

Improving the Delivery of Military Child Care

An Analysis of Current Operations and New Approaches

Gail L. Zellman, Anne S. Johansen, Lisa S. Meredith

RAND

**NATIONAL DEFENSE
RESEARCH INSTITUTE**

The research described in this report was sponsored by the Assistant Secretary of Defense (Force Management and Personnel). The research was conducted in the National Defense Research Institute, RAND's federally funded research and development center supported by the Office of the Secretary of Defense and the Joint Staff, Contract No. MDA903-90-C-0004.

Library of Congress Cataloging in Publication Data

Zellman, Gail.

Improving the delivery of military child care : an analysis of current operations and new approaches / Gail L. Zellman, Anne S. Johansen, Lisa Meredith, with Molly Selvin.

p. cm

"Prepared for the Assistant Secretary of Defense (Force Management and Personnel)."

"R-4145-FMP."

Includes bibliographical references.

ISBN 0-8330-1242-8

1. Children of military personnel—Services for—United States.
2. Child care services—United States. I. Johansen, Anne S. (Anne Staehr), 1958–. II. Meredith, Lisa, 1959–. III. United States. Office of the Assistant Secretary of Defense/Force Management and Personnel. IV. Title.

UH755.Z46 1992

362.7'08'8355—dc20

92-15336

CIP

RAND is a nonprofit institution that seeks to improve public policy through research and analysis. Publications of RAND do not necessarily reflect the opinions or policies of the sponsors of RAND research.

Published 1992 by RAND
1700 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138

R-4145-FMP

Improving the Delivery of Military Child Care

An Analysis of Current Operations and New Approaches

Gail L. Zellman, Anne S. Johansen, Lisa S. Meredith
with Molly Selvin

Prepared for the
Assistant Secretary of Defense
(Force Management and Personnel)

RAND

Approved for public release; distribution unlimited

PREFACE

This document was prepared for the Assistant Secretary of Defense (Force Management and Personnel). The research was conducted by the Defense Manpower Research Center, part of RAND's National Defense Research Institute, a federally funded research and development center sponsored by the Office of the Secretary of Defense (OSD) and the Joint Staff.

The objectives of the research were fourfold: to assess the extent to which existing child development services meet the needs of military users in terms of accessibility, quality, readiness, morale, and affordability; to recommend alternative ways to allocate existing resources to more effectively meet both military and family objectives; to suggest new policies regarding the organization and structure of child development services; and to examine excess demand for child care, particularly its implications for the size and scope of child care operations.

The report presents data from site visits to 16 military installations, from interviews with DoD policymakers and those responsible for child care policy and operations in each service, and from secondary analyses of data from the RAND Arroyo Center Survey of Army Families.

These data and the recommendations that follow should help military policymakers, child care managers, and installation-level commands better understand how child care is currently delivered to military families and encourage efforts to improve these services.

SUMMARY

INTRODUCTION

Today, roughly half of all military members have one or more children below school age. In many of those families, both parents work; the percentage of military spouses in the general labor market climbed from 30 percent in 1970 to over 60 percent in 1988. Many military spouses are themselves on active duty. In addition, the number of single parents in the military has steadily increased.

These demographic and behavioral changes have led to expanded availability of military child care. The Department of Defense (DoD) provides child care through installation-level Child Development Services (CDS) systems as an essential service to maintain readiness, increase productivity, and improve morale. Two settings predominate. The first is the child development center (CDC), which provides care for children on a fee-for-service basis. CDCs were designed to offer centralized day care at lower cost than is available in the private sector, and to provide care not offered by the private sector. The second type is family day care (FDC).¹ Here, military spouses trained as family day care providers are authorized to care for up to six children in the government quarters that they occupy. Fees are assessed by individual providers. Other arrangements such as before- and after-school programs and parent cooperatives, as well as resource and referral services, are also available on some installations.

Military child care has become a significant enterprise. Reports of Fiscal Year 1990 capacity made to the DoD by the services reveal that there are now 690 CDCs throughout the world offering care for children as young as six weeks through age 12 (Defense Manpower Data Center, 1991). These same data reveal the capacity for all CDCs and FDC homes was 129,030 children.²

¹The name for child care provided by military family members in military quarters on base varies across the services. We use the term family day care because it is used by both the Air Force and Marine Corps. The Army calls its program family child care, whereas the Navy uses the term family home care.

²To put capacity figures into perspective, recent data based on matches of active duty personnel records with Defense Eligibility and Enrollment System (DEERS) data indicate that as of December 31, 1990, there were 453,696 dependents of active duty members aged 0-4 years. This figure represents all children, and thus includes some fraction whose parents have not sought and will not seek military child care.

Even with such growth, however, there remains substantial excess demand. DoD data indicate a waiting list of 59,858 names at the close of FY 1990, which is a source of considerable concern to the DoD. At the same time, recent incidents of child abuse in several CDCs have raised questions about the *quality* of military child care. The growing perception of a “day care crisis” in the military has also fueled Congressional concern. The Military Child Care Act (MCCA) of 1989 was Congress’ response.

Military CDS systems are supported in part with appropriated funds, which cover center construction and renovation, some center operating costs, and oversight of family day care homes. Under the Military Child Care Act of 1989, FY 1990 appropriated funds must match parent fees.³ Subsidies are authorized to FDC providers under the MCCA.

Decisions about child care operation and management are broadly interpreted at the installation level. Commanders have discretion over several key aspects of child care programs, including use of unfenced (discretionary) funds, the mix of services offered, expansion plans, and child eligibility criteria.

This study was designed to examine issues of quality and availability of child care for military families, as well as to address larger policy issues associated with the organization and delivery of child care services. Specifically, its objectives were to assess the extent to which existing child care programs meet the needs of military users in terms of accessibility, quality, readiness, morale, and affordability; to recommend alternative ways to allocate existing resources to more effectively meet both military and family objectives; to suggest new policies regarding the organization and structure of child care; and to consider the issue of excess demand for child care.

METHODS

To address study objectives, three methods were employed:

- Interviews with DoD policymakers and those responsible for child care policy and operations in each service
- Observations and interviews on 16 military installations with people who administer and run programs and with parents

³The match has been continued under DoD policy.

- Secondary analyses of data from the RAND Arroyo Center Survey of Army Families.

Military installations were visited between April 1990 and January 1991. DoD and other policymakers were interviewed between August 1990 and January 1991.

INTERVIEW FINDINGS

Child Care Goals

Child care is provided on military installations around the globe as a means of addressing important military and family goals. Because these goals are multiple and sometimes inconsistent, their effect on the provision of services is often uneven.

Most commonly, child care was described in the interviews as an important means of enhancing readiness by decreasing the conflict between parental responsibilities and mission requirements. Many respondents described child care as a quality of life or family support activity that allows spouses the opportunity to earn an income and contribute to the family's economic well-being.

Some respondents argued that child care serves retention goals as well. Despite the lack of a direct empirical link between child care availability and retention, a number of respondents believed the relationship was there. Others noted that a primary goal of child care is to foster better and more productive citizens.

The above goals apply equally to CDCs and FDCs, the two major components of the current CDS system. FDC has additional goals as well, which include management of excess demand and providing military spouses with opportunities to earn money while remaining at home.

Youth Activities (YA), which is not a formal part of CDS, increasingly provides child care to young children. The provision of child care is not entirely consistent with longstanding YA goals, which include strong sports and recreation programs.

Given the variety of views about military child care objectives, it is not surprising that objectives do not track with the provision of care. Indeed, we often found inconsistencies between stated goals and their operationalization.

Organizational Context

Military child care exists in a culture that in some ways is inimical to its goals. Whereas some commanders accept the importance of child care, others view it as a diversion from their primary purpose: supporting the defense of the nation.

Commander discretion is an important aspect of the military culture. The arguments for commander discretion are fundamental to the military endeavor: In the words of one general, "the Commander must have discretion to meet his mission."

Nevertheless, a number of respondents rued the fact that commander discretion dominated decisions about the ultimate use of funds for child care. Such respondents would like to see an end to the authority of commanders to take funds allocated for child care and use them for other purposes.

The tradition of and support for commander discretion collides with the substantial amount of regulation that governs the operation of military child care. Like civilian centers, CDCs must conform with sanitary, health, fire, and safety codes, most of which are more restrictive when young children are involved.

Frequent commander complaints of "micromanagement" were fueled by the passage in November 1989 of the Military Child Care Act (MCCA). The underlying purposes of the Act are threefold: to improve the quality of child care available, to expand the availability of care to more children, and to make access to child care more equitable.

Our installation visits coincided with the first implementation of the MCCA. For many of the people who administered child care programs on installations, the Military Child Care Act of 1989 was *the* major child care issue. And it was a critical one, as meeting the requirements of the Act required substantial changes in the ways that child development services were funded, organized, and delivered.

Respondents generally agreed that the Act was causing problems. Many of these problems stemmed directly from the failure of the Act to appropriate funds while specifying fairly rapid implementation of many of the Act's provisions.

In contrast to the considerable regulation of CDCs imposed by the MCCA, FDC was largely excluded from the MCCA legislation. This

exclusion continued a pattern in which CDCs receive considerable oversight, whereas FDC receives little.⁴

Although Youth Activities provides child care to many young children, it elicits at best a minute proportion of the attention and concern lavished on CDS. And, as one Morale, Welfare, and Recreation (MWR) staffer delicately put it, it provides services to children under a set of regulations that are “more flexible” than those that govern CDS. In the YA programs that we visited, no minimum child-to-staff ratio was required, although in formal classes ratios of 15 children to 1 adult were the norm. The strict physical plant requirements imposed on CDCs were totally lacking.

The lack of clarity about the status and goals of child care is reflected in its varied organizational location across services and installations and in the considerable amount of discussion about where it belongs. Many respondents believe that significant advantages accrue to child care’s association with MWR.

However, the MWR connection was criticized by many. Even those who were not particularly concerned that CDS was in MWR did express concern about its placement under Recreational Services in Air Force locations.

The greater emphasis on safety, staff training, and regulation in CDS has led some respondents to believe that the child care provided by YA should be integrated more closely into the CDS system. This would improve coordination between the programs, and standardize the delivery of child care.

Provision of Child Development Services

Turnover is a problem in all child care settings, because of low salaries, long hours, and few, if any, benefits. In military settings, turnover levels are often higher because most caregivers are spouses subject to frequent Permanent Change of Station (PCS) moves. The CDC directors whom we interviewed provided turnover estimates that rarely were below 40 percent, and often well exceeded this figure.

As a means of reducing staff turnover and increasing caregiver quality, the MCCA specified a series of pay raises. Preliminary DoD data show substantial impact of this change on employee turnover. Six-

⁴This pattern of greater regulation of centers also occurs in the civilian sector (Hayes, Palmer, and Zaslow, 1990). There, the vast majority of family-based child care providers are unlicensed (Fosburg, 1981; Glantz, Layzer, and Battaglia, 1988).

month turnover rates for CDS caregivers fell below 40 percent in every service, and were under 25 percent in the Army and Air Force (17.6 percent and 23 percent, respectively). These figures compare favorably with annual turnover rates of 61–300 percent prior to pay increases.

None of the pay increase provisions apply to FDC providers, who set their own fees. Their incentives and disincentives differ substantially from those of CDC caregivers. FDC providers to whom we spoke talked about a range of disincentives to participate in FDC. A number mentioned rigid training requirements that had to be fulfilled after hours. Long hours and difficulties arranging time off were described by one service child care manager as the major disincentives to FDC recruitment.

On some of the installations that we visited, child development staff have attempted to increase FDC incentives through the provision of equipment loans and toy lending services. There was a marked absence of discussion of compensation as an incentive to become an FDC provider. Our sense was that while CDC caregivers have achieved a modicum of professionalization, so that increased wages were seen as both legitimate and an important way of providing program quality, such thinking had not extended to FDC.

The funding of CDS presents a range of challenges, beginning with the issue of commander discretion and fenced funds, and ending with the issue of who will pay for crayons. Funding issues also affect parental preferences with regard to FDC.

These complexities are exacerbated in many places by a lack of clarity about the fiscal expectations for CDS. On a number of the installations that we visited, CDS staff operated under the expectation that CDS would at least break even. Such expectations had led to some troubling and demoralizing practices. Infant care in the CDC on several installations was eliminated because it cost too much to provide. Caregivers in many CDCs told us that they purchase their own supplies because of inadequate budgets.

Funding problems also contribute to strict limitations on FDC coordinator positions in some locations. Many parents couched their preference for the CDC in monetary terms. Particularly in places where the CDC does not accept infants, unregulated FDC fees had escalated to the point where FDC care rivaled the cost of civilian care.

We found a strong tendency among our respondents—both parents and military personnel—to rate their CDC highly. In contrast to their high-quality ratings for CDCs, parents often expressed concerns about the quality of care in FDC homes. Shared perceptions of lower FDC quality reflect command and parent anxieties, but may also reflect a failure by the DoD and the services to publicize information that supports FDC care.

For installation commanders and other members of the command, liability issues surrounding the delivery of child care represent major concerns. For the most part, safety concerns in the CDCs were perceived to have been effectively dealt with in current regulations. Most of our respondents' safety and liability concerns focused on FDC. Commanders in particular worried about what went on in these quarters, and regretted that only limited monitoring was possible. The relative lack of concern about safety and liability in Youth Activities may be a legacy of the original mission as provider of recreational services.

The child care options available to military families—CDC, FDC, YA, civilian centers, and civilian home care providers—vary substantially in the flexibility that they provide parents who may have long or unpredictable duty hours.

If readiness were the primary or only goal of military child care, one would expect to see the child development center used primarily by those whose duty hours were stable or who had a spouse or other resource person who could cover when duty hours were long or unpredictable, whereas FDC would be strongly favored by single parents, dual military families, or those who for other reasons needed flexibility in their child care arrangement. But we found instead a heavy reliance on child development centers, which provide the least flexible care on the installation. During our installation visits, we heard of many instances where the inflexible hours at the CDC had created difficulties for parents and in some cases for whole units.

Inflexibility is not limited to hours of operation. Two areas that cause particular difficulty for parents are sick child policies and the administration of medication to recovering children. The inconsistency between the notion of child care as a means of increasing readiness and the lack of attention to such issues as sick child care was striking.⁵

⁵Although some efforts have been made to address the issue, it remains a difficult problem.

Excess Demand

Everywhere we went, excess demand was a major topic of discussion, and on many installations, excess demand was perceived to be the most pressing and important child care issue.

Given how waiting lists are currently managed and demand is assessed, it is impossible to determine how many families have acceptable care but want a cheaper alternative, how many have care of unacceptable quality, and how many are not working because of the inability to obtain subsidized care.

Some excess demand results from the way that military child care is funded. Subsidizing a limited number of child care slots will typically result in excess demand and waiting lists. The extent to which waiting lists consist of parents who cannot work because of a lack of child care cannot be determined without an in-depth study of the relationship between child care costs and the labor supply of military spouses.

Excess demand has led to pressure nearly everywhere to construct new facilities. But the decision to request military construction (MILCON) funds for a new child development center was rarely an easy one. Requesting the construction of a child care center in lieu of, for example, a supply depot raises difficult questions about the role and importance of child care to military operations.

The decision to build a new CDC typically raises questions about the role and viability of FDC as well. CDC construction requests also raise questions about what child care is—a service, a benefit, or an entitlement—and how much child care needs to be provided.

Decisions to request new construction may risk additional problems. We heard several times about an installation on which a new center had been requested and built, based on a very large waiting list. When the center failed to fill immediately after it opened, it created a “very embarrassing” situation for the commander and CDS staff. More awareness of the ways and the time frame in which new centers fill might enable centers to open at more propitious times, or would at least provide commanding officers and CDS staff with ammunition against charges of overbuilding.

Commander concerns about overstated needs and empty child development centers are fueled by the imprecise ways in which demand is measured. Virtually everywhere, waiting lists are used to index demand. The substantial variation in the ways in which waiting lists

are developed, maintained, and monitored across installations make the counts of people on these lists extremely untrustworthy.

A first step in understanding excess demand involves standardizing waiting list procedures and monitoring, so that waiting lists become comparable across installations. A second is to better predict demand.

Despite their limitations, long waiting lists in many locations suggest a fairly high level of excess demand for child care services. We found almost everywhere that this demand is being addressed through the expansion of FDC. Other responses to excess demand were notable for their absence.

SECONDARY ANALYSES

Nearly 83 percent of all Army families with preschool-aged children surveyed rely on some kind of child care more than five hours per week. A large percentage (45 percent) of families rely on more than one type of child care, suggesting that the child care needs of most families cannot be filled by one type of care. Whereas 17.6 percent of all Army families report some use of Army CDCs, only 3.5 percent rely on them exclusively. Furthermore, only 8 percent use the CDC as their modal (i.e., most frequently used) type of care arrangement.

A greater proportion of single-parent families report relying on Army CDC as their modal child care arrangement, which is not surprising given that single parents receive first priority for CDC slots.

Nearly one-third of all families report fair or poor child care during deployments of two or more weeks. Families in which the spouse did not work outside the home were no less likely than families in which the spouse was employed outside the home to report this problem.

Parents on average lose about three days per year from duty for child care reasons, a significant amount of time when viewed from the perspective of an employer. Single parents report a significantly higher number of days (eight) per year lost from duty for these reasons.

The highest number of days lost to duty because of children and child care can be found among CDC users. The lowest number of days lost to duty are found among users of family-based care. This suggests that CDC care may be a less reliable source of care than FDC, even though the perception of many parents we interviewed in our site visits was to the contrary. This association between CDC care and more days lost is not surprising, given the more flexible nature of family day care.

A significantly higher proportion of CDC users report fair or poor ratings than do FDC users. It is interesting that our site visits revealed that most parents strongly prefer the CDC, yet the data show that parents using FDC were more satisfied with their child care arrangements than were CDC users.

RECOMMENDATIONS

Based on our interviews and secondary analyses, we have a number of recommendations on how the DoD might improve the management and delivery of child development services on military installations. Our recommendations are based on the perspective of military child care as employer-sponsored child care, which implies that child care services must benefit the employer, as well as enhance the welfare of the children who receive services.

The goals of military child care should be clarified and efforts made to address these goals through CDS operations and priorities.

The measurement of demand should be standardized and the cost per slot of care in CDCs and FDC should be determined.

To do so, efforts should be made to:

- Standardize waiting lists
- Analyze excess demand
- Estimate the full cost per slot of CDC and FDC care.

A more systemic approach to the provision of child care should be considered.

Elements of this approach might include:

- Helping parents find alternative care
- Providing more flexible care
- Reexamining CDS' organizational location.

Closer integration of FDC with CDS should be considered.

Integration might include:

- Strengthened FDC provider training and oversight
- Marketing of FDC care to parents and command
- Selective subsidization of FDC care
- Reduction of FDC provider disincentives
- Targeting of services so that family and military needs are better met.

A systematic assessment of Youth Activities and its increasing involvement in the provision of care to young children should be initiated immediately.

Administrators should be educated about child care quality.

CONTENTS

PREFACE	iii
SUMMARY	v
FIGURE AND TABLES	xix
GLOSSARY	xxi
Section	
1. INTRODUCTION AND BACKGROUND	1
Introduction	1
Study Objectives	3
Organization of This Report	4
Background	4
2. STUDY METHODS	7
Interviews with DoD Policymakers	7
Site Visits to Selected Installations	7
Secondary Data Analyses	9
3. INTERVIEW FINDINGS	11
Child Care Goals	11
Organizational Context	18
The Provision of Child Development Services	32
Excess Demand	46
4. SECONDARY ANALYSES	56
Survey Measures	56
Results	58
Conclusion	64
5. CONCLUSIONS AND RECOMMENDATIONS	65
Conclusions	65
Recommendations	66
Appendix	
A. THE MILITARY CHILD CARE ACT OF 1989	75
B. EXCESS DEMAND	78
REFERENCES	81

FIGURE

B.1.	The Supply and Demand for Child Care	79
------	--	----

TABLES

3.1.	Kinds of Care	42
4.1.	Distribution of Child Care Combinations	59
4.2.	Modal Type of Child Care by Spouse Employment Status	60
4.3.	Problems with Child Care or Children by Spouse Employment Status	61
4.4.	Problems with Child Care by Child Care Arrangements	63
4.5.	Reasons for Using Civilian Instead of Army Child Care	64

GLOSSARY

AFPR	Army Family Programs and Readiness
APF	Appropriated Funds
CDC	Child Development Center
CDS	Child Development Services
CO	Commanding Officer
DEERS	Defense Eligibility and Enrollment System
DHHS	Department of Health and Human Services
DoD	Department of Defense
DoDI	Department of Defense Instruction
FCC	Family Child Care
FDC	Family Day Care
FM&P	Force Management and Personnel
FS	Family Services
GAO	General Accounting Office
IG	Inspector General
MCCA	Military Child Care Act
MILCOM	Military Community
MILCON	Military Construction
MOS	Military Occupational Specialty
MWR	Morale, Welfare, and Recreation
NAF	Non-appropriated Funds
PCS	Permanent Change of Station
PX	Post Exchange
SPS	Supplementary Programs and Services
TRADOC	Training and Doctrine Command
YA	Youth Activities

1. INTRODUCTION AND BACKGROUND

INTRODUCTION

Today, roughly half of all military members have one or more children below school age (Inspector General, 1990). In many of those families, both parents work; the percentage of military spouses in the general labor market climbed from 30 percent in 1970 to over 60 percent in 1988. Many other military spouses are themselves on active duty; dual military families (both spouses in the military) with children now represent 2.9 percent of all active duty personnel.¹ In addition, the number of single parents in the military has steadily increased.²

In the civilian sector, similar trends have led to sharp changes in child care arrangements. In 1977, only 35 percent of women with preschool-age children were in the labor force. By 1987, that figure had risen to 56 percent (U.S. Dept. Labor, 1989). During that same period, the proportion of all children in the United States under age five who were cared for in organized child care facilities increased from 13 to 24 percent.

