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Examining the Implementation and Outcomes of the Military Child Care Act of 1989

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WHAT DID THE MCCA DO FOR MILITARY CHILD CARE?

INTRODUCTION

In November 1989, Congress passed the Military Child Care Act (MCCA) as part of the National Defense Authorization Act for 1990 and 1991. The law was a response to considerable unmet child care demand, which led to concerns about the quantity of care. Incidents of child abuse in several military child development centers (CDCs) raised questions about the *quality* of military child care as well. The goals of the new law were to improve the quality and increase the quantity of child care services in the military, and to ensure the affordability of care. An additional aim of the act was to standardize the delivery and quality of care across installations and military services, which in 1989 varied considerably. Although the MCCA was to apply to children from birth to twelve years of age, virtually all provisions of the act referred to those who were less than school-aged, and nearly all dealt with those receiving care in CDCs.

The MCCA relied heavily on four policies to realize the goals of the legislation. A number of additional policies would support those goals and address other goals as well. The four new policies included substantial pay increases for those who worked directly with children, with pay raises tied to the completion of training milestones; the hiring of a training and curriculum specialist in each CDC to direct and oversee staff training and curriculum development; the requirement that parent fees (which would henceforth be based on family income) be matched, dollar for dollar, with appropriated funds (APF$); and the institution of unannounced inspections of child development centers to be conducted four times yearly. The legislation specified a series of remedies for violations discovered during inspections. It also provided for the establishment of a child abuse reporting hot line. This hot line came to be important as a means of directing inspectors to those CDCs most in need of technical assistance or program improvement.

Finally, the MCCA contained a mandate to accredit at least 50 military CDCs according to the standards of a national accrediting body for early childhood programs.[1]

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[1]The National Academy of Early Childhood Programs (NAECP) of the National Association for the Education of Young Children (NAEYC) administers what continues to be the only professionally-sponsored national voluntary accreditation system (Hayes et al.,

Accreditation of these 50 centers was to be completed by June 1, 1991. (See the appendix for a brief description of the various components of the MCCA.)

With support from the DoD, RAND set out to assess MCCA implementation, both in terms of process and outcomes.[2] In this paper, we focus on the impact of the act. The analyses presented here examine these impacts and assess them in terms of the act's initial goals and the extent to which they contributed to a more coherent system of child care that meets military and family needs.[3] A system of services would seek to cover the gaps in care that threaten readiness and to identify and channel families to the care that best matched child needs and workplace demands.

BACKGROUND

The proportion of active-duty military personnel who are single parents and the proportion of military families in which both parents work have steadily increased. Today, roughly half of all military members have one or more children below school age (Inspector General, 1990). In more than 60 percent of these families, both parents work.

Many military spouses are themselves on active duty; 8.9 percent of all active-duty spouses report that their spouse is also on active duty. In addition, the number of single parents in the military has steadily increased.[4] These demographic trends have placed pressure on the Department of Defense (DoD) to expand the availability of child care to military families, not only to meet the child care needs of military families, but to maintain the readiness of the military, to increase its productivity, and to improve morale.

To meet these needs, the DoD provides child care as an essential service. Two settings predominate. The first is the CDC, which provides care for children on a fee-for-service basis. CDCs offer centralized day care at lower cost than is available in the private

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1990). We use the term NAEYC throughout the text to refer to both NAEYC and NAECP because the former term is more widely known.

[2]See Zellman and Johansen (forthcoming) for detailed reports of those efforts.

[3]Zellman and Johansen (1995) stress the value of a system of child care to both the military and to families.

[4]This figure was derived using data from the 1992 DoD Health Care Survey, which is a stratified random sample of active-duty and retired military households wordlwide. The survey includes 13,721 active-duty respondents; only active-duty respondents were used in deriving data for this report. The response rate among active-duty with dependents was 67 percent. The total number of active-duty members was drawn from the Defense Eligibility Enrollment Reporting system as of September 30, 1992.

sector, and provide care not offered by the private sector.[5] The second type is family child care (FCC). Here, military spouses trained as family child 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.

The most recent data indicate that there are now 831 CDCs and 9,810 FCC homes throughout the world offering care for children as young as six weeks.[6] The capacity for all CDCs and FCC homes (including school-age child care facilities) as of March 1995 was 162,527 (U.S. Department of Defense, 1995).

METHODS

Because this study was undertaken after the implementation of the MCCA, it was impossible to measure changes deriving from the act directly. This difficulty was overcome in part by asking child development staff and other key military and civilian personnel about the changes that had occurred, and in part by studying the new or changed regulations issued by each service to implement the MCCA, as well as the requirements to obtain accreditation.

In all, the study relied on three different sources of data:

1. Relevant military and NAEYC documents;
2. Data collected from a worldwide mail survey of 245 child development program managers;
3. Face-to-face interviews with a total of 175 individuals at the DoD, at four major commands, and on 17 local installations.

The military documents provide a window on the top-down aspects of the implementation process, which helps to explain inter-service differences in both the implementation and outcomes of the MCCA. The worldwide mail survey of child development managers obtains information concerning both the implementation process and the impact of the MCCA at the ground level from those most closely involved in the

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[5]Lower costs are possible because of subsidization of CDCs. The level of subsidization increased under the MCCA—to a point where subsidies were to match parent fees.

[6]This number includes school-age child care facilities.

implementation process; the installation visits and interviews examine up close and in greater detail the implementation process and its outcomes at all levels of local installations.

Military Documents. All military documents in service headquarters files that contained information pertinent to the implementation of the MCCA and its outcome(s) were read and evaluated as to their usefulness for this study. Those concerning key MCCA components and those that illuminated key aspects of the implementation process were pulled and copied. Documents eligible for copying were written from November 1989, the date of MCCA passage, to July 1993, the time of our visits. Altogether, we pulled and copied a total of 336 documents from headquarters files, which represented approximately half of all the eligible materials in the MCCA-relevant files.

Worldwide Mail Survey. The survey (available upon request from the authors) was developed in consultation with military child development specialists, and field-tested by two child development directors. The survey contained a total of 113 questions, focusing on all aspects of the MCCA, the impact of the changes brought about by the act, as well as experience with the implementation. Most of the questions were closed-ended, although many provided a write-in option. The survey was mailed to all installations with a CDC in May 1993. A total of 245 installations—80 percent of those eligible—completed the survey. The majority of the nonresponses were from installations outside the continental U.S. (OCONUS), which means that our ability to generalize results to OCONUS is limited.

The responses from the mail survey were analyzed statistically, using the software package STATA (Computing Resource Center, 1992). As appropriate, statistical tests of significance (e.g., F-tests, t-tests) were performed. The type of test and the results are noted in the text where relevant.

Face-to-Face Interviews. The second primary data source derives from a series of 175 face-to-face interviews conducted with key personnel at the DoD, headquarters of each service, four major commands, and on 17 local installations. Staff interviewed included military personnel at all levels, CDC employees, FCC and Youth Programs (YP) staff, parent users of child care, and kindergarten teachers. Prior to these visits, a semi-structured instrument was developed for each respondent category to enable us to obtain information which that respondent was uniquely able to provide because of his or her position.

