

# **KITH and KIN—INFORMAL CHILD CARE: Highlights from Recent Research**

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by Melanie Brown-Lyons, Anne Robertson,  
and Jean Layzer of Abt Associates Inc.



## **NATIONAL CENTER FOR CHILDREN IN POVERTY**

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# INTRODUCTION

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Over the last four decades, the steady movement of women with young children into the labor force has been accompanied by vastly increased use of out-of-home care arrangements for the young children of these working parents. While many children receive care in licensed child care centers, preschools, or licensed family child care homes, a good deal of child care takes place in settings that are, for the most part, not regulated. This type of child care is referred to as “informal” or “kith and kin” care. These terms, which are often used interchangeably, include care provided by grandmothers, aunts, and other relatives of the child, as well as care by friends and neighbors. These caregivers may or may not be legally exempt from state licensing requirements, depending on the state and the specific circumstances.<sup>1</sup>

Although this may be the oldest and most widespread form of child care, kith and kin child care received very little attention from either researchers or policymakers until the late 1980s, when states were required to allow the use of federal subsidies for all legal forms of child care, rather than restrict their use to licensed providers. For child care advocates, the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996 raised concerns that moving large numbers of parents from dependence on cash assistance into the workforce would result in an increase in the proportion of subsidies paid to informal caregivers (Collins and Carlson, 1998). The absence of a body of research on this type of care made it difficult to assess the likely consequences for parents (in terms of their ability to obtain and hold onto jobs) and for children’s well-being.

The purpose of this document is to summarize what the available research tells us about informal child care,<sup>2</sup> and to identify significant gaps in knowledge. Published articles and reviews, research reports, and other literature were examined to provide answers to the following questions:

- What proportion of children are in informal child care and what have been the trends in usage over time?
- What are the characteristics of families that use informal child care?
- Why do families use informal child care?
- What are the costs of informal child care?
- Who provides informal child care and what are their experiences?
- What are the experiences of children and parents who use informal child care?

Abstracts of each of the reviewed reports follow this synthesis.

## PROPORTION OF CHILDREN USING INFORMAL CHILD CARE AND TRENDS OVER TIME

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In recent years, several large data collection efforts have provided insight into the types of child care arrangements families use for their children. One of the few studies that collected information on child care usage after passage of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was the Urban Institute's National Survey of America's Families (NSAF). This study found that, in 1997, 76 percent of children under age five with employed mothers regularly used a nonparental child care arrangement. A significant proportion of these children used some type of informal child care provider for their primary child care arrangement. While only a small proportion used in-home care (8 percent), approximately 30 percent used relative care. As is the case with most child care consumer surveys, the NSAF did not present data on the regulatory status of family child care homes used by families in its study. However, it did report that 21 percent of the children were in some type of family child care home (Capizzano et al., 2000). Assuming that approximately three-quarters of children in family child care are in homes that are not regulated or registered (Kontos et al., 1995), then over half of these children were using informal care. All totaled, nearly half of children with employed mothers in nonparental arrangements were using informal child care.

A comparison of the NSAF findings with the findings from several national surveys conducted earlier in the decade reveals that there was little change over a seven-year period in the pattern of child care usage.<sup>3</sup> There was, if anything, a slight reduction in the proportion of children in family child care and a corresponding small increase in the proportions of children in center and relative care (see Table 1). Looking back farther to the period 1965–1985 (see Table 2), it is clear that, over a 30-year period, the use of center care climbed dramatically from 9 percent of children in 1965, to 32 percent 20 years later, and to more than 50 percent in 1985. (The NSAF shows a small drop in the use of center care by 1997.) After a sharp drop between 1965 and 1977 in the proportion of children who received care in their own homes, use of this type of care has held steady at between 4 percent and 9 percent. Use of family child care was the same in 1995 as it was in 1965, although there was some fluctuation over the intervening period. The use of relative care has declined substantially over the 30-year period.

Nationally, these changes reflect a complex array of social, cultural, and economic changes. As more and more occupations have opened up to women, the number of female relatives able and willing to care for children has grown smaller. An increased emphasis on the importance of early learning and the example of Head Start may have persuaded more parents to use center care for their preschool-age children.

In addition to temporal changes in the patterns of child care usage, there is significant variation across states in the types of child care used. Data from the NSAF show that the percentage of young children in relative care ranges from 18 percent in Minnesota to 39 percent in California, while in-home care usage ranges from 2 percent in Mississippi to 16 percent in New York (Capizzano et al., 2000). Several other studies have shown that relative and in-home care arrangements are more common in the Northeast, while center-based care is most commonly used in the South (Capizzano et al., 2000; Casper, 1997; Fuller et al., 2000). Explanations offered for these differences include differences in the demographic make-up of states, family values, economic conditions, and the availability of regulated facilities, as well as differences in state subsidy policies and child care regulations.

Even within states, some research suggests that there are differences in child care usage patterns across different types of communities. For example, Atkinson (1994), Hofferth et al. (1991), and Siegel and Loman (1991), found that rural families were more likely than families living in metropolitan areas to use relative care and far less likely to use center-based care. This may reflect the absence of centers and family child care homes in some rural localities, as well as the differences in community demographics and values concerning child care. By contrast, Casper (1997) did not find significant differences in use of relative or center-based care between families living in rural versus inner-city neighborhoods, although differences were found in their use of in-home and family child care; inner-city families were also more likely to use unregulated in-home care providers and less likely to use family child care homes.

**TABLE 1**  
**Type of Nonparental**  
**Child Care Used by**  
**Children Under Age**  
**Five<sup>4</sup> (1990–1997)**

	1990 National Child Care Survey (NCCS) <sup>5</sup>	1994 Survey of Income and Program Participation (SIPP) <sup>6</sup>	1995 National Household Education Survey (NHES) <sup>7</sup>	1997 National Survey of America's Families (NSAF)
Relative Care	27%	33%	35%	30%
In-home Care	4%	7%	7%	8%
Family Child Care <sup>8</sup>	28%	20%	23%	21%
Center Care	39%	39%	52%	42%
Other Care <sup>9</sup>	3%	1%		

**TABLE 2**  
**Type of Nonparental**  
**Child Care Used by**  
**Children Under Age**  
**Five (1965–1985)**

	1965 <sup>10</sup>	1977 <sup>11</sup>	1982	1985
Relative Care	47%	42%	41%	32%
In-home Care	21%	9%	8%	6%
Family Child Care <sup>12</sup>	23%	31%	31%	29%
Center Care	9%	18%	20%	32%

# CHARACTERISTICS OF FAMILIES USING INFORMAL CHILD CARE

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The proportion of families that use informal child care arrangements for their children varies considerably across demographic groups. Empirical data suggest that use of informal child care is related to the educational level of parents, household income, employment status, work schedule, receipt of public assistance, household composition, and ethnicity.

As both education and household income increase, parents are more likely to rely on regulated child care settings.<sup>13</sup> Less educated mothers and lower-income families are more likely to rely on informal child care arrangements with relatives and unregulated family child care providers (Capizzano et al., 2000; Casper, 1997; Emlen et al., 1999; Folk, 1994; Galinsky et al., 1994; Hofferth et al., 1991; West et al., 1996). Receipt of AFDC benefits was associated with greater use of informal child care arrangements in a national survey and several state studies (Casper 1997; Bowen and Neenan, 1993; Gilbert et al., 1992; Piecyk et al., 1999; Siegel and Loman, 1991).

