Chapter Six

# CONCLUSIONS AND RECOMMENDATIONS

Child care is costly, and those costs are higher for younger children. The fact that child care is expensive to provide is not surprising. Because young children require a great deal of attention from adults, only small numbers of children can be attended to by any one adult (child-to-staff ratios specify the parameters of this level of attention). Within child-care centers, direct-care costs account for a large proportion of the total costs of providing child care (about 50 percent for preschool care and nearly 80 percent for infant care). Indeed, child-care cost studies find labor costs accounting for 70 to 75 percent of the total expended costs (Cost, Quality, and Child Outcomes Study Team, 1995; GAO, 1999).

Because accredited care and safety requirements demand that centers meet minimum staffing ratios, there are limited ways to reduce the costs of accredited care.[1] Consequently, the cost of the caregiver's salary (or in the case of FCC, the caregiver's compensation) must be shared by the relatively small number of children for whom he or she provides care. While it is certainly true that caregivers are not well paid and contribute to lower costs through foregone wages (Cost, Quality, and Child Outcomes Study Team, 1995), they don't work for free. Once caregiver salaries are factored in, child care cannot be provided inexpensively.

At the same time, the incremental cost of high-quality care over mediocre or poor-quality care is quite small. The Cost, Quality, and

[1]For example, for the youngest children, staff-to-child ratios are driven by the number of children each staff member can evacuate quickly in the event of an emergency.

Child Outcomes Study Team found, for example, that the mean difference between the cost of care in mediocre-quality centers and the cost of care in developmentally appropriate centers was 25 cents per child hour across a multistate sample. In a related study, Mocan (1997) estimated that the cost of raising a center's quality level from mediocre to the lowest level deemed developmentally appropriate would increase total variable costs 12 cents per hour per child, or 7.5 percent of the center's total costs.

What we know about the benefits of high-quality care to children suggests that providing high-quality care is a very good investment, particularly in light of the small incremental cost involved. The Colorado study and others found that children's cognitive and social development is positively related to the quality of their child-care experience.

Our work also makes clear that costs vary substantially by child age. This is hardly a surprising finding, given that child-to-staff ratios change dramatically as a child matures, from 4-to-1 for infants to 12-to-1 for preschoolers, according to the operative Department of Defense Instruction.[2]

Yet, the current DoD fee structure does not recognize these cost differentials. Rather, it bases fees on total family income in an effort to make care affordable and realizing that infants grow into preschoolers who then average out their cost during their five-year stay in military child care. Because it is the youngest, lowest-earning families who tend to have the youngest children, fee income from the parents of infants is likely to be even less per child than fee income from the parents of older children. As a result, the DoD bears a larger cost burden for the CDC care of younger children. Yet, infants and pretoddlers may be precisely the children that CDCs *should* serve in a community because their care is the most costly. In addition, the number of slots that is available for infant care in any given community is usually far less than the number of slots that is available for older children. If the government wants to promote more care for infants, it must accept the higher cost per child associated with infant

[2]DoDI 6060.2, para. E.4.2.1.

care. Another option, discussed later in this chapter, is to strongly promote infant and pre-toddler care in FCC.

## CHILD DEVELOPMENT CENTER CARE

Our work demonstrates once again that care in centers is particularly costly. Our analyses reveal that costs across centers vary substantially, and we highlighted some differences across Military Services. We did not observe a consistent difference between the cost of contractor-operated versus DoD-operated centers. This suggests that using a contractor will not necessarily save the DoD money.

This conclusion that money will not necessarily be saved by outsourcing is important input to the outsourcing debate. According to OMB Circular A-76, the federal government can outsource an activity to a contractor following a competitive bidding process only if the contracted costs are at least 10 percent lower than the government's proposed cost.[3]

In the competition process, both the government and contractor proposals must meet the same quality specifications. Our results and the results of an A-76 MEO competition in San Diego (discussed later in this section) suggest that A-76 studies of DoD child care will not lead to much outsourcing because accredited care cannot be provided at a significantly lower cost than what the government currently spends.

