

The main goals of the MCCA were to increase the quantity and quality of child care on military installations and to ensure the affordability of care. In addition, the act sought to standardize the delivery and quality of care across installations and military services, which in 1989 were perceived to vary widely.

To do so, the MCCA prescribed remedies for a number of problems that characterized many parts of the system at that time, e.g., high staff turnover and inadequate facilities. The first part of this chapter describes the extent to which the problems that the MCCA addresses were perceived as such before its passage. The chapter then focuses on perceptions of the degree to which the MCCA has successfully resolved these problems. The chapter then analyzes the degree to which the main goals of the MCCA—increased availability and quality—have been met. The chapter ends with an analysis of the extent to which the MCCA changed FCC and YP.

PRE-MCCA PROBLEMS

We asked respondents to our worldwide mail survey to report on the major program problems with military child care before the MCCA to determine the extent to which these problems were resolved by the act. Table 13.1 shows the percentage of respondents who endorsed each listed problem.¹

¹The exact wording of the question was as follows: “Prior to the MCCA, what in your view were the major program problems with military child care?” The seven response

Table 13.1
Major Child Care Problems Pre-MCCA

Problem	Percentage ^a	Rank
Staff training	78	1
Staff retention	70	2
Lack of developmental care	53	3
Inadequate facilities	50	4
Quality of care	43	5
Unmet demand	34	6
Other problems	12	7

SOURCE: Data from mail survey.

NOTE: N = 244.

^aPercentages sum to more than 100 because respondents could indicate more than one problem.

The most frequently endorsed problems concerned child care staff. Almost 80 percent of survey respondents indicated that staff training was a major problem before the MCCA, and 70 percent reported staff retention to be a major problem. About half of respondents indicated that lack of developmental care and inadequate facilities were a problem; 43 percent thought that overall quality of care was a concern. About one-third of the respondents indicated that unmet demand was a problem. The most frequently reported “other problems” included low pay, lack of funding, and lack of command and/or MWR support.

The most frequently reported major problems before the MCCA—staff training, staff retention, and lack of developmental care—were problems that have been found in other work to negatively affect the quality of care provided (e.g., Belsky, 1984; Ruopp et al., 1979). Reducing the prevalence and magnitude of these problems would seem to hold promise for improving the quality of care.

It is interesting to note that unmet demand was the lowest-ranked response aside from “other problems.” Thus, although enormous waiting lists played an important role in persuading Congress to undertake a military child care act, this was perceived to be less of a problem among child care administrators at the installation level

categories listed in Table 13.1 were provided. In addition, there was space to write in other problems.

some three years into the implementation effort than quality-of-care concerns.

One reason why unmet demand may have been perceived by fewer respondents as a major child care problem is that in contrast to staff training or turnover, unmet demand may be less evident and may have fewer behavioral implications for the child development managers who completed our survey. A caregiver's decision to leave her job will force a CDP manager to take steps to replace her, but the addition of one or two more families to the waiting list, while troubling, may not require any response on a manager's part.

It may also be that issues of unmet demand are more likely to play out higher up in the system, where decisions are made concerning the allocation of resources to address the problem. Indeed, on 11 of the 17 installations that we visited, the command representative described unmet demand as a significant child care problem. Two other command representatives said a long-standing problem with unmet demand had recently been resolved when a new CDC opened.

When analyzing perceived problems pre-MCCA by service, some interesting results emerge. There were no significant differences in the percentage of respondents reporting that quality of care was a problem across the services, nor were there any significant differences in reported staff retention problems (results not shown). However, staff training, unmet demand, lack of developmental care, and inadequate facilities were reported to be major problems at significantly (or borderline significantly) different rates across the services. These results are reported below.²

Table 13.2 shows the percentage of respondents, by service, who indicated that each of the problems listed had been a major child care problem before the MCCA.

²“Other problems” were reported at borderline significantly different rates across the four services. However, because of the overall low response rates for this category, these results are not shown.

Table 13.2
Major Child Care Problems Pre-MCCA, by Service
(in percent)

Service	Staff Training	Staff Retention	Lack of Developmental Care	Inadequate Facilities	Quality of Care	Unmet Demand	Frequency
Air Force	89	70	63	62	52	27	88
Army	73	73	43	37	34	29	70
Marine Corps	85	62	69	62	46	31	13
Navy	70	70	48	51	38	49	73
Mean	78 ^a	70	53 ^a	50	43	34 ^b	244

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.05$ (F-test).

^bMeans are significantly different: $p < 0.01$ (F-test).

The means for staff training were significantly different from one another. The problem of staff training was perceived to be greater in the Marine Corps and the Air Force than in the Army and the Navy pre-MCCA. This makes sense because the Navy and Army were using Navy-developed training modules before the MCCA. Or, Air Force personnel, many of whom had gone through accreditation by the time of our survey, were in a position to be more critical of past policies and procedures. The cross-service means for staff retention were not significantly different, reflecting the widespread nature of this problem before the MCCA.

The means for lack of developmental care are significantly different. That the Marine Corps and the Air Force report having more of a problem with developmental care before the MCCA than either the Navy or the Army is consistent with their higher rates of reported problems with lack of trained staff and their less developed training programs before the MCCA.

The means for inadequate facilities are significantly different at the 0.06 level, thus just barely past accepted significance levels, indicating service differences in problems with inadequate facilities. The fact that Marine Corps respondents reported the highest level of problems with inadequate facilities is consistent with the other data we collected.

The means for quality of care as a major problem pre-MCCA did not vary significantly by service. However, the means for unmet demand are significantly different, indicating that respondents from different services perceived unmet demand to be a major problem before the MCCA at varying rates. In particular, the Navy reported more of a problem with unmet demand.

PROBLEM RESOLUTION

It is interesting to examine the extent to which respondents at the installation level perceived the act to have been successful in resolving the problems that they perceived to exist before the MCCA. Table 13.3 shows the distribution of responses to this question.

It is noteworthy that 85 percent of respondents reported that many or all or almost all of the problems that existed before the MCCA were resolved by the act. Less than 3 percent indicated that none or almost none of these problems have been resolved by the MCCA.³

There are no significant differences across the four services in the distribution of responses to the question concerning the extent to which the MCCA has resolved existing program problems with military child care (results not shown). In other words, the MCCA was perceived as being equally effective by all the services in resolving major program problems despite initial differences in the types and prevalence of problems reported.

³To facilitate the interpretation of the responses to this question, it is possible to convert the response categories to percentages. This is necessarily a somewhat arbitrary exercise, but it does provide a more intuitive understanding of the overall extent to which the MCCA resolved existing problems. If the response categories 1–4 are converted to 100 percent, 67 percent, 33 percent, and 0 percent, respectively, the average amount of problems resolved is 70 percent. Alternatively, if one converts the response categories 1–4 to the midpoint of the quartile intervals (i.e., to 87.5 percent, 62.5 percent, 37.5 percent, and 12.5 percent), the average improvement reported is 65 percent. It is impossible to determine which conversion scale is better, but together, they provide a sense that respondents perceive that about two-thirds of preexisting problems have been resolved by the MCCA.

Table 13.3
Respondents' Perceptions of the Extent to Which the MCCA Resolved Existing Major Program Problems

MCCA Resolved	Percentage	Cumulative Percentage	Frequency
All or almost all	29	29	66
Many	56	85	126
A few	13	97	29
None/almost none	3	100	6
Total	101 ^a		227

SOURCE: Data from mail survey.

^aEntries do not sum to 100 because of rounding imprecision.

PRE-MCCA QUALITY OF CARE

To get a sense of the quality of care before the implementation of the MCCA, we first asked our respondents to rate the quality of care in the CDC(s) on their installations before the act. As shown in Table 13.4, before the MCCA less than 10 percent of respondents indicated that they thought the overall quality of care had been excellent; 17 percent reported that it had been not very good or not good at all. The average quality rating was 2.7, or somewhere between very good and OK/fair, but closer to OK/fair (see Table 13.5 for average quality ratings by service).

