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ENHANCING THE COMMON GOOD SINCE 1918

September 17, 1997

Jen -
Zigler's study
state-by-state
N

Nicole Rabner
Associate Director for Domestic Policy
The White House
West Wing, 2nd floor
Washington, DC 20502

Dear Nicole:

Deborah Phillips suggested I send you our recent study of infant and toddler child care regulations that I conducted with Ed Zigler and Kate Marsland. I believe Deborah had mentioned the study to you in a previous conversation. I know the First Lady is very interested in young children and child care, and the findings may be useful for her October conference on child care. The study is being published by the *American Journal of Orthopsychiatry*, hopefully in the October, but if not then, January 1998 issue.

I met the First Lady at the 1994 Starting Points conference where she spoke so eloquently on the needs of young children. I had the honor of being the Director of Studies for the Carnegie Task Force on Meeting the Needs of Young Children and was the principal author of the *Starting Points* report. One of the report's four goals was to guarantee quality child care choices. To date our country is doing a fairly dismal job in this area.

Best regards,

Kathryn Taaffe Young

Kathryn Taaffe Young, Ph.D.
Assistant Vice President

KTY:tt

enclosures

Day-care dilemma

YOU SEEM TO BELIEVE THAT THE ANSWER to day care's dangers lies in greater government regulation: "In most states, the course of study for a driver's license is longer than for certification as a day-care worker" ["Dangerous Day Care," Cover, August 4]. The real question, which you totally avoided, is what are the requirements for parenting? Teaching in a building shared by a school-site day-care facility with very caring workers, I have watched 3-to-10-year-olds be dropped off at 6 a.m. and picked up at 6 p.m. I've listened to their swearing and fighting and screaming for an hour and a half before school and three hours after. I've watched parents hurrying them there and bustling them home, when they were half awake for both trips. Factor in divorce with joint custody and you've got an enormous number of parents who see their kids far less than either their teachers or day-care providers. I've wondered why in a world so overpopulated that we are destroying the very planet we live on these people bother to have kids in the first place?

CAREN BLACK
Aptos, Calif.

WHILE THERE ARE HORROR STORIES that keep working parents up at night, I don't know that your article offers a sufficient solution. What is suggested is more government intervention. Yet the author almost seems to blame parents for being "cheap" when it comes to choosing child care. The obvious solution is a melding of the two ideas. Why is it that our government can regulate our day care without contributing one dime to the cost? The public-education system is paid for with tax dollars and is heavily regulated by the government. Why doesn't this carry over into preschool education? Why aren't day-care facilities government subsidized and regulated? When nearly every parent works, child care is such an obvious national need. Even people without children could benefit from having their tax dollars invested in our children.

VIRGINIA D. WYETH
Benton, Ark.

AS THREE OF THE EXPERTS CITED IN your story, we would like to offer a few points of clarification. By vividly documenting the life-and-death consequences of inadequate child care, your article made a compelling case for health and safety standards. However, we are concerned that readers, especially parents of young children, may have been left with the mistaken impression that safety and health factors alone constitute minimally acceptable care. Though these factors are critically important, care that addresses only the physical aspects of children's development is merely custodial. In contrast, care that is considered minimally acceptable by early-childhood professionals adequately promotes children's social, emotional, and cognitive, as well as physical, development. This means that parents must be informed and assertive consumers, selecting only caregivers who are knowledgeable about child development, maintain a safe and healthy environment, are sensitive and responsive to children's individual needs, and are nurturing and affectionate. Consistent with the thrust of your article, parents should also demand better monitoring of child-care settings by appropriate state agencies.

KATHRYN TAAFFE YOUNG
Commonwealth Fund
EDWARD ZIGLER, KATHERINE MARSLAND
Yale University
New Haven, Conn.

THE DEATH OF 76 CHILDREN LAST YEAR while in day care is a tragedy but, as your article noted, there were 4.6 million children who survived being in a day-care facility. We certainly need regulation and the highest standards for day-care workers. I worked in a day-care facility as a volunteer and was impressed with the good personal hygiene, focus on healthy diet, and absence of the influence of television. The children thrived with loving care, which I feel certain is typical of most child-care programs. Your report conveyed the idea that there is a crisis in the programs, but that is not supported by the numbers you cited. Parents shouldn't be frightened unnecessarily.

GERRIE RYAN
Escondido, Calif.

