Home-Based Child Care: Its Nature and Effectiveness

Welfare reform is leading more mothers to become employed, so the need for child care for children from low-income families has never been greater. While government support of child care is often directed at child care centers, the most common form of care for infants and toddlers, especially those from low-income families, is home-based care. Some argue that home-based care is more "family-like" and better for children; others contend it is largely unmonitored, unregulated, and often of poor quality.

What does national research tell us about home-based care, what are the issues to be solved, and what could government do to support it?

What is Home-Based Child Care (HBCC)? Terminology in this field is not used consistently across the country. In this report, home-based child care (HBCC) consists of non-parental care provided for six or fewer children in someone's home. The caregiver may be a relative or non-relative of the child, and she (typically) is usually the only adult present. Caregivers may also care for their own children in addition to those of others.

There are two broad categories of care within HBCC**.** **Relative care** consists of care provided by a relative in the relative's home, presumably with no unrelated children being present. **Family child care** (**FCC**) refers to care provided to children in the home of a non-relative. Family child care may be **regulated** or **unregulated**, with criteria varying from state to state. In Pennsylvania, relative care and family child care for 1-3 children are legally unregulated; family child care for 4-6+ children is regulated, although many FCC homes are illegally unregistered. (Sometimes the term "family child care" is used to refer only to regulated care.)

HBCC is the most common type of care. Home-base child care (HBCC) is the most common form of non-parental child care in the nation, especially for children birth to 3 years of age, children older than 6 years, and children of mothers who work part- rather than full-time. Most HBCC, roughly 82% to 90%, is not regulated nationwide, while center care, which is the most common form of non-parental care for 4- and 5-year olds, typically is regulated.
Specifically, the United States Census reported that in 1994 half of the 20 million mothers of preschool children worked for pay. More than half (58%) of the young children (under age 5) of employed mothers were cared for in home-based contexts --- 43% by relatives (18% by fathers; 16% by grandparents; 9% by siblings, aunts, and uncles) and 15% by non-relatives in their homes. Organized facilities (i.e., centers, nursery schools) cared for 30% of children of employed mothers. In the early 1990s, organized facilities (hereafter simply called "centers") increased enrollments, relative care remained steady, and non-relative home-based care declined, partly, it is speculated, as a result of some highly publicized media reports of abuse.

Claims and Evidence for Purported Advantages of HBCC

Many parents, providers, and politicians believe that home-based child care (HBCC) has several advantages relative to center care. These purported advantages are listed below, followed by the national research evidence that either substantiates or refutes that claim.

- **HBCC is more private and less regulated by government than other forms of care**.

True. Politically, some argue that the government has no place in regulating and presumably interfering with services provided in the privacy of the home, especially when those services are directed entirely or partly at the caregiver's own children or relatives. Others argue that most HBCC services are paid for, constitute a business, and therefore potentially come under government regulation. In fact, national studies estimate that the vast majority of HBCC (82-90% by some estimates) are not regulated by government, but unregulated homes, especially family child care homes, conform to the regulations as frequently as regulated homes, so government regulation does not seem to be "interfering" with providers.

- **HBCC permits women to stay home to raise their children and to earn extra income**.

True. Most caregivers cite these two advantages prominently among the reasons they choose to provide child services. But the average income generated in this manner is modest. Nationally, the typical FCC caregiver is married, female, in her mid 30s, has a high school diploma, has 2-3 children of her own (although most of them are in school), and earns $10,000 or less per year, which represents one-fourth to one-third of her family's income. She works 45-50 hours per week caring for 4-6 children if regulated (fewer if not regulated), and makes a hourly wage of approximately $5.00 with no benefits. Therefore, being a FCC provider does not, on average, pay a self-sufficient wage. While providing FCC services may represent a first job, for example, for those welfare mothers making the transition to employment as some have urged, becoming an FCC provider is unlikely to generate a self-sufficient wage for single mothers and others who must exist on one income.

- **Compared to center care, HBCC is more "natural," more similar to the typical home environment, and therefore more likely to promote a secure attachment between child and caregiver**.

