Introduction

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POLICIES ARE GENERALLY BASED UPON SOME NORmative assumptions that have been shaped by perceptions of how, why, when, and where people and their needs are distributed around those norms. In a heterogeneous society, many of these assumptions are strained: policies based upon them will be imperfect, at best, and may even entrench maldistributions. In a changing society, this process is likely to be increasingly divisive.

These supplements are intended to examine the relation between policy and the distribution of needs and effects in a general way. None of the currents of policy is explored as a specific legislative program.

This focus on the policy impacts on black Americans is meant to serve two purposes. First, and with due regard for the caveats that follow, this is a relatively identifiable subpopulation against which the normative assumptions can be measured. Second, and with further caveats, black Americans are often assumed to be the portion of the population least benefited by past and current policies.

The politics of enumeration—who are counted, how they are categorized, and for what purposes—is an integral part of the recorded history of all nations. Two hundred years ago, the new American republic inscribed the process in Article I of its Constitution. Representational apportionment in the House of Representatives was to be based on "the whole Number of free Persons . . . [and] . . . three fifths of all other Persons." The status of the white population, almost all of European birth or ancestry, was unambiguously that of whole persons. (Native American Indians were variably whole or nonexistent, depending on whether they lived in the general population or on

reservations.) The relatively few free blacks, concentrated in the nonrural North, were whole persons. But without ambiguity, race was made to count—perversely, to "discount"—differently for more than 90 percent of America's black population.

Our purpose here is not to root out the injustices and contradictions inherent in this political (and, ineluctably, economic and social) apportionment of meaning and worth by race. Rather, it is to underscore that the way we classify people—and the ascriptive terms (they are rarely precisely descriptive) used to do so—most often reflects a specific set of purposes. As the purposes change, so do the classifications and the terminology.

The story of the rise of "ethnicity" in our cultural life and national record keeping postdates that of "race," and, indeed, has served different purposes. It is also a more nettlesome and plastic taxonomic construct. One need only consider the use of the term "Hispanic" to gauge the problems of definition. The still more recent term "minority" is equally troublesome and obfuscating for analytic purposes; for purposes of advocacy it may have its uses.

We have chosen to organize these supplements around race because, after sex and age, it has probably been the most consistently gathered and reliably reported involuntary attribute of variation measured within the American population. But even here, consistency and reliability over time, and accuracy at any point, must be accepted with great caution, even with a measure of skepticism.

Race, like any dichotomous variable, masks extraordinary heterogeneity and generates dysfunctional stereotypes, either negative or positive. Paradoxically, the last national census before Emancipation reported more race-specific variables pertinent (or presumed to be so) to blacks than did the census of 1980. Sex, age, residence, and other enumerated items were tabulated separately for free Negroes, mulattoes, and West Indians. Of course, some of the attributes ascribed to these classifications were patently wrong, and are more precisely captured by direct measurements today. Nevertheless, we still lack ways to summarize the heterogeneity of biology, ethnicity, and culture of race. The "black condition" is no more homogeneous than is the "white condition." But the distribution of persons along the *range* of conditions is likely to be different between the black and the white populations. Thus, comparison between the respective *medians*—or norms—will be misleading and often futile.

The decision to impose *black* over *Black* as the basic racial descriptor throughout was made by the editor, and is symmetrical with the use of *white.* Such usage has become common and standard in the scientific and scholarly literature. Several contributors demurred and argued forcefully for other choices. In the end, they graciously consented—in this instance—to allow the data and the analyses to make the points rather than risk the reader's distraction by variant capitalization.

These two supplements are organized into seven thematic sections: three in part 1 and four in part 2. Even while highlighting special aspects of *Currents of Health Policy: Impacts on Black Americans,* each section—indeed, each article—has elements in common with others. The ambiguity of race is pervasive, as is attention to heterogeneity. Many also caution about the limitations imposed by cross-sectional data as a guide to our understanding of change. There are, as well, the inevitable calls for more research and for better longitudinal data. These are balanced by counsel to improve our critical understanding and interpretation of the data we already have, upon which many public policies are now being based.

I. Who Are Black Americans?

This portrait of black Americans raises fundamental questions for any scheme of depiction: Who will be included? Is it to be a snapshot or a moving picture? How many dimensions will be included?