Prozac and children

ARIANNA HUFFINGTON'S "PEPPERMINT Prozac" column is a masterpiece of irony [On Culture, August 18-25]. She is able to determine the appropriate medical evaluation of mood disorders, the correct FDA

Running Head: INFANT & TODDLER CHILD CARE REGULATIONS

The Regulatory Status of Center-based Infant & Toddler Child Care

Kathryn Taaffe Young

The Commonwealth Fund

Katherine W. Marsland and Edward Zigler

Yale University

Abstract

A decade ago Young & Zigler (1986) reviewed the status of state and federal regulation of center-based infant and toddler child care. Results of that analysis indicated that state regulations fell far short of the recommended quality standards set forth in the Federal Interagency Day Care Requirements (FIDCR). In fact, not one state met these standards across all three of the assessed quality dimensions: group composition, staff training and program of care. The purpose of this study was to determine the extent to which minimum quality standards are reflected in current state regulations for center-based child care and to assess changes in these regulations over the last decade. Toward that end, a five point rating scale was developed to rate nine quality indices, grouped into three dimensions: (1) Grouping (staff:child ratios and group size); (2) Caregiver Qualifications (general level of education, specialized training, and inservice training); and (3) Program (program of care, orientation, equipment, and facilitates). Results indicate that very little progress has been made toward strengthening state infant and toddler child care regulations. The majority of states do not require child care centers to meet acceptable standards for infant and toddler care. Moreover, while most states had language that would require centers to follow most or all guidelines for appropriate practice, almost all of the states had staff training ratings of either unacceptable or very poor on their requirements for staff training. Analysis of regulatory changes between 1982 and 1990 revealed minimal and uneven improvement. These findings are discussed in terms of both the interrelation of quality dimensions and the ongoing importance of improved state-level infant and toddler child care regulation.

The Regulatory Status of Center-based Infant and Toddler Child Care

Within a relatively short period of time, the use of out of home child care has become a necessary reality for the majority of families with children in the United States (US Bureau of Labor Statistics, 1990; Hofferth, 1992; Willer, Hofferth, Kisker, Divine-Hawkins, Farquhur, & Glantz, 1990). This change in the care and rearing of very young children has prompted a significant amount of analysis and debate within both the scientific and policy arenas. Importantly, research on the developmental effects of child care has demonstrated that child care is a heterogeneous phenomenon with both identifiable and regulatable features that are strongly associated with quality and that ultimately influence children's psychological development (Cost, Quality, & Child Outcomes Study Team, 1995; Phillips & Howes, 1987).

One area that has received considerable empirical attention concerns the relation between early child care and and infants' socio-emotional development as indicated by attachment style. Some (e.g., Belsky & Rovine, 1988) have argued that nonmaternal infant care is strongly associated with insecure and avoidant attachment styles, particularly when such care is initiated during the first year. However, others (e.g., Howes, Phillips, & Whitebrook, 1992; Lamb, Sternberg, & Prodromidis, 1992; National Institute of Child Health and Human Development Early Child Care Research Network, 1996) have concluded that child care itself neither promotes nor comprimises infants' security of attachment; rather attachment is influenced by a combination of factors including the over-all quality of child care, the number and stability of care arrangments during the first 15 months, maternal sensitivity, and the number of hours in child care per week.

Other studies have investigated child care's effects on both language and cognitive development (e.g., McCartney, 1984; Studer, 1992). For example, investigators have found that twelve month old infants' cognitive development was positively related to the quality of their child care center while poor communication skills were related to inadequate

infant:adult ratios. Most recently, a longitudinal study of the effect of child care on children's cognitive and language development found that better outcomes in both domains were associated with better quality care (NICHD, 1997).

While the effects of child care remains the topic of some debate (e.g., Scarr, 1996), there is general consensus regarding one point: the better the quality of care, the better the outcomes for young children (Love, Schochet & Mechstroth, 1996). There is also considerable agreement about which features of child care are most important to overall quality, particularly with respect to the care of infants and toddlers. These features include: staff:child ratio and group size, appropriateness of care provided (i.e. the extent to which care meets infants' social, cognitive, physical, and emotional needs) and staff training and education (Hayes, Palmer, & Zaslow, 1990). Despite this evidence, however, the actual quality of infant and toddler child care varies tremendously.