Premises are true; conclusion is false. HBCC is provided in a home-like setting with fewer children than centers, but HBCC does not promote more secure emotional attachment to the provider. In one study, for example, only half the children in HBCC older than 30 months are emotionally secure with their caregiver. Further, children who are cared for without the presence of other children do not have an opportunity for interaction with peers and are less developed socially than children who are cared for in the context of other children either in HBCC or in centers. In fact, research shows that secure emotional attachment and peer social relations are *least* developed in children cared for by relatives, which is the most "natural" context. This anomaly may occur because some relatives provide care primarily to help the parent, rather than because they are devoted to caring for children; and some are resentful of being in this position.

Further, studies indicate that adults having only a few children in their homes are more likely to do housekeeping and watch television rather than play with and teach the children. Relatives, for example, were found to spend less time teaching, playing, and helping their children than non-relative caregivers. Center and family child care providers who have chosen child care as an occupation, primarily because they like and want to care for children, tend to care for more children but are more likely to plan activities for children and to be child- rather than adult-oriented in their daily interaction with children.

- **HBCC is an ideal environment for children to learn from everyday activities**.

False. On average, HBCC is not providing a caregiving environment likely to promote optimal development. Studies show that while regulated caregivers typically provide adequate custodial care equivalent to the average child care center (but not educational preschool), unregulated providers and relatives (i.e., the vast majority of HBCC) are less likely to do so, and the children they care for are less developed cognitively. Only one-fourth of the HBCC children in one national study engaged in high-level peer play and only 40% in high-level object play relative to their ages, which rates are lower than average.

- **HBCC provides a parent with more flexible hours of care**.

Partly true. Surveys indicate that hours of service in HBCC are less prescribed and therefore more flexible than centers. But many HBCC providers, especially relatives, have other jobs (e.g., most fathers and one-third the grandmothers in one study), so the hours the caregiver has available must match or be juggled to fit those hours needed by the parent.

- **HBCC homes are more conveniently located**.

False. The average distance of HBCC homes from the parent is greater than for centers. This may be because some parents, especially those using a relative, do not pay or pay minimally for the care received and sacrifice proximity for low cost.

- **HBCC is cheaper than center care**.

Partly true and false. Obviously, if a relative provides free care (10% of all users and 38% of welfare mothers do not pay), HBCC is cheaper than paying for center care. But for parents (and perhaps governments) who pay for HBCC, the average cost (approximately $50 per week in one national study, but the rate varies with location) is about the same as for center care. Furthermore, in contrast to most centers and regulated FCC providers, 95% of relatives and more than half of non-regulated HBCC providers do not report their incomes to the IRS and do not provide their social security numbers to the mothers whom they serve, which is required for those mothers to obtain the federal child care tax credit. Therefore, the net cost to government and parents could be greater for HBCC, and these facts must be considered when governments design financial support of care.

Claims and Evidence for Purported Disadvantages of HBCC

There are at least two allegations that proponents of center care make against home-based child care:

- **Since most HBCCs are not regulated, they are more likely to violate standards for care**.

False. The vast majority (83% in one study) of HBCC sites are in compliance with state regulations regarding group size, staff:child ratios, and age mix, and compliance rates are essentially the same for non-regulated as for regulated services. However, this fact may not be saying as much as it appears about the quality of care. For one thing, by definition, HBCC is primarily for groups of six or fewer children, so it is almost guaranteed that a service qualifying as HBCC has a group size and a staff:child ratio within the regulated limits. Second, not all states have regulations even for FCC, and some states have more lenient regulations for FCC than for centers.

- **The quality of care provided in HBCC sites is lower than that of centers**.