Table 13.4
CDC Quality of Care Ratings Pre-MCCA

Rating		Percentage	Cumulative Percentage	Frequency
Excellent	1	9	9	20
Very good	2	37	47	80
OK/fair	3	36	83	78
Not very good	4	12	95	25
Not good at all	5	5	100	11
Mean	2.7			
Total		99 ^a		214

SOURCE: Data from mail survey.

^aEntries do not sum to 100 because of rounding imprecision.

Table 13.5
Average CDC Quality of Care Rating Pre-MCCA,
by Service

Rating	Mean	Std. Dev.	Frequency
Air Force	2.9	0.99	77
Army	2.5	0.81	60
Marine Corps	2.7	0.89	12
Navy	2.5	1.08	65
Mean	2.7 ^a	0.98	214

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.06$ (F-test).

As already noted, there was a perception in Congress before the MCCA that quality of care varied substantially across installations and services. Table 13.4 indicates that across the DoD, perceived quality ratings ranged from excellent to not good at all before the MCCA. Mean quality ratings by service are shown in Table 13.5. Recalling that higher quality ratings are denoted by lower scores, this table indicates that Army and Navy respondents reported the highest level of quality of care before the MCCA. Differences across services are significant at the 0.06 level of significance (F-test).

This quality ranking by service is consistent with information we obtained during our interviews with DoD and headquarters child care staff in each military service. As discussed above, the Army and Navy had staff training programs in place before the MCCA; respondents from these services were less likely to describe staff training as a problem. In addition, the Army had T&C specs working in CDCs before the MCCA. In contrast, the Marine Corps in particular lacked staff and support to pursue improved quality of care.

It was somewhat surprising that Air Force respondents reported the lowest average pre-MCCA quality of care. Our interviews with service headquarters child care staff as well as installation visits during our earlier investigation of military child care (see Zellman, Johansen, and Meredith, 1992) did not indicate that the Air Force deserved this quality of care designation, which suggests, as noted above, that Air Force respondents may have been particularly critical because so many had undergone self-study and accreditation.

These rankings by service suggest that survey respondent ratings must be approached with care. These ratings are based on installation level child care manager perceptions. They are likely to be influenced by the respondents' ability to recognize good quality of care as well as the respondents' expectation about what the level of quality of care should be. These perceptions may be biased in unknown ways by limited experience in observing CDCs in many cases (Zellman, Johansen, and Meredith, 1992). To the extent that these two factors varied across services, this may have influenced the reported ratings of pre-MCCA quality of care. Pre-MCCA ratings, in particular, may be biased because respondents may not have been employed at the installation before the MCCA. Although respondents were encouraged to seek out the views of colleagues in cases where the respondent herself was unable to answer pre-MCCA questions, we do not know if respondents sought more reliable sources in answering pre-MCCA questions.

It is interesting to note, however, that poorer quality ratings by Air Force respondents are consistent with the responses provided to a question concerning the major problems faced by military child care before the MCCA. On a problem checklist, a higher percentage of Air Force respondents than those in the other services reported quality of care to be a problem before the MCCA (see Table 13.2, above).

QUALITY OF CARE POST-MCCA

To what extent did the MCCA improve the perceived quality of care? Table 13.6 shows the distribution of responses to a mail survey question concerning the overall quality of care at the time of our survey (mid-1993). The table is striking in that the distribution of responses has narrowed considerably in comparison to the comparable question for the pre-MCCA period. Instead of five quality ratings, there are now only three, because no one reported the quality of care to be not very good or not good at all. Furthermore, 60 percent of respondents reported the quality of care to be excellent, and only 4 percent reported the quality to be OK/fair. Thus, more than 95 percent of respondents indicated that the quality of care after the implementation of the MCCA was very good or excellent, a considerable improvement over the situation reported before the MCCA.

Table 13.6
CDC Quality of Care Ratings Post-MCCA

Rating		Percentage	Cumulative Percentage	Frequency
Excellent	1	61	61	145
Very good	2	35	96	84
OK/fair	3	4	100	10
Mean	1.4			
Total		100		239

SOURCE: Data from mail survey.

Table 13.7 shows the average post-MCCA quality rating both overall and by service. Not surprising given the results shown in Table 13.6, the average reported quality of care was higher post-MCCA (1.4), somewhere between excellent and very good, but closer to the former than the latter. Quality ratings by service border on being significantly different ($p = 0.09$), indicating that although the overall variation in reported post-MCCA quality of care has declined, differences in reported quality across services remain post-MCCA. However, although the pre-MCCA quality ratings were highest in the Army and the Navy, post-MCCA quality ratings show that Marine Corps respondents rate their quality of care post-MCCA most highly, and that Army respondents take the last position on this measure.

Table 13.7
CDC Quality-of-Care Ratings Post-MCCA, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.4	0.52	85
Army	1.6	0.69	70
Marine Corps	1.2	0.44	13
Navy	1.4	0.52	71
Mean	1.4 ^a	0.58	23

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.09$ (F-test).

This rank-ordering is inconsistent with a range of other quality indicators we collected and points up the subjective nature of the survey data. For example, the CDC accreditation rate in the Army is more than three times that of the Marine Corps (34 compared to 10 percent), and is the highest in the Air Force. Survey data on perceived changes in the level of command support for the MCCA indicate that Marine Corps respondents were significantly more likely than respondents in other services to perceive less support. This lack of command support is inconsistent with high quality.

Our installation visits also indicated that quality of care continued to be less of an issue in the Army because of greater support for child development among Army commanders. One Army CO, for example, decided to continue the quarterly developmental assessment team (DAT) meetings after MCCA implementation was largely accomplished, as they provided a means of keeping him informed of child development operations.

High-quality ratings among Marine Corps respondents that are at variance with our own perceptions and with other more objective indicators may be a function of the amount of improvement experienced—that is, respondents were noting *relative* change. In other words, current quality ratings may reflect substantial change as much as high current quality. In contrast, high-quality care of long standing that is somewhat or only slightly improved may suffer by comparison. To test this hypothesis, we investigated both the absolute amount of perceived quality improvement after the MCCA (see Tables 13.8 and 13.9)⁴ as well as the relative amount of reported change (see Table 13.10).

Table 13.8 shows that about 70 percent of survey respondents indicated that the quality of CDCs on their installation had improved by one or two quality rating categories after the MCCA. Twenty percent of respondents indicated no improvement, and one respondent actually reported a decline in quality of care after the MCCA.

⁴Table 13.8 was created by subtracting the pre-MCCA quality rating from the post-MCCA quality rating. As a higher-quality rating results in a lower score, a quality improvement would result in negative score. The minus sign has been suppressed in Tables 13.8 and 13.9 to improve the interpretability of the tables.

Table 13.8
Absolute Quality Improvement Scores Pre-Post-MCCA

Quality Score Improvement	Percentage	Cumulative Percentage	Frequency
-1	0	0	1
0	20	20	42
1	46	66	96
2	24	90	50
3	9	99	18
4	1	100	3
Total	100		210

SOURCE: Data from mail survey.

Table 13.9
Average Quality Improvement Scores Pre-Post-MCCA, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.5	0.98	75
Army	1.0	0.82	60
Marine Corps	1.4	1.00	12
Navy	1.1	0.91	63
Mean	1.2 ^a	0.93	210

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.01$ (F-test).

Table 13.10
Relative Improvement in Quality of Care Rating, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	48	23	75
Army	36	26	60
Marine Corps	49	21	12
Navy	38	25	63
Mean	41 ^a	25	210

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.01$ (F-test).

Looking at the average reported quality improvements in Table 13.9, we see that overall, average reported quality improvement is 1.2 response categories. Perhaps not surprisingly, Army respondents reported the least absolute quality improvement, and Air Force respondents reported the most.

Relative to their pre-MCCA quality rating, Marine Corps and Navy respondents reported the greatest improvement (see Table 13.10),⁵ suggesting that the Marine Corps' high ranking in Table 13.7 does reflect substantial change.

Overall, the average reported quality ratings improved by 41 percent.⁶ This tremendous increase in perceived quality of care as a result of the MCCA was widely echoed in our installation interviews as well as at the headquarters level in each service and at the DoD. Everywhere we went we heard the same message: care had improved substantially, sometimes dramatically, as a result of the MCCA.