The installation sample was chosen to reflect a range of MCCA implementation and accreditation experiences.[7] The installation sample was stratified by service. On the basis of information obtained from child development specialists in each service headquarters, installations were categorized according to the degree of difficulty (easy, average, difficult) they had experienced with the overall implementation of MCCA requirements. Installations were also categorized according to the presence (or absence) of at least one accredited center. Those installations with one or more accredited center were further divided into early, middle, and late accreditors according to the date of accreditation of the first center.[8]

In all, the final study sample included 17 installations distributed evenly across the four services: four Air Force, five Army, four Navy, and four Marine Corps installations. The selected installations represent a mix of the categories discussed above. Two of the installations were classified as having had relatively easy experiences with the MCCA implementation. Ten were rated as average, and five were rated as having had a difficult time meeting the requirements of the act. Ten of the installations had successfully accredited at least one CDC; three of these had two accredited centers.

As noted above, these installation visits were supplemented by visits to four major commands: Pacific Air Force (PACAF), U.S. Army Pacific (USARPAC), Training and Doctrine Command (TRADOC), and the U.S. Military Academy (USMA).

The notes from the face-to-face interviews were transcribed after the installation visit and then coded using sets of descriptive, interpretive, and explanatory codes (Miles and Huberman, 1984). When all notes were coded, the data were searched for instances of both verification and non-support of apparent patterns (Miles, 1990). Conclusions were drawn on the basis of those findings that appeared consistently in the data. These analyses were then compared to the findings from the survey and from the review of documents.

Our three-pronged data analysis provides us with rich data about MCCA implementation and impact. Interviews with a range of individuals who had a hand in the implementation of the act on local installations combined with survey data from child development program managers worldwide and the analysis of documents in headquarters

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[7]Accreditation experience was chosen as one dimension of stratification because of the need to evaluate the impact of accreditation on child outcomes, a requirement of the MCCA. See Zellman and Johansen (1996) and Zellman, Johansen, and Van Winkle (1994) for the results of this evaluation.

[8]See Zellman and Johansen (forthcoming) for more details concerning sampling.

files allow us to examine the process and the outcomes from many perspectives. At the same time, it is important to remember in reviewing our analyses and conclusions that each data source has its own limits.

Interview data are biased in unmeasurable ways by the fact that interviewees were not selected at random. Small numbers of individuals in each role position make this limitation more significant. The survey data, while representing far more respondents, measures people's perceptions of the facts, and not the facts themselves. In a few cases, indeed, perceptions were not entirely consistent with "harder," contemporaneous data. And of course, these perceptual data, collected in 1993, may not correspond to the situation today. We have footnoted these changes over time as relevant throughout the paper. Finally, the analysis of documents is based on a sample of documents selected from service headquarters files that were maintained in different ways. In relying on the three data sources, we believe we balance the problems and limitations of each, but do not eliminate them entirely.

FINDINGS

The MCCA has largely met its goals: improved quality of care in child development centers, increased availability of care, and reduced variation across CDCs in quality and affordability of care. We discuss the effect of the MCCA on each of these goals below. We also discuss the impact of the MCCA on FCC and on YP, to determine whether these important components of any coherent system of care were affected.

Quality of Care

The goal of improving the quality of care provided in CDCs was overwhelmingly achieved, as evidenced both by our fieldwork and by the results of our mail survey, which indicated that quality improvements were both widespread and apparent. This is not surprising. The quality goal received the most attention in the legislation and implementing regulations. The MCCA focused on those provisions designed to improve CDC quality, structuring their implementation and building in mechanisms such as inspection reports to monitor it.

Our survey results indicate that quality was rated substantially higher after the MCCA (see Table 1 for rating scales). Less than half of respondents rated the quality of care provided in CDCs before as excellent or very good. However, nearly all considered the post-MCCA quality of care in their installation's center(s) excellent or very good, as shown in Table 1. When comparing ratings of pre- and post-MCCA quality of care, it is apparent that

the average quality rating changed from 2.7 to 1.4, or a total of 1.3. As a lower score implies better quality, this means that the average quality score improved by one and one-third categories. In fact, about 70 percent of survey respondents reported that the quality of CDCs on their installation had improved by one or two quality rating categories (e.g., the quality rating went from OK/fair to very good or excellent), and 10 percent reported quality rating improvements of three or four categories (e.g., the quality rating went from not very good to excellent) as a result of the MCCA. This tremendous increase in perceived quality of care as a result of the MCCA was widely echoed in our installation interviews as well as at the headquarters level in each service and at the DoD. Everywhere we went, we heard the same message: care had improved substantially, sometimes dramatically, as a result of the MCCA.

Table 1

CDC Quality of Care Ratings

Rating	Pre-MCCA Quality Score	Pre-MCCA Percentage	Post-MCCA Quality Score	Post-MCCA Percentage
Excellent	1	9	1	61
Very good	2	37	2	35
OK/fair	3	36	3	4
Not very good	4	12	4	0
Not good at all	5	5	5	0
Mean	2.7		1.4	
Total		99*		100
N		214		239

*Entries do not sum to 100 because of rounding imprecision. Data from mail survey.

Because we were also interested in some of the specific dimensions of quality improvements, we asked mail survey respondents to describe major program problems with military child care prior to the MCCA in order to determine the extent to which these problems were resolved by the act. Table 2 shows the percentage of respondents who endorsed each listed problem.[9]

The most frequently endorsed problems concerned child care staff. Almost 80 percent of survey respondents indicated that staff training was a major problem prior to the MCCA, while 70 percent reported staff retention to be a major problem. About half of respondents

[9]The exact wording of the question was as follows: "Prior to the MCCA, what in your view were the major program problems with military child care?" Seven response categories were provided. In addition, there was space to write in other problems.

indicated that lack of developmental care and inadequate facilities were a problem; 43 percent thought that overall quality of care was a concern. About one-third of the respondents indicated that unmet demand was a problem. The most frequently reported "other problems" included low pay, lack of funding, and lack of command and/or MWR support.

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

Table 2

Major Child Care Problems Pre-MCCA

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

N = 244. Responses do not sum to 100 because respondents could indicate more than one problem. Data from mail survey.

Indeed, these problems were resolved to a large extent by the MCCA. Eighty-five percent of respondents reported that all or almost all of the problems that existed before the MCCA were resolved by the act. As shown in Table 3, less than three percent indicated that none or almost none of these problems had been resolved by the MCCA.

Explaining Improved Quality

What explains the greater quality that we and others observed?[10] Several things stand out. First, many of the mechanisms that would increase quality were built into the MCCA as provisions of the mandate. Thus, there was no need to debate *how* to make quality happen. Furthermore, the high degree to which the MCCA structured implementation of key

[10]We were able to observe quality improvements firsthand in some of those CDCs to which we returned during this study after a visit during an earlier study of child care. (See Zellman, Johansen, and Meredith (1994) for a discussion of that work.)

quality-related provisions contributed substantially to improved quality outcomes. The required APF$ match, an inspection program that defined success in terms of facility safety and appropriate care and specified public consequences for failure,[11] a hot line that enabled the DoD to learn of substandard CDCs, and the caregiver wage increase tied to training milestones set in place the means and mechanisms to bring about higher-quality programs and to monitor the improvement process.

