Illinois Study of License-Exempt Child Care: Final Report

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The linked survey of parents using license-exempt care and their providers was administered through a collaboration arrangement between the University of Illinois at Springfield Survey Research Office (SRO) and the Metropolitan Chicago Information Center (MCIC). SRO, under the supervision of Director Richard Schuldt, conducted all telephone interviews for the study. Thais Seldess of MCIC then directed the completion of personal interviews for cases in which telephone contacts were unsuccessful. SRO also programmed our survey instruments for use with Computer Assisted Telephone Interviewing (CATI), field tested the surveys, coded and cleaned open-ended data, and developed SPSS data files with survey results.

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Executive Summary

Background and Research Questions

This Final report presents findings from the Illinois Study of License-Exempt Care, which investigated subsidized license-exempt care provision through the Illinois Child Care Assistance Program (CCAP). The use of license-exempt caregivers, such as relatives and neighbors, is common in Illinois and in other subsidized child care programs across the United States. Its prevalence raises important policy questions in subsidized child care programs.

The Illinois Department of Human Services (IDHS) received funding for the study through the Child Care Bureau, Administration on Children, Youth and Families, U.S. Department of Health and Human Services. IDHS contracted with researchers at the University of Illinois at Urbana-Champaign to conduct project research activities. The three-year study used both survey and administrative data methods to examine license-exempt caregiving issues, with an emphasis on learning about the perspectives of both subsidized license-exempt caregivers and parents who use this type of care. Most of the project research was carried out in three diverse geographic areas: the North Lawndale and South Lawndale neighborhoods in Chicago (large city), Peoria County (mid-sized urban), and the "Southern Seven" Illinois counties (rural).

For study purposes, we defined license-exempt care as child care provided in home settings that have been legally exempted from Illinois licensing requirements. License-exempt providers can care for no more than three children, including their own children, unless all children are from the same household. Four types of settings are included in this definition: non-relatives providing care in their own home; non-relatives providing care in the child's home; relatives providing care in the relative's home; and relatives providing care in the child's home.

Seven principal research questions guided project research activities:

1. What are the patterns of care for families and children that utilize subsidized license-exempt child care, and how do these differ from families and children that rely on subsidized licensed child care?

2. Do parents who use license-exempt child care differ in demographic characteristics and other important respects from parents who rely on licensed care?

3. What factors influence families to choose license-exempt child care providers rather than licensed providers, or to choose a mix of these providers?

4. What are the characteristics of license-exempt subsidized child care providers, and what levels of experience and training do they have in providing child care?

5. How do parents and license-exempt child care providers describe the quality of license-exempt care, and what specific strengths and weaknesses do they identify with this type of care?

6. What training and resources are needed to support the quality of care offered by license-exempt providers involved in the subsidy system, and how can these resources best be provided?

7. Based on study findings and analysis of related research, what policy implications can be drawn for enhancing the quality of subsidized license-exempt child care?

The specific program context in which these research questions were examined has important study implications. The CCAP is a large, statewide child care program that provides subsidies to families with incomes up to 50 percent of the state median income level. The program features parental choice of either licensed or license-exempt providers, and there are no waiting lists for services. The co-payments that the program requires parents to make are the same whether the parent uses licensed or license-exempt care.

Data and Methods

Interviews with parents and their license-exempt caregivers in the three study areas were the principal data source for this report. Parents were randomly selected from all subsidy recipients using a license-exempt provider at least 15 hours per week in the study areas. If parents agreed to be interviewed, then the license-exempt caregiver who provided the most care for that family was approached. Interviews were completed with 303 of these parent and provider pairs, with roughly comparable numbers in each study area.

The survey instruments were designed to measure parent and provider views on diverse topics related to license-exempt caregiving. Several subsets of questions were intended to compare parent and provider perspectives on the same caregiving situations and issues. Parents and providers were asked to consider the same randomly selected focal child in answering these questions, to assure that each was referencing the same caregiving arrangement. Such areas of common questioning included perspectives on the most important goals to emphasize in caregiving, parent and provider relationships in caring for the child, resources useful in care provision, the impact of subsidies, and the operation of the CCAP.

Other questions focused on issues specific to either parents or providers. Parents were asked about factors that influenced their selection of license-exempt caregivers, and whether they had considered other options. They also were questioned about their reasons for needing care, the times care was needed, and child care cost issues. Providers were asked about motivations for providing care, patterns of care provision, child care experience and training, interest in training and licensing, and what they found most satisfying and most difficult about care provision.

Survey data were complemented by selected statewide analyses of administrative records prepared by the Chapin Hall Center for Children. Administrative data analyses allowed description of patterns of subsidized license-exempt care, as well as comparisons with families using subsidized licensed care. Selected characteristics of subsidized families and children also were assessed. In addition, longitudinal analyses provided information on length of care spells for subsidy users, and on repeat use of the program over time.

Summary of Major Study Findings

Over 87,000 families and 170,000 children received CCAP subsidies in January 2003, an increase of 63.2 percent from January 1998. Administrative data analysis revealed the prevalence of license-exempt care statewide. Over half (51.1 percent) of the families and 58.5 percent of

children using the program in January 2003 received care from at least one license-exempt provider, with the vast majority of these cared for by a single provider. License-exempt care was substantially higher when longitudinal data were analyzed, with over 70.4 percent of families using license-exempt providers at some time within three years of program entry.

Characteristics of Families Using License-Exempt Care

- Nearly three-fourths (74.5 percent) of all CCAP families statewide had two or less children in subsidized care in January 2003. Families relying solely on license-exempt care commonly had more children in care than those using only licensed care. For example, 69.7 percent of CCAP families using only license-exempt care had two or more children in subsidized care, compared to 42.7 percent of families that relied solely on licensed care.

- License-exempt care use varied substantially according to age of children. Administrative data analysis found that nearly three-fourths of subsidized children age 6 and over were using a license-exempt provider in January 2003, as compared to 26.2 percent who were using a licensed provider. License-exempt care also was slightly more common than licensed provision among infants. However, toddlers and preschool-aged children (ages 1 - < 2.5 and 2.5 < 6) were slightly more likely to be cared for by licensed providers.

- Analysis of state wage reporting data showed that CCAP families had average quarterly incomes of only $2,686 in January 2003 (about $10,744 annually). Average incomes were slightly lower for families using only license-exempt care compared to families using only licensed care. Use of other means tested social service programs was especially prevalent among families using license-exempt care, with 66.1 of such families statewide simultaneously using either TANF, Food Stamps, or Medicaid in January 2003.

- The parent survey sample consisted almost entirely of unmarried women, although one-third did have at least one other adult in the household. The average age of the parents interviewed was 29.3 years, and nearly two-thirds (63.6 percent) had at most a high school diploma or GED. The racial composition of the survey sample was 73.3 percent African American, 22.1 percent Caucasian, and 2.3 percent Hispanic.

Patterns of License-Exempt Care Use

- Average spell lengths for a cohort of families who first entered the program in Fiscal Year 1999 were 13.4 months, and spell lengths were comparable for families using license-exempt versus licensed care. Administrative data analysis further revealed that about two-thirds of cases that closed did not use the program again within two years. Repeat use was slightly more common among families that had relied solely on license-exempt care than families using only licensed care (33.0 percent for license-exempt only versus 26.6 for licensed only).

- Statewide, relatives provided 62.3 percent of subsidized license-exempt care for families in January 2003. Slightly over half (54.6 percent) of the license-exempt care was provided in the child's home, while 37.8 percent was provided in a relative's home and 8.9 percent in a

non-relative license-exempt home. Among survey respondents, grandparents easily were the most common relative caregivers, followed by aunts and uncles.

- Survey respondents typically were using full-time child care, with at least one child in care an average of 35.8 hours in the last week. Nearly two-fifths (38.0 percent) of parents reported having at least one child with special care needs such as asthma or ADHD.

- The prevalence of license-exempt care during evening, weekend, or overnight hours was among the most striking survey findings. Nearly four-fifths (79.2 percent) of parents reported being at work, school, or training during such non-traditional hours in the past three months, and 70.0 percent had used child care during these hours in the last week. In addition, 18.7 percent indicated that they had inconsistent work, school, or job training schedules.

Characteristics and Care Patterns of License-Exempt Providers

- Administrative data analysis revealed that license-exempt providers cared for an average of only 2.31 subsidized children in January 2003. Over three-fifths (61.6 percent) of license-exempt providers were caring for either one or two subsidized children, while an additional 22.3 percent were caring for three children.

- 57.3 percent of the license-exempt providers active statewide in January 2000 were caring for a child that remained with them in subsidized care for at least one year. Survey data further examined lengths of time that license-exempt providers had cared for children regardless of whether subsidies were received. Using this less restrictive criterion, respondents reported having cared for at least one child in the family for an average of 37.1 months.

- Survey respondents generally provided care full-time, and about one-fourth (24.4 percent) had their own children under age 13 with them while providing care. About one-fourth (25.9 percent) reported providing some unpaid care for children in the family we interviewed, and 30.2 percent received some non-monetary compensation for the care they provided.

- Over fourth-fifths (84.1 percent) of the providers surveyed were women. The mean age for the providers was 42.0, and 36.5 percent were age 50 and over. Nearly three-fourths (73.1 percent) were not married or living with a partner when interviewed, but 62.3 percent reported having at least one other adult in the household. Particularly notable was that 30.7 percent of the providers lived with the focal family for which they provided care.

- Providers in the survey sample were less educated on average than parents in the families they served. While 29.6 percent had attended some college and an additional 40.9 percent had completed high school, 29.5 percent had not completed high school or received a GED.

- Illinois license-exempt providers commonly have very low incomes. For example, 36.7 percent of the providers surveyed reported annual household incomes of less than $10,000, and an additional 30.7 percent were in the $10,000-19,999 range. When considered as pairs, 57.1 percent of survey parents and their providers both had incomes of less than $20,000. Administrative data analysis further found that 18.4 percent of January 2003 license-exempt

providers statewide have received TANF in the last five years, and that 44.8 percent had received either TANF, Food Stamps, or Medicaid.

Why Parents Choose License-Exempt Care

- Parent selection of license-exempt caregivers appeared to be driven largely by positive care attributes. Parents most often mentioned trust when choosing among factors that were most important in selecting their current license-exempt provider (85.4 percent of survey respondents). In addition, 94.7 percent said they still would choose their current license-exempt provider if cost was not a factor.

- Over half (55.1 percent) of the parents surveyed reported convenience or location among their three most important reasons for selecting their license-exempt caregiver, and 31.2 percent mentioned scheduling. These choice factors are reinforced by the large amount of care during non-traditional hours reported by both parents and providers.

- Learning opportunities were mentioned among the top three choice factors by only 12.0 percent of parents surveyed. However, this should not suggest that parents were uninterested in learning for their children while in care. Rather, considerations of learning opportunities may be subsidiary to more basic concerns such as trust in the caregiver or the extent to which care meets the demands of parental work or school schedules.

- Only 16.8 percent of parents surveyed indicated that their neighborhoods affected their choice of caregivers, but significantly higher numbers of parents in poor neighborhoods did so. This suggests the importance of further research to better understand the impact of neighborhood quality on child care choice and quality.

Why License-Exempt Providers Offer Care

- License-exempt survey respondents most often reported family and altruistic caregiving motives. For example, 19.8 percent of providers indicated wanting to help out the focal family as their most important caregiving reason, and 15.5 percent reported a desire to have the focal family's children cared for by a family member. Enjoyment in caring for the focal family's children (9.9 percent), wanting to provide structure and discipline for the focal family's children (9.9 percent), and expecting to be a role model for the focal family's children (8.3 percent) also were frequently mentioned care motives.

- Needing to earn money was reported as the most important caregiving reason by only 5.6 percent of the providers surveyed, and only 0.3 percent said they chose this work primarily because it was the only job they could find.

- Consistent with previous research, a sizable proportion (25.1 percent) of providers stated that being able to stay home with their own children was a major care motivation, although only 4.0 percent said this was the most important reason for caregiving.

Provider Experience and Interest in Training

- License-exempt providers had limited formal child care training. Only 14.6 percent of those surveyed had ever taken a college course in early childhood education or child development, and only one in five reported receiving any child care training in the past year. However, nearly two-thirds reported receiving some training in the past. Experience as paid caregivers was more extensive, with 63.2 percent reporting at least three years of paid experience.

- Three-fourths of the providers surveyed expressed an interest in receiving some type of training, with interest in CPR, first aid, child development, and activities for children all substantial. Provider interest in becoming licensed also was fairly high, with 34.2 percent very interested and 23.4 percent somewhat interested. However, over half (52.7 percent) indicated that they did not know what was involved in getting licensed.

