# A Touchdown for Subsidies

"Should Cities Be Ready for Some Football? Assessing the Social Benefits of Hosting an NFL Team" by Gerald A. Carlino and N. Edward Coulson, in *Business Review* (2nd qtr., 2004), Federal Reserve Bank of Philadelphia, 10 Independence Mall, Philadelphia, Pa. 19106.

It's become a familiar spectacle: Cities frantically compete for the favor of the National Football League (or the like) and offer to subsidize a stadium to attract a team. Do the benefits a city derives from having a professional sports team really outweigh the costs? Many analysts say no. But economists Carlino, of the Federal Reserve Bank of Philadelphia, and Coulson, of Pennsylvania State University, argue that an important factor is often overlooked: the pleasure city residents take in rooting for a home team, even if they never go to a game. "They root for the local athletes, look forward to reading about their success or failure in the newspaper, and share in the citywide joy when the home team wins a championship."

If people appreciate such things, they should be willing to pay for them, just as they pay for other "quality-of-life" benefits, such as scenic views or good weather. And that taste should be reflected in higher land prices and rents.

Carlino and Coulson looked at the record in eight cities that gained or lost NFL franchises during the 1990s. Holding other city traits constant, the economists calculated that having an NFL team raised annual rents for housing an average of eight percent. (All figures are in 1999 dollars.) That translates into about $480 a year per housing unit—or about $139 million in an average central city. In other words, people are willing to pay nearly $500 a year to live in a city with an NFL team.

As a result, the authors estimate, the host cities may each reap about $50 million annually in higher revenues from real estate taxes. Subsidies cost each city an average of only $27 million annually.

Still, Carlino and Coulson stop short of giving stadium subsidies their full endorsement. After all, spending millions on stadiums might mean not funding "possibly more worthy" projects, such as new schools.

# Fighting for Health

"Redefining Competition in Health Care" by Michael E. Porter and Elizabeth Olmsted Teisberg, in *Harvard Business Review* (June 2004), 60 Harvard Way, Boston, Mass. 02163.

Is there any way out of the health-care mess? The costs to businesses alone of providing health insurance have outpaced inflation in 13 of the past 17 years, reaching more than $6,200 per employee last year, yet the system keeps failing to provide care to all Americans. When it comes to health care, the vaunted magic of the market appears not to work, but making health care a government monopoly hardly seems a better alternative. So what's the solution?

"The most fundamental and unrecognized problem in U.S. health care today is that competition operates at the wrong level," write Porter, a Harvard Business School professor, and Teisberg, a business professor at the University of Virginia. "It takes place at the level of health plans, networks, and hospital groups. It should occur in the prevention, diagnosis, and treatment of individual health conditions or co-occurring conditions." That's the level at which "true value is created—or destroyed."

Exacerbating the wrong-level competition is the pursuit of "the wrong objective: reducing cost," as if health care were a standardized commodity. Health plans compete to sign up subscribers. Health-care providers compete to be included in health plan networks by giving deep discounts to insurers and employers with large patient populations. They also compete to form the largest provider groups, offering the widest array of services. Instead of cost reduction, what occurs is cost shifting. And instead of providing better quality care, the object becomes securing greater bargaining power and restricting access to services.

In the "healthy" competition the authors envision, providers would try to develop dis-

tinctive offerings, and most hospitals "would not try to be all things to everyone." All restrictions on patient choice of health-care providers would disappear. Providers would charge all patients the same price for treating the same medical condition, regardless of the patient's insurer or employer; billing would be simplified. And instead of trying to limit patients' choices and control physicians' behavior, insurers and other payers would compete in giving subscribers helpful information about treatment alternatives and providers who have track records of excellent outcomes with given diseases and procedures.

How to achieve all that? Porter and Teisberg look to employers, "the major purchasers of health care services," to lead the way—by making quality, not price, the key criterion in their purchases, and by insisting "that choice and information be made truly available at the level of specific diseases and treatments."

## Society

# *A Real Head Start*

"The Black-White Test Score Gap" by George Farkas, in *Contexts* (Spring 2004), Univ. of California, Dept. of Sociology, No. 1980, Berkeley, Calif. 94720–1980.

The persistent gap between the standardized-test scores of black and white children has long resisted explanation. *Biased tests?* The tests focus on basic abilities needed in school and well-paying jobs (and the gap shows up even when the teachers are black). *Race-related test anxiety?* The gap is found even among very young children. A *genetic basis?* There's no evidence for genetic superiority in IQ in individuals of either race. *Social class and family background?* Yes, of course, but most studies find that these account for only about half of the gap. And while racial differences in income have narrowed since 1990, the test score gap has not.

According to Farkas, a sociologist at Pennsylvania State University, research now points to an explanation rooted in cultural differences in child rearing that are expressed when children are very young.

Some of the differences are class based. Researchers studying 42 families of both races found that by the time their one-year-olds had turned three, professional parents had spoken 35 million words to them, middle- and working-class parents 20 million words, and low-income parents only 10 million words. Less talk produced smaller vocabularies in the children.

However, there's a black-white gap in vocabulary even when parents are of the same social class. Farkas's own study of youngsters ages three to 13 showed that black children from high-income families had significantly smaller vocabularies than their affluent white counterparts. The African-American children had about the same vocabulary knowledge as white children from low-income families.

In yet another study, which showed a widening racial gap in a group of 20,000 youngsters who entered kindergarten in 1998, teachers, including black teachers, told the researchers that black students at all income levels were less likely "to persist at tasks, be eager to learn, or pay attention"—and as a result of this and their initial disadvantage, were less likely to be placed in "higher ability groups." Race- and class-based differences in "home environment" again appear to be the key, writes Farkas. For example, middle-class black parents are less likely than their white counterparts (but more likely than poor black parents) to be "encouraging and positive" in verbal exchanges with their young children.

What can be done? Smaller class sizes and an emphasis on phonics instruction will help, Farkas says, but the racial gap appears well before children reach school. Yes, black parents should be encouraged to "interact more with their children in ways that will better prepare them for school," but Farkas emphasizes the need to thoroughly transform Head Start and similar preschool programs so that they teach crucial pre-reading and pre-math skills rather than the social skills that are their focus today. And he sees even greater potential in Early Head Start, a new program for children as young as one year old.