What Is Quality in Early Care and Education?

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This paper summarizes results from a 1994 study of quality in home-based child care settings. *The Study of Children in Family Child Care and Relative Care* looked at 820 randomly selected mothers and 225 of their children in the homes of 226 providers in three communities that participated in Family-to-Family Child care training programs: San Fernando/Los Angeles, California; Dallas/Fort Worth, Texas; and Charlotte, North Carolina.

Thirty-three percent of mothers with children under 5 years old use in-home care. For 61% of these mothers the provider they use is not related, while 39% use relatives. This study examined three distinct groups of providers offering care in the home: regulated family child care providers, nonregulated family child care providers, and nonregulated relatives who provide care.

The quality of care offered by these providers is of critical importance in light of growing recognition that early child care experiences comprise a child's education before conventional schooling (Galinsky and Friedman 1993), blurring the distinction between child care and early education.

This study addressed a number of crucially important policy questions:

- How is quality in family child care defined by parents and providers?
- What differentiates high- and low-quality care?
- What differences are found among regulated, nonregulated and relative providers?
- What do children experience in family child care and relative care?
- How satisfied are parents?

Sampling procedures

Four sampling methods were used to obtain and interview mothers: random digit dialing to telephone exchanges with higher-than-average proportions of low-income and minority families; commercially available lists of families with young children; birth records; and provider referrals.

Two sampling methods were used to select providers: Direct selection from licensing lists and responses to newspaper advertisements; and referrals from the sample of mothers.

For each mother whose provider agreed to participate, one child was selected for observation.

Data collection and measures

Interviews with mothers were conducted over the telephone and lasted approximately 30 minutes. Measures used in the interviews included questions about certain features of child care as related to perceived quality, as well as the importance of these features and respondents' satisfaction with them. Overall satisfaction with child care was also measured.

Interviews and observations with providers were conducted by observers (primarily graduate students or early childhood educators) who received one week of extensive training prior to meeting with and observing providers in their homes. The observation period lasted for two to three hours with the timing designed to cover a period when the target child was awake and engaging in typical daily activities. Self-report assessments were filled out by the providers.

Measures used in the provider interviews, observations and self-report assessments included business and safety practices; children's activities; three measures of process quality; structural quality; and the providers' perceptions of quality.

Definitions of quality

Determining what constitutes quality in family child care has been difficult amid the variety offered. This study suggests that, despite ethnic and income differences, parents and providers agree about what is most essential in defining quality: a safe environment, good communication between parent and provider, and a warm and attentive relationship between the provider and child. These measures of quality were positively related to children's development across ethnic lines and among the three types of providers studied.

Results of the study reveal that parents and providers are correct in emphasizing the importance of a warm and attentive relationship, and validate the measured quality indicators used to ascertain quality. Children are more likely to be securely attached to providers who are sensitive (warm). Children are more likely to play with objects and engage in more complex play when providers are responsive (attentive). Children are also more likely to be securely attached to providers who, as a measure of global quality, offer good or adequate (neither growth-enhancing nor harmful to growth) custodial care.

Levels of quality

Although it is widely argued that no national child care problem exists because parents are generally very satisfied with their child care, this study showed otherwise.

Low global quality ratings

Few homes in the study—only 9%—received "good quality" ratings. Thirty-five percent received global quality scores in the inadequate range, leaving 56% rated as adequate, strongly suggesting that quality can be improved.

Choice is limited

Although mothers report being satisfied, 62% percent had looked for other alternatives. Sixty-five percent of those looking found no other acceptable options, and 25% expressed a preference for other arrangements. If other care was available, 28% of the mothers in the study would use it.

How providers are selected

Although they frequently mentioned trust in providers or their personality and expertise as selection criteria, mothers almost never mentioned formal credentials such as education and licensure high on their list of what constitutes quality care, instead relying on factors such as safety and the provider's communication. Research has shown that parents always report high levels of satisfaction with quality even when no relationship to quality is observed by researchers (Cryer & Burchinal 1997; Shinn, Galinsky and Gulcur 1990).

Family income and ethnicity effects

In a 1997 study we sought to clarify recent research suggestions that low-income families using family child care and relative care were using lower quality care than their higher-income counterparts (Kontos et al 1997). Using a subsample from the study upon which this paper is based, researchers in this rigorous study used interviews and three-hour observation sessions to examine provider behavior, children's activities and characteristics of the environment for 186 African American, European American and Latino children (average age = 26 months) and their child care providers.