- Parent and provider survey respondents agreed that a wide range of resources would enrich the care that children received. Over half indicated that the following resources would be very helpful: safety equipment, resources to help children learn, access to recreational or community activities for children, someone for the provider to call when problems occur, outdoor recreational equipment, and short-term care backup.

- The modes through which training is delivered may be especially important for license-exempt providers, because they often work alone and during non-traditional hours. Providers most often suggested that books (63.0 percent), videotapes (61.1 percent), and newsletters (52.1) were the most convenient training modes, while workshops or classes and meetings with other providers received less support. Slightly over two-fifths of providers indicated that home visits would be very convenient for training purposes, and another 29.6 percent said home visits would be somewhat convenient.

Perceptions about Quality of Care and Caregiving Relationships

- Parents and providers emphasized safety when selecting their three most important quality of care concerns (76.9 percent of providers and 67.6 percent of parents). Positive provider-child relationships were selected the most often by parents (68.3 percent), while health was mentioned the second most often (after safety) by providers. In contrast, caregiver training and experience was infrequently selected as a quality concern by both providers and parents.

- Nearly all parents and providers surveyed knew each other before care for the focal child began. Over 39 percent of these parents and 48.0 percent of these providers said that their relationships had improved as the result of their caregiving interactions, and nearly all others stated that their relationships had not changed. Disagreements related to caregiving were not commonly reported, and usually appeared to be resolved through mutual discussion.

Parent and Provider Assessments of CCAP and Subsidy Impacts

- Assessments of the CCAP by the parents and providers surveyed were positive. Consistent with program goals, parents most often cited their appreciation of receiving financial help

with child care costs, or of receiving help that allowed them to attend school. When asked what most needed to be changed about the program, increasing pay levels was easily most often mentioned by providers. Parents likewise emphasized payment issues, including higher pay levels for providers, lower co-payments, and improvements in payment processing.

- Over 90 percent of parents and providers indicated that the provider would continue caring for the focal child if subsidies were not available. However, both parties emphasized that the absence of subsidies could compromise the quality and stability of their caregiving relationships. In addition, over 70 percent of parents and providers asserted that the subsidies allowed providers to do things for children that they otherwise could not. These included basic provisions such as the purchase of food, clothing, and books and educational materials.

- Nearly all parents surveyed understood that the CCAP required them to make co-payments to their providers, and the vast majority reported paying these in full. However, the flexibility in when co-payments were made was stressed, which points to a financial advantage of license-exempt care for many parents. Furthermore, confusion regarding subsidy co-payment rules was suggested by the fact that only 17.5 percent of parents understood that their subsidy co-payment would be the same regardless of whether they used license-exempt or licensed care.

License-Exempt Policy Recommendations Based on Study Findings

- Our overarching study conclusion is that license-exempt caregiving in the CCAP generally represents a positive confluence of both parental choice factors and provider motivations. The broad inclusion of this form of care has facilitated parents' child care choices, and has allowed the program to serve large numbers of children whose parents work non-traditional schedules. Our findings suggest that license-exempt care can play an important role in assuring that a continuum of child care options are offered in large subsidy programs.

- There are two broad directions that policy makers may consider to assure that child care choices in subsidized programs are well-informed. First, given that research increasingly has demonstrated the importance of early brain development and early childhood learning, it is important that parents facing child care decisions be informed about the benefits of early learning and related developmental activities. Continued experimentation on the most effective ways to educate parents about supportive caregiving practices, regardless of setting, therefore is needed. Second, making informed choices about caregivers in subsidized programs requires a clear understanding of program rules. In addition to providing written information, both program orientation sessions for parents and initial individual meetings with child care program staff are important opportunities to convey such information.

- By their nature, license-exempt care settings are less regulated than licensed settings. Yet, in state subsidy programs involving billions of dollars in public funds, accountability concerns demand the establishment of basic monitoring standards. The provision of orientation sessions for providers may be one useful step. Limited follow-up with providers once care provision begins also merits consideration if states are to assure acceptable care standards.

- Continued development and testing of quality assessment instruments in license-exempt settings is vital and serves two related purposes. First, such instruments will allow more refined comparisons of the relative quality of licensed and license-exempt settings. Second, studies assessing license-exempt care quality can help define best practices in those settings, and therefore can guide the development of training for license-exempt providers.

- Our findings indicate considerable promise regarding the possibility of enhancing the care offered by license-exempt providers. Frequent provider interest in receiving training and becoming licensed, their attachments to children in care, and their interest in teaching children all suggest opportunities for improving care. The following are among the possibilities that merit attention.

    - Strategies for improving license-exempt reimbursement rates deserve consideration. Tiered reimbursement systems, where pay levels are increased as providers complete training or meet other requirements, are one promising approach. Assuring that license-exempt providers are eligible for child care food and nutrition programs is another vehicle for extending tangible resources to providers.

    - More carefully researched comparisons of the relative effectiveness of various training approaches for license-exempt providers also are an important need. Testing the effectiveness of meetings with license-exempt providers to discuss expectations and opportunities seems one useful approach for experimentation. Program orientation sessions (which are required in 14 states) may be a useful vehicle for this purpose. In addition, some locales are experimenting with "welcome visits" to license-exempt providers, where information and tangible resources are shared. This approach not only provides individualized contact, but also can allow staff to begin building relationships with these caregivers.

    - Programming that utilizes different training delivery modes also is needed. For example, providers in our survey preferred books, videotapes, and mailings to group sessions, so research on the effectiveness of these and public television provision would be useful. Likewise, although internet modes were not commonly requested, some testing of internet options seems desirable as use of this technology grows.

    - It is likely that the relatively low preferences among providers for training in traditional group sessions reflects both practical constraints and concerns with attending this type of session. Provid training at hours that correspond with provider needs, as well as offering supports such as transportation and child care, may improve receptivity to such training modes.

    - Regardless of the training approaches utilized, effective strategies are needed for consistently providing information about available training and resources to providers. Controlled studies measuring the relative effectiveness of varying information dissemination techniques on training take-up rates and utilization of program resources merit attention in this respect.

Chapter 1: Introduction

This report presents research findings from the Illinois Study of License-Exempt Care, which investigated subsidized license-exempt child care provision in the Illinois Child Care Assistance Program (CCAP). The use of such license-exempt caregivers, such as relatives and neighbors, is common both in the Illinois program and in other child care subsidy programs across the United States. Its prevalence raises important public policy questions in rapidly growing subsidized child care program environments.

The study employed multiple methods to assess caregiving patterns and parent and provider perspectives on a wide range of child care issues. Illinois Department of Human Services (IDHS) administrative data were used to examine aggregate statewide caregiving patterns in the Illinois program, as well as to make selected comparisons between license-exempt and licensed care provision. Interviews with 303 linked pairs of parents receiving subsidies and their license-exempt providers were conducted in three diverse geographic areas to ascertain perspectives on issues such as parental choice of providers, child care quality, costs, resource and training needs, and the functioning of the subsidy program. These survey results represent the largest data set of linked subsidized parent and their license-exempt providers available nationally to date.

The administrative data analysis and linked surveys constitute the body of this report. An earlier interim project report (Anderson, Ramsburg, & Rothbaum, 2003) presented initial project findings, which were based on preliminary administrative data analysis, focus groups with parents receiving subsidies and with license-exempt providers, and interviews with key informants and direct service staff working in the subsidy program.

The project was guided by seven principal research questions, all of which are important for assessing subsidized license-exempt child care. These questions are:

1. What are the patterns of care for families and children receiving subsidies that utilize license-exempt child care, and how do these differ from families and children that use subsidies for licensed child care?

2. Do parents who use subsidized license-exempt care differ in demographic characteristics and other important respects from parents who rely on subsidized licensed care?

3. What factors influence families receiving subsidies to choose license-exempt child care providers rather than licensed child care providers, or to choose a mix of these provider types?

4. What are the characteristics of license-exempt child care providers in the subsidy system, and what levels of experience and training do they have in providing child care?

5. How do parents receiving subsidies and their license-exempt care providers assess the quality of license-exempt care, and what specific strengths and weaknesses do they identify with this type of care?

6. What training and resources are needed to support the quality of care offered by license-exempt providers involved in the subsidy system, and how can these resources best be provided?

7. Based on study findings and analysis of related research, what policy implications can be drawn for enhancing the quality of subsidized license-exempt child care?

Research on these issues is important in a wide variety of child care settings, given that previous studies have demonstrated the benefits of high quality child care for children's development (Cost, Quality, and Child Outcomes Study Team, 1995; National Institute of Child Health and Human Development, 1999). The rapid growth of subsidized programs for low-income families since the passage of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has made these issues even more compelling. The Temporary Assistance for Needy Families (TANF) programs established under PRWORA have led to large increases in welfare recipients entering work or training, and to a concomitant increase in demands for child care by low-income working families. The federal government and the states have responded by significantly expanding child care funding, particularly through the establishment of the Child Care Development Fund (CCDF)**.** In Illinois, for example, funding for the CCAP in Fiscal Year 2004 was $650.9 million, which was more than six times the $107.4 million expended for TANF cash assistance. This is a remarkable shift in social program direction and associated funding in a short time period.

License-Exempt Care Definition and Study Context

Because definitions of license-exempt care vary across program contexts and research studies, it is important to first establish how license-exempt care is defined in the current study. We will define license-exempt care as legal care in home settings that has been exempted from state licensing requirements. This definition includes four types of license-exempt care: (1) non-relative family child care home providers who care for no more than three children including their own (unless all of the children are from the same household); (2) non-relatives providing care in the child's home; (3) relative providers caring for children in the relative's home; and (4) relatives providing care in the child's home. For comparative purposes, we will at times contrast such license-exempt care with other forms of care provided through the program, which we will refer to as "licensed". This broad licensed care category includes all licensed child care centers and licensed family child care homes, and a small number of license-exempt child care centers in schools or government agencies.

The specific program context in which the research questions will be examined likewise has important study implications. The CCAP is a large, statewide child care program that provides subsidies to families with incomes up to 50 percent of the state median income level. Beginning in September 2003, this income eligibility criterion is indexed each year. The program features parental choice of either licensed or license-exempt providers, and there are no waiting lists for services. The co-payments that the program requires parents to make are the same

whether the parent uses licensed or license-exempt care, but the state payment rates are much higher for licensed providers than for license-exempt providers (for state payment rates, see page 20). The CCAP therefore is an excellent environment in which to study parental and provider perspectives on subsidized license-exempt care.

While selected research activities were conducted statewide, the project focused upon three Illinois geographic areas: the North and South Lawndale neighborhoods in Chicago, Peoria County, and the southernmost seven counties in the state (hereafter referred to as the "Southern Seven"). These three study sites represent a mix of large central city (Chicago); mid-sized urban (Peoria), and rural (Southern Seven) areas. In addition, North Lawndale is predominantly African American and South Lawndale is largely Hispanic, which brings additional ethnic diversity to the project. Both Peoria County and the Southern Seven areas also have sizable African American populations.

Organization of This Report

The report is organized to emphasize findings from various project activities on the selected license-exempt child care issues defined by the study research questions. After this brief introduction, Chapters 2-4 establish the context in which study finding should be considered. Chapter 2 reviews previous research related to license-exempt care, with the intent to highlight important findings from previous work and to define issues on which relatively little is known. Chapter 3 provides background information both on the Illinois Community Care Program and on the three project study areas, while Chapter 4 details our study methodologies.

Chapters 5-15 present study findings. Chapter 5 describes selected characteristics of parents who use license-exempt care statewide, as well as more detailed characteristics of parents in our linked survey sample. Chapter 6 provides background information on license-exempt providers in our sample. Chapter 7 then presents care patterns for parents using license-exempt care, while Chapter 8 provides similar information for license-exempt providers.

The remaining findings chapters focus on parent and provider perceptions of selected license-exempt care issues, based on the linked survey results. Chapter 9 examines parental motivations for selecting license-exempt caregivers, while Chapter 10 explores license-exempt caregiver motivations for providing care. Chapter 11 analyzes parent and provider views on child care goals and quality of care issues, and Chapter 12 examines their perspectives on the interactions they experience in the caregiving context. Chapter 13 describes the educational and training of license-exempt providers, as well as both parent and provider assessments of training and resources that could usefully support the delivery of license-exempt child care.

Child care costs of parents are presented in Chapter 14, and then Chapter 15 examines views on programmatic issues in the specific context of the Illinois Child Care Program. The concluding chapter discusses the implications of various study findings for subsidized child care program and policy development.

Chapter 2: Literature Review

This chapter reviews previous research on selected license-exempt caregiving issues. In particular, we focus upon factors that may influence parental choice of license-exempt care, the characteristics of license-exempt caregivers and their motivations for providing care, and quality of care factors that may be important in license-exempt settings. We also identify areas in which additional research is needed.