At the same time, Gates and Robbert (2000) find that A-76 studies, while costly to implement, do generate cost savings, even if the activity remains in-house. In the process of developing the MEO, government organizations typically identify opportunities for cost savings, primarily by finding ways to do the same work with fewer people. In the child-care area, such labor cost savings are inherently limited by child-to-staff ratio requirements, which apply to contractors and the DoD alike. The staffing ratios place a limit on the cost

[3]The "10-percent rule" is designed to ensure that the government does not initiate an outsourcing effort, which is often associated with significant transition costs and staff turnover, in pursuit of small savings. See Robbert, Gates, and Elliott (1997) for more information.

savings that can be generated through competitive pressure in the child-care area.

Cost differences across centers appear to be significantly influenced by the number of children being served in a given center, with lower per-child costs in larger centers. CDC costs are also influenced by the cost of living in the local area, with higher per-child costs observed at installations located in areas with a high cost of living.

Our survey revealed dramatic differences across installations in the cost of care per child. For infants, we observed a few low-cost installations that were providing care for less than $7,000 per child, whereas the highest-cost installations were spending upwards of $20,000 per child. While some of the variation reflects idiosyncratic differences in expenditures (for example, one center went through a major renovation and all the excess costs were incurred in the study year), much of the variation is not explainable by such factors. This variation represents a useful opportunity for DoD CDCs to learn from one another and potentially identify opportunities to reduce costs without sacrificing quality.

The DoD runs one of the largest and most highly regarded systems of child care in the country, and is continuing to improve the system by highlighting and learning from cost and quality improvement efforts conducted in individual centers and regions and disseminating information on those efforts across the system. For example, the Navy's San Diego Region A-76 competition for an MEO suggested some potentially useful strategies for cost savings by streamlining administration for the entire region and reducing overstaffing. One important caveat in determining CDC costs stems from the difficulty we encountered in calculating CDC costs that fell into the "other" category. This difficulty reflects a larger problem in calculating both activity costs in the DoD and child-care costs in any setting; it is in no way a problem unique to DoD CDCs. Respondents to our cost survey often did not have all the administrative information that we requested. Our estimates of "other costs" are correspondingly less than fully accurate.

This dearth of administrative information reflects a larger problem: No systems are in place to monitor the cost of existing programs; therefore, program managers often do not have complete cost in-

formation. This lack of essential information makes it very difficult to come to management decisions that would improve efficiency without sacrificing quality. One reason that this information is not available is that, in the past, financial information was collected and disseminated primarily to ensure that activities managers did not overspend their appropriation. The idea of using cost information to improve the effectiveness and efficiency of the organization was secondary to not overspending the budget (Gates and Robbert, 2000).

To some degree, this focus on providing information pertaining to present cost overruns still dominates the cost arena. In fact, Gates and Robbert (2000) found that none of the managers of programs that won a competitive sourcing competition (MEO winners) could provide complete cost information on the implemented MEO. When asked by the researchers to provide cost data, the program managers could only provide personnel authorization information. As Gates and Robbert note, such information provides an insufficient basis for monitoring and managing costs, even if there were incentives in the system to be efficient (and the authors also note that such incentives were strikingly absent). The DoD has recognized the importance of cost information to activities managers and has been making improvements in this area over the past several years.

## FAMILY CHILD CARE

Our data indicate that the cost of care in FCC homes is considerably lower than the cost for CDC care. Cost is not so closely tied to child age in FCCs; consequently, cost savings for the youngest children are the most substantial. However, cost comparisons with CDCs must be made with caution because of some limitations in our data collection and subsequent analyses. In the case of CDCs, we are basing cost estimates on a fairly comprehensive description of costs, including salaries, fringes, overhead, and maintenance. In contrast, in the case of FCC costs, we are estimating costs based only on the sum of the parent fees and DoD expenditures needed to administer the program. As a result, the cost estimates that we reached for FCC must be understood to be somewhat different from those derived for CDCs. Our FCC cost estimates essentially answer the following question: How much are parents (and the government) paying to have their children cared for? (In using the word “their,” we are referring to the

parents of the 80 percent of children in FCC whose do pay for their children's care.)