In addition to underscoring the relation between child care quality and children's developmental outcomes, these findings emphasize the importance of regulatory standards in determining the quality of child care. This position is far from new; numerous reports have made the case for improved regulatory practices—that the quality of care improves when standards are more stringent (e.g., CQ&O, 1995; Howes, Smith, & Galinsky, 1995; Morgan, 1980; Phillips & Zigler, 1987; Whitebrook, Howes, & Phillips, 1989; Zigler & Ennis, 1989; Zigler & Gilman, 1992).

In fact, a decade ago Young and Zigler (Young & Zigler, 1986) reviewed the status of infant and toddler day care regulations at both the federal and state levels. This paper analyzed the extent to which state infant and toddler regulations reflected the quality standards set forth in the Federal Interagency Day Care Requirements (FIDCR: Federal Register, 1980). Regulations were assessed across three domains: grouping (staff:child ratio and group sizes); staff qualifications and training; and whether the regulations called for developomentally appropriate care. The data for these analyses were drawn from the Comparative Licensing Study, Profiles of State Day Care Licensing Requirements for Day

Care Centers, Family Day Care Homes, and Group Day Care Homes (Administration for Children, Youth and Families, 1982).

Analysis of these data indicated that state regulations did not consistently reflect FIDCR recommended quality standards. In fact, not one state met the recommended standards across all three dimensions of quality. Specifically, no state met the infant and the toddler FIDCR guidelines for both staff:child ratios and group sizes. Only one state met the staff:child ratio guidelines for both infant and toddlers, and 32 states (62%) failed to meet FIDCR group size recommendations. Further, only eight states (16%) required that caregivers in centers serving infants and toddlers have training in child care or child development; 26 states (52%) allowed a person with no previous training in child care or development to be director of a day care center. Finally, only 21 states (42%) met or exceeded FIDCR guidelines for program.

The study reported here builds on this earlier report in two respects. First, a rating system derived from an array of established quality standards, including the FIDCR, afforded a more fine-grained analysis of state regulations. Importantly, this system produced ratings of individual quality domains (e.g. grouping, staff qualifications, and programming) as well as an overall quality rating for each state. This represents a significant improvement over previous analyses of state child care regulations in that it enables both within- and across-state analysis of the extent to which states' regulations reflect an appreciation of the interrelatedness of the individual features that affect quality. Moreover, while prior ratings of child care regulations have been largely dichotomous (e.g., regulations did or did not meet the specified standards), this rating system quantified the extent to which regulations meet or exceed minimal quality thresholds . Secondly, we also assessed the extent to which the status of state infant and toddler child care regulations has changed over the intervening years.

In sum, by quantifying established indices of child care quality, the current study sought to determine: (1) whether states are currently assuring that programs are expected to be

guided by basic standards of acceptable, developmentally appropriate practice; (2) whether states are currently assuring that infants and toddlers are protected from poor and possibly neglectful situations; and (3) whether states' regulation of center-based infant and toddler child care improved between 1982 and 1990.

Method

Data were drawn directly from state child care regulations as of July, 1990, for all fifty states and the District of Columbia. The definition for infants and toddlers was based on age. Infants were defined as children from birth to 18 months of age, and toddlers were defined as children from 18 to 36 months of age.

The development of the coding system was guided by existing developmental research. Because their work represents a consensus of leading researchers, we relied heavily on the National Academy of Sciences (NAS) Panel on Child Care Policy's quality criteria, which delineated both the structural (e.g., group size, staff:child ratios, and staff characteristics) and programmatic (e.g., space, equipment, and activities) dimensions of good quality child care (Hayes et al., 1990). Additionally, we drew from both the FIDCR (Federal Register, 1980) and the guidelines for infant and toddler care set forth by the National Association for the Education of Young Children (NAEYC: Bredekemp, 1987).

Nine quality indices were identified and were grouped into three domains: (1) Grouping (staff:child ratios and group size); (2) Caregiver Qualifications (general education, specialized training, and inservice); and (3) Program (physical facilities, equipment and toys; orientation; and developmentally appropriate program). In order to further refine the components of quality care as they would appear on a scale, we bolstered the relatively broad statements made by the NAS Panel on Child Care Policy with our reading of current research. We were, however, obliged to omit some dimensions of quality that are not part of state regulation, such as regulatory enforcement, staff compensation, and staff turnover.

A five-point quality scale was developed, and regulations were coded by the first author and a second rater who had assisted with the development of the scale and was thus

knowledgable about the criteria. Interrater reliability of .90 was found with a subsample of 15 randomly selected states, and disagreements were resolved through discussion.