As day care use has increased, it has begun to affect employers. Among civilian women with children under age 15, 7 percent in any given month reported work disruptions resulting from failures in their child care arrangements for their youngest child (U.S. Census Bureau, 1990). Although parallel information is not available for military parents, long and unanticipated duty hours suggest that it may be an even larger problem there.

These demographic and behavioral changes have led to expanded availability of military child care. The Department of Defense (DoD) provides child care as an essential service to maintain readiness, increase productivity, and improve morale. Two settings predominate. The first is the child development center (CDC), which provides care

¹These data are drawn from the Defense Eligibility and Enrollment System (DEERS), current through December 31, 1990. They may be less reliable than other DEERS data because it is not clear if children claimed are accompanying parents, and because double counting of dual military marriages may occur because these data are not cross checked.

²DEERS data indicate that 2.9 percent of all active duty personnel are single parents. Whether children are currently accompanying their parent is uncertain, as noted above.

for children on a fee-for-service basis. CDC was designed to offer centralized day care at lower cost than is available in the private sector, and to provide care not offered by the private sector. The second type is family day care (FDC).³ Here, military spouses trained as family day care providers are authorized to care for up to six children in the government quarters that they occupy. Fees are assessed by individual providers. Other arrangements such as before- and after-school programs and parent cooperatives, as well as resource and referral services, are also encouraged.

Child care is also provided through Youth Activities Centers on many installations. However, Youth Activities (YA) is not a formal part of CDS.

Military child care has become a significant enterprise, and is one that we assume will continue in more or less the same form. Reports of Fiscal Year 1990 capacity made to the DoD by the services reveal that there are now 690 CDCs throughout the world offering care for children as young as six weeks through age 12.⁴ These same data reveal that the capacity for all CDCs and FDC homes was 129,030 children, a figure more than twice that estimated by the Government Accounting Office (GAO) in 1988 (GAO, 1989).⁵

Even with such growth, however, there remains substantial excess demand. DoD data indicate a waiting list of 59,858 names at the close of FY 1990, which is a source of considerable concern. At the same time, recent incidents of child abuse in several CDCs have raised questions about the *quality* of military child care. The growing perception of a "day care crisis" in the military has also fueled Congressional concern. The Military Child Care Act (MCCA) of 1989, Congress' response to these concerns, seeks to improve the availability and quality of child care provided on military installations. (See Appendix A for more discussion of the MCCA.)

³The name for child care provided by military family members in military quarters on base varies across the services. We use the term family day care throughout this report because it is used by both the Air Force and Marine Corps. The Army calls its program family child care, whereas the Navy uses the term family home care.

⁴Department of Defense, unpublished reports from the services, September 1990. Military parents also have some access to day care in civilian communities that is free of military subsidy or oversight.

⁵To put capacity figures into perspective, recent data based on matches of active duty personnel records with DEERS data indicate that as of December 31, 1990, there were 453,696 dependents of active duty members aged 0-4 years. This figure represents all children, and thus includes some whose parents have not sought and will not seek military child care.

To address such concerns, the DoD Inspector General (IG) recently launched the first full-scale evaluation of the quality and sufficiency of child development programs in the military (DoD, 1990). The inspection was conducted to review the criteria used for formulating and implementing policy for meeting the child care needs of military families. Inspection teams visited 70 installations worldwide.

The IG report concludes that the DoD has not formally decided whether child care is a benefit or an entitlement. In the absence of a clear policy, some commanders have decided to work toward making child care available to all. The report makes two key recommendations. First, it calls for a policy statement from the DoD that clarifies whether child care is an entitlement or a benefit. If the latter, it calls on the DoD to clearly define target levels and priorities for providing child care. This recommendation is designed to resolve potential misperceptions about whether parents should always expect to receive subsidized on-base child care. The report suggests that policy should more clearly communicate that child care is a benefit to supplement off-installation resources—not an entitlement program. The other key recommendation calls for the development of a long-range plan to meet the substantial excess demand for child care once a clear child care policy has been developed. This study builds on the IG report by examining Child Development Services (CDS) in more detail, and by focusing on issues associated with excess demand.

STUDY OBJECTIVES

Efforts to determine the extent and ways in which the military should be involved in promoting child care are often hindered by a lack of empirical research. Little information exists on the demand for child care, its costs, or the burden that child care fees impose on military families. Neither is there a clear sense of the unique services that military child care must provide, nor about the most effective ways to provide it.

To help provide such information, this study was designed as a first step to gather qualitative information and existing data on the quality and availability of child care for military families, as well as to address larger policy issues associated with the organization and delivery of child care. Specifically, its objectives were to:

- Assess the extent to which existing child care programs meet the needs of military users in terms of accessibility, quality, readiness, morale, and affordability;

- Recommend alternative ways to allocate existing resources to more effectively meet both military and family objectives;
- Suggest new policies regarding the organization and structure of child development services; and
- Examine excess demand for child care, particularly its implications for the size and scope of child care operations.

ORGANIZATION OF THIS REPORT

This section concludes with a brief description of the military child care system: how it evolved, what policy guidelines direct it, and how it is funded, organized, and administered. Section 2 describes our study methods, which include an examination of policy documents, secondary analyses of data from the RAND Arroyo Center Survey of Army Families, interviews with DoD policymakers, and site visits to military installations. Section 3 presents the data from our interviews. Section 4 presents the results of our secondary analyses of the Army Families Survey data. Conclusions and recommendations may be found in Section 5.

BACKGROUND

Prior to 1985, a considerable amount of child care was provided on military installations, largely through private organizations such as Wives' Clubs. This care was, by and large, loosely structured and minimally regulated. In 1985, the Military Family Act was passed by Congress to establish an Office of Family Policy within the Office of the Secretary of Defense. This office, which operates under the Assistant Secretary of Defense for Force Management and Personnel (FM&P), took on the responsibility for coordinating all programs and activities relating to military families. Its main goal is to enhance the well-being of military families by conducting surveys to assess their needs; designating an advisory committee (including family members) for assisting the DoD, increasing spouse employment opportunities through such policies as hiring preferences for qualified spouses, establishing funds for dependent student travel, expanding relocation assistance, amending food programs to make allowances for lower enlisted ranks, and establishing guidelines for the reporting of child abuse.

In recent years, FM&P has issued several family-oriented policy guidelines for child development programs. The DoD Instructions for Family Policy (DoD Directive 1342.17, December 30, 1988) laid the

groundwork for implementing such policy, including child care programs. This document sets criteria for policies involving quality of life programs and family support services for DoD personnel and their families. It views the total commitment required by military service as a partnership between the military and the family. Such a partnership requires a comprehensive family support system to help families meet force readiness goals. The extent and nature of family support systems are determined at the installation level according to local needs. Programs included under family policy are: premobilization and deployment support, relocation assistance, special needs support, elder care, family advocacy, foster care, family life education, dependents' education, substance abuse prevention, family health and fitness, spiritual growth and development, emergency services, counseling, support and services for off-base families (outreach), consumer affairs and financial planning assistance, volunteer training and management, separation and retirement planning, family centers, and community development.

The DoD Instruction for Child Development Programs (DoD Directive 6060.2, March 3, 1989) establishes policy for services provided to minor children of DoD military and civilian personnel aged birth–12 years “as needed for effective operation and for accomplishment of assigned mission and tasks.” Demand for such services is based on local needs according to five factors: (1) the number of personnel who require child care, (2) support of readiness by addressing military child care needs during deployments, mobilizations, and other missions, (3) alleviation of recruitment or retention problems related to inadequate child care, (4) absenteeism or productivity problems that could be alleviated by reliable child care, and (5) availability of services and rates comparable to those in the civilian community. According to this directive, CDS systems are established for the promotion of intellectual, social, emotional, and physical development of children.

Military child care programs are supported with appropriated funds that cover center construction and renovation, some percentage of center operating costs, and oversight of family day care homes. Under the MCCA, appropriated funds used for center programs must match fees paid by parents for CDC care. The Act also established a fee structure in the CDCs based on total family income⁶ and man-

⁶How total family income was to be determined was not specified in the Act. For fiscal year 1991–1992, total family income was based on income reported on the latest copy of users' combined federal income tax form 1040, line 23; form 1040A, line 14; or W-2 tax statement.

dated caregiver wage increases. Subsidies are authorized, but not mandated, to FDC providers under the MCCA.

At the DoD level, the Deputy Assistant Secretary for Personnel, Support, Families and Education, and Safety is responsible for the development of overall child development services policy and for coordination among the different services. However, each service branch develops and implements its own separate and independent child care policies in accordance with DoD guidelines and administers its own program.

There are differences among the services in the way that Child Development Services are administered. The Air Force and the Navy include child care within Morale, Welfare and Recreation (MWR), which sponsors recreation activities such as bowling and golf, as well as libraries and youth activities. In the Marine Corps, child development programs were recently placed within Family Programs in the Human Resources Division (formerly in Morale Support). The Army has located CDS under their Community and Family Support Division, where it is managed with other family-oriented services.

The Air Force and Army systems are more centralized than those of the Navy or Marine Corps. Each Air Force installation with a CDC files a semiannual report with headquarters. This report includes program operation data such as capacity, hours of operation, hours of care for each type of service provided, daily attendance, enrollment, fees, staffing, and number on the waiting list. In the Army, installations file an annual report with headquarters that contains information about funding, staffing, programs, services, volunteers, facilities, population served, and corrective actions. Waiting list information is provided for validating requests for construction projects. The Navy in 1989 implemented a semiannual reporting procedure. The Marine Corps has no formal reporting process in place, although data are collected periodically through installation surveys.

Decisions about actual operation and management of child care programs are broadly interpreted at major/interim command and installation levels. Commanders have discretion over several key aspects of child care programs including use of unfenced (discretionary) funds, the mix of services offered, expansion plans, and child eligibility criteria.

2. STUDY METHODS

Three methods were employed to collect information about military child care:

- Interviews with DoD policymakers and those responsible for child care policy and operations in each service;
- Observations and interviews on 16 military installations with people who administer and run programs and with parents; and
- Secondary analyses of data from the RAND Arroyo Center Survey of Army Families.

Each method provided a different perspective on child development services and contributed to our understanding of the issues within a broader framework.

INTERVIEWS WITH DOD POLICYMAKERS

Between August 1990 and January 1991, we met with key child care staff responsible for child care policy at the DoD level and within each service. During these meetings, we discussed issues facing child care in the military, including the implementation and implications of the Military Child Care Act (MCCA) of 1989 and the implications of the drawdown on child development services. Respondents included Force Management and Personnel (FM&P) staff, and in each service, deputy assistant secretaries responsible for personnel issues, deputy chiefs of staff, child development program managers, and MWR and family support directors.

SITE VISITS TO SELECTED INSTALLATIONS

We visited 16 installations distributed fairly evenly among the four branches of military service. The purpose of these visits, which were made between April and November of 1990, was to understand how child care is delivered at the installation level.¹ Visits provided information about the military community and about the context for child development services.

¹Because of the timing of our interviews and visits, Operations Desert Shield and Desert Storm had had little impact as yet on CDS.

Selection of Installations. We asked the child development program manager in each service to recommend appropriate sites and to set up our visits. We asked to visit sites which were varied in terms of child care quality, installation and CDC size, installation mission, proximity to a metropolitan area, and geographic location (e.g., in the United States or overseas).

The installations visited included:

- *Air Force:* Andrews, Barksdale, Edwards, Rhein Main
- *Army:* Fort Carson, Fort Irwin, Fort Monroe, Frankfurt MILCOM
- *Marines:* Camp Pendleton, El Toro, Twentynine Palms
- *Navy:* Long Beach, Miramar, Port Hueneme, Subbase San Diego, Norfolk

Who We Interviewed. Since our goal was to understand current policies and objectives that govern the way child development services are provided on military installations, we spoke not only with child development service staff but with staff from other family support services. In addition, we interviewed MWR directors, installation-level command, and parent users of CDS services.² Respondents on each installation included:

- Installation commander or other command-level individual
- MWR director
- CDS director
- CDC staff (i.e., caregivers in center)
- Family day care provider(s)
- Parent consumers of both CDC and FDC care (in different ranks)
- Parent advisory group representatives (when such a group existed on the installation)
- Wait-listed parents
- Youth activities director
- Family services director

²We use the term Child Development Services to describe the organizational unit that provides and oversees child care. However, some services use a slightly different term (e.g., Air Force uses Child Development Program).

What Did We Ask?

Where appropriate, we asked respondents to describe general installation characteristics such as size and mission. We also asked about the organizational structure of the installation, MWR programs and Family Services programs offered, and where child development services programs fit into that structure.

We asked CDS staff about the types of services offered, their patterns of staffing, reporting requirements, and coordination with other related programs. We also asked about funding priorities and program financing.

Our interviews focused on the organization and delivery of child care, and how those services are administered and funded. In addition to information about formal policies and procedures that govern child care, we asked about the informal processes involved in delivering such services.

All respondents were asked to describe what they felt was the main purpose of military-sponsored child care. We also solicited their opinions about the most important child care issues in the military (e.g., equity, institutional obstacles, parental conflicts) and how important the issue of quality was to them. Finally, we asked each interviewee about the MCCA. Interviews were confidential. Interview data were transcribed and analyzed on the basis of research objectives and hypotheses.

SECONDARY DATA ANALYSES

The data for our secondary analyses were drawn from the RAND Arroyo Center Survey of Army Families, fielded in 1987. This study was conducted by RAND's Arroyo Center to assist the Army in defining its support policies toward soldiers and members of their families (Burnam et al., 1992). Because of continuing changes in military family structure, spouse labor force participation, and military child care programs, these data are somewhat dated; they nonetheless provide us with some useful insights concerning child care use and readiness implications.

The survey collected data from a sample of both soldiers ($N = 6014$) and spouses ($N = 3143$). The sample was drawn using a three-stage stratified random sampling design that allowed for more powerful analyses of contextual factors associated with family well-being and service needs and use.

In the first stage, a sample of 23 installations was drawn. Installations were stratified into categories based on location (overseas or domestic), size (installations with under 1000 active soldiers were excluded), dominant mission, and proximity to a large civilian metropolitan area.

In the second sampling stage, companies at each installation were selected randomly and proportionately to the number of companies in each branch (e.g., Armored, Infantry, Engineers) represented at each installation.³

Finally, soldiers were selected within companies using a weighted probability random-sampling strategy to ensure adequate numbers of both officers and enlisted personnel, junior and career soldiers, male and female soldiers, single and married soldiers, and soldiers with and without children (Burnam et al., 1992).

The overall response rate was 71 percent, with soldiers slightly more likely to respond than spouses. Of those who responded, 2528 had accompanying children under the age of 12 years; 697 had children but were not accompanied by them at the time of the survey. Of the 2528 parents with accompanying children, 2265 (90 percent) were married; the remaining 263 (10 percent) were single. For this report, we analyzed the data from 1031 parents with preschool-aged children (aged 0–5 years) who were accompanying their parents at the time of the survey.

³For logistical and cost reasons, two constraints were imposed upon the selection of companies. First, the number of companies was not to exceed 40 at any installation, and second, the number of soldiers selected in each company was not to exceed half the respective total number of soldiers (Burnam et al., 1992).

3. INTERVIEW FINDINGS

Most formal child care on military installations is provided in CDCs and in FDC,¹ as discussed above. Increasingly, Youth Activities (YA) Centers provide child care to young children as well.² CDCs capture most Child Development Services systems' attention and resources. Our findings reflect this focus. But FDC and YA are critical components as well. We discuss these latter components throughout this section, and focus on them in our recommendations.

The data in this section are organized around four key issues: (1) the goals of military child care, (2) the organizational environment in which child care is provided, (3) the delivery of child development services, and (4) the amount of care available. We discuss these issues in the context of CDC, FDC, and YA, as each provider operates in very different settings and under very different rules.

CHILD CARE GOALS

Child care is provided on military installations around the globe as a means of addressing important military and family goals. But these goals are multiple and sometimes inconsistent. The impact of these goals on the provision of services is often uneven and in some cases may undermine them. The purpose of military child care was inconsistently described across services, installations, and individuals. Although respondents generally understood that child care was not an entitlement, as is the case for medical care, a number of respondents made the point that personnel had come to expect that the military would provide them with child care, and would become angry if it were not available. Said one Air Force enlisted representative, "child care is seen as an entitlement now, which is why personnel get so upset when they cannot be accommodated."

The Navy attempted to formally clarify availability expectations through the issuance of a memorandum in October 1990. This docu-

¹FDC programs operate on 46 percent of Naval bases, 92 percent of Army installations, 83 percent of Air Force bases, and on 47 percent of Marine Corps installations (Inspector General, 1990).

²We use the term Youth Activities (YA), which is used by many programs, because it best conveys the current focus of most of these programs: sports activities for school-aged children.

ment emphasized that child care is neither a right nor an entitlement, but “a service that can be provided to a finite portion of the population, within budget constraints, to promote operational readiness, mission accomplishment and retention.” The piece was unique in that it set numerical goals: 100 percent availability for single and dual military parents; 30 percent availability for other families. The goals were subsequently replaced with an approved plan to provide a specified number of spaces by a given date.

Opinions about child care goals varied. Most commonly, child care was described as an important means of enhancing readiness because it decreased the conflict between parental responsibilities and mission requirements. According to an Army general, providing quality care to soldiers’ children allows soldiers to focus on immediate job requirements. “Knowing that their kids will be taken care of and develop allows them to be free of worry while they work,” he said. Readiness is the key goal of child care, according to a sergeant major, because “everything is tied to readiness, and should be.”

An admiral linked the need for child care to the fact that there were many more women in the military than ever before. “It is a fact of life—a good fact of life—that there are women in the Navy, and they have to be helped to be as effective as possible,” he said in describing an important goal of child care. An Army colonel saw child care a bit more negatively. In his view, children interfere with the Army’s mission; child care helps to reduce that interference.

Many respondents described child care as a quality of life or family support activity, because it allows spouses the opportunity to earn an income and contribute to the family’s economic well-being. Child development program staff in several high-cost locations noted that spouse employment was essential. A CDC director in a high-cost area estimated that 90–99 percent of spouses attached to her base work for pay outside the home.

Part-time care and preschool programs support families by providing spouses with opportunities to engage in volunteer work or to continue their education. Such programs also help young children by fostering the development of age-appropriate cognitive and socialization skills.

Some respondents argued that child care serves retention goals as well. Despite the lack of a direct empirical link between child care availability and retention, a number of respondents believed the re-

lationship was there.³ This view was supported by the oft-heard slogan, "The military recruits single personnel but retains families." Since retention is associated with family well-being, and spouse employment increases family well-being, child care availability promotes family well-being by facilitating spouse employment, according to proponents of this view. This connection between child care and retention seemed true for a Navy enlisted spouse to whom we spoke. In her family, child care is a key service that permits her husband to remain in the Navy. Given her husband's salary, she needs to bring in an income. Without the low-cost child care provided by the CDC to her three young children, she said, "it would make no economic sense for me to work." Her view was echoed by the Head of Child Development Services on that base. She noted that child care is one more benefit that helps retention. "The Navy wants to keep the cream of the crop and needs to keep them," she said.

The possibility that child care may promote retention of other than "the cream of the crop" had not been considered by the above respondent. It had been considered, however, by a Navy commander to whom we spoke, who worried that the availability of inexpensive child care "tacitly encouraged" sailors to become single parents. Few people can be both good solo parents and good sailors, he believes. Such parents often must ask for hardship discharges, which leaves the Navy no return on its investment in their often expensive training.

