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.