For example, a Navy MWR director noted that the MCCA had increased staff quality and professionalism and had resulted in "tremendous improvement" in how care in CDCs is delivered. An Air Force CO concurred, noting that higher pay has attracted better-quality staff, which has led to significant improvements in the delivery of care. At another Air Force base, the MWR director told us that in his view, the MCCA has made military child care the best in the world. Said his counterpart at another Air Force base, "despite groans and grunts, it [the MCCA] has given us a quality program."

A Marine Corps garrison commander agreed that, since the MCCA, children are "better developed," but this has come at a price: "Quality is up," he said, "but quantity is down." Even those who were not supportive of the MCCA acknowledged that such provisions as increased caregiver wages and more rigorous training had improved the quality of care. There was less consensus about whether improvement had been needed: At one Marine Corps base that we

⁵As in the case of Table 13.8, the negative sign on the reported quality improvement has been suppressed to improve the interpretability of the results.

⁶Dividing the results in Table 13.5 by the results in Table 13.8 does not yield the identical results reported in Table 13.9 because of missing values on a number of respondents in Table 13.5.

visited, both the CO and comptroller agreed that quality had increased, but the CO thought it had been OK before, whereas the comptroller described the level of pre-MCCA quality as “warehousing.”

In a few instances, RAND had visited the same CDC before the MCCA during our previous study (see Zellman, Johansen, and Meredith, 1992, for a report of study findings), thus we were able to see the tremendous improvements ourselves. In a few cases, CDCs that had had major problems with the quality of care had become accredited. The difference was tremendous; a number of things were visibly changed, e.g., the amount and type of resources, the interaction between the children and between the children and the caregivers, and the pride exuded by the caregivers and the staff.

In places that we had not previously visited, we heard repeatedly how much quality had improved as a result of the MCCA. Even at the CDCs that were known to have been providing good quality care before the MCCA, we were told of improvements. However, the greatest improvements were generally reported on those installations that had had the worst quality of care before the act. Repeatedly, we heard that the act’s threat of center closure in case of a failed inspection provided the clout to obtain resources needed to improve quality.

A high-level headquarters interviewee was clear on this point. The inspections definitely resulted in increased command attention; “no commander wants an unsatisfactory rating,” she said. Even in the services that had had inspections before the MCCA, inspections with teeth were reported to be a benefit, because inspections without the threat of center closure had not motivated command to fix identified deficiencies. The increased visibility of the inspection report—communicated during an outbriefing with the commander—also helped create pressure to obtain necessary improvements.

In addition, the establishment of a T&C spec position, also a provision of the MCCA, helped achieve improvements in the actual provision of services to children. Thus, quality of care improved because of two of the MCCA’s major provisions: inspections and the hiring of T&Cs specs.

DECREASED VARIABILITY IN QUALITY OF CARE

In addition to information regarding variations in quality of care across services, we also investigated the effect of the MCCA on variations in quality of care across the CDCs on a single installation. Specifically, we asked our mail survey respondents on installations with more than one CDC to indicate the extent of variation that they perceived in quality of care across CDCs before and after the MCCA. The results concerning pre-MCCA variation in quality of care are shown in Tables 13.11 and 13.12.

According to our respondents, variation in quality of care across CDCs on their installation was minimal before the MCCA. Almost 40 percent reported little or no variation in pre-MCCA quality of care.

Table 13.11

Variations in Pre-MCCA Quality of Care Across CDCs on an Installation

Amount of Variation		Percentage	Cumulative Percentage	Frequency
No variation	0	26	26	29
A little variation	1	14	40	16
Some variation	2	42	81	47
A lot of variation	3	19	100	21
Mean		19		21

SOURCE: Data from mail survey.

Table 13.12

Variations in Pre-MCCA Quality of Care Across CDCs on an Installation, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	1.8	0.98	40
Army	1.5	1.02	39
Marine Corps	1.8	1.17	6
Navy	1.1	1.13	28
Total	1.5 ^a	1.07	113

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.04$ (F-test).

The average amount of variation reported is “1.5,” or somewhere between a little and some variation.

However, during fieldwork we encountered a few installations with multiple CDCs where quality varied substantially. On one of these installations, the child development coordinator had decided to address the issue of unequal quality by accrediting the least-ready center first. By so doing, she would be dramatically improving quality in the least capable center and would also be sending a message to the other centers that accreditation should be fairly readily achievable for them.

In contrast, on another fieldwork installation with acknowledged quality variation between the two CDCs, the child development coordinator accredited both centers together. She knew that the process would have been easier if she had gone with the more-capable center first, she told us, but she worried that accreditation of the higher-quality newer center would make parents even less happy with the older one.⁷ Both centers were successful on the first try.

Although there was not much reported variation on installations in pre-MCCA quality of care overall, there were significant differences ($p = 0.04$) in this measure by service. As can be seen in Table 13.12, Marine Corps and Air Force respondents reported greater variation in quality of care among CDCs on the same installation before the MCCA.

Table 13.13 shows the amount of post-MCCA variation in perceived quality of care across installation CDCs. Almost 85 percent of all respondents report a little or no variation in the quality of care among the CDCs on their installation. This is more than twice the proportion of respondents reporting a little or no variation in quality of care at the installation level pre-MCCA. Similarly, the average reported variation in quality of care after the MCCA declined by more than 50 percent to 0.73, or somewhere between no variation and a little variation. It is interesting that although there were significant differences across the four services in the average amount of reported quality variation among CDCs on an installation pre-

⁷In fact, the Air Force required that all centers on an installation be accredited at the same time to ensure improved quality for all children in care on the installation.

Table 13.13**Variation in Post-MCCA Quality of Care at the Installation Level**

Amount of Variation		Percentage	Cumulative Percentage	Frequency
No variation	0	45	45	58
A little variation	1	39	84	50
Some variation	2	12	97	16
A lot of variation	3	3	100	4
Total		99 ^a		128

SOURCE: Data from mail survey.

^aEntries do not sum to 100 because of rounding imprecision.

MCCA, there are no significant differences in the average amount of reported variation in post-MCCA quality of care (results not shown).

To better understand the reduced variation in post-MCCA quality of care across CDCs on a single installation that we found, we analyzed whether the reduction was related to the amount of quality improvement that respondents indicated had occurred. Table 13.14 shows the average reduction in variation in quality of care by the total amount of reported quality improvement.⁸

Table 13.14**Reduction in Variations in Quality of Care at the Installation Level**

Quality Im- provement	Mean	Std. Dev.	Frequency
0	0.39	0.72	23
1	0.90	0.94	41
2	0.94	0.97	17
3	1.67	0.87	9
Mean	0.86 ^a	0.94	90

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.004$ (F-test).

⁸Improvements in quality of care are reported as positive to aid the interpretation of the table. Thus, a higher number corresponds to a higher reported level of improvement in quality of care; similarly for the reductions in variation of quality of care at the installation level.

There is indeed a striking relationship between rated overall improvement in quality of care and reduction in variation in quality of care across CDCs on a single installation. The greater the amount of quality improvement that respondents perceived, the less the amount of quality variation across CDCs on a single installation that they reported.

EXPLAINING IMPROVED QUALITY

What explains the greater quality that we and others observed?⁹ Several things stand out. First, many of the mechanisms that would increase quality were built into the MCCA as provisions of the mandate. Thus, there was no need to debate *how* to make quality happen. As our model suggests, the high degree to which the MCCA structured implementation of key quality-related provisions contributed substantially to improved quality outcomes. The required APF\$ match, an inspection program that defined success and specified public consequences for failure, a hot line that enabled the DoD to learn of substandard CDCs, and the wage increase tied to training milestones set in place the means and mechanisms to bring about higher-quality programs and to monitor the improvement process. The accreditation demonstration program contributed as well to improved quality standards and also precipitated accreditation mandates in the Army and Air Force.¹⁰ In addition, mechanisms that recognized the way in which the military works, such as the CO out-brief at the end of the inspection process, ensured that information about quality reached those who had a stake in its presence.