A number of respondents viewed the goals of child care more broadly. Said a director of family programs, the Army's commitment to child care reflects that "we care about the family." Such concern, he said, often translates into a recruiting advantage. If the Army provides good services to soldiers, "soldiers will do the recruiting for us." He contrasted the many benefits provided by the military—excellent and affordable child care, commissaries, the Post Exchange (PX), among others—with the very limited benefits provided by civilian employers. These services impress young people, he maintained. An Air Force general echoed the Army colonel's views. He noted that the armed services expect a lot of their personnel, and must therefore provide more to their people. "If you want a product and a commitment, you have to take care in return." No one lays the responsibility for general welfare on the civilian employer as the armed forces do on the

³Subsidized child care is a form of compensation for families who have or expect to have children. For these families, child care increases the income stream relative to most civilian alternatives. Since increased income is associated with increased retention, child care almost certainly increases retention, but the amount of increase remains unclear.

base commander, he explained. Therefore, he concluded, we have an "institutional commitment" to take care.

Some respondents discussed child care goals from the perspective of the children served. A Marine Corps general noted that an important goal of child care is to foster better and more productive citizens. A poster in a Marine Corps CDC presented this goal in a more self-interested way. It reminded readers that a substantial proportion of today's military children would grow up to serve in the military themselves, a reminder borne out by research (see, for example, Faris, 1981). Other respondents offered similar arguments from slightly different perspectives. A CDC caregiver noted that many of the children in her care spend virtually all their waking hours in the CDC, so that what they receive at the center essentially constitutes their upbringing in their early years. Looked at this way, a critical child care goal must be quality developmental care, she continued. This view was shared by an Air Force policymaker. Another provider, concerned about the limited parenting skills of many of the young junior enlisted parents who use the center, believes that the CDCs provide an important model to parents about how to help their children. Now that the ratios of caregivers to children have been lowered and caregiver training much improved, she said, "our problem is educating our parents."

The above goals apply equally to CDCs and to FDC; FDC has some unique additional goals, including management of excess demand and providing military spouses with opportunities to earn money while remaining at home. To a significant extent, these latter goals are incompatible with the former ones, as discussed below.

YA, which is not a formal part of CDS, increasingly provides child care to young children. The provision of child care is not entirely consistent with longstanding YA goals, which include a strong sports program and a place where young people can get together for informal sports activities. Despite its growing involvement in child care, for at least some of our respondents, the YA recreational focus has not changed. A YA director to whom we spoke told us that one of her biggest problems is the differential expectations of program staff and parents; "these are recreation programs," she said, "even though some parents think it's day care." For program staff, the YA mission is to provide a strong sports program. For many parents, YA is a cheap babysitting service, according to another YA staffer. Some parents, another YA director said, "want more accountability" than the center can offer. They want their children "to be babied" there. But, she noted, these children are not babies. "They have to learn to be on

their own." Moreover, she added, some parents want their children to be "educated" at the Youth Center. In her view, the children are being educated in school. The Youth Center is a place for fun and games.

Relationship of Goals to Provision of Care

Given the variety of views about military child care goals, it is not surprising that these goals do not always track with the provision of care. Indeed, we often found inconsistencies between stated goals and their operationalization. An Air Force colonel noted this inconsistency. Whereas the first child care objective is readiness, he said, it is "not practical" for CDCs to attempt to meet all readiness requirements, for example, by remaining open 24 hours a day. A Navy commander had considered this inconsistency as well. If readiness were the major child care goal, the base would have to provide 24-hour child care, he had concluded some time ago. He actually had looked into the finances of doing so, and had determined that "it would bankrupt me." As a result, he had revised his views of the goals of military child care; he now believed that the main goals of child care are improved quality of life and improved morale. A Morale, Welfare, and Recreation director had also noted the inconsistency between readiness goals and the provision of child care, especially the care provided through CDCs. "If the main goal of child care was readiness," she noted, "parents shouldn't use the CDC anyway, but FDC," because the CDC could not offer the flexibility that is often essential to readiness. Consequently, she viewed the goal of child care more narrowly: "to allow people to have jobs and not be concerned about where their kids are. It also gives parents the confidence that their kids are receiving developmental care in a safe environment," she added.

Readiness goals are not furthered in the priorities that the services have established for determining which families receive child care. A concern for readiness would lead one to expect that single and dual military parents would receive top priority for child care slots, as their child care gaps are the most likely to affect readiness. While the Army has established the priority of these families for receiving child care in CDCs, the other services have not done so, although the Navy's October 1990 document stresses the pressing child care needs of these groups and the direct effect of their child care problems on readiness. As the recent IG report (1990) notes, "To ignore the child care needs of this population segment would cause an adverse impact on readiness and retention. Because of this, we believe single mili-

tary parents should receive priority placement when installation CDCs are at capacity" (p. 6).⁴ We encountered considerable opposition to providing single parents such priority.⁵

Equity as a Child Care Goal

The provision of child care is an expensive, labor intensive operation. Those who use child care tend to do so on a full-time basis, limiting the total number of people who can use the service. Its high costs and the relatively small numbers of personnel who use it at any one time are a source of concern to those responsible for the well-being of military personnel. Many regard some measure of equity as a goal in delivering child care.

Child care advocates generally respond to such concerns by noting that over time, the picture of child care utilization looks far more equitable than any snap-shot picture can provide. They note that most personnel (70 percent or more) who remain in the military marry and have children, which makes them potential consumers of child care. Moreover, all workers in a unit are negatively impacted when one worker cannot do his or her share because of lack of child care.

These arguments are less than compelling to everyone. Those involved in other family service programs, nearly all of which are short of funds, point to the large amounts of money necessary to staff and run CDCs. They argue that family services monies should perhaps be more evenly distributed across family programs. Moreover, many families with children do not use military child care. Although our secondary analyses reveal that nearly 83 percent of all families with preschool-age children in the Army Families Survey reported using some kind of child care for more than five hours per week, most did not use military child care. As shown in this section, 17.6 percent were using an Army CDC on a regular basis; 6.9 percent were using family-based care. Nonrelative and relative care accounted for the vast majority of child care.

Others argue that the funds going to serve the small percentage of personnel with children in child care should be used instead to fund programs that serve all personnel, or for which all personnel are eli-

⁴As discussed below, readiness goals may be better served by giving these families priority in FDC, which can provide more flexible care.

⁵Indeed, legislation has been introduced recently into Congress to bar single parents from continuing military service because of readiness concerns.

gible. An admiral worried that the large amounts of money (both non-appropriated funds (NAF) and appropriated funds (APF) being taken from MWR for child care were undermining recreation programs and consequently the fitness and readiness of the whole Navy. A Marine colonel shared this concern. Closing down other MWR programs to keep child care going, as he expected to have to do in the near future, seemed unfair to him. An Army general noted, "They [commanders] have an obligation to take care of the entire community. Are we doing the right thing?" he asked, when the base commander takes NAF dollars that come from single soldiers to cover child care. A CDS director described her commanding officer's worries about equity. Only 2 percent of active duty personnel assigned to the base where she currently works are using child development services, she noted. Consequently, while the commander cares about child care, he is torn about providing it more resources. When he gives money to child care he is aware that he is taking money from the much larger group of single and married personnel without children who have no current child care need.

Interestingly, virtually none of our respondents had heard criticisms about the large sums going to child care from parents not using it or from single personnel. Indeed, a few parents told us that their childless friends were surprised about how much they were charged to use the CDC. But many noted that the lack of complaints reflected ignorance rather than acceptance. A chief master sergeant to whom we spoke noted, "Junior people don't know how it (the system of moving NAF dollars around) works anyhow. They put their faith in senior leadership to take care of those issues for them."

Several respondents told us that they had taken pains to conceal the fact that proceeds from other MWR activities were being channeled into the CDC. "If they [nonparents] knew [that MWR proceeds are being spent on child care] they'd be irate," said a Naval commander, who was himself uncomfortable about the practice. When money comes to child care directly from MWR programs, we are, he said, "penalizing 7000 people to benefit 70 [the approximate number of children served in the base CDC at the time of our visit]." A Child Development Services director had not encountered any problems about equity, but actively worked to prevent them. She recently had hosted single sailors for lunch at the CDC, and got a large and enthusiastic turnout.

Concerns about equity led the Navy to investigate whether single sailors were shouldering too much of the cost of child development

services. Using their yearly survey of Naval personnel, which includes about one-third of personnel each year, the Navy was able to determine the amount of money that married and single personnel spend at the PX. According to our respondent, the survey revealed that most of the dollars that are spent in the PX are spent by married sailors. Because of this, our respondent believes that it was fair that PX dollars are directed to child care programs.

Other equity issues emerged as well. The Army's policy to accord single and dual military parents first priority for child care slots is viewed by other parents as unfair, according to a sergeant major to whom we spoke. Besides getting first call on available child care slots, their use of the CDC, with its inflexible hours, often allows them to avoid end-of-the-day duties, which fuels feelings of unfairness.

Some equity concerns involve income and rank. A few junior enlisted parents to whom we spoke had not yet been able to use the CDC. They argued that they should have first priority for limited CDC slots, since the higher salaries of senior enlisted and officers allow them more child care options, including expensive civilian care.

The income and rank issue played out in a somewhat different way on an Army installation that we visited. There, high-priority single and dual military parents were using hourly care on a regular basis until a full-time slot became available.⁶ Hourly care in this location was limited to 25 hours weekly, which created problems for these parents. These problems were exacerbated when temporary care slots had been pre-booked by organizations to cover child care during meetings and activities. According to the head of CDS on this installation, there is a good deal of resentment about this, as the organizational users tend to be officers' wives, whereas those getting by with hourly care tend to be lower-ranked enlisted personnel.⁷

ORGANIZATIONAL CONTEXT

Child care is provided in an organizational context that in turn defines, constrains, and facilitates its delivery. Salient features of that context are described below.

⁶Hourly care slots are not supposed to be used for regular full-day care.

⁷In situations like this, the Army expects that Supplemental Programs and Services would be called upon to help meet the demand for a large number of hourly care slots for a short period of time. SPS involvement might have reduced resentment on this installation.

Organizational Location

The lack of clarity about the status and goals of child care is reflected in its varied organizational location across services and installations and in the considerable amount of discussion about where it belongs. On most installations, child care is administered through MWR, which also administers golf, libraries, arts and crafts, clubs, YA, bowling, and other activities. In the Air Force, it falls under Recreation Services, a division of MWR. On Marine installations, CDS may be found in Family Services or in MWR. The standard location for Army CDS programs is under Family Support.

Many respondents believe that considerable advantages accrue to child care's association with MWR. Primary among them, it was often noted, is that many MWR activities are revenue-generating (golf was often mentioned at this point), and these revenues can be and typically are easily transferred to child development services. As one CDS director put it, "They [MWR] have the most money, and they generate the most money." A commanding officer made this point in talking about an upcoming Air Show. Such shows are very profitable, and some of the profits would be diverted to CDS. However, we also learned of instances where CDS profits had been used to support other MWR activities.

Transfers of funds from golf to child care led many MWR directors to think that child development services belong elsewhere. They argue that monies generated by golf should be used to maintain and improve the golf course, not to purchase toys. An MWR director told us that the standard question in his office these days is, "is there money for [an activity], or did it all go to the Child Development Center?" The resentment in this question goes all the way up to the base commander, he contended.

Other arguments were tendered for maintaining child care in MWR. MWR is a business organization, some respondents argued, and its expertise and experience with the bottom line help child development services directors run their operations more efficiently and cost-effectively. Moreover, since parents pay fees to use CDS, its location in MWR, with its experience in fee collections and in the administration of NAF funds helps CDS as well. At an installation where CDS is in Family Services (FS), the FS head told us that it made more sense to him for CDS to be in MWR, since MWR does the financing and accounting as well as the hiring and firing.

The MWR connection was criticized by many. Some argued that being in MWR had led CDS administrators, MWR administrators, and

commanders to expect that CDS should make a profit, just like the other major MWR programs. Such concerns have led CDS to distort its goals and purpose on more than one installation, according to critics of the MWR affiliation. They note, for example, that providing infant care is inherently more costly than serving older children, since the ratio of children to providers must be lower when infants are involved. On more than one installation, these costs, combined with concerns or beliefs that making a profit or at least breaking even were expected, had led to policies that excluded infants from the CDC. While such policies may ironically be beneficial for infants, who experience lower morbidity in family-based care (Johansen, Leibowitz, and Waite, 1988), respondents expressed concern that it was the MWR ethos, not what was good for children, that led to such decisions.

An MWR director argued strongly that CDS cannot be operated under the same principles that govern other MWR activities. She is expected by MWR supervisors to run MWR programs "according to business standards," but because of Congressional mandates and headquarters directives, she cannot run CDS this way. Instead, the latter mandates and directives, which are more child welfare-oriented, push her to run CDS like "a social welfare agency." She would like to see CDS move to Family Services, to be run there without MWR subsidy. Arguments for such placement centered around the similarity of goals and concerns between FS and CDS. Issues of the bottom line would be lacking, and policy could more easily be child welfare-oriented, supporters argued.

Moving CDS to FS had been tried in a few of the installations that we visited. The problems posed by this organizational home were to some degree the obverse of those found in MWR. For example, FS administrators had no experience in collecting or managing large amounts of money. Moreover, respondents noted, FS was a poorly funded enterprise. Without golf courses or bowling alleys to provide supplements to the CDS budget, family programs and child development services were soon fighting over a very small pie.

Further, CDS had little to gain from a move to FS, many argued. The compatibility of CDS and FS is more apparent than real. One FS director argued that FS is essentially a clinical practice, an offshoot of medical services, which provides parenting classes and personal and financial counseling, among other services. As such, it is as inappropriate a place for CDS as is MWR. An MWR director worried that locating the two together could cause potential conflicts of interest, because FS handles child abuse investigations. An admiral concurred,

arguing that family advocacy and child development programs should be separately administered to ensure checks and balances.

Even those who were not particularly concerned that CDS was in MWR expressed concern about its placement under Recreational Services in Air Force locations. The fact that the director of CDS reported to a person whose professional expertise was limited to golf or bowling seemed both absurd and frightening to these respondents.

Organizational Location of Youth Activities. As first visualized, YA was a program that offered organized sports and recreational activities, and that provided youth (generally assumed to be considerably older than 5 or 6) a place of their own to hang out and participate in a game of pick-up ball. Its organizational location under Recreation Services on many installations has served to continue this tradition. As a recreational service devoted to "dependents," a family support director told us, it has always been low on the list of priorities for base funding. A YA director on another installation shared this view. He referred to YA as "the black sheep of the family." Each commanding officer has a favorite concern, he added, and YA is rarely the one that anyone picks.

Its low priority at the installation level mirrors its low priority higher up. For example, the people who run YA at the Pentagon are paid less than their CDS counterparts. One respondent attributed this differential to the lobbying skills of the service child care managers, who have worked hard to make CDS a priority. Their stories of problems in CDCs are usually received well, because they concern babies and very young children. Recent child abuse incidents have cemented their claim. "The system can deal with only a few things at once," she noted, "CDS horror stories have put it into the spotlight."

The greater emphasis on safety, staff training, and regulation in CDS has led some respondents to believe that YA should be integrated more closely into the CDS system. A lieutenant colonel who heads Recreation Services on an installation we visited believes that "YA is child care." On that installation, YA is mainly used for after-school care. Therefore, our respondent concluded, YA should be under the supervision of the CDS director. This would improve coordination between the programs, and standardize them. Putting both programs under a separate MWR division would be even better, he added. A CDS director echoed these concerns. She noted that on her installation, the youth centers provide "marginal custodial care." She would like to see YA come under CDS, and to see continuity in programs from birth through age 12. As one respondent noted, such continuity would be consistent with Congressional intent as expressed in the

MCCA, which addresses itself to children 12 and under. However, MCCA implementation has focused almost exclusively on young children.

Institutional Culture

Military child care exists in a culture that in some ways is inimical to its goals. Although some commanders accept the importance of child care, others view it as a diversion from their most important purpose: supporting the defense of the nation. Viewed through this lens, child care seems at best peripheral to some. Said a chief of staff on one installation that we visited, "we only exist to be prepared to kill people." Child care does not further that goal, he indicated, and thus it seemed unimportant. An installation commander's response to a meeting of installation human services providers was described to us by another respondent who had also attended: "Here we were, three trained killers, standing around, talking about child care" A Marine Corps general described this same phenomenon in somewhat less colorful terms: "most senior leaders are unprepared to deal with their new [child care] responsibilities because most of us are warriors. Most of our spouses raised kids and did not work; however, that has changed and families now have dual wage earners."

The "warrior" leader may be a dying breed, according to an Army colonel. He believes that commanding generals are selected in part because their views are consistent with those of the current chief of staff. Since child care has been "of the utmost importance" to top Army management for some time, new commanding officers (COs) will increasingly reflect these views.

Whatever the commander's views on child care, commander discretion frees him or her to carry them out. Commander discretion is an important aspect of the military culture, and was frequently discussed by our respondents with regard to the funding of child care programs. The arguments for commander discretion are fundamental to the military endeavor: In the words of one general, "the commander must have discretion to meet his mission." Said an Army colonel at the Pentagon, "Commander discretion is one of the most important parts of this [military] operation." There are times, he admitted, when he would like to dictate policy to commanders, but that is not how the system works. Support for this position was broad-based, and was by no means restricted to uniformed respondents or to people unsympathetic to child care. Fenced funds would in some ways be nice, some child care advocates acknowledged, but they would undermine the military mission. Instead, noted one, "you have to try to

bring the commanders along [on the importance of child care].” One admiral walked the line on the issue of discretion and fencing, “it’s important that they [commanders] have that leeway. However, we need standards for child care which we can enforce at the same time.”

Nevertheless, a number of respondents rued the fact that commander discretion dominated decisions about the ultimate use of funds for child care. Such respondents would like to see an end to the authority of commanders to take funds allocated for child care and use them for other purposes. Said a CDC director, “so much depends on the commander. You can have great planning, but then a new guy comes in [and takes] command and redirects the priorities.” We heard from several respondents about an instance where commander discretion overrode child care priorities. In that case, Air Force Headquarters had allocated money for FDC home coordinators at all installations with FDC programs. However, only about half of the installations actually got additional coordinators; on the other installations, the commanders used the money for other things.⁸

At least some of those who would like to see less commander discretion have not sat idly by. A respondent who oversees child care has strategized about ways to reduce discretion. “The trick is to take it [commander discretion] away from them without their realizing it. Ratios, employee qualifications, training standards, health and safety, we’ve taken it away from commander discretion.” Proponents of reduced commander discretion have applauded the MCCA for doing just this, as discussed below.

Regulation of Child Care

The tradition of and support for commander discretion collide with the substantial amount of regulation that governs the operation of military child care. Like civilian centers, CDCs must conform with sanitary, health, and fire and safety codes, most of which are more restrictive when young children are involved.

Frequent commander complaints of “micromanagement” were fueled by the passage in November 1989 of the MCCA, Congress’ response to growing concerns about the amount and quality of child development services available to military children. The underlying purposes of the Act are threefold: to improve the quality of child care available, to

⁸Commander discretion extends to decisions about whether to have a CDS program at all. DoD urges commanders to support CDS programs, noting that child care will be provided informally and without oversight in the absence of a formal CDS program.

expand the availability of care to more children, and to make access to child care more equitable.

Key features of the Act include increased training, higher caregiver salaries, a new fee structure based on family income, and a required matching of parent fees with appropriated funds. Higher caregiver salaries were designed to reduce caregiver turnover and improve applicant quality. The new fee structure was designed to increase child care costs for those who could most afford them, and to decrease costs for those who could afford them least. In addition, a fee structure that was consistent across installations would help parents to anticipate and cope with child care expenses. The required 50/50 match of parent fees with appropriated funds was designed to compel the services to view and support child development centers in a new way. By requiring a 50 percent match, Congress was conveying to the services that child care is important and deserving of appropriated funds support.⁹ (See Appendix A for additional discussion of the MCCA.)

The DoD first opposed the Act because it was already taking action on several key issues ultimately included in the Act and wanted time to implement the changes. Indeed, prior to the passage of the MCCA, the DoD had issued an Instruction that concerned the need to increase caregiver wages, improve safety procedures in centers, and improve and standardize quality across centers.

Our installation visits coincided with the first implementation of the MCCA. Consequently, almost inadvertently, we came to chronicle important aspects of the implementation process. Because of substantial variation in the speed with which implementation was begun and the long period during which our visits took place, we visited installations that were in all stages of the implementation process, from first questions about the implications of the Act for CDS, to active implementation of many of the Act's provisions.