License-Exempt Care Utilization Patterns

National data reveal that in 2002, three out of four children under age five with employed mothers were regularly in non-parental child care (Capizzano & Adams, 2003). About half of these children in non-parental child care arrangements were using license-exempt child care (Brown-Lyons, Robertson, & Layzer, 2001). These arrangements include care by relatives, in-home care by non-relatives (e.g., nannies or sitters), and license-exempt family child care homes.

In national studies of child care usage, the proportion of families that use license-exempt care has been found to vary according to several demographic characteristics. These include the parents' education level, household income, work schedule, family structure, ethnicity, and community setting. Several studies have found that less educated mothers and lower income families are more likely to rely on relative care and license-exempt family child care homes (Cappizano & Adams, 2003; Capizzano et al., 2000; Casper, 1997; Ehrle, Adams, & Tout, 2001; Emlen, Koren, & Schultze, 1999; Galinsky, Howes, Kontos, & Shinn, 1994; and West, Wright, & Hausken, 1996).

Census data and other large-scale national population surveys (e.g., National Survey of American Families) have found that mothers employed part-time are more likely than mothers employed full-time to rely on relative care for children under age five (Casper, 1997; Ehrle et al., 2001; Hofferth, Brayfield, Deich, & Holcomb, 1991; West et al., 1996). In addition, mothers who work evening or overnight shifts have been found to be more likely than mothers who work day shifts to rely on license-exempt care arrangements (Casper, 1997).

Children in single parent families are more likely than children from two-parent families to be cared for by relatives (Ehrle et al., 2001; Sonenstein, Gates, Schmidt, & Bolshun, 2002). The use of license-exempt care also has been found to vary across ethnic groups. For example, Hispanic families more commonly use relative care with infants and toddlers than African American families or Caucasian families (Ehrle et al., 2001).

While there appear to be differences across geographic areas in the proportions of parents using different types of providers, findings in this respect have been inconsistent. For example, Hofferth et al. (1991) found that families living in rural areas are more likely than families in metropolitan areas to use relative care and less likely to use center care. This trend may be partly attributed to the absence of child care centers and licensed family child care homes in rural areas (Brown-Lyons et al., 2001). In contrast, Casper (1997) did not find differences in the use of relative or center-based care between families living in rural versus inner-city neighborhoods. However, among those using license-exempt care, inner-city families were more likely to use

license-exempt in-home care providers and less likely to use family child care homes than families in rural areas.

Factors Influencing Parental Choice of License-Exempt Care

Several studies have examined the underlying factors that might influence whether or not parents select license-exempt care. These studies suggest that parents make their child care choices based on a variety of considerations, and that their choices reflect trade-offs between the needs of the children, the parent, and/or the family (Brown-Lyons et al., 2001). Parent preferences, child factors (such as the child's age), and practical constraints (such as parent work schedules) are all inter-related factors in this selection process.

Many families have a preference for license-exempt care because they want their children cared for by someone they know and trust (Brown-Lyons et al., 2001). According to the low-income mothers moving from welfare-to-work interviewed by Mensing, French, Fuller, and Kagan (2000), trust referred to mothers' feeling confident that their children would be physically safe from harm, and their children's basic needs would be attended to (e.g., child will have diapers changed, be fed, and will not be ignored or abused). Studies have found that parents of all income levels are seeking a caregiver that they are comfortable with, who they believe will care for the child in a similar manner as the parent, or who shares similar values and beliefs as the parent (Coley, Chase-Lansdale, & Li-Grining, 2001; Galinsky et al., 1994; Hertz & Ferguson, 1996).

It appears that parent preferences may vary depending on the age of the child. For example, the number of children cared for by relatives or in family child care settings has been found to decrease as the age of the child increases from age one to age five (Tout, Zaslow, Papillo, & Vandivere, 2001). Studies also have reported that parents prefer to have their infants and toddlers cared for in home-like settings; and prefer the learning opportunities provided by center-based programs for their preschoolers (Hayes, Palmer, & Zaslow, 1990; Porter, 1999). However, this trend reverses once children enter school. School-age children tend to be cared for in license-exempt settings more often than preschoolers (Brandon et al., 2003; King, Waters-Boots, Chen, & Dones, 2002; Todd & Robinson, 2003).

Some studies have found that aside from parental preferences for license-exempt care settings, at times parents choose license-exempt care because they lack regulated child care options that match their families' needs (Butler, Bringham, & Schultheiss, 1991; Siegel & Loman, 1991). This includes a lack of child care options that meet the family's scheduling needs or that are affordable to the family. Licensed child care options, especially child care centers, frequently do not offer care during non-traditional work hours (e.g., evenings, weekends). Yet, many low-income parents work rotating shifts (e.g., in a restaurant or hospital) or during evening or weekend hours (Henly & Lyons, 2000; Okuyama & Weber, 2001). As a result, license-exempt providers have been found to better accommodate non-traditional work schedules (Butler et al., 1991; Emlen, Koren, & Schultze, 1999; Henly & Lyons, 2000). It is important to note, however, that several state and community efforts aimed at increasing the amount of non-traditional hour care within licensed child care settings have not succeeded due to a lack of enrollment (Brown-

Lyons et al., 2001). This suggests that other factors, such as parental preferences, need to be disentangled from the issue of flexible schedules when examining parental choice of child care.

The cost of care is frequently cited as a major factor in the choice of child care. In particular, some studies have found that the high rates charged by licensed centers and family child care homes have prevented many families from enrolling their children (Siegel & Loman, 1991). Some have argued that this lack of affordable licensed child care options forces low-income families to use lower cost license-exempt care (Brown-Lyons et al., 2001). Child care subsidies have been introduced to alleviate such cost constraints, and have been demonstrated to result in increased use of licensed facilities in some instances (e.g., Fuller & Kagan, 2000; Siegel & Loman, 1991). Yet, other studies have found that child care subsidy programs were associated with increased use of license-exempt care (e.g., Emlen et al., 1999; Piecyk, Collins, & Kreader, 1999). These conflicting results suggest that the specific administrative policies of the state subsidy program may affect how subsidies impact parental choice (Brown-Lyons et al., 2001).

When compared to licensed care, license-exempt care may be more desirable to families because of both lower overall costs and greater flexibility in payment schedules. For example, studies have found that between 46 and 83 percent of relative providers do not charge for their services (Brown-Lyons et al., 2001). In addition, license-exempt providers have been found to allow flexible payment schedules or accept in-kind payments from parents (Henly & Lyons, 2000). In contrast, licensed child care settings cannot afford to continue operating if they do not receive regular payments from the parents they serve. Beach (1997) has found that the affordability and flexibility of license-exempt care appears to be as important to families in rural areas as in families in larger metropolitan areas.

Characteristics of License-Exempt Providers

Research findings on the characteristics of license-exempt providers vary depending on the specific group of providers studied, and limited representative national data are available. The available findings are summarized below.

Provider Relationship to Children in Care

Data from two national studies demonstrate that grandparents provide considerable child care. The National Survey of Families and Households (NSFH) shows that close to one-half of all grandparents provide child care assistance (Guzman, 2004). According to data from the National Household Education Survey (NHES), children age six and younger received an average of 23 hours of care a week from grandparents (Guzman, 2004). Several localized studies also report grandmothers as the most common relative caregivers (Brandon, Maher, Joesch, & Doyle, 2002; Emlen, 1998; Galinsky et al., 1994; Henly & Lyons, 2000). Other studies have also found aunts to be common relative providers (Galinsky et al., 1994; Porter, 1999). Galinsky et al. (1994) found that two-thirds of the relative caregivers in their sample were grandmothers and one-fourth were aunts. In the Brandon et al. (2002) study, over one-third (36 percent) of the license-exempt caregivers were grandmothers, and one-fifth were other relatives (22 percent).

Provider Age and Race

A few studies have reported on the age of license-exempt caregivers. These studies have found that relative caregivers tend to be older than other license-exempt providers. Galinsky et al. (1994) found that the average age of their sample of family child care providers from three large cities in the U.S. was 42.4 years, with relative providers being substantially older on average (52.9 years) than other license-exempt providers (35.9 years) or licensed providers (40.5 years).

In their study of child care use by low-income mothers moving from welfare to work in three states (California, Connecticut, and Florida), Fuller and Kagan (2000) found that the average age of the relative caregivers was 47 years. Center teachers were younger, with an average age of 37 years, and the average age of family child care home providers (both licensed and license-exempt) was 43 years. Brandon et al. (2002), in their survey of 300 license-exempt caregivers in Washington State, found that the average provider age was 41 years. Butler et al. (1991) surveyed in-home[1] and relative caregivers who provided child care for families receiving subsidies in Rhode Island. These authors found that the average age overall was 48 years, with a considerable difference between relatives (54 years) and in-home providers (36 years).

While all of these studies include race/ethnicity demographic data, the findings varied depending on the sample of license-exempt providers studied, and were not representative of the population as a whole.

Provider Education/Training

License-exempt caregivers on average are less educated than licensed providers, and relative providers have been found to have less education than other license-exempt providers (Brown-Lyons et al., 2001). Galinsky et al. (1994) found that almost half (46 percent) of the relative caregivers in their study and one-third (33 percent) of license-exempt non-relative caregivers had not completed high school, compared with 6 percent of licensed providers. Porter (1999) reported that most of the 99 caregivers who participated in her license-exempt caregiver focus groups in New York and California had no education beyond high school. Fuller and Kagan (2000) found that just over one-fourth (26 percent) of the relative caregivers had some formal education beyond high school, compared to half (51 percent) of the family child care providers and almost two-thirds (65 percent) of the center-based providers. Brandon et al. (2002) found that only 15 percent of the license-exempt caregivers in their study had a college degree or beyond. In the National Study of Low-Income Children sub-study, only 5 percent of relative caregivers had an undergraduate degree (Layzer & Goodson, 2003).

As might be expected, licensed providers generally report receiving more training in child care or early education than license-exempt non-relative providers (Brandon et al., 2002; Butler et al., 1991; Galinsky et al., 1994; NICHD, 1996). In turn, license-exempt non-relative

[1] An in-home provider was an individual who provided child care services in the child's own home. These providers were generally unregulated (license-exempt) and care was purchased by the Rhode Island Department of Human Services from providers with DHS approval (Butler et al., 1991).

caregivers in those studies generally report having received more training than relative caregivers. Brandon et al. (2002) found that the majority of the license-exempt providers (61 percent) had no specific training. Those who had attended training mentioned a variety of topics and formats, including parenting training, courses in early childhood education, courses in child development, workshops, and video training.

Some studies have investigated whether this lack of training by many license-exempt caregivers is tied to a lack of interest in receiving training and educational resources. Brandon et al. (2002) found that almost two-thirds (65 percent) of the license-exempt caregivers reported wanting at least one form of caregiving support, with an average of four supports and resources chosen. Of those, over half wanted a newsletter containing ideas, tips and resources on caring for children. In addition, close to one-third were interested in each of the following caregiving supports: toys or activity kits, home safety items (e.g., fire extinguisher), someone to call to help resolve problems, back-up care when the provider was unavailable, and meetings with other caregivers. Less popular options were help with transportation, training on becoming licensed, and home visits (only mentioned by 10-15 percent of the providers).

In a survey of subsidized license-exempt caregivers in Oregon, Emlen (1998) found that about one-third were interested in health and safety training. Among these, about one-fourth had already completed at least some health and safety training. Porter (1999) also found that the license-exempt caregivers in her focus groups in New York and California wanted information on a variety of topics. These topics included child development, health and nutrition, discipline, activities for children, and dealing with parents. These providers indicated that they wanted to get the information from "meetings like this one" (p. 33), where they could exchange information, problem solve, and learn from each other, rather than in a workshop or lecture format. They generally thought that written materials would be less useful and that they would not have time to watch video tapes. Over 87 percent of the subsidized in-home and relative caregivers surveyed by Butler et al. (1991) also expressed interest in get-togethers or support groups to learn more about child care from each other.

License-Exempt Caregiver Motivations for Providing Care

License-exempt caregivers offer a variety of reasons for beginning to provide care and for continuing to remain a child care provider. Galinsky et al. (1994) found that both licensed and license-exempt family child care home providers most often reported wanting to be employed (i.e., earn an income) while staying at home with their own children as the primary motivator for providing care. On the other hand, relative providers most often reported wanting to help the mothers/family of the children as the primary motivator for providing care.