Larger families are more likely to use relative or in-home care arrangements than families with only one or two children (Hofferth et al., 1991; Piecyk et al., 1999; Siegel and Loman, 1991). Like low-income families, families with several children are likely to consider the greater affordability of informal care a major factor in their child care decisions.

Mother's work schedules influence their choice of child care setting. Mothers employed part-time are more likely than mothers employed full-time to rely on a relative to care for children under age five (Caruso, 1992; Casper, 1997; Folk and Beller, 1993; Hofferth et al., 1991; West et al., 1996). Mothers who work evening or night shifts are more likely than mothers who work day shifts to rely primarily on informal care arrangements (Bowen and Neenan, 1993; Casper, 1997).

The use of informal care providers differs across ethnic groups. For Hispanic families, care by a relative is the type of care most often used, and the proportion who use this type of care is greater than for any other ethnic group. Black families are more likely to use relative care than white families, although studies suggest that they are either more likely or just as likely to use center care as they are to use care by relatives. White families are more likely than families in other ethnic groups to use both regulated and nonregulated family child care. However, among children who use family child care, white children are more likely to use regulated homes, while black children are just as likely and Hispanic children are more likely to use unregulated homes. While similar small proportions of white and Hispanic preschoolers use in-home care, this type of care is used by a much smaller percentage of black families (Casper, 1997; Folk, 1994; Galinsky et al., 1994; Hofferth et al., 1991; West et al., 1996).

# WHY FAMILIES USE INFORMAL CHILD CARE

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While some researchers have used demographic or other data to generate explanations for the differences in child care usage patterns, others have asked parents directly about their child care decisions. This research suggests that parents base their child care decisions on a variety of considerations and that their choices reflect tradeoffs between the perceived needs of the child and parental and family needs, as well as the constraints of the child care options that are available to them. Factors that may influence child care decisions include parental values and views of quality child care, as well as various constraints that may prevent parents from using the type of child care they prefer.

## PARENTAL VALUES

Many families who use informal care do so because they prefer to rely on relatives and other providers whom they personally know and trust (Galinsky et al., 1994; Hofferth et al., 1991; Zinsser, 1991). These choices reflect deeply held beliefs about the importance of arrangements that resemble parental care, as well as efforts to maintain strong family or community bonds and to seek out providers who hold similar cultural or religious beliefs, share their views about life and child rearing, or are similar to them in other ways (Fosburg, 1981 in Hayes et al., 1990; Fuller et al., 1996; Galinsky et al., 1994; Smith, 1991; Waite et al., 1988; Zinsser, 1991). For many parents, these qualities are seen as essential elements of quality care.

## PARENTS' VIEWS OF QUALITY

The research suggests that, regardless of the type of child care used, most parents care about the quality of their child care arrangement. However, their definitions of what constitutes quality vary, as do their perceptions of what different types of care have to offer (Galinsky et al., 1994; Hofferth et al., 1991; Siegel and Loman, 1991). In addition to placing a greater emphasis on opportunities for cognitive and social development, families who use regulated child care providers tend to stress the benefits of professional standards, while informal child care users are more likely to emphasize the familiarity of their providers. For example, regardless of type of care used, safety considerations play a key role in the choice of a provider. However, for parents who use informal care, safety is assured by individuals they personally know and trust, while parents who use regulated care believe that there is safety in a structured, monitored environment with trained staff (Butler et al., 1991; Galinsky et al., 1994; Hofferth et al., 1991; Kuhlthau et al., 1996; Siegel and Loman, 1991; Smith, 1991). Although state licensing requirements include a variety of health and safety measures, many parents do not believe that there are real differences between licensed and unlicensed providers, and some are simply not sure about what is involved in child care licensing (Siegel and Loman, 1991). When Galinsky et al. (1994) asked parents to rate the factors essential to quality child care, regulatory status was often ranked near the bottom of the list.

In addition to safety considerations, reliance on relatives, friends, and neighbors for care often reflects an attempt to maintain some stability and familiarity for children whose lives may be disrupted by employment requirements. Parents who believe their employment poses risks to their child's development tend to choose informal arrangements with relatives or in-home care providers. Parents who believe that their employment poses little risk to their child and that their child will do well when they are away choose to begin child care in infancy and are more likely to use formal child care arrangements, such as care within regulated centers and family child care homes (Peth-Pierce, 1998). In making a judgment about the quality of the child care provider, families that use informal care are more likely to rely on their own knowledge of the provider or a recommendation from someone they trust. Mothers who use licensed care are more likely to rely on objective information about the provider's professional experience and training, as well as their own judgment about the provider's personality (Beach, 1997; Butler et al., 1991; Hofferth et al., 1991; Porter, 1991; Galinsky et al., 1994; Smith, 1991).

When parents rate their satisfaction with their children's child care arrangements, they consider multiple factors, and their judgments do not always correspond with the quality ratings made by child development experts (Galinsky et al., 1994). Parents vary in their definitions of quality care, with some emphasizing a desire for nurturing, attentive care for their children and others stressing their desire for educational and social development opportunities (Siegel and Loman, 1991). However, when parents considered program quality and convenience across informal child care settings and center-based care, no one type of care was identified as ideal. Each type of care had strengths in some areas and was less strong in other areas (Gilbert et al., 1992). Parents' ratings of quality of care were comparable across a wide variety of types of child care (Emlen et al., 1999).

Although research findings are not entirely consistent, parents generally report high levels of satisfaction with whatever child care arrangement they are currently using, whether both formal and informal types of care are included (Hofferth et al., 1991) or only in-home and relative care (Butler et al., 1991; Smith, 1991). When asked about specific preferences for one type of child care and whether they would want to switch to a different type of child care, some parents' responses appeared to be influenced by family income and the age of the child in child care (Hofferth et al., 1991). Low-income families were more likely to express a preference for center-based care (Bowen and Neenan, 1993; Hofferth et al., 1991). Data from the NCCS (1990) and the profile of child care settings (PCCS) indicate that low-income mothers using relative child care were most likely to want to change arrangements and those using a center were least likely to want to change (Hofferth, et al., 1995, in Phillips and Bridgman, 1995). Parents stated that they believed center-based care would provide more learning opportunities, greater safety, and more reliable care for their children (Hofferth et al., 1995, in Phillips and Bridgman, 1995).

## **CHILD AGE**

Parental preferences for child care arrangements change as their children get older. Data on child care usage indicate that parents of infants and toddlers are much more likely to use informal home-based child care arrangements than parents of preschoolers (Capizzano et al., 2000; Casper, 1997; Gilbert et al., 1992; Hofferth et al., 1991; Siegel and Loman, 1991; West et al., 1996; and Zinsser, 1991). While these differences in usage may be partly attributable to the reduced availability and higher cost of center care for infants and toddlers, research on parental preferences suggests that families prefer more informal, home-like arrangements for their infants and toddlers, but then opt for the learning opportunities provided by center-based early care and education programs for their preschool-aged children (Hayes et al., 1990; Kisker et al., 1989; Mason and Kuhlthau, 1989; Porter, 1991). Some usage data suggest that, once children enter school, parents choose less expensive informal providers for after-school care, assuming that school has provided the necessary educational experience (Hofferth et al., 1991). As the availability of free or inexpensive organized after-school programs increases, these choices may change.