For many of the people whom we interviewed, the MCCA was *the* major child care issue. And it was a critical one, as meeting the conditions of the Act required substantial changes in the ways that child development services were funded, organized, and delivered.

Whether or not they supported the goals of the MCCA and believed that it would be beneficial in the long run, respondents generally agreed that the Act was causing problems. Many of those problems stemmed directly from the failure of the Act to appropriate any funds

⁹The match specified in the Act applied only to FY 1990, but was continued under DoD policy.

while specifying fairly rapid implementation of many of the Act's provisions.¹⁰ Respondents tended to complain far more about the lack of funds than about the implementation schedule.¹¹ The lack of appropriation, said an Army colonel, was "a serious blow." Virtually everyone to whom we spoke who was aware of the lack of appropriation expressed anger and concern about the expectation that they would come up with additional funds to comply with the provisions of the MCCA. Attempts to find these funds midyear, according to an admiral to whom we spoke, has led to wholesale robbing of Peter to pay Paul. An Air Force colonel echoed these views. "Congress should have put their money where their mouth is [on the MCCA]," he said. He would like to tell Congress to "give us the money to comply with the provisions mandated."

An Air Force general saw the lack of an appropriation as an opportunity to put his stamp on MCCA implementation. He expressed pleasure about the inconsistencies in the MCCA between what is expected and what resources are available to meet those expectations. "Bluntly," he said, "this inconsistency allows me to make up my own mind" about the way in which implementation will proceed and how fast it will go.

The services have responded to the lack of funds for implementation in different ways. The Marines and the Navy expected installation commanders to find the money themselves. On a Marine base that we visited, this policy was understood by child care administrators to translate into "nothing doing"; they were told to expect no additional funds. The MCCA does not have the force of law, a respondent told us, because no funds were appropriated for it. On a Naval base that we visited, the MWR director planned to close down some money-losing activities, including the auto hobby shop and the bowling alley, to pay for the changes mandated by the MCCA. In a way, he said, MWR is being penalized for its success in organizing and operating the CDC.

The Army has made funds for implementation available from headquarters, but, as noted above, such funds have not always found their

¹⁰The problems associated with a lack of appropriation in the Act were exacerbated by diversion of funds identified for child care to other programs on some installations. Had these funds been available to CDS, the CDS deficit would have been smaller; MCCA requirements heightened awareness of these diversions.

¹¹Lack of an appropriation is not unusual, but typically when there is no appropriation, requirements are phased in, allowing budget planning to keep apace with implementation. In the case of the MCCA, rapid implementation of many provisions was required.

way into child development services. However, the Army installations that we visited for the most part had made considerable progress in approaching the 50/50 match. On one installation, the CDS director anticipated that they would be very close to the 50/50 match by the end of the fiscal year. Here, the match was facilitated by money from both Army headquarters and from post funds.¹² Air Force headquarters provided funding for half of the positions required by the MCCA in its FY 1991 budget, with the other half funded in the FY 1992 budget.

The larger the center, the more expensive it becomes to run it, as each new enrollee requires a 50 percent appropriated funds match. This implication of the MCCA had not been lost on many of our respondents. They viewed the requirement for an appropriated funds match as a major impediment to future expansion of child development services. A respondent noted that while the MCCA goal of improved quality may be met, the appropriated funds match, combined with the lower ratios of children to caregivers specified in the DoD Instruction on Child Care (DoDI) are likely to undermine another goal, the expansion of care.

Some respondents doubted that even the first goal, increased quality, would be realized. An Army general noted that the increased wages required under the MCCA would be going to the same people as before, who would now be "overpaid." A Marine Corps major expressed the same sentiment when he said that the CDC will be paying staff more and "for all that we won't show much visible improvement in care."

Another major complaint about the MCCA and the DoDI was the constraint that they imposed on commander discretion. Pay increases, the uniform fee structure, and the appropriated funds match have, in the words of a Navy captain, "hamstrung the commander." An Army general saw the MCCA as another indication that the Congress thought that it could control the military. A high-level respondent sensed another goal on Congress' part. Heavy-handed Congressional management, according to this respondent, comes about because "the people [in Congress] who most like child care most dislike the military, so they *want* to tie our hands with child care and take money from military activities."

According to an Air Force colonel, such attempts at control are costly in terms of program quality. "we're running a better operation than

¹²Army wide, the 50/50 match has been exceeded, with more appropriated funds than parent fees going into CDCs.

we could be dictated to provide," he said about CDS on his installation. "The lower down you can run something, the more efficient it can be."

Child care advocates disagree that mandates undermine program quality. Indeed, several to whom we spoke expressed tremendous disappointment that the 50/50 ratio (of appropriated to non-appropriated funds) was a "target" as opposed to a "floor." As a result, they believed, the match was unlikely to be achieved, since, said one, "floors have to be achieved, while targets do not."

Funding for child care will change to some extent in 1992 when a new system is to be implemented. Under this system, Child Development Services funding will be moved out of the general account for base operations into a smaller account earmarked for schools, education, and related programs. In this account, CDS funds will be a line item, but will still not be fenced within that account. This degree of protection of child care funds, will, however, come at a cost. Commanders will no longer be able to transfer money from the base operations' account to CDS, which has become an end-of-year tradition on some installations. Furthermore, line items in the budget are subject to across-the-board cuts.¹³ Finally, within the account, the commander can choose to use CDS funds for other purposes, for example, higher education programs.

Regulation of Family Day Care. In contrast to the considerable regulation of CDCs included in the MCCA, FDC was largely excluded from the MCCA legislation. This exclusion continued a pattern in which CDCs receive considerable oversight, whereas FDC receives far less.

The relative lack of regulation of FDC stems at least in part from the uncertain goals of these programs. The uncertainty discussed above about the goals of military child care is magnified and further mud-died by concerns about liability and about the relationship of FDC to CDS.

Despite government investment in FDC,¹⁴ many respondents viewed FDC primarily as a spouse employment program, an opportunity, said one respondent, "for military wives to make some money while being able to be with their own young children." Viewed through this lens,

¹³Congress has allowed reprogramming across line items in such instances.

¹⁴These investments include the training, licensing, and oversight of FDC providers, and some subsidization of liability insurance and equipment needs (e.g., toy and equipment loan programs).

FDC deserves no more regulation or oversight than the military requires of those engaged in other private businesses operating out of their military quarters: essentially none. Said a senior enlisted representative who supported this view, “we don’t regulate the Avon lady or tell her how much of what kind of lipstick to sell. So we can’t do that with FDC either.”

But child care is clearly not the same as selling lipstick, a reality acknowledged by most. Indeed, a Marine Corps respondent described an FDC license as “a privilege the CO extends to some Marine families.” But fixing on the appropriate type and extent of regulation was difficult for many. The extremes were fairly clearly drawn: some regulation was clearly required, but according full status and full regulation to FDC as part of CDS was unacceptable. Indeed, a service child care manager who began to rethink FDC as “a center without walls” was quickly reminded that liability issues precluded such an approach.

Typically, FDC was regulated to some degree. A colonel who had oversight of CDS described the service’s FDC involvement as dealing with certification, with no interest in “the business end.” Often, the effects of the regulation appeared to undermine some program goals while supporting others.

Everywhere, ratios of children to providers were regulated and monitored, although such limitations undermined the earning potential of FDC caregivers. Providers are allowed to care for up to six children if no more than two are under two years of age or for three children two years and under. Some respondents regarded these ratios as a strong disincentive to become a licensed provider. At the same time, the amount of money that the caregiver could charge parents was left completely to the discretion of the caregiver and the willingness of parents to pay. We encountered many FDC providers who kept their fees low, in the range of \$40–\$60 weekly, by calibrating them to those of the CDC.¹⁵ But in some places, the CDC’s policy of excluding infants under six months had created such tremendous demand for infant care that FDC fees were close to those charged by civilian providers, running as high as \$100 a week or even more.¹⁶

¹⁵When FDC providers calibrate their fees to those of the CDC, they are effectively subsidizing parents. In the CDCs, the government provides the subsidy, which allows them to charge fees ranging from \$45–\$58 weekly for full-time care.

¹⁶These high fees were a concern to many respondents because they appear to undermine the MCCA’s goal of more equitable child care access. But required fee reductions would add an unwanted layer of regulation to FDC. Moreover, fee reductions would create a substantial disincentive to provide FDC care and would lower FDC

In a few places with severe shortages of infant slots, a decision had been made to try to regulate the distribution of FDC slots by age. For example, on one Army installation, new FDC providers had to agree to become "infant homes," where only children under two would be cared for. The intent of this policy was to increase the availability of infant care on the installation in response to a long waiting list dominated by infants and toddlers.¹⁷ One effect was to limit the potential income of new providers on this base: as noted above, infant homes may serve a maximum of three children.

CDS personnel on this installation were aware of the disincentive created by requiring providers to become infant homes. At the time of our visit, some thought was being given to helping such providers with a subsidy to compensate for the loss of income inherent in caring exclusively for infants, but no figures had been discussed.¹⁸ Several respondents noted that the amount of any subsidy had to be viewed against the significant subsidization of each child in the CDC, which a respondent estimated to be almost \$2000 yearly. The Army has recognized the supply problems that result from low ratios in infant homes. It implemented a six-month subsidy test in four Army communities in Europe in FY 1990 to assess the impact on supply of subsidies to FDC providers who care exclusively for infants.¹⁹ Despite the short time frame and substantial uncertainties about the availability of funding into FY 1991, the test resulted in the creation of an additional 39 slots in FDC homes. According to Army documents, these new slots represented an average increase of 63

provider hourly wages substantially, thus interfering with MCCA goals of improved quality through reduced caregiver turnover and expanded availability of care.

¹⁷Although not discussed further here, this policy would also encourage placement of infants in the most appropriate care setting. Studies have shown that small group care as opposed to center-based care promotes positive health and emotional outcomes for infants and toddlers (Johansen, Leibowitz, and Waite, 1988; Anderson et al., 1988).

¹⁸Direct APF subsidies to FDC providers are allowed under the MCCA, but with the exception of a single Army pilot study discussed below, they have not been tried.

The loss of income incurred in becoming an infant home is substantial. Even if a provider charges just \$40 a week for full-time care, she stands to lose as much as \$6000 yearly by accepting only infants rather than mixed-age children. (This assumes 50 weeks of paid care per child yearly for the three children who cannot be cared for.)

An FDC provider who ran an infant home told us that the tradeoff was worthwhile: infants were far easier to care for because they did not run around. In addition, one of her babies was multiply-handicapped and needed considerable attention. She could not provide it if there were five other children in her home. (She charged the disabled infant's parents the same rate, and received no subsidy for his care, although subsidies for special needs children are authorized.)

¹⁹Under the pilot program, subsidies were also available to FDC providers who cared for special needs children or sick children, or who provided care for extended hours.

percent in the total number of FDC slots available to infants and toddlers and to extended-hours children, suggesting that subsidies hold considerable potential for creating additional FDC slots.

Training requirements for FDC providers vary. In some cases, FDC providers are expected to complete the same amount of annual training as CDC employees, which typically is 24 hours yearly after initial training.²⁰ But often the level of training required for FDC providers was considerably less. On a number of installations, plans were being made to increase the amount of training required of FDC providers, despite awareness that receiving the training is more difficult for them (CDC employees often can work on training requirements during nap times, whereas FDC providers must devote nights and weekends) and that increased training may create additional disincentives to become involved in the FDC program.

Only rarely was there any discussion of imposing regulations that might build on the inherent strengths of FDC. For example, a CDS director had considered the possibility of requiring all FDC providers to agree to provide at least some overnight and weekend care, with a subsidy for after-hours care that would encourage voluntary caregiver participation.²¹ Such care, she contended, was a unique advantage of FDC, and one she would like to see formally made available to parents. In fact, FDC providers often did make such care available, but it was typically done informally and on an as-needed basis. A few caregivers resisted such extra care, arguing that they already worked long hours with little or no assistance. A requirement to provide extra care would cut into their family life and make the provision of FDC services far less appealing.

Regulation of Youth Activities. Although YA provides child care to many young children, it elicits at best a minute proportion of the attention and concern lavished on CDS. And, as one MWR staffer delicately put it, it provides services to children under a set of regulations that are "more flexible" than those that govern CDS.

In the YA programs that we visited, no child-to-staff ratio was in effect, although in formal classes ratios of 15 children to one adult were

²⁰FDC and CDC training are the same in the Army, which improves career mobility between the two systems.

²¹Rotating after-hours "on-call" responsibilities might follow procedures used in medical facilities.

the norm.²² The physical plant requirements imposed on CDCs were totally lacking.

Also striking were the differences in training requirements for CDC and YA staff. While CDC caregivers were tackling new training curricula developed in response to MCCA requirements, training for YA staff was minimal at best. A Youth Center director told us that there is no formal training at all for newly hired employees. When a new staff member begins work, the director and her assistant work with the person for what constitutes about a week of orientation. After that, all training is "on the job."

Limited regulation becomes more problematic as younger children are served by YA and its mission shifts operationally from exclusive provision of recreational services to provision of substantial amounts of child care. On a number of the installations that we visited, Youth Activities' child care function had recently been expanded when programs for kindergarteners were moved out of the CDC to make room for more full-day slots.²³ Most children in these programs spend the majority of the day at the Youth Center, as public kindergarten programs rarely extend beyond three hours. In addition, large numbers of early primary children spend several hours daily at the Youth Center in formal or, more often, *de facto* after-school care. Even when child care is not formally provided through YA, age requirements are falling in many places. On one installation we visited, the minimum age for YA participation had recently been reduced from six to five years.

The striking disparity in the level of regulation between CDCs and YA deserves special note because of the often intense concerns expressed by command about the liabilities inherent in providing child care, as discussed below, and because of the increasing numbers of young children being served by YA. Although YA was not designed to provide regular child care, the reality is that a growing proportion of the clientele uses YA services in this way. YA facilities have received none of the infusion of funds that have flowed in recent years to CDCs. The regulatory context for YA has changed little if at all. Whereas the MCCA was allegedly targeted to children from birth to age 12, the vast majority of its mandates and regulations have been

²²Ratios of staff to children in various activities (e.g., drop-in recreation, before- and after-school programs) are recommended in the DoD Action Plan for Youth Activities (June 1990, p. 5), but these ratios were not being implemented in the YA facilities we visited.

²³The DoD Action Plan for Youth Activities (June 1990) notes that the lower bound for YA eligibility is grade 1.

devoted to children under five. The enormous concerns about safety and liability that drive a good deal of the regulation of CDCs seem to be curiously absent with regard to YA. Concerns about developmental care and the wish to avoid custodial care, which are centerpieces of new CDS initiatives, are also lacking, or at least seem not to have found their way into YA regulation or practice.

Many of our respondents had thought little about YA, but those who had done so worried about its status, its mission, and the lack of regulation governing its operations, particularly as it assumed new responsibilities for younger children on some installations. A CDS director told us that in her view, it was just a matter of time before YA "generated headlines" about abuse or other serious problems.

THE PROVISION OF CHILD DEVELOPMENT SERVICES

Those who provide child development services must contend with a multitude of difficulties and constraints in staffing, funding, and delivering services. Some of these problems are exacerbated in military settings, and some are unique to them.

Staffing

Turnover is a problem in all child care settings, because of low salaries, long hours, and few, if any, benefits. In the recent Child Care Staffing Study (Whitebrook, Phillips, and Howes, 1990), an annual average turnover rate of 41 percent was reported. In military settings, turnover levels are often higher because most caregivers are spouses subject to frequent PCS moves. The CDC directors whom we interviewed provided pre-MCCA turnover estimates that rarely were below 40 percent, and often well exceeded this figure.

At the same time as these factors contribute to high turnover, hiring constraints may reduce the numbers or quality of caregivers available to the CDC. In some locations, particularly overseas, a high cost of living, limited numbers of accompanied tours, and low salaries for caregiver positions (typically less than \$5 hourly) have combined to make it difficult to recruit qualified staff.²⁴ Spouse preference reduces CDC director discretion in selecting the most qualified and stable staff. Finally, overseas, rules governing the hiring of in-country personnel limit director discretion.

²⁴Under the MCCA, starting salaries now begin at \$5.70 an hour.

As a means of reducing staff turnover and increasing caregiver quality, the MCCA specified a series of pay raises tied to completion of training milestones. The Civilian Personnel Pilot Program for Child Care Operations, which began in February 1990, met MCCA requirements by increasing caregiver salaries under a pay banding system based on standardized child care position descriptions. Under this system, entry-level caregivers are paid at rates competitive with those of other entry-level workers on their installation drawn from the same labor pool. Pay banding already had been implemented in several sites. CDC directors on two installations that we visited where pay banding was in effect reported that far more qualified applicants were seeking caregiver positions. On one installation, the CDC director reported that turnover appeared to have "dramatically" decreased. Before pay banding, she noted, 10-15 out of about 170 caregivers had been leaving each week. Since pay banding, that number had decreased substantially.

Preliminary DoD data show a substantial effect of pay banding on employee turnover. Six-month turnover rates for CDC caregivers fell below 40 percent in every service, and were under 25 percent in the Army and Air Force (17.6 percent and 23 percent respectively). These figures compare favorably with annual turnover rates of 61-300 percent prior to pay banding, although a simple doubling of the six-month rate to achieve an annual rate is not appropriate (Whitebrook et al., 1990).

Moreover, study results suggest that child care staff are completing the training required to advance in pay and status somewhat faster than expected. The study concludes that pay banding will help to achieve MCCA goals by increasing caregiver stability and quality.

None of the pay banding provisions apply to FDC providers, who set their own fees. Their incentives and disincentives differ substantially from those of CDC caregivers.

FDC providers to whom we spoke talked about a range of disincentives to participate in FDC. A number mentioned rigid training requirements that had to be fulfilled after hours. Long and rigid hours were described by one service child care manager as the major disincentive to FDC recruitment. If a provider needs or wishes to take time off, she must make special arrangements to do so. The inclination to allow a teenaged child or a spouse to take over must be resisted, as it violates FDC regulations except in extreme emergencies. On some installations, hourly slots in the CDC are available on a first-call basis to FDC providers who may need to take time off; on at least one of these installations, none of the FDC providers whom we

interviewed were aware of this opportunity. Several providers told us that they were encouraged to rely on other FDC providers to care for their charges when they needed time off. This rarely worked, most noted, because providers could not accommodate extra children without violating adult-to-child ratios. Nowhere had other efforts been made to reduce this important disincentive to providing FDC care.

Several FDC providers with whom we spoke viewed required retraining at each PCS move as a strong disincentive to participate, particularly because, unlike CDC staff, training time comes out of their leisure time and they must pay any costs incurred out of their own pockets.²⁵ Required insurance (although sometimes heavily subsidized), furniture, fire extinguishers, and other equipment must be purchased as well.

On some of the installations that we visited, child development staff have attempted to increase FDC incentives through the provision of equipment loans and toy-lending services. On one installation, discussions were under way about the possibility of loaning FDC providers the equipment that they are required to have (e.g., fire extinguishers) as a means of reducing start-up costs. Transferrable licenses would also encourage involvement and stability. A CDS director noted that the ultimate incentive to become an FDC provider was the avoidance of problems: undertaking unlicensed child care in military quarters can lead to expulsion from those quarters. But avoiding sanctions does little to encourage those who currently provide no care to become involved in the program: for those people to become involved, the program must seem appealing and the costs of participation relatively low.

There was a marked absence of discussion of compensation as an incentive to become an FDC provider. Indeed, we were struck by the many providers whom we interviewed who seemed compelled to tell us how little they earned doing this work.²⁶ Our sense was that while CDC caregivers have achieved a modicum of professionalism, so that increased wages were seen as both legitimate and an important way of providing program quality, such thinking had not extended to FDC. FDC providers are presumed to operate under an older model, in which largely untrained people care for children out of love (e.g., Nelson, 1990). According to this model, too much compensation

²⁵Such retraining is not required in all services.

²⁶An informal Army study conducted in 1988 revealed that most FDC providers surveyed were not earning the hourly minimum wage (L. Smith, personal communication, May 30, 1991).

would attract the “wrong” types—those who wanted or needed to make a living wage from their work.

The lack of efforts to subsidize FDC providers noted above fits neatly with this latter model, but the model needs revision. Lack of adequate compensation limits the number and quality of potential caregivers, which reduces both FDC availability and parental inclination to use it.

Funding

The funding of CDS presents a range of challenges, beginning with the issue of commander discretion and fenced funds, and ending with the issue of who will pay for crayons. Funding issues also have an effect on parental preferences regarding FDC.