Table 3

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

MCCA resolved:	Percent	Cumulative percent	Frequency
All or almost all	29	29	66
Many	56	85	126
A few	13	97	29
None/ almost none	3	100	6
Total	101		227

Entries do not sum to 100 because of rounding imprecision. Data from mail survey.

The MCCA's requirement that 50 CDCs become accredited as part of the accreditation demonstration program contributed as well to improved quality standards and also precipitated accreditation mandates in the Army and the Air Force.[12] The resulting widespread accreditation of military CDCs[13] is likely to have resulted in continuing improvements in the quality of military child care because, as documented in Zellman, Johansen, and Van Winkle (1994), accreditation by NAEYC is a valuable and powerful tool for improving CDC quality.

One of the reasons for the improved quality resulting from accreditation is the self-study process, which forms the core of the accreditation process.[14] Our respondents

[11]Child development programs that failed an inspection would be reported to the Deputy Assistant Secretary of Defense and immediate corrective action would be required. In cases of serious (life-threatening) violations, the CDC would be closed immediately.

[12]The Navy and Marine Corps have adopted universal accreditation policies since the end of our data collection period.

[13]By March 1997, 337 military CDCs (72 percent) were accredited. The highest rates were in the Air Force (98 percent), followed by the Army (81 percent) (Zellman and Johansen, forthcoming).

[14]Achieving accreditation requires completion of a three-step process that includes (1) a self study, (2) a site validation, and (3) a commission decision (NAEYC, 1991). For further details about the accreditation process, see Zellman, Johansen, and Van Winkle (1994).

indicated that self-study resulted in more culturally diverse curricula, improved caregiving, and increased prestige and recognition for accredited programs. The self-study process also revealed inappropriate activities on the part of the caregivers, who had a tendency to be too directive. Thus, the self-study process resulted in more child-initiated and child-controlled activities, which in many instances resulted in a reduction in discipline problems.

During the self-study process, center managers, staff, and parents work together to measure their caregiving practices against the criteria established by NAEYC. The self-study process also seemed to provide caregivers with a clearer sense of what constituted age-appropriate child development activities and why certain things were done. As a result, they felt more empowered to make both decisions and changes. Finally, accreditation resulted in activities better suited to particular age groups and in more age-appropriate disciplinary techniques.

In short, there is overwhelming evidence that the MCCA fully achieved its goal of improving quality of child care in CDCs. Moreover, the results of our mail survey indicate that variation in post-MCCA quality of care across CDCs on a single installation was much reduced. Respondents on installations with more than one CDC were asked to rate quality variations before and after the MCCA. We found that 60 percent reported some or a great deal of variation in pre-MCCA quality of care. Statistically significant differences across services were reported, with Army and Navy respondents reporting significantly less variation than respondents from the Air Force and Marine Corps. Only 15 percent of the respondents indicated that there was still variation in quality of care across CDCs on their installation after the MCCA. Interestingly, those installations that reported the greatest overall improvement in quality of care also reported the greatest reduction in variation in that quality. Finally, there were no statistically significant differences across the services post-MCCA in the amount of variation in reported quality of care, indicating that the MCCA has been successful in minimizing the differences in quality of child care across the services.

Availability of Care

Another of the major goals of the MCCA was to increase the availability of military child care in order to alleviate the excess demand reported by all the services prior to the act. The MCCA itself did not specify whether the intent was to increase availability of all types of child care (i.e., full-time, part-time, and hourly care) or only full-time care. The implementing guidance issued by the DoD soon after the passage of the act did not raise the issue either. But the lack of such language in the act or the initial guidance did not mean

that the issue was ignored. Both the services and a report by the Inspector General raised the issue, declaring that priority for child care had to be given to those children whose parent(s) work outside the home, i.e., to full-time care.

Increasing availability of full-day care presented a major challenge to child care managers and command. Some of the very MCCA requirements designed to improve quality, such as more rigorous inspections that enforced child-to-caregiver ratios, caused availability to decline in some cases. In addition, mechanisms that would ensure increases in availability were not written into the act or the regulations, as they were for the improvement of quality. Nor was it clear what those mechanisms might be. Indeed, some of the ways in which capacity might be increased, such as MILCON construction projects, were specifically rejected by some commanding officers (COs) in reaction to other MCCA requirements, particularly the APF$ match, which required continuing APF support for each new slot. Many COs did recognize that there were other ways to increase availability, mainly through increased use of FCC. These slots, which were considered by many COs prior to the MCCA to impose unacceptable costs in the form of child abuse risk and monitoring of providers without hope of revenue generation, were now seen as a far less costly way to generate care than through the development of additional CDC capacity. This realization is evidenced in our finding that almost one-third of our mail survey respondents indicated that the number of FCC slots on their installation had increased as a result of the MCCA; only 10 percent reported a decrease.

We also asked our mail survey respondents directly about the effect of the MCCA on the total number of full-time spaces available in CDCs. Table 4 indicates that about one-fifth of the respondents indicated that there were fewer (or substantially fewer) full-time spaces in CDCs, while two-fifths reported no change. Two-fifths reported more (or substantially more) CDC spaces after the MCCA.

In short, the second major goal of the MCCA—increased availability of care—was achieved to a much lesser extent than the quality goal. There are several reasons for this. First, unlike the quality goal, the legislation did not structure an implementation process or specific provisions that, once complied with, would lead to increased child care availability. Indeed, the contrary was the case. Furthermore, there was no compliance monitoring with regard to availability. Required inspections—the most public compliance indicator—do not address the issue at all. Nor has availability been the focus of documents emanating from major commands, headquarters, or the DoD. The MCCA also made CDC slots more costly

because of the required APF$ match. Thus, the legislation made one of its key goals less appealing and more difficult to attain.

Table 4

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

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

Data from mail survey.

Affordability of Care

Another goal of the MCCA was to increase the affordability of care and to reduce variations in affordability across locations. While not directly addressed by any of the MCCA provisions, the act did require a 1:1 match of appropriated funds to fee dollars, thereby increasing subsidization to CDCs. Furthermore, a new fee schedule based on total family income was developed by the DoD to ensure that care was affordable to all.[15] The schedule applied across locations and services, making fees predictable for families facing relocation. The DoD set fees so that they would remain at approximately their current levels so that the average family would pay essentially the same amount as it did prior to the MCCA. Using data from the National Child Care Survey (Hofferth et al., 1991) for comparison purposes, our analyses indicate that the average weekly fee paid by military families was substantially (almost 25 percent) lower than the average fee paid by civilian families with children in center-based care, even though civilian families typically used care only 38 hours per week as

[15]The first fee schedule included four fee categories, but this was subsequently expanded to include five categories, as follows:

Category	Total family income for period 9/1/91 - 8/31/92	Range of weekly fees authorized per child	Optional high-cost range
I	$0 - 11,000	$31 - 39	$34 - 43
II	11,001 - 27,000	35 - 45	38 - 48
III	27,001 - 40,000	46 - 57	49 - 61
IV	40,001 - 55,000	58 - 69	62 - 74
V	55,001 +	70 - 81	75 - 86

CDC directors were free to set fees with these indicated ranges. CDCs in high-cost designated areas were allowed to use the optional high-cost ranges.

opposed to 50 hours per week for military families (see Zellman and Johansen, forthcoming, for details).