The general criteria were as follows:

5 Points: Optimal. Meets high quality standards for infant and toddler care as identified through research and practice; and articulates the direct links between practice and its goals for fostering child development.

4 Points: Good. Meets most or all perameters for appropriate practices for high quality care for infants and toddlers as developed through research and practice, but does not articulate the purposes of such practices.

3 Points: Minimally Acceptable. Articulates broad guidelines calling for appropriate practice but do not define what appropriate practice means.

2 Points: Poor. Incorporates some minimal guidelines calling for appropriate practice.

1 Point: Very Poor or No Regulations. Incorporates guidelines that are poor practice or fails to set certain basic minimal guidelines.

Criteria for the five points were specified for each quality index. The criteria for Minimmally Acceptable standards for each index were as follows:

Grouping

Ratios: Infants 1:4; Toddlers 1:5

Group Sizes: Infants 8 or 9; Toddlers 10 or 11

Caregiver Qualifications

Education: High School/GED

Specialized Training in Development/Care/Education of Young Children:

At least three college-level courses (9-12 credits)

Annual Inservicing in Care/Development/Education of Young Children:

5 - 14 clock hours per year

Program

Environment: Guidelines specify that environment should enhance the quality of the program as well as meet basic safety standards

Equipment: Guidelines specify that equipment should enhance the quality of the program as well as meet basic safety standards

Orientation: General orientation related to child development theory and practice/early childhood education as well as orientation regarding health, sanitation, and safety guidelines

Program for Infants and Toddlers: Regulations contain broad language requiring developmentally appropriate practices for infants and toddlers or describing some developmentally appropriate activities

The number of points awarded for each quality indice were then summed within each domain, yielding a raw score for each state for each domain. Because the number of indices varied across dimensions, the maximum number of possible points was different for each of the domains. However, given no empirical or theoretical reason to weigh one dimension more or less heavily than another, the scores for each domain were adjusted to afford each domain equal weight.

This process generated four weighted scores for each state: three domain scores (Grouping, Caregiver Qualifications, and Program) and an overall score reflecting the sum of the weighted domain scores. These weighted scores were then translated into ratings (Optimal, Good, Minimally Acceptable, Poor and Very Poor) based on the range of possible weighted scores for each domain. A rating of Optimal reflected the fact that a state received the maximum number of points possible for a given domain. The remaining range of points was divided equally among the ratings Good, Minimally Acceptable, Poor and Very Poor.

In sum, the coding system entailed a two part process. States were first awarded points based on the extent to which regulations met the criteria specified for the indices within each of three quality domains. These points were then totaled within each domain and were

transformed into weighted scores in order to afford each domain equal weight. Thus, the first part generated weighted scores for each of three domains as well as an overall score reflecting the sum of the weighted domain scores. Second, these scores were translated into quality ratings, yielding an overall rating and three domain ratings for each state.

Results

Status of Current Regulations

As the charts in Figure 1 illustrate, not a single state met the criteria for Optimal or Good standards, and only 17 states (33%) had regulations rated as Minimally Acceptable for infants and toddlers. Thirty states (59%) had regulations that received overall ratings of Poor, and four states (8%) had no infant and toddler child care regulations at all or had regulations rated as Very Poor. The overall and dimension specific quality ratings of all states are summarized in Table 1.

Grouping. Twenty-seven states (72%) received ratings of either Poor (N= 18) or Very Poor (N=19) for this domain, indicating that they failed to adequately regulate staff:child ratios and group size. Only 14 states (28%) had Good (N=6) or Minimally Acceptable (N=8) ratings for Grouping. Not one state received an Optimal rating for this domain. This means that 18 states permit staff:child ratios of between 1:5 and 1:7 for infants and between 1:6 and 1:8 for toddlers, and 19 states allow ratios of 1:8 or less for infants and 1:9 or greater for toddlers. Moreover, 23 of these states failed to regulate group size for either infants or toddlers.

Caregiver Qualifications. Almost all of the states (98%) had Poor (N=25) or Very Poor (N=25) ratings for caregiver education, training, and inservicing. In fact, most states permit infants and toddlers to be cared for by staff who, on average, have not completed high school, have only had some general training in child development or early-childhood education, and receive fewer than 5 hours of inservice training annually. Only one state, Minnesota, received a rating of Minimally Acceptable in this domain. No states received ratings of either Good Or Optimal.