As discussed above, the commander has enormous discretion with regard to the structure and funding of CDS, which complicates CDS planning and management. These complexities are exacerbated in many places by a lack of clarity about the fiscal expectations for CDS. On a number of the installations that we visited, CDS staff operated under the expectation that CDS would at least break even. Indeed, on one installation, a \$270,000 deficit the year before had caused serious problems.

Such expectations had led to some troubling and demoralizing practices. Infant care in the CDC on several installations was eliminated because it cost too much to provide. Caregivers in many CDCs told us that they purchase their own supplies because of inadequate budgets, and because the time between a supply order and receipt of materials can exceed two years. One CDS director spends much of her time on weekends at garage sales, looking for inexpensive supplies for the CDC. In a few locations, parents were asked to contribute supplies as well, a policy, claimed a colonel, that has a nice “silver lining”—it gets parents involved in the center.

The new fee policies mandated under the MCCA, implemented in a number of the installations that we visited, were causing difficulties. Parents resented the requirement that they show evidence of income, and at least one CDC director worried about the possibilities of falsification of the copied tax forms that were required as evidence. Those whose fees increased under the new plan resented it; on one installation a number of indignant parents had forsaken the CDC for civilian care. In other places, the increased fees that higher ranking parents would pay ironically enough created problems for admin-

istrators. Since fees had to be matched, higher fees required more appropriated funds.

Those whose fees decreased, the majority on most installations, were naturally pleased with the change. A senior enlisted representative described his own child care goal as making access to child care "fair and equal, based on grade." The new fee policy went a long way toward meeting that goal, in his view. Fee reductions created their own problems, however. Lower fees meant less total income to many CDCs at a time when caregiver wages were rising and lower ratios were going into effect. This policy had caused several centers that were not receiving sufficient appropriated funds support to match fees to experience an unplanned deficit.

Funding problems also contributed to reduced FDC coordinator positions in some locations. Given limited budgets, money tends to be channeled to the CDC rather than to FDC. According to many respondents, the money spent on FDC coordinators is "wasted," since FDC providers cannot hope to improve the CDS fiscal picture. As one respondent described it, the salaries of coordinators are a drain on CDS, since their work does nothing to increase the number of CDC slots, which are the revenue-generating mechanism for CDS.²⁷

Many parents couched their preferences for the CDC in monetary terms. Particularly in places where the CDC does not accept infants, unregulated FDC fees had escalated to the point where FDC cost rivaled that of civilian care. Higher ranking military members could handle these fees and remained with FDC providers, but lower ranking personnel were left without the option of FDC, which reinforced their preference for the CDC.

Perceived Quality

At least some high-level personnel in all the services wondered about the continuing push toward increased quality of CDS. A commander, for example, argued that to some extent the *Child Development Center* is a misnomer, as the name promises more than it should be delivering. He would prefer that it be called the *Child Care Center*. Another manager (different service) agreed. He suggested that it would be sufficient if the services provided "quality custodial care."

²⁷The likelihood that CDC slots will generate revenues in the future is doubtful, given MCCA requirements. But a number of respondents noted that that possibility remains, whereas money spent for FDC will never benefit the government.

Congress and advocates disagree. They argue that the long hours that children spend in care allow no less than high-quality, developmental care. Extensive data that demonstrate the relationship of high-quality developmental care to improved cognitive and social development (e.g., Ruopp, et al. 1979; Hayes, Palmer, and Zaslow, 1990; McCartney, 1984; Howes and Olenick, 1986; Howes, 1988) support their argument.

Most of the parents to whom we spoke expressed a clear and strong preference for the CDC over FDC because they perceived that stability, quality of care, and safety were better there. The greater perceived stability frequently derives from bricks and mortar rather than from continuity of care. One mother to whom we spoke expressed the typical preference for the CDC because of its greater stability; she noted in passing that her twin daughters had had nine different teachers over the last year.

We found a strong tendency among our respondents—both parents and military personnel—to rate their CDC highly. For example, an Army general told us, “We’ve got the best child care in the world in the U.S. Army.” An admiral echoed this view, contending that the Navy is doing a “great” job with its child care programs, and that the programs were far superior to those offered in the civilian sector. In many cases, the praise came from people, such as commanders, who had not visited any center other than their own; in these instances, they reported to us what they had heard from others. Others had concluded that their center was better than civilian centers because, in the words of one, “more people are watching.” Excellent training programs and careful screening of caregivers were believed to contribute to the higher quality of military centers.

These assessments were particularly striking because they were collected at about the time that the no-notice inspections required by the MCCA were beginning. The early inspections in CDCs chosen because of quality concerns were turning up fundamental problems in meeting health and safety codes. In addition, the quality of care in the centers visited in the first waves was not considered very good by inspection teams, and had led, in at least two instances, to the immediate closing of a CDC. One high-level civilian policymaker in the Navy argued that there is a widespread tendency to overestimate quality on local installations, and suggested that commanding officers and CDS directors on installations where CDS had a way to go should be encouraged to visit good centers, so that they could see what a

quality center looks like.²⁸ A Marine colonel echoed this view, noting that while there are some really good programs, there are some pretty bad ones whose personnel actually believe that they are doing a good job.

Quality in FDC. In contrast to their high quality ratings for CDCs, parents often expressed concerns about the quality of care in FDC homes. One mother was pleased with the center's carefully designed curriculum, and contrasted it with the absence of any curriculum in FDC homes, a reality underscored for her by the fact that the TV was on in every FDC home that she had visited prior to choosing the CDC. The lack of training of FDC providers worried some parents, although in at least some places FDC providers were required to have the same training as CDC caregivers. Another parent noted that the facilities, especially play spaces, were far superior in the CDC, since the housing on-base was small and outside space limited.

An Air Force recreation director responsible for CDS summed up the views that we heard about FDC from many parents: 99 percent of the parents using FDC would move to the CDC if they could, he contended. Its more structured program, better-trained staff, carefully monitored food program, better emergency preparedness, and subsidies allow the CDC to offer a higher quality, safer program. In addition, its institutional status provides a measure of stability and reliability not possible in FDCs. Would this assessment lead him to urge changes to the FDC program designed to reduce some of these differentials? "No," he replied, "there is little point in training FDC providers because there is so much instability there."

Little data exist that can support or refute the oft-heard contention that center-based care is a more reliable child care source. Our secondary analyses of data from the Army family survey, discussed in Section 4, do address this point. They suggest that in fact CDCs may not provide more reliable care, if one measures reliability in terms of days of work lost because of child care problems. Although there are no relevant published data concerning civilian child care, unpublished tabulations from a large national survey indicate that a much higher proportion of working parents with preschoolers lose time from work

²⁸The military will be in an excellent position to make this happen after the accreditation component of the MCCA is implemented and evaluated. This provision required the DoD to accredit 50 CDCs by June 1991. Once an evaluation of the impact of accreditation on childrens' development is completed, effective programs are to serve as "models."

for child-related reasons when their primary care arrangement is a day care center as opposed to a family day care home.²⁹

Shared perceptions of lower FDC quality reflect command and parent anxieties, and the limited empirical data about FDC (Hayes, Palmer, and Zaslow, 1990), but may also reflect a notable failure by the DoD and the services to publicize information that supports FDC.³⁰ Data on improved health outcomes for infants, noted above, and reduced days lost to work among parents who use FDC could be used to actively encourage greater use of FDC. Moreover, a number of changes could be made to the program to increase both perceived and real quality. Training requirements that equal those of CDC caregivers, subsidies to promote stability and encourage higher quality recruits, and greater integration of CDC and FDC activities would all help to elevate the status, quality, and appeal of FDC.

A minority of parents prefers FDC. A mother of a three-year-old likes the fact that FDC provides one-on-one care and greater learning opportunities in a small group. A number of parents were grateful for the flexibility accorded by FDC providers, both in terms of hours and illness, as discussed below. Several parents indicated that their initial reluctance to use FDC changed once they experienced it. This was especially true of parents of infants and toddlers.

Quality in YA. Children who use YA facilities are on their own to a considerable extent. Once they have parental permission to participate in YA programs, they generally are free to come and go as they please. When YA facilities do not provide transportation to and from school, children who use the center for after-school care get to and from the center on their own. These open-door policies are a concern to some YA staff. Said one YA director, "YA is not adequate for the youngest kids sometimes." But others want to keep YA the way it has always been.

Safety and Liability

For installation commanders and other members of the command, liability issues surrounding the delivery of child care represent major

²⁹Unpublished data from the 1986 follow-up survey to the National Longitudinal Survey of the High School Class of 1972.

³⁰Goelman and Pence (1987) found that quality of care in civilian FDC is much more variable than in centers, and that quality is a potent predictor of some child outcomes. Quality is associated with being licensed and part of a network (e.g., Goelman and Pence, 1987; Kahn and Kamerman, 1987); both of these characteristics apply to military FDC.

concerns. Recent incidents of abuse in child development centers on several installations and the flood of publicity that accompanied them have alarmed commanders, many of whom would prefer being out of the child care business for other reasons as well, as discussed below.

Safety and Liability in CDCs

For the most part, safety concerns in the CDCs were perceived to have been effectively dealt with in current regulations. A number of centers that we visited were in the process of modifying their physical plant to conform to regulations promulgated out of concerns about child abuse prevention. CDC staff and command were uniformly supportive of such regulations. Several, in fact, indicated that they were very glad to have done the work, which usually involved cutting windows into classroom and closet doors.

Sometimes, however, these efforts met with difficulties. In two sites, attempts to make the center safer were found to violate fire regulations. In another site, the center was cited by safety inspection teams for the lack of windows in several classrooms. The director speedily arranged for the prescribed windows to be cut. Once done, the fire inspection team promptly cited the center for having compromised the fire safety of the walls—the windows installed did not meet the fire code. At the time we visited, the director was in the process of negotiating with the safety and fire people to work out an acceptable way to meet both sets of requirements.

Safety and Liability in FDC

Most of our respondents' safety and liability concerns focused on FDC. Commanders in particular worried about what went on in these quarters, and regretted the limited monitoring that was possible. One respondent contrasted the heavy emphasis on child abuse prevention in the CDC with the few efforts, or even opportunities, to prevent child abuse in FDC. With only one caregiver working in family day care settings, a child abuse incident involving a caretaker will happen "sometime," said a CDS director.

Parents share these concerns. Whereas many believe that FDC is safer than civilian care, most believe that FDC is far riskier than care in the CDC. This risk was described by several respondents as particularly difficult for military parents to accept. A Family Services director described military parents as very security oriented. A senior enlisted representative told us, "most people can't wait to get them-

selves and their kids behind that twelve foot fence [which surrounds the installation].”

The services have attempted to address these concerns by requiring background checks on potential FDC providers and their spouses, and by the institution of more rigorous training and unannounced visits to FDC homes. Nevertheless, training and requirements for FDC providers are often less stringent than those for CDC caregivers. The absence of standard training requirements for all caregivers contributes to continuing safety concerns with regard to FDC. At the DoD level, the limited attention paid to FDC in the DoDI, where just one page is devoted to FDC, conveys the sense that FDC receives little oversight.

Commanders as well dislike the risks that they associate with FDC, and act accordingly. An admiral whom we interviewed told us that the Navy had been reluctant at first to promote family-based care, preferring CDCs, where more control could be exercised. Demand for child care compelled them to support the program, as discussed below. According to the IG report, many installations still do not have a formal FDC program, as noted above. Commanders on installations without FDC programs almost uniformly cite safety risks as the reason.³¹

We found little data relevant to these concerns.³² Certainly, the most publicized child abuse in military child care has occurred in CDCs, and respondents described those incidents as nightmares they strove to avoid. Data from the civilian sector show that nine out of ten family day care providers have never had a complaint filed against them. Of those who have, the average claim was less than \$500 (Kalemkiavian, 1989).

Safety and Liability in YA

The relative lack of concern about safety and liability in Youth Activities may be a legacy of its original mission as a provider of recreational services. Often, the YA programs that we visited were housed

³¹At a Commander's Conference held in December 1990, it was noted by DoD staff that the absence of a formal FDC program does not ensure that there is no care being provided in military quarters. Indeed, they argued, a major command incentive for initiating an FDC program is to create a means of monitoring and regulating quarters-based care that will be provided, formal program or not.

³²Much like the rest of the child care literature, the data on abuse incidence in day care is limited to centers. Finkelhor and Williams (1988) found that the rate of child sexual abuse in civilian centers to be 5.5/10,000; no estimate was available for family-based care.

in an old gym, some with more than one floor, where many rooms were not easily visible. Children are permitted to be on a second floor (which they are not in a CDC) and closets and storage rooms do not have to be windowed or locked.

Furthermore, children of widely different ages often share the same space, with only signage to demarcate age groups. Typical was a Youth Center that we visited where only the Teen Club was physically separated from the other programs. Programs serving 5- to 12-year-olds coexist side by side.

Flexibility of Care

The child care options available to military families—CDC, FDC, civilian centers, home care providers, and YA—vary substantially in the flexibility that they provide parents who may have long or unpredictable duty hours. As shown in Table 3.1, we view on-base family day care as the most flexible type of care, whereas center-based care, whether provided on the installation or off-base, provides the least flexibility. These assessments are based on two factors: the closeness of the caregiver to the military environment, and whether or not the care is institutional. Respondents generally believe that caregivers who are themselves military family members are more sympathetic to the often unpredictable demands of military duty, and thus may be more inclined to cover for a parent who must remain in the field or work long hours. Care that is provided in non-institutional settings is by its nature more flexible. Institutions must set policies surrounding hours of opening and closing. Despite long hours of availability, child development centers cannot hope to serve all parents' child care needs all the time, and in fact do not do so. In addition, on a few installa-

Table 3.1
Kinds of Care

Parental Preference	Care Type	Flexibility
1	On-base child development center (CDC)	4
2	On-base family day care (FDC)	1
3	Off-base military family day care	2
4	Off-base civilian child care center	5
5	Off-base civilian family day care	3

tions, limits on the number of hours each day that a child may be in care have been set by the commander in the interests of the child.

If readiness were the primary or only goal of military child care, one would expect to see the child development center used primarily by those whose duty hours are stable or who have a spouse or other resource person who can cover when duty hours are long or unpredictable, whereas FDC would be strongly favored by single parents, dual military families, or those who for other reasons need substantial flexibility in their child care arrangement. Such a sorting out by need was envisioned by the Chief of MWR on an Air Force base to whom we spoke, who pointed out that the CDC and FDC programs complement each other, because FDC homes generally will care for children whose parents are away on duty around the clock, while the center does not.³³ Heavy use of the CDCs, in her view, speaks to the goals of child care: “if the main goal of child care was readiness, parents shouldn’t use the CDC anyway, but the FDC.”

But we found instead a heavy reliance on child development centers, which provide the least flexible care on the installation. One reason for their predominance has to do with parental preference. As shown in Table 3.1, most parents to whom we spoke ranked the child development center as far and away their first choice for child care. A recent parent survey conducted by Child Development Services staff in the Army’s Training and Doctrine Command (TRADOC) supports our findings. Army center-based care received the highest preference ratings on each of the three installations for which data were reported.

In the view of one CDS director, parents often prefer the center because it is familiar. “They [parents] immediately think of the center first because they know the most about it,” she said. “We do try to educate them as they come through to understand that the center may not be the best place for them.” In her view, it is critical to get single parents and dual military parents into FDC if their Military Occupational Specialty (MOS) involves a lot of deployment. This way, the FDC provider can simply keep the child longer during deployments, resulting in greater continuity of care. She indicated that such arguments by CDC staff are usually well received by parents. A long waiting list on her installation makes the message more palat-

³³CDC hours are set at the discretion of the commander, so the CDC could be open longer if the commander so chose. However, limited use during extended hours has led commanders to conclude that extended CDC hours are not justified under normal circumstances, given high hourly costs to keep the CDC open.

able as well. As a corollary to this approach, the same director feels strongly that FDC providers must be willing to care for children nights and weekends when parents deploy.

During our installation visits, we heard of many instances in which the inflexible hours at the CDC had created difficulties for parents and in some cases for whole units. A single mother, for example, had had to work late to repair a plane scheduled for an imminent flight. When the number of hours that her children were permitted to remain in the CDC that day had elapsed, the mother had to leave her work and head for the center.³⁴ Once the children were picked up, she brought them back to the runway, where they played in a van under the supervision of a sitter. While this mother went to the center and retrieved her children, the repair and flight crews were unable to work. In another instance, a remote desert installation was gearing up to go on summer hours, which meant that all activities would commence an hour earlier. The CDC switched to summer hours at the same time as the rest of the installation made the transition, so that care continued to be available during regular working hours. However, one unit commander decided to go to summer hours two weeks earlier than the rest of the installation. Parents in this unit had to make arrangements for one hour's care in the early morning. A dual military couple assigned to this unit was unable to find such care; they alternated reporting to work an hour late each day for those two weeks.

CDC staff generally felt that there was little they could do about child care gaps, since they were already open for as long as 12 hours daily. CDC directors in many sites talked about efforts over the years to provide care for those single parents and parents with long or irregular hours by keeping the center open late or opening it especially early. In virtually every case, they found that such efforts were very costly and served only a few children at any one time. Consequently, these efforts were eliminated. Some worried, in fact, that children were spending too many hours at the CDC. Only rarely had anyone thought beyond extended center hours as a response to inevitable gaps in care.³⁵

Inflexibility does not pertain exclusively to hours. Sick child policies and the administration of medication to recovering children cause

³⁴Some CDCs limit the number of hours a given child may be cared for in a given day, whereas others do not. This policy is at the discretion of the commander.

³⁵The Army's Supplemental Programs and Services (SPS) program is designed to help fill gaps in care, but on the Army installations that we visited, we did not find SPS being used to accomplish this goal.

particular difficulty for parents. We were told of numerous instances in which strict sick child policies caused parents to lose duty time. A registered nurse who worked in the on-base hospital complained bitterly of the CDC policy that required parents to get physician approval before a child with a temperature of 99 degrees would be allowed to return to the center. This policy not only involved considerable amounts of time taken from duty, it burdened the base's health care delivery system.

Policies on medication vary by service; the Army and Air Force permit some staff members with Surgeon General's training to administer medication because child care is a mission issue; forcing parents to come in and administer medication would interfere with the mission. Policies that prohibit staff from administering medication in other services are predicated on liability concerns. A CDS director on a Naval base noted that the exclusion of sick children and the inability of staff to administer medication create "frequent problems" for parents who have to get to work.

Such problems were readily acknowledged by the service child care managers, and some change has occurred. The Navy, for example, has somewhat reluctantly altered its policy about the administration of medication: such administration is not advised, but it is no longer prohibited.

Most parents whom we interviewed had no plan at all for times when the usual provider could not be used. Indeed, a good deal of time was spent in our interviews talking with parents about care for sick children or care when their normal provider was unavailable. Typically, parents jointly assume the burden for such care. In some families, the employed civilian spouse first uses up available paid leave, since, as a Family Services director noted, "the military structure is intimidating," and active duty parents are reluctant to ask for time off to care for a sick child. A civilian parent told us that at first she had cared for the children while they were ill. But she had used up all her leave doing so, and hesitated to request more time off when a child recently became sick lest her performance rating suffer. Her active duty husband agreed to care for the child. To do so, he had to get approval from three separate levels of authority, and felt so embarrassed and angry when his commitment to the service and his veracity were questioned, and the reasons why his wife could not do it were elicited, that she doubted he would ever ask again.

Other parents reported a different approach. In these families, the active duty spouse was the favored sick child caretaker, because time off for this reason did not count against annual leave, whereas the

civilian worker would have been docked. The implications of these arrangements for unit readiness are striking.

Interestingly, command respondents rarely had thought about care for sick children. In many cases, CDS staff had paid little attention to this issue either. In fact, on one installation, the CDS director told us that when a child seemed unwell, staff called the parents, who, almost without exception, came quickly to pick the child up. She remembered during our discussion that at one time, the base hospital provided care for mildly ill children, but did not know if that program was still available.

The inconsistency between the notion of child care as a means of increasing readiness and the lack of attention to such issues as sick child care was striking. A garrison commander explained his lack of attention: most married soldiers have spouses who are presumed to be available in emergencies. Single parents are supposed to have a plan for emergencies known to the command. But, he acknowledged, "There has been no full court press regarding these plans."³⁶ Those few command respondents who had thought at all about sick child care assumed that parents just took care of it, which they in fact did, although at some cost to their own careers and to the efficiency of their units. In response to our questions about care for sick children, an Air Force Colonel recited his motto: "no one is irreplaceable," which negated such concerns. Those who had thought more about the issue were divided. Some believed that caring for their own children when they were sick or finding providers to do so was simply one of the burdens of parenthood, and one which parents, and not the military, should assume. A few argued, however, that the military can and should be actively involved in helping parents plan for inevitable gaps in child care, out of concern for readiness.