Other studies (Brandon et al., 2002; Layzer & Goodson, 2003; Porter, 1999; Smith, 1991) have reported that the majority of license-exempt caregivers reported wanting to help out a relative or friend as the primary reason for beginning to provide care. Then, these caregivers reported that their motivations for continuing to remain a child care provider include the satisfaction of watching the children grow and learn, an interest in working with children, and the gratification of being able to help out and support their community. It is interesting to note that in Smith's (1991) study of families participating in the New Jersey welfare-to-work

program, only 9 percent of the license-exempt providers used by these families reported money as their primary motivation for providing child care.

Quality Components of License-Exempt Care

One concern about license-exempt care is the level of child care quality provided, because these settings are not regulated. While parents, researchers, and child care providers do not always agree on definitions of quality of care, there are several core elements of child care quality that have been recognized as being important to children's development, regardless of the child care setting. According to Cryer (1999), these include:

- "Safe care, with diligent adult supervision that is appropriate for the child's age, safe toys, safe equipment, and safe furnishings;
- Healthy care, where children have opportunities for activity and rest, developing self-help skills in cleanliness (e.g., washing hands), and having their nutritional needs met;
- Developmentally appropriate stimulation, where children have choices of opportunity for play and learning in a variety of areas such as language, creativity through art, music and dramatic play, fine and gross motor skills, and nature or science;
- Positive interactions with adults, where children can trust, learn from and enjoy the adults who care for and educate them;
- Promoting individual emotional growth, encouraging children to act independently, cooperatively, securely, and competently; and,
- Promoting positive relationships with other children, allowing children to interact with their peers, with the environmental supports and adult guidance required to help such interactions go smoothly." (p. 42)

Using these core elements identified by researchers, parents, and providers, several researchers have attempted to examine child care quality using a variety of techniques in different settings. However, measuring quality of care in license-exempt settings is more complex than in licensed settings (Brown-Lyons et al., 2001). For example, quality of care scales such as the Early Childhood Environment Rating Scale (ECERS) or the Family Day Care Rating Scale (FDCRS) have been developed for licensed settings to assess several dimensions of the child care environment (Harms & Clifford, 1998; Harms & Clifford, 1989). These include space and furnishings, health and safety, learning activities, basic needs, social development, language and reasoning, and child-provider interactions. These scales provide a composite score of quality for those dimensions. However, overall quality of care in license-exempt settings may not be adequately assessed by these global environmental scales. Therefore, additional research is needed to develop an adequate measure of quality of care in license-exempt settings.

Nevertheless, in those studies that have attempted to compare the quality of care provided across different child care settings using global assessments of quality, variability has been found both within types of care and across types of care. For example, research on parents' perceptions of child care quality indicates that parents perceive more variations in the quality of care within different types of child care than between the types of care (e.g., center versus family child care versus relative care; Emlen, 1998). Yet, in several studies, home-based settings have been rated

lower in quality than center-based programs, and license-exempt programs have been rated lower than licensed programs (Brown-Lyons et al., 2001).

Fuller and Kagan (2000) found that 71 percent of license-exempt family child care providers and relative caregivers were rated at the minimal level of quality or worse using the FDCRS, while 42 percent of child care centers were rated similarly using the ECERS. Likewise, Galinsky et al. (1994) found that 13 percent of the licensed family child care providers, half of the license-exempt family child care providers, and over two-thirds (69 percent) of the relative providers had inadequate quality ratings. Reasons for poor quality ratings in these studies include few educational materials, high usage of videos and television, lack of an organized environment, and lack of cleanliness.

Because of the complexity in measuring child care quality across settings with a global assessment scale, other studies have examined specific structural elements of child care that have been linked to children's outcomes. The elements most often studied include health and safety indicators, child-adult ratios, the number of children in the group, and the child care provider's training and experience (Brown-Lyons et al., 2001).

The National Institute of Child Health and Human Development (NICHD) is currently conducting a comprehensive national longitudinal study of early child care and youth development to investigate links between the structural aspects of the child care arrangement and providers' caregiving practices across five different types of care. In initial reports from this study, these researchers found that small group size; low child-adult ratios; safe, clean, and stimulating environments; and caregivers' non-authoritarian child-rearing beliefs were linked with providers who provided sensitive, responsive, warm, and cognitively stimulating infant care in all child care settings studied (Brown-Lyons, 2001; NICHD, 1996). In addition, small group sizes and low child-adult ratios were most often found in license-exempt care in the child's home, and there were no significant differences found in the quality of the physical environment between licensed and license-exempt home-based care settings.

Some studies have found health and safety problems in license-exempt settings that parallel similar problems found in the children's own homes (Collins & Carlson, 1998). Butler et al. (1991) found that in 42 percent of the children's own homes and relative caregivers' homes there were safety problems such as peeling paint, electrical outlets without safety caps, open windows on upper floors, or dangerous objects within a child's reach. This same study found that 92 percent of the children observed were clean and well-cared for physically.

License-exempt settings consistently have been found to have less of an educational focus than center-based care. In one study, license-exempt family child care providers reported that their primary goal was keeping the children safe and healthy, and emphasized physical care over providing opportunities for educational or social development (Zinsser, 1991). Children in license-exempt settings likewise have been found to be less likely to engage in activities aimed at promoting literacy and learning than children in centers and licensed family child care homes (Brown-Lyons, 2001). Others have found license-exempt homes to have fewer books (Butler et al., 1991); to use educational toys and materials less often (Butler et al., 1991; Zinsser, 1991);

and to use television and videos more often than other teaching activities (Fuller & Kagan, 2000; Layzer & Goodson, 2003; Porter, 1998; Zinsser, 1991).

Despite all of this research on child care quality, only one study has attempted to assess both parents' and providers' definitions of child care quality (Galinsky et al., 1994). In that study, providers and mothers rated the same aspects of care as most crucial, regardless of the type of care: a safe environment, a warm and attentive relationship with the child, and positive parent-provider communication. In addition, both the parents and providers rated a provider who is licensed by the state and the teaching of cultural or religious values as least important to the quality of care. With all of the variability in findings on quality in license-exempt settings, it is important to develop a better understanding of how parents who use license-exempt care and license-exempt providers define child care quality. It also is critical to link the views of the parents and providers in order to better understand if they define child care quality in the same way or if they have divergent views of quality care. Without understanding how parents and providers define child care quality in license-exempt settings, it will be difficult for researchers or policymakers to assess the quality of care in those settings.

Summary

While this research review summarizes the growing body of information on license-exempt care, there is still much to learn. License-exempt caregivers by their nature are not part of any regulated system, which creates difficulties in identifying representative samples of these caregivers for study. For example, previous research generally has studied those license-exempt caregivers who are part of state subsidy and/or welfare programs, or alternately is based on findings from population surveys of families who use non-parental child care. Only a handful of studies have been able to recruit samples of license-exempt caregivers without contacting parents first to gather information on the providers (e.g., Porter, 1998).

National survey data on child care usage patterns of families indicate that more children are in non-parental care than ever before. Examining these data over time reveals variations in the types of care used both across and within states. Some of these variations can be attributed to differing definitions of child care types. For example, the definition of who is considered to be a license-exempt family child care home provider varies from state to state. In one state, a neighbor caring for her own child and two non-related children in her home for compensation might be defined as providing licensed family child care, yet in another state that same neighbor might be defined as providing license-exempt family child care. Other variations are related to demographic differences in the families surveyed. Finally, some variations in usage patterns are related to changes in state subsidy programs that have occurred over the last twenty years. For example, the Family Support Act of 1988 required states to use federal subsidies to pay for all legal forms of child care, and PRWORA then continued to emphasize parental choice of all legal forms of child care.

Reasons for parental choice of license-exempt care have remained fairly consistent over time and across economic levels. Several studies over the past decade have found that parents choose license-exempt care primarily because they prefer to have their children cared for by someone they know and trust (Brandon et al., 2002; Galinsky et al., 1994; Hofferth et al., 1991;

Fuller & Kagan, 2001; Smith, 1991; Zinsser, 1991). These studies have included families receiving subsidies (e.g., Butler et al., 1991) and those who were not (e.g., Galinsky et al., 1994). Yet, despite this consistency in reasons for choosing license-exempt care, questions remain regarding whether the frequency of this preference varies across families who have different demographic characteristics (e.g., age of child, family income, and education level). Additional information also is needed to disentangle parental preferences for license-exempt care from family constraints (e.g., work schedules and cost issues) that may lead parents to choose license-exempt arrangements.

Less is known nationally about license-exempt providers than about parents who use license-exempt care. Only fragmented and localized data are available on license-exempt caregivers. This results partially from the fact that many studies have used different definitions of the providers surveyed, because state regulations vary on who is considered to be license-exempt. This disparity in regulations not only complicates cross-state comparisons, but also makes drawing a composite picture of the supply of license-exempt care almost impossible. Further complexity arises because some states may subject subsidized license-exempt caregivers to a set of regulations that are more stringent than licensing standards for licensed family child care providers in other states (e.g. Georgia requires license-exempt providers caring for subsidized children to have 8 hours of annual training). Such differences in state requirements probably account for some of the variations in types of care used by some families (Collins & Carlson, 1998).

The impact of state regulation on child care choice is another issue on which further study is needed. Those studies that have explored the motivations for providing license-exempt care have consistently found that the primary reason relative caregivers provide care is to help out a relative or friend. License-exempt and licensed family child care home providers most often report that their primary motivator for providing care is a desire to be employed while staying at home with their own children. Some studies additionally have found that license-exempt caregivers report an interest in working with children and helping children learn as reasons for continuing to provide child care.

Most license-exempt providers surveyed have not received much, if any, child care training. Yet, many license-exempt providers have expressed an interest in having training and other supports available to them. Some variability in how the providers would like to receive the resources has been reported, so additional research is needed on this issue.

The quality of care in license-exempt settings is of concern to parents, child care providers, and policymakers. Policymakers often are hesitant to invest public resources in unregulated settings, but many want to respect parental choices and do not want to impose regulations on relative caregivers that may restrict a parent's care options.

Several studies that have compared child care quality between the types of care have used scales that were developed for licensed settings; license-exempt settings are usually rated lower than licensed settings in such studies. Other studies have examined specific structural quality elements of child care, and the results vary. The NICHD study (1996) found no differences in the quality of the physical environment between licensed and license-exempt home-based settings.

Others have found that license-exempt settings have more health and safety problems than licensed settings (Butler et al., 1991), and are less educationally focused. Despite this complexity in measuring child care quality, only one study has examined whether parents' and providers' have shared or divergent perceptions of child care quality (Galinsky et al., 1994).

Given the many dimensions of license-exempt care yet to be fully understood, the current study of subsidized license-exempt care in Illinois focused on learning more about 1) the characteristics of the parents using license-exempt care; 2) the factors that contribute to parental choice of license-exempt care; 3) the characteristics of license-exempt providers and their motivations for providing care; 4) the types of resources license-exempt providers would like to have available to them, and the method for delivering such resources; and, 5) the components of quality in license-exempt care according to both parents and providers. Because less is known about child care in rural areas, we included both urban and rural areas of the state to determine whether any geographic variations appear to exist.

Chapter 3: Study Context

This chapter provides information on the context in which the current study was conducted. This involves understanding the scope of the Illinois Child Care Assistance Program (CCAP), including the program rules that appear to have the greatest impact on license-exempt caregiving. Because the characteristics of the communities where the study was conducted also may affect findings, profiles of these communities are then presented.

Description of CCAP

The Illinois Child Care Assistance Program (CCAP) was established in 1997 and served approximately 192,000 children per month in Fiscal Year 2004.[2] The goal of the program is to ensure that high quality child care services are available, affordable, and meet standards that promote the healthy development of children. The program is administered through the Illinois Department of Human Services (IDHS), and uses a combination of federal funds, state funds, and parent co-payments. Families must fall within established income limits, and be either working or in an educational program, to qualify for CCAP services.

Child care spending in Illinois has increased dramatically since the implementation of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1997. Before PRWORA, Illinois initiated the Direct Pay Child Care Program in 1993. This program guaranteed child care subsidies to welfare recipients who were employed. In 1994, the Direct Pay Program disbursed $15 million in funds, and by 1996 it had grown to $144 million. The Transitional Child Care program supplemented the Direct Pay program by providing subsidies for up to one year for families that left welfare. Overall, Illinois spent $262.8 million on child care subsidies in Fiscal Year 1997, the last year before PRWORA was implemented. Since the establishment of the CCAP in 1997, combined federal and state child care spending has grown by 148 percent, reaching $650.9 million in Fiscal Year 2004 (Table 3-1).