The FCC cost estimate is not arrived at in quite the same way as the estimate for CDC care. With center-based care, we have a great deal more insight into how costs are allocated. Take food as an example. For CDC care, we are able to capture the full cost of delivering meals to children. This may include the cost of service personnel and supplies, in addition to the cost of the food itself. For our FCC estimate, we had to rely on the amount of monies being recouped from the USDA food program. All other costs associated with food preparation are essentially absorbed by the provider. For example, the energy needed to heat the oven and run other appliances, water to wash dishes, and wear and tear on kitchen utensils are not captured. The time to prepare a meal probably comes out of the time available for direct care, or may be donated by the provider if he or she prepares food in advance.

In addition, we don't know how much money providers are earning on a per-hour basis. In order to have obtained an estimate more analogous to that for CDC costs, we would have had to impute a wage rate to FCC providers. Such an imputation is difficult because many providers care for their own children along with those of others. Obviously, no one is paying a fee for those children. Yet, they are a part of the program (and we did include them in dividing up other costs).

## CONTRACTOR-OPERATED CARE

In the DoD, contractor-operated care is provided through several types of arrangements, ranging from a plan that pays the difference between the DoD fee schedule and the fee at several accredited child-care centers in the local area, to a system in which the government subsidizes both the facilities and the parent fees.

The cost of contractor-operated care clearly falls within the range of costs observed for DoD-run care. The estimated cost per infant in the contractor-based centers is generally lower than the average cost per infant in DoD-run centers, whereas the cost per preschooler in the contractor-based centers is generally higher than the average cost per preschooler in DoD-run centers. There is, therefore, no evidence

that contractor-run centers are either cheaper or more expensive than DoD-run centers.[4]

## CIVILIAN EMPLOYER CARE

Our visits to civilian employer-sponsored centers helped to identify factors that lead to higher costs. In centers in which the employer doesn't question subsidy levels, care is provided under extremely low child-to-staff ratios, pay caregivers at higher rates, hire well-educated directors, and have stunningly attractive centers.

Those visits provided insights into the different approaches to running centers. For example, even the highest-quality contractors have moved to a system of regional curriculum advisors. They believe that through regionalization of this function, important local input into curriculum design can be maintained while the costs for better-educated, and therefore more costly, curriculum developers can be contained. These contractors devote less attention and resources to on-site training than DoD CDCs do.

These civilian centers also put the issue of cost differentials by child age into a broader perspective. All of these centers charged fees that vary as a function of a child's age. Our civilian interviewees believed that such differentials not only made sense but were also an important educational tool. More than one interviewee said explicitly that parents need to understand that taking care of an infant simply costs more than taking care of an older child, and therefore, centers need to charge higher fees for infants.[5]

## IMPLICATIONS AND ISSUES

The fact that it costs more to care for an infant than an older child in a CDC, and that it costs *much* more to care for an infant in a CDC

---

[4]We emphasize that we did not examine the quality of the contractor-run centers, although we do note that they are all accredited.

[5]The DoD, of course, has a very different view on parent fees. Its overriding concern is to ensure that care is affordable to all families. Moreover, the DoD has built a longer time line into its fee structure. By linking fees to family income, fees *increase* over time, even as children age, which the DoD considers a fair way to assess fees without overburdening families.

than in FCC, raises important questions and issues for the DoD. Key among them is this: What are the primary goals of military child care? If the primary goal is to serve as many children as possible given a fixed amount of funds, serving infants in CDCs makes little sense. Given a fee schedule that does not differentiate by child age, and given much higher costs for infant care than older-child care in CDCs, the current policy, which permits care for infants in CDCs, means that a great deal of money is being devoted to a small number of infants.[6] If these same infants were cared for in FCC, the program could serve substantially more children for the same cost. If, on the other hand, the primary goal is to allow parents to choose among care settings and select the type of care they prefer (and, if families have multiple children, allow the children to be cared for in the same location), then having infant slots in CDCs (as well as FCC) makes sense.

