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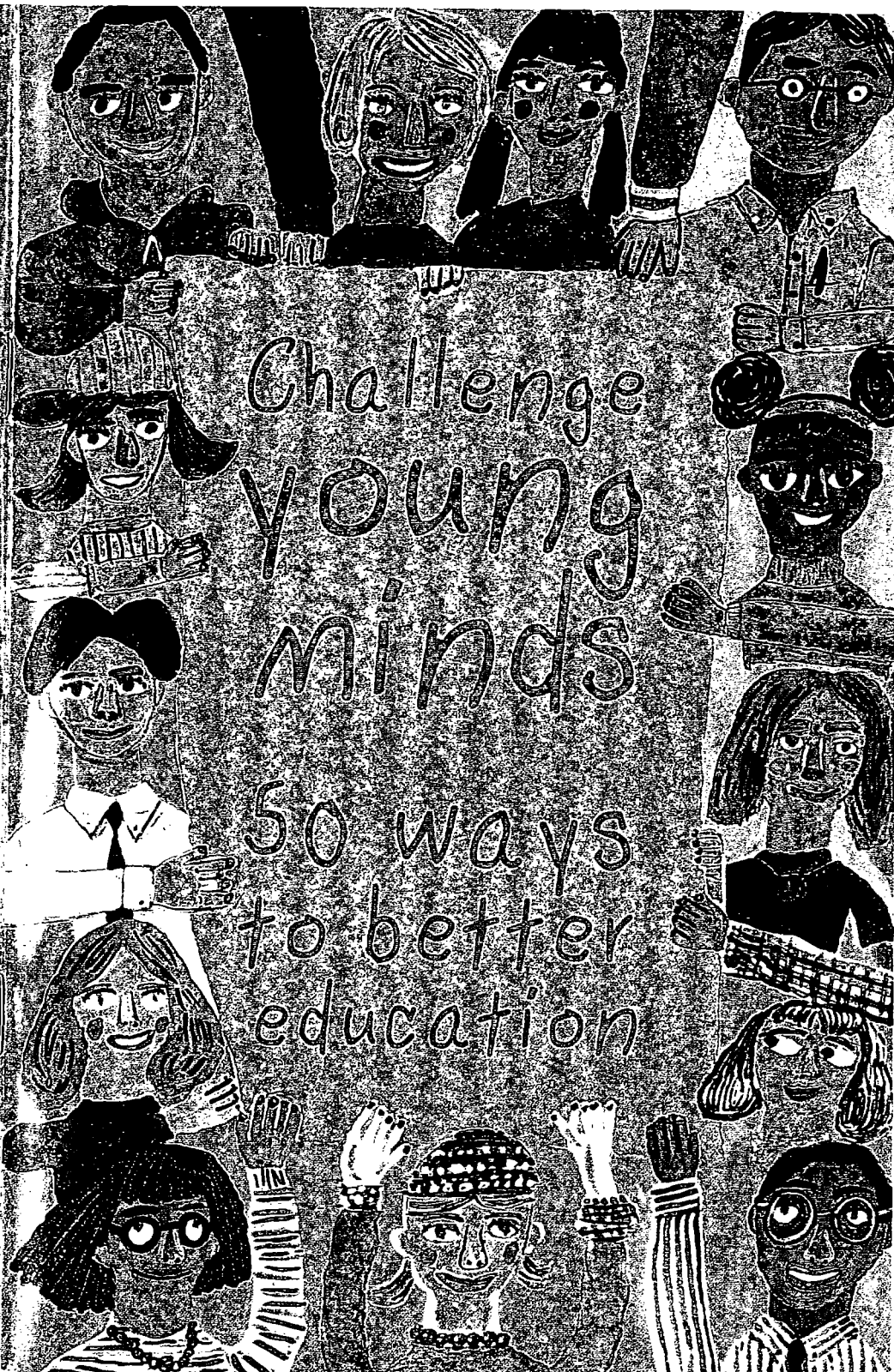
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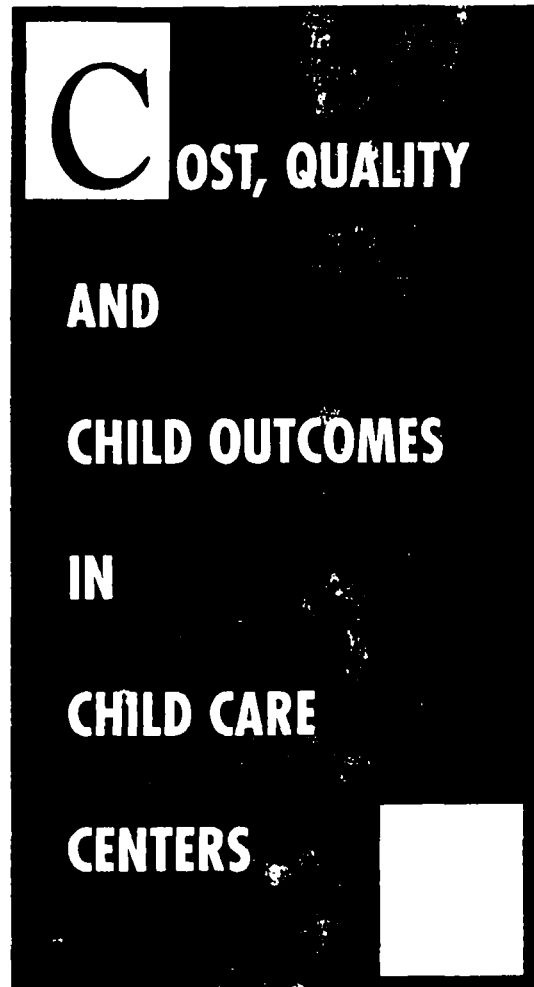
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EXECUTIVE SUMMARY

APRIL, 1995

Cost, Quality, and Child Outcomes in Child Care Centers

Executive Summary

Conducted at a time when increasing numbers of the nation's young children are in child care and when the American public is duly concerned about the readiness of young children for school, the Cost, Quality, and Child Outcomes Study provides the first comprehensive econometric and psychometric analysis of child care and children's outcomes. Uniquely designed to examine the relationships among the costs of child care, the nature of children's child care experiences, and their effects on children, this study provides fresh provocative information for practitioners, policymakers, and the public.

In brief the study found that while child care varies widely within and between states and sectors of this industry, most child care is mediocre in quality, sufficiently poor to interfere with children's emotional and intellectual development. Market forces constrain the cost of child care and at the same time depress the quality of care provided to children.

Results indicate similar fees, low profit margins, and minimization of costs—all characteristics associated with strong price competition. Good-quality care costs somewhat more to produce than poor-quality care, but generally higher costs are not obviously reflected in parent fees, which are relatively similar in centers of different quality. Consumers thus show little differential effective demand for higher quality, in part because they have difficulty observing the quality of care the children actually receive. This means that there are few economic incentives for centers to improve quality.

The research team collected cost and quality data during the spring of 1993 through visits to 50 non-profit and 50 for-profit randomly chosen centers in each of four states: California, Colorado, Connecticut, and North Carolina. Trained data collectors conducted interviews and distributed questionnaires to center directors, teachers, and parents and observed two randomly chosen classrooms in each center. That summer, the team collected data on 826 children from preschool classrooms visited earlier, which allowed an examination of the concurrent developmental outcomes related to their child care experience.

This report summarizes findings in four major areas: 1) quality, 2) costs, revenue, and support, 3) sector comparisons, and 4) the child care economic environment.¹ It discusses implications of these findings and makes recommendations for change. Study methodology is summarized in Appendix 1.

Major Findings

QUALITY:

Based on criteria established by the early care and education (ECE) professional communities, we define "quality" child care as that which is most likely to support children's positive development. To ascertain classroom quality, trained observers used instruments that permitted evaluation of the quality of the total child care environment as well as more specific aspects of the relationship between teacher and child (see Appendix 1 for detail). An overall index of center quality was constructed, from 1 to 7, interpreted as follows:

¹ Unless otherwise stated, all findings reported here are statistically significant at least at the 5% level.

- 1 - Inadequate: Children's needs for health and safety not met; no warmth or support from adults observed, no learning encouraged.
- 3 - Minimal: Children's basic health and safety needs met; a little warmth and support provided by adults; few learning experiences.
- 5 - Good: Health and safety needs fully met; warmth and support for all children; learning in many ways through interesting, fun activities.
- 7 - Excellent: Everything in "good," plus children encouraged to become independent; teacher plans for children's individual learning needs; adults have close, personal relationships with each child.

The range of quality between these scores is also important. In particular, we call services that are rated below minimal (less than 3) "poor" or "less than minimal"; those that are between minimal and good (3 to less than 5) "mediocre"; and those that are between good and excellent (5 and over) "developmentally appropriate."

FINDING 1: Child care at most centers in the United States is poor to mediocre, with almost half of the infants and toddlers in rooms having less than minimal quality.

The level of quality at most U.S. child care centers, especially in infant/toddler rooms, does not meet children's needs for health, safety, warm relationships, and learning. While there is a great deal of variation in the sample, the mean score for all centers in the study was 4.0, a full point below the good-quality level (5). Figures 1 through 3 show the distribution of quality scores. Only one in seven centers (14%) received a rating of developmentally appropriate (5 or above), and one in eight (12%) were less than minimal (less than 3).

Child care for infants or toddlers is of particular concern. Of the 225 infant or toddler room observations, only 1 in 12 (8%) met the good-quality level, while 2 in 5 (40%) rated less than minimal. Babies in poor-quality rooms are vulnerable to more illness because basic sanitary conditions are not met for diapering and feeding; are endangered because of safety problems that exist in the room; miss warm, supportive relationships with adults; and lose out on learning because they lack the books and toys required for physical and intellectual growth.

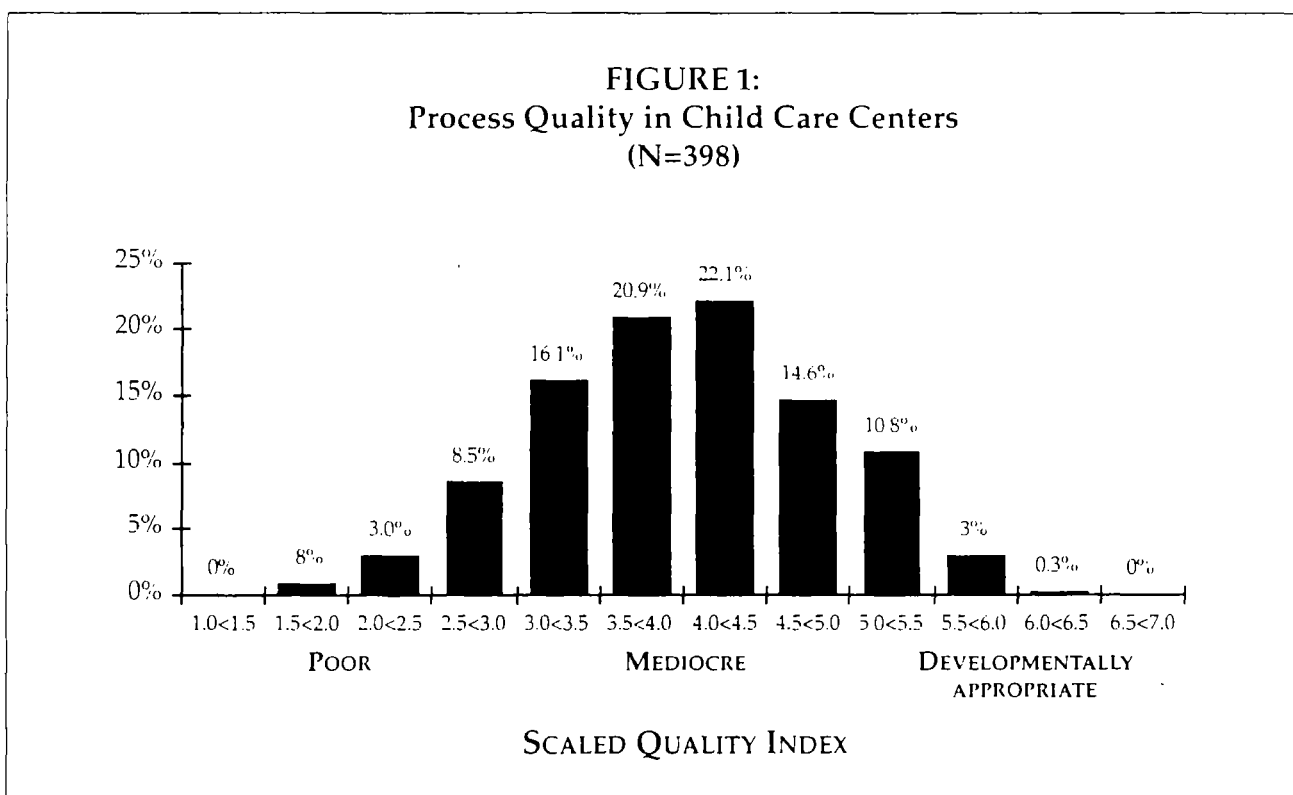


FIGURE 2:
Process Quality in Child Care Centers
Infant/Toddler Classrooms
(N=225)