It is also noteworthy that while military CDC fees may have increased overall as a result of the MCCA fee policy, they are still less than those in the civilian sector, both on an hourly and a weekly basis. This is particularly noteworthy because the average quality of care in military CDCs exceeds that in civilian centers, which have not seen the increase in quality brought about by the MCCA in military CDCs and which, with rare exception, are not accredited (see Zellman, Johansen, and Van Winkle, 1994). Thus, from this perspective, military child care is far more affordable than civilian care, given the higher quality of care being purchased on average.

When looking at the issue of affordability from the perspective of the share of income going to child care, our results paint a somewhat different picture. In spite of paying lower fees, military families, perhaps because of lower income, actually pay a larger share, on average, than civilian families (for center-based care) (see Zellman and Johansen (forthcoming) for details).

This average, however, hides some distributional differences between the military and the civilian sector. First, the two lowest income groups in the military—those with income below $27,000—spend the same proportion on child care as those in the civilian sector. Second, the higher income groups pay a relatively greater share in the military than in the civilian sector, although the difference is greatest in the middle income ranges ($27,001-$55,000).

Thus, judging affordability of military child care from the perspective of child care expenditures as a percentage of (annual) income, it is clear that military child care is as affordable for the lowest income people in the military as in the civilian sector, while it is slightly less affordable for higher income families in the military than in the civilian sector.

CROSS-SERVICE DIFFERENCES

The positive overall effects of the MCCA mask important differences in outcomes by service. Such differences in outcomes were hardly surprising given different service cultures, support for child care and the MCCA, and financial and organizational resources available for the MCCA implementation effort.

The Army seemed most prepared to implement the MCCA and did so more quickly and with less apparent difficulty or uncertainty than the other services. The Army's relative ease of implementation reflected greater organizational resources, i.e., amount of APF$ budgeted in FY'90 for child development programs. In addition, the similarity of many MCCA provisions to existing Army policies and procedures meant that the Army had fewer changes to make in order to implement the MCCA.

To a lesser extent, the Navy was also ahead of the MCCA implementation curve, e.g., training was already in place. At the same time, the more decentralized Navy organizational structure meant that central policies may not have filtered down to the base level, requiring more work to implement the MCCA.

The Air Force was unique in having a committed general who prodded reluctant or slow implementors and actively monitored the process over time. At the same time, the Air Force's relatively low level of APF$ support prior to the MCCA meant that there was a lot of need for change in order to implement MCCA provisions.

The Marine Corps began the implementation of the MCCA with few resources and a long way to go. There was no precedent in the Marine Corps for most of the MCCA provisions. Funding was limited, and headquarters staff were too few to actively monitor the implementation process. In addition, the Marine Corps was the most defiant in the face of MCCA requirements. Our document analysis indicates the early years of implementation were marked by lack of funds, delay, and resistance, although as time went by, the Marine Corps seemed to work harder to comply with the act.

In addition to, or perhaps as a result of the different service cultures and support for child care before the MCCA, perceived child care problems prior to the MCCA also varied across services, as shown in Table 5. The problem of staff training was perceived to be greater in the Marine Corps and the Air Force than in the Army and the Navy pre-MCCA. This makes sense because the Navy and Army were using Navy-developed training modules prior to the MCCA. Or, Air Force personnel, many of whom had gone through accreditation by the time of our survey, were in a position to be more critical of past policies and procedures.

With respect to developmental care, it is not surprising that the Marine Corps and the Air Force reported having more of a problem before the MCCA than either the Navy or the Army because they also reported the lowest pre-MCCA quality of care rating (results not

shown). It is also consistent with their higher rates of reported problems with lack of trained staff and their less developed training programs prior to the MCCA.

Table 5

Major Child Care Problems Pre-MCCA, by Service (in Percentages)

Service	Staff training	Staff retention	Lack of develop-mental care	Inade-quate facilities	Quality of care	Unmet demand	Fre-quency
Air Force	89	70	63	62	52	27	88
Army	73	73	43	37	34	29	70
Marine Corps	85	62	69	62	46	31	13
Navy	70	70	48	51	38	49	73
Mean	78*	70	53*	50	43	34**	244

*Means are significantly different p. < .05 (F test).
**Means are significantly different p. < .01 (F test).
Data from mail survey.

The service means for unmet demand are also significantly different, indicating that respondents from different services had different perceptions of the extent to which unmet demand posed serious problems before the MCCA. In particular, the Navy reported more of a problem with unmet demand. Furthermore, the means for inadequate facilities are significantly different at the .06 level, indicating service differences in problems with inadequate facilities. The fact that Marine Corps respondents reported the highest level of problems with inadequate facilities is consistent with the other data we collected that pointed to limited APF$ support for child care prior to the MCCA.

The means for quality of care and staff retention as major problems pre-MCCA did not vary significantly by service, reflecting the widespread nature of these problems prior to the MCCA.

In addition to these cross-service differences, there are also statistically significant differences by service in the average perceived change in the number of full-time CDC spaces after the MCCA. With the exception of the Marine Corps, respondents in each of the services reported a net increase in the number of full-time spaces in CDCs (see Table 6). Army respondents reported the greatest average increase. The Marine Corps results are understandable given pre-MCCA regulations, which allowed staff-to-child ratios to exceed scheduled ratios by 50 percent. Consequently, we would expect Marine Corps availability to decline under stricter enforcement of existing regulations.

Table 6

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

Service	Mean*	Std. dev.	Frequency
Air Force	.30	1.25	84
Army	.63	.90	64
Marine Corps	-.38	1.26	13
Navy	.28	.97	71
Mean	.34**	1.10	232

*Respondents were asked to assess the changes in the number of full-time CDC spaces on the following scale: Substantially fewer (-2); a few less (-1); no change (0); a few more (1); and substantially more (2). The responses were converted to numerical values according to the values indicated in the parentheses. Thus, a positive average indicates that on average, full-time CDC spaces increased. Conversely, a negative score indicates that they decreased.
**Means are significantly different p. < .02 (F test). Data from mail survey.

OTHER CDC IMPACTS

A number of other changes took place in CDCs as a result of the MCCA. We asked our mail survey respondents to indicate which changes had occurred on their installations. The results are reported in Table 7, below.

Table 7

MCCA-Precipitated Changes in the Provision of CDC Services

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

*Tied ranking.
Data from mail survey.