EXCESS DEMAND

Everywhere we went, excess demand was a major topic of discussion, and on many installations, excess demand was perceived to be the most pressing and important child care issue. Typically, the CDCs were filled to capacity and had long waiting lists; indeed, long waiting lists were part of the impetus behind the MCCA. Many parents would never succeed in getting their child into the CDC. The issue of excess demand includes four components—definitional issues, deci-

³⁶Child care plans have become a salient issue of late because of the massive troop deployments to the Persian Gulf during Operations Desert Shield and Desert Storm.

sionmaking, methods of demand assessment, and ways to better meet demand—each of which is discussed below.

Defining Excess Demand

To better understand why long waiting lists exist and what they mean, it is important to understand the economic concepts of demand and supply, because they provide considerable insight into this issue. The following paragraphs bring to bear economic information and theory to summarize these concepts; see Appendix B for more detailed discussion.

Basically, child care is provided by people who earn wages providing it. These wages are paid out of parents' earnings. If the price charged for child care is high, more providers will offer it because it represents an opportunity for them to earn good wages. But fewer parents will buy it, since high child care costs taken out of their often low wages will result in low net wages, or even negative net wages. Women in this situation will drop out of the labor market and no longer demand child care.³⁷

If the price charged for child care is low, many parents will want to buy it, because they will be able to keep a larger share of their earnings. In a competitive market in which prices are allowed to fluctuate, a condition of excess demand will not remain for very long because parents seeking care will bid up the price and more providers will be willing to work at the higher wage rate. With subsidization of some slots, however, excess demand will never be eliminated, as discussed below.

Subsidized Child Care. When subsidies are available, caregivers are willing to provide care at a lower price, since the subsidy makes up the difference. The demand for care, however, will increase because the price consumers have to pay declines. If subsidies are provided only to a limited number of slots, these slots will become relatively more attractive than unsubsidized, more expensive, or lower quality slots. The result is excess demand for the subsidized child care slots that must be rationed in some way. Typically, in the child care sector this happens through the creation of waiting lists. Long waiting lists for subsidized care, however, do not indicate that there is an overall shortage of child care. They merely indicate that the demand for subsidized child care exceeds the supply of subsidized child care slots at the subsidized price.

³⁷They may still demand preschool care, however, as discussed below.

Although there is excess demand for subsidized child care spaces, it cannot be assumed that the children on these waiting lists are without child care, since parents using nonsubsidized care are likely to go on the waiting list for subsidized care should it become available. The length of the waiting list is also not a reliable indicator of the amount of excess demand when children can be signed up for more than one subsidized child care slot. Furthermore, some parents may not place their child(ren) on the waiting list if they perceive that the chance of getting subsidized care is very low. If they believe that they could not obtain a job that would make it worth their while to work given unsubsidized child care costs, they might not work and might not go on a waiting list for subsidized care.

Waiting Lists: What Do They Mean? Other forces in addition to excess demand for subsidized child care contribute to long and growing waiting lists for military child care:

- There may be few care alternatives available, particularly in remote areas or overseas.
- The labor force participation rates of married women have been increasing dramatically as a result of the declining standard of living for single-earner families.
- Recognition has increased among the general population of the developmental benefit of day care centers and preschools for children aged three and above, even when such care is not required because of parental employment outside the home.

In remote areas and overseas, there are few care alternatives available to the military spouses who wish to work. As a result, long waiting lists are likely to include a much larger percentage of families without any care than in areas with plenty of unsubsidized child care.

Because the standard of living for single-earner families has been falling during the last two decades, increasing numbers of married mothers with young children have been drawn into the labor force (Leibowitz and Waite, 1988). The net benefit to a family of a mother's labor force participation is a direct function of the cost of child care. If the cost of child care is too high, it will not pay for the mother to work.

Although there is little evidence about the frequency with which mothers in the military choose not to work because of child care costs, evidence from the civilian sector indicates that 20 to 25 percent of

mothers with preschool-age children choose not to work for this reason (Presser and Baldwin, 1980; Mason, 1987). These studies also show that the group most constrained by high child care cost are those in most need of employment income: the young, the poor, and the poorly educated. This is not surprising given that poor families spend 21–25 percent of their income on child care expenses, whereas nonpoor families spend only 8 percent of their income on child care (U.S. Department of Labor, 1988).

Military families are likely to experience these constraints as well. But without further study of the characteristics of the waiting list population, it is not possible to determine what proportion of the list consists of families who are constrained in their work by the lack of subsidized child care.

Finally, there has been increasing recognition of the developmental benefit of day care centers and preschools for children aged three and older (Ruopp et al., 1979; Philips, 1987). The result has been increased demand for part-day preschool programs. Given the subsidy available for such programs in the CDCs, it is not surprising that the waiting lists for such programs have grown. In areas where the quality of preschool programs is below that of the CDCs, the waiting list is likely to be even longer.

Because of the way waiting lists are currently managed and demand is assessed, it is impossible to determine what fraction of those on waiting lists have acceptable care but want a cheaper alternative, what fraction have care that is unacceptable in terms of quality, and what fraction are currently not working because of the inability to obtain subsidized care, as discussed above.³⁸

It is important to understand that subsidized care to a limited number of child care slots will always result in excess demand and waiting lists. The excess demand for subsidized child care can only be eliminated by providing enough slots for all military dependents whose parents want it. The extent to which the waiting lists consist of parents for whom excess demand results in a constraint on their labor force participation cannot be determined without an in-depth study of the relationship between child care costs and the labor supply of spouses in the military.

³⁸The Air Force has developed a data collection form that should help to sort out these groups of waiting list parents.

Decisionmaking

Excess demand for child care creates difficult choices for installation commanders. Many of these choices are political, involving the allocation of limited resources, the satisfaction of multiple constituencies with different needs, and the resolution of the place of child care on military installations.

Excess demand has led to pressure nearly everywhere to construct new facilities. However, the decision to request military construction (MILCON) funds for a new child development center is rarely an easy one. In many places, the commander had been told that only two or three MILCON projects would be funded: the decision to request funds for a child development center often meant that other needed projects, such as a supply depot, could not be built.

Moreover, requesting the construction of a child care center in lieu of a supply depot raised difficult questions about the role and importance of child care to military operations. On some installations, such decisions resurfaced issues of equity. In one sense, some argued, a new center would increase equity, by making child care available to more families. Others viewed a new CDC as reducing equity, by putting the needs of a relatively few families ahead of mission-related construction or ahead of programs serving far more people.

Requesting a new center has also been constrained of late by the requirements of the MCCA. Under this legislation, each child in care essentially increases the appropriated funds that must be devoted to child care, since parent fees must be matched dollar for dollar with appropriated funds. Because most commanders had received no additional funds to support new MCCA requirements, they were having difficulty projecting how they would meet the MCCA match requirement with current resources. The idea of increasing capacity and thus required appropriated funds allocations was rather unappealing.

At the same time, capacity in many centers has been reduced because of the lower child-to-caregiver ratios specified in the DoD Instruction. A number of respondents told us that in their view, two of the major goals of the MCCA, to improve quality and increase capacity, appear to be mutually exclusive. Reduced capacity compels efforts to increase the number of slots, while the required match in the face of the lack of appropriated funds under the MCCA limits incentives to provide more care, at least through CDCs.

The decision about whether to allocate finite construction funds to building a new CDC typically raises questions about the role and viability of FDC as well. There was general consensus that a faster and

cheaper means of increasing capacity was to expand the FDC program. Indeed, the ability to rapidly increase child care capacity through FDC was often described by members of the command as one of the FDC's major advantages.³⁹

But there were a substantial number of command staff who took a completely different view of FDC. These respondents noted that although FDC expansion did not require new construction, FDC represented a money drain, because it generated no funds for the installation while forcing the installation to pay for the required FDC home coordinator(s). In contrast, at least before the MCCA, each new CDC slot carried the possibility (and in some locations, the reality) that money would actually be generated. In making this assertion, none of our respondents "figured in" the substantial subsidies surrounding the construction and operations of the CDC. Whereas it is certainly true that the government does not benefit monetarily from creating FDC slots, calculating the true cost of each CDC slot may show a deficit there as well, and potentially a much larger one than is created by opening another FDC home. Cost-benefit analyses of the relative cost of different child care options would help military policymakers to make more informed decisions about the best ways to increase the supply of child care for military families.

CDC construction requests in most instances also raised questions about what child care is—a service, a benefit, or an entitlement—and how much child care needs to be provided. In some locations, local markets made these questions easy to answer. For example, in an urban location in an expensive area, it was clear that most personnel could not afford to pay civilian child care fees. Consequently, there appeared to be considerable consensus about the need to provide additional child care on the installation. Similarly, in the isolated locations we visited, respondents generally agreed that child care sufficient to meet a large percentage of the need had to be provided on the installation, as civilian care was simply inaccessible to the large numbers of families living in military housing. In contrast, on an installation on which on-base housing was severely limited, the expansion of child care on-base was the subject of considerable debate.

Decisions to request new construction may risk additional problems. We heard several times about an installation on which a new center had been requested and built, based on a very large waiting list.

³⁹The new DoD Instruction will clarify the role of FDC by requiring a specified level of FDC involvement before MILCON funds for a new CDC can be requested. This specification is designed to curb the tendency to prefer CDC to FDC care.

When the center failed to fill immediately after it opened, it created a "very embarrassing" situation for the commander and CDS staff, according to a CDS director on an installation that we visited.

Part of the problem in this case, and in other similar ones, is the lack of awareness that we encountered about new supply. Civilian experience has demonstrated that new child care centers almost never fill immediately, even when need and demand are great (Burud, Aschbacher, and McCroskey, 1984). In many cases, parents have had to find alternative care. That care frequently is satisfactory enough that parents decide not to subject their children to the stress of changing providers. In others, contracts have been signed that can be broken quickly only at considerable cost. Civilian experience shows that there are several times over the course of a year when parents are more able to make a rapid commitment to a new center. Typically, these times are at the beginning of the school year and the beginning of the calendar year. More awareness of the ways and the time frame in which new centers fill might enable centers to open at more propitious times, or would at least provide commanding officers and CDS staff with ammunition against charges of overbuilding.

Methods of Demand Assessment

Commander concerns about overstating need and winding up with empty child development centers are fueled by the imprecise ways in which demand is measured. Virtually everywhere, waiting lists are used to index demand. Although respondents are aware of their limitations, they perceive no readily available alternative.

We found substantial variation in the ways in which waiting lists are developed, maintained, and monitored across installations. On some installations, the list is maintained with little or no oversight. Parents sign up and wait until they are called. Typically, if they are unable or do not wish to take an available slot they are either dropped from the list or reassigned to the bottom. Usually, parents who are offered slots are given two weeks to move their child into the placement or begin paying for full-time care, whether or not they are ready to use the slot at that time.

In contrast, we visited installations on which the waiting list was maintained by one or more full-time equivalents. In these locations, parents were called as often as monthly to confirm their continuing interest in a child care slot. In other locations, parents were sent interest cards they had to return by a certain date to remain on the list. In some cases, the steps required to remain on the waiting list were

unclear to parents. In several instances, parents had been dropped from the list because of failure to follow procedures that they had not understood. In other places, formal procedures for maintenance of the list were not always followed.

Sometimes, parents are charged a nominal fee (\$2-\$4) to get on the list; in a few instances, these fees are paid on an annual basis; payment entitles the family to use hourly care. When such fees are assessed, they apply to parents of all ranks.

Because of servicewide priorities assigned to certain family types, for example, single parents, waiting lists may be governed by fairly elaborate category systems that keep people in the proper place relative to the total population of care-seekers and to the others in their subgroup. For example, if a single parent applies for care in an Army CDC, he or she is assigned to the "A" category and goes to the bottom of the "A" group, which is restricted to other single parents. Some installations add their own rules, such as parents already receiving care through FDC receive lower priority than those with no available care, or no available military care, but such rules are infrequent.

On some installations, separate lists are maintained for FDC and for the CDC. On others, a policy decision had been made that the installation would be responsible for helping parents to find military child care, but that no distinction would be made between the CDC and FDC programs. A preference for one or the other might be accommodated, but the waiting list was not designed to do so. On one installation, the waiting list was exclusively for the CDC. A file box of FDC providers was made available for seekers of FDC. In some locations with multiple CDCs, one central waiting list was kept; on other installations with multiple CDCs, parents had to put themselves on multiple lists.

These variations in the way in which waiting lists are established and maintained make the counts of people on these lists extremely untrustworthy. When there is no cost to remaining on a list, parents may choose to stay on indefinitely, artificially inflating demand. When parents perceive little likelihood that they will ever be accommodated, demand may be artificially deflated.⁴⁰ Everyone was aware that planning and resource allocation decisions could not depend on waiting list data, but with few or no other indicators, they essentially did.

⁴⁰Moreover, the complexity and length of these lists make it difficult for families to reestablish their day care arrangements when they move.

A first step in understanding excess demand involves standardizing waiting list procedures and monitoring, so that waiting lists become comparable across installations. A second is to better predict demand. Recently, the Air Force devised a new, more precise means of assessing demand, which is presented on Form 3501. This approach involves the collection and combination of a number of demographic variables, for example, number of children 0–5 years whose parents are likely to use installation services, number of children of military couples, number of children with employed mothers, and number of civilian children to be served. This form is to be used by all bases to collect and combine data in a consistent way. The Air Force hopes to use the data from Form 3501 in refining demand studies by testing the predictions of the model underlying the form against CDS enrollments and waiting lists.

A draft of a DoD report entitled “Determining the 5-Year Demand for Child Care Services Within the Department of Defense,” which was mandated under the MCCA, presents a set of procedures for identifying child care need. These procedures include the collection of data on the number and categories of personnel assigned to the installation and on the number of children by age and family status, and the manipulation of these data in a formula to determine “total potential need.” Subjective factors unique to each installation are also considered. Once the services comment on the report and revisions are made, each service is expected to implement the procedures and to provide guidance on where the installation-level information required can be found: an installation report for meeting child care demand is the ultimate product. Both of these efforts are laudable for their attempts to standardize the assessment of demand; empirical validation of the formulas is a critical next step.

Ways to Better Meet Demand

Despite their limitations, long waiting lists in many locations suggest a fairly high level of excess demand for child care. We found almost everywhere that this demand is being addressed through the expansion of FDC.⁴¹

As noted above, support for the establishment and expansion of FDC programs is at best mixed, with considerable concern expressed for the safety of children and the acceptability of this kind of care to most parents. In most instances, command support has been offered when

⁴¹As noted above, the preferred response is a new CDC. But even when funding for one is approved, it is sometimes several years before the new center opens.

it has become clear that construction of a new center would not occur in the near future, and that the demand must be met in some way. Service directives promoting increased FDC expansion, some of which make construction approval contingent on a certain level of FDC, facilitated this support.⁴²

The emphasis on FDC to regulate demand helps to explain the widespread failure to better link FDC into the CDS system. On several installations that we visited, respondents understood that FDC existed solely to supplement the center, and that its continuing existence depended upon excess demand. Should waiting lists disappear, numerous respondents told us, the first thing that they would do is close FDC to new providers. Others indicated that they would act to close down existing FDC homes as well. Indeed, on one installation, FDC had been closed down when the new center opened, out of concern that the center would not fill rapidly enough. At the time of our visit, some time after the center's opening, a substantial waiting list existed, and FDC had been reestablished. Such actions, while understandable, contribute to preexisting perceptions of FDC as an unreliable source of child care.

Other responses to excess demand were notable for their absence. Some Army installations have been actively pursuing information and referral efforts through the third branch of its CDS program, Supplemental Programs and Services. These efforts generally involve development and monitoring of a list of child care providers in the local community. Usually, such lists include licensed FDC provided by military and nonmilitary families, as well as the names of civilian child care centers. Such lists include clear statements that the Army does not monitor these facilities and is not endorsing them. One Army installation had begun discussions with county policymakers about the possibility of the Army providing military spouses living in civilian housing with training and support. Such an arrangement would increase the supply of FDC to both military and civilian children who would be eligible to use the new homes.

Although several high-level policymakers in Washington advocated other approaches to meeting demand (e.g., support for parent child care cooperatives), we found no evidence of such efforts during our installation visits. CDS operations in most locations were limited to CDC and some FDC. The many parents who needed services but were unable to receive them through CDC or FDC were largely left to make do.

⁴²It is important to note that the amount of FDC in certain locations may be constrained because of high employment rates among potential FDC providers or because of limited or inappropriate base housing (e.g., mobile homes that cannot meet fire code requirements for FDC without expensive remodeling).

4. SECONDARY ANALYSES

As part of its work for the Arroyo Center, RAND undertook a study of family programs and readiness in the Army (Burnam et al., 1992). A Survey of Army Families was fielded in 1987 with the following goals: (1) to determine the effect of personal and family problems on Army duties (primarily readiness), (2) to evaluate the effects of Army practices (e.g., deployments and rotations) on individual and family well-being, (3) to systematically measure the need for, use of, and effectiveness of important services (including child care), and (4) to determine the relative magnitude of specific concerns and identify particularly affected subpopulations or locations.

Although the RAND Arroyo Center Survey of Army Families included previous reports from the child care programs (see Burnam et al., 1992), our analyses provide greater detail than was previously reported about issues that are particularly relevant to the present study. In this section we analyze those data to address the following questions:

1. To what extent is time lost from duty a problem for families with children? Does this vary by type of child care arrangement or by the employment status of the spouse?
2. Which subgroups lose the most time to duty?
3. Do CDCs and FDC appear to meet all the child care needs of the families that they serve?

SURVEY MEASURES

Child Care Arrangements. We analyze the child care arrangements of the respondents' youngest (or only) preschool-aged child¹ by defining the "modal child care arrangement" as the type of child care relied upon the most hours during the week by each respondent. We created six child care categories: (1) Army Child Development Center (CDC); (2) civilian day care center, preschool, or kindergarten; (3)

¹The Survey of Army Families obtained child care data only for the youngest or the sole child in each study age group. We selected data for only the youngest child in families with more than one child.

Army Family Child Care (FDC);² (4) care by a nonrelative (including babysitters, friends, and neighbors); (5) care by a relative (including spouse, siblings, or self care); and (6) no care. We classify someone as having child care if the respondent reported using at least six hours of care per week.³ As a result, the group referred to as having no care includes those respondents who reported five or fewer hours of care per week. We assumed that parents using fewer than six hours per week are not regular users of child care (e.g., they use child care only periodically).

If parents reported using more than one type of care for equal amounts of time each week, they were assigned to the category representing the most formal type of care. For example, if a parent reported using Army CDC and a nonrelative sitter for 20 hours per week each, the modal type of child care arrangement for that family was classified as Army CDC.

Spouse Employment Status. We analyze spouse's employment status by distinguishing families in which the military parent was: (1) single, (2) married to a nonworking spouse, or (3) married to a spouse who was currently in the labor force.⁴

Problems with Child Care and Children. We assess the extent of time lost from duty by determining the number of days of absence for child care reasons in the past year, excluding leave (vacation) time. The total amount of time lost to duty was derived by summing responses to two questions concerning the amount of time lost due to: (1) caring for child(ren) on a daily basis (e.g., supervision, discipline), and (2) other child care concerns (e.g., the child is sick, a visit to the school).⁵ The period of recall in the survey for these two questions

²As noted above, the Army calls its quarters-based program family child care (FCC), but for consistency with the rest of the report, we will continue to use FDC to describe this care.

³This criterion was selected so that children who attend part-day preschool programs are included. Children often enroll in these programs for two or three mornings or afternoons a week, for two- to three-hour sessions.

⁴Since only about 300 of the 3100 spouses surveyed are also in the military, and of those fewer than 250 have accompanying children, the numbers were too small to conduct separate analyses for dual military families.

⁵The two questions were:

In the past month, how much time did you take off from duty ("your job" for spouses) for the following FAMILY reasons? (Please count time when you arrived late or left early, but do NOT include leave time.)

- a. Caring for child(ren) on a daily basis (for example, supervision or discipline).
- b. Other care of child(ren) (for example, sick child or visit to school).

was a month. To obtain annual measures, we multiplied each value by 12.⁶

We examine the perceived adequacy of child care during military exercises by creating an indicator variable for soldiers according to whether they rated their child care arrangements during the most recent planned deployment or exercise of two or more weeks (if such a deployment had occurred in the previous year) as fair or poor, or would have been fair, poor, or impossible if they had been deployed for six months or more.

We created an indicator variable for classifying parents' overall rating of their child care arrangements. This variable takes on the value "1" if the parents reported their overall satisfaction with their child care arrangement as fair or poor, and "0" otherwise.