More similarities than differences were found in children's experiences in family child care and relative care across income groups, although some variance was found based on income and ethnicity. Income-level differences in provider behavior and income and ethnic differences in activities were found, suggesting that the ecology of child care environments for very-low-income and minority children may vary in important ways from children of White and moderate- or upper-income families.

Low-income Latino families were found to rely on care that was significantly lower in quality than African American and European

American families with similar incomes, and were most likely to cared for by a nonregulated relative, reflecting findings of previous research that Latina mothers took issue with norms and values reflected in child-care center practices (Fuller, Holloway, Rambaud & Eggers-Pierola 1995). Although care by a relative is likely to increase confidence in congruence with family norms and values, and is less expensive than home- or center-based alternatives, research has shown that relative care is more likely to be inadequate in quality (Kontos et al 1994). The tendency of Latino families to rely on relative care may explain the measure of lower quality care that was experienced when compared with other ethnic groups.

Children from low-income Latino families being cared for by relatives were also less likely to be provided with learning activities than were European American children being cared for by regulated nonrelatives.

The three income groups experienced a stark contrast in child-care environments, with nearly three-quarters of very-low-income families receiving care that was inadequate in quality—in fact, no child in the very-low-income group was in good quality care. In contrast 43% of low-income and only 13% of moderate-income families received inadequate care. And providers of children from very-low-income families were less sensitive in their interactions, reducing the likelihood that children would form secure attachments or experience development-enhancing opportunities.

Predictors of quality

One of the most revealing findings of this study relates to intentionality on the part of the provider. This intentionality is represented in providers who have a commitment to caring for children, who pursue opportunities for continued learning, and who seek the company of other providers in an effort to learn from them. Home-care environments that offer children higher-quality, warmer and more attentive care create opportunities for learning experiences that contribute to better growth and development.

Characteristics of the predictors of quality in child care go together. Providers who have one of the measured characteristics are likely to have the others. Providers are more likely to be rated as sensitive, observed as responsive, and rated as having high global quality scores when they show a commitment to working with children; pursue continuing education opportunities; engage in planning; seek the company of peers; are regulated; have larger groups and higher adult to child ratios; and charge higher rates and follow standard business and safety practices.

Highlights of what the study revealed about each of these predictors follows, along with findings from other studies and research that illuminate implications for public policies and programs.

Quality found in a commitment to taking care of children

Providers who are intentional in their approach to caregiving are more sensitive, more responsive, and offer better-quality care. One feature of this intentionality is their commitment to taking care of children.

This commitment was measured by asking providers for their primary reason for becoming a provider, their perceptions of their work and their commitment to their jobs. Providers who are caring for children from a sense of obligation tend to be adult-focused (to help out mothers) rather than child-focused (to be with children) and do not perform as well in the measured quality indicator categories.

Current policy relevance is found in the fact that some states push welfare recipients to convince others—friends, neighbors and relatives—to care for their children as they return to work, or to become child care providers themselves. The data are unequivocal—providers offer better care when they want to be providers. Welfare-to-work participants should be screened for interest and commitment . Public policy measures that, in effect, create providers out of individuals who are not committed to taking care of children do not create quality in child care.

One further implication of this finding on commitment is that both business and government should support providers who want to offer care through reimbursements, training opportunities and public recognition. Consideration should also be given to subsidizing quality child care for low-income parents who are returning to work.

Additionally, public and private investments in child care consumer education and advocacy would allow parents to access information on child care options and to pursue improvement in available options.

Professional development yields sensitivity

Another feature of intentionality is found in providers who seek out opportunities to learn more about child care and child development. This professional preparation yields providers who are more likely to be sensitive and responsive.

Fears that training will in some way diminish the caring, nurturing relationship fundamental to quality child care have become an assumption often heard in public policy debates. Yet providers with more formal education were rated as more sensitive and less detached, and were observed as more responsive.

An awareness of how children grow and learn yields an ability to provide developmentally appropriate levels of care. Training can also stimulate new ideas and provide renewed motivation. Years of experience in the child care field will not necessarily translate to the greater sensitivity that is a

hallmark of quality; improvement in care comes from training, not experience.

Effects of training

A 1996 study to determine the effects of training on the quality of care offered by providers examined the outcomes of 130 family child care providers (Kontos, Howes, & Galinsky 1996). These providers had enrolled in the 15- to 25-hour Family-to-Family training offered at three sites around the country, and were examined against a comparison group of 112 regulated providers in the same communities who were not involved in the training.