Generally false, with exceptions. On average, the global quality of *custodial care* provided to children in HBCC sites is roughly the same as in centers. However, among HBCC types, the quality of care is better in regulated than in unregulated sites, and both of these are better than relative care. But the average quality of care is none too good. In the most recent national study, quality was assessed in terms of space and furnishings, basic children's needs, language and

reasoning stimulation, learning activities, activities promoting social development, and adult services. The average HBCC and center were considered “barely adequate,” which meant care was custodial and neither developmentally enhancing or harmful, but ratings ranged from “inadequate and potentially harmful” to “good” (that is, developmentally enhancing). No HBCC site received a rating of “excellent.” While some preschool-type activities (manipulative play, fantasy play, art, stories) were observed in HBCC services, there was much more gross-motor indoor and outdoor play, television watching, and time in which children were not occupied at all or simply watched other activities. On this basis, at least, the quality of both HBCC and centers could be improved.

HBCC is primarily custodial care, not developmental enrichment. In a recent study carried out in three sites across the country, 41% of HBCC providers never planned specific activities for their children, and most who did plan such activities, did not do so daily. Therefore, HBCC, including FCC, services are perceived as informal, home-like, and unstructured, as opposed to the atmospheres in most educational preschools, for example, in which deliberate planned enrichment activities are conducted.

Factors Related to Quality Care and Benefits to Children

Studies show that parents, caregivers, and child development experts agree on what constitutes quality. Very briefly, it consists of a warm, caring, responsive relationship between the child and the provider, a safe environment, good communication between parents and provider, and nutritious meals if they are part of the service.

While all parties agree on what constitutes quality, they disagree on which factors produce quality child care, especially when quality is assessed by direct observation of providers and measurements of children’s mental, social, personal, and emotional development.

Parents and providers believe that experience as a mother is the most important factor, but research indicates that this is not true. Instead, three other circumstances are associated with quality:

- **Regulation**. Generally, regulated providers are more businesslike and professional; they offer more planful, sensitive, and responsive care; and their children display improved developmental progress relative to those of non-regulated providers. Both of these types of caregivers are better than the average relative. However, HBCC environments that conform with regulatory standards for group size, staff:child ratio, age mix, and other standards are not obviously better in quality than those that are not in compliance. This suggests that *who chooses to become regulated*, rather than conformity to the regulatory standards per se, is associated with quality care and beneficial child outcomes. However, regulation is associated with quality, but neither caregivers nor parents perceive this fact; and while parents are typically aware of whether the services they use are regulated, regulation is usually not a basis they use to choose the service (primarily, perhaps, because

most low-income parents have very limited choices in services that are affordable and convenient).

- **"Professionalism."** Providers who deliberately select child care as an occupation, who like and want to help young children develop, who seek out opportunities to learn about child care and children's development, who have a wide network of supports in the child care community, and who operate their services in a business-like manner are more likely to provide sensitive and responsive care, deliberately plan activities that promote children's development, and generally provide better quality of care and foster better outcomes in children. Indeed, the providers' own desire for "professionalism" may well be the factor, not regulation per se, that produces better quality care and outcomes for children in regulated care.

- **Training**. Caregivers who have more formal and specific training, especially with respect to child development, provide better quality care and improved mental and social outcomes in the children they serve than those with less training. Several studies show that the conventional belief by parents and caregivers that experience as a mother and household manager are the crucial ingredients to providing quality care for children is much less related to quality of care and outcomes for children than is the amount and nature of caregiver training. Regulatory standards, however, often have no or minimum training requirements.

Policy Issues and Options

Although many people feel that government should play no role in home-base child care services, others feel that government must play some financial and/or regulatory role. The latter argue that 1) welfare mothers who want to make the transition to work need, but cannot afford, child care to do so; 2) the cost of child care for substantial numbers of low-income women is too much to pay and the wages for providers are too little to earn; and 3) the general quality of child care is "barely adequate" and needs improvement for the safety and development of the nation's children.

While those who favor government involvement can agree on these general priorities, there is much less consensus on how to achieve them. The following represent some of the major issues and options.