We also created an indicator of parental uncertainty concerning the Army's helpfulness with child care during prolonged separation. Based on the question "If a military conflict separated you from your family for six months or more, how sure are you that the Army would help your family with child care?" a 1 indicates that a soldier responded "somewhat unsure" or "completely unsure" to the question. This variable takes on the value of 0 for all other responses.

RESULTS

The results of our analyses are reported in Tables 4.1–4.5. These results are based on our sample of 1031 respondents with accompanying children aged 0–5 years at the time of the survey. Because of nonresponses to individual items, the sample size obtained for individual measures varies. The data are weighted to adjust for differences in response rates, oversampling of unique groups, and for underrepresentation of the universe of Army members and spouses. As a result of this weighting, the responses represent about 80 percent of the Army's 777,000 soldiers in 1987 with accompanying children aged 0–5 years. To the extent that this population has changed since the fielding of this survey (in 1987), the results may not be completely generalizable to this population today.

Table 4.1 contains information about the use of various types of child care. Several interesting results emerge. First, nearly 83 percent of

⁶There may be seasonal differences in time lost that make our transformation somewhat questionable.

Table 4.1
Distribution of Child Care
Combinations

Type of Child Care	Percent
< 6 hours weekly (N = 138)	17.4
Only one type of care (N = 294)	37.2
Two or more types of care (N = 358)	45.4
Army CDC, 1+ hours (N = 115)	17.6
1-5 hours	7.5
Only, 6+ hours	3.5
Plus other, 6+ hours	6.6
Modal care 6+ hours	8.0
Army FDC, 1+ hours (N = 45)	6.9
1-5 hours	2.0
Only, 6+ hours	1.1
Plus other, 6+ hours	3.8
Modal care 6+ hours	2.7
Civilian, 1+ hours (N = 74)	11.3
1-5 hours	0.9
Only, 6+ hours	3.4
Plus other, 6+ hours	7.0
Modal care 6+ hours	13.9
Nonrelative, 1+ hours (N = 452)	69.3
1-5 hours	30.7
Only, 6+ hours	16.7
Plus other, 6+ hours	21.9
Modal care 6+ hours	30.5
Relative, 1+ hours (N = 337)	51.8
1-5 hours	25.2
Only, 6+ hours	5.4
Plus other, 6+ hours	21.2
Modal care 6+ hours	14.8

NOTE: Sample is restricted to those reporting use of one or more hours of care weekly (N = 652).

all families with preschool-aged children rely on some kind of child care for at least six hours per week.

Second, a large percentage (45 percent) of families rely on more than one type of child care. Indeed, among families using child care for at least six hours per week, 55 percent ($45.4/(45.4 + 37.2)$) rely on more than one type of care, suggesting that the child care needs of most families cannot be filled by one type of care.

Third, whereas 17.6 percent of all Army families report some use of Army CDCs, only 3.5 percent rely on them exclusively. Furthermore,

only 8.0 percent use the CDC as their modal (i.e., most frequently used) type of care arrangement.

Fourth, whereas 6.9 percent of Army families report some use of FDC, only 1.1 percent rely on FDC exclusively. And only 2.7 percent use FDC as their modal care arrangement.

Fifth, a much lower percentage (less than 1 percent) of families use civilian day care centers for five or fewer hours of care per week than use Army CDC (7.5 percent). This is probably a reflection of the fact that most civilian child care centers do not offer hourly care. To the extent that some Army families need such care, the Army seems to be meeting at best some of that need.

Table 4.2 shows the distribution of modal type of care by spouse employment status. A greater proportion of single-parent families report relying on Army CDC as their modal child care arrangement, which is not surprising given the priority this group receives for CDC slots.⁷ Also noteworthy is the fact that civilian day care centers predominantly are used by families with working spouses. Finally, 33.5 percent of single-parent families report using less than six hours of

Table 4.2
Modal Type of Child Care by Spouse
Employment Status

Modal Type of Child Care	Spouse Employment Status			
	All	Single	Nonworking	Working
Army CDC	7.9	18.0	6.0	9.8
Civilian	7.3	3.8	4.3	13.0
Army FDC	2.7	7.4	0.5	5.9
Nonrelative	30.6	35.2	18.6	51.1
Relative	15.0	2.2	18.4	10.9
1-5 hours/no use	36.5	33.5	52.2	9.3
All	100.0	100.0	100.0	100.0

NOTE: The percentage of parents using each type of child care includes all parents, even those using no care and those using less than six hours weekly. The distribution is based on weighted estimates of a sample (N = 1031).

⁷Although the Army gives single-parent families priority for family-based care as well, parental preference for CDC care leads to greater exercise of the CDC priority.

child care per week. One explanation for these data may be that some children of single parents are not living with them.⁸

Table 4.3 displays findings from the various measures of problems resulting from child care or children as a function of the employment status of the spouse. Parents on average lose about three days per year from duty for child care reasons, not an insignificant amount of time when viewed from the perspective of an employer. Indeed, given the large number of families with young children in the military, a substantial number of work days are lost per year.⁹ Not surprisingly, single parents report a significantly higher number of days (eight) per year lost from duty for these reasons. This is more than 2-1/2

Table 4.3
Problems with Child Care or Children by
Spouse Employment Status

Type of Problem	Spouse Employment Status			
	All	Single	Nonworking	Working
Days lost from duty for child care reasons (N = 914)	3.1	8.0[a]	1.9[b]	4.5[b]
% reporting fair or poor child care during de- ployment (N = 289)	32.6	32.2	29.8	35.8
% rating child care ar- rangements fair or poor (N = 937)	12.2	13.6	12.2	12.0
% unsure Army would help (N = 988)	48.8	72.5[a]	43.1[b]	55.4[c]

NOTE: Row 1 entries are means. Cell entries for rows 2-4 are percentages. Entries significantly different from one another at the 5 percent level are denoted by unique letters [] in the same row.

⁸Numerous respondents told us that parents are disinclined to report this, as accompanying minors entitle parents to more generous living allowances. We were not able to estimate possible numbers.

⁹Comparable data from the civilian sector are not available. However, 7 percent of employed mothers in a 1987 Current Population Survey sample reported that they had lost time from work in the past month because of failed child care arrangements (U.S. Census Bureau, 1990). Over a year's time, this percentage would be substantially higher (Hayes et al., 1990).

times the overall average. Even in families in which the spouse does not work, the military member still reports losing duty time because of children.

Nearly one-third of all families report fair or poor child care during deployments of two or more weeks duration. There are no statistically significant differences across the groups, indicating that for a large proportion of all families, regardless of spouse employment status, child care during deployments presents a problem.

Approximately 12 percent of families rate their child care arrangement(s) as fair or poor. Although the proportion of single parents reporting fair or poor child care arrangements is higher than among families with either working or nonworking spouses, the difference is not statistically significant.¹⁰

Single parents are more likely than married parents to report being unsure about whether the Army would help with child care during a military conflict lasting six months or more. Overall, nearly 50 percent of all Army families were somewhat or completely unsure about whether the Army would help out in such a situation.

Table 4.4 shows child care ratings and problems as a function of the modal type of child care arrangement. It is interesting to note that the highest number of days lost to duty because of children and child care can be found among CDC users. The lowest number of days lost to duty are found among FDC users. This suggests that CDC care may be a less reliable source of care than FDC, even though the perception of many parents we interviewed in our site visits was to the contrary, as discussed in Section 3. The association between CDC care and more days lost is not surprising, given the more flexible nature of FDC, as discussed in Section 3. Moreover, these results are consistent with civilian data, as discussed below.

Similar patterns of responses are reported for the rating of both daily child care and child care during deployments. A significantly higher proportion of CDC users report fair or poor ratings than do FDC users. It is interesting that our site visits revealed that most parents strongly prefer the CDC, yet these data show that parents using FDC were less dissatisfied with their child care arrangements than were CDC users. This is, however, consistent with information from several FDC parents whom we interviewed who indicated that they

¹⁰The quality of care in both FDC homes and CDCs since this survey was fielded has been improved, so these results should be interpreted with caution.

Table 4.4
Problems with Child Care by Child Care Arrangements

Type of Problem with Child Care	Child Care Arrangement						
	All	CDC	Civilian	FDC	Non-relative	Relative	1-5
Days lost from duty for child care reasons (N = 922)	3.1	7.0[a]	3.1	1.4[b]	2.2[b]	4.3	2.7
% reporting fair or poor child care during deployment (N = 293)	32.8	45.4	24.7	23.2	34.8	44.1	25.6
% rating child care arrangements fair or poor (N = 942)	12.4	16.9[b]	10.4	3.1[a]	10.8[b]	16.1[b]	12.3[b]
% unsure Army would help (N = 998)	49.0	41.4[b]	47.7	44.5	57.0[a]	49.3	44.4[b]

NOTE: Row 1 entries are means. Cell entries for rows 2-4 are percentages. Entries significantly different from one another at the 5 percent level are denoted by unique letters.

had been opposed to FDC only until they actually tried it. Once they used FDC, they were very satisfied with it.

A few other results from Table 4.4 deserve mention. Parents using both CDC and FDC are less likely than the overall average to be unsure that the Army will help with child care during an extended military conflict. Each of these differences was significant.

Table 4.5 shows the reasons respondents offered for using civilian child care. Less than 25 percent of the families using civilian day care centers reported using such care because Army child care was unavailable to them either because it was full (and they were on a waiting list) or because it was not available for other reasons. A much larger proportion report using civilian care because of its characteristics (e.g., convenience of location, hours of care, or quality of care). It is interesting that a higher proportion identified location convenience as the reason for being in civilian day care than the proportion who chose it for its quality. This may mean either that parents care more about convenience of care than quality of care in gen-

Table 4.5
Reasons for Using Civilian Instead
of Army Child Care

Reason	N	%
Waiting to get into Army program	11	14.3
Army program needed is not available	7	9.1
Convenience of civilian service location	44	57.1
Convenience of civilian service hours	32	41.6
Quality of civilian service care	37	48.0
Cost of civilian service	22	28.6

NOTE: The total number of parents who used civilian care is 77. Respondents may have provided more than one reason.

eral (Johansen, 1990), or that quality of care in military settings is acceptable, whereas location presents a problem.¹¹

CONCLUSION

Results of our secondary data analyses using the Survey of Army Families fielded in 1987 by RAND raise several interesting points.

First, most families use some type of child care, and most families using child care rely on more than one type of child care to meet their child care needs. Furthermore, whereas a large number of families report some use of Army CDCs, a much smaller number use it as their only or even modal type of care. Clearly, CDCs were not meeting most families' child care needs. Second, a significant amount of time is lost from duty because of problems with children and child care by all families, but the most time is lost by parents with children in CDC, and the least by families using FDC. Third, although most parents seem to express a strong preference for CDCs, a higher proportion of CDC users than FDC users report fair or poor ratings of their child care arrangements. Finally, among parents using civilian day care centers, the proportion reporting use of such care because of the characteristics of that care is much greater than the proportion reporting that they use civilian care because Army CDC was not available to them.

¹¹Again, these results should be interpreted with care because of the changes that may have occurred in the military (and civilian) setting(s) since the Army family survey was fielded in 1987. Furthermore, these results are generalizable to the military at large only to the extent that the other military services are similar to the Army.

5. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

This study was undertaken to identify ways in which to improve the provision of child development services in the military. To better understand the Child Development Services (CDS) system, we visited military installations around the country and overseas, and interviewed a wide range of people involved with military child care. Our data revealed an ambitious system of employer-sponsored child care that is far more progressive than that provided by the vast majority of private employers. At the same time, we identified a number of areas in which improvements could be made that would benefit parents, children, and the military.

The principles underlying military service—that one's service responsibilities can, if necessary, take precedence over all other responsibilities, including parenting, and that service responsibilities may involve long hours and odd hours—create significant challenges to the provision of child care. Increasing numbers of working spouses, single parents, and dual military parents further complicate the task. As currently structured, the challenges in the delivery of military child care include tradeoffs between the construction of military facilities and child development centers, between child care for the few and recreational services for the many, between limiting center child care hours for the sake of breaking even and knowing that those hours sometimes do not allow parents to fulfill their military responsibilities.

The Child Development Services systems that have evolved reflect the contradictions inherent in these tradeoffs. Three areas stand out; we present them here, then make recommendations about each below.

- First, the goals of CDS are not clearly defined, and consequently remain multiple and often inconsistent. Moreover, the goals are often not expressed in practice.
- Second, once the goals have been more clearly specified, there needs to be a systematic way of determining the amount of child care that should or will be made available. Although there is considerable consensus that child care is not a benefit on the order of medical care, the amount that should be provided and the way that the level of services will be arrived at have not been determined.

Nor is it clear who should have first call on these services. A major factor that inhibits such efforts is the limited amount of data on the demand for child care and about the real costs of providing it. Currently, demand is generally assessed through waiting lists. But with widely varying policies and levels of monitoring, they are at best crude indicators of demand. With a few notable exceptions, efforts to improve demand assessment have yet to be made.

- Third, the degree to which the military will or should intervene to create a better integrated system of child development services that deals with current service gaps has not been addressed. The heavy reliance on CDCs promotes “fair weather” readiness, providing care to many children and freedom from worry and child care responsibilities to many parents, as long as children are not ill and their parents are not deployed or working especially long hours. Inconsistent regulation and beliefs surrounding the delivery of child care outside of CDCs complicate the potential for system integration, despite its promise for addressing readiness goals more adequately.

RECOMMENDATIONS

Based on our interviews and secondary analyses, we make a number of recommendations about ways to improve the management and delivery of child development services on military installations. Our recommendations are based on the perspective of military child care as employer-sponsored child care, which implies that child care programs must benefit the employer as well as enhance the welfare of the children who receive services.

The goals of military child care should be specified and efforts made to address these goals through CDS operations and priorities.

The goals of military child care are multiple and at times inconsistent. Our respondents described many goals, including readiness, family economic well-being, retention in the service, increased parental work efficiency, parental peace of mind, respite for parents, enrichment for children, and an enhanced image for the military that might translate into improved recruitment. The multiplicity of goals reflects different child care constituencies and the failure of policy-makers to clarify which groups and which needs it will satisfy. It is important to clarify the goals of the CDS system, and to act to ensure that the goals are expressed in practice. For example, if readiness is

a key priority, then priority for child care should reflect the readiness goal. Retired military, who do not contribute to current readiness, should be given a lower CDS priority than, for example, civilians in key jobs on the installation. Efforts to provide regular care in settings consistent with readiness, for example, directing single parents to FDC, should be made. A systemic approach to the provision of care, in which a key system goal is filling gaps in regular care, should be undertaken.

Efforts to reassess and monitor priorities should, to the extent possible, include specific goals for meeting child care needs. Such targets (e.g., serving all single and dual military parents) will provide a yardstick against which the CDS system can be evaluated. Without specific goals, it is impossible to evaluate how well the system is working; specific goals also make planning easier. The Navy has taken an important step in this regard by developing targets for the intensity of CDS. A recent document specifies that the Navy will endeavor to provide CDS to 100 percent of single-parent and dual military families and to 30 percent of other families.

The measurement of demand should be standardized and the cost per slot of care in CDCs and FDC determined.

The CDS system needs to improve both the way it measures demand and the way that costs are assessed and resources allocated. Fundamental to improved demand assessment is the need to understand more clearly the demand for child care and the meaning of ubiquitous waiting lists. As discussed above, waiting lists may include parents who cannot work because unsubsidized care is not available, families whose current care is suboptimal in terms of quality, and parents who prefer subsidized care because it is less expensive and perhaps more convenient. Respondents everywhere believed that nearly all parents found alternative child care when the CDC—parents' first choice in most instances—was unavailable.¹ They also believed that many of these parents could be found on CDC waiting lists, contributing to excess demand statistics. On a few installations, policy on this point had been established; often, it specified that the installation had an obligation to offer military child care to all families, but not their first choice. In most places, however, the issue remained unaddressed.

¹However, as discussed above, we know that some parents leave the labor force if nonsubsidized care is not available. Very long waiting lists may lead parents to believe that they will never receive subsidized care.

Standardize Waiting Lists. The first step toward a better understanding of waiting lists is to make all waiting lists uniform within each service, and preferably across services as well. Furthermore, procedures for keeping waiting lists should ensure to the extent possible that duplication is avoided. For example, central waiting lists should be kept within each local market. In areas with different installations close together or installations that house members from different services or multiple CDCs, there should be a centralized waiting list for everyone.

The waiting list application should elicit information about current child care arrangements and the reasons for seeking care in the CDC (or FDC). Demographic information about the parent(s) should also be obtained. Information on the waiting list should be updated at regular intervals so that it will be reliable for analysis.

Analyze Excess Demand. Streamlining waiting list procedures will provide additional information, but will not, as discussed above, suffice to estimate the excess demand that causes parents to leave the labor force or that results in child care arrangements of suboptimal quality. To assess these issues, it will be necessary to examine the relationship between child care costs, labor supply, and child care arrangements. A first step will be to examine the evidence from the civilian sector and determine the extent to which models of child care costs and labor supply might be applied to military data. The second step will be to build a model of the demand for military child care that could be used to predict the future demand for such care.

The Air Force and DoD have begun developing models to predict child care usage. These models need to be further developed and validated. A demand study, discussed below, should include such validation.

Improve Cost Estimates. Currently, CDCs receive substantial subsidization, and as a result charge fees that are lower than many of the (unsubsidized) FDC providers and the civilian day care centers in surrounding communities. This contributes to the strong parental preference for CDCs. Our data reveal that there is little understanding of the cost per slot to the government of providing care in different settings. Many respondents appear to overestimate the costs to the government of providing FDC while substantially undervaluing the costs associated with construction and maintenance of CDCs.

As long as these costs remain largely unknown, the DoD will have no empirical basis for reassessing resource allocation decisions within the CDS system. To allocate resources more efficiently, we recommend that a cost-effectiveness analysis of CDCs and FDC be under-

taken. To perform a cost-effectiveness analysis, however, it will be necessary to first assess the steps needed to improve FDC quality, so that the FDC can become a viable alternative to CDCs in the minds of parents. The cost of improving the quality of FDC would be included in the cost-effectiveness analysis.

A more systemic approach to the provision of child care should be considered.

CDS does not function as a system in most places. The bulk of administrative time and attention focuses on the CDC, a focus that has increased substantially since the passage of the MCCA. FDC receives minimal attention, and in most places, other services, such as information and referral, are limited, if they are available at all. Youth Activities is often administratively removed from CDS, despite the growing tendency for it to provide child care to young children, and it receives minimal oversight. Moreover, there are no system-level goals, such as helping parents find and use the most appropriate care setting, or helping parents fill inevitable gaps in care created by child illness or work demands. It seems worthwhile to explore the efficacy of a systems approach to child care in which CDS provides both a range of regular care options and backup options when normal care arrangements fail. Such an approach holds promise for promoting parent, child, and military goals.

Help Parents Find Alternative Care. Under current practice, attention focuses on each of the separate components of the system, leaving even high-ranking parents scrambling for care when the regular source of care cannot be used. Some monitoring of the need for and use of night and weekend care would help CDS staff to identify families that might be better served in FDC. A systems approach would encourage CDS staff to talk with such families and encourage or direct them to the care setting that is most likely to meet their needs.

The need to provide flexible care options should begin with an assessment of readiness losses resulting from inflexible care. Our analyses of the Survey of Army Families data revealed, for example, that parents lose more time from work for child care reasons when their children use the CDC than when they use FDC, despite widespread beliefs to the contrary.

Providing care when the regular provider cannot be used is especially important for those who rely on CDCs. There, the strict implementation of sick child policies and limited hours appear to create problems

for parents whose children are ill or who must work long hours or weekends. To facilitate the provision of such care, someone on each installation might be designated to help parents set up a backup system that could be quickly activated if such care is required or to arrange for care on short notice. A program through which on-call FDC providers make evening and weekend care easily and formally available might be another way to help parents and the military address readiness goals. Parents who learn of extra duty requirements could contact the CDS staff member responsible for such care to obtain the name of the FDC provider who will be on call at the time extra care is required. The parent could then fairly easily arrange for care and for the transition to it. Such a system would require children to change providers, particularly if their normal source of care is the CDC, but such children generally must make the transition at these times in any case.

A program similar to the Health Care Finder program developed by the Air Force might also be considered. This program obtains a medical appointment in a military facility or provides care-seekers the name of a civilian provider who has agreed to limit fees. This program is expanding at a rapid rate, despite liability concerns similar to those that exist for child care. Such a program for child care might help parents who have just arrived at a new installation to find regular care, and could also help parents who need extra care to find it. Although some cost would be involved in setting up such a program, reduced losses to readiness and greater use of non-CDC providers might compensate.