For the most part, the wage increases, training requirements, and inspection system overcame what was missing in the MCCA—an initial allocation of financial resources, adequate planning time and, in some services, a strong consensus as to the value of the new policy to the organization.

⁹We were able to observe quality improvements firsthand in some of those CDCs to which we returned during this portion of the study.

¹⁰The Navy and Marine Corps have also adopted universal accreditation policies since the end of our data collection period.

An inspection process in which DoD personnel were active players was particularly powerful in ensuring compliance with the MCCA's provisions. In the first round of inspections, a Marine Corps CDC was closed. This action caused shock waves that reverberated far beyond the Marine Corps. Reluctant implementors everywhere understood that compliance failures (or at least those concerned with safety and ratios) would be noticed and publicly sanctioned.

The message was heard. As discussed above, our survey data indicate that differences in perceived quality across services before MCCA implementation narrowed considerably by the time of our survey. Improvements in average quality rating by service from before the MCCA to the time of our survey were significantly different from one another, with Army respondents, not surprisingly, reporting the least pre-post improvement, and Air Force and Marine Corps respondents reporting the most. Indeed, Marine Corps respondents experienced so much improvement that their post-MCCA quality ratings were the highest of the four services.

The absence of an initial appropriation and adequate planning time did, however, matter, and was particularly significant in those services and on those installations with limited capacity and less commitment to child development programs. Indeed, more than one command representative told us that without funds, certain quality improvements mandated by the MCCA were not made.

A range of quality indicators such as percentage of accredited centers demonstrate that improved quality was not easily or uniformly achieved even a year after our survey. Increased capacity and commitment pre-MCCA led both the Army and the Air Force to mandate universal accreditation of CDCs, although in different ways. The Air Force's accreditation deadline led to a very high rate—86 percent accreditation by October 1994. The absence of a deadline in the Army's accreditation mandate led to a 34 percent rate; a rate considerably higher than the Navy's 19 percent and the Marine Corps' 10 percent.

At the same time, lack of funds, lack of support, and an overwhelming implementation task led many to essentially ignore some of the optional provisions, particularly FCC subsidies. In many respects, this behavior seemed rational; there was only so much that could be done immediately. But the choice to ignore these provisions rather

than some others also reflected both the enforcement process and the validity of the causal theory implicit in the MCCA.

EXPLAINING DECREASED VARIABILITY

A substantial part of Congress' concern about child care quality was founded on the enormous variability that existed in 1989 in CDCs within and across services: Congress' intent was that the more rigorous quality standards required in the MCCA would reduce this variability.

Our data indicate that for the most part, variability in quality did decline. As discussed above, nearly all survey respondents (85 percent) told us that many, almost all, or all of the major program problems that existed before the MCCA had been resolved by the time of our survey. Our data also show that in those services with the lowest pre-MCCA quality, survey respondents reported the most pre-post MCCA quality improvement, suggesting that variability declined across services. Finally, survey respondents indicated that variations in quality across the (multiple) CDCs on their installation had declined since MCCA implementation. More than twice as many survey respondents indicated that there was little or no quality variation across CDCs post-MCCA as had perceived this before MCCA implementation.

EFFECT OF MCCA ON AVAILABILITY OF CARE

One major goal of the MCCA was to increase the number of military child care slots to alleviate the excess demand reported by all the services before the act. The MCCA itself did not specify whether the intent was to increase availability of all types of child care (i.e., full-time, part-time hourly care), or only full-time care. Implementing Guidance put out by the DoD soon after the passage of the act (March 23, 1990) did not raise this issue either.

But the lack of such language in the act or initial guidance did not mean that the issue was ignored. Indeed, the Inspector General's report on military child care, which came out in the summer of 1989, had been critical of the DoD for the lack of priorities and goals in the child care program. As is standard procedure, the DoD had to re-

spond to the criticism and did so by describing as a priority those children whose parent or parents work full-time outside the home. This priority was justified by the substantial amounts of taxpayer funds going to child care.

The services also addressed this issue. The Army, in an undated Point Paper on Installation Child Care Availability Plan, states, "Full-day care should be maximized. A minimum of 75 percent of the CDC space will be designated for full-day care on installations with a full-day waiting list in excess of 30 days."

The Navy, in its plan to address unmet demand, notes that the goal of the plan is to meet the needs of working parents, a phrase that is understood to focus concern on full-day care.

The new Department of Defense Instruction (DoDI) on Child Development Programs (CDPs), published on January 19, 1993, made clear the DoD's position with regard to increased availability of care: It is full-time care that is to be encouraged. Indeed, the 1993 DoDI states, "The purpose of CDPs offered by the DoD Components is to assist DoD military and civilian personnel in balancing the competing demands of family life and the economic viability of the family unit" (p. 2).

This purpose, in mentioning economic viability of the family unit, clearly focused the effort on those families where both parents or a single parent work outside the home. The DoDI goes on to make this point even more clearly in discussing priorities for receipt of child care: "In all cases, first priority shall be given to children of active-duty military and DoD civilian personnel who are either single parents, or whose spouse is employed on a full-time basis outside the home or is a military member on active duty" (p. 2).

The DoDI underscores the focus on full-day care by further noting that "whenever possible, the DoD components will support the needs of their personnel for hourly care and preschool programs by expanding the use of facilities and programs other than the Child Development Centers (CDCs)" (p. 2).

Increasing the number of full-day care slots presented a major challenge to child care managers and command. Some of the very requirements designed to improve quality, such as stricter monitoring

of child-to-caregiver ratios, caused availability to decline. In addition, mechanisms that would ensure increases in quantity were not written into the act or the regulations, as they were for the improvement of quality. Nor was it nearly as clear what those mechanisms might be. Indeed, some of the ways in which capacity might be increased, such as MILCON construction projects, were specifically rejected by some COs in reaction to other MCCA requirements, particularly the APFS match. Numerous COs told us that they understood that under the MCCA, each CDC slot now incurred a funding commitment. Consequently, they considered fewer, rather than more CDC slots to be desirable.

Many COs did recognize that there were other ways to increase availability, mainly through increased use of FCC. These slots, which were considered by many COs before the MCCA to impose unacceptable costs in the form of child abuse risk and monitoring of providers without hope of revenue generation, were now seen as a far less costly way to generate care than through the development of additional CDC capacity.

We asked our mail survey respondents about the effect of the MCCA on the total number of full-time spaces available in the CDCs. Table 13.15 indicates that about 20 percent reported substantially or a few less CDC spaces, whereas about 40 percent reported no change, and the remaining 40 percent reported either a few or substantially more full-time spaces in the CDC as a result of the MCCA.

Table 13.15
Changes in the Number of Full-Time CDC Spaces Post-MCCA

Amount of Change	Percentage		Cumulative Percentage	Frequency
Substantially fewer	-2	5	5	12
A few less	-1	15	20	34
No change	0	39	59	91
A few more	1	22	81	52
Substantially more	2	19	100	43
Total	100			232

SOURCE: Data from mail survey.

Although about 60 percent of the respondents report no change or a reduction in the number of full-time CDC spaces, on average, there has been a slight *increase* in the number of full-time spaces, according to survey respondents (see Table 13.16). It is interesting to note that there are significant differences by service in the average perceived change in the number of full-time CDC spaces after the MCCA. With the exception of the Marine Corps, respondents in each service reported a net increase in the number of full-time spaces in CDCs. Army respondents reported the greatest average increase. The Marine Corps results are understandable given pre-MCCA regulations, which allowed staff-to-child ratios to exceed scheduled ratios by 50 percent. Consequently, we would expect Marine Corps availability to decline under stricter enforcement of existing regulations.

Table 13.16
Average Change in the Number of Full-Time CDC Spaces Post-MCCA, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	0.30	1.25	84
Army	0.63	0.90	64
Marine Corps	-0.38	1.26	13
Navy	0.28	0.97	71
Mean	0.34 ^a	1.10	232

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.02$ (F-test).

EXPLAINING INCREASED AVAILABILITY

This second major MCCA goal was more difficult to achieve in several respects. First, unlike the quality goal, the legislation did not structure an implementation process or specific provisions that, once complied with, would increase the quantity of child care. Indeed, the contrary was the case.