The very low ratings for staff preparation led us to look more closely at how each qualifications for three staff positions (directors, unsupervised caregivers, and supervised caregivers) influenced the aggregate quality ratings. Only 14 states (27.5%) met Minimally Acceptable standards for the education and training of directors of child care centers. This means that only a minority of the states require a program director to have, at minimum, a high school degree, three college-level courses in child development or early childhood education, and to participate in five to 14 hours of inservice training per year.

Program. The data reveal that a total of 45 states (88%) had at least broad language requiring centers to provide developmentally appropriate programs of care for infants and toddlers. Twenty-eight states (55%) were rated as either Good (N=27) or Optimal (N=1), indicating that they required centers to operationalize a developmentally appropriate program of care in the areas of social, intellectual, emotional, or physical development. In contrast, six states (12%) had regulations that failed to meet minimally acceptable standards for program guidelines; eight percent (N=4) were rated as Poor, and two (4%) were rated as Very Poor.

A closer look at these data reveals an important pattern. While many states required developmentally appropriate programs of care, few mandated minimally acceptable Grouping or Staff Qualification standards. In fact, there was no significant correlation among the scores for the three domains. Although the mean Program score was 21 (Minimally Acceptable), the mean Grouping and Caregiver Qualification scores were 13 (Poor) and 11 (Poor) respectively. Consequently, although 17 states received overall ratings of Minimally Acceptable, this rating does not indicate that the states established Minimally Acceptable standards for each of the three domains. Rather, high Program scores tended to compensate for low Grouping and Caregiver Qualification scores. In fact, five of the 17 states that received Overall ratings of Minimally Acceptable were rated as either Poor or Very Poor in both the Grouping and Caregiver Qualification domains but Good in the Program

domain. Only one state (Minnesota) received ratings of Minimally Acceptable for each of the three domains.

Follow-up Analyses

Zigler & Young's (1986) analyses employed a dichotomous rating system: regulations either did or did not meet quality standards as articulated in the FIDCR. Therefore, to compare the current findings with those of this earlier study, the more recent data were transformed into categorical form based on whether or not they met the current criteria for minimum acceptable quality . It is important to note that although the two studies employed quality criteria based on different sources, the two sets of criteria are comparable in that both the FIDCR and NAS criteria articulate a comon core of minimum acceptable standards. *

Grouping. Regulations governing ratio/group size showed some improvement. Of the 13 states (27%) that altered their regulations concerning this domain, all evidenced improvement. While it is heartening to note that no states relaxed their ratio/group standards and approximately one quarter strengthened their requirements in this area, the regulations of 37 states (74%) continued to fall short of minimum grouping guidelines when reassessed in 1990.

Caregiver Qualifications. In contrast to Grouping standards, regulations regarding Caregiver Qualifications actually worsened. The only state to improve regulations in this domain was Minnesota. Perhaps most distressingly, 41 states (82%) failed to improve their regulations regarding caregivers' education, training, and inservicing. Moreover, all 41 of these states failed to meet minimum guidelines for this domain in both 1982 and 1990. Further, of the nine states whose regulations did change, eight (88%) relaxed, rather than strengthened, their regulations. The potential importance of this to the actual overall quality of care provided will be discussed below.

* A state by state summary of this comparison across all three domains is available upon request.

Program. With respect to regulation of program of care, 21 states (51%) showed no improvement; 18 states (44%) improved sufficiently to meet or exceed minimum quality criteria; and two states , Colorado and Indiana, relaxed their regulations to such an extent that they no longer meet minimum quality thresholds. Of the states whose ratings did not change, 18 (56%) met minimum quality criteria in both 1982 and 1990.

Finally, despite the continued call for more stringent regulations, the overall thresholds of quality set forth in virtually all state regulations continue to fall short of minimum acceptable levels for infants and toddlers. Notably, none of the states met the quality criteria for every domain in 1982 and only one state, Minnesota, did so in 1990.

Discussion

The results of this study quantitatively document that state child care regulations continue to allow infants and toddlers to be cared for in environments that do not meet basic standards of appropriate practice that assures the safe and healthy development of very young children. Specifically, 67% of the states received overall ratings of Poor or Very Poor, indicating that they failed to require even minimally acceptable care. Not one state received an overall rating of Good or Optimal. These findings are in keeping with previous studies that have examined state level child care regulations and are particularly distressing in light of previous findings documenting the relation between state regulatory standards, the provision of high quality care, and child outcomes (CQ&O, 1995; Howes, Smith & Galinsky, 1995).