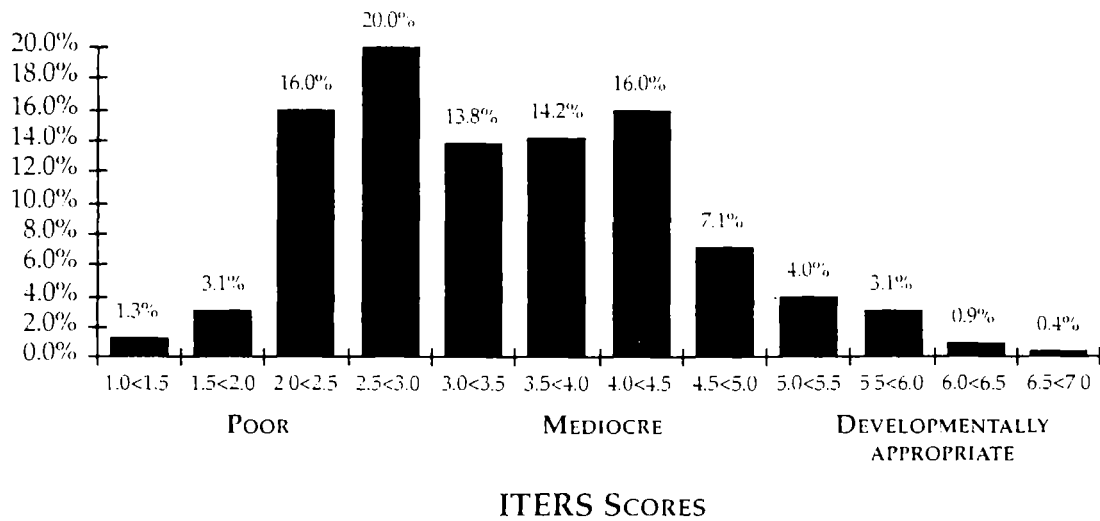
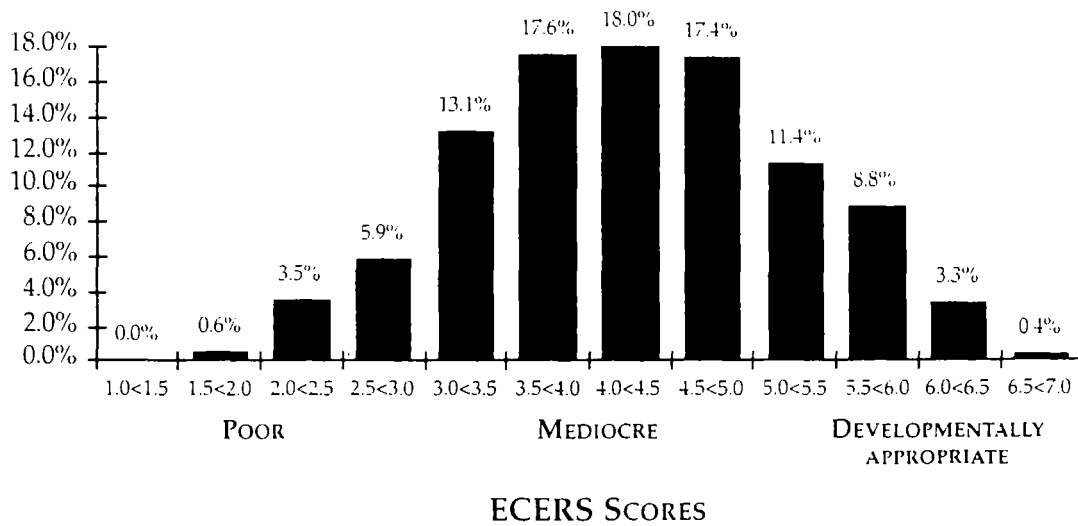


FIGURE 3:
Process Quality in Child Care Centers
Preschool Classrooms
(N=511)



FINDING 2: Across all levels of maternal education and child gender and ethnicity, children's cognitive and social development are positively related to the quality of their child care experience.

Children in higher quality preschool classrooms display greater receptive language ability and pre-mathematics skills, and have more advanced social skills than those in lower quality classrooms. Children in higher quality centers have more positive self-perceptions and attitudes toward their child care, and their teachers are more likely to have warm, open relationships with them. All of these factors are considered important to a child's capacity to enter school ready to learn. Further, these relations were obtained in analyses that controlled for child and parent characteristics known to be related to both child care selection and developmental outcomes, including maternal education and child gender and ethnicity.

While many previous research projects have studied the impact of child care on the development of at-risk children, this study focuses on the broad range of children in center care. For these children, developmental outcomes on a wide variety of measures improve with the quality of the center across all levels of maternal education and child characteristics. In some instances, however, quality had even more impact on children typically at risk (specifically on receptive language ability of minority children and on the self-perceptions of children of less-educated mothers).

FINDING 3: The quality of child care is primarily related to higher staff-to-child ratios, staff education, and administrators' prior experience. In addition, certain characteristics distinguish poor, mediocre, and good-quality centers, the most important of which are teacher wages, education, and specialized training.

This study affirms how important the ratio of adults to children is to quality of services. In the statistical analysis to predict the determinants of quality, the staff-to-child ratio is the most significant determinant of quality, even when controlling for other factors affecting quality. Center quality also increases as the percentage of center staff with a high level of education increases. An increase in a center administrator's prior experience generates higher quality, all else being constant. Finally, there is some evidence that staff tenure at the center also increases quality.

A different analysis identified classroom and center characteristics that distinguished among centers of poor, mediocre, and good quality. This analysis was particularly successful in identifying poor-quality centers, and only moderately helpful in discriminating between mediocre care and good-quality care. The most important discriminators were average teacher wage rates, and teaching staff education and specialized training.

FINDING 4: States with more demanding licensing standards have fewer poor-quality centers. Centers that comply with additional standards beyond those required for licensing provide higher quality services.

More poor-quality centers were found in North Carolina than in the other three states. Of the four states included in the study, North Carolina is the state with the least stringent child care standards. For example, at the time of data collection, North Carolina allowed 1 adult to every 6 infants or 15 three-year-olds, while the other states required 1 adult to every 4 or 5 infants or 10 or 12 three-year-olds. Similarly, North Carolina required far less early childhood education of its center staff than did the other three states.

In addition, centers that meet higher standards than required of all centers in their state in order to receive public funding pay higher wages, provide better benefits and working conditions and have higher overall quality. Finally, accredited centers, those that voluntarily meet a higher set of standards specified by an outside organization, have higher quality than do nonaccredited centers.

FINDING 5: Three specific types of centers provide higher than average overall quality. The financial characteristic these centers share is that they have access to extra resources that they use to improve quality.

The 28 centers operated by a variety of public agencies (in public schools, state colleges, and universities, or operated by municipal agencies), the 16 worksite centers, and the 30 centers with public funding tied

to higher standards (the same group cited in Finding #4) provide higher quality care than other centers. With few exceptions they share the following characteristics: they have higher expended costs and total revenue per child hour, have more donated resources, and are less dependent on parent fees than other centers; they pay higher wages and provide more staff benefits; they have higher staff-to-child ratios; and teachers have more education, more specialized training, and longer tenure in the centers.

The econometric analysis shows that centers operated by public agencies (and nonprofit centers in general) use resources as efficiently as other centers. That is, for a particular level of quality, wage rates, full-time-equivalent (FTE) children, and size of facility, the cost per child hour is the same as at other centers.

These results suggest that quality is higher in centers that have in-kind donations or outside funding that they use to increase quality. While parent fees may represent a major source of revenue (for instance, in the worksite centers and centers operated by state colleges or universities), these centers do not have to depend solely on parent fees to finance the provision of quality services.

COSTS, REVENUE, AND SUPPORT:

Before discussing costs and revenue, several terms must be defined. First, we use the term *expended costs* to refer to cash costs that are actually incurred to run centers. Second, we use the term *donations* to refer to the goods and services that are donated by individuals and agencies to support child care. Those donations—facilities, volunteer services, or other kinds of goods or services—must be included to report accurately all of the costs of providing care. Third, we use the term *foregone wages* to refer to the difference between the wage a staff person could earn in another occupation (based on the person's education, sex, age, race, and marital status) and the person's wage as a child care worker.² Fourth, we use the term *full cost* to refer to the amount it would take to operate centers if all costs were included. That is, the full cost of care equals expended costs plus donations plus foregone wages. Finally, we use the term *total revenue* to refer to the total amount of income received by a center, including fees paid by parents, publicly reimbursed fees, USDA food grants, other public funds, sponsor and other private contributions, and other revenue.

FINDING 6: Center child care, even mediocre-quality care, is costly to provide. Even so, donations and foregone wages are large, accounting for more than one-fourth of the full cost of care.

The average *expended cost* (or cash cost) is \$95 per week per child, or \$2.11 per child hour, to provide mediocre care. (See Figure 4 on the following page for costs by state.) In this labor-intensive industry, labor costs account for 70% of total expended costs. Facilities costs represent 15%, and all other cash expenses make up only 15% of the total. That expended costs are as low as they are is due to the use of primarily female employees (97% were women in this sample) who earn even less in child care than they could in other female-dominated occupations. In this study, the mean foregone wages given up by teachers was \$5,238 per year; assistant teachers gave up \$3,582 per year.

Our estimate of the mean *full cost* of producing center child care services is \$2.83 per child hour (\$127 per week), or \$.72 per child hour more than expended costs. Figure 5 (on the following page) shows that this additional \$.72 per hour of costs comes from: 1) workers who contribute 19% of full costs (\$.54 per child hour) in the form of foregone wages and benefits, 2) occupancy donations, which average about 5% of full cost (\$.14 per child hour), and 3) volunteer services and donated goods, which represent 2% of full costs (\$.06 per child hour).³

The amounts of foregone wages and in-kind donations vary by state. When foregone wages are adjusted for regional differences in the cost of living, they are smallest in Connecticut, where overall quality is

² Foregone wages represent another kind of cost. Child care is a labor-intensive industry dependent on female employees who work for wages below those they could earn, even in other female-dominated occupations, all of which pay less than comparable male occupations. Regardless of the reason that child care employees accept jobs in the field, centers are using labor resources which embody human educational investments and work experience that do not show up in center cash outlays. As the industry expands or improves quality or if the national labor market tightens, it may be naive to expect more and more women to continue to work for these lower wages.

³ These do not add up to exactly \$.72 because of rounding errors.