Table 3–1. State and Federal Child Care Spending in Illinois (in millions)

Year	FY 1996	FY 1997	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Spending	$226.0	$262.8	$307.0	$448.0	$574.0	$620.8	$635.0	$651.3	$650.9

Eligibility Guidelines

Illinois has made a commitment to serve every family that applies for the CCAP and meets the eligibility requirements. Of the estimated 372,000 children under age 13 who were potentially subsidy eligible, approximately 59 percent received assistance in 2002 (Stohr, Lee, & Nyman, 2002). There is currently no waiting list for assistance, or limits on the length of time that families may receive the subsidies. The CCAP is designed to assist families whose income is

[2] This figure is higher than the number of children reported in subsequent administrative data analyses, because the administrative records used exclude children served at sites operated by the City of Chicago.

up to 50 percent of the State's median family income level. Table 3-2 shows the income guidelines for selected family sizes.

Table 3–2. Subsidy Income Limits as of July 2004

Family Size	Monthly Income[1]	Annual Income
2	$1,960	$23,520
3	$2,421	$29,052
4	$2,882	$34,584
5	$3,344	$40,128
6	$3,805	$45,660

[1] Income is defined as the total gross employer salary or wages, plus any government benefits, child support, or self-employment income.

In addition to meeting income eligibility requirements, parents must have a child under age 13[3] and must either be working or engaged in approved education or training activities. If families receive TANF, they are eligible for child care assistance if working or in an education/training or other program approved by their caseworker. Eligible education and training activities for non-TANF families include:

- Working toward completion of a high school degree, Adult Education Program, GED Program, or English as a Second Language Program; **or**

- Attending an occupational or vocational training program (e.g., dental hygiene programs); **or**

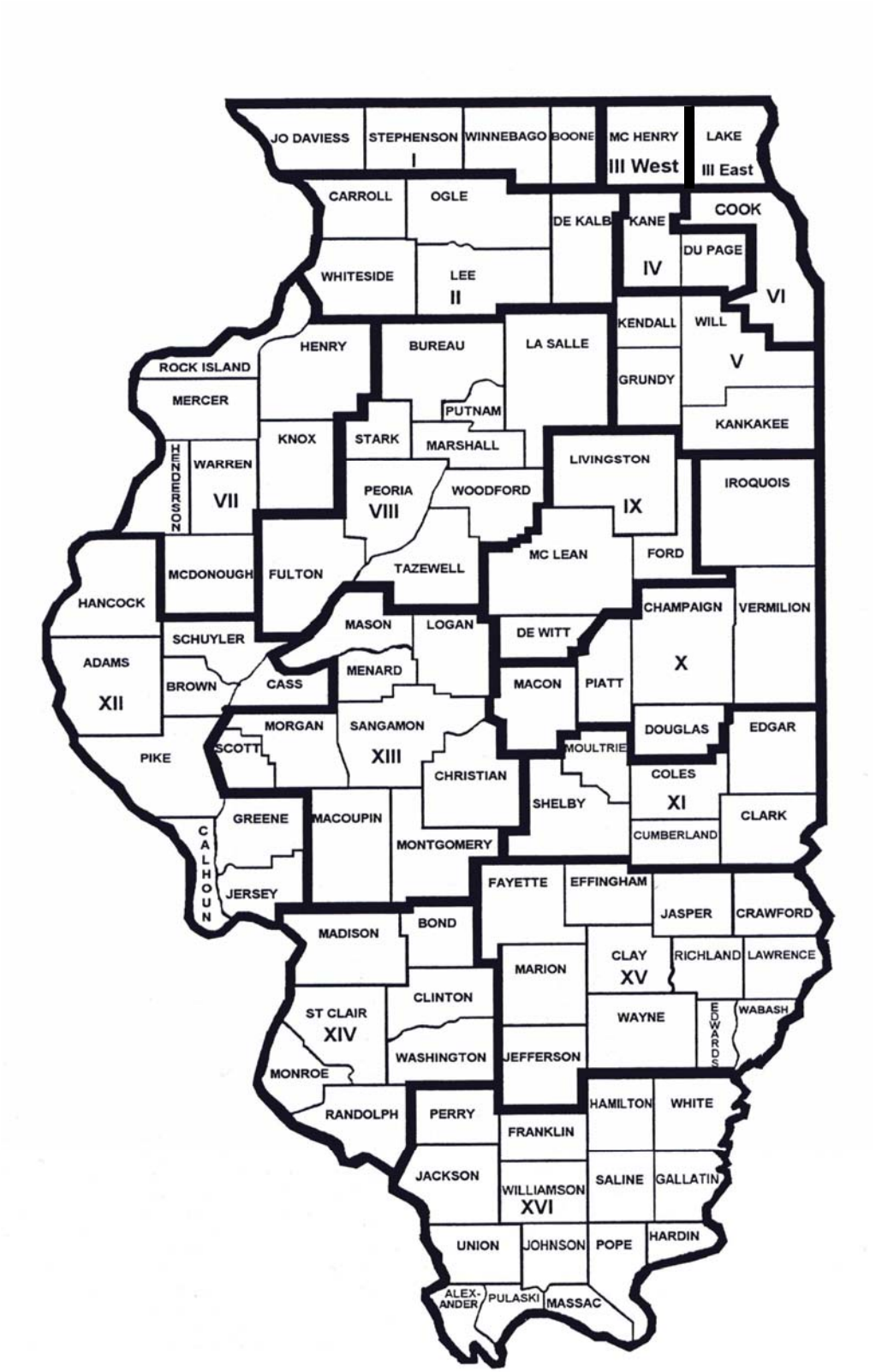
- Working a minimum of 10 hours/week (can be averaged on a monthly basis) **and** attending classes towards a Bachelor's or Associate's Degree (1st degree only), **or** a combination of employment and unpaid educationally required work activity (e.g., student teaching, internships, practica, or clinicals averaging 20 hours/week)**.**

Subsidy Application and Provider Selection Procedures

The most common way for parents to apply for a child care subsidy is through their local Child Care Resource and Referral agency (CCR&R). These 17 agencies, which serve all 102 counties, operate through contracts with IDHS to provide a variety of child care related services. Each family has a designated agency based on the county in which they live (Figure 3–A). It should be noted that Cook County (Region VI on the map) includes the City of Chicago and surrounding suburban areas. CCR&R's are responsible for determining parent eligibility for the child care subsidy, calculating the parent co-payment, issuing provider billing certificates each month, and processing billing and provider payment paperwork for IDHS.

[3] Children 13 or older are eligible if they are under court supervision or have written documentation from a medical provider that they are mentally or physically incapable of caring for themselves.

Figure 3–A. Geographic Areas Served by Each Illinois CCR&R



Parents must have selected a legal child care provider arrangement before they can submit their child care subsidy application. Legal child care is defined as:

- Licensed child care centers, which are profit or not-for-profit centers licensed by the Department of Children and Family Services (DCFS);

- Licensed family child care homes, which are licensed by DCFS and in which care is provided for more than three and up to 12 unrelated children under age 13, including the provider's children;

- License-exempt child care centers, which are for children at least three years of age and include programs operated by public or private school systems, on federal government premises, and other programs recognized or registered with the Illinois State Board of Education;

- Group licensed child care homes licensed by DCFS where up to 16 unrelated children under age 13 (including provider's children) are cared for;

- License-exempt family day care homes, in which providers are non-relatives who are at least 18 years of age and who care for no more than 3 children, including their own children, unless all of the other children are from the same household; or,

- Relatives, who are not the parents, stepparents, or legal guardians of the children, either in the relative's or the child's home.

If the parent does not have a child care provider or if they lose their child care provider after they have been approved for a child care subsidy, the parent can contact the Parent Referral department of the CCR&R to obtain assistance in finding a child care provider. All CCR&R's can provide child care referrals to parents from a provider database they maintain of both licensed and license-exempt child care centers and family child care homes. While the CCR&R's do not directly arrange care for a family, they will perform a customized search of the database to identify a list of referrals best matching each family's child care needs and preferences (e.g., age of child, work hours, location, and type of care).

After finding a provider, the parent must submit a child care subsidy application to the CCR&R that includes four pages of parent/family information. The provider completes two pages of this application, including certification of compliance with several health and safety statements. If the parent has more than one provider (either on a regular basis or for back-up care), all providers must complete the provider pages on the application. Both the parent and provider must sign the application. Parents must also send the CCR&R copies of their two most recent pay stubs and/or class schedule before the child care subsidy application can be approved.

Each provider must also submit a W-9 tax form that will be certified by the State of Illinois Comptroller's Office. If the provider is license-exempt, an authorization form for conducting a Child Abuse and Neglect Tracking System (CANTS) check must also be completed by the provider and all members of the provider's household who are 13 years of age and older.

This form authorizes DCFS to run a computerized check of the CANTS databases to determine if a person ever committed child abuse or neglect. These forms must all be returned before child care subsidy payments can be approved for the provider.

Eligibility is re-determined every six months if there have been no changes in the family or provider status. If there has been any change of parent or provider status, such as a new job or a change in provider, then re-determination is done at that time. Parents are sent a re-determination form by the CCR&R two months prior to their re-determination date, which contains much of the same information as the application. If the completed re-determination form is not received by the CCR&R by the re-determination date, the child care subsidy will be cancelled.

A second way that parent eligibility for a child care subsidy is determined is through one of nearly 200 site-administered licensed child care centers or family child care home networks across the state. These centers and networks have been contracted by IDHS for payment for service up to a specified maximum number of children from subsidy-eligible families. The child care subsidy eligibility for the parents is determined initially by the contracted center, and then finalized by IDHS Bureau of Child Care and Development staff. For approved families, the site-contracted center or home network is then directly reimbursed for the children in their care by the state. It is estimated that the site-administered programs served 14,000 children per month in Fiscal Year 2004, at a cost of about $74.3 million.

Child Care Subsidy Approval and Payments

Within 30 days of receipt of completed child care applications, both the parent and provider are notified by IDHS of approval or denial of the child care subsidy for the family. If the application is denied, the reason for denial is included in the notice letter.

Families approved for child care subsidies are required to pay a portion of their child care costs, through a co-payment made directly by the parent to the provider.[4] The co-payment amount is based on income, family size, the number of children receiving care, and whether the children are in care full-time or part-time. For example, in September 2003, a single parent earning $20,000 per year with two children (family size of 3) in care full-time would be assessed a monthly co-payment of $190.65, or $44.00 per week.

Co-payments are determined by the CCR&R as part of the child care application process. The amount of the co-payment is printed on the approval notice, which is sent to both the parent and approved provider(s) from IDHS. The parent also receives a co-payment information sheet, which describes the co-payment process and contains a series of co-payment charts that provide the co-payment amounts based on family size and income. For example, the co-payment information explains that if the parent is approved for more than one provider, only the provider who receives the highest reimbursement amount will be assigned to collect the co-payment. In addition, the information sheet explains that providers can collect the co-payment on a weekly or

[4]The only exception to the co-payment rules is a non-parent representative payee (RPY) case. For example, a non-parent RPY might be a grandmother who has custody of a child receiving a TANF grant.

monthly basis. There is no monitoring by the state or the CCR&Rs to determine whether the parent makes the required co-payment.

The remaining amount of the child care subsidy rate is reimbursed directly to the provider, based on reimbursement rates established by IDHS. Reimbursement rates vary depending on the age of the child, the county in which the care is provided, the type of child care arrangement, licensure status, and whether the child is in full-time or part-time care. IDHS conducts a market rate survey of child care providers every two years, as required by Child Care Development Fund (CCDF) rules.

The provider receives their first payment 4-8 weeks after the application has been approved and the provider's W-9 form has been certified by the Comptroller's Office. Subsequently, billing certificates are sent to the provider each month to be completed and signed by both the parent and provider, and then returned to the CCR&R. Payments arrive 3-4 weeks after the provider has submitted the monthly billing certificate. All providers are notified in the child care subsidy application form that they are considered self-employed (not employees of the IDHS or the CCR&R) and are responsible for paying taxes on their income to the IRS. Consequently, there is no income tax withholding from the pay checks that providers receive. The Comptroller's Office will send providers earning more than $500 a 1099 form at the end of the year.

Table 3–3 presents the daily reimbursement rates that have been in effect since July 1, 2000. For care provided less than five hours per day, either the part-day or school age-day rate is used to calculate the daily subsidy reimbursement rate, depending on the age of the child. For care provided five through 12 hours per day, the full-day rate is used. For care provided more than 12 hours but less than 17 hours in a day, the full day rate is used for the first 12 hours and then the part-day rate is used for the remainder. For care provided from 17 through 24 hours in a day, two full-day rates are used to calculate the subsidy reimbursement. Travel times to and from work or other eligible activities are included in the reimbursable hours of care.