The most frequently reported change, reported by almost 60 percent of the respondents, was a reduction in the availability of hourly care, that is, fewer slots devoted to

care for children who use care on an occasional basis. Loss of such care has been a source of concern since the MCCA's inception. These concerns led to the mounting of a DoD survey of responses to hourly care requests made to Child Development programs during the period June 12-July 11, 1995 in a small number of locations. Preliminary findings reveal that 96 percent of those who requested hourly care during the survey period were offered such care and used it. Among the small percentage who requested but did not use hourly care, about half turned down an available hourly care slot, usually because the requestor did not want care in an FCC home. The survey will be fielded again during the winter to ensure that results are not seasonally biased. They do suggest, however, that there is enough hourly care provided within the system to meet the need.

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

In addition to these changes, about nine percent indicated that additional (or different) changes had occurred. These included both reductions and increases in child care services, although there were considerably more of the former. Reductions included fewer hours of operation, elimination of a half-day program, and reduced infant and toddler care. Service increases included increased hours of service and increased numbers of full-day slots.[16]

We heard a good deal about CDC changes during our fieldwork visits as well. For the most part, respondents reported that changes were designed to increase the number of full-day care slots. Thus, they focused on moving part-day and after-school programs elsewhere, and in some cases on moving infants spaces to FCC. Fieldwork interviewees who had done the latter considered moving infant care out of CDCs a fiscally prudent policy given higher

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

costs for infant care and the inability to raise fees accordingly. In most instances of such movement, an active FCC recruitment program preceded the move, so that displaced infants continued to receive care.

Other MCCA Effects

In addition to the impact on CDC, we also investigated the effects—both positive and negative—on FCC and YP.

Family Child Care. Although FCC was paid scant attention in the MCCA or the implementing regulations, changes in FCC could be expected because of the MCCA's support for subsidies to FCC providers and because of the changes required by the legislation in CDCs. The use of subsidies has been quite limited, but we did expect that decreased CDC capacity and increased appropriated funds support attached to each CDC slot would make FCC slots far more appealing to command than they had been in the past. In addition, the DoD made a decision early on in the implementation process to begin to treat FCC much the same as CDCs. This decision reflected DoD's concern with equity of resources across the two types of care.

On average, there was a slight increase in the number of FCC spaces reported by survey respondents, with no significant differences by service in reported changes in the number of full-time FCC slots. But changes to FCC were not limited to availability of slots. Another significant change was the availability of APF$ support for the FCC monitor position. As a GS position, the FCC monitor position became a more stable job and a more desirable one. It gave FCC enhanced status and because of the stability of the position, allowed the FCC coordinator to plan training and other improvements with some sense that she would be around to carry them through.

This position has also energized recruiting of FCC homes, which has resulted in substantial program expansion on some installations. Overall, 24 percent of our survey respondents indicated that the number of FCC providers had increased as a result of the MCCA. The inclusion of the FCC program in the MCCA-required inspection and certification process has increased attention to the program as well.

FCC provider training also improved in almost half of the programs, according to mail survey respondents. Providers now receive more and better training, sometimes from a CDC training and curriculum specialist.

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

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

Youth Programs. Virtually all MCCA provisions focused on children who were less than school-aged. Any impact on youth programs would be an unintentional consequence of MCCA implementation. As expected, survey respondents reported few effects on YP. The most frequently cited change (by 38 percent of survey respondents) was that the administration of before- and after-school programs was moved from CDS to YP, although this change only resulted in a physical relocation of these programs 9 percent of the time. A small number of YP respondents to whom we spoke during fieldwork were able to describe concrete benefits that accrued to YP from the MCCA. Most of these concerned improved training for CDC caregivers that was also provided to YP staff. There were also some fieldwork interviewees who told us that YP had benefited from the MCCA in less concrete but nevertheless important ways. For example, the MCCA had underlined the importance of programs for children, the importance of staff training, and the need for vigilance about child abuse.

A few interviewees clarified for us that the lack of change in YP that we found in our survey data was really a lack of *positive* change. Several of those whom we interviewed in the field noted that YP, always in a less favored position than child development programs, had suffered further as a result of the MCCA because far more appropriated funds support was going to CDP than before. This left administrators less inclined to provide support to YP, since such support was optional, while support to CDCs was not.

In short, the MCCA had a very minor but mixed impact on YP.

CONCLUSIONS AND RECOMMENDATIONS

There can be little doubt that the MCCA has achieved most of its goals. It has been an extremely effective tool in improving CDC quality. Improved quality everywhere has dramatically reduced the substantial quality differences across CDCs and installations that existed prior to its passage. While the effect has been more modest, the MCCA has also resulted in increased availability of care.

The degree of difficulty in implementing the legislation and resulting regulations varied substantially across provisions and services. Those provisions whose implementation process was structured in the law were more easily and fully implemented. Those that relied on DoD and service guidelines were implemented more slowly and less completely.

The effects of the MCCA extended well beyond the CDCs that were the focus of implementation efforts. In particular, the FCC program expanded and became more professional. Perceptions of its value increased as well. Effects on YP were evident, but far more mixed. In some cases, the MCCA has had a salutary effect on YP; in others, the effects have been less positive.

This study demonstrates that the MCCA has had a powerful effect on how the military delivers child care to its families. Most agree, despite varying levels of support for its mission, that the MCCA increased consistency across services and installations in the delivery of child development programs, that the MCCA established strong and specific standards for these programs, and that the law created powerful mechanisms for enforcing these standards. These changes did not occur, of course, without a considerable amount of struggle among both supporters and opponents of the act.

Further, our data indicate that these changes substantially improved the quality of care in CDCs. Limited data suggest that availability and affordability also improved.

There is always more to do. Our analyses suggested a number of approaches that the military might take to further improve the delivery of child care to military families and to extend the benefits of the MCCA beyond the CDCs that were the focus of the legislation.

In particular, we would suggest more integration of Youth Programs. Child care in CDCs is just one part of military child development programs. These programs include CDCs, FCC, school-age care, and hourly care. In earlier work (Zellman et al., 1992; Zellman

and Johansen, 1995), we question whether these elements cohere into a system of care. What was clear at that time was that the then-current "system" did not extend to YP.[17]

It should. YP needs more appropriated funds, more scrutiny, and an expanded mission that includes recreation but is not limited to that aspect of school-aged children's developmental needs. Such a program, organized and run in a way that maximizes interaction with CDP, would better serve children, communicate to parents that the military's concern for their children does not stop at age five, and would address the obligation to families that the military has accepted in return for their commitment to putting the military mission above all.

Furthermore, we also suggest equalizing Family Child Care to the extent possible. FCC experienced a key benefit from the MCCA in the availability of an appropriated funds-supported program monitor position on each installation with an FCC program. In many cases, this position and its occupant have energized and dramatically improved the program. In addition, FCC was included in the no-notice inspection process, which made the program more visible and for the first time gave child development staff a stake in FCC's success. Nevertheless, implementation of the act focused heavily on CDCs. This focus reinforced FCC's lesser status in the child development system, a status that reflects commander and parent concerns about limited opportunities for scrutiny, substantial subsidy of CDCs that result in low fees there, and very limited use of authority to directly subsidize FCC providers in order to equalize fees.