## **CHILDREN WITH SPECIAL NEEDS**

A majority of families with seriously disabled or chronically ill children use relative or in-home care arrangements for their children under age six. Research has suggested that this may often be a matter of preference. For example, Siegel and Loman (1991) found that, although a relatively large number of formal providers, both centers and family child care homes, indicated that they were able to care for children with physical and intellectual limitations or health problems, over half of the families with children who were chronically ill or disabled reported difficulties in finding a provider.

## **CONSTRAINTS ON PARENTAL CHOICE**

Although research based on parental report suggests that most low-income families who use informal care providers do so because they prefer this type of care, some studies suggest that a significant proportion of informal care users choose this type of care because they are unable to enroll their child in a regulated child care setting (Butler et al., 1991; Gilbert et al., 1992; Siegel and Loman, 1991). The factors most often cited as constraining families from using their preferred child care option are availability and accessibility, cost and affordability, and the hours of operation and other restrictions in the services offered by certain types of child care providers. These factors are usually intertwined; a community may have an adequate supply of center care, for example, but the care may be too expensive for parents, operate during hours that do not match their work schedule, or may not offer care for a wide enough age range to accommodate their children.

Parents think of availability within the constraints of affordability and accessibility. The NCCS found a strong positive relationship between income and perceived availability of center care; 49 percent of families with incomes under \$25,000 perceived a center to be available compared with 70 percent of families earning \$50,000 or more (Hofferth et al., 1991). Low-income families' choice of

child care was constrained by the limited number of programs that offered sliding-fee scales or accepted subsidies (Hofferth, 1995, in Kontos et al., 1995).

It is not just in parents' perceptions that affordability, accessibility, and availability are intertwined. Traditionally, the supply of center-based programs has been lowest in low-income and rural communities (Beach, 1997; Fuller et al., 2000; Kreader et al., 2000 in Lesser, 2000; Siegel and Loman, 1991; Zinsser, 1991). In both types of communities, there may not be enough families to support more than a minimal number of centers, in one case because most families cannot afford center care without assistance and in the other because the area is sparsely populated and families are widely scattered. Since parents typically look for child care close to home, both because transportation may be a problem and because they want to minimize the amount of time the child must spend traveling, informal care providers may offer the most convenient arrangement, especially in low-income and rural communities.

Parents who are required to work rotating shifts or during evening or weekend hours that do not conform to normal business hours may be constrained in their choice of care arrangement. A significant proportion of child care centers do not offer care during weekend or evening hours; informal providers are much more willing to accommodate nontraditional work schedules (Butler et al., 1991; Emlen et al., 1999; Fuller et al., 2000; Hofferth, 1995, in Kontos et al., 1995; Malaske-Samu, 1996; Siegel and Loman, 1991; Zinsser, 1991). Not surprisingly then, mothers who work either part-time or during nontraditional hours are more likely than mothers who work during normal business hours to use informal arrangements.

Emlen et al. (1999) theorized that a certain degree of flexibility is necessary in order to balance the competing demands of daily life and, for working parents, this flexibility must come from work,<sup>14</sup> family, or child care providers; the less flexibility offered by one, the more required of the others. A study of parents in the Pacific Northwest found that each choice of child care was associated with a unique pattern of flexibility. Child care centers offered the lowest level of caregiver flexibility and were predominantly used by families with a fair amount of flexibility at work and in their family situation; families with the lowest level of flexibility at work or in the home were most likely to choose care by relatives or in-home care providers.

Despite evidence that the demand for nontraditional hour care exceeds supply, several state and community efforts to increase the amount of nontraditional hour care within centers have failed because of low enrollment. This suggests that other factors, in addition to the flexibility of the arrangement, need to be considered. For instance, parents may prefer that their children remain in familiar home-based settings during overnight shifts and rely on familiar faces to bring about some sense of stability in their children's lives when work schedules are variable and unpredictable (Collins and Carlson, 1998). The research does not offer much guidance in these efforts because it usually does

not disentangle parental preference and the constraints imposed by irregular work schedules.

## **COSTS OF CARE AND EFFECT OF SUBSIDIES**

The cost of child care is an integral part of the child care decisions of most families with young children. In study after study, a substantial portion of parents mention child care costs as an important factor in their child care decisions. Some studies suggest that the high costs of care have prevented many families from enrolling their children in regulated child care facilities (Siegel and Loman, 1991; Zinsser, 1991). There is some support for this research in demographic data suggesting that low-income families are more likely to use informal providers.

If cost were indeed the major factor in families' choice of a child care arrangement, the availability of a child care subsidy should result in a different usage pattern (as long as administrative policies did not constrain parent choice). And indeed, several studies suggest that this is the case. The NCCS found that low-income families that received child care subsidies were much less likely to use relative care and much more likely to use center care than their unsubsidized counterparts (Brayfield et al., 1993). Similarly, other state-specific studies have found that families that received subsidies were more likely to use regulated care (Siegel and Loman, 1991; Meyers, 1993; Gilbert et al., 1992; Fuller et al., 2000).

A longitudinal study of California's GAIN program<sup>15</sup> conducted between 1990 and 1992 reported that child care subsidies increased the use of organized child care. During the three months before participating in the GAIN program, the vast majority of the women in this study relied on informal child care arrangements for their youngest child. As they entered training and job readiness activities in the GAIN program, and became eligible for child care subsidies,<sup>16</sup> these low-income mothers made a significant shift toward the use of organized care. Within the first three months of GAIN participation, usage of informal care substantially decreased as many families enrolled their children in licensed child care centers or family child care homes. After leaving the GAIN program, when eligibility for child care subsidies ended, a significant proportion of families using organized care began relying on family and friends to care for their children (Gilbert et al., 1992; Meyers, 1993).

Similarly, in Illinois, Siegel and Loman (1991) found that AFDC recipients participating in either Project Chance<sup>17</sup> or the Transitional Child Care Assistance program<sup>18</sup> were more likely to use regulated child care facilities, and less likely to use informal care providers, than AFDC recipients who were not participating in these programs.<sup>19</sup> In a more recent study of TANF families in Illinois who used child care vouchers, Piecyk et al. (1999) found that, between January 1997 and January 1998, usage of all types of child care increased, especially regulated care. However, the distribution of usage by type of provider did not significantly change.

Other studies, including two conducted in Maryland and Oregon, found that child care subsidy programs were associated with an increase in the use of informal care. In Maryland, expansion of the subsidy program resulted in a substantial increase in the proportion of subsidy recipients that used informal care arrangements. As a result, the percentage of subsidized families using relative and in-home care rose to match that of families using family child care; the proportion of families using center-based care did not change significantly (Piecyk et al., 1999). A 1996 study of Oregon families reported that subsidized families were more likely to use relative care than nonsubsidized families, who were more likely to use family child care homes and just as likely to use child care centers (Emlen et al., 1999).

It is hard to draw a firm conclusion about the role of the cost of care in determining child care choices. There seem to be changes over time and across states in the effect of subsidies on parental choice.

## COSTS OF INFORMAL CHILD CARE

A good deal of research has focused on the cost of various types of child care. While estimates may vary because of differences in methodology, there are consistent findings that in-home care is the most expensive form of child care, while relative care is the least expensive (Casper, 1995; Galinsky et al., 1994; Hofferth et al., 1991; Siegel and Loman, 1991). This trend has remained fairly consistent over time and, with the exception of in-home care, which has experienced steep cost increases since the 1970s, costs for each type of care have increased steadily at about the same rate. (See Table 3.)