Each Family-to-Family training project is unique, but common components of training—such as topics to be covered—were required at each site. These topics include business practices; local regulations; health, safety and nutrition; child development and age-appropriate activities; environments to promote learning; guidance and discipline; special needs children; parent-provider relationships; professional development and community resources; diversity issues; and personal and family development.

Results revealed that training did increase global quality in two out of three sites (the site showing no change had high pre-training global quality scores), although process quality (focusing on the provider's interactions with children) was not affected. This may be reflective of the difficulty of changing patterns of behavior or it may a result of limited observation data.

The significance of the global quality improvements is tempered by the fact that the improvements were extremely small in an absolute sense. It does demonstrate, however, that statistically significant changes in quality may not be observably significant to either child care professionals or parents. But it is important to the extent that improvements in the providers' business and safety practices can contribute to provider longevity and to making family child care financially viable, since changes in these types of practices can result in financial benefits to the providers.

The overall modest impact of the training suggests that it may not be rigorous enough, and that its impact may have been affected by the emphasis on the classroom component (that reaches greater numbers of providers) over the more expensive coaching that can occur during home visits (Galinsky, Howes & Kontos 1995). Although classroom topics provide important information, previous research suggests that frequent home visits are a critical component of successful training (Kontos 1994).

Professional development initiatives would do well to correct the imbalance between classroom and coaching components in family child care training. This would require greater funding, and a new perspective

that measures training success in terms of enhanced quality rather than of numbers of providers involved.

Planning ahead for quality experiences and activities

Little is known about the experiences of children in family child care. We do know that caring for and educating children in family child care is more than simply "watching" them, it requires thinking ahead about what they are going to do and planning for their involvement, an aspect of intentionality. These activities that require planning do not always need to be structured; but providers who are intentional about planning a variety of experiences that can contribute to developmental progress, social skills and school readiness for the children in their care are more likely to be rated as sensitive and observed as more responsive.

Involvement with other providers offers support and enrichment

Providers who seek the company of peers appear to be seeking more than merely social support; contact with other providers offers opportunities to learn from them—another indication of intentionality.

Providers do not often have the opportunity to be with other adults during the hours they offer care, and informally report feeling isolated from other adult contacts. Those who report more involvement with the family child care community through membership in associations or participation in programs are rated as more sensitive and responsive.

The implication is that national, state and local associations that involve providers in social support and technical assistance networks can improve quality of care.

Regulation does yield quality, and important implications

Providers and mothers both rate regulation at the bottom of a list of quality factors (17th and 18th, respectively, out of 19 factors), yet regulated providers are actually rated as more sensitive and observed to be offering more responsive care than nonregulated or relative caregivers.

This study reveals that regulated care is consistent with the aspects of quality —warmth and attention to the child—that providers and parents value, and points to the fact that being regulated adds to the perception that taking care of children is important work. Efforts on the part of states and businesses to bring family child care providers into the regulatory system, and to ensure that the system helps improve the quality of care can provide an important bridge on the road to high-quality child care.

Although the finding that relatives who are unregulated are perceived as less sensitive and responsive is surprising, we realize the study does not take into account crucial aspects of relative care that center on cultural

grounding and unique family expressions of love and caring that were not measured.

However, an additional finding that 60% of the relatives became providers for adult-focused reasons points to the possibility that a sense of obligation rather than commitment could affect the level of sensitivity and responsiveness to children. Furthermore, almost two-thirds of the relative providers live in poverty, with little social support.

Children cared for in these circumstances, and under other difficulties such as poverty and social isolation, may not receive the warmth and attention that is known to affect their growth and development in positive ways.

The implications once again point to the fact that providers offer better quality care when they want to be providers.

Higher ratios and group size represent higher preparedness

Some research on group size and number of children per adult indicates that slightly larger groups and slightly higher ratios in family child care are better (Dunn 1993). Consistent with that literature, this study also showed that providers with slightly larger groups are more likely to be sensitive, and that larger group sizes and slightly higher numbers of children per adult yielded higher global quality scores (i.e., 6 children as compared to 2 or 3).

This should not be interpreted to mean that larger groups and high ratios are to be sought or even accepted in the quest for quality. No provider in this study was caring for more than three infants; larger groups were comprised of older children only. This finding speaks more to the fact that providers who care for more children and higher ratios are more likely to have had more formal education and child care training, thus they are better prepared to offer quality care and to be more intentional in their approach.