Regulation

Proponents of regulation argue that 1) the quality of HBCC, even FCC, is below desirable standards, 2) parents and providers agree on what constitutes quality but are mistaken about the factors that produce it, 3) parents do not select HBCC services on the basis of factors that are relevant to quality (e.g., a substantial number of parents do not even visit a home before enrolling

their children), and 4) low-income parents have few options for quality care that they can afford. Consequently, while opponents of regulation suggest that parents are the best judge of quality for their own children, proponents of regulation argue that this is not true. Too much regulation, of course, may raise the cost of care and discourage caregivers from being regulated at all, creating an underground economy that does not pay taxes and does not provide parents with social security numbers necessary for parents to claim the tax credits for child care that the federal government provides.

Types of regulation. HBCC regulation is the responsibility of states, and there is little consistency among states with respect to whether and what kind of regulation is required. The types of regulation are listed below, and some states have one or a combination of these.

- **Licensing**. Standards are prescribed, licensing grants permission to the provider to operate, and the licensing body has the authority (which it may or may not exercise) to monitor compliance.

- **Registration**. The provider signs a statement that services are in compliance, parents may be given a copy of the standards, parents potentially could file a compliant for violations, but the state does not guarantee or monitor that services meet the standards.

- **Certification**. This is the same as registration, but the provider receives public funds.

What is regulated? Again, states vary in what is regulated and the standards that are invoked. The following items are the most common domains of regulation:

- **Service characteristics**, including maximum group size, liability insurance, indoor square footage per child, inspections, compliance with zoning regulations (but it is not clear whether FCC qualifies as a business in many locales), prohibition against the use of corporal punishment, and sick care (i.e., circumstances under which children must be isolated or removed from the facility).

- **Caregiver characteristics**, including minimum age, a physical exam or TB test, criminal and child abuse checks, fingerprinting.

- **Caregiver training**, including a degree or certificate (depending on position), attendance at an orientation session and number of hours of inservice or informal training (but not usually its content).

Does regulation work? There is widespread agreement that current regulatory policies do not work very well. Specifically:

- The vast majority of HBCC, even FCC, providers are not regulated even in states where regulation is mandated.

- Standards are often quite lenient so that nearly all non-regulated as well as regulated providers conform with those standards (that is, government is not driving providers underground or forcing them to comply with standards that they otherwise would not choose).

- There is little difference in the quality of care as a function of compliance or lack of compliance with the existing standards (although "regulated" care is better than "nonregulated").

- Regulation does not influence a parent's selection of which service to use.

- The cost of serious monitoring of compliance with standards is prohibitive.

Consequently, some have argued that states should do away entirely with attempts to regulate. Others suggest that standards should be raised and monitoring and regulation should be expanded and improved, but it is not clear how this can be accomplished effectively and at reasonable cost.

Accreditation

Accreditation is the voluntary participation in a program of training and compliance with a set of standards prescribed by a professional organization. Some suggest accreditation represents an alternative to mandatory regulation; others prefer it to supplement regulation.

Potential benefits. Accreditation has certain potential benefits.

- It is not operated by governments.

- It is voluntary.

- Standards are dictated by professional organizations and may be higher than minimum government standards.

- Parents who are concerned about standards can choose providers who are accredited and presumably complain to the accrediting agency if the provider is not in compliance.

Potential limitations. Unfortunately, relatively few providers have been accredited by either of the two national accreditation programs, the CDA (Child Development Associate) Family Day Care Credential and the National Association for Family Day Care Accreditation. The primary reasons are the cost (from $150 to $650), the time required (12-18 months), and the lack of incentives from parents or governments to become accredited (except pride and self-satisfaction, which is the main documented outcome of accreditation).

Improving Quality

Two themes are often cited by those who desire government to improve the quality of care --- training for providers and increased financial support to attract and maintain providers and reduce child:staff ratios.

Training. HBCC caregivers who have extensive training provide better quality care than those with less training. However, the training standards in states that regulate typically are so minimal and many training programs are so modest in scope that there is little direct evidence that requiring or providing such minimum training actually produce obvious benefits, especially improved outcomes for children. For example, most training requirements are met by simply learning CPR, first aid, and other safety procedures in informal workshops or "orientation" sessions. More than these basics --- especially direct training in child development, child care, and early childhood education --- are required to produce improvements in the quality of care and the outcomes for children. Unfortunately, neither parents nor caregivers recognize the importance of such training in producing the quality of care that both desire.