TABLE 3  
Mean Weekly Child  
Care Payments for  
Youngest Child  
Under Age Five<sup>20</sup>

	1975 National Child Care Consumer Study <sup>21</sup>	1985 National Longitudinal Survey of Youth (NLSY) <sup>22</sup>	1990 National Child Care Survey (NCCS) <sup>23</sup>	1993 Survey of Income and Program Participation <sup>24</sup>
Relative Care	\$29	\$35	\$31	\$42
In-home Care	\$18	\$49	\$51	\$68
Family Child Care <sup>25</sup>	\$38	\$43	\$45	\$57
Center Care	\$46	\$44	\$53	\$64

The relatively low costs of relative care are the result of a number of factors, including the use of nonmonetary payments to compensate child care services (Folk, 1994; Henly and Lyons, 2000) and the reluctance of many providers to charge their relatives for care. Relative providers are the least likely to charge money for providing child care, especially when the provider is caring for a grandchild. Although percentages vary widely from one survey to the next,

research suggests that between 46 and 83 percent of relative providers do not charge for their services. The vast majority of in-home care providers, child care centers, and family child care homes (both regulated and unregulated) require monetary payments (Casper, 1995; Folk, 1994; Galinsky et al., 1994; Hofferth et al., 1991; Presser, 1989). Relative providers that do charge for their services are often motivated more by the assistance that they could provide to the parents or the children than by their desire to earn a living. Zinsser (1991) found this to be true for most informal providers in her ethnographic study of families living in an urban residential community. Informal providers in that community were more comfortable in the role of a helping hand, supporting others even at their own expense, than in the role of a businessperson calculating reasonable fees to be charged to clients.

According to the 1993 Survey of Income and Program Participation, among families who paid for child care for children between the ages of birth to four, employed mothers paid an average of \$42 per week for relative care arrangements, \$57 for family child care arrangements,<sup>26</sup> \$64 for center-based arrangements, and \$68 for in-home care arrangements (Casper, 1995). These figures vary by child age, with the youngest children being charged the highest fees (Siegel and Loman, 1991).

Hofferth et al. (1991), in analyses of cost data collected between 1975 and 1990, found that, despite significant cost increases between 1975 and 1985, the mean weekly child care payments for relative care in 1990 were similar to those in 1975.<sup>27</sup> However, all other types of child care arrangements experienced dramatic cost increases within this time period. Cost increases were especially large for in-home care providers whose weekly payments increased from an average of \$18 to \$49 between 1975 and 1985 and then to \$51 by 1990. One of the many factors that influenced cost increases was changes in the average number of paid hours per week that children spent in child care. Between 1975 and 1990, all four of the main child care arrangements experienced significant increases in the mean number of hours per week children under age five spent in their care (Hofferth et al., 1991).

# INFORMAL CHILD CARE PROVIDERS AND THEIR EXPERIENCES

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Research findings are limited on the characteristics and experiences of informal child care providers. Findings also vary considerably depending on the specific group of informal child care providers studied. Most of the studies cited below provide information on a sample of convenience and are not representative of informal child care providers more generally.

## DEMOGRAPHIC CHARACTERISTICS OF THE STUDY PARTICIPANTS

The majority of relative child care providers who participated in the studies reviewed here were the children's grandmothers, and they were from the same ethnic group as at least one of the parents. Most, but not all, of these studies used samples of convenience. (Brayfield et al., 1993; Butler et al., 1991; Casper, 1997; Emlen et al., 1999; Hofferth et al., 1991; Lesser, 2000; Piecyk et al., 1999; Presser, 1989).

Two separate studies of providers, using samples of convenience and completed at different times, found that close to 75 percent of kith and kin providers who participated in the studies were ethnic minorities (Fuller et al., 2000; Galinsky et al., 1994). In one of these studies, family child care providers were found to be fairly evenly divided among ethnic groups (Fuller et al., 2000).

In the Fuller study, family child care providers were roughly equally divided across ethnic groups (20 percent white, 27 percent black, 26 percent Latino, and 23 percent Asian). Kith and kin providers were less evenly distributed across ethnicities, and much more likely to be Latino (43 percent). The parent population, on the other hand, was more likely to be black (34 percent); white and Latino parents constituted 27 percent and 28 percent of the parent sample, with the remaining 10 percent being Asian. Of the four groups, white parents who used either family child care or kith and kin care were more likely to have ethnically matched providers than any other group.

On average, of the caregivers in these studies, the youngest child care providers worked in unregulated family child care settings, the next oldest were in regulated family child care settings, and the oldest provided relative care. Mean ages of providers ranged from 36 years for unregulated family child care providers to 40.5 years for regulated family child care providers and between 52.9 and 54 years for relative providers (Butler et al., 1991; Galinsky et al., 1994).

Research has found that the economic status of informal child care providers is generally similar to that of the parents for whom they work. As mentioned, relatives, especially grandparents, are the least likely to charge money for their child care services. In her study of grandparents providing child care, Jendrek (1993) found that 71 percent of grandparents were not paid for their services.

A number of informal providers' household incomes are supplemented by their own or other family members' work. Galinsky et al. (1994) found no difference among regulated and unregulated family child care homes and relative providers who participated in the study in terms of whether another adult contributed to the household income. Presser (1989) reported that over one-third of grandmothers who cared for their grandchildren had additional income from other work.

Research has found differences among types of providers participating in the studies in whether they report their taxable income from child care (Galinsky et al., 1994; Zinsser, 1991). For example, 94 percent of regulated family child care providers participating in one study reported their income, compared to only 42 percent of unregulated family child care providers and 5 percent of relative providers (Galinsky et al., 1994).

Most grandmothers and other relative providers who participated in the studies were married or living with a partner (Galinsky et al., 1994; Jendrek, 1993). Even so, the relative providers in one of these studies were more likely to be single than were the regulated and unregulated family child care providers (Galinsky et al., 1994).

## **RELEVANT EDUCATION AND EXPERIENCE**

In several studies, child care providers of different types varied in terms of their formal education, specialized child care training, and child care experience. On average, informal providers participating in the studies have had less formal education than providers in regulated child care settings and, among informal child care providers, relative providers usually have the least amount of formal education (Butler et al., 1991; Fuller et al., 2000; Galinsky et al., 1994; Siegel and Loman, 1991). As with the findings on income, the educational achievement levels of informal care providers closely match those of the parents in the studies. By contrast, Fuller et al. (2000) found that family child care providers were twice as likely and center providers three times as likely as parents to have pursued education beyond high school. Galinsky et al. (1994) reported that 46 percent of relative providers in her sample had not finished high school, while this was true of 33 percent of unregulated family child care providers and only 6 percent of regulated family child care providers. Other researchers reported similar rankings of formal education across different types of child care (Siegel and Loman, 1991; Butler et al., 1991). The Growing Up in Poverty Project found that providers with some post-high school formal education made up 26 percent of kith and kin providers, 51 percent of family child care providers, and 65 percent of center-based providers (Fuller et al., 2000). Zinsser's (1991) sample was atypical in that she found similar educational backgrounds for both informal child care providers and center-based child care staff. Both sets of providers were likely to have completed high school, but not to have continued their formal education.