Reynolds Farley begins by suggesting that phenomena at any one time are best understood in relation to what has preceded them. Here, change is seen in light of the promise and the expectations of the mid-1960s, through a variety of indicators. William O'Hare focuses on other demographic measurements of portraiture, largely those of spatial distribution. Residential patterns, while themselves the product of other political, social, and economic phenomena, also effectively produce color-coded access to services and opportunities. Finally, Doris Wilkinson and Gary King raise profound and abiding questions about *any* racial portraiture: Just what is being portrayed, and for what purposes? Policy responses will differ according to whether the depiction is implicitly genetic or is an indicator of socioeconomic status. There are times (cf. Savage, McGee, and Oster on hypertension) when both may be involved, making the explication of meaning even more essential.

II. Mortality and Morbidity of Black Americans

The purposes of health policy—to address public and private resources to health needs in effective ways—are shaped, in large measure, by how we perceive need. This section elucidates some of the implications of using the grossest measurements of death and sickness.

Ronald Andersen and his coauthors begin with attention to the most fundamental methodological issues, especially as they relate to measuring sickness and wellness as a numerator. But the denominator—who we count—is cause for equal concern. Problems of sampling (cf. Gibson and Jackson) and observational bias (cf. Friedman et al.) can lead to profound distortions. Perhaps the most objective and uniform measure—albeit an imperfect one—of relative differential need is death. Douglas Ewbank's historical reconstruction of black mortality is importantly descriptive and suggestive. Public health improvements, such as clean water supplies, have been more colorblind in their impact than have specific medical care interventions. Kenneth Manton and his colleagues attempt to describe need through measuring excessive and premature deaths among black Americans. Whether the rates for whites are the best measure of progress and well-being for blacks is a contentious question (cf. Savage, McGee, and Osten; Baquet and Ringen; Miller) but reducing the preventable relative disadvantage of blacks is an attainable—but difficult—goal.

III. From Universal Entitlements to Employment-based Entitlements

Public health services in the United States are generally distributed across populations in an undifferentiated way, i.e., without regard for individual needs, preferences, and descriptive or ascriptive categories. Not so with personal health care services, to which individuals must seek access and for which providers seek payment. "Entitlement" describes the basis upon which access is granted and paid for. Traditionally, for some *classes* of people—e.g., Indians, veterans, presidents—entitlement was universal and publicly paid for. Medicare was widely regarded (expectantly by some, ruefully by others) as "a foot in the door" for a policy of universal entitlement for entire populaions. Today, a host of public decisions, even including provisions of the

Tax Reform Act of 1986, indicate a redirection of public policy. More and more do we look to the private employer as the guarantor of goods and services. In the past, employers in large national industries (those most likely to have strong trade union representation) provided the most generous benefits. As the overall economy shifts—the highest employment gains are in the less organized and lower-paying service sectors—this depth and breadth of insurance is likely to change. The impact of such structural change in employment opportunities will be most marked on the black labor force.

Stephen Long's synoptic review of employment-related insurance for health care services codifies the results of these trends. Measured by the increase in number of the uninsured, current policies are highly imperfect. For complex reasons, employment-related insurance, even if mandated, cannot singularly correct deeper problems in the structure of employment or social arrangements.

Karen Davis and her coauthors critically examine the complementary role of public insurance and service programs. They attribute to these procedures much of the absolute and relative health gains made by black Americans. Public programs, carrying public sanctions, have effectively lowered racial as well as economic barriers (cf. Schlesinger). Even though politically vulnerable, these programs are essential—a safety net for some, a foundation for others.

IV. Implications of Selected Policy Directions

American approaches to national health policy are only infrequently and inconsistently characterized by the usual political "isms." Pluralism, incrementalism, and a certain pragmatism do constrain the often ambiguous *processes* of reaching goals, but they do not describe the *content* of the end result very precisely. (The World Health Organization's "Primary Care for All by the Year 2000," specific of goal, but devoid of process, is non-American.) One process-cum-direction of current health policies is "making the system more efficient"—i.e., reducing expenditures for ineffective use of services by constraining their supply and raising their price. Three separate and independent policy clusters moving in this direction are reviewed in the five articles in this section. Each is seen to have special implications for black Americans.