Additionally, there was little compliance-monitoring with regard to quantity. Required inspections—the most public compliance indicator—do not address the issue. Nor has quantity been the focus of documents emanating from major commands, headquarters, or the DoD. The MCCA also made CDC slots more costly because of the re-

quired APFS match. Thus, the legislation made one of its key goals *less appealing and more difficult to attain*.

Yet, these same provisions increased the appeal of additional FCC slots. As discussed above, these slots required no APFS match and could be created quickly. In addition, an FCC monitor, now a GS employee (thanks to another MCCA provision), was overseeing FCC quality, which reduced the risks of FCC in the view of many command staff.

As our data indicate, some installations embarked on organized efforts to create additional FCC slots after the MCCA, including the relocation of the most costly infant slots out of CDCs. Overall, almost one-third of mail survey respondents indicated that the number of FCC slots had increased as a result of the MCCA; only 10 percent reported a decrease.

OTHER CDC EFFECTS

A number of other changes took place in CDCs as a result of the MCCA. We asked our mail survey respondents to indicate which changes had occurred on their installations. The results are reported in Table 13.17.

Table 13.17

MCCA-Precipitated Changes in the Provision of CDC Services

Changes in Provision of Services	Frequency	Percentage	Rank
Reduced hourly care availability	135	59	1
Moved school-age care to YP	102	44	2
Reduced hours of operation	81	35	3
Reduced infant care availability	47	20	4
Moved preschool out of CDC	45	20	5
Moved hourly care out of CDC	44	19	6
No change	31	13	7
Centralized hourly care in one CDC	28	12	8
Other change	20	9	9
Moved infants out of CDC	17	7	10 ^a
Relocated school-aged care to FCC	17	7	11 ^a
Total	230		

SOURCE: Data from mail survey.

^aTied ranking.

The most frequently reported change, reported by almost 60 percent of the respondents, was a reduction in the availability of hourly care, that is, fewer slots devoted to care for children who use care on an occasional basis. Loss of such care has been a source of concern since the MCCA's inception. These concerns led to the mounting of a DoD survey of responses to hourly care requests made to child development programs between June 12 and July 11, 1995, in a small number of locations. Preliminary findings reveal that 96 percent of those who requested hourly care during the survey period were offered such care and used it. Among the small percentage who requested but did not use hourly care, about half turned down an available hourly care slot, usually because the requestor did not want care in an FCC home. Only 3 percent of those requesting hourly care indicated that they needed such care to fulfill a volunteer commitment. The survey will be fielded again during the winter to ensure that results are not seasonally biased. They do suggest, however, that there is enough hourly care provided within the system to meet the need.

The second most frequently reported change in provision of services was a change in the location of care for school-age children, which 44 percent of respondents reported moving to YP; 7 percent reported moving it to FCC. The third most frequently reported change was a reduction in CDC hours of operation, which just over one-third of respondents indicated had taken place. About 20 percent of respondents reported that the availability of infant care in CDCs had been reduced, whereas 7 percent indicated that infant care had been moved out of CDCs. About 20 percent of respondents reported that preschool and hourly care had been moved out of CDC. Only about 13 percent reported that no change had occurred in the provision of child care services in installation CDCs as a result of the MCCA.

In addition to these changes, about 9 percent indicated that additional (or different) changes had occurred. These included both reductions and increases in services, although there were considerably more of the former. Reductions included fewer hours of operation, elimination of a half-day program, and reduced infant and toddler

care. Service increases included increased hours of service and increased numbers of full-day slots.¹¹

We heard a good deal about CDC changes during our fieldwork visits as well. For the most part, respondents reported that changes were designed to increase the number of full-day care slots. Thus, they focused on moving part-day and after-school programs elsewhere and in some cases on moving infants' spaces to FCC. Fieldwork interviewees who had done the latter considered moving infant care out of CDCs as a fiscally prudent policy given higher costs for infant care and the inability to raise fees accordingly. In most instances of such movement, an active FCC recruitment program preceded the move, so that displaced infants continued to receive care.

Table 13.18 shows the percentage of respondents in each service who indicated that they had made each type of change discussed above. Almost 60 percent of all respondents indicated that they had reduced the availability of hourly care in response to the MCCA, but Air Force

Table 13.18
Percentage of Respondents Reporting CDC Changes Noted, by Service

Changes Noted	Air		Marine	
	Force	Army	Corps	Navy
Reduced hourly care	79	49	54	43 ^a
Programs moved to YP	65	30	15	37 ^a
Reduced CDC hours	64	20	46	11 ^a
Reduced infant care	29	0	69	19 ^a
Moved preschool out of CDC	29	11	8	17 ^a
Moved hourly care out of CDC	13	20	31	24
Centralized hourly care in one CDC	7	25	31	4
Moved infants out of CDC	13	7	0	3
Relocated school-age care to CDC	10	7	8	4
No.	86	61	13	70

SOURCE: Data from mail survey.

^aMeans are significantly different: $p > 0.0002$ (F-test).

¹¹Our fieldwork indicated that an increased number of full-day slots was usually the result of the changes described by respondents in this question. We suspect that increased numbers of full-day slots was not written in more often because it was the outcome of the many other changes described.

respondents reported doing so in much greater numbers than respondents in the other services.¹²

The second most frequently reported change—moving school-age child care programs to youth programs—also varied significantly across the services. In this case, Air Force respondents were the most likely to have reported this change and the Marine Corps the least likely, with the Army and the Navy in the middle.

Again, the Air Force was significantly more likely to report having reduced hours of CDC operation than the other services, followed by the Marine Corps.

It is interesting to note the huge variation in responses across the four services concerning reductions in infant care. None of the Army respondents reported cutting back on the availability of infant care in CDCs, whereas more than two-thirds of all Marine Corps respondents reported reducing such care.

Although the absolute differences in the proportion of respondents indicating that they had moved preschool programs out of the CDCs are small, they are still significantly different from one another ($p < 0.03$). Again, Air Force respondents are most likely to report that preschool programs were moved out of CDCs; Marine Corps respondents were least likely to report that this had occurred.

In contrast, the proportion of respondents who reported that hourly care moved out of CDCs in response to the MCCA does not vary significantly by service. It is interesting to note that Army respondents, who were least likely to report reduced hourly care availability in response to the MCCA, are most likely, after the MCCA, to report centralizing hourly care in one CDC. Marine Corps respondents are most likely to report having reduced hourly care and centralizing the remaining hourly care in one CDC. Thus, survey data indicate that the provision of hourly care was both reduced in scope and tended to be centralized on installations after the MCCA.

¹²The Air Force limits the percentage of spaces that may be used for hourly care as a matter of policy. This decision implements DoD policy to give priority to employed parents.

We found differences by service in the proportion of respondents reporting no changes to CDCs. As shown in Table 13.19, respondents in the Army and Navy, which had a leg up on MCCA implementation, were most likely to indicate that they had not made changes to CDCs in response to the MCCA.

Finally, we looked at the total number of changes made to CDCs. As Table 13.20 indicates, respondents reported on average just over two changes in the provision of CDC services in response to the MCCA. The greatest number of changes were reported by Air Force and Marine Corps respondents, which is consistent with the quality-of-care results, which indicated that the Air Force and the Marine Corps reported the most improvement in quality of care as a result of the MCCA.

Table 13.19
Percentage of Respondents Reporting No CDC Changes, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	3	0.18	86
Army	20	0.40	61
Marine Corps	8	0.28	13
Navy	21	0.41	70
Mean	13 ^a	0.34	230

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.003$ (F-test).

Table 13.20
Average Number of Changes in the Provision of CDC Services, by Service

Service	Mean	Std. Dev.	Frequency
Air Force	3.2	1.6	86
Army	1.8	1.4	61
Marine Corps	2.8	1.6	13
Navy	1.7	1.3	70
Mean	2.3 ^a	1.6	230

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.0001$ (F-test).