Similarly, regulated providers generally report receiving more training in child care or early education than unregulated providers, who, in turn, receive more training than relative providers (Butler et al., 1991; Galinsky et al., 1994; Kontos et al., 1995; NICHD, 1996). The Profile of Child Care Settings (Kontos et al., 1995) found that approximately two thirds of regulated child care providers and just over one third of unregulated providers had received some sort of specialized child care training.

Most informal child care providers have had extensive experience caring for children, both their own and others (Butler et al., 1991; Fuller et al., 2000; Porter, 1998). In fact, research has suggested that, on average, informal providers, especially relatives, have had more years of child care experience than formal providers. For relatives, this may be partially explained by their generally older ages. One study reported that kith and kin providers had an average of 22 years of child care experience, family child care providers 19 years, and center-based providers 13 years (Fuller et al., 2000).

## **MOTIVATION FOR PROVIDING CARE AND JOB COMMITMENT**

Relative providers and family child care providers who participated in the studies reveal sharply different motivations for providing informal child care. The vast majority of relative providers care for children to help out the children's parents (Galinsky et al., 1994; Kontos et al., 1995; Malaske-Samu, 1996; Porter, 1998; Smith, 1991). By contrast, most family child care providers choose to care for children in order to be employed while staying home with their own children (Eheart and Leavitt, 1989; Nelson, 1990, in Kontos et al., 1995; Galinsky et al., 1994). Other motivating factors mentioned by relative providers include not wanting the child to be in another child care setting and giving the relative something to do. Additional motivators for family child care providers include feeling that work is a natural extension of their role as mothers and the flexibility of this type of work (Zinsser, 1991). Providers in both groups talk about the satisfaction of helping children grow and learn.

Relatives are less likely than family child care providers to be committed to the role of professional child care provider. According to several studies, most relative providers report that they are not in their chosen profession; many don't even consider themselves child care professionals (Galinsky et al., 1994; Kontos, 1995; Zinsser, 1991). Zinsser (1991) found that, while most informal providers did not say that child care was their career choice, 69 percent of regulated providers did. No difference in the level of commitment of regulated and unregulated family child care providers has been found (Galinsky et al., 1994). However, center-based providers participating in the studies usually expressed the highest level of commitment to their work (Fuller et al., 2000).

## **BENEFITS AND PROBLEMS FOR PROVIDERS**

Family child care providers interviewed by Zinsser (1991) described a number of job satisfactions. They enjoyed caring for children and formed close bonds with the children and their families. Providers were generally pleased to bring

in some income while being able to care for their own children. Sources of dissatisfaction mentioned by these providers included their husbands' not wanting them to work and the increased difficulty of managing their own families (Zinsser, 1991).

Another group of informal child care providers described work-related problems. These included managing children's behavioral problems, conflicts over payment, differences with parents in child-rearing approaches, and concern about being taken advantage of by parents (Porter, 1998).

As part of a study of grandparents with in-home custody of their grandchildren, Jendrek (1993) included a comparison group of grandparents who provided daily child care. Not surprisingly, daily child care did not affect the lives of these relative providers as much as child custody affected the lives of the other grandparents. The relative providers organized their days around the children for whom they provided care, but the majority did not report significant disruptions in their friendship or family networks or in their marriages (Jendrek, 1993). The most common problem reported was the need to alter routines and plans (73 percent) and having less time to get everything done (52 percent). Twenty-one percent of the grandparent providers did report a decrease in their contact with friends. Fifty-two percent said they felt a greater purpose for living since beginning to care for their grandchild (Jendrek, 1993).

As self-employed workers, informal child care providers, as well as many family child care providers, do not receive typical employment benefits such as health insurance and vacation pay. Also, for those providers who do not report their taxable income, they are not contributing to social security and do not qualify for federal unemployment insurance (Zinsser, 1991).

Although child care providers in settings other than centers typically work alone, type of care was related to the extent of contact providers had with other providers. Regulated providers had the most contact with other family child care providers, unregulated providers had less contact with other providers and relative providers had the least contact (Galinsky et al., 1994). Providers with stronger ties to other providers were found to provide more sensitive and responsive care (Galinsky et al., 1994). Zinsser (1991) points out that, even when informal providers lack work colleagues, the flexibility of their jobs usually allows them ongoing contact with friends and family.

## **INFORMAL PROVIDERS AND REGULATION**

There is consensus among researchers that the vast majority of caregivers are still unregistered and unregulated (Kahn and Kamerman, 1987, in Hayes et al., 1990). Some providers regard themselves as temporarily caring for the children of relatives and neighbors while raising their own children, and they may be unaware of the requirements or may regard the licensing process as too complex and costly to negotiate. Others may regard licensing as an intrusion, especially if they have no interest in seeking government subsidies. Still others may

be hoping to avoid the tax liabilities or lost welfare benefits and transfers that would result from having to report their income (Kahn and Kamerman, 1987, in Hayes et al., 1990).

The primary incentives for family child care homes to become licensed or registered appear to be receiving public subsidies, such as the Child Care Food Program, the possibility of referrals from resource and referral agencies and public social service agencies, as well as the ability to obtain liability insurance. Providers who see their activities as a business or career are frequently more eager to gain the visibility that licensing and registration may bring (Hayes et al., 1990).

Most of the unregulated providers (81 percent) in the study conducted by Galinsky et al. (1994) were illegally unregulated because they had more than the number of children required by their states to be regulated. The states in this study, however, had stringent thresholds for regulation and required providers who cared for more than one to three unrelated children (depending on the state) to be regulated. Moreover, 17 percent of regulated child care providers were out of conformance with state laws that regulate ratios, group size, and the age mix of children (Galinsky et al., 1994).

In a study of child care providers enrolled in Rhode Island's in-home and relative care subsidy program, conducted by Butler et al. (1991), almost half (46 percent) of the providers said they had considered becoming a licensed family child care provider. Urban providers were more interested than rural and suburban providers in changing their regulation status (Butler et al., 1991). However, in New Jersey, only 34 percent of providers participating in the state's process to approve home child care programs for subsidies indicated that they were willing to complete all of the requirements for becoming a registered family child care home,<sup>28</sup> even though they were informed that this would result in a higher payment rate. Three percent said they would be willing to complete some of the requirements, but 63 percent said they wouldn't complete any. Fifty-two-percent of the providers reported knowing that they could receive a higher subsidy payment rate if they became a registered family child care provider. Younger providers and renters, as opposed to homeowners, were more likely to agree to comply with all of the registration requirements. County, education level, length of services, knowledge of the higher pay scale, and the number of children in care from families who were not participating in welfare-to-work activities were not statistically related to the willingness to comply (Smith, 1991).

# EXPERIENCES OF CHILDREN AND PARENTS

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A central aspect of the experiences children and parents have with informal child care is the quality of care provided. Quality of care is a primary concern for both parents and policymakers. However, defining and measuring quality of child care, especially informal types of care, is difficult. The definition of quality child care varies across communities and families. Researchers, parents, and family child care providers do not always agree on definitions of quality for informal child care arrangements (Modigliani, 1991; Perrault, 1992, in Kontos et al., 1995).