To establish healthy bonds with their caregivers, very young children need warm, stimulating and individualized nurturance from an adult who is knowledgable about children's growth and development and who stays in the job long enough to establish a consistent relationship. Thus, in interpreting these results the interrelation among the three quality dimensions must be considered. Structural features such as ratios, group sizes and caregiver training largely determine how effectively a specified program of care can be implemented (Hayes et al., 1990). It is hard to imagine that one adult can possibly ensure

the safety, let alone provide an appropriately nurturing and stimulating environment for nine (or more) infants. This scenario, however, meets the regulatory guidelines set forth in the 37 states that endorse such ratios and group sizes.

Similarly, the likelihood that a developmentally appropriate program of care will be implemented is reduced if care givers do not receive appropriate training and are responsible for caring for more than a few infants or toddlers. Nevertheless 36 states currently allow less than acceptable practice in both the Grouping and Caregiver Qualifications domains. Thus, although state policy makers' awareness of the importance of both small staff:child ratios and developmentally appropriate practice in defining program goals and activities seems to have improved somewhat, regulations still do not reflect a sufficient appreciation of the need to keep infant group sizes small and the importance of an educated and trained staff to care for and nurture children during their most formative early years.

This disconnect is reflected most distressingly in the results of the follow-up analysis. Despite significant advances in our understanding of how environmental factors influence early development and repeated calls for more stringently regulated child care, states have not significantly improved guidelines for the care of children during their most formative years. A majority of states continue to fall short of Minimally Acceptable levels across all three quality domains. Although a minority of states strengthened their requirements in the Grouping and Program domains, the opposite trend was evident with respect to Caregiver Qualifications: here states actually relaxed their requirements.

Recently there has been discussion among policy makers of relaxing staff:child ratios and group size guidelines. Proponents of this view argue that staff:child ratios and group size regulations unnecessarily restrict providers' ability to mix children of different ages, thereby reducing the costs of child care (e.g., Passell, 1996; Scarr, 1996). While this argument may be worthy of debate with respect to preschool and school-age child care, particularly in combination with more exacting requirements for caregiver training and education, it is

inappropriate with respect to infants and toddlers who require more individualized care. Further, the findings reported here indicate that only six states had staff:child ratio and grouping standards that were more restrictive than those that are considered minimally acceptable, and only eight states met the criteria for minimally acceptable standards in this domain. The remaining 37 states were rated as poor or very poor. Thus, only six states could relax staff:child or grouping standards without falling below the level that is considered minimally adequate for children's safe and healthy development.

Though the debate over the exact nature of the relationship between quality of care and child outcomes continues, there is unanimity regarding one aspect of the relationship: Poor quality care compromises children's development. Moreover, recent findings (e.g., Greenough, Black, & Wallace, 1987; Jones, & Greenough, 1996; Kolb, 1989) regarding the specific influence of experience on early brain development have important implications regarding the relationship between the quality of early care and children's outcomes, underscoring the importance of safe and stimulating environments. Care that does not provide sufficient nurturance and stimulation during the first three years of life compromises the development of the neuronal networks that provide the underpinnings for later children's later development (Shore, 1997). In light of this, it is particularly disheartening to note that 34 states would allow children to be cared for in environments that compromise their development.

As noted earlier, the rating system employed in this analysis enabled us to quantify the quality of states' regulation of the structural dimensions of center-based infant and toddler child care. Despite the strengths of this focused analysis, however, we note that it does not address all factors relating to the actual provision of good quality care (e.g., staff compensation and turnover) nor does itt assess the regulation of non-center-based care (e.g., family day care).

Additionally, while not a focus of this study, the importance of on-going oversight and monitoring must also be considered. The specifics of quality oversight vary from state to

state, and in many cases little monitoring occurs once a center is licensed. In the best cases, licensed facilities are subject to periodic inspections, unannounced visits and specified procedures for licensing renewal; however even the most stringent oversight occurs as infrequently as once every three years (Gazan, 1997)

In sum, the results of our analyses indicate that current state regulations for center based infant and toddler child care do not consistently establish minimally acceptable thresholds of quality. Further, minimum thresholds are just that: minimal. No states require or actively promote the provision of optimal care as defined by experts in child development and early childhood education. While some states have made movements in that direction over the past decade, such improvement has been limited to individual quality dimensions and has not translated into stronger overall standards.