Conformance

Since requirements for licensing varied by state, providers were examined in relation to their state's threshold of required regulation (i.e., the number of non-related children in care above which a provider must be licensed). Results revealed that 81% of the nonregulated providers were illegally caring for more children than the state allowed nonregulated providers, but were caring for only 2.6 children, on average, compared to 5.8 children, on average, for regulated providers. This was a surprising finding since it has been generally thought that nonregulated providers were caring for more children than the maximum allowed by the state for regulated providers. Eighty-three percent of all providers were in conformance with their state regulations for group size, adult-child ratio, and number of infants. Being in conformance with these three features of state regulations was less predictive of quality than being regulated.

Nonconformance typically meant a slightly higher number of children than allowed by state regulation. Had this study been done in states that allow larger groups of children (such as Indiana), nonconformance may have been associated with lower levels of quality.

Compensation and quality

Higher quality child care is offered by providers charging higher rates and following standard business and safety practices. As with center care, where staff compensation is linked to the quality of care and education children receive (Whitebook, Howes, and Phillips 1990), this study revealed a strong association between what providers earn and the quality they deliver.

Regulated workers (who are more likely to be trained and intentional in their child care practices) are more likely to comply with tax laws, declare their earnings, deduct their expenses and provide Social Security numbers so parents can participate in federal subsidies, claim tax credits and participate in employer assistance plans. And providers who offer better care are more likely to follow standard safety practices.

Results of the 1996 Family-to-Family training study referenced earlier revealed that providers who dropped out of the training were less experienced and used fewer business and safety practices than those who completed it.

Parent fees

Costs for child care offered by providers in this study were low, with a median cost of $50 per week. The majority of parents report that they would be willing to pay more, even though current costs represent a substantial portion of income for many of the families. Nevertheless, very few of the families receive help with child care payments. It would appear, in fact, that many providers subsidize the child care they offer by the low amount they charge. Additionally, the rates charged for family care appear to be strongly related to intentionality in providing high-quality care.

A willingness on the parents' part to pay more is not the solution to child care problems. Lower-income families use providers who charge lower fees, and receive correspondingly lower-quality care; they cannot afford to pay more. The implication is that additional sources of revenue and quality improvement initiatives are especially needed for low-income families.

Concerns about quality available to low-income children have increased following a number of studies that document the prevalence of poor-quality childcare. Low-income parents are forced to seek inexpensive or free child-care arrangements that offer the flexibility their low-wage jobs and lack of resources require. Relative care, family child care and multiple child care arrangements result (Phillips 1995). Low income families are less likely to

rely on center-based care and more likely to rely on grandparents (Hofferth 1995).

Low income families relying on family or relative care may be receiving lower quality care than higher income families (Kisker, Hofferth, Phillips & Farquhar 1991; Kontos 1994; Phillips 1995), while the small percentage of low income families using center-based care are receiving child care of comparable quality experienced by higher income families. Evidence also exists that a smaller proportion of families using home-based care are receiving child care subsidies compared to families using center-based care.

Although the quality of care offered by center- and home-based care is similar, low income families who choose home-based care with no subsidy may have greater difficulty finding the same quality as families who choose center-based care.

Because better-quality care is received by parents who are able to pay more, the implication is that government and business should consider undertaking efforts directed toward helping families pay for child care.

Conclusion

The Study of Children in Family Child Care and Relative Care sought to shed light on what constitutes quality care and areas of concern. The following recommendations are reprinted from the study's findings.

- No public policies at the federal or state level should push or require people to care for children if they do not want to be providers.

- There should be public and private investments in childcare consumer education and advocacy.

- Government and business should fund high-quality family child care training initiatives.

- Family child care providers should have access to resources that help them anticipate and create learning experiences for the children.

- National, state and local associations should be developed and supported to involve providers in social support and technical assistance networks.

- States and businesses should undertake efforts to bring family child care providers into the regulatory system and ensure that the regulatory system helps providers improve the quality of care they offer.

•Government and business should undertake efforts to help families pay for child care.

•Studies of various public and private efforts to improve the quality of regulated, nonregulated, and relative care should be conducted.

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Galinsky, E., Howes, C., Kontos, & S. Shinn, M. (1994). *The Study of Children in Family Child Care and Relative Care*. (Families and Work Institute)

Kontos, S., Howes, C., & Galinsky, E. (1996). Does training make a difference to quality in family child care? *Early Childhood Research Quarterly*, 11, 427-445.

Kontos, S., Howes, C., Shinn, M., & Galinsky, E. (1997). Children's experiences in family child care and relative care as a function of family income and ethnicity. *Merrill-Palmer Quarterly*, 43 (3), 386-403.

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