FIGURE 4:
Expended Cost per Child Care Hour
by State

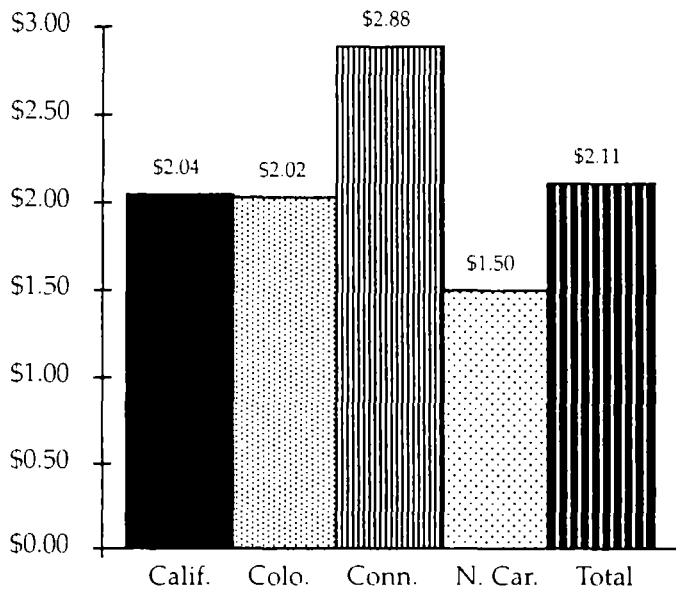
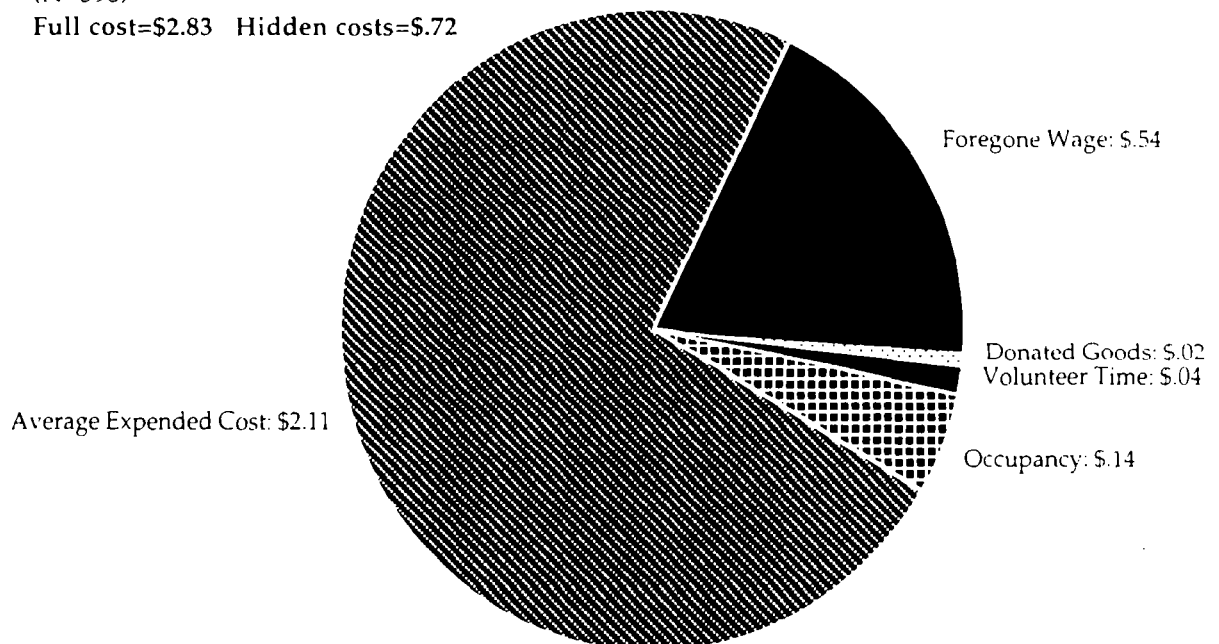


FIGURE 5:
Full Cost of Child Care per Child Hour
(N=398)
Full cost=\$2.83 Hidden costs=\$.72



higher, and largest in Colorado, where quality is lower than expected (based on licensing standards). This suggests a positive relationship between quality and the payment of wages that are more competitive with those in other industries using similarly qualified workers.

A comparison of the expended cost of child care with a typical family's income indicates the high cost of producing even mediocre-quality care. The average annual expended cost paid by a center to provide services for one child is \$4940 per year. This represents 8% of the 1993 median U.S. family before-tax income of about \$60,000 for a dual-earner family when both were employed full time, and 23% of the 1993 median before-tax earnings of just over \$21,000 for families headed by a single parent employed full time (*Statistical Abstract of the U.S. 1994*, pages 429 and 474).

FINDING 7: Good-quality services cost more than mediocre quality, but not a lot more.

The cost of providing care is modestly and positively related to the level of quality of services.⁴ The additional cost to produce good-quality services compared to mediocre-quality care was about 10%. The cost of increasing quality increases, however, at higher levels of quality.

This 10% estimate is based on cross-sectional data and cannot, therefore, be used to project the quality change from increasing industry-wide expenditures. For a 10% increase in cost to significantly improve quality, the money would have to be spent wisely and not cause any increase in the prices of resources used.

FINDING 8: Center enrollment affects costs.

The effect of enrollment on costs shows up in two ways. First, the larger the number of children served (up to the legal capacity of the center) and/or the longer the hours of service, the lower the cost per child hour for a particular level of quality. That is, using the same facility space, serving more children or serving them more hours brings about a proportionately smaller increase in cost per child hour. Second, larger centers, those serving a larger number of FTE children, also have lower average total expended costs per child hour than centers serving a smaller number of children, even holding quality constant.

FINDING 9: Cash payment from government and philanthropies are sources of center revenue that demonstrate a social commitment to sharing the expense of child care. On average, these cash payments represent 28% of center revenue.

As a society we consider center child care an important service that some children need regardless of their family's income. Economists call such things *merit goods*, because all who need the service merit having it. Cash philanthropic contributions, public funding of centers, and child care tax credits all help reduce the fees paid by parents and other purchasers of child care as do donations and foregone wages.

For the whole sample, including families whose child care is subsidized, parent payments to centers represent the equivalent of \$1.55 per child hour or \$70 per week. This represents 71% of center revenue (and 55% of full cost). For families that pay full tuition, tuition for preschool-aged children averages \$1.92 per child hour or \$86 per week. If the typical family elects to take the federal child care tax credit available to them, this represents another government contribution, reducing parent expense by an estimated average of \$.21 per child hour (20% of \$200 per month/193 hours per month).

⁴ The cost referred to in Findings 7 and 8 is based on the definition used in the econometric analysis, where, for consistency with economic theory, cost was measured as variable cost (excluding facilities cost and including in-kind donations and the imputed value of administrators' salaries for owner-operated centers).

SECTOR COMPARISONS:

Child care centers operate in a mixed market made up of private nonprofit centers, nonprofit publicly operated centers, and centers owned and operated for profit. The existence of nonprofit centers reflects long-standing public and philanthropic willingness to support provision of child care as a merit good. However, the fact that different kinds of financial structures co-exist and compete in local markets can affect the cost and quality of services.

FINDING 10: There are differences between for-profit and nonprofit sectors. Overall quality of services, however, is not significantly different between the two sectors except in the one state with very lax licensing standards.

Quality is not significantly different between for-profit and nonprofit centers except in North Carolina, where for-profit centers provide much lower quality care. In addition, our econometric analysis indicates that there is no significant difference in variable costs per child hour (see footnote 4 for definition) between the two sectors, holding constant the number of hours of service, quality, wage rates paid, and size of facility. This means that the nonprofit sector is about as efficient in the use of resources as the for-profit sector.

Despite overall similarities, there are also differences. In nonprofit centers staff-to-child ratios in preschool rooms are higher than those in for-profit centers; teachers and teacher-directors have more specialized training and formal education; assistant teachers and teacher directors have more prior experience; staff have worked more months at the center; and annual turnover rates are lower. Nonprofit centers pay higher wages, and foregone wages of their staff are lower than those in for-profit centers. While these findings replicate those of earlier studies (Phillips & Howes, 1987; and Whitebook, Howes & Phillips, 1989) that nonprofit centers have higher structural quality measures and higher wages than for-profit centers, it is the first to find such limited differences between sectors with respect to process quality.

FINDING 11: Within each sector, particularly the nonprofit sector, there is variation by subsectors in center characteristics and quality.

To examine differences *within* each sector we divided the nonprofits into three subsectors: 1) independent nonprofit, 2) church-affiliated nonprofit, and 3) publicly operated nonprofit. We divided the for-profits into three subsectors: 1) independent for-profits, 2) local chains, and 3) national systems.

Within the for-profit sector, there is considerable homogeneity among the three subsectors with regard to staffing ratios and staff quality. In addition, the different subsectors do not significantly differ in their costs, revenues, and overall quality of services. National systems do, however, offer more staff benefits such as health insurance, maternity leave, and staff child care discounts, and they pay lower wages in California and Connecticut.

Nonprofits are less homogeneous; indeed, there are important differences among subsectors. Centers operated by public agencies have higher costs, revenues, and quality than other nonprofit centers. Church-affiliated centers have lower staff-to-child ratios, lower levels of trained and educated staff, lower wages, lower cost and revenues per child hour, and most importantly, lower overall quality than other nonprofits. These centers seem to resemble for-profit centers more closely than centers in the nonprofit sector. Indeed, the lower quality of church centers accounts for our finding that for-profit and nonprofit sectors do not differ significantly in quality.

These findings dispel the notion that quality (or lack thereof) is crisply aligned with a particular sector. To the contrary, these findings suggest that it is difficult to associate any given level of quality with a sector overall; rather, levels of quality may be more clearly aligned with subsectors.

THE ECONOMIC ENVIRONMENT:

A unique focus of this study was to learn more about the effects of market conditions on the cost and quality of care. Differences in demand and supply conditions faced by different kinds of centers (that is, for-profit and nonprofit sectors or subsectors) may affect the quality of care provided in the market.⁵

FINDING 12: Characteristics of the market setting for child care—notably, market competition and subsidy dependence—affect center finances. For-profit and nonprofit centers face different competitive conditions that can affect their performance.

This study provides evidence of strong competition in local markets. First, centers in for-profit and nonprofit sectors charge similar fees per child hour. Second, both sectors seem to minimize costs. Third, both sectors receive similar low rates of profit (surplus) on sales (3.7%).

Despite evidence of a high degree of competition between sectors, the composition of costs and the ability to take advantage of scale economies is different. For-profit centers spend a higher percentage of total costs on facilities and a smaller percent on labor, which could lower quality. These centers, however, typically serve a larger number of children and/or provide more hours of service than do nonprofit centers. That allows for-profit centers to operate at lower average cost per child and enables them to compete successfully with their nonprofit counterparts at a given level of quality. Nonprofit centers, many of which depend on donated facilities, may not have the option of increasing their size (enrollment).

FINDING 13: There is evidence of inadequate consumer knowledge, which creates market imperfections and reduces incentives for some centers to provide good-quality care.

This study suggests some reasons for the prevalence of low-quality child care, particularly for centers dependent on parent fees. In our parent survey, while parents say they value the characteristics of good-quality child care, they substantially overestimate the quality of services their children are receiving. Ninety percent of parents rate programs as very good, while the ratings of trained observers indicate that most of these same programs are providing care that ranges from poor to mediocre.

There are numerous possible explanations for this discrepancy between parent and observer ratings, some of which we investigated. For instance, there is evidence that parents are hindered in assessing care by the inherent difficulty of monitoring service. The disparity between scores given by parents and observers assessing quality is higher for aspects of care that are difficult for parents to observe. Also, parents' priorities seem to affect their assessments. The more they value an aspect of care, the greater the disparity between their evaluation and that of the trained observer. There may be other reasons why parents rate their child care arrangement highly. For instance they may not feel that they have a choice of care, or they may never have seen good-quality care, giving them no basis of comparison. The inability of parents to recognize good-quality care implies that they do not demand it. There is little difference in fees between poor-quality and high-quality centers, which lends credence to this hypothesis. Given both a competitive market that equalizes fees across centers and parents' difficulty in identifying center quality, centers dependent on parent revenues have no incentive to provide a higher level of quality at higher cost.