EFFECTS ON FCC

Although FCC was paid scant attention in the MCCA or the regulations, MCCA-precipitated changes in FCC were expected because of the changes required in CDCs. In particular, decreased CDC capacity and increased APFS attached to each CDC slot made FCC slots far more appealing to command than they had been in the past. Indeed, one Marine Corps CO described FCC as “our salvation.”

We asked our mail survey respondents about the effect of the MCCA on the total number of full-time FCC spaces. As shown in Table 13.21, on average, there was a slight increase in the number of FCC spaces, as the overall mean was 0.34. About 10 percent of respondents reported a decline in the number of full-time FCC slots, almost 60 percent reported no change, and the remaining 30 percent reported an increase in the number of full-time FCC spaces. There were no significant differences by service in reported changes in the number of full-time FCC spaces.

But changes to FCC were not limited to availability of slots. A critical change that has helped to more closely integrate FCC into the child development system was the establishment of the FCC coordinator position as a GS position in response to the MCCA. This competitive service position has provided increased legitimacy and stability to the FCC program on many installations. One FCC coordinator

Table 13.21
Changes in the Number of Full-Time FCC Spaces

Amount of Change	Percentage	Cumulative Percentage	Frequency
Substantially fewer	-2	4	8
A few less	-1	7	14
No change	0	67	118
A few more	1	84	35
Substantially more	2	100 ^a	33
Mean	34		
Total	101 ^a		208

SOURCE: Data from mail survey.

^aPercentages may not sum to 100 due to rounding imprecision.

told us that the new GS coordinator position has brought FCC into the mainstream of child care on her Navy base. As a result, FCC providers now see themselves as more professional; they provide child care, not just babysitting. This increased professionalization was noted elsewhere as well. However, one FCC coordinator told us that the professionalization came at a price: Some of her older providers decided to quit rather than undergo the increased training now required of FCC providers by the Army. As was true for some CDC directors, this coordinator rued the loss of these grandmotherly types, and wondered if the system ultimately benefited from the imposition of stricter training requirements. However, most FCC coordinators to whom we spoke believed that the increased training requirements had been a boon to FCC.

The FCC coordinator position has also allowed for increased recruiting of FCC providers. On one Marine Corps base, monthly articles in the local paper, talks at the predeployment session given by the Family Support Center, and an FCC newsletter—all things that were not possible before there was an FCC coordinator position—have helped to substantially expand the program, from four homes to 16 in a short period of time.

The inclusion of the FCC program in the MCCA-required inspections and certification process has also brought the FCC program more into the child development mainstream. Child development managers now ignore FCC at their peril; problems in that program could deny them certification. Consequently, the program has received more attention, and the attention has resulted in program improvements.

Better training for FCC providers, more frequent and rigorous inspections, and, in the case of the Army, designated FCC T&C specs and IEPs for each FCC caregiver that track her training, all help to legitimize FCC and reduce concerns about its inherent liabilities.

Our survey attempted to assess the extent of these changes. We asked respondents who had an FCC program on their installation if there had been any changes in the FCC program in response to the MCCA. As shown in Table 13.22, most respondents indicated that their FCC program had indeed changed.

Table 13.22
Changes in the FCC Program in Response
to the MCCA, by Service

Service	Percentage	No.
Air Force	86	85
Army	75	57
Marine Corps	83	12
Navy	48	52
Mean	73 ^a	206

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.001$ (F-test).

Those who indicated that changes had occurred to their FCC program were asked to describe those changes. As shown in Table 13.23, changes were identified throughout the program, although respondents most often identified changes in the amount and quality of provider training. Indeed, the widespread nature of these changes is quite dramatic, given the limited attention to FCC in the MCCA. One reason for the widespread nature of the changes is that in some cases, these changes were required in policies that followed from the MCCA. For example, the Army chose to require that there be a separate T&C spec for the FCC program. The presence of an FTE responsible for training would be likely to increase both its quantity and quality. The relatively low numbers for the Army in Table 13.23 probably reflect the Army's greater emphasis on FCC before the MCCA; for example, provider IEPs were already required when the MCCA passed. In addition, some of the changes that the Army made may not be reflected in the categories that we provided respondents on the survey form.

In addition, the Army required that the amount of training that FCC providers receive be the same as that required of CDC caregivers. Army respondents were unanimous in describing this change as the critical difference in the improved quality of the FCC program. Provision of identical training also allows FCC providers to fairly easily become CDC caregivers.

A few Marine Corps respondents attributed an energized and expanded FCC program to a realization on the part of some COs that the MCCA's APFS match requirement meant that each CDC slot

Table 13.23
Changes to FCC Program Noted, by Service
(percent)

Service	Increased No. of Providers	Lower Ratio of Providers to Monitors	More Provider Training	Better Provider Training	Moved Infant Care to FCC	Moved After-School Care to FCC	No.
Air Force	33	20	67	67	16	3	88
Army	10	3	38	45	4	1	69
Marine Corps	54	8	69	69	8	0	13
Navy	19	4	25	28	4	3	72
Total	24 ^a	10 ^a	46 ^a	49 ^a	9 ^b	2	242

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.001$ (F-test).

^bMeans are significantly different: $p < 0.05$ (F-test).

would now cost even more. Evidence that the expansion was quality-focused may be found in the data showing widespread increases in the amount and quality of FCC provider training in both the Marine Corps and Air Force.

On one Air Force base, we were told that FCC homes are more frequently inspected since the MCCA. Before the MCCA, homes were inspected quarterly; now, inspections occur monthly, on a no-notice basis. Marine Corps respondents told us that FCC inspections became part of a newly energized inspection program that was fueled by MCCA requirements.

The findings in Table 13.23 were substantiated by our fieldwork data. Respondents in many places told us that the quantity of FCC training had increased and the quality of this training had improved. Several respondents pointed to the T&C spec position as a major factor in an improved FCC program. The T&C spec was knowledgeable about child development and would often serve as a resource to the FCC program, even when the CDC was her primary focus. Some fieldwork interviewees attributed the changes in FCC training to an increased focus on the issue of training that was part of the pay banding program. A few noted that improved CDC training curricula were made available to FCC. FCC providers in a number of places

were now eligible for and were taking joint training with CDC staff. A few FCC directors told us that their own personal goal was to make FCC training comparable to that provided by CDCs.¹³

As shown in Table 13.24, comparability of training between FCC providers and CDC caregivers varied significantly by service. As one might expect given its explicit policy on this issue, Army respondents were most likely to indicate that an FCC provider would require no additional training to become a CDC caregiver. The mean Army response was between “none” and “part.” Air Force respondents indicated the greatest amount of additional training required.

Given the higher level of parity in the Army between CDC caregiver and FCC provider training, it is not surprising that Army survey respondents were most likely to describe the amount of FCC provider training as adequate to enable them to deliver high-quality care.

Table 13.24
Average Amount of Additional Training Necessary
for FCC Providers to Become CDC Caregivers,
by Service

Service	Mean Rating ^a	Frequency
Air Force	2.45	83
Army	1.58	57
Marine Corps	2.25	12
Navy	2.36	53
Mean	2.17 ^b	205

SOURCE: Data from mail survey.

^a1 = no extra training; 2 = part; 3 = all of CDC caregiver training.

^bMeans are significantly different: $p < 0.0000$ (F-test).

¹³FCC training modules are now available DoD-wide. They teach the same 13 competencies as the CDC modules but focus on FCC issues.

EXPLAINING EFFECTS ON FCC

The fact that the changes in the CDCs brought about by the MCCA caused some changes in FCC is not surprising, even though FCC was not much addressed in the legislation or regulations. As discussed above, decreased capacity in some CDC facilities because of stepped-up inspections and increased APF\$ attached to each CDC slot made FCC slots much more appealing to command than they had been in the past. In addition, FCC slots could be created in a fraction of the time that it would take to create new slots in a new or remodeled CDC.

But other aspects of the MCCA also increased the attention paid to FCC and contributed to improved quality in that program. Probably the major change of this type was APF\$ support for the FCC monitor position. As a GS position, the FCC monitor position became a more stable job and a more desirable one. It gave FCC enhanced status and, because of the stability of the position, allowed the FCC coordinator to plan training and other improvements with some sense that she would be around to carry them through.