Ruth Hanft and Catherine White examine a set of responses to the

presumed "surplus" of physicians, the putative agents of excessive use and explosive costs. Retrenchment in federal support to medical education has particularly disadvantaged young black aspirants to medical practice. The promise of relieving a physician *shortage* in major areas will be negated (cf. Schlesinger; Davis et al.). Mark Schlesinger reviews the widening promulgation of the ethos and and economics of competition in the health care system. In both publicly and privately funded markets, institutional responsiveness to local community needs will be diminished. The least advantaged—disproportionately black—will be at greatest risk.

The next three articles examine a parallel but older set of issues only recently revived under an economic/efficiency rubric. These deal with "prevention," i.e., earlier case-finding and more efficient intervention.

Daniel Savage and colleagues note that a uniform national approach to hypertension control has had marked success, especially among blacks. In examining the program's sociocultural adaptations and community acceptance that promoted this achievement, the authors caution that more biologically strategic targeting for blacks may be needed to sustain progress in the future. Claudia Baquet and Knut Ringen, on the other hand, find that approaches to control of cervical cancer disproportionately have benefited white women. Differences in racial biology cannot account for the discrepancy that the authors attribute to mutually dysfunctional behaviors between providers and black women. Harold Neighbors takes a less clinical and more social-structural view of preventing psychological malfunctioning and distress. Strategies will have to begin earlier, last longer, and be invoked at more critical points if mental health is to become a positive enablement, as well as an end in itself.

V. Groups at Special Risk

Although the United States has no coherent and cohesive policy directed to or covering most groups per se, special group interests and needs are not entirely neglected. Sometimes, as with adolescents, the attention is directed to localized and miniscule efforts to cope with the unintended fallout from the disarray of more massive policies and programs. In the case of workers in high-risk jobs, the seeming consensus among

policies and agencies of 15 years ago now appears as a conflict of competing rights. Once again, the least advantaged are the most vulnerable. In contrast, the "aged" were singled out by a policy for the most comprehensive universal health insurance, but essentially without differentiation by needs or resources of members of the group.

Frank Furstenberg, Jr. carefully analyzes how teenage sexuality has been cloaked in myth and misperception, thereby stigmatizing a group and obscuring the real problems. Without a more penetrating understanding of the cross-sectoral nature of the issues—education, employment, welfare—limited health policies are not likely to have an impact. James Robinson notes both cross-sectoral and intra-sectoral shortfalls in the *implementation* of policies that need not be in conflict. Racial equity in employment opportunities can be achieved along with increased safety in all jobs. Rose Gibson and James Jackson discuss the black elderly, the beneficiaries of a universal policy based on assumptions of a "normal" and linear process of aging. They find it impossible to isolate a "norm" in the heterogeneity of functional status and need; indeed, key measures may indicate that the aging process among blacks occurs in different ways and at different points in the life cycle. In common with others (cf. O'Hare; Neighbors; Furstenberg, Jr.), Gibson and Jackson call attention to the need to incorporate cohort effects in future projections. Black elderly of the next few generations may be increasingly middle class, but still larger numbers will have fewer traditional family supports and a lifetime of greater poverty.

VI. Racial Dimensions of AIDS: Attitudes and Policies

If policy is broadly construed as the product of a political and administrative consensus at an effective operational level, then nowhere in the nation do we find an AIDS policy. The course of the epidemic reveals how rigid attitudinizing—both within and without the communities at risk—may deflect attention from policies needed to protect the public.

Samuel Friedman and his nine coauthors find it helpful to reveal their own racial and ethnic diversity as they deal with the disproportionate toll of AIDS among blacks and Hispanics. In their agglutinative approach to the cultural variables surrounding various modes of trans-

mission, they elucidate the cultural constraints to effective action within each "community at risk." Myths and stereotypes impede rational policy making at all levels.

VII. Conclusion

Health policy—as a whole and in its parts—is ultimately a part of broader public policy. S. M. Miller, in summarizing the evidence of preceding articles, argues that differentials in health mirror differentials in other dimensions of life. Traditional frameworks of analysis of need and approaches to entitlement may not serve well in the future if they are perceived as opposing equity against efficiency. The national interest compels attention to both.

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