Provide More Flexible Care. Our interview data point to strict implementation of sick child exclusion policies in the CDCs as a major contributor to lost work time. We recommend that consideration be given to the revision of sick child exclusion policies along the lines of new guidelines recently issued by the American Academy of Pediatrics and the American Public Health Association (AAP/APHA, 1992). Based on evidence that the exclusion of children with mild illnesses may serve little preventive function, the new guidelines encourage children who are only mildly ill and feeling reasonably well to be allowed to continue in group care.²

Policies that do not permit CDC staff to administer medications to recovering children also appear to interfere with readiness. Whether or not they administer medications, caregivers should be aware of pos-

²D. Peabody, American Public Health Association, personal communication, June 6, 1991.

sible drug reactions to the small number of medications commonly prescribed. It is a small step then to permit designated caregivers to administer these medications, but one which would be of immense help to the military and to parents.

Examination of other approaches to providing employer-sponsored child care in situations that are similar to the military (e.g., irregular and long hours) would also be worthwhile. A number of civilian employers have established programs to serve the children of such employees. Analysis of these programs would shed light on new options that might provide more flexible care for military families.

Reexamine Organizational Location. The organizational placement of CDS deserves attention as well. Although there are arguments on both sides concerning the appropriateness of CDS being in MWR, it seems clear that placement under recreational services accords CDS no benefits but levies considerable costs. We recommend that CDS be removed from recreational services, and that its placement in MWR be reconsidered.

The DoD should consider increased integration of FDC into CDS with respect to provider training, provider income, and distribution of services.

FDC is clearly the poor stepchild of the current Child Development Services system, the nonpreferred alternative for parents and command alike. Yet FDC has the potential to provide care that generally is not provided in CDCs—weekend and late-night care, and care for infants and toddlers that is superior in terms of both physical health and cognitive and emotional development. Moving infant care to FDC, as has occurred on a few installations, would open CDCs to more children, as child-to-staff ratios for older children are higher. This would serve the important system goal of better meeting demand for child care.

For FDC to reach its potential and better address CDS system goals, a number of actions should be considered:

1. *Strengthening FDC Provider Training and Oversight.* FDC providers currently are subject to varying training requirements across installations. If they received the same training everywhere and that training was the equivalent of the training required of CDC caregivers, a major disincentive would be removed to becoming and remaining a FDC provider: the need to undergo retraining at each new location. Moreover, providing FDC providers the same training

as CDC caregivers receive conceivably could lead to improvements in both perceived and real quality of FDC.

2. *Marketing FDC.* An assessment of parent and command concerns about FDC, to be followed by efforts to address these concerns, might be a first step in attempting to make FDC more attractive to both parents and command, thus reducing unmet demand for CDC care. Data that show reduced illness and improved cognitive and emotional development in infants in FDC (e.g., Johansen et al., 1988; Anderson et al., 1988) could be presented to parents with an infant or toddler who apply for a slot in a CDC. This information might help them make more informed decisions about the type of care they wished to buy. Data which show fewer days lost to work for parents of children in FDCs could also be provided to parents and the command. A detailed study of the cost-effectiveness of FDC and CDCs would help to clarify advantages and disadvantages of CDC and FDC care. Such a study would also have to consider what quality improvements would have to be made to bring the quality of FDC care up to the level provided by the CDC, and the cost of such improvements. Such a study would help in future resource allocation decisions, and, if FDCs prove to be more cost-effective, would provide additional arguments for integrating FDC into the CDS system.

3. *Subsidizing FDC.* Consideration should be given to using the authority to subsidize FDC granted in the MCCA to achieve military, parental, and child goals. Currently, unsubsidized FDC appears to result either in high fees that drive parents to CDCs and inflate waiting lists with families already receiving FDC, or in FDC providers subsidizing parents by charging low fees, which creates a disincentive to provide that care.

Subsidies might allow some FDC providers who currently charge close to market rates to charge less for care, which could help to reduce demand for CDC care and encourage use of FDC. At the same time, subsidies might enable providers to earn enough that they would be motivated to enter and remain involved with the program, reducing the FDC provider supply problems that we encountered on some installations.

Selective subsidies that further military and child goals should be particularly explored. Since infant and toddler care is the most expensive care to provide in CDCs, and since infants and toddlers benefit more from FDC than CDC care, subsidization of FDC providers who provide infant care would be an appropriate policy to consider. Selective subsidization might open more infant slots in FDC, which

would allow CDCs to focus on children three and older, who have been found to benefit most from group care.

4. *Reducing Provider Disincentives.* The disincentives to provide care through FDC are many and varied, including low wages, high start-up costs, retraining at each move, long work hours, and limited or no backup support. To improve FDC quality and supply, consideration should be given to ways that the DoD might reduce or remove each of these disincentives.

CDS-issued equipment, elimination of retraining requirements at each move, and formal procedures for ensuring that FDC providers can call on reliable backup care might help to increase the appeal of FDC substantially, and would thereby increase both quality and supply. Improved compensation for FDC caregivers might also increase its appeal to potential providers. Although the DoD has chosen to remain uninvolved in FDC compensation, it might be worthwhile to revisit this policy.

5. *Targeting of Child Development Services.* Greater integration of the CDS system might well include efforts to help parents not only find care, but find care that best meets their needs, their child's needs, and the military's needs. FDC appears on the face of it better equipped than CDCs to handle irregular or long hours, or care for slightly ill children. Numerous respondents freely identified CDC families who they felt should be using FDC, either because it was a single-parent family, both military parents had a Military Occupational Specialty (MOS) that required a good deal of time away, or for other reasons. But few felt comfortable directing or even suggesting that the family receive care from an FDC provider. Given the emphasis on CDC and, in some cases, the priority accorded single parents for CDC care, a policy that promotes the matching of families with the most appropriate care setting should be considered. If such matching proves to be acceptable and effective, it would help the CDS system to better meet readiness goals and provide children more consistent care.³

Additional FDC oversight might also help to allay command and parent concerns about FDC quality and improve the quality of care itself. These training and oversight provisions could then be included in a greatly expanded section on FDC in the governing DoD Instruction.

³A model for such an integrated approach may be found in the military health care system's "coordinated care" structure.

A systematic assessment of Youth Activities and its increasing involvement in the provision of care to young children should be initiated immediately.

Youth Activities provides child care to growing numbers of young children, and does so with little regulation or oversight. In the YA programs that we visited there were no required child-to-staff ratios. Safety regulations that have required many CDCs to undertake costly remodeling projects do not apply. Whereas CDC caregivers were tackling new training curricula developed in response to the pay banding component of the MCCA, training for YA staff was minimal at best.

This limited regulation becomes more problematic as younger children are served by YA, and YA's mission consequently shifts from exclusive provision of recreational services to the provision of child care.

An assessment of YA should include an examination of the involvement of Youth Activities in providing child care as opposed to youth activities, and the implications of this new mission for staff qualifications, age integration, and the need for regulation. If it is determined that YA should provide before and after school care, it is imperative that new health and safety regulations be implemented and funds committed. If not, then measures to discourage parental use of YA as child care for young children should be identified and implemented. Continued lack of regulation of child care to young children simply because YA provides it cannot be countenanced. Integration of YA into a revitalized CDS system should also be discussed.

Administrators should be educated about child care quality.

Overestimates of CDC quality were common in our visits, and resulted at least in part from lack of experience with a range of child care settings, particularly exemplary ones. Education of command and child development staff about what constitutes quality would address this problem and perhaps increase motivation to improve the quality of care. Such education could occur by visits to "model" settings (CDCs and FDCs) and through briefings, perhaps at commander conferences. The Demonstration Program for Accredited Centers mandated as part of the MCCA holds promise as a means of identifying program models that appear to be effective in fostering child development.

Appendix A

THE MILITARY CHILD CARE ACT OF 1989

The Military Child Care Act of 1989 (MCCA) was passed by both the House and Senate in November 1989. The goal of MCCA was to improve the availability, management, quality, and safety of child care provided on military installations. Its major components include:

- *An increase in the military's mandated contribution to the operation of Child Development Services (CDS), to a 50 percent match between appropriated funds and parent fees¹*

This provision increases funds for some services but not for others. Priority for use of these funds should go to increasing the number of child care employees who provide direct care to children and to expanding the availability of child care. Other uses of funds are unlikely since that would require special approval from the Secretary of Defense.

- *The development of training materials and training requirements for child care staff*

Centers must designate an employee responsible for the delivery of the training and oversight of employee performance. This provision appears to address widespread Congressional concern over the quality of child care programs.

- *A pay increase for child care employees directly involved in providing care*

This provision compensates CDC caregivers at rates equivalent to that of other employees with comparable training, seniority, and experience on the same military installation.

- *Employment preference for military spouses*

Military spouses are given priority for hiring, or promotion within, the position of child care employee.

¹The match applied only to FY 1990, but has been continued under DoD policy.

- *The addition of child care positions*

Competitive service positions (3700) are to be made available in the DoD for child care personnel. These positions may be filled by employees involved in training and curriculum development, child care administrators, supplemental care administrators, Child Development Center (CDC) directors, or family day care coordinators.

- *Uniform parent fees based on family income*

This change addresses concerns about affordability of child care by lower-ranked military personnel.

- *Expanded child abuse prevention and safety*

The MCCA directs the Secretary of Defense to establish and maintain a special task force to respond to child abuse allegations, and to establish and maintain a national child abuse and safety hotline that accepts anonymous calls. The legislation calls for four unannounced annual inspections with needed remedies to be made within 90 days, unless this requirement is waived by the Secretary.

- *Parent partnerships with CDCs*

A board of parents at each military CDC is to be established at each center. Parent participation in the centers' programs is encouraged with reduced fees.

- *Report on five-year demand for child care*

The law instructs the Secretary of Defense to issue a report on the five-year demand for child care six months after passage. The report should include a plan for meeting demand and a description of methods for monitoring family day care providers.

- *Subsidies for family home day care*

Appropriated funds may be used to provide assistance to family day care providers as a means of providing these services at the same cost as CDC care.

- *Early childhood education demonstration program*

Fifteen percent (about 50) of the military child development centers are to be accredited by "an appropriate national early childhood accrediting body." These centers will be designated as early childhood education programs and will serve as models for CDCs and family home day care. The law also specifies that an independent body evaluate the effects of the accreditation on children's development.

Appendix B

EXCESS DEMAND

As a starting point in understanding excess demand, we begin with the traditional supply and demand model, illustrated in Fig. B.1.¹ In this figure, the price at which child care is demanded or supplied is represented on the vertical axis; the amount of child care (e.g., number of hours of care per week) is given on the horizontal axis. The market demand for child care (curve DD') depicts the maximum number of hours of child care demanded at each price. This curve is downward sloping indicating that as the price of child care increases, the amount of care demanded declines, because some parents will no longer find it worth their while to work. As a result, they will drop out of the labor market and no longer demand any child care.

The market supply for child care (curve SS' in Fig. B.1) represents the minimum price at which child care producers (i.e., providers) will supply a given amount of child care. This curve is upward sloping because higher prices are needed to attract additional providers into the market. As the price of child care goes up, providing child care will become more and more profitable and hence draw more and more people into becoming child care providers, either by becoming family day care providers or by opening up new day care centers.

Assuming a competitive market,² the price of child care services (at a specified level of quality) will be determined by the intersection of the market demand and supply curves. In Fig. B.1, this occurs where the price is equal to P^* . At this price, the amount of child care parents are willing to buy exactly equals the amount providers are willing to supply, and the market clears. In other words, there will be neither excess supply nor excess demand.

If the price that parents are willing to pay for child care increases, perhaps because they are earning more, the demand curve will shift upward, and the new equilibrium in the child care market will result in a higher price. The higher price in turn will result in a greater amount of child care services being supplied.

¹This section relies heavily on Leibowitz and Waite (1988).

²This assumption is not unreasonable given the large number of child care providers and the easy entry and exit into and out of the industry.

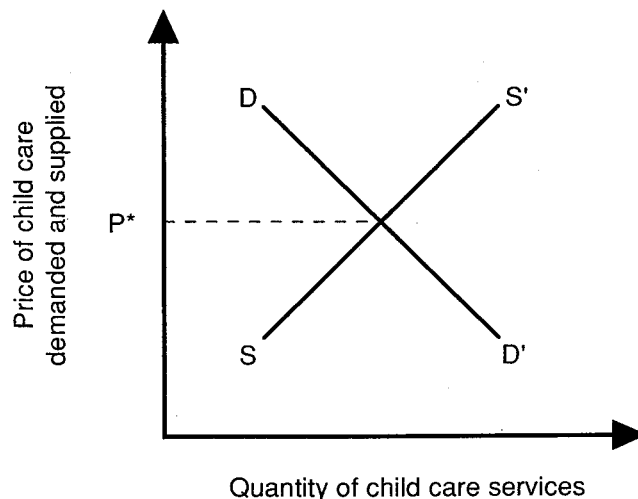


Figure B.1—The Supply and Demand for Child Care

If the price of child care is above the market clearing price, there will be many providers willing to supply child care at that price but few parents willing to purchase it. This phenomenon is called the affordability problem (or excess supply). If the price is set below the market clearing price, there will be plenty of parents demanding care but few providers willing to supply care at that price. This is called the availability problem, or excess demand. In a competitive market in which prices are allowed to fluctuate, a condition of excess demand will not remain for very long because parents seeking care will bid up the price until the price reaches the market clearing price and the excess demand has been eliminated. With subsidies of some child care slots, however, the price of these slots can remain below the market clearing price and thus create a permanent excess demand that clears in nonpecuniary ways (e.g., through waiting lists). The following two paragraphs discuss this situation.

A subsidy to child care can be represented in Fig. B.1 as a downward shift in the supply curve (SS') because providers would be willing to offer child care at a lower price (the subsidy would make up for the difference). The demand for care, however, will increase because the price consumers have to pay declines. If only a limited number of providers are eligible for subsidies, however, these providers will become relatively more attractive than providers who are not subsidized (and hence are more expensive). The result would be that more parents would demand child care from the subsidized providers than

they would be able to provide. The result would be excess demand for the subsidized child care slots. This excess demand must be rationed in some way. In the child care sector this typically happens through the creation of long waiting lists. These waiting lists, however, do not indicate that there is an overall shortage of child care. It merely indicates that the demand for subsidized child care exceeds the supply of subsidized child care slots at the subsidized price.

Although there is excess demand for subsidized child care spaces, it cannot be assumed that the children on these waiting lists are without child care. It would be in the interest of parents with children in other types of care to sign up (i.e., be placed on the waiting list) for subsidized care in case it became available. The length of the waiting list is also not a reliable indicator of the amount of excess demand when children can be signed up for more than one subsidized child care slot. Furthermore, some parents may not place their child(ren) on the waiting list if they perceive the chance of getting subsidized care to be so low that there is effectively little hope that they could obtain a job that would make it worth their while to work.

REFERENCES

- American Academy of Pediatrics and American Public Health Association (AAP/APHA), *Caring for Our Children. National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs*, Washington, D.C., and Elk Grove Village, Illinois, 1992.
- Anderson, L. J., R. A. Parker, R. A. Strikas, J. A. Farrar, E. J. Gangarosa, H. L. Keyserling, and R. K. Sikes, "Day-Center Attendance and Hospitalization for Lower Respiratory Tract Illness," *Pediatrics* 82(3), September 1988, pp. 300-308.
- Burnam, A., L. Meredith, C. Sherbourne, R. Valdez, and G. Vernez, *Army Families and Soldiers Readiness*, RAND, R-3884-A, 1992.
- Burud, S. L., P. R. Aschbacher, and J. McCroskey, *Employer-Supported Child Care, Investing in Human Resources*. Dover, MA: Auburn House Publishing Company, 1984, p. 172.
- Defense Manpower Data Center, unpublished data from the Defense Eligibility and Enlistment Reporting System, 1991.
- Department of Defense, *DoD Action Plan for Youth Activities*, June 1990.
- Faris, J. H., "The All-Volunteer Force: Recruitment from Military Families," *Army Forces and Society* (7), 1981, pp. 545-557.
- Finkelhor, D., and L. M. Williams, *Nursery Crimes: Sexual Abuse in Day Care*. Newbury Park, CA: Sage Publications, 1988.
- Fosburg, S., *Family Day Care in the United States: Summary of Findings*. DHHS Publication No. 80-30282, Washington, D.C.: U.S. Department of Health and Human Services, 1981.
- Glantz, F., J. Layzer, and M. Battaglia, *Study of the Child Care Food Program: Final Report*. Cambridge, MA: ABT Associates, 1988.
- Goelman, H., and A. Pence, "Effects of Child Care, Family and Individual Characteristics on Children's Language Development," in D. Phillips (Ed.), *Quality in Child Care: What Does Research Tell Us?* Washington, D.C.: National Association for the Education of Young Children, 1987.

- Government Accounting Office, *Military Child Care: Extensive, Diverse, and Growing*. Washington, D.C.: Government Printing Office, 1989.
- Hayes, C. D., J. L. Palmer, and M. J. Zaslow (eds.), *Who Cares for America's Children? Child Care Policy for the 1990s*. Washington, D.C.: National Research Council, National Academy Press, 1990.
- Howes, C., "Relating Between Early Child Care and Schooling," *Developmental Psychology* 24, 1988, pp. 53-57.
- Howes, C., and M. Olenick, "Family and Child Influences on Toddlers' Compliance," *Child Development* 57, 1986, pp. 202-216.
- Inspector General, U.S. Department of Defense, *Report of Inspection on Military Service Child Care Programs*. Washington, D.C.: U.S. Department of Defense, September 1990.
- Johansen, A. S., *Child Care: Preferences, Choice, and Consequences*, RAND, N-3237-RGSD, 1990.
- Johansen, A. S., A. Leibowitz, and L. J. Waite, "Child Care and Children's Illness," *American Journal of Public Health* 78(9), September 1988, pp. 1175-1177.
- Kahn, A., and S. Kamerman, *Child Care: Facing the Hard Choices*. Dover, MA: Auburn House, 1987.
- Kalemkiarian, S., "Insuring Child Care's Future: The Continuing Crisis," in J. S. Lande, S. Scarr, and N. Gunzenhauser (eds.), *Caring for Children, Challenge to America*. Hillsdale, NJ: Lawrence Erlbaum Associates, 1989.
- Leibowitz, A., and L. J. Waite, *The Consequences for Women of the Availability and Affordability of Child Care*, RAND, P-7525, 1988.
- Leibowitz, A., L. J. Waite, and C. Witsberger, "Child Care for Preschoolers: Differences by Child's Age," *Demography* 25(2), May 1988, pp. 205-220.
- Mason, K. O., *The Perceived Impact of Child Care Costs on Women's Labor Supply and Fertility*, Population Studies Center, research report no. 87-110, University of Michigan, June 1987.
- McCartney, K., "Effect of Quality of Day Care Environment on Children's Language Development," *Developmental Psychology* 20, 1984, pp. 244-260.
- Nelson, M. K., "Mothering Others' Children: The Experiences of Family Day Care Providers," *Signs* 15, 1990, pp. 586-605.

- Philips, D. (ed.), "Quality in Child Care: What Does Research Tell Us?" Washington, D.C.: National Association for the Education of Young Children, 1987.
- Presser, H. B., "Child Care Use and Constraints in the United States," in A. Holberg (ed.), *Women and the World of Work*. New York, NY: Plenum Press, 1982, pp. 295-304.
- Presser, H. B., and W. Baldwin, "Child Care as a Constraint on Employment: Prevalence, Correlates, and Bearing on the Work and Fertility Nexus," *American Journal of Sociology* 85(5), 1980, pp. 1202-1213.
- Ruopp, R., J. Travers, F. Glantz, and C. Coelen, *Children at the Center: Final Report of the National Day Care Study*. Cambridge, MA: ABT Associates, 1979.
- U.S. Bureau of the Census, "Who's Minding the Kids? Child Care Arrangements: Winter 1986-87," *Current Population Reports P-70(20)*, Washington, D.C., 1990.
- U.S. Department of Labor, "Child Care: A Workforce Issue," *Report of the Secretary's Task Force*. Washington, D.C.: U.S. Government Printing Office, April 1988, pp. 212-248.
- U.S. Department of Labor, *Handbook of Labor Statistics*, Bulletin 2340, U.S. Bureau of Labor Statistics, Washington, D.C., August 1989.
- Whitebrook, M., D. Phillips, and C. Howes, *Who Cares? Child Care Teachers and the Quality of Care in America*. Oakland, CA: National Child Care Staffing Study, Child Care Employee Project, 1990.

RAND/R-4145-FMP