Our findings suggest that FCC and children have benefited from new DoD policy. More provider training, more oversight, and, in limited instances, the use of subsidies have contributed to improved quality of care and greater provider professionalism.

In many ways, the military stands to benefit from more use of FCC as well. As noted above, FCC slots can be created far more quickly and cheaply than those in CDCs, a key advantage. In addition, FCC has the potential to provide care that may have a substantial effect on readiness: late-night, weekend, and sick child care. Thus, a vitalized and more professional FCC program may benefit all child care constituencies.

EFFECT ON YOUTH PROGRAMS

Although the MCCA was to apply to children from birth to 12 years of age, virtually all provisions of the act referred to those who were younger than school-age and, as noted above, nearly all dealt with those receiving care in CDCs. Because of our interest in a child development system and the DoD's concerns about youth programs,

we expanded our exploration of the implementation of the MCCA to include its possible effects on youth programs. Any effects on youth programs would be an unintentional consequence of MCCA implementation, thus we did not expect widespread change. Yet we felt that exploring MCCA effects on YP might help to clarify both MCCA implementation and the potential and problems facing the military in creating a child development system that spans the period from birth to pre-adolescence.

We asked survey respondents who had a YP on their installation to tell us if there were any changes to that program in response to the MCCA. As shown in Table 13.25, a fairly substantial percentage of respondents who had youth programs indicated that there had indeed been changes.

We asked those respondents who indicated that their installation's YP had changed in response to the MCCA to describe the nature and extent of those changes. We provided three options based on our early fieldwork visits: relocation of the before- and after-school program to YP, transfer of the administration of the before- and after-school program to YP from child development, and YP staff departures for now-better-paying CDC caregiver jobs. We also encouraged respondents to describe any additional changes in an "other" category.

As shown in Table 13.26, the changes that we asked about were not widespread. The most prevalent of the three changes noted above was the transfer of the before- and after-school program

Table 13.25
Changes to Youth Program in Response to MCCA,
by Service

Service	Percentage	No.
Air Force	48	83
Army	30	57
Marine Corps	38	8
Navy	44	50
Mean	41 ^a	198

SOURCE: Data from mail survey.

^aMeans are not significantly different (F-test).

Table 13.26
Specific Changes to the YP in Response to the MCCA, by Service

Service	YP Administers Before- and After-School Program	YP Location for Before- and After-School Program	YP Staff Left for CDC Caregiver Jobs	No.
Air Force	58	6	11	88
Army	23	14	14	69
Marine Corps	8	0	8	13
Navy	33	10	8	73
Mean	38 ^a	9	9	243

SOURCE: Data from mail survey.

^aMeans are significantly different: $p < 0.001$ (F-test).

administration to YP. Although 38 percent of survey respondents indicated that administration of before- and after-school programs had moved to YP in response to the MCCA, only 9 percent indicated that these programs had physically moved to the YP center. An Air Force youth director with whom we spoke during fieldwork explained that a shortage of space in the CDC and a very long waiting list for full-day care led to a decision to move the before- and after-school program to the youth center. The move enabled the before- and after-school program to triple in size.

Although there was some concern that youth programs staff might abandon YP for now-better-paying CDC caregiver jobs, our survey data suggest that such movement was not common. Only 9 percent of respondents indicated that there had been any movement of YP staff to such positions as a result of increased caregiver wages under the MCCA.

During fieldwork, we did hear of a few instances in which YP staff had left for CDC jobs. One Navy YP director told us that as a result of the MCCA, YP was now forced to compete with CDP in hiring their before- and after-school program staff. YP regularly loses out, she said, because CDC offers better pay and more hours. A youth director on an Army base concurred. She has found that since the MCCA raised CDC caregiver salaries, YP recreation aides move to caregiver jobs as soon as they open. Another YP director noted that the opportunity to earn college credits through CDC training had

convinced two of her staff to leave YP for the CDC.¹⁴ Said an outspoken Air Force YP director, “It’s hard to keep someone you pay \$4.25 an hour, provide no benefits, and can’t offer full-time work.” Nevertheless, she claimed, she had not lost staff to the CDC.

However, in several cases when YP staff left for the CDC, our YP respondent concluded the story by telling us that the prodigal staff member had returned to YP. In a few instances, we were told that the staff member had concluded that the higher pay was more than justified by the harder work (diaper changing was invariably mentioned at this point). Another respondent told us that former YP staffers had trouble with the far more structured setting in the CDCs. She’d had one staff member leave CDP for YP because she found the CDC environment “stifling.”

We asked our fieldwork interviewees the same question that we asked survey respondents: Had the MCCA changed the before- and after-school program? A number of respondents told us that the thrust of the MCCA, which was to convert CDCs to the almost exclusive provision of full-day care, had forced the before- and after-school program out of the CDC. In some cases, the program continued under CDP auspices, but in other places the administration of the program had changed as well.

A few YP respondents to whom we spoke during fieldwork were able to describe concrete benefits that accrued to YP from the MCCA. Most of these concerned improved training for CDC caregivers that was also provided to YP staff. For example, on two Air Force bases that we visited, the CDC T&C spec trains before- and after-school program staff. This has improved the quality of that program and has created a cadre of more knowledgeable staff in the youth center. One YP director whose staff receives this training views it as one part of the effort to move the before- and after-school program towards compliance with the MCCA. According to a high-level Pentagon respondent, many of these sorts of efforts have been “preventive strikes” designed to keep Congress from sticking its nose into YP. An Air Force interviewee argued that preventive strikes would not suffice. She warned that YP will not get the funds it needs until it gets

¹⁴School-age care training modules recently have been developed that include the same 13 competencies as the CDC and FCC ones.

its own equivalent of the MCCA. In any case, such “preventive strikes” are far from universal. A YP director on a naval base we visited told us that the Navy requirement for youth training of 30 minutes a month had not changed.

Some fieldwork interviewees told us that YP had benefited from the MCCA in less concrete but nevertheless important ways. For one thing, these respondents said, the MCCA had underlined the importance of programs for children, the importance of staff training, and the need for vigilance about child abuse. A few respondents wanted to take it farther. Said one, “I would like [YP] to be an extension of child development—equal pay, equal staff training, integrated curriculum (especially for the before- and after-school programs), and as much emphasis on creating buildings and spaces as in child development.” This director hoped to benefit from the material and other resources being lavished on child development by having YP become an extension of child development. “We need a playground,” she said, “but there is none attached to the new [YP] center. Child development has a two-inch-thick book about playgrounds.” A high-level Army officer echoed these sentiments. In his view, the “program break” that now exists between CDP and YP should not be there. He thinks that there should be a continuum, with Youth Services becoming Youth Development Services. This same respondent noted that the MCCA has been helpful to YP in both reinforcing the presence of APFS in child care programs and giving the force of law to quality standards in child care.

But an Army director of community and family activities disagreed. His staff wants a CDP-YP consolidation, but he has vetoed the idea out of concern that “excessive” CDP regulations might be visited on YP if they were one program.¹⁵

A savvy YP director on another installation that we visited has used all the attention that CDP has received to help her program. “The MCCA has made them [commanders] sit up and take notice [of CDP].” In her view, they need to pay attention now to YP. She believes that on her base, this message has been conveyed to and

¹⁵Since our data collection period, the Army has implemented such a consolidated system.

heard by command—she doubts they would have their brand-new youth center facility if someone high up had not been interested.

A high-level Army officer at headquarters validated her view. “As I understand it, it [the MCCA] does not directly pertain to YS,” he said, but MCCA goals have led him to point YP in a developmental direction. “The same public pressure [to improve the quality of care and reduce the possibility of child abuse] that led Congress to pass the MCCA remains there, and is pushing YA.”

In a few cases, YP staff were attempting to emulate the MCCA; mostly this occurred in the context of before- and after-school programs, which most closely resemble CDPs in terms of parental expectations for fairly close supervision. An Air Force YP staffer told us, for example, that in the before- and after-school program on her base, they were allowed to have 18 children per staff member. But staff had decided to move the program more “into” the MCCA mode by trying to keep that ratio closer to 15:1.¹⁶ One YP director told us that the part-day enrichment program at the youth center had been accredited at the same time as the CDC.