We strongly urge far more widespread use of the subsidization authority permitted under the MCCA. Direct subsidies maximize the advantages of FCC to the system in several ways. First, as we argue in Zellman, Johansen, and Meredith (1992), the substantial subsidization of CDCs in the absence of subsidies for FCC care result in higher fees in FCC. This serves to increase parental preferences for CDC care, reinforcing in most cases a preexisting preference based on the attractiveness and perceived safety and stability of CDCs. Direct subsidies would serve to decrease the extra costs to parents associated with FCC care. This would make this care more attractive and might reduce the numbers on waiting lists, since some portion of those on waiting lists are there because they prefer CDC

[17]As discussed in some detail in Zellman, Johansen, and Van Winkle (1995), the Air Force has integrated child care and youth programs under youth flights, which has brought increased attention to YP. The Army has also consolidated child and youth programs.

care to the FCC care that they are receiving. A targeted subsidization program would also help to open slots to infants, the parents of whom have the hardest time finding care.[18]

The MCCA has been instrumental in improving the quality and to some extent the quantity of care provided in the military to the benefit of military children and their families. Civilian families can only wonder whether they will ever be so lucky.

[18]Since our field period, the Navy and Marine Corps have begun to actively subsidize FCC care, which represents a dramatic policy change. The Marine Corps has targeted subsidies to infant/toddler, hourly, extended hours, and special needs care.

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AMENDMENT NO. ____ Calendar No. ____

Purpose: To state the sense of the Senate on Department of Defense sharing of experiences with military child care.

IN THE SENATE OF THE UNITED STATES—104th Cong., 2d Sess.

S. 1745

To authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes.

Referred to the Committee on ______________________ and ordered to be printed

Ordered to lie on the table and to be printed

AMENDMENT intended to be proposed by Mr. KENNEDY

Viz:

At the end of subtitle F of title X, add the following:

SEC. 1072. SENSE OF THE SENATE ON DEPARTMENT OF DEFENSE SHARING OF EXPERIENCES WITH MILITARY CHILD CARE.

(a) FINDING.—The Senate makes the following findings:

(1) The Department of Defense should be congratulated on the successful implementation of the

Military Child Care Act of 1989 (title XV of Public Law 101–189; 10 U.S.C. 113 note).

(2) The actions taken by the Department as a result of that Act have dramatically improved the availability, affordability, quality, and consistency of the child care services provided to members of the Armed Forces.

(3) Child care is important to the readiness of members of the Armed Forces because single parents and couples in military service must have access to affordable child care of good quality if they are to perform their jobs and respond effectively to long work hours or deployments.

(4) Child care is important to the retention of members of the Armed Forces in military service because the dissatisfaction of the families of such members with military life is a primary reason for the departure of such members from military service.

(b) SENSE OF SENATE.—It is the sense of the Senate that—

(1) the civilian and military child care communities, Federal, State, and local agencies, and businesses and communities involved in the provision of child care services could benefit from the develop-

ment of partnerships to foster an exchange of ideas, information, and materials relating to their experiences with the provision of such services and to encourage closer relationships between military installations and the communities that support them;

(2) such partnerships would be beneficial to all families by helping providers of child care services exchange ideas about innovative ways to address barriers to the effective provision of such services; and

(3) there are many ways that these partnerships can be developed, including—

(A) cooperation between the directors and curriculum specialists of military child development centers and civilian child development centers in assisting such centers in the accreditation process;

(B) use of family support staff to conduct parent and family workshops for new parents and parents with young children in family housing on military installations and in communities in the vicinity of such installations;

(C) internships in Department of Defense child care programs for civilian child care providers to broaden the base of good-quality child

(c) REPORT.—Not later than June 30, 1997, the Secretary of Defense shall submit to Congress a report on the status of any initiatives undertaken this section, including recommendations for additional ways to improve the child care programs of the Department of Defense and to improve such programs so as to benefit civilian child care providers in communities in the vicinity of military installations.

SEC. 1079. INCREASE IN PENALTIES FOR CERTAIN TRAFFIC OFFENSES ON MILITARY INSTALLATIONS.

Section 4 of the Act of June 1, 1948 (40 U.S.C. 318c) is amended to read as follows:

"SEC. 4. (a) Except as provided in subsection (b), whoever shall violate any rule or regulation promulgated pursuant to section 2 of this Act may be fined not more than $50 or imprisoned for not more than thirty days, or both.

"(b) Whoever shall violate any rule or regulation for the control of vehicular or pedestrian traffic on military installations that is promulgated by the Secretary of Defense, or the designee of the Secretary, under the authority delegated pursuant to section 2 of this Act may be fined an amount not to exceed the amount of a fine for a like or similar offense under the criminal or civil law of the State, territory, possession, or district where the

"(P) Costs of compensation (including bonuses and other incentives) paid with respect to the services (including termination of services) of any one individual to the extent that the total amount of the compensation paid in a fiscal year exceeds $200,000.".

SEC. 1077. SENSE OF THE SENATE ON DEPARTMENT OF DEFENSE SHARING OF EXPERIENCES UNDER MILITARY YOUTH PROGRAMS.

(a) FINDINGS.—The Senate makes the following findings:

(1) Programs of the Department of Defense for youth who are dependents of members of the Armed Forces have not received the same level of attention and resources as have child care programs of the Department since the passage of the Military Child Care Act of 1989 (title XV of Public Law 101–189; 10 U.S.C. 113 note).

(2) Older children deserve as much attention to their developmental needs as do younger children.

(3) The Department has started to direct more attention to programs for youths who are dependents of members of the Armed Forces by funding the implementation of 20 model community programs to address the needs of such youths.

(4) The lessons learned from such programs could apply to civilian youth programs as well.

(b) SENSE OF SENATE.—It is the sense of the Senate that—

(1) the Department of Defense, Federal, State, and local agencies, and businesses and communities involved in conducting youth programs could benefit from the development of partnerships to foster an exchange of ideas, information, and materials relating to such programs and to encourage closer relationships between military installations and the communities that support them;

(2) such partnerships could benefit all families by helping the providers of services for youths exchange ideas about innovative ways to address barriers to the effective provision of such services; and

(3) there are many ways that such partnerships could be developed, including—

(A) cooperation between the Department and Federal and State educational agencies in exploring the use of public school facilities for child care programs and youth programs that are mutually beneficial to the Department and civilian communities and complement programs

104TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
104-724

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 1997

CONFERENCE REPORT

TO ACCOMPANY

H.R. 3230

JULY 30, 1996.—Ordered to be printed

Transfer of excess personal property to support law enforcement activities (sec. 1033)

The House bill contained a provision (sec. 362) that would provide permanent authority for the Department of Defense (DOD) to provide excess personal property to state and local law enforcement agencies. This property includes vehicles, helicopters, weapons, ammunition and other property that is needed by law enforcement agencies. Section 1208 of the National Defense Authorization Act for Fiscal Years 1990 and 1991 (Public Law 101–189) estabished a one year program to provide excess personal property to law enforcement agencies for use in drug enforcement activities. This provision was extended until September 30, 1997 by section 1006 of the National Defense Authorization Act for Fiscal Year 1991 (Public Law 101–510). This provision would make the section 1208 program permanent and expand it to all law enforcement activities with a priority to counter-narcotics activities.