Providers cannot charge a parent approved for a child care subsidy a higher rate than parents who are private paying (not receiving a subsidy). However, if a provider's rate to all families is higher than the subsidy reimbursement rate, the provider may require subsidy parents to pay the differential in addition to their co-payment fee. As a result, in some regions of the state, the price of desired child care arrangements may be too high if families cannot afford to pay the co-payment plus the rate differential to the provider.

Finally, given the study focus on license-exempt care, we should note the license-exempt care rates presented in Table 3-3. These rates, which are uniform throughout the state, are $9.48 per day for full-day care and $4.74 for part-day care. The rates are substantially lower than those paid for all forms of licensed care. While these rates are much lower than those for licensed providers, requirements to become a license-exempt provider are minimal. These include being 18 years old; not having been convicted of a crime other than minor traffic violations; undergoing the previously mentioned Child Abuse and Neglect Tracking System check to determine if there is a record or child abuse or neglect; and the previously mentioned standards regarding allowable numbers of children in care (see page 17).

Table 3–3. Illinois Daily Child Care Subsidy Rates

Group 1A Counties *Cook, DuPage, Kane, Kendall, Lake, McHenry*					
	Under Age 2 ½		**Age 2 ½ and Over**		
	Full-Day	**Part-Day**	**Full-Day**	**Part-Day**	**School-Age Day**
Licensed and License-Exempt Child Care Center	$33.77	$16.89	$24.34	$12.17	$12.17
Licensed Day Care Home or Licensed Group Day Care Home	$21.53	$10.77	$20.50	$10.25	N/A
Group 1B Counties *Boone, Champaign, DeKalb, Kankakee, Madison, McLean, Monroe, Ogle, Peoria, Rock Island, Sangamon, St. Clair, Tazewell, Whiteside, Will, Winnebago, Woodford*					
	Under Age 2 ½		**Age 2 ½ and Over**		
	Full-Day	**Part-Day**	**Full-Day**	**Part-Day**	**School-Age Day**
Licensed and License-Exempt Child Care Center	$33.77	$16.89	$20.50	$10.25	$11.85
Licensed Day Care Home or Licensed Group Day Care Home	$19.14	$9.57	$16.40	$8.20	N/A
Group II Counties *All other counties not listed above*					
	Under Age 2 ½		**Age 2 ½ and Over**		
	Full-Day	**Part-Day**	**Full-Day**	**Part-Day**	**School-Age Day**
Licensed and License-Exempt Child Care Center	$24.36	$12.18	$17.68	$8.84	$10.74
Licensed Day Care Home or Licensed Group Day Care Home	$16.59	$8.30	$13.84	$6.92	N/A

All Counties/All Children	**Full-Day**	**Part-Day**
License-Exempt Day Care Home, Non-Relative in a Child's Home, or Relative	$9.48	$4.74

Community Profiles

The three study sites of North and South Lawndale (Chicago area), Peoria County, and the Southern Seven counties were chosen to represent the wide array of geographic, ethnic, and economic diversity throughout Illinois. In 2000, the total population of the state was 12.4 million, with about 5.4 million of these located in Chicago's home county of Cook and 2.9 million in the City of Chicago. The state also has extensive rural areas. Nearly 68 percent of the state's population is Caucasian, while African Americans and Hispanics comprise 15.1 percent and 12.3 percent of the population, respectively (Tables 3-4 and 3-5). A brief description of each study area follows, with Tables 3–4 to 3–11 providing basic social and economic characteristics for each area. All data are from the 2000 Census, unless otherwise indicated.

Table 3–4. Selected Population Characteristics

		State of Illinois	Peoria County	Southern Seven Counties	South Lawndale	North Lawndale	City of Chicago
Total Population		**12,419,293**	**183,433**	**72,483**	**91,071**	**41,768**	**2,896,016**
Ages of Children	Under 5 years	876,549	12,612	4,025	9,032	4,020	218,522
	5 to 9 years	929,858	13,161	4,546	8,440	4,846	224,012
	10 to 14 years	905,097	12,684	4,819	6,850	4,682	200,802
	15 to 19 years	894,002	13,471	5,130	9,018	3,774	200,962
Families with Own Children under 18 Years		1,514,561	21,711	8,462	10,903	5,187	306,456
Family Type	Married Couple Families	1,113,582	14,302	6,116	8,132	1,266	179,408
	Single Mother Families	315,957	6,081	1,846	1,899	3,571	105,705
	Single Father Families	85,022	1,328	500	872	350	21,343
Race & Ethnicity	Caucasian	8,424,140	143,932	61,386	3,210	383	1,215,315
	African American	1,876,875	29,532	8,729	11,759	39,164	1,065,009
	Hispanic	1,530,262	3,827	1,308	75,613	1,896	753,644

Source: U.S. Census Bureau, 2000.

Table 3–5. Percent Distribution of Selected Population Characteristics

		State of Illinois	Peoria County	Southern Seven Counties	South Lawndale	North Lawndale	City of Chicago
Total Population		**12,419,293**	**183,433**	**72,483**	**91,071**	**41,768**	**2,896,016**
Ages of Children	Under 5 years	7.1%	6.9%	5.6%	9.9%	9.6%	7.5%
	5 to 9 years	7.5%	7.2%	6.3%	9.3%	11.6%	7.7%
	10 to 14 years	7.3%	6.9%	6.6%	7.5%	11.2%	6.9%
	15 to 19 years	7.2%	7.3%	7.1%	9.9%	9.0%	6.9%
Families with Own Children Under 18 Years		**1,514,561**	**21,711**	**8,462**	**10,903**	**5,187**	**306,456**
Family Type	Married Couple Family	73.5%	65.9%	72.3%	74.6%	24.4%	58.5%
	Single Mother Family	20.9%	28.0%	21.8%	17.4%	68.8%	34.5%
	Single Father Family	5.6%	6.1%	5.9%	8.0%	6.7%	7.0%
Race & Ethnicity	Caucasian	67.8%	78.5%	84.7%	3.5%	0.9%	42.0%
	African American	15.1%	16.1%	12.0%	12.9%	93.8%	36.8%
	Hispanic	12.3%	2.1%	1.8%	83.0%	4.5%	26.0%

Source: U.S. Census Bureau, 2000.

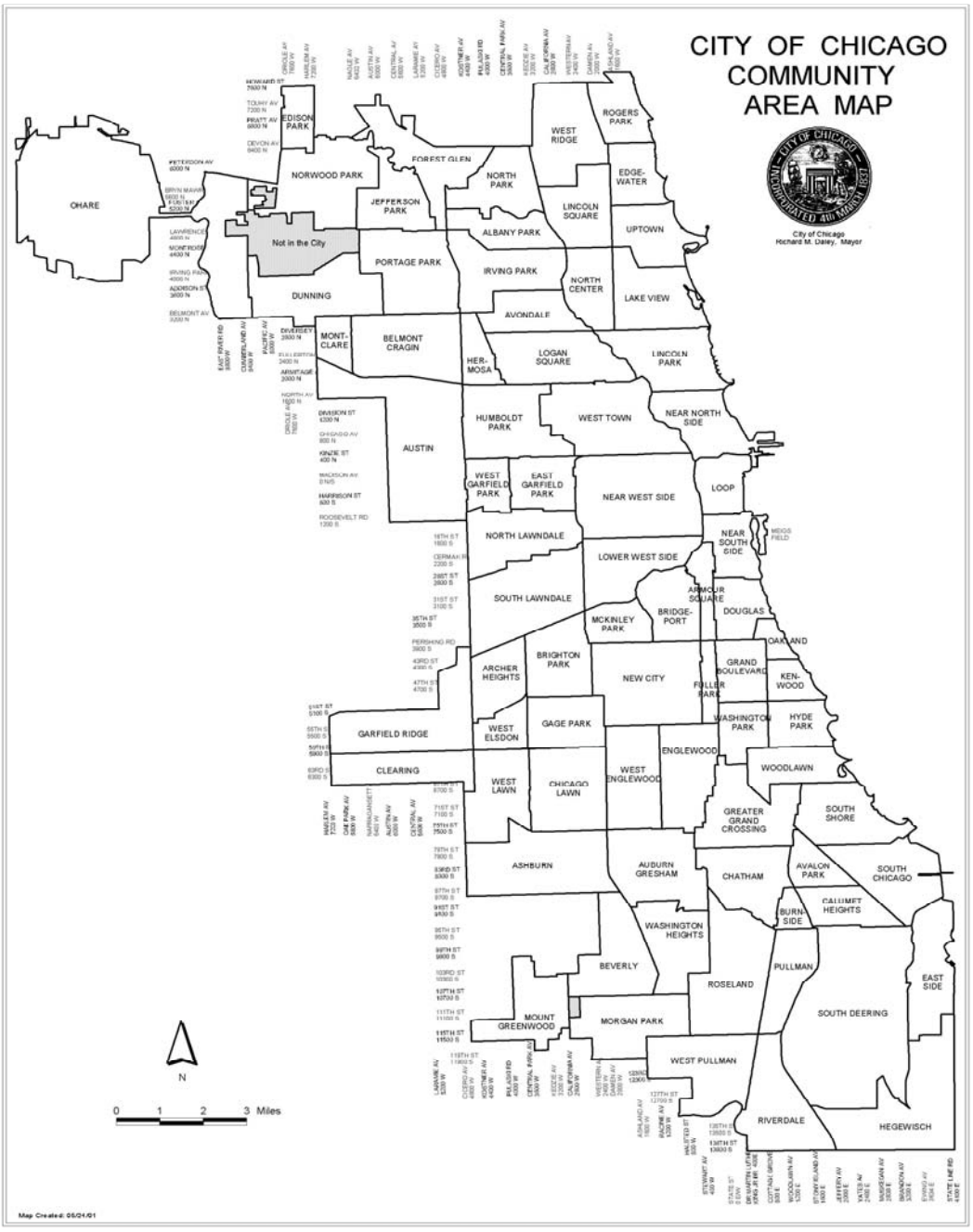
Overview of Study Areas

North and South Lawndale

North and South Lawndale are two of Chicago's 76 designated community areas (Figure 3-B). The northeastern border of the neighborhoods begins about 20 blocks west and a few blocks south of Chicago's central downtown area. Bus and elevated train routes serve both neighborhoods. Although North and South Lawndale are contiguous, like many urban neighborhoods they are fundamentally different. In particular, ethnic differences are striking. North Lawndale's population of 41,768 is almost 93.8 percent African American, and 97.7 percent of the residents are U. S. natives. In comparison, 83.0 percent of South Lawndale's population of 91,071 is Hispanic, with the large majority of these individuals of Mexican

descent. Only half of South Lawndale residents were born in the United States, and about four-fifths speak a language other than English in their homes.

Figure 3-B. City of Chicago Community Area Map with Targeted Neighborhoods



North Lawndale has been experiencing a declining population and a loss of jobs, and efforts are being made to revitalize the area. For example, the Pyramid West Development Corporation is attempting to bring commercial enterprise to the area. Most recently, a movie theatre complex has been opened. Homan Square, a development containing townhouses, condominiums, and rental apartments, also was recently completed. A few social service centers and Mount Sinai Hospital serve the area (Illinois Facilities Fund, 2001).

South Lawndale is known as "Little Village" by most of the people who live there. In the past ten years, the neighborhood's population has grown significantly. Three new schools have been built, and more are planned. The population growth has led to limitations in available housing, and several organizations are working with residents to increase home ownership. There are active initiatives in the neighborhood on crime reduction, educational reform, and child care (Illinois Facilities Fund, 2001).

Because population, ethnic, and other characteristics vary so much between sub-areas within large urban centers, some basic information on Cook County and the City of Chicago also is useful in establishing the current study context. Cook County is an urban, ethnically diverse area that includes the City of Chicago and 30 surrounding townships. The suburban townships constitute the older, inner suburbs of the greater Chicago metropolitan area, and vary substantially in social and economic characteristics. Cook County has seen a decrease in the Caucasian population and an increase in other ethnic populations in the last ten years, especially among African American and Hispanic populations.

Chicago is the third largest city in the United States. Its population of 2.9 million is ethnically diverse; 42.0 percent is Caucasian, 36.8 percent is African American, and 26.0 percent is Hispanic.

Peoria County

Located between Chicago and St. Louis, Peoria County (see Figure 3-A) has a total population of 183,433, with 61.6 percent of these individuals living in the city of Peoria. Over three-fourths of the population (78.5 percent) is Caucasian, while 16.1 percent is African American, and 2.1 percent is Hispanic.

Peoria County includes four cities (Peoria, West Peoria, Chillicothe and Elmwood), 11 villages, and 20 townships, and has both urban and rural areas. The county has 103 public schools, and also is the home to Illinois Central College, Bradley University, Robert Morris College, and the University of Illinois College of Medicine. The world headquarters of Caterpillar Inc. (earthmoving equipment manufacturer) are in Peoria County. Other major employers include Keystone Steel and Wire, OSF St. Francis Medical Center, and the United States Postal Service.