The findings do suggest that centers are providing the services parents demand so they can go to work. Preschool classrooms meet health and safety needs. Centers in the sample are open long hours, 10 to 12 hours per day. They provide part-time care, before-school and after-school programs, and summer camps. Parents, however, while they value good-quality services, apparently are not demanding quality. To the extent that government agencies involved in purchasing care for low-income children impose low payments for services or fail to provide higher reimbursement for higher quality, they too contribute to lowering the demand for good-quality child care.

⁵ It should be noted that this study was not designed to make a thorough comparison of the long-run advantages and disadvantages of a particular profit status. We did not collect data on capital invested in centers; nor did we investigate tax advantages and disadvantages of profit status.

Summary and Implications

We found that only 1 in 7 centers provides a level of child care quality that promotes healthy development and learning, and that quality of child care affects children across all levels of maternal education. These findings confirm earlier reports about the quality of child care available to the average family in the United States, presented in the National Child Care Staffing Study (Whitebook, Howes & Phillips, 1989) and the Study of Children in Family and Relative Care (Galinsky, Howes, Kontos & Shinn, 1994). Our results indicate that care for infants and toddlers may be even lower quality than previously thought.

This does not mean that good-quality care does not exist or that the early childhood profession does not know how to provide it. We know that high staff-to-child ratios, more highly educated staff, administrators with more experience, and staff stability together do much to create good-quality services.

This study provides evidence of market competitive characteristics and imperfections that we have reason to believe affect the cost and provision of quality. Efficient markets require that buyers have full information. Until parents and other purchasers of care can easily distinguish good from mediocre and poor-quality centers, and demand higher quality, centers cannot increase their fees to cover the increased costs of providing better care. Since most centers have limited budgets, they cannot afford to provide better quality, given the existing fee structure.

Other conditions affect quality of services. First, weak licensing standards seem to induce some for-profit centers and church-affiliated centers to provide lower quality services. Second, accredited centers have higher quality. Third, publicly operated centers, worksite centers, and centers that conform to higher standards in order to receive public funding have higher quality; those centers seem to have sizeable donations or cash contributions, which they use to raise quality. Fourth, larger centers, or centers that maintain full capacity, can reduce costs and increase revenue, thus permitting an increase in quality.

Lower quality centers pay lower wages. We also found that wages of women working in child care are low, even compared to women's wages that already are lower than men's wages. Foregone wages are lower in Connecticut, where quality is higher. They are also lower in publicly operated and worksite centers where quality is higher. There is every reason to believe that higher foregone wages reduce staff job satisfaction and increase turnover. In the nonprofit centers studied, longer staff tenure is related to higher quality.

Recommendations

In this nation, there is a strong commitment to meeting the first of our national education goals—that by the year 2000, children will enter school ready to learn. Yet despite this knowledge and intent, the reality of child care in the United States today makes it highly unlikely that we will reach that goal. Unless poor-quality child care is curtailed, the development and well-being of large numbers of our nation's children may be jeopardized. To that end, we make one critical recommendation:

The nation must commit to improving the quality of child care services and to ensuring that all children and their families have access to good programs. That is, GOOD-QUALITY child care must become a merit good in the United States.

We predicate this recommendation on several assumptions:

- Child care participation will remain totally voluntary; that is, parents will have the right and responsibility to choose whether or not they use child care;
- Parents' right to choose child care will be preserved; that is, parents will have the right and responsibility to select the type of child care they wish;
- Child care will remain a mixed sector industry; that is, centers will continue to operate in the profit, nonprofit, and public sectors;
- As a merit good, a service we as a society want to provide for all children, the financing of quality child care will continue to be shared by responsible parties; that is, to the extent feasible, families will help pay for child care, as will responsible employers, philanthropic organizations, and the government.

To achieve this goal, we recommend four action steps.

ACTION STEP 1: Launch consumer and education efforts in the public and private sectors to help parents identify high-quality child care programs and to inform the American public of the liability of poor-quality programs.

- Give parents clear information regarding the observable ingredients of good-quality child care.
- Give parents and others information that clearly identifies good-quality programs.
- Initiate a long-term public media campaign analogous to the one addressing the impact of smoking on health, to raise public awareness of the nature and importance of good-quality child care.
- In collaboration with other private and public agencies, initiate a federally supported program of research to increase understanding of the child care market and to provide an ongoing data base on the status of child care and the effects on children in the United States.

ACTION STEP 2: Implement higher standards for child care at the state level, as a major approach to eliminating poor-quality child care.

- Create higher standards at the state level and improve monitoring of child care as a part of consumer protection. Standards must do more than protect the basic health and safety of children—they must also take into account children's developmental needs.
- Eliminate all exemptions from state licensing standards.

- Encourage centers to seek and maintain voluntary professional center accreditation based on high standards.
- Give state and federal financial incentives for centers to provide care that meets higher standards, eliminating federal regulations that restrict the ability of states to pay higher prices for higher quality care.

ACTION STEP 3: Increase investments in child care staff to assure a skilled and stable workforce.

- Invest more federal, state, and local government funds and private sector funds in the education and training of child care teaching staff and administrators.
- Provide all child care staff compensation appropriate to their training, experience, and responsibility.

ACTION STEP 4: Assure adequate financing and support of child care.

- Increase investment in child care by federal, state, and local government as well as the private sector, to help families pay the cost of good-quality care.
- Tie all federal and state child care funding to standards that demonstrably produce high-quality care.
- Provide financial incentives that enable centers to hire experienced administrators and skilled staff and to learn how to keep them.
- Tailor employee benefits to provide significant help to employees with young children, as part of the private sector's support of child care.

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Appendix 1: Study Methodology

This study examines the relationship between cost and quality of child care in centers, and the developmental outcomes of children enrolled in a subsample of the centers studied. The centers were located in four states—California, Colorado, Connecticut, and North Carolina—selected for their regional, demographic, and ECE program diversity.

Data were collected during the first half of 1993 on a stratified random sample of approximately 100 programs in each participating state, approximately evenly split between for-profit and nonprofit programs. The study included only state-licensed child care centers serving infants/toddlers and/or preschoolers that offered services at least 30 hours per week, 11 months per year. To be used in the sample, a program had to have been in operation at least one full fiscal year, and the majority of children had to attend at least 30 hours and five days per week. A total of 228 infant/toddler classrooms and 521 preschool classrooms were included.

The part of the study which addressed children's developmental outcomes included a subsample of observed preschool classes enrolling children eligible to enter kindergarten in fall 1994. A total of 826 children (approximately 200 per state) from 181 centers were included in this phase of the study. During the summer of 1993 individual assessments of the children were conducted at the centers by trained observers, and teachers and parents completed surveys.⁹

MEASURES AND PROCEDURES:

Through on-site interviews with center directors, data collectors obtained in-depth financial information such as center costs, revenue sources, and donation amounts. They also collected data on aspects of program characteristics, such as total attendance; enrollment and capacity; number of infants, toddlers, preschoolers, and school-aged children; number of publicly subsidized children; operating hours; ownership status; fee schedules; and source of payment. Finally, directors provided information on the education, training, demographic characteristics, and wages of each staff person working directly with children.

Staff persons in the sampled rooms completed questionnaires regarding their family and work experience. Center directors and lead teachers in each sampled room completed questionnaires on administrative leadership in the center. Parents in the sampled rooms were asked to complete a questionnaire about how they valued aspects of child care that professionals associate with child care quality, and about their assessment of quality in their children's classrooms.

Two well-established global measures were used to assess comprehensively the day-to-day quality of care provided for children: *The Early Childhood Environment Rating Scale* (Harms & Clifford, 1980) and its infant/toddler version, *The Infant/Toddler Environment Rating Scale* (Harms, Cryer & Clifford, 1990). In addition, two instruments designed specifically to measure teacher involvement and style were used, *The Caregiver Interaction Scale* (Arnett, 1989) and *The Teacher Involvement Scale* (Howes & Stewart, 1987). For each center, results of these observations for the two classrooms were combined into an overall quality index number for each center. The center quality index is a weighted average of the scores of the two rooms in the center, weighted by the percent of children in the center who were in the given age-group. Five times during the day, classroom observations of staff-to-child ratios and group size were made.

Data collected for the developmental outcomes component included individual child assessments, teacher ratings, and parent surveys. Each child was seen individually at the center for about 30 minutes to administer the following assessment instruments. Receptive language ability was measured using the *Peabody Picture Vocabulary Test-Revised* (Dunn & Dunn, 1981). The *Woodcock-Johnson Tests of Achievement-Revised* (Woodcock & Johnson, 1989; 1990) were used to examine pre-reading skills and pre-math skills. Children's attitudes toward child care and perceptions of competence were measured using the *Attitudes/Perceptions of*

⁹ Those children were assessed again during the spring of 1994, and will be assessed at the end of their kindergarten year in May 1995 in the longitudinal continuation of this study.

Competence Scale (Stipek, 1993). The children's teachers completed ratings of children's social skills using the *Classroom Behavior Inventory* (Schaefer & Edgerton, 1976). They rated the teacher-child relationship using the *Student-Teacher Relationship Scale* (Pianta, 1992; Pianta & Steinberg, 1992). Finally, parents completed demographic surveys.

All measures were studied descriptively to determine whether there were reliable differences related to region, auspice, or three measures of program scope: the proportion of center full-time-equivalent children who were subsidized, the proportion who were infants/toddlers, and whether the center offered a before-school and after-school program.

The econometric analysis involved estimating short-run total cost functions and quality production functions. We employed multiproduct translog cost functions where the services provided for infants-toddlers, preschoolers, and school-aged children are distinguished. Quality of the child care is controlled by the quality index described above. A vector of dummy variables, representing center attributes, is included to capture efficiency differentials due to center characteristics.

The quality production function is estimated using ordinary least squares, where the center quality index is explained by standard structural inputs (e.g., staff-child ratio, staff education, and experience) and the composition of programs offered by the center, as well as variables capturing center-specific idiosyncracies, such as an administrator's involvement in the center's organization and curriculum. The model also includes controls for the financial, regulatory, and institutional constraints surrounding the center's operation.

A psychometric analysis of correlates of quality was also performed using hierarchical regressions in which process quality was regressed onto 7 sets or "chunks" of structural variables. Seven sets of regression models were fit to the data. The first included the first set of variables, state and profit status. The second included the first two sets of variables—state, profit, and the teacher's background variables. Each successive regression involved adding another chunk of variables to the model.

A third analysis was performed, a discriminant analysis to identify the factors that are most able to classify centers offering poor, mediocre, or developmentally appropriate care.

Hierarchical linear regression models were used to test the concurrent relationship between children's developmental outcomes and the quality of their child care. The initial model for each outcomes variable included all main effects and two-way interactions to determine whether child and family functions, center sector, or geographic location mitigated the association between developmental outcomes and quality. Non-significant interaction terms were omitted one at a time until the model included all main effects, the state by sector interaction (which constituted the sampling frame) and all other significant two-way interactions.