Measuring quality of care across the range of informal child care settings is more complex than comparing the quality of care among child care centers. While researchers can readily assess specific common features of diverse child care settings such as how many books are available and how often providers talk with the children, it is more difficult to compare the overall quality of care provided by a loving relative who is a permanent figure in a child's life with care provided in a regulated family child care home with a strong preschool curriculum (Fuller et al., 2000). The measures used most often to assess overall quality of child care programs are the Early Childhood Environment Rating Scale (ECERS) for child care centers and Family Day Care Rating Scale (FDCRS) for family child care homes (Harms and Clifford, 1989). The FDCRS rates six areas of caregiving practice: space and furnishings, basic needs, language and reasoning, learning activities, social development, and adult needs.

## GLOBAL ASSESSMENTS OF QUALITY

In these studies, which draw samples of convenience and used the global assessments scales described above, informal child care is frequently rated as providing the lowest quality child care. Home-based programs are rated lower in quality than center-based programs, and unregulated programs are rated lower than regulated programs (Fischer, 1989; Goelman and Pence, 1987; Hofferth, 1995, in Kontos et al., 1995; Peth-Pierce, 1998). Using the ECERS and the FDCRS, Fuller (2000) rated 71 percent of both kith and kin providers and licensed family child care providers at the minimal level of quality or worse, while 42 percent of child care centers were similarly rated. Galinsky et al. (1994) reported similar findings, with inadequate quality ratings assigned to 13 percent of the regulated family child care providers, 50 percent of the unregulated family child care providers, and 69 percent of the relative providers.

## CHILDREN'S EXPERIENCES

When researchers assess specific aspects of child care that affect children, factors most often considered are structural dimensions of care, interactional dimensions of care, educational dimensions of care, and the social context of care. These dimensions often are measured using scales developed for more formal care settings.

The structural dimensions of child care most often investigated include health and safety indicators, child-adult ratios, number of children in a group, and the child care provider's training and experience. These aspects of child care settings affect children directly (compliance with health guidelines contributes to fewer injuries and accidents) and indirectly by influencing the provider's interactions with the child. The NICHD (1996) study of infant child care clearly linked structural aspects of the child care arrangement to providers' caregiving behaviors across five types of child care. Researchers found that small group size, low child-adult ratios, safe, clean, and stimulating physical environments, together with caregivers' nonauthoritarian childrearing beliefs, were consistently associated with caregivers who provided sensitive, responsive, warm, and cognitively stimulating infant care for each type of child care setting. Previous research has linked these positive kinds of caregiver interactions to better outcomes for children. In the NICHD study (1996), a large and carefully designed research effort, small group sizes and low ratios were most often found in informal care provided in the child's home, and there were no significant differences in the quality of the physical environment between licensed and informal home-based care arrangements.

### **Health and Safety Concerns**

The NICHD study (1996) emphasizes the importance of the physical environment of a child care setting since caregivers working in safe, clean, and stimulating settings are more likely to interact in positive, sensitive ways with infants. A number of studies have investigated the health and safety aspects of informal child care settings, using samples of convenience, and found the home settings to be generally clean, safe, and healthy (Butler et al., 1991; Zinsser, 1991). In one such study, regulated family child care providers had higher levels of compliance with health and safety indicators than unregulated family child care providers and relative providers (Galinsky et al., 1994).

### **Child-Adult Ratio and Group Size**

Group size and child-adult ratio have been found to be associated both with caregivers' interactional styles and child outcomes, but the findings are not always consistent. Smaller numbers of children in care have been linked with more positive caregiving for providers in both child care centers (Howes, 1983, in Kontos et al., 1995) and family child care homes (Fosburg, 1981, in Hayes et al., 1990; NICHD, 1996). Providers caring for a smaller group of children are likely to be more responsive, more positive, more socially stimulating, and less restrictive (Stallings, 1980; Stith and Davis, 1984, in NICHD, 1996; Fosburg, 1981, in Hayes et al., 1990; Howes, 1983, in Kontos et al., 1995). In the National Day Care Home Study (Fosburg, 1981, in Hayes et al., 1990), group size was the strongest predictor of home-based caregivers' behavior. However, Galinsky et al. (1994) reported that home caregivers in her study provided "higher quality" care when they cared for relatively more children—three to six children—instead of one to two children.

Additional studies have investigated the impact of group size and child-adult ratio on child outcomes. Although investigations of child care for toddlers have been quite consistent in revealing positive effects of low child-adult ratios (NICHD, 1996), studies of child-adult ratios for preschool-age children have not always indicated a strongly positive effect. Fuller (2000) reported that preschool children demonstrated more improvement in both cognitive and social skills when they were in child care settings with fewer children or where the ratio of children to well-educated adults was low. Larger groups and poorer child-staff ratios have been linked to poor social interaction and cognitive development (Clarke-Stewart and Gruber, 1984; Fosburg, 1982; Howes and Rubenstein, 1985, in Kontos et al., 1995). However, other studies found the reverse to be true (Kontos et al., 1994, in Kontos et al., 1995) or have found no association (Dunn, 1993, in Kontos et al., 1995). Peth-Pierce (1998) found that children who spent more time in group arrangements with more than three children had fewer behavior problems (as reported by the caregiver) and were observed to be more cooperative in child care.

In those states that regulate all forms of child care, including care by relatives and smaller family child care homes, limitations on the child-adult ratio and group size are frequently specified in the regulations. The regulations that govern informal caregivers who receive subsidies do not specify group size and ratio but rather focus on health and safety protections. Kontos et al. (1995) found that the large majority of family child care homes participating in their study fell within the regulation limitations and that most informal child care providers cared for only a few children. Those providers who cared for larger numbers usually provided care on staggered schedules which kept them within the legal enrollment limits (Kontos et al., 1995). When instances of large groups of children and high child-adult ratios occurred, most studies found that they were more likely to be found in child care centers than in informal child care settings (Fuller et al., 2000, Galinsky, 1994; Gilbert et al., 1992; NICHD, 1996). The average adult-child ratio in one sample of child care settings (Hofferth et al., 1991) ranged from 1.37 children for relative providers, to 3.11 children for family child care homes, to 6.55 children in child care centers.

## **INTERACTIONAL DIMENSIONS OF CARE**

Earlier research has documented that verbal, sensitive, responsive, stimulating interactions between children and caregivers are related to better child development outcomes. Recent studies of child care settings have explored the relationship between the type of child care and the provider's interactional style. Galinsky et al. (1994) and the National Child Care Staffing Study (Child Care Employee Project, 1989, in Butler et al., 1991) found that regulated providers were rated as more sensitive and responsive to children than unregulated and relative caregivers, while there were no significant differences between unregulated family child care providers and relative providers. Other researchers found that home-based providers, whether regulated or unregulated, were more likely to talk to children than child-care center staff (Fuller et al., 2000).

Compared with relative care, providers caring for unrelated children interacted more with the child in ways that involved teaching, playing, and helping (Fosburg, 1982, in Kontos et al., 1995). The interactional style of relative providers was described as less structured and less focused on the child (Kontos et al., 1995).

Using the Arnett Scale, which assesses a provider's positive interactional style with children, Fuller et al. (1991) found little difference among kith and kin providers, family child care providers, and center staff. Differences were only found in the extent to which providers gave children explanations, with center staff scoring significantly higher and kith and kin providers scoring the lowest. Other studies reported that interactions observed between children and informal child care providers were largely positive (Butler et al., 1991; Smith, 1991). Providers were responsive, nonpunitive, and handled discipline positively (Butler et al., 1991; Smith, 1991).