The Southern Seven Counties

The Southern Seven area includes Alexander, Hardin, Johnson, Massac, Pope, Pulaski, and Union counties (see Figure 3-A). These heavily rural counties, which are located in the southern tip of Illinois, have a total population of 72,483. The largest city in the area, Metropolis,

has a population of only 6,482, followed by Anna with a population of 5,136. The Shawnee National Forest covers large portions of the area. Table 3-6 provides some basic demographic and economic information on each of the counties comprising the Southern Seven area.

Over four-fifths (84.7) of the Southern Seven population is Caucasian, 12.0 percent is African American, and 1.8 percent is Hispanic. However, the ethnic composition of the population varies considerably between the seven counties. For example, 35.4 percent of the Alexander County population is African American, as is 31.7 percent of the Pulaski County population (Table 3-6). In comparison, African Americans comprise less than 5.0 percent of the population in Hardin, Pope, and Union counties.

Alexander County is located at the southern tip of Illinois, where the Mississippi River and the Ohio River meet. The population center in this heavily rural county is Cairo, an economically depressed city with a population of 3,632. In the last few years the largest employer in the area closed, and many of the remaining jobs in the county involve part time and shift work. The poverty rate in Alexander County is 26.1 percent.

In the last ten years, Hardin County has had a decline in both the economic climate and in population. The median family income for the county is only $31,625, which is the lowest among the Southern Seven. Conversely, Johnson County has seen a 13.5 percent increase in population and a decrease in the number of people living in poverty. A majority of the population works in retail, heath and social service jobs. The Vienna Correctional Facility is a major employer in the area, and public discussions about closing it were occurring as this study began.

Massac County is located on the Ohio River, with a riverboat casino in Metropolis as its largest employer. Pope County also borders the Ohio River, but has no single major employer. Both Shawnee Community College and the Tamms Correctional Center are located in Pulaski County. Despite these two employers, the population has been decreasing, and the poverty rate is 24.7 percent. Many of the people employed in Pulaski County commute from other counties.

The final county in the Southern Seven area is Union County. The county has had a slight increase in population in the last ten years, but also has experienced economic setbacks. There are several small towns that provide retail and social service centers, with Anna and Jonesboro the largest of these.

Table 3–6. Southern Seven Counties -- Selected Demographic Information

		Alexander		Hardin		Johnson		Massac		Pope		Pulaski		Union	
Population	**Total**	**9,590**	**%**	**4,800**	**%**	**12,878**	**%**	**15,161**	**%**	**4,413**	**%**	**7,348**	**%**	**18,293**	**%**
	Under 5 years	600	6.3	263	5.5	604	4.7	940	6.2	211	4.8	450	6.1	957	5.2
	5 to 9 years	673	7.0	251	5.2	654	5.1	989	6.5	236	5.3	548	7.5	1,195	6.5
	10 to 14 years	731	7.6	260	5.4	673	5.2	953	6.3	273	6.2	622	8.5	1,307	7.1
	15 to 19 years	691	7.2	343	7.1	827	6.4	1,013	6.7	412	9.3	591	8.0	1,253	6.8
Race And Ethnicity	Caucasian	5,968	62.2	4,554	94.9	10,553	81.9	13,962	92.1	4,104	94.6	4,841	65.9	17,404	95.2
	African American	3,347	35.4	132	2.9	1,840	14.3	831	6.0	166	4.1	2,278	31.7	150	1.0
	Hispanic	138	1.4	51	1.1	368	2.9	123	0.8	40	0.9	107	1.5	481	2.6
Poverty	Total persons in poverty	2,352	26.1	850	18.6	1,149	11.3	2,000	13.5	793	18.2	1,746	24.7	2,975	16.5
	Families in poverty	536	21.2	200	14.7	245	8.1	448	10.4	122	9.8	397	20.5	542	10.8
	Families with children less than 18 years in poverty	420	32.7	142	24.1	152	11.3	335	16.0	96	16.8	292	29.0	421	18.1
	Families with children less than 5 years in poverty	154	36.0	65	31.4	84	17.0	155	18.1	38	19.4	89	26.3	207	24.1
Family Income	Median	$31,824		$31,625		$40,275		$39,068		$37,860		$33,193		$37,710	

Household Composition

Household composition is of obvious importance in considering child care issues across geographic areas. The relative proportions of children in a geographic area provide crude indications of the likely need for child care. In addition, indicators such as the presence of single parent families often are correlated with limited incomes and the need for subsidized child care.

In Illinois, nearly 21.9 percent of the population is under fifteen years of age, and 7.1 percent is under the age of five (Table 3-5). The percentage of the population below age fifteen and age five in Peoria County and the Southern Seven counties is similar to the state average. In comparison, both North Lawndale and South Lawndale have higher percentages of children in their populations. In North Lawndale, 9.6 percent of the population is under age five, and 32.4 percent is under age fifteen. In South Lawndale, 9.9 percent of the population is under age five, and 26.7 percent is under age fifteen.

Nearly three-fourths (73.5 percent) of Illinois families with children under age eighteen include a married couple (Table 3-5). In comparison, a single-parent mother heads 20.9 percent of these families, and a single-parent father heads 5.6 percent. These family composition characteristics are similar to the state percentages in both the Southern Seven counties and in South Lawndale. Families with children under 18 in Peoria County are slightly less likely to consist of married couples and more likely to be headed by a single parent; about two-thirds (65.9 percent) of these families include two parents, and 28.0 percent are in families headed by a single female parent. North Lawndale easily varies the most from the state percentages and from the other study areas. Only 24.4 percent of families with children under 18 include both parents in North Lawndale, while 68.8 percent live in female headed single parent families and 6.7 percent live in male headed single parent families.

Educational Attainment

Educational levels vary dramatically across the study areas (Table 3-7). Statewide, only 18.6 percent of the population has not completed high school, and 53.7 percent has completed at least some college. Educational attainment levels are very similar to the state levels in Peoria County, while they are somewhat lower in the Southern Seven counties. For example, 28.1 percent of the population has not completed high school in the Southern Seven area, and only 40.3 percent has attended some college.

Educational levels lag even further behind the state averages in North and South Lawndale, and also are considerably lower in these neighborhoods than for the City of Chicago as a whole. In North Lawndale, 39.5 percent of the population has not completed high school, and only 31.1 percent has attended college. Probably reflecting the recent immigrant status of many residents, 62.7 percent of the South Lawndale population has not graduated from high school, and 39.9 percent has not even completed ninth grade. Only 17.8 of South Lawndale residents have attended college.

Table 3–7. Selected Educational Characteristics

		State of Illinois		Peoria County		Southern Seven Counties		South Lawndale		North Lawndale		City of Chicago	
Population Over 24 Years		**7,973,671**	**%**	**118,498**	**%**	**49,753**	**%**	**46,511**	**%**	**21,461**	**%**	**1,815,896**	**%**
Highest Grade Completed	Less than 9th grade	597,684	7.5	6,585	5.6	5,502	11.1	18,578	39.9	2,361	11.0	225,497	12.4
	9th to 12th grade (no diploma)	882,759	11.1	12,571	10.6	8,452	17.0	10,590	22.8	6,122	28.5	286,277	15.8
	High School Graduate	2,212,291	27.7	34,920	29.5	15,789	31.6	9,058	19.5	6,311	29.4	418,113	23.0
	Some College	1,720,386	21.6	28,375	23.9	10,805	21.7	4,928	10.6	4,451	20.7	338,983	18.7
	Associate Degree	482,502	6.1	8,386	7.1	3,608	7.3	1,169	2.5	705	3.3	84,243	4.6
	Bachelor's Degree	1,317,182	16.5	18,049	15.2	3,564	7.2	1,483	3.2	1,174	5.5	281,549	15.5
	Graduate Degree	760,867	9.5	9,612	8.1	2,033	4.1	705	1.5	337	1.6	181,234	10.0

Source: U.S. Census Bureau, 2000.

Income and Employment

The median family income for the state of Illinois is $55,545 (Table 3-8). Only 8.3 percent of households have incomes of less than $10,000, 16.8 percent have incomes between $10,000-24,999, 11.9 percent have incomes between $25,000-34,999, and 63.0 percent have incomes over $35,000. The poverty rate for all persons is 10.7 percent, while 11.6 percent of families with children under 18 and 14.5 percent of families with children under age five have incomes at or below the poverty level.

All study areas have income and poverty characteristics worse than the state figures, although Peoria County most closely parallels the state. The Southern Seven poverty rates are higher, and correspondingly lower percentages of Southern Seven residents have incomes above $35,000 (42.5 percent in the Southern Seven vs. 63.0 percent statewide). The median family income in the Southern Seven area also is considerably lower than the state median ($35,936 vs. $55,545). The South Lawndale income distribution is similar to that of the Southern Seven counties, although poverty rates are somewhat higher and median income is lower. This is especially true for families with children under age five; about one-third (32.7percent) of South Lawndale families with children under age 5 are in poverty, as compared to 23.4 percent in the Southern Seven area. The median income in South Lawndale is $32,317. North Lawndale has the most troubling economic characteristics among the study areas. The median income is only $20,253, which is only 36.5 of the state median. The poverty rate for all persons is 45.2 percent, and 55.9 percent of the families with children under age 5 are in poverty. In addition, only 28.5 percent of North Lawndale residents have incomes over $35,000.

Illinois has a diversified economy. More than one-third (34.2 percent) of employed persons age 16 and over are in management or professional positions (Table 3-9). Sales or office positions are the next most common occupations in the state, with 27.6 percent of the employed population in these positions. Large portions of the population also are employed in production, transportation, and material moving (15.7 percent), and in service occupations (13.9 percent). Education and health (19.4 percent), manufacturing (16.0 percent), retail sales (11.0 percent), and professional services (10.1 percent) are the most common industries.

Peoria County occupational and industrial distributions are very similar to the state as a whole. In the Southern Seven area, lower percentages of people are employed in management and professional and in sales or office positions, while higher percentages are employed in service occupations and construction or maintenance. The Southern Seven area also has more employees working in agriculture, fishing, and mining and in educational and health positions than the state distribution, and less in manufacturing, finance, insurance and professional services. North Lawndale likewise has proportionally fewer persons working in professional and management positions and more in service occupations than the state distribution, and also higher percentages working in production, transportation and material moving. The occupational and industrial classifications for South Lawndale differ the most from the state and other study areas. Over three-fifths (42.1 percent) of its employees work in production, transportation and material moving, which is nearly triple the state percentage. About one-third (32.6 percent) of South Lawndale employees work in the manufacturing industry, which is double the statewide percentage.

Table 3–8. Selected Income Characteristics

		State of Illinois		Peoria County		Southern Seven Counties		South Lawndale		North Lawndale		City of Chicago	
Total Households		**4,592,740**	**% of total**	**72,739**	**% of total**	**28,169**	**% of total**	**19,265**	**% of total**	**12,391**	**% of total**	**1,061,964**	**% of total**
Income and Benefits	Less than $10,000	383,299	8.3	7,344	10.1	4,330	15.4	2,649	13.8	4,213	34.0	146,192	13.8
	$10,000 to $14,999	252,485	5.5	4,939	6.8	2,973	10.6	1,586	8.2	1,232	9.9	71,103	6.7
	$15,000 to $24,999	517,812	11.3	9,851	13.5	4,628	16.4	3,026	15.7	1,915	15.5	132,339	12.5
	$25,000 to $34,999	545,962	11.9	9,768	13.4	4,255	15.1	3,107	16.1	1,501	12.1	133,670	12.6
	$35,000 or more	2,893,182	63.0	40,837	56.2	11,983	42.5	8,897	46.2	3,530	28.5	578,660	54.5
Median Family Income		$55,545	---	$50,592	---	$35,936	---	$32,317	---	$20,253	---	$42,724	---
Total Persons in Poverty		1,291,958	10.7	24,228	13.7	11,865	17.7	21,057	26.5	18,485	45.2	556,791	19.6
Families with Children Less Than 18 years in Poverty		192,590	11.6	3,962	16.7	1,858	20.2	3,398	27.6	3,422	51.5	84,598	23.1
Families with Children Less Than 5 years in Poverty		98,467	14.5	2,135	22.4	792	23.4	2,210	32.7	1,645	55.9	43,994	26.4

Source: U.S. Census Bureau, 2000.