At the same time, as our survey data suggest, most fieldwork interviewees reported that there had been no changes to their youth program as a result of the MCCA. The lack of change was brought home on one installation that we visited, where the CDC director we interviewed did not know the YP coordinator’s name. A few respondents clarified for us that the lack of change in YP that we found in our survey data was really a lack of *positive* change. Several fieldwork interviewees noted that YP, always in a less favored position than CDP, had suffered further as a result of the MCCA because far more APFS were going to CDP than before. One CDP administrator described YP as a “time bomb;” a program that had gotten worse since the MCCA. Moreover, so much time had been required to launch MCCA implementation that there was little time or energy left for YP. This led, on one installation, to a deterioration in the relationship between YP and child development.

An Army YP head told us that she feels she is always competing with providers of preschool care; usually, she loses. With the

¹⁶The Air Force staff-to-child ratio is now 1:12 for all ages.

MCCA's funding scheme, the installation is required to match parent fees with appropriated funds, so CDP is "naturally covered." Her own budget has declined but CDP's budget has expanded enormously. She said that she could not get \$19,000 for sand for her playground because of the huge amount of money going to CDP. She told us how disappointed she was that YP had not been included in the MCCA. This same respondent told us that parents often asked her why YP did not have their own MCCA. A Marine Corps colleague echoed her sentiments. This YP director described command as very supportive of youth programs, but acknowledged that there was competition with CDP for funds. Then she corrected herself. "Actually," she said, "we *don't* compete; CDP gets the money." Her program no longer gets APFS, but APF support for CDP has mushroomed since the MCCA. She worries that teens on her isolated base need more than just a recreation program, but she does not have the funds to do more. She believes that older kids are just as important as babies and preschoolers, but they do not receive the same kind of attention or support. "All of the kids are important, but the needs of the older ones are not being met because of [lack of] funding."

An Air Force colleague agreed. The focus on newborns to five-year-olds has left six- to twelve-year-olds in poor facilities with poorly trained staff, he said. A Marine Corps YP director said that her relationship with CDP staff had deteriorated since passage of the MCCA. She was tired of hearing about how much money CDP was getting. An Air Force colleague concurred. "The act resulted in some bad feelings between CDP and YP. Some people in YP feel 'we're not important enough to be regulated.'" CDP responses exacerbate the problem in some places. "They think they're better than we are," she added. "The differences in regulation contribute to parental unhappiness," she continued. "Parents come over here [to YP], people who have been in child development, they have the perception that we're not doing things right." At the same time, she noted, there is some halo effect—CDP was *so* good, some parents say, we'll go ahead and try the older kids' program, because it is part of the same organization.

There was another group of fieldwork interviewees for whom the MCCA had pressed alarm buttons. They believed that the passage of the MCCA presaged the passage of a similar bill for youth. One high-

level Pentagon respondent told us that the major effect of the MCCA on YP was that it made “some segments wary that we’ll be getting some direction [in YP] as in a Military Youth Act of 199__.”¹⁷ A MACOM YP manager appeared to represent one of those segments. He told us that he had been moving YP in a more developmental direction for the last five or six years. The MCCA galvanized these efforts. He tells installation commanders that YP is a “monster sleeping, which shouldn’t be woken up.” What he means by this is that they should put more money into youth services now to avoid the [child abuse] scandals that occurred in CDP. Such scandals resulted in the MCCA; he did not want such an act for YP. One policy he had initiated to stave off problems required six- to eight-year-olds to be in organized classes at the youth centers; they could not participate in open recreation. In fact, the relevant policy in this major command states that if a child in this age range remains at the center more than 30 minutes after a class ends, the military police are to be called.¹⁸

Although a few respondents were pleased by the prospects of APFS and other benefits if a youth bill were to pass, most of the people who mentioned this possibility were distinctly negative. They believed that a Military Youth Act might bring appropriated funds largesse, as it had done for CDP, but they were unwilling to pay the price of much stricter regulation that they believed inhered in the benefits. These people generally believed that YP had a distinctly different mission than that of CDP—that they were there to provide recreational opportunities to kids who had spent most of the day in school. Consequently, they much preferred to provide their young charges with a range of recreational options (and sometimes other options as well, such as homework rooms) and allow the kids to make choices about how they spent their time. They contrasted this with the carefully planned developmental curricula that define the delivery of services in the CDCs.

One such person was a Marine Corps YP director. She told us that it “raises her hair” when YP is associated with CDP or called “day care,”

¹⁷These perceptions may have changed since the realignment in the 104th Congress, but we do not have the data to address this.

¹⁸The Air Force has issued school-age program standards since our fieldwork.

because it changes parents' expectations. With day care, parents want low ratios and increased accountability, all of which "gets in the way of recreation," she said. An Air Force YP director concurred that differing levels of regulation between CDP and YP create problems. There is "a view in some quarters" that child development provides better programs, but this view is based on their stricter regulations, she said. "People don't understand the difference between what they're doing and what we're doing. We don't speak in hushed tones. We're not a hands-on program—YP is not designed to provide direct supervision of children." An Army officer concurred with this assessment but in less positive terms: "Kids in YS (and not in SALK programs) are largely unsupervised."

Ironically, some of the very people who opposed the idea of greater scrutiny for YP noted that the MCCA, in raising the specter of a youth law, had actually improved youth programs. In these cases, YP directors had often used the MCCA as a stick to enforce increased compliance with existing regulations.

A number of fieldwork interviewees told us of other changes to YP, changes that had not occurred in (direct) response to the MCCA. One of the most important and salutary was the Air Force decision to move both CDP and YP under a Youth Support Flight Chief, a change that reflected a similar consolidation of both programs under a single individual at Air Force headquarters. At the time of our fieldwork, this change had not been made at all installations, but where it had, it was having an effect on YP.

At one Air Force installation that we visited, the change had resulted in increased attention and support to YP. According to the youth director there, parent surveys indicate that the perceived quality of youth programs has also increased since the reorganization. When YP was under recreation services, money that might have gone to YP went instead to the gym or the bowling alley. Under the Youth Support Flight Chief, children now have someone who negotiates with the commander who is solely concerned with children and youth. This place at the table led to a \$100,000 infusion of resources into the YP budget on his installation.

At another Air Force base, the consolidation under the Youth Support Flight Chief meant that child development trainers would now

be working with YP staff as well. An Air Force YP director at the major command level told us that since the CDP and YP were reorganized under the Youth Support Flight Chief, we are “one big happy family.” Satisfaction has increased because the new structure conveyed to YP directors that they might expect more APFS within the next year or so.

CONCLUSIONS

The MCCA was designed to correct a number of problems that existed in CDCs at the time of its passage. For the most part, the legislation and regulations have been very successful in doing so. Our data indicate that CDC quality has improved; the quantity of care has increased as well. In addition, the changes that have occurred have decreased the variability across CDCs, another MCCA goal. Moreover, policy changes have followed from the MCCA implementation effort that will ensure the stability of these improvements. A universal accreditation mandate, consolidation of CDP and YP on Air Force and Army bases, and expansion of CDC training requirements to FCC are all mechanisms to reinforce quality in CDCs and expand the reach of the MCCA to other child- and youth-serving components.

Limited data suggest that the MCCA's effect on FCC has been salutary. An FCC monitor, supported by APFS, has provided FCC with much-needed resources and stability. Modification of the CDC training modules for FCC has improved professionalism and the quality of care.

Effects on YP have been more mixed. The MCCA precipitated a small amount of change in these programs, but those changes were far from widespread or solid. Lack of change in YP reflects lack of YP focus in the legislation and the absence of a *system* of services for children and youth. At the same time, the MCCA's focus on CDCs reduced the relative level of support for YP. This was evident in both perceptions and in the flow of dollars and other resources to these programs. Some were able to exploit MCCA concerns about kids on behalf of YP and were optimistic that YP would soon benefit more directly, but for most others, their second-class status had been reinforced by the act and its sequelae.