Financial support. For those low-income parents who must pay for care, the average cost of $50-$60 a week (but costs can easily reach $150/week) represents a substantial percentage of their incomes. Conversely, for those who seek to provide care as an occupation, $5-$6 an hour with no benefits is not a self-sufficient or even fair wage for the time and responsibility involved. Proponents of government support admit that child care is a "business," but, they argue, it is a necessary service that currently is not sustainable financially at a needed level of quality on the basis of supply and demand alone. Also, parents need more options ---low-income parents frequently have difficulty finding care (10% take longer than four months) and must take the least expensive care regardless of its quality. While most parents say they are "satisfied" with their HBCC arrangements, two-thirds admit they have no acceptable option to their current service and one-fourth make the unusual admission that they have settled for an arrangement other than the one they would prefer. Further, when parents say they would like to change their HBCC service, the vast majority prefer to send their children to a center (the reverse preference is rarely the case). This is because some centers, for example, provide a program that is more deliberately enhancing to the development of children and is more likely to be available for full-time care, which mothers making the welfare-to-work transition often require.

Some Possible Options

There is not agreement on what could and especially should be done to improve the availability, quality, and affordability of HBCC services for low-income parents. However, both the federal government and the Commonwealth of Pennsylvania recently have proposed a variety of strategies, some of which are included in the following list of alternatives suggested by professionals:

- **Government support for training and accreditation**. The principle reasons training and accreditation are not more popular is that they are costly, time consuming, and without incentives. Government could *support national and local professional associations to provide accreditation and training* by financially supporting such organizations directly and/or by providing "scholarships" to low-income women that would make it worthwhile for them not to be otherwise employed while taking such training. Home training programs that do not require absence from work could also be supported. In addition, some incentives might be offered to graduates, such as 1) small business start-up grants or at least low-interest loans; 2) gradual phase out of income assistance to welfare-to-work individuals who provide child care until a sufficient income from such employment is attained; 3) certifications and honors for training performance and graduation that are meaningful and public; 4) low-cost or no-cost insurance (few HBCC providers have insurance); and 5) support services that might include mentoring, technical assistance, and guides to activities for children and help developing good business practices.

  Such assistance would have the advantage of supporting local professional associations that would provide continuing support to HBCC providers, it would allow self-regulation by this profession and minimize government's intrusion into the details of this business and the homes of providers, and it would take a more palatable carrot-versus-stick governmental approach and still allow parental choice. Such organizational support should be complemented by consumer education regarding the relevant characteristics of quality and assistance to parents in how to select quality care. California's Child Care Initiative and its Resource and Referral Network are examples of state-supported initiatives in this vein, and the North Carolina TEACH program is an example of a teacher training scholarship program that ties compensation to training.

- **Vouchers for low-income parents**. Some form of vouchers for low-income parents, especially those making the transition from welfare to work, that can be used for center and HBCC services are being enacted by states and localities in support of welfare reform regulations. If such vouchers (or the ceilings for provider reimbursements) were worth at least the cost of the care involved, they would constitute an incentive for providers to take children from such families (in some locales, the vouchers do not cover the actual cost of care so providers restrict the number of such families they are willing to serve because they need full-scale paying customers to make up the cost difference). Vouchers might pay more if the provider were accredited or trained, which would support the improvement of quality, provide incentives for training and accreditation, and alert parents to the importance of these factors in quality care. By paying a reasonable amount relative to the cost of care, a voucher system (or direct support of providers) could improve the attractiveness of the profession, reduce the staff turnover that is even greater among HBCC than center staff, and increase the likelihood that welfare-to-work mothers can become providers and make a self-sufficient wage. Further, if the vouchers or payments were of sufficient value that providers could afford to report their incomes and pay taxes,

then it may be reasonable to require that HBCC providers accepting vouchers or reimbursements give parents their social security numbers and receipts so that parents can obtain tax credits.

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