The Senate amendment contained no similar provision.

The Senate recedes with an amendment which would give priority to counter-narcotics and counter-terrorist law enforcement activities. The amendment would also ensure that DOD would incur no cost of transferring this excess equipment to these law enforcement agencies except the cost associated with the management of the program within DOD.

Sale by Federal departments or agencies of chemicals used to manufacture controlled substances (sec. 1034)

The Senate amendment contained a provision (sec. 1082) that would prevent the sale of chemicals that could be used in the manufacture of controlled substances. These chemicals could be sold, however, if the head of the department or agency certifies that there is no reasonable cause to believe the sale will result in an improper use.

The House bill contained no similar provision.

The House recedes with a clarifying amendment.

Subtitle D—Reports and Studies

LEGISLATIVE PROVISIONS ADOPTED

Annual report on Operation Provide Comfort and Operation Enhanced Southern Watch (sec. 1041)

The House bill contained a provision (sec. 1021) that would require a consolidated annual report on the conduct of Operations Provide Comfort and Enhanced Southern Watch over and within Iraq. This annual report would be required to be submitted to the Congress so long as the operations continue.

The Senate amendment contained no similar provision.

The Senate recedes with a technical amendment.

Annual report on emerging operational concepts (sec. 1042)

The Senate amendment contained a provision (sec. 1051) that would require the Chairman of the Joint Chiefs of Staff to provide an annual report to Congress describing the process of defining emerging operational concepts in each of the services and the

manner in which the services' processes are coordinated in matters of doctrine, operational concepts, organization and acquisition strategy.

The House bill contained no similar provision.

The House recedes with an amendment requiring the Secretary of Defense to prepare and submit the report in consultation with the Chairman of the Joint Chiefs of Staff.

Report on Department of Defense military child care programs (sec. 1043)

The Senate amendment contained a provision (sec. 1078) that would express the sense of the Senate that the Department of Defense should share its experiences with providing child care services with other federal, state, and local agencies.

The House bill contained no similar provision.

The House recedes with an amendment that would express the sense of the Congress.

Report on Department of Defense military youth programs (sec. 1044)

The Senate amendment contained a provision (sec. 1077) that would express the sense of the Senate that the Department of Defense should share its experiences in conducting youth programs with other federal, state, and local agencies.

The House bill contained no similar provision.

The House recedes with an amendment that would express the sense of the Congress.

Quarterly reports regarding coproduction agreements (sec. 1045)

The House bill contained a provision (sec. 1046) that would amend the Arms Export Control Act (22 U.S.C. 2776(a)) to require that quarterly reports to the Congress required by this statute include information on specified government-to-government agreements on foreign co-production of defense articles.

The Senate amendment contained no similar provision.

The Senate recedes.

Report on witness interview procedures for Department of Defense criminal investigations (sec. 1046)

The House bill contained a provision (sec. 1023) that would require the Comptroller General to survey and report on the policies and practices of all military criminal investigative agencies with respect to the manner in which interviews of witnesses and suspects are conducted.

The Senate amendment contained no similar provision.

The Senate recedes with an amendment that would narrow the scope of the survey to the subject of procurement fraud investigations in the Department of the Navy.

Report on military readiness requirements of the Armed Forces (sec. 1047)

The Senate amendment contained a provision (sec. 1063) that would establish a requirement for a one-time report from the Chairman of the Joint Chiefs of Staff on the military readiness re-

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the anaesthesia was accomplished, for example, using a novel anaesthetic or a novel dosing schedule, the objective of the claimed method would include the provision of a novel use of an anaesthetic in transplantation surgery and the use of the composition of matter (ie., the anaesthetic) would directly contribute to the achievement of the objective.

It is intended that the applicability of the exception in (c)(2)(A)(ii) for a patented use of a composition of matter can usually be decided by a motion to dismiss or summary judgment under Rule 12(b) or Rule 56, respectively, of the Federal Rules of Civil Procedure. For example, an accused infringer seeking to invoke the relief from remedies afforded under 287(c)(1) would ordinarily prevail under such a motion if the following conditions are met: (1) the movant shows by clear and convincing evidence that the recited uses of the compositions of matter, both individually and collectively, lack novelty, and (2) the movant also shows by a preponderance of the evidence that the steps of the claimed method that do not involve uses of compositions of matter (ie., the medical or surgical procedure steps) are, by themselves, novel and non-obvious, provided, however, that the movant may concede the non-obviousness in lieu of making the required evidentiary showing.

Paragraph (c)(2)(A)(iii) excludes from the definition of "medical activity" the practice of a patented process in violation of a biotechnology patent. For the purposes of this provision, the definition of the term "biotechnology patent" includes a patent on a "biotechnological process" as defined in 35 U.S.C. §103(b), as well as a patent on a process of making or using biological materials, including treatment using those materials, where those materials have been manipulated *ex vivo* at the cellular or molecular level.

Biological materials which may be manipulated *ex vivo* at the cellular or molecular level include a variety of cellular, intracellular, extracellular, and acellular substances. Cellular substances include (but are not limited to) cultured microbial and mammalian cells. Intracellular substances include (but are not limited to) genetic materials, such as DNA and RNA that is obtained from within the cell. Extracellular substances include (but are not limited to) proteins and other molecules that are secreted or excreted by cells. Acellular substances include (but are not limited to) viruses and other vectors for transmitting genetic material.

Ex vivo manipulation includes propagation, expansion, selection, purification, pharmaceutical treatment, or alteration of the biological characteristics of these substances outside of a human body.

This definition excluded medical procedures which do not involve *ex vivo* cellular or molecular manipulation of a biological material. For example, a patent on a method of performing heart transplantation surgery, including the use of a heart-lung machine, is excluded from this definition on two grounds: first, the method involves manipulation *in vivo*, not *ex vivo*, and second, the method does not manipulate the cellular or molecular characteristics of the heart.

The House bill included a provision which prohibited funds from being used by the Patent and Trademark Office to issue patents for surgical and medical procedures and diagnoses, with certain exceptions for medical and biomedical devices and processes.

Sec. 617.—The conference agreement includes section 617, which eliminates current reprogramming requirements which are redundant with section 605 of this Act. The Senate-reported bill included this provision as section 620. The House bill contained no similar provision.

Sec. 618.—The conference agreement includes section 618, which permits the Secretary of Transportation to issue a guarantee under title XI of the Merchant Marine Act, 1936, upon such terms as the Secretary may prescribe, to assist in the reactivation and modernization of currently closed shipyards that historically built military vessels if the State in which it is located is making a significant financial investment and is paying the credit subsidy cost of the guarantee. The provision requires the Secretary to impose such conditions as are necessary to protect the interests of the United States from the risk of a default. Total guarantees under this section are not to exceed $50,000,000, and no commitment to guarantee obligations under this provision may be issued more than one year from the date of enactment of this section. The Senate-reported bill contained a provision under section 622 that provided authority to make these guarantees, but did not require State contributions or require the imposition of any conditions relating to the risk of default. The House bill did not contain any provision on this matter.