Table 3–9. Selected Employment and Industry Characteristics

		State of Illinois	Peoria County	Southern Seven Counties	South Lawndale	North Lawndale	City of Chicago
Employed Civilian Population 16 Years and Over		**5,842,406**	**85,258**	**28,441**	**27,394**	**9,492**	**1,220,040**
Occupations by Percentage of Total Employed	Management/Professional	34.2%	35.2%	26.8%	9.7%	21.7%	33.5%
	Service Occupations	13.9%	16.2%	21.5%	17.6%	22.5%	16.6%
	Sales/Office	27.6%	26.6%	20.7%	18.4%	28.8%	27.0%
	Farming/Fishing/Forestry	0.3%	0.1%	1.0%	0.4%	0.0%	0.0%
	Construction/Maintenance	8.2%	7.7%	12.0%	11.8%	5.1%	6.6%
	Production/Transportation/ Material moving	15.7%	14.1%	18.0%	42.1%	21.9%	16.2%
Industry by Percentage of Total Employed	Agriculture/Fishing/Mining	1.1%	0.7%	7.4%	0.2%	0.0%	0.0%
	Construction	5.7%	5.2%	6.7%	7.0%	3.2%	4.4%
	Manufacturing	16.0%	17.8%	10.3%	32.6%	12.8%	13.1%
	Retail	11.0%	11.2%	10.7%	9.3%	9.8%	8.9%
	Transportation/Utilities	6.0%	4.1%	7.7%	4.4%	10.8%	6.8%
	Finance/Insurance	7.9%	5.8%	3.2%	3.9%	7.4%	9.1%
	Professional Services	10.1%	9.4%	3.5%	10.3%	9.6%	13.6%
	Educational/Health	19.4%	22.9%	25.4%	8.3%	24.3%	19.0%
	Arts/Recreation/Food	7.2%	8.7%	7.1%	9.9%	7.3%	8.5%
	Other	15.6%	14.2%	18.0%	14.1%	14.8%	16.6%

Source: U.S. Census Bureau, 2000.

Chapter 4: Study Methodology

This chapter describes the methods used in conducting the research activities upon which this final report is based. First, we discuss the development and implementation of surveys with linked pairs of parents receiving child care subsidies and their license-exempt providers. Second, the procedures utilized in analyzing administrative data to assess statewide license-exempt child care patterns are presented.

Several other research activities conducted during the first year of the project were important in informing the development of the parent and provider survey instruments. Interviews with 25 key informants were conducted, in order to identify license-exempt caregiving issues considered important by child care experts in each of the three project study areas. In addition, focus groups with 60 license-exempt providers and 55 parents using license-exempt care also were held in each study area to obtain parental and provider perspectives on subsidized license-exempt caregiving. Finally, a statewide survey of 115 subsidy specialists who determine eligibility for child care subsidies, as well as qualitative interviews with program resource development specialists, was conducted to gain an understanding of the views of program staff. The methods and associated findings from each of these activities are presented in our interim project report (Anderson, Ramsburg, & Rothbaum, 2003).

Parent and Provider Surveys

The central activity of this project was to interview linked pairs of parents receiving child care subsidies and their license-exempt providers, in order to obtain the perspectives of each on a range of issues considered important in developing license-exempt care policies. Project staff developed two separate survey instruments for this purpose – one for parents and one for providers. The surveys then were implemented in the three project areas with the use of both telephone and in-person interviews. The following sections describe the procedures used in conducting these surveys.

Survey Content

The survey instruments included a wide range of content related to project research questions. For parents, questions addressed reasons for choosing a license-exempt caregiver, reasons for needing care and child care usage patterns, perceptions about child care quality issues and developmental goals from their license-exempt arrangements, operation of the Child Care Assistance Program (CCAP), costs of care and impact of subsidies on the care received, interactions with license-exempt caregivers, and potential resources that may improve the quality of license-exempt care.

The provider survey addressed some of the same questions as the parent survey in order to compare perspectives on similar issues. Comparable questions addressed quality issues, perceptions about CCAP, potential resource needs, and caregiving interactions. In addition, the survey contained questions to develop information on license-exempt provider backgrounds, motivations, training, and care patterns.

The survey instruments were reviewed by national experts on license-exempt care, child care and program evaluation staff from the Illinois Department of Human Services (IDHS), and survey research staff from the Survey Research Office (SRO) of the University of Illinois at Springfield and the Metropolitan Chicago Information Center. After revisions based on these reviews were incorporated, Computer Assisted Telephone Interviewing (CATI) versions of each instrument were developed.

Units of Analysis and Frames of Reference in Survey

Because of the unique nature of this survey, several unit of analysis and frames of reference variations contained in the analyses should be noted. First, when the intent of questioning is to compare parent and provider perspectives on the same caregiving issue, the linked parent-provider pair at times is considered the unit of analysis. When questions focus on the individual perspectives of parents or providers, the unit of analysis varies as appropriate.

For a limited number of questions related to basic characteristics of children and their child care arrangements, data were collected on up to six children under age 13 in the household (or children age 13 and over with special needs). This age criterion was selected to correspond with Illinois subsidy eligibility requirements. For this information, data will be presented at the individual child level in some analyses.

The frame of reference used by parents and providers as they considered caregiving issues also varied depending on the nature of the questioning. When discussing many caregiving issues, respondents were questioned with respect to a randomly selected "focal child". The same focal child was used in the parent and linked provider interview, in order to assure that parents and providers were considering the same caregiving situation. This selection of a focal child balanced survey implementation feasibility with concerns that parents and providers focus on specific caregiving contexts. That is, it was not considered feasible to ask the full range of survey questions about each child in the household. At the same time, it seemed likely that care considerations often vary with respect to different children in a household, depending on factors such as age or special needs. Framing questions to reference general caregiving considerations for all children in the household therefore seemed inadvisable for several areas of questioning, and the use of a randomly selected focal child was selected as a reasonable compromise.

One other frame of reference issue is of importance for the subset of families that used more than one provider, as well as the subset of license-exempt providers that provided care to more than one family. If families were using more than one provider, we asked them to focus on the license-exempt provider who provided the most care to their family under the subsidy program. We referenced this provider by name when interviewing parents, and will at times use the terminology "main provider" in referencing this provider in the report. Similarly, we commonly asked license-exempt providers who were providing care to more than one family to focus upon the family with which we had conducted a parent interview, which we refer to as the "focal family". As with the previously mentioned reference to a focal child, the intent of the main provider and focal family referencing was to assure that parents and providers were

assessing the same caregiving situation. It also should be noted that, while some providers served more than one parent, none were main providers to more than one linked parent in the sample.

Sampling Procedures

The intent of the project was to survey 300 pairs of parents and their license-exempt providers in the three study areas, with approximately 100 pairs to be interviewed in each area. There are several important nuances to this sampling approach of which readers should be aware. First, a decision was made to approach the parent in all cases as the entry point to the provider. That is, parents always were interviewed first, and parents were informed that providers also would later be interviewed. In fact, as part of the parent interview, we asked for address and telephone information for the license-exempt provider. If we were not able to locate a parent or if a parent refused to be interviewed, we did not attempt to interview the provider. Although interviewing providers without first talking with parents would have been possible through the use of available IDHS provider records, we were concerned about approaching providers without letting parents know about the intent of our survey and our procedures.

Second, we developed specific definitions concerning the type of care that we would consider, so that the license-exempt care under consideration would be consistent with project objectives. In particular, we limited questioning to parents who were receiving subsidies through the Illinois program and who used a license-exempt provider for 15 hours or more of paid child care per week for at least one child. License-exempt care was defined to include care provided by a provider either in the parent's home or in the provider's home. Consistent with Illinois program rules, we also required that the parent have at least one child under 13 who was receiving care, or who was age 13 and over but had special needs.

The 15-hours of care criteria were added to increase the likelihood that the included parent-provider pairs would be engaged in license-exempt care as a primary form of care. Research has shown that license-exempt care also may be used as a subsidiary form of care for those using center or other licensed care arrangements. Although this as an important issue in license-exempt caregiving, we decided to focus limited project resources on those caregiving circumstances in which license-exempt care appeared to be more prominent.

These definitions were implemented both through sampling procedures and screening questions asked of parents. As an initial stage in sampling, staff at the Chapin Hall Center for Children at the University of Chicago extracted all parent cases meeting project definitional requirements from the IDHS Child Care Tracking System (CCTS) with June 2003 voucher dates the North and South Lawndale and Peoria County study areas, and with August 2003 voucher dates in the Southern Seven area.[5] Random samples of parents then were drawn for each of the three study areas. Due to difficulties in locating some cases, as well as the fact that some cases did not meet the definitional requirements specified above at the time of contact, a supplemental sample later was drawn using CCTS data with August 2003 voucher dates in the North and South Lawndale and Peoria County areas, and with January 2004 voucher dates in the Southern Seven area. The size of this second sample varied by study area, according to estimates based on

[5] The later date for the Southern Seven area reflected a decision to proceed first in the other two study areas, because of expected greater difficulty in conducting in-person interviews in the large, rural Southern Seven area.

how many additional interviews were needed to reach targeted numbers. Table 4-3 shows the size of the sample drawn in each area.

Survey Implementation

The survey was pre-tested with 20 parents and providers in July 2003. Minor revisions were made to the survey instruments based on pre-test results. The study interviews then were completed between August 2003 and July 2004.

In each study area, initial attempts were made to contact parents in the sample by mail and by telephone. The overall implementation of the survey was coordinated by SRO, which is a professional survey organization. SRO first sent a letter to all parents in the sample, which described the survey and offered a $20 payment for completing an interview. The letter indicated that SRO would be following up with a telephone call, and also provided an 800 number that parents could call to schedule an interview. SRO then made calls to all sample members, using numbers obtained from the CCTS administrative records.

Those parents contacted were asked screening questions to determine if they met the project definitions related to use of subsidized license-exempt care, and those who did not were closed as being "out of the population". Those who were eligible and interested either were interviewed immediately, or else scheduled for a subsequent telephone interview. Attempts to reach parents were made on different days of the week and different times of day, and cases with workable phone numbers were not considered unreachable until at least 8 calls had been made.

Cases for which there were no working phone numbers or that could not be reached were forwarded to the Metropolitan Chicago Information Center (MCIC), which was responsible for conducting in-person interviews with these persons. MCIC sent interviewers into the three study areas to locate subjects and conduct interviews, using address information included in the IDHS administrative records. In the North and South Lawndale and Peoria County areas, MCIC already had interviewers for other projects and hence could draw upon their existing staff. In the Southern Seven area, interviewers were recruited through contacts with local community agencies, and then trained by the MCIC project coordinator.

Provider interviews proceeded in a similar manner as parent interviews, except that initial provider contacts only occurred if a parent already had agreed to be interviewed. Provider contact information obtained from the parent was entered into a provider contact file, and telephone interview attempts were made. Personal interviews then were attempted if telephone contacts were unsuccessful. As with parents, providers were paid $20 for interview completions. They also were told that the parent for whom they provided subsidized care already had been interviewed.

Interview Completions and Response Rates

A total of 704 interviews were completed. Of this total, 606 resulted from completion of 303 paired parent and provider interviews, with the pairs fairly evenly distributed across the three study areas (Table 4-1). In addition, because of our procedure of interviewing providers

only if a parent interview had been completed, an additional 98 parent interviews were conducted. In these "parent-only" interviews, providers either subsequently chose not to be interviewed or could not be located. When added to the 303 parent interviews for which provider interviews also were completed, a total of 401 parent interviews were completed.

Table 4-1. Summary of Interview Completions by Study Area

	Total Sample	North & South Lawndale	Peoria County	Southern Seven
Parents	401	135	134	132
Providers	303	105	93	105
Total Pairs	303	105	93	105
Total Interviews	704	240	227	237

About three-fifths (58.1 percent) of study interviews were completed by telephone, while the remaining 41.9 percent were conducted in-person (Table 4-2). As the table shows, the distribution of telephone versus in-person interviews varied somewhat between areas, with the Southern Seven area employing relatively more telephone interviews and the North and South Lawndale area conducting the highest proportions of interviews in-person.

Table 4-3 provides response rate information for the parent interviews. We began with a randomly drawn sample, stratified by the three study areas, of 810 parents. However, 126 of these parents did not qualify to be interviewed, either because they no longer were involved with the program when contacted, could be verified to have moved from the study areas, or had died. These exclusions resulted in an adjusted eligible sample of 684 parents. Of this number, 401 parent interviews were completed, resulting in a response rate of 58.6 percent. As the table indicates, non-responses resulted much more frequently from inability to contact parents than from interview refusals. That is, 230 or 81.3 percent of all non-responses were due to inability to contact parents, as opposed to only 53 refusals to be interviewed.

Table 4-3 also shows that the response rate varied somewhat between the study areas. The response rate was highest in the Chicago North and South Lawndale area, