U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation

QUALITY IN CHILD CARE:

WHAT IT IS AND HOW IT CAN BE ENCOURAGED

May 1989

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

This report was prepared by HHS's Office of Social Services Policy (now the Office of Disability, Aging and Long-Term Care Policy). It was a speech given for the Family Impact Seminar by the Director, Division of Children, Youth, and Family Policy. For additional information about this subject, you can visit the ASPE home page at http://aspe.hhs.gov. The Project Officer was Ann Segal.

QUALITY IN CHILD CARE:
What It Is and How It Can Be Encouraged

Ann Segal

Division of Children, Youth, and Family Policy
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

May 31, 1989

Prepared for
Office of the Assistant Secretary for Planning and Evaluation
U.S. Department of Health and Human Services

Discussions of strategies to promote quality in child care nearly always begin with consideration of regulation. Most legislators and policy makers can agree that some government regulation of child care is broth acceptable and necessary. From this point on, however, opinions differ greatly over the kinds of care that should be regulated (center care, family day care, in-home care), the characteristics of care that should be regulated (health and safety only or program and credentials), and who should set and enforce the standards (Federal or state level). Near one end of the spectrum of opinions is Michael Schwartz from the Free Congress Foundation: "The main task of regulation is to protect children from foreseeable threats to their health and safety. As regulation goes beyond that point, it becomes a matter of replacing the personal judgment of parents with the abstract judgments of regulators." This position is based in the belief that quality can only be defined and best judged by the parent. Near the other end of the spectrum are such groups as the Children's Defense Fund and NAEYC, who feel comfortable endorsing national standards based on interpretations of research and the best judgment of a number of child care advocates. They, too, believe that the parent should choose the care best suited to his or her child, but that the choices should be limited to care that meets certain specifications for quality.

When considering regulation as a method for promoting quality, one needs to understand its history. Child care regulation in the United States has followed a long, twisted road since Pennsylvania passed the first licensing law in 1885. The early child care centers or day nurseries were considered to be "a necessary evil" used to protect poor children or children being cared for while mothers worked in war-related jobs. Few centers were regulated, and those standards that were enacted primarily addressed supervision and a safe play area. When the welfare system was reformed in the early 1960's, Congress provided the first direct child care funding other than the short-term funding during World War II--and to this funding was added the requirement that care supported with this money must meet state licensing standards. Again, health and safety, not broader program dimensions, were the major concerns.

Meanwhile, interest in early childhood education programs was growing, first due to the work of Maria Montessori and Friedlich Froebel and later because of research in the 1950's and 1960's that demonstrated that well designed, comprehensive preschool programs could stimulate the development of children. Head Start was a direct result of this research, and child developmentalists then began to focus their concern on child care.

As various social welfare programs were developed during the 1960's, child care was often included as a support service and various regulations were imposed. In 1967, Congress mandated that the many child care programs in many departments of the Federal Government be brought under one set of regulations (the FIDCR or Federal Interagency Day Care Requirements) to ensure that children would be protected from harm. The federal staff that developed the first FIDCR were primarily developmentalists, but they quickly realized that high-cost requirements could result in fewer children being served and less parents working. Therefore, they drafted a set of ambiguous, unenforceable, and unenforced goals that had little practical effect on the operation of

child care programs. Many of the staff that drafted the first FIDCR also helped to develop the 4-C program, Community coordinated Child Care, to attempt to coordinate all early childhood programs regardless of their funding source. The idea was to improve child care services but the program had little funding and a fuzzy role, so in most communities, it quietly ended about seven years later.

The 1974 passage of Title XX of the Social Security Act, consolidating many social services programs, again raised the issue of federal standards; this time Congress and the Ford Administration struggled with the concept of quality. The 1974 legislation called for enforcement of the 1968 standards with real penalties for non-compliance. However, a study showed that one-half of all Title XX funds used on child care would have had to be withheld due to non-compliance, and Congress became concerned that the availability of child care in many states would be significantly reduced. As a result, Congress decided to delay enforcement of the most costly requirements, the child-staff ratios and froze states' ratios at their 1975 levels. They also provided funds to states to help them upgrade their centers and directed the Department of Health, Education, and Welfare to conduct a study to assess the appropriateness of the 1968 standards. A number of states then maintained two levels of requirements--one simply for operation of a child care facility in the state and a higher one for support by public funds.

The appropriateness report, completed in 1978, found that the 1968 FIDCR should be revised. The 1979 revised, proposed rules reflected research findings that group size has a greater positive influence on child outcomes than does child-staff ratio. Adjusting group size is less costly than implementing more restrictive child-staff ratios, and many centers already operated with groups sizes proposed in the regulation. It was estimated that eighty percent of centers in the country would have been in compliance with the rules; however, it is unclear how many family day care providers would have been in compliance. Many states remained greatly concerned about the possible supply effects of the regulation, and in 1981 Congress voted to end federal regulations. Instead, the revised Title XX program, the Social Services Block Grant, again required that Title XX child care meet state and local standards.

Many of the current child care bills under consideration reopen the issue of federal regulations, but the Administration is firmly opposed to them, believing regulation is better handled at the state and local level, where regional differences and needs can be reflected. In addition, the Administration is convinced that federal standards "would increase the cost of supplying child care," limiting the choices for families with moderate and lower incomes.

State licensing standards are the standards that child care providers must now meet both for operation in the state and generally for receipt of public funds. State standards are only a floor beneath which no provider, who must meet state requirements, may operate; they are not goals or agreements on what quality means. States differ in their definition of the providers who must meet certain types of licensing standards--some states exempt church-run facilities; some states exempt part-day

facilities; states define child care centers differently, often by the number of children served; states may license or register family day care or they may not; states certainly differ in their definition of family day care--again, often by the number of children served. Local standards are even more diverse than state standards and they deal primarily with issues of zoning and fire safety, not issues of quality.

Why do standards vary so greatly?--Partly because there is no real agreement or research evidence to support one definition of minimum requirements, much less to support one definition of quality. Where there is general agreement, states move toward reflecting it--staff-child ratios for infants are going down and there is more required ongoing training for staff. Another reason that state standards vary is that all levels of government, providers, and parents must make trade-offs between cost and supply. To reach the goals of standards such as the NAEYC accreditation standards costs money, and parents, providers, and government are all faced with budgets.

Are standards really the way to establish quality anyway? We know from research done for the appropriateness study, an assessment study of title XX day care, and a recent study of three metropolitan areas that providers often operate at a level that exceeds standards, indicating that providers and parents define a level of quality with which they are comfortable. We also have found in the three metropolitan area study that unlicensed family day care providers cared for less children than licensed providers did; at the same time, more licensed family day care providers had some child care training--what does this combination of characteristics say about quality? We know, too, that unenforced standards mean very little. States generally try to visit all centers once a year; family day care providers may never be visited. It is unrealistic to believe that the Federal Government could do better or even as well given the vast numbers of small providers. Licensing and monitoring resources are limited. Finally, most child care experts would agree that just meeting regulations does not guarantee quality--frankly, I, like most people knowledgeable about child care, would not want to label any provider as a quality one without observing that provider in action--and the things observers notice and their decisions about the provider's level of quality will differ, especially based on the needs of any individual child in care.

So what can be done to move child care toward those things we can agree on as quality indicators--such as smaller group sizes, health and safety measures, and some child care training for staff. The most effective approach to improving child care is to educate consumers--parents--to understand what we know about quality, to visit providers before selecting one (and it is surprising that a number of parents do not shop around), and to note certain things like the staff-child interaction. Parents also need to know that good child care comes in many varieties--we know that when parents are comfortable with their child care, the outcomes for their children are improved. Parent education can be accomplished through educational materials, through the activities of resource and referral agencies, and through employee assistance programs. Once parents select a provider, they need to be aware of things to keep noticing. During the Department's analysis of ways to prevent child abuse, it was clear that the only effective mechanism was for parents to have easy access to providers caring for their children.

Parents have daily contact with providers and they can be program monitors. Parent involvement is also an important way to increase quality.

Another way to improve quality is through voluntary accreditation programs like that of NAEYC and the Children's Foundation. A good example of such a voluntary effort is the two levels of standards set by several states--one level is a minimum standard, the other is a goal. The 4 C's of Orlando, Florida has another approach. Long ago, the 4 C's developed a scheme of different reimbursement levels for centers depending on whether centers met or exceeded certain requirements. In addition, in Florida, all family day care providers must be registered. However, if a family day care provider will meet higher standards of licensing, the 4 C's will: sponsor that provider for the Child Care Food Program; make available to the provider a lower cost liability insurance policy; give access to low cost physicals and, free immunizations and help with children's special health problems; and provide a special notation in the 4 C's resource and referral listing. Other local communities like Fairfax County, Virginia have tried similar incentive programs for family day care providers.

Model standards, help with enforcement techniques (such as the Indicator Checklist developed under a five-state monitoring transfer consortium sponsored by HHS), and research can all help influence state, provider, and parent decisions about quality. In 1990 and 1991, $13 million is available under the New Family Support Act to assist states "improve their child care licensing and registration procedures and to monitor child care provided to children" under the Act. The American Academy of Pediatrics and the American Public Health Association will soon release draft model standards designed to protect the health and safety of children in child care settings. Numerous research projects, funded by government, foundations, and universities provide insight into the child care market and quality issues. For example, with two projects about to be launched, one by HHS and one by the Department of Education, there will be updated national pictures of the supply of and the demand for child care. The consumer study will directly address parental preferences.

Research has demonstrated that child care training does improve quality. There are numerous child care training programs. The Child Development Associate training program has been used to improve quality in Head Start; CDA training is just as valuable for improving the quality of child care, not just in Preschool centers, but also in infant programs and in family day care. Other training is available from community colleges, from college and university degree programs, and from resource and referral agencies. There is also in-service training conducted by providers and training provided directly by state and local governments. Many training materials are available.

In the end, raising quality really has to be accomplished by parents and providers at the provider level. It is the center director who will hire staff and the director and sometimes parent boards who will make the decisions that will directly affect staff--and the caregivers are the most critical determinants of quality. Working conditions and salaries definitely influence who will become staff and who will stay as staff. It is no secret that child care is a lowly paid profession, but raising salaries significantly is not

easy--parents, providers, and government all have limited budgets. It is at the provider level that staff-child ratios above minimums will be set--and the provider, both center directors and family day care providers, will have to balance carefully a decision to have a ratio of 1-6 for 3 year olds with staff at lower salaries, with a ratio of 17 or 1-8 with somewhat higher salaries. The provider must seek out training opportunities and provide in-service training. Family day care can be improved by linkages to resource and referral agencies or centers that provide support and training. Businesses can also provide materials and financial support to, increase a provider's quality. Parents, too, help determine quality by deciding whether or not to purchase the care available--that is why it is important to empower them with funds that allow them to make choices as an expansion of the Earned Income Tax Credit would do.