Appendix 2: Cost & Quality Findings for All Centers by Profit Status

Variable	Mean Values		
	Non-Profit N=200	For Profit N=201	All N=401
Center Structure: Spring 1993			
Total FTE Children Enrolled	60	76	68
Percent of Centers Accredited	7	8	8
Percent of Infants & Toddlers	18	25	22
Percent of Centers with Before and After Care for School-Age	47	72	59
Annual Percent Center Turnover for Teachers	31	46	39
Annual Percent Center Turnover for Administrative Directors	13	18	15
Percent of Children Subsidized	34	13	23
Center Quality: Spring 1993			
Weighted Process Index, Scaled to ECERS	4.16	3.87	4.02
ECERS Total Quality Score	4.39	4.05	4.22
ITERS Total Quality Score	3.55	3.35	3.42
Midmorning Teacher to Child Ratios for Infants and Toddlers	0.31	0.26	0.28
Mid-Morning Teacher to Child Ratios for Preschoolers	0.19	0.14	0.16
Percent of Teachers with College Education or More	39	33	36
Months of Tenure for Teachers	53	36	43
Cost: Fiscal Year 1992			
Hourly Wage for Teachers	\$ 7.83	\$ 6.62	\$ 7.22
Hourly Wage for Assistant Teachers	5.97	5.43	5.70
Hourly Wage for Administrative Directors	12.22	9.89	11.33
Labor Cost per Child Hour	1.75	1.24	1.49
Facilities Cost per Child Hour	0.16	0.40	0.28
Total Cost per Child Hour	2.22	2.00	2.11
Foregone Wages per Child Hour	0.53	0.55	0.54
Total In-Kind Gifts per Child Hour	0.31	0.09	0.20
Full Cost (Total Cost + In-Kind Gifts + Foregone Wages)	3.03	2.63	2.83
Revenue & Fees: Fiscal Year 1992			
Revenue from Parent Fees per Child Hour	\$ 1.27	\$ 1.85	\$ 1.56
Revenue from Public Fee Payments per Child Hour	0.48	0.20	0.34
Total Revenue per Child Hour	2.28	2.10	2.19
Surplus or Deficit per Child Hour	0.06	0.09	0.08
Hourly Cost to Parents Net of Tax Credit*	1.10	1.62	1.36
Full-time Monthly Infant Fee Charged by Centers	434.78	461.53	450.80
Full-time Monthly Preschool Fee Charged by Centers	358.18	384.29	371.50
Preschool Hourly Fee (Monthly Fee/Hours of Care)	2.01	2.05	2.03

Note: Elements may not add to totals due to rounding.

* Equals full tuition discounted by subsidized children and federal income tax credit.

Technical Advisory Committee:

David Blau, *University of North Carolina*
Jerlean Daniel, *University of Pittsburgh*
Heidi Hartmann, *Institute for Women's Policy Research*
Anna Jo Haynes, *Mile High Child Care, Denver CO*
Ellen Magenheimer, *Swarthmore College*
Kim Moore, *Children's World Learning Centers*
Roger Neugebauer, *Child Care Exchange*
Barbara Reisman, *Child Care Action Campaign*
Bea Romer, *First Lady, State of Colorado*
Shelly Smith, *National Conference of State Legislatures*
W. James Smith, *University of Colorado at Denver*
Claudia Wayne, *National Center for the Early Childhood Work Force*
Marcy Whitebook, *National Center for the Early Childhood Work Force*
Barbara Willer, *National Association for the Education of Young Children*

Consultants:

David Blau, *University of North Carolina*
Patricia Hnatiuk, *Wheelock College*
Barbara Robles, *University of Colorado at Boulder*
Jeffrey S. Zax, *University of Colorado at Boulder*

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ADMINISTRATION: Evelyn Atkins, Lynn Ferguson, Jane Murray, Peter Neville, Cathy Riley, Carol Tagstrom.

DATA COLLECTORS:

University of Colorado at Denver: Bobbie Counihan, Ann Heiman, Tobin Follenweider, Sarah (Price) Follenweider, Carla Spence, Bradley Venner, Regina Sheehan Vigil, Regina Wieder, and Marie Wilwerding.
University of California at Los Angeles: Tanya Akel, Lisa Clarke, Ken Elkind, Diane Hembacher, Joan Herberg, Ellen Mark, Suzanna Morrell, Erin Oldham, Terry Tyor, and Lindsey Yeager
University of North Carolina: Catherine Adams, Paige Bebee, Kathleen Bernier, Debby Cryer, K.K. Lam, Adam Levinson, Jolie Long, Paula Malek, Carmelle Minton, Pam Rolandelli, Lauren Trine, Beril Ulku, and Bridget Wagoner.
Yale University: Caryn Blitz, Mary Ann Bonenberger, Teri Elniski, Barbara Hamlin, Harriet Kroop, Janet Lynne, Susan Nolan, Christine Roberts, Jean Rustici, and Carolyn Zittel.

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Rajan Kose of Standing Stone Productions, Boulder, Colorado.

PUBLIC RELATIONS: Phil Sparks of Communications Consortium, Washington, D.C.

RESEARCH ASSISTANTS: Kathleen Bernier, Teri Elniski, Sarah (Price) Follenweider, Adam Levinson, Jolie Long, Tim Martin, Carla Spence, Danny T. Rees, Cuong "Ken" Thieu Tran, Peter Neville, Bridget Wagoner, Joseph Ronald "LeRoy" White, Noreen Yazejian, and Carolyn Zittel.

VOLUNTEERS: Martha Daley, Carla Horwitz, Carolyn Lester, Karen Maggio, Carol MacElwee, Nancy Moriarity, Frankie Scott-Byrd, Kathleen Shindler, Claudia Shuster, Eileen Ward, Gail Wilson, Anne Wirwer, and Andrea Wickes.

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Send your name and address, along with a check
or money order payable to "Cost & Quality Study", to:
Cost, Quality, and Child Outcomes Study

Economics Department
Campus Box 159
P.O. Box 173364
University of Colorado at Denver
Denver CO 80217-3364

Phone: (303) 556-4934

Fax: (303) 556-3547

Access to Child Care for Low-Income Working Families



**U.S. Department of Health and Human Services
Administration for Children and Families**

October 19, 1999

Access to Child Care for Low-Income Working Families



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Executive Summary

Out of necessity or choice, mothers are working outside the home in greater numbers than ever before. In 1996, three out of four mothers with children between 6 and 17 were in the labor force, compared to one in four in 1965. Two-thirds of mothers with children under six now work. Reliable, high-quality child care is critical to these mothers' productivity at work, as well as to their children's health and intellectual development.

With the unemployment rate at 4.2 percent, a 30-year low, many employers are having difficulty finding the workers they need. Women are expected to make up over 60 percent of new entrants to the labor force between 1994 and 2005. Welfare reform makes it likely that the demand for quality child care will be even greater in the future. Unfortunately, the cost of child care is often beyond the means of low and moderate-income working families, including those that have never been on welfare.

The Child Care and Development Fund (CCDF) is the major source of Federal child care assistance for low and moderate-income families. The program provides funding to states for subsidizing care of the parent's choice, whether in a family child care home, with a relative, or in a child care center.

This report provides new information on the number of children receiving subsidies through the CCDF in fiscal year 1998 and on the number of children eligible for assistance, by state. Nationally, in an average month in 1998, only 1.5 million of the 9.9 million low and moderate-income children eligible for CCDF assistance actually received help through the program – just 15 percent of eligible children.

The gap between eligibility and receipt of services would be greater if states had chosen to define the eligible population to include all of the low and moderate-income working families that are potentially eligible under Federal law. If all states set eligibility limits at the maximum levels allowed under Federal law – 85 percent of state median income – an estimated 14.7 million children would have been eligible for subsidies in fiscal year 1998, of whom only 10 percent were served.

The percentage of children eligible under state limits who are served with CCDF funds varies across states. About one-fifth (9) of all states are serving less than 10 percent of the eligible children, three-fifths (31 states) are serving between 10 and 25 percent of eligible children, and one-fifth (11 states) are serving 25 percent or more of the eligible population. Differences in state definitions of the eligible population explain some of this variation, which is also caused by differences in funding amounts, local child care costs, reimbursement rates, co-payment policies, and the number of low and moderate-income working parents in each state. If all states expanded eligibility to the Federal maximum limits, over half the states (27 states) would be serving less than 10 percent of eligible children, with the remaining half (24 states) serving between 10 and 25 percent of eligible children.

The CCDF Program. The Child Care and Development Fund (CCDF) is a Federal-state program which enables states to subsidize the child care expenses of low and moderate-income families. The Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) consolidated most Federal child care funding, thereby allowing states to serve families through a

single integrated child care system. States have tremendous flexibility to design policies and define eligibility guidelines, service priorities, provider payment rates, and family co-payment amounts, in conformance with broad parameters specified under Federal law.

NOTE: The Child Care and Development Block Grant (CCDBG) Act provides discretionary funding for child care assistance. PRWORA consolidated mandatory child care funding under the Social Security Act and applied the CCDBG Act rules to these mandatory dollars. The term “CCDF” refers to the combination of the CCDBG discretionary funds and the Social Security Act mandatory funds, both of which are subject to the provisions of the CCDBG Act.

Large numbers of children remain unserved despite the fact that states drew down all available Federal mandatory CCDF funding in 1998 and transferred \$636 million in Federal TANF dollars to CCDF programs.

In all, states in FY 1998 spent \$3.5 billion in Federal mandatory and discretionary funds (including dollars transferred from TANF) and \$1.6 billion of their own funds on child care assistance through CCDF. As a result of these investments, 250,000 more children were served through CCDF in an average month in 1998 as compared with 1997.

NOTE: Some states provide child care assistance through programs separate from CCDF, but there is no source of consistent and reliable information on the number of children served through such programs. In most states, the bulk of child care subsidies are funded with CCDF dollars.

Affordability. Regular child care arrangements are often beyond the reach of working poor families if they do not have access to subsidies. In fact, child care expenses are often the second or third largest item in a low-income working family’s household budget. In 1993, for example, child care expenses averaged 18 percent of family income, or \$215 per month, for poor working families paying for care for one or more preschool children. For families with income of less than \$14,400 (\$1,200 per month) the average share of income devoted to child care was even higher – 25 percent, or one-fourth of family income.

Two recent studies suggest that increased funding for child care subsidies increases employment rates and earnings for low and moderate-income parents, while other studies find that families on waiting lists for child care assistance cut back their work hours and are more likely to receive public assistance or go into debt (including declaring bankruptcy).

Quality. When families cannot get help in paying for child care, it is harder for them to find quality care that helps prepare their children for success in school. Although this report does not provide new information about child care quality, it does include a very brief summary of quality research and references. As this summary indicates, new research on preschoolers finds that quality child care programs make a difference in children’s cognitive performance, language development, social adjustment, and overall child behavior, with differences found as many as four years after program participation. Existing child care arrangements, however, vary in quality, and too many children are exposed to poor conditions in care. Studies of investments in quality have found that state-wide quality initiatives, such as those undertaken in Florida and North Carolina, have resulted in improved quality of child care programs and enhanced child development.

Information Sources. The new information reported here comes from two sources. The average monthly estimate of children receiving CCDF subsidies – 1.5 million in 1998 – is a preliminary estimate based on state administrative data reported to HHS for the months of April – September

1998. These administrative data reflect children served (at least in part) through CCDF programs, not those served by other Federal, state, or local programs.

The eligibility estimates were generated from the Urban Institute's TRIM3 microsimulation model, based on three years' worth of Current Population Survey (CPS) data. The estimate of 9.9 million children eligible under state-set limits includes all children under age 13 (or older disabled children in certain states) who are living in families where the family head (and spouse if present) work or are in education and training programs and family income is below the states' income guidelines for assistance under the CCDF October 1997 state plans.

Access to Child Care for Low-Income Working Families

I. Introduction: Child Care and Development Fund under Federal and State Law

The Child Care and Development Fund (CCDF) is a Federal-state program which enables states to help subsidize the child care expenses of low and moderate-income families so they can work or attend education or training programs. The Personal Responsibility and Work Opportunity Reconciliation Act (P.L. 104-193) consolidated most Federal child care funding, thereby allowing states to serve families through a single, integrated child care system. States have tremendous flexibility to design policies and define eligibility guidelines, service priorities, provider payment rates, and family co-payment amounts, in conformance with broad parameters specified under Federal law.

NOTE: The Child Care and Development Block Grant (CCDBG) Act provides discretionary funding for child care assistance. PRWORA consolidated mandatory child care funding under the Social Security Act and applied the CCDBG Act rules to these mandatory dollars. The term "CCDF" refers to the combination of the CCDBG discretionary funds and the Social Security Act mandatory funds, both of which are subject to the provisions of the CCDBG Act.

Child care assistance under CCDF is generally limited by Federal law to families with children under age 13, although states may assist families with children up to age 19 who have special needs or are receiving protective services. In addition, both parents (or one parent in a single-parent family) must be in a work-related activity and family income cannot exceed 85 percent of state median income (SMI). Priority for services must be given to children in families with very low incomes and children with special needs. Within those parameters, states may set their own income eligibility limits and define other priority rules.

A comparison of state eligibility guidelines shows that state income limits vary considerably. As of October 1997, state limits for a family of 3 ranged from less than \$16,000 in Wyoming to over \$39,000 in Connecticut. As a result, in some states, families earning as little as \$18,000 are not eligible for any help with child care costs – costs that generally run between \$3,000 and \$10,000 annually if purchased at market prices. Only 9 states set the limit for a family of 3 at the maximum level of 85 percent of SMI, as allowed under Federal law.

Subsidized child care services are generally available to eligible families through certificates or vouchers that allow families to purchase care from a provider of their choice. States set the payment, or "reimbursement," rates that providers receive to serve children through CCDF. In addition, states establish sliding fee scales, based on family income and family size, which are used to determine each family's "co-payment," or contribution to the cost of care. Under Federal law, states are required to set aside a minimum of 4 percent of CCDF funds to improve the quality of child care and other services to parents. States must also have health and safety requirements that apply to all providers receiving CCDF subsidies.

II. The Child Care Subsidy Gap: Estimates of Need and Services

To date, estimates of need for CCDF child care services have been limited by the lack of simulation models incorporating the CCDF eligibility criteria that, as explained above, vary across states. To correct this information gap, the Department of Health and Human Services

contracted with the Urban Institute to enhance the existing Transfer Income Model (TRIM3) to produce estimates of the potential need for child care subsidies on a national and state-by-state basis. Initial results from this model are reported below, along with information on the number of children served according to administrative data reported to HHS.

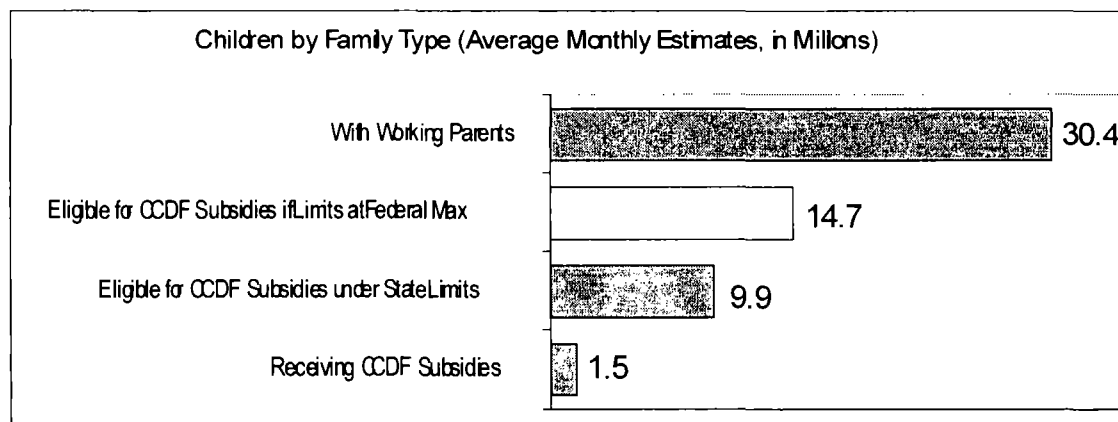
National Estimates. According to the Urban Institute model, there are 30.4 million children with working parents (regardless of income), of which 9.9 million are estimated to meet the states' CCDF income eligibility guidelines in place at the beginning of fiscal year 1998.

Only 1.5 million children actually received child care subsidies funded by CCDF in an average month in 1998. This estimate of children served, based on state administrative data from April to September 1998, suggests that only 15 percent of the eligible population were served, leaving a large gap between child care need and services, as shown in Figure 1. NOTE: The 1.5 million figure is preliminary and subject to revision.

The gap would be even greater if states had chosen to define the eligible population to include all of the low and moderate-income working families that are potentially eligible under Federal law. In fact, if all states set eligibility limits at the maximum levels allowed under Federal law – 85 percent of state median income – an estimated 14.7 million children would have been eligible for subsidies in an average month in fiscal year 1998. Only 10 percent of this larger eligibility pool were actually served.

NOTE: Some states provide child care assistance through programs separate from CCDF, but there is no source of information on the number of children served through such programs that is either uniform across states or verified. In most states, the bulk of child care subsidies are funded with CCDF dollars.

Figure 1. Child Care and Development Fund (CCDF) Eligibility and Receipt in the U. S.



Note: The 1.5 million estimate is preliminary and subject to revision.

Sources: Urban Institute simulations and state administrative data reported to the Child Care Bureau.

The model also provides information on the characteristics of children eligible for child care subsidies. Most children (8.8 of the 9.9 million) are under age 13 with working parents; the remaining children have parents in education/training programs or are disabled youth age 13 or older. About 14 percent of eligible children live in families that report receiving welfare. A substantial proportion (42 percent) has income below the Federal poverty threshold.

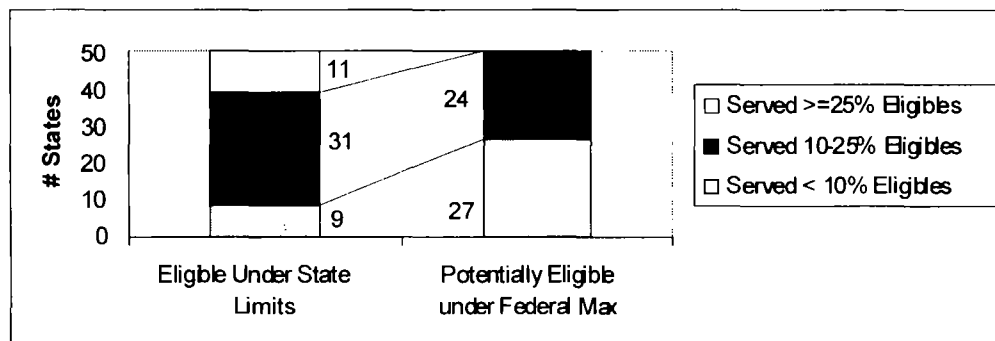
State Estimates. State-by-state estimates of children eligible for and receiving CCDF assistance are shown in Table 1. The total pool of children with working parents, regardless of income, is shown in the first column, followed by estimates of potential eligibility under the Federal maximum of 85 percent of state median income (SMI) and actual eligibility under state income guidelines. The fourth and fifth columns show the number of children receiving CCDF subsidies and the number served as a percentage of those eligible under the Federal maximum, based on administrative data reported by the state to HHS.

In Pennsylvania, for example, there are 1.2 million children with working parents (regardless of income), of which 443,300 are estimated to meet the state's October 1997 income eligibility guidelines. The eligible population would be larger – 533,900 children– if the state's income guidelines were raised from the current state-set level (74 percent of SMI) to the maximum allowable level of 85 percent of SMI. State administrative data indicate that 72,700 children received subsidies in an average month in fiscal year 1998 – only 16 percent of the eligible population under state limits and 14 percent of the potentially eligible population under the Federal maximum.

Some states served a higher percentage of eligible children in 1998 than the 15 percent national average. Michigan, for example, served a monthly average of 92,060 children, or one-fourth (25 percent) of the 375,000 children who were eligible according to state income criteria and 17 percent of the 545,000 children potentially eligible under Federal law. On the other hand, some states served a lower percentage than the national average. The 79,000 monthly average reported by Texas represents only 8 percent of the over 1 million children eligible under Texas income limits as of October 1997 and 7 percent of 1.16 million children potentially eligible if the income ceiling were increased to the Federal maximum.

In general, one-fifth (9) of all states are serving 10 percent or less of the children who are eligible under state limits, three-fifths (31 states) are serving between 10 and 25 percent of eligible children, and one-fifth (11 states) are serving 25 percent or more of the eligible children, as shown in the first bar of Figure 2. Differences in state definitions of the eligible population explain some of this variation. That is, states that define the eligible population as families with income below 85 percent of State Median Income, the maximum limit set in Federal law, may find it harder to serve 25 percent of eligible children than states that use lower income eligibility criteria.

Figure 2. Number of States Serving 10 to 25 Percent of Eligible Population, by Alternative Definitions of Eligible Population



Source: Urban Institute simulations and state administrative data reported to Child Care Bureau.

Table 1. Estimates of Child Care and Development Fund (CCDF) Eligibility and Receipt

State	Children (Average Monthly Estimates)				
	(1) Parents Working or in Education & Training (no income limit)	(2) Eligible for CCDF (if state limits raised to Federal maximum)	(3) Eligible for CCDF (under state rules in effect Oct. 1997)	(4) Receiving CCDF Subsidies (April-Sept 1998)	(5) Served as % of Potential Eligibles (Col. 4./Col. 2)
Alabama	494,700	233,300	103,500	20,530	9%
Alaska	99,400	46,700	43,800	5,080	11%
Arizona	516,700	283,800	154,400	33,060	12%
Arkansas	348,100	180,600	100,200	9,240	5%
California	3,481,700	1,732,500	1,381,900	100,640	6%
Colorado	486,600	226,300	139,100	20,170	9%
Connecticut	397,900	187,700	103,300	11,910	6%
Delaware	89,300	50,700	22,100	6,140	12%
District of Columbia	51,100	31,500	31,500	3,850	12%
Florida	1,434,200	705,300	421,900	46,640	7%
Georgia	913,200	485,200	331,200	47,210	10%
Hawaii	134,500	81,200	70,900	6,670	8%
Idaho	139,000	68,200	40,200	6,550	10%
Illinois	1,408,100	676,000	326,300	88,330	13%
Indiana	713,000	299,800	197,200	12,670	4%
Iowa	415,600	199,200	102,100	11,810	6%
Kansas	348,400	172,800	126,500	10,240	6%
Kentucky	427,100	170,200	90,800	25,010	15%
Louisiana	450,800	219,700	219,700	35,180	16%
Maine	128,800	60,900	60,900	**	**
Maryland	610,000	259,900	91,300	21,380	8%
Massachusetts	632,100	301,700	146,900	46,010	15%
Michigan	1,136,900	545,100	374,600	92,060	17%
Minnesota	637,500	297,400	251,600	25,530	9%
Mississippi	364,600	185,500	160,000	7,870	4%
Missouri	654,000	305,600	129,400	42,600	14%
Montana	108,500	60,800	49,200	5,530	9%
Nebraska	234,500	115,000	73,400	9,350	8%
Nevada	193,900	97,000	84,000	4,830	5%
New Hampshire	146,100	71,600	27,000	6,390	9%
New Jersey	798,900	350,500	176,900	32,500	9%
New Mexico	235,000	126,900	112,600	14,980	12%
New York	1,733,000	880,900	631,600	158,610	18%
North Carolina	819,600	411,400	343,100	74,250	18%
North Dakota	91,000	37,700	34,700	4,160	11%
Ohio	1,257,100	577,300	249,900	59,360	10%
Oklahoma	374,500	191,100	178,800	39,930	21%
Oregon	371,300	188,500	188,500	15,210	8%
Pennsylvania	1,232,300	533,900	443,300	72,680	14%
Rhode Island	105,900	42,500	24,100	6,330	15%
South Carolina	466,400	231,000	115,200	21,730	9%
South Dakota	98,800	46,200	26,900	3,530	8%
Tennessee	671,000	346,000	183,600	54,820	16%
Texas	2,309,600	1,161,700	1,013,400	78,960	7%
Utah	271,000	130,400	52,800	12,550	10%
Vermont	74,400	33,400	21,300	4,740	14%
Virginia	685,200	348,100	216,300	23,880	7%
Washington	667,100	310,500	167,100	41,850	13%
West Virginia	117,400	52,700	28,200	12,900	24%
Wisconsin	758,500	365,800	175,400	23,870	7%
Wyoming	59,700	31,600	12,500	3,200	10%
Puerto Rico, Terr.	---	---	---	7,980	NA
Total	30,393,900	14,749,500	9,851,000	1,530,500	10%

Notes: First four columns of estimates were generated from the Urban Institute's TRIM3 model.