Children frequently develop close ties to their child care providers. Galinsky et al. (1994) found that half of the children in her sample were securely attached to their providers, and the children were just as likely to be attached to nonrelative providers as to relative providers. Given these attachments, the frequent changes in child care reported by many parents may have a negative impact on children. This is an aspect of child care which has scarcely been studied. One study did find that children who experienced more caregiver turnover as infants and toddlers performed less well in their preschool years (Howes and Steward, 1987, in Kontos et al., 1995).

## **OPPORTUNITIES FOR LEARNING**

Research findings consistently report that informal child care settings have less of an educational focus than center-based care. One sample of informal family child care providers (Zinsser, 1991) seemed to view keeping the children safe and healthy as their primary task, and emphasized physical care over providing opportunities for educational or social development. This general noneducational orientation is reflected in numerous aspects of a child's daily experience in informal child care. Children in informal child care settings were much less likely to engage in activities geared to promote literacy and learning than children in centers and regulated family child care homes. One study found books in only 42 percent of the informal child care homes observed (Butler et al., 1991). Children were also less likely to use educational toys and materials in informal child care settings (Butler et al., 1991; Zinsser, 1991). Educational input in informal child care settings came more often from educational television programs than from active teaching by the provider (Zinsser, 1991). Children watched more television and videos of all kinds in informal child care settings than in centers (Fuller et al., 2000; Porter, 1998; Zinsser, 1991). The greater educational focus of center-based care is associated with better cognitive and language outcomes for children and a higher level of school readiness (Peth-Pierce, 1998).

Parents view child care centers as providing better learning environments for children than informal settings (Gilbert et al., 1992). Parents were also more likely to think that center-care staff had more relevant education or training than either in-home or family child care providers (Hofferth et al., 1991).

The amount of planning done by child care providers for children's activities has also been found to be associated with the type of child care. In one study, regulated family child care providers were much more likely to plan activities for children than unregulated family child care providers or relatives (Galinsky et al., 1994). Galinsky et al. (1994) found that providers who do plan for children's activities were more likely to be rated as sensitive and responsive. In another study, child-care center providers did more planning for children's activities than did regulated family child care and kith and kin providers, but children in centers are still more likely than children in these home-based settings to be seen wandering around without any activities. (Fuller et al., 2000). Unlike the Galinsky research, Fuller's study also found that caregivers' sensitivity was similar in regulated and unregulated child care settings.

Informal child care providers observed by Zinsser (1991) did not typically take an active role in their approaches to children's misbehavior. They tended to accept the child's behavior as attributable to the child's temperament and so considered it unchangeable rather than analyzing difficult behavior in order to solve the problem.

## **SOCIAL CONTEXT OF CARE**

Although an association has not been reported in every study (e.g., Clarke-Stewart et al., 1994; Dunn, 1993, in Kontos et al., 1995), caregivers' formal education and specialized training have been linked to caregivers' behavior in many toddler and preschool programs (Arnett, 1989; Berk, 1985; Roupp et al., 1979, in NICHD, 1996). Caregivers with college educations and specialized training in child development were less likely to restrict children's activities, more likely to use indirect forms of guidance, and more likely to make efforts to develop the children's verbal skills (NICHD, 1996). Optimal caregiver qualities vary with the developmental age of the child in care, so that, in child care with infants, the caregiver's affective quality and sensitivity would be more significant than style of discipline (NICHD, 1996).

The training and experience of child care providers has also been linked to better outcomes for children. Key provider attributes that have been linked to positive child development include the caregiver's educational level, professional commitment to the field, and earnings. These factors together have been found to create more stable environments for young children (Fuller et al., 2000).

The opportunity to interact with other children varies across types of child care. Children in child care centers were more likely than children in home-based care to interact with other children (Fuller et al., 2000). The age range of

children in family child care homes has emerged as a factor influencing a child's development (Fosburg, 1982, in Kontos et al., 1995).

## **IMPACT ON WORK LIVES**

While most of the research on informal child care has focused on children's experiences, a number of studies have also addressed parents' experiences. Because most parents need child care in order to work, parents' satisfaction with a particular child care arrangement is influenced by its impact on their work lives as well as by their assessment of the quality of care provided. Research has addressed parents' overall satisfaction with informal child care, its impact on work life, and relationships between providers and parents.

Parents' work lives are substantially affected by the flexibility and stability of their child care arrangements. Breakdowns in child care arrangements and changes in schedules can cause substantial problems for families irrespective of the type of child care (Gilbert et al., 1992). One study found that 70 percent of families in one year reported problems because of breakdowns in their usual child care arrangements (Siegel and Loman, 1991). Families using formal child care facilities such as centers reported the fewest problems due to unreliable child care arrangements (Siegel and Loman, 1991). Another study found that, in general, parents lost less time from work when their children were cared for outside the child's home, whether that care was in a center or informal child care.

On the other hand, some parents find the greater flexibility of informal child care an advantage when it comes to matching irregular and changing work and school situations, with the result that fewer work days are missed (Gilbert et al., 1992; Hofferth et al., 1991). Employed women using informal child care arrangements were the least likely to stay home from work to care for a sick child (Hofferth et al., 1991).

Changes in child care arrangements happen frequently and can be stressful for both children and parents. Siegel and Loman (1991) found the majority of families using informal child care reported they had made changes in child care arrangements within the previous 90 days. These researchers suggested that, since informal child care providers are often unpaid or paid very little, parents are dependent on good will to maintain a child care relationship. On the other hand, Hofferth et al. (1991) reported that informal care arrangements had the greatest stability, with a median duration for relative care of 15 months, compared with 10 months for family child care and 8 months for center care.

Given the frequency of problems with child care due to changes in a parent's work schedule, a child's sickness, or changes in a provider's routine, nearly all families are sometimes in need of back-up child care arrangements. Most frequently this back-up or secondary arrangement takes the form of informal care, whether in-home or relative care, especially for the youngest children (Bowen and Neenan, 1993; Caruso, 1992). Hofferth (1991) found that, while

37 percent of the families used an informal provider for their youngest child's primary child care arrangement, 44 percent relied on a relative or in-home provider for their secondary arrangement. The fact that so many families rely on informal child care arrangements for either their primary or secondary form of child care underscores the importance of this form of care.

## **PARENT AND PROVIDER RELATIONSHIPS**

Several researchers have addressed the relationships between child care providers and parents, who together shape children's daily lives. While in one study most informal care providers reported talking with parents about child rearing (Butler et al., 1991), another group of informal child care providers reported these discussions were infrequent and brief (Zinsser, 1991). In-home providers were more likely than relatives to have child-related conversations with parents (Butler et al., 1991). Compared with center staff, informal child care providers scored higher on an index of agreement with parents (Fuller et al., 2000). Zinsser (1991) reported that some informal providers expressed animosity toward the career mothers who employed them and held the belief that mothers of young children should be at home.

## **IMPROVING THE QUALITY OF INFORMAL CARE**

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In addition to efforts to license or register informal care providers, many states offer training opportunities or other kinds of assistance, such as safety kits, fire extinguishers, toys, and equipment. While these efforts often draw providers who are already licensed and wish to upgrade their skills, they are usually less successful in reaching informal care providers. It is not clear whether this is because providers are not interested in the offers or because the information does not reach them.

The research offers conflicting evidence on this issue. In a mail survey of 192 license-exempt providers in Los Angeles, a majority (71 percent) indicated that they would be interested in opportunities to learn more about child care (Malaske-Samu, 1996, in Porter, 1998).

