physicians, hospitals, and patients deliver and receive medical care. Patients would choose doctors; physician practice patterns would not be disturbed; we could save, according to the Congressional Budget Office, as much as $100 billion in paperwork and administration that could be invested in job-creating enterprises to take up slack from the near-abolition of the private health insurance industry. In terms of *medical* care, then—the thing most people worry about—single payer is the sensible, conservative alternative. And financially it is the soundest way to control costs. Budget limits can be used in states that opt for single payer or other variants. The managed competition crowd hates them because if, as international experience clearly suggests, a single payer state next door to a managed competition state controls costs and satisfies its people better, then the tide could turn toward single payer.

This is the crossroads; no longer is reform the stuff of conferences and think tank ruminations. We could end the season in legislative stalemate, with majorities against every option for every manner of reason. Or we could end up with a majority for stripped-down Clinton ("Clinton Lite") which shares the aims but does not offer the means of large-scale reform. Clinton Lite, however, is not a lean plan but an inadequate one. Or ideally, we could have a bill with the right principles that permits enough state flexibility to experiment with different systems. This is not Clinton Lite but American federalism in the absence of a determined progressive majority in the Congress. □

Memo of the Month

NORTH BELLMORE UNION FREE SCHOOL DISTRICT
2616 MARTIN AVENUE • NORTH BELLMORE, NEW YORK 11710
TEL: (516) 221-2200 FAX: (516) 785-5670

April 26, 1994

Dear Parents:

The purpose of this letter is to clarify particular questions/assumptions that have materialized over the past two days and which relate to the death of former President Richard M. Nixon:

1. The decision as to whether the American flag should be flown at half staff does not rest with local school districts. Direction for such action must come from the N.Y.S. Education Department through the local Board of Cooperative Educational Services, who in turn informs the various school districts.

2. For whatever reason it deemed appropriate, the State Education Department did not authorize that flags be flown at half staff on Monday and Tuesday of this week. Flags will be flown at half staff tomorrow, April 27th.

3. The fact that the flags have been flying at half staff on federal buildings has nothing to do with the public schools. The schools are under state jurisdiction and are not governed by the federal government.

4. Contrary to information being communicated by some children to their families, our schools will be open tomorrow, April 27th, as will all New York State public schools.

As a closing and additional piece of information, school districts may make individual decisions regarding flying the flag at half staff when local circumstances, such as the death of a staff member, warrant it.

Sincerely yours,

Laurence H. Johnson, Jr.
Superintendent of Schools

LBJ:mt