Even if the DoD decided to more aggressively promote FCC infant care, it is not clear that it would be easy to increase the supply of FCC slots, even with increased subsidies. Most military spouses are already employed, are in school, or are not looking for work. Many potential providers have college degrees and are looking for work on a career track; others want only part-time work that does not interfere with their own family life.

The Services are actively pursuing new FCC models that address the concerns of both would-be providers and parents. For example, the Army has created some group homes, which provide home-based care for twice or even three times as many children as the standard FCC home. Such homes make providers less isolated and give parents more stability and greater oversight. The Air Force and the Army are offering "wraparound care" in nearby homes for children in CDCs whose parents need extended hours care. Providers transport children to and from the CDC, which reduces the parental burden (see Zellman et al., 1992). An important element of the San Diego MEO was a 50-percent reduction in the number of infants and toddlers cared for in CDCs and a concurrent increase in FCC slots for

[6]Some installations, in recognizing this situation, have chosen not to serve infants in CDCs and refer them to FCC instead.

those children. FCC slots were to be increased through an aggressive recruitment and subsidization program.

All of these new approaches must be implemented in a way that reflects specific local needs and relies on local resources. An approach that works in a large metropolitan area with a large number of military personnel, such as San Diego, might be useless in a remote installation, such as Minot Air Force Base in northern North Dakota.

Another important DoD child-care goal, as reflected in its fee policy, is to provide *affordable* child care to military families. The DoD certainly achieves this goal, if its fees are compared against the fees that we encountered in the private employer-sponsored centers. Our cost analyses make clear that the DoD achieves this goal through a substantial subsidy, which varies with child age, and that subsidy is most generous for the parents of infants.[7]

To its credit, the DoD has achieved affordability without sacrificing quality. The high rate of accreditation of DoD centers attests to the quality built into the system (Zellman and Johansen, 1996).

And the DoD has done all of this while providing care to many thousands of children. In this respect, the DoD's goals are far grander than those of any of the private-sector employers that we examined. For many of those employers, a showplace center and equitable access met their goals; the fact that the center served a small number of employees was not an issue.

Our research suggests that employers such as the DoD face complicated trade-offs in deciding whether and how to provide child care for the children of employees. Those employers must balance concerns of cost, quality, and access. Our data make it clear that the cost of providing center-based care is substantial, whether that care is provided by the DoD or by a contractor. However, the cost for this provision is not out of line with the costs associated with other employer-based centers.

Our results also suggest that outsourcing is unlikely to generate substantial cost savings in the child-care arena. Given the substantial

[7]Since costs are highest for infants but fees do not take into account child age, subsidies are highest for the youngest children.

costs associated with staging an A-76 competition and the small likelihood given the strict regulations (particularly the unyielding ratio requirements) that any contractor could provide care for 90 percent or less of what it costs the DoD, it seems unlikely that outsourcing will be a viable policy option. Other, more-complicated options must be considered.

We urge the DoD to use the cost data provided here in concert with clearly articulated child-care system goals to develop policy that will produce an optimal mix of child-care options. It is clear, for example, that FCC care, particularly for infants, is cost-effective. A more aggressive subsidy policy, and other approaches that the Services are currently pursuing, could increase the attractiveness of this option to both parents and providers. Our data also indicate that CDC size is an important cost driver. The DoD may want to develop policy that encourages larger and more cost-efficient CDCs.

The military child-care system provides high-quality care to large numbers of children. Generous subsidies enable this care to be affordable as well. With the cost data provided in this report, the DoD has an additional tool at its disposal that can help it further improve system efficiency, affordability, and reach—all of which have made military child care a model for the nation.