In the absence of federal child care regulations, energies must be directed at strengthening regulation at the state level. This is particularly true now, given the recent push for greater state autonomy in areas not constitutionally designated to the federal government. State-level efforts need to address the regulation of four interrelated dimensions: staff:child ratios, group sizes, caregiver qualifications, and programmatic features such as equipment, health and safety. The establishment of a national child care conference, for instance, would facilitate the exchange of information among child care professionals, advocates, and policymakers about what constitutes good quality care, the relationship between quality care and children's development, and the importance of regulation in establishing minimal quality thresholds. *

Additionally, efforts must be made to assist parents, who are the consumers of child care services, to be better informed and more effective consumers. The child care market is driven largely by price, and good quality care does cost more than poor quality care (CQ&O, 1995). However, two recent studies indicate that parents would be willing to pay up to $10 more per week for better quality care and that strengthened regulation resulted in an

* We note that Hillary Clinton recently announced that the White House will sponsor such a conference in the fall of 1997.

modest price ($4-5 per week) and did not deter enrollment (CQ&O, 1995; Sibley, Abbott-Shim, & Galinsky, 1994).

As a society, it is time we recognize that the sound development of an increasing proportion of children is compromised by inappropriate care during their most formative years. While stricter regulation and monitoring can never guarantee improved quality, they can clearly establish minimal quality thresholds, thereby contributing significantly to the healthy development of all of our nation's children.

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Table 1

Ratings of 1990 State Infant and Toddler Center-based Child Care Regulation by Domain and Category

OVERALL

OPTIMAL (Score = 81)
No States

GOOD (Range = 65-80)
No States

MINIMALLY ACCEPTABLE (Range = 49-64; Mean=)
Alabama, Connecticut, Hawaii, Illinois, Kansas, Maine, Maryland, Massachusetts, Minnesota, Missouri, North Dakota, Oklahoma, Oregon, Rhode Island, Utah, Vermont, Wisconsin

POOR (Range = 33-48)
Alaska, Arizona, Arkansas, California, Colorado, Delaware, District of Columbia, Florida, Georgia, Indiana, Iowa, Kentucky, Louisiana, Michigan, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, South Dakota, Tennessee, Texas, Virginia, Washington, West Virginia

VERY POOR OR UNREGULATED (Range = 17-32)
Idaho, Mississippi, South Carolina, Wyoming

GROUPING

OPTIMAL (Score = 27)
No States

GOOD (Range = 21-26)
Connecticut, District of Columbia, Maryland, Massachusetts, Oregon, Vermont

MINIMALLY ACCEPTABLE (Range = 16-20)
Alabama, California, Hawaii, Kansas, Minnesota, Missouri, Wisconsin, Utah

POOR (Range = 11-15)
Colorado, Illinois, Indiana, Iowa, Maine, Michigan, Montana, Nebraska, New Hampshire, New York, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Washington, West Virginia

VERY POOR OR UNREGULATED (Range = 5-10)
Alaska, Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Kentucky, Louisiana, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Rhode Island, South Carolina, Texas, Virginia, Wyoming

CAREGIVER QUALIFICATIONS

OPTIMAL (Score = 81)
No States

GOOD (Range = 21-26)
No States

MINIMALLY ACCEPTABLE (Range = 16-20)
Minnesota

POOR (Range = 11-15)
Alaska, Arizona, Arkansas, California, Delaware, Illinois, Indiana, Maine, Massachusetts, Missouri, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Rhode Island, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia, Wisconsin

VERY POOR OR UNREGULATED (Range = 5-10)
Alabama, Colorado, Connecticut, District of Columbia, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, Oklahoma, Oregon, South Carolina, Vermont, Washington, Wyoming

PROGRAM

OPTIMAL (Score = 27)
Alaska

GOOD (Range = 22-26)
Alabama, Arizona, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin

MINIMALLY ACCEPTABLE (Range = 17-21)
Arkansas, California, Connecticut, Florida, Georgia, Iowa, Kansas, Kentucky, Louisiana, Michigan, Minnesota, Nebraska, Nevada, Pennsylvania, South Carolina, South Dakota, Tennessee

POOR (Range = 12-16)
Colorado, District of Columbia, Indiana, Mississippi

VERY POOR OR UNREGULATED (Range = 7-11)
Idaho, Wyoming

Figure Caption

Figure 1. Quality Ratings of State Regulations for Center-based Infant and Toddler Child Care

Figure 1

Overall