(1) Children <13 (or disabled and below state age limit for disabled) with both parents working or in education/training programs. No income limit.

(2) Children from (1), if family income below 85 percent of State Median Income, the maximum limit allowed under Federal law.

(3) Children from (1), if family income below eligibility limits set by each state (based on limits in effect as of October 1997).

(4) Estimated children receiving CCDF child care subsidies, April - Sept 1998. State administrative data reported to Child Care Bureau and adjusted to reflect CCDF subsidies only. Estimates are preliminary and subject to revision.

** Data not yet received.

10/15/99

For this reason, it is important to examine the number of children served as a proportion of those who would be eligible if all states used the income guidelines set in Federal law. Over half the states (27 states) are serving less than 10 percent of potentially eligible children under the Federal maximum guidelines, as shown in the second bar in Figure 2. The remaining half (24 states) are serving between 10 and 25 percent of the potentially eligible population. Differences in the proportion of children served are caused by differences in funding amounts, local child care costs, state reimbursement rates, co-payment policies, and the number of low and moderate-income working parents in each state.

Notes on National and State Estimates. The eligibility estimates were generated from the Urban Institute's TRIM3 microsimulation model, based on Current Population Survey (CPS) data. To increase the reliability of the estimates, the numbers in this report were based on three years worth of CPS data – income and labor force participation data for calendar years 1995, 1996, and 1997. Eligibility under state income eligibility limits was based on the limits reported in the October 1997 state plans. The alternate eligibility under the Federal maximum of 85 percent of state median used the state median incomes for calendar year 1995 – the latest year for which medians were available as of the October 1997 submission of the CCDF plans.

Note that the model cannot capture all the complexities of the CCDF program. For example, the estimate does not include foster families that may be eligible for subsidies regardless of family income. Nor does it capture the potential effect of behavioral changes. If, as some studies indicate, the availability of child care subsidies enables more low-income parents to work, that would increase the need for child care and the size of the gap beyond the estimates shown here. Another limitation is that the CPS data from 1995-1997, although adjusted for inflation, may not fully capture the economic and demographic conditions of families in fiscal year 1998. Eligibility may be overestimated because of rising real incomes or underestimated because of increases in female labor force participation, declines in the welfare caseload and overall population increases. In addition, the state estimates should be viewed with some caution, particularly those from small states, because of the small size of the samples drawn for the CPS interviews.

Finally, note that the numbers of children served in 1998 are monthly averages (preliminary and subject to revision) based on administrative data for April-September 1998. These administrative data reflect children served (at least in part) through CCDF programs, not, as noted above, those served by other Federal, state, or local programs.

III. State Spending on CCDF in 1998

Recent data show that states are fully utilizing Federal resources and often invest more than required state spending levels, but the problem of unmet need remains critical.

The CCDF consists of three funding streams – discretionary funds, mandatory dollars that do not require a state match and mandatory funds that must be matched.

In 1998, states obligated all the available Federal mandatory child care funding, including Federal matching funds. States invested additional state dollars to serve 1.5 million children through CCDF – 10 percent of those potentially eligible for the program.

Of the Federal mandatory amount, close to half required a state match at the Federal Medical Assistance Percentage (FMAP) – the state match varied from 23 percent to 50 percent (the maximum). A state with a 50 percent match was required to contribute a dollar of state funds for

every dollar of Federal matching funds, while a state with a 23 percent match had to put up about one dollar of state funds for every three Federal dollars.

States not only met the CCDF maintenance of effort (MOE) requirement and contributed the additional matching funds needed to draw down their full Federal allotments, but also invested at least \$144 million in state dollars that were not matched. While some of these state-only funds were used to serve children through the CCDF, some may have been used to provide child care assistance through other, state-only programs.

States also transferred \$636 million in FY 1998 TANF funds to CCDF in that fiscal year. By comparison, they transferred \$510 million in FY 1999 TANF dollars to CCDF in the first two quarters of FY 1999 alone.

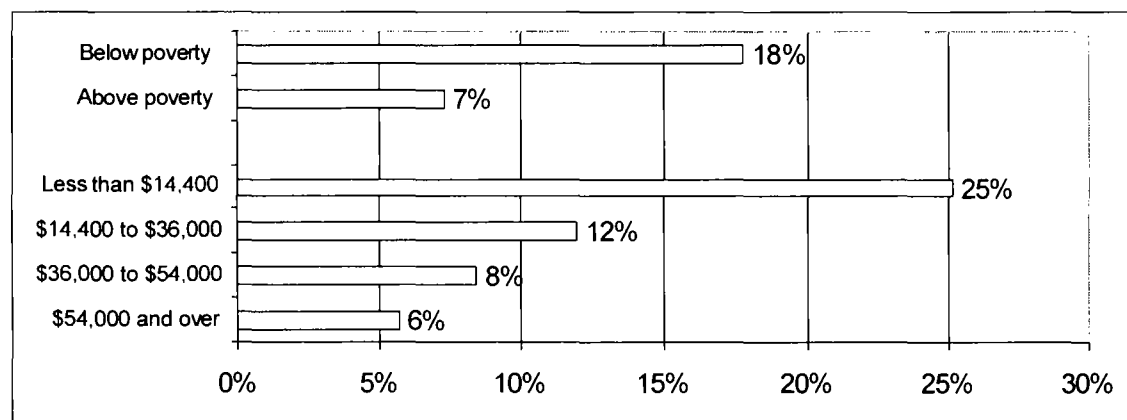
In all, in FY 1998 states spent \$3.5 billion in Federal mandatory and discretionary funds (including dollars transferred from TANF) and \$1.6 billion of their own funds on child care through CCDF. States also spent \$259 million in Federal funds on child care provided directly through the TANF program.

IV. Affordability of Child Care

Regular child care arrangements are often beyond the reach of working poor families if they do not have access to subsidies. Below are national survey data on how much families spend for child care, as well as new information, recently collected by Urban Institute researchers, on the price of child care in selected states and cities.

The national survey data show that child care expenses are often the second or third largest item in a low-income working family's household budget. In 1993, for example, child care expenses averaged 18 percent of family income, or \$215 per month, for poor working families paying for the care of one or more preschool children (see Figure 3). This average includes all types of care – full-time and part-time, full-price and partially subsidized, center-based and in-home, infant and preschool. Average monthly costs for non-poor families with employed mothers and preschoolers were higher in absolute terms – \$329 per month – but lower as a percentage of the household budget – 7 percent. For families with income of less than \$14,400, (\$1,200 per month), the average share of income devoted to child care was even higher – 25 percent, or one-fourth of family income.¹

Figure 3. Percent of Family Income Spent on Child Care, by Poverty Status and Income



Source: Census Bureau, P70-52 (SIPP, fall 1993). Limited to families with preschool children.

Prices for child care vary considerably, by such factors as geographic area, type of provider, and age of child. Average prices for preschool center care, for example, range from \$565 in Connecticut to \$303 in New Orleans, Louisiana, according to a comparison of average prices in several states and cities in summer 1999 (see Figure 4). Though not shown in the figure, center care for infants tends to be more expensive (e.g., \$719 in Connecticut and \$506 in Salt Lake County, Utah) than center care for preschoolers. Rates for family child care homes tend to be lower (e.g., \$217 in New Orleans, Louisiana and \$353 in Delaware) than for center-based care – this is true for both infant and preschool care.

Child care is more affordable for families who receive child care subsidies and contribute to the cost of care through “co-payments” that are much lower than the full price of care. Examples of co-payments in selected states and cities are shown in Figure 4, for a family with \$15,000 in income and one pre-school child.

Figure 4. Child Care Prices and Co-Payments for a Hypothetical Family Earning \$15,000 with one Preschool Child in Full Time Center Care

	WITHOUT SUBSIDY		WITH SUBSIDY	
	Average Monthly Prices	% of Income	Monthly Co-Payments*	% of Income*
Connecticut	\$565	45.2%	\$50	4.0%
Michigan	\$487	39.0%	\$12-\$25	1.5-2.0%
Delaware	\$390	31.2%	\$81	6.5%
Florida	\$325	26.0%	\$70	5.6%
Pittsburgh, Pennsylvania	\$490	39.2%	\$25	2.0%
Salt Lake County, Utah	\$392	31.4%	\$10	0.8%
New Orleans, Louisiana	\$303	24.2%	\$29	2.3%

* State policy allows providers to charge parents additional amounts, above the co-payment, if the provider's rates exceed the state reimbursement level.

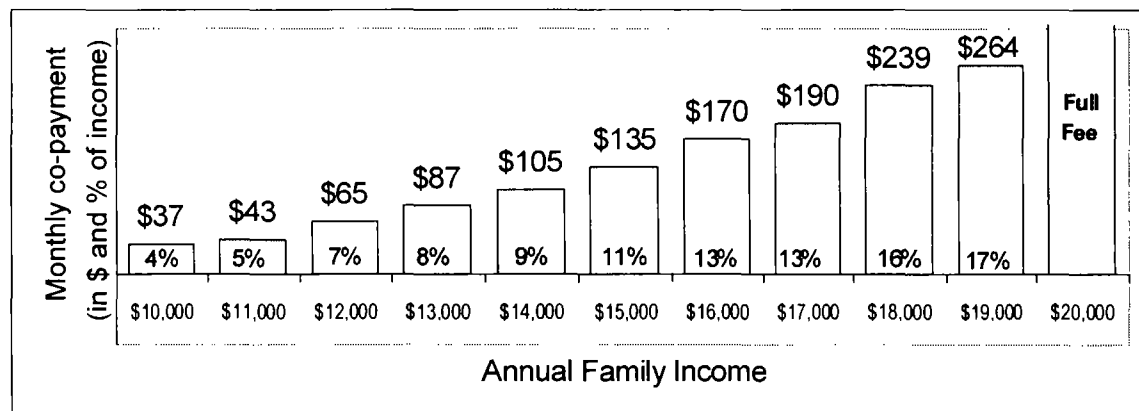
Source: Data collected by the Urban Institute from state and local resource and referral agencies, summer 1999.

Co-payments are established according to sliding fee scales; the co-payments vary across states and by family income, family size, and, in some states, cost of care. For example, a two-person family (mother and child) with \$10,000 in income and a CCDF subsidy for full-time center based care would be charged a co-payment of less than \$37 per month (4 percent of income) in half the states. This median co-payment increases from \$37 for a family with \$10,000 in income to full market rate for a family with \$20,000 in income, as shown in Figure 5.²

Even families receiving child care subsidies, however, may still find it difficult to afford child care. In 24 states, providers are allowed to charge parents additional amounts, above the co-payment, if the provider's rates exceed the state reimbursement level. For example, if a state's maximum reimbursement rate is \$300 per month for preschool care, and such care costs \$380 in ABC Center, the family may have to pay the \$80 difference, in addition to the official co-payment. These additional costs can deter even families receiving child care assistance from choosing higher quality care, which can be more expensive.