TITLE VII—RESCISSIONS

DEPARTMENT OF JUSTICE

GENERAL ADMINISTRATION

WORKING CAPITAL FUND

(RESCISSION)

The conference agreement includes a rescission of $30,000,000 from unobligated balances under this heading, as proposed in the Senate-reported bill. The House bill did not include a rescission from this account.

IMMIGRATION AND NATURALIZATION SERVICE

IMMIGRATION EMERGENCY FUND

(RESCISSION)

The conference agreement includes a rescission of $34,779,000 from unobligated balances under this heading, as proposed in the Senate-reported bill. The House bill did not include a rescission from this account.

TITLE VIII—FISCAL YEAR 1996 SUPPLEMENTAL AND RESCISSION

DEPARTMENT OF JUSTICE

FEDERAL PRISON SYSTEM

SALARIES AND EXPENSES

The conference agreement includes a $40,000,000 supplemental appropriation for fiscal year 1996, for the Federal Prison System and makes these funds available until September 30, 1997, in order to allow total carryover funding for this account to be $90,000,000. This provision was not included in the House and Senate-reported bills, but is necessary for technical reasons to ensure that adequate funds are available for prison activations which were scheduled for 1996, but have been delayed until 1997.

(RESCISSION)

The conference agreement includes a rescission of $40,000,000 from funds appropriated in fiscal year 1996 for the Federal Prison System. Neither the House nor the Senate-reported bills included this rescission. Funding is available for rescission as a result of delayed activations of prisons scheduled to open in fiscal year 1996. This provision, in conjunction with the previous provision, is necessary to ensure that additional resources may carry forward from fiscal year 1996 to fiscal year 1997 to support ongoing prison system operations.

TITLE IX—FISCAL YEAR 1997 DISASTER ASSISTANCE

DEPARTMENT OF COMMERCE

ECONOMIC DEVELOPMENT ADMINISTRATION

ECONOMIC DEVELOPMENT ASSISTANCE PROGRAMS

The conference agreement includes $25,000,000 in emergency fiscal year 1997 funding for infrastructure expenses related to recovery efforts associated with Hurricanes Fran and Hortense and other natural disasters, instead of $18,000,000 requested as a fiscal year 1996 emergency supplemental appropriation. Amounts provided under this account are designated as emergency requirements pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

RELATED AGENCY

SMALL BUSINESS ADMINISTRATION

DISASTER LOANS PROGRAM ACCOUNT

In addition to amounts provided under title V of the bill, the conference agreement provides an additional $113,000,000 in emergency fiscal year 1997 subsidy appropriations for disaster loans for recovery efforts related to Hurricanes Fran and Hortense, and other natural disasters.

In addition to amounts provided under title V of the bill, the conference agreement includes an additional $22,000,000 in emergency fiscal year 1997 funding for administrative expenses necessary to carry out the disaster loan program for Hurricanes Fran and Hortense and other natural disasters, instead of $22,000,000 requested as a fiscal year 1996 emergency supplemental appropriation. Amounts provided under this account are designated as emergency requirements pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended.

SECTION 101(b)

DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 1997

The conference agreement on the Department of Defense Appropriations Act, 1997, incorporates some of the provisions of both the House and Senate versions of the bill. The language and allocations set forth in House Report 104-617 and Senate Report 104-236 should be complied with unless specifically addressed in the accompanying bill and statement of the managers to the contrary.

DEFINITION OF PROGRAM, PROJECT, AND ACTIVITY

The conferees agree that for the purposes of the Balanced Budget and Emergency Deficit Control Act of 1985 (Public Law 99-177) as amended by the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (Public Law 100-119) and by the Budget Enforcement Act of 1990 (Public Law 101-508), the term program, project, and activity for appropriations contained in this Act shall be defined as the most specific level of budget items identified in the Department of Defense Appropriations Act, 1997, the accompanying House and Senate Committee reports, the conference report and accompanying joint explanatory statement of the managers of the Committee of Conference, the related classified annexes and reports, and the P-1 and R-1 budget justification documents as subsequently modified by Congressional action. The following exception to the above definition shall apply:

For the Military Personnel and the Operation and Maintenance accounts, the term "program, project, and activity" is defined as the appropriations accounts contained in the Department of Defense Appropriations Act. At the time the President submits his budget for fiscal year 1998, the conferees direct the Department of Defense to transmit

of the Department carried out at its facilities; and

(B) improving youth programs that enable adolescents to relate to new peer groups when families of members of the Armed Forces are relocated.

(c) REPORT.—Not later than June 30, 1997, the Secretary of Defense shall submit to Congress a report on the status of any initiatives undertaken this section, including recommendations for additional ways to improve the youth programs of the Department of Defense and to improve such programs so as to benefit communities in the vicinity of military installations.

SEC. 1078. SENSE OF THE SENATE ON DEPARTMENT OF DEFENSE SHARING OF EXPERIENCES WITH MILITARY CHILD CARE.

(a) FINDINGS.—The Senate makes the following findings:

(1) The Department of Defense should be congratulated on the successful implementation of the Military Child Care Act of 1989 (title XV of Public Law 101–189; 10 U.S.C. 113 note).

(2) The actions taken by the Department as a result of that Act have dramatically improved the availability, affordability, quality, and consistency of

the child care services provided to members of the Armed Forces.

(3) Child care is important to the readiness of members of the Armed Forces because single parents and couples in military service must have access to affordable child care of good quality if they are to perform their jobs and respond effectively to long work hours or deployments.

(4) Child care is important to the retention of members of the Armed Forces in military service because the dissatisfaction of the families of such members with military life is a primary reason for the departure of such members from military service.

(b) SENSE OF SENATE.—It is the sense of the Senate that—

(1) the civilian and military child care communities, Federal, State, and local agencies, and businesses and communities involved in the provision of child care services could benefit from the development of partnerships to foster an exchange of ideas, information, and materials relating to their experiences with the provision of such services and to encourage closer relationships between military installations and the communities that support them;

(2) such partnerships would be beneficial to all families by helping providers of child care services exchange ideas about innovative ways to address barriers to the effective provision of such services; and

(3) there are many ways that these partnerships can be developed, including—

(A) cooperation between the directors and curriculum specialists of military child development centers and civilian child development centers in assisting such centers in the accreditation process;

(B) use of family support staff to conduct parent and family workshops for new parents and parents with young children in family housing on military installations and in communities in the vicinity of such installations;

(C) internships in Department of Defense child care programs for civilian child care providers to broaden the base of good-quality child care services in communities in the vicinity of military installations; and

(D) attendance by civilian child care providers at Department child-care training classes on a space-available basis.

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RAND

Examining the Effects of Accreditation on Military Child Development Center Operations and Outcomes

Gail L. Zellman, Anne S. Johansen, Jeannette Van Winkle

National Defense Research Institute