In another study, 73 percent of the in-home and relative providers surveyed said that child care training services would not be helpful to them, although 87 percent expressed interest in get-togethers or support groups to learn more about child care from each other. Urban providers were more likely than rural and suburban providers to say they would be able to attend such sessions (Butler et al., 1991).

Parents surveyed in this second study thought it would be helpful for their Department of Human Services to offer child care training for providers in the areas of discipline and child rearing (63 percent), and in health and nutrition

(31 percent). Parents who did not say it would be helpful to offer such training were doubtful that the provider would be willing to participate (Butler et al., 1991).

In a third study, most low-income providers expressed interest in gaining information on a wide range of issues, ranging from how to support children's development to other services in the community and opportunities for employment in child care. When asked how they wanted to obtain this information, participants voiced strong opinions in favor of both written materials and video tapes, with arguments about the advantages of each. Participants also expressed overwhelming interest in support groups, where providers could talk to and learn from one another (Porter, 1998).

## CONCLUSIONS

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As this synthesis of research on informal child care makes clear, a good deal is known about informal child care providers: approximately what portion of the child care market they represent, what kinds of families use them and why, who these providers are, and their reasons for doing what they do. Researchers know a little about the relationships among the providers and the parents and children they serve, and they have some ambiguous information about the quality of the child care experience and the kinds of help and information these providers might want and need. Most of this information, aside from the survey data on usage, is fragmentary; often different studies give different answers to the same question. Differences in the answers may be a function of the relative weakness of many of the measures. In addition, widely differing sample sizes and populations and the prevalence of single-site studies contribute to the confusion. Nevertheless, it seems likely that researchers will not achieve a much more precise understanding of many of the issues identified here, primarily because these providers are largely hidden and, especially in the case of relative providers, not especially anxious to be part of large-scale intensive research of the kind investigators undertake in more organized care settings.

## ENDNOTES

1. They also may be subject to some form of regulation if they receive public subsidies.
2. For this review, informal child care providers were grouped in three categories: relative care; in-home care; and unlicensed family child care. *Relative care* is care by extended family members (e.g., grandparents, aunts, and uncles) either in the child's home or in the relative's home. *In-home care* is care by nonrelatives in the child's home (e.g., nannies, au pairs, and babysitters). *Unlicensed family child care* is care by a nonrelated provider in that person's home that is legally exempt from licensing requirements. The size of these homes varies from state to state according to the individual state regulatory requirements.
3. When comparing usage data from these various data sets it is important to keep in mind that, in addition to differences in geographical locations and data collection time points, varying target populations (e.g., children under age five, low-income families, young mothers, employed mothers, AFDC mothers, etc.) and other methodological differences may have influenced their results. So that differences between research studies could be reviewed, the abstracts in this report include information on study design. For a list of some methodological differences that are worth considering, please refer to Appendix B of this document.
4. The NHES includes five-year-olds who have not yet entered school.
5. Data based on statistics from Hofferth et al. (1991) after parental care was removed from the denominator of statistics on primary child care arrangements for youngest child in household. Although the complete NCCS data set was larger, for comparison purposes, data in this table are limited to households with an employed mother and at least one child under age five. Due to rounding error, percentages do not sum to 100 percent.
6. Data based on statistics from Casper (1997) after parental care was removed from the denominator on primary child care arrangements for youngest child in household. Sample limited to households with an employed mother and at least one child under age five.
7. Data based on statistics from West et al. (1996) after parental care was removed from the denominator on child care arrangements for up to two children in the respondent's household. Note that usage data were not limited to primary care arrangements; if a child spent time in more than one setting on a regular basis, all of these settings were counted, regardless of the amount of time spent in each arrangement. As a result, percentages do not sum to 100 percent. Also note that the sample included households with employed mothers as well as non-employed mothers, and child care usage data were collected for up to two children in the respondent's household who were under age six but had not yet entered school.
8. Since these reports did not present data on regulatory status, this category includes both regulated and unregulated family child care homes.
9. Definitions of "other care" vary. For the NHES and NLSY, other care includes all nonrelative care. For the NCCS, this category is defined as including lessons, sports, clubs and self-care. For the SIPP, this category includes all school-based activities.
10. Data based on statistics from Low and Spindler, 1968 (cited in Hofferth et al., 1991).
11. Data for 1977–1985 based on statistics from U.S. Bureau of the Census, 1982, 1983, 1987 (cited in Hofferth et al., 1991).
12. Since these reports did not present data on regulatory status, this category includes both regulated and unregulated family child care homes.
13. The exception is in-home care, which, while infrequent, is most likely to be used by the most highly educated mothers and families in the highest income category (Casper, 1997; Hofferth et al., 1991; West et al., 1996).
14. Examples of policies that take away employee's flexibility include inflexible work schedules, rotating shifts, overtime, quotas for billable hours, severe absenteeism policies, and scheduling business meeting early, later, or at the lunch hour.
15. The California Greater Avenues for Independence (GAIN) program mandates that AFDC recipients work, prepared for work, or attend school after their youngest child reached age three. Local GAIN programs offer various services to help recipients move from welfare-to-work, including child care assistance through venter-voucher arrangements with family babysitters and private child care providers (Gilbert et al., 1992).
16. After starting GAIN activities, usage of child care subsidies increased from 36 percent to 98 percent.
17. Project Chance is Illinois' welfare-to-work program. Participants are potentially eligible for child care assistance while they are in school or traveling to school or engaged in other employment and training activities. At the time of the survey, 47 percent of all the people who said they were currently in Project Chance reported receiving child care assistance from the state (Siegel and Loman, 1991).
18. This program guarantees one year of child care subsidies to families required to leave AFDC for work under the Family Support Act (Siegel and Loman, 1991).
19. Note that increases in Project Chance participants' use of center care was due in large part to the availability of centers at community colleges where many participants attended classes. Also, Project Chance participants who had been given information about child care providers through the Illinois Department of Public Aid were significantly more likely to be successful in obtaining formal facility

care (Siegel and Loman, 1991).

20. Data limited to expenditures for the primary care arrangement used by the youngest child in the respondent's household; households limited to those with employed mothers paying for child care. Note that data for 1975–1990 are represented in constant 1990 dollars, while 1993 data represent 1993 dollars.

21. Source: National Childcare Consumer Study (Unco, 1975, in Hofferth et al., 1991).

22. Source: National Longitudinal Survey of Youth (Hofferth, 1987, in Hofferth et al., 1991).

23. Source: National Child Care Survey (Hofferth et al., 1991).

24. Source: Survey of Income and Program Participation (Casper, 1995).

25. Since these reports did not present data on regulatory status, this category includes both regulated and unregulated family child care homes. Note that, because a large proportion of unregulated family child care homes do not report their income, cost data for family child care homes may be unreliable; Kahn and Kamerman (1987) report that 94 percent of family child care is carried out through “largely invisible and unprotected” cash transactions (Hayes et al., 1990).

26. Research has suggested that regulated family child care homes charge more than unregulated homes (Fosburg, 1981, in Hayes et al., 1990; Galinsky et al., 1994).

27. Measured in 1990 dollars.

28. Requirements mentioned included: a physical exam at the provider's expense, attending 6 hours of training, being monitored regularly, having a structured program, and paying a one-time \$25 registration fee.

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