Though not shown in Figure 5, there is substantial variation in co-payment fee schedules across states. A two-person family with an income of \$15,000, for example, would be charged a co-payment of less than \$50 per month in 7 states, \$50 to \$100 in 7 states, \$100 to \$150 in 15 states, \$151 to \$200 in 10 states, more than \$200 but less than full market price for care in 1 state, and full market price in 11 states.

Figure 5. Median State Co-payment Charged to Single Parent with Preschool Child in Center-based Care, by Family Income



Source: Congressional Research Service, from state plans on file with HHS as of August 1998.

V. Impact of Child Care Subsidies on Employment and Earnings

Two recent studies suggest that enhanced funding for child care subsidies increases employment rates and earnings for low and moderate-income parents. A study of the relationship between child care funding, employment and earnings in Miami-Dade County, Florida found that boosting child care funding increases the probability that current and former welfare recipients will find paid employment. An increase of \$145 in subsidy spending per child increased the likelihood of employment from 59 to 71 percent for current and former recipients with few barriers to employment. According to the study, augmenting child care subsidy funding increases not only employment rates but also the earnings of current and former welfare recipients who are already working. The \$145 increase in subsidy funding per child was associated with a 3.9 percent

increase in earnings for those with few barriers to employment and a 7.2 percent increase for current and former recipients with moderate to severe barriers to employment.

NOTE: These findings are for the period after the legislature established a separate pool of child care subsidy funds for current and former welfare recipients.

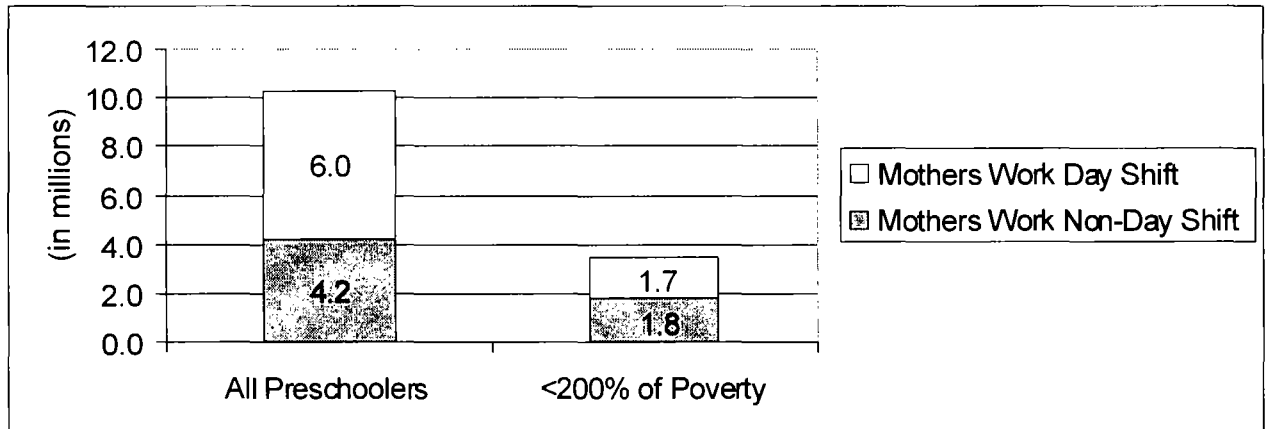
Similarly, a Massachusetts study found that greater investment in child care subsidies results in higher employment rates for current and former TANF recipients.

Conversely, other studies of eligible families on waiting lists for child care subsidies find that these families often reduce their work hours or do not work at all, are more likely to receive public assistance, go into debt, lose their health insurance and declare bankruptcy.

A North Carolina study found that unemployed parents waiting for a child care subsidy were seven times as likely to use three or more types of public assistance as were employed parents with a subsidy. A Texas research effort comparing families receiving subsidies to eligible families without subsidies found that employed families with subsidies earned \$260 more per quarter than families without subsidies. A study of families on the waiting list for child care subsidies in Santa Clara, California found that 29 percent were unable to work because they could not find affordable child care, 32 percent reduced their work hours, and two-thirds changed their child care arrangements while on the list. According to a Seattle study, 57 percent of wait-listed families used up savings to pay for child care, while 13 percent dropped their health insurance. Parents receiving subsidies, on the other hand, were much less likely to be late for or miss work completely due to breakdowns in child care arrangements.

Access for low-income working families is made more complicated by the likelihood that these mothers will work non-day shifts -- that is, evenings, weekends, or rotating shifts. While there is little research that specifically addresses the question of whether it is easier for families to find after-hours care if they have a subsidy, it seems likely that the challenge of finding care during non-day shifts is accentuated if parents are seeking care with extremely limited financial resources. There are 4.2 million preschool children with mothers who work non-day shifts -- this represents 4 out of 10 preschoolers with employed mothers, as shown in Figure 6. The proportion of preschoolers from families with incomes below 200 percent of poverty that have employed mothers working non-day shifts is even higher -- 52 percent.³ Some mothers choose to work non-traditional hours, so that they can split child care responsibilities with the child's father. For mothers who cannot rely on care by the child's father, however, it is hard to find child care during odd hours.

Figure 6. Preschoolers by Mother's Work Shift



Source: SIPP, fall 1994.

VI. The Quality of Child Care

When families cannot get help in paying for child care, it is harder for them to find quality care that helps prepare their children for school success.

The overwhelming majority of children today are in child care before entering school. In 1995, nearly 13 million of the 21 million children under 6 were in child care. Only 14 percent of children spend all of their first three years at home with their mothers.

Quality in each type of child care setting – centers, family child care homes, etc. – varies from very poor to very good. As a result, too many children receive low-quality care. A 1994 HHS Inspector General Study, *Nationwide Review of Health and Safety Standards at Child Care Facilities*, found more than 1,000 violations in 169 child care facilities in five states. Among the hazards were fire code violations, toxic chemicals, playground hazards, and unsanitary conditions. According to other research, almost half of the infants and toddlers in child care centers are in rooms rated at less than minimal quality. This means that the care did not have basic sanitary conditions for diapering and feeding; safety problems existed in the room; warm, supportive relationships with adults were missing; and the rooms did not contain books and toys important for physical and intellectual growth.

Findings from recent studies reinforce the results of earlier research – children in higher quality child care programs develop stronger language, reading and math skills and fewer behavior problems than children in mediocre or poor quality programs. The better the child care program, the more likely the child is to enter school ready to learn.

The latest report from the Cost, Quality and Child Outcomes Study found that the quality of child care programs attended by preschool children had a lasting impact on their school performance. Children in better programs had higher language and math test scores and fewer behavior problems in the second grade than children attending weaker programs (the children have only been followed through the end of second grade so far). Children at risk of not doing well in school (due to economic and other factors) benefit more from high-quality child care, and are hurt more by low-quality care, than their better situated peers are.⁴

According to the ongoing NICHD Study of Early Care, children who attend child care centers meeting standards set by pediatricians or public health professionals score higher on school readiness and language tests and have fewer social problems than children in centers not meeting such standards.⁵

Moreover, evidence suggests that interventions to improve child care quality can make a major difference. Research on Florida's state-wide investment in quality -- lowering staff-to-child ratios and increasing educational qualifications of staff -- found positive impacts on the cognitive and social development of children in care.⁶ Longer-term results suggest that enforcement of enhanced standards is important to maintain such gains. North Carolina's Smart Start initiative funds multiple quality enhancements to child care programs, as well as efforts to help families access child care. Enhancements include improved training, curricula and equipment, and incentives for programs to become accredited. Evaluation results indicate that more children are receiving care, the quality of care has improved, and children have higher levels of skills at kindergarten entry.⁷

In addition to the recent research, hundreds of studies of demonstration and large-scale early intervention programs (many of which are also child care programs) have generated a wealth of evidence that quality child care programs have positive short and long-term effects on school success and social adjustment.⁸

Due to the tremendous need for child care subsidies to help families pay for the cost of care, states in 1998 were able to devote only 5 percent of their CCDF funds to quality improvements.

VII. Conclusion

While the child care picture varies from state to state, it is clear that there is a large unmet need for child care assistance throughout the country. States are fully utilizing CCDF funding, the primary source of Federal child care assistance for low and moderate-income families, and are using TANF transfers and state-only funds to address the need. Despite these efforts, just 15 percent of children eligible under state income limits and only 10 percent of those potentially eligible under Federal guidelines, are actually being served through the CCDF. As a result, child care consumes a major portion of many low or moderate-income families' budgets, parents are unable to work productively or take better paying jobs, and children's health and development suffer when parents must make do with makeshift arrangements.

¹ Census Bureau, P70-52 (SIPP, Fall 1993).

² Congressional Research Service, "Child Care Subsidies: Federal Grants and Tax Benefits for Working Families," Table A-5, March 15, 1999. Co-payment estimates based on CCDF plans on file at HHS on August 14, 1998, assuming cost of care is at the CCDF payment rate for the state.

³ Census Bureau, "Who's Minding Our Preschoolers? Fall 1994 (Update) (PPL81)." Detailed tables and documentation for P70-62. Internet release: U.S. Bureau of the Census, 1998. Note that day shift is defined as a work schedule where at least one-half of the hours worked daily were between 8 a.m. and 4 p.m. All other schedules (i.e., those in which the majority of hours are worked outside 8 a.m. to 4 p.m., and those with irregular or rotating hours) are defined as non-day work shifts.

⁴ National Center for Early Development and Learning, "The Children of the Cost. Quality, and Outcomes Study Go to School," 1999.

⁵ "Child Care Outcomes When Center Classes Meet Recommended Standards for Quality," *American Journal of Public Health*, 1999.

⁶ Howes, Smith, and Galinsky, *The Florida Child Care Quality Improvement Study: Interim Report*, 1995.

⁷ Smart Start Evaluation Team. University of North Carolina. "The Effects of Smart Start on the Quality of Preschool Child Care." 1997; "The Effects of Smart Start Child Care on Kindergarten Entry Skills." 1998; "North Carolina's Smart Start Initiative." 1999.

⁸ Reynolds, Mann, Meidel, and Smokowski. "The State of Early Childhood Intervention." *Focus*, 1997.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Administration for Children and Families
Administration on Children, Youth and Families
330 C Street, S.W.
Washington, D. C. 20201

May 28, 1999

John Schnur
Senior Domestic Policy Advisor for Education
Office of the Vice President
Washington, D.C. 20501

Dear Mr. Schnur:

Thank you for your interest in the Advisory Committee on Head Start Research and Evaluation. The Committee is required by statute to submit a report to the Secretary of Health and Human Services by September 30, 1999. That report is to outline a design (or coordinated set of designs) for studying the impact of Head Start. Enclosed is background information that you may find helpful.

We are posting all material related to the Advisory Committee on the Head Start web site – <http://www2.acf.dhhs.gov/programs/hsh/>. For example, we have posted contents of the first briefing book, a summary of the first Committee meeting, papers written by Committee members regarding proposed design options for studying the impact of Head Start, and other related documents.

The second meeting of the Committee is scheduled for June 2-3, 1999 at the Holiday Inn Hotel and Suites, 625 First Street, Alexandria, VA (703/548-6300). You are certainly welcome to come observe this meeting or send staff. We anticipate that the discussion will be quite lively, focusing on the best scientific approaches to studying impact and the feasibility of such approaches within the context of Head Start.

Please call me if you have any questions about the Advisory Committee. I can be reached at 301/889-0430 or DRS889@aol.com.

Sincerely,

A handwritten signature in black ink, appearing to read "D Stark", is positioned above the printed name.

Deborah Roderick Stark

SAVE THE DATES!!

Advisory Committee
on
Head Start Research and Evaluation
will convene again
on

June 2 - 3, 1999
and
July 26 - 27, 1999



Holiday Inn Hotel and Suites
Historic District Alexandria
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(703) 548-6300

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Head Start Program Performance Measures Second Progress Report



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Administration for Children & Families
Administration on Children, Youth & Families
Research, Demonstration and Evaluation Branch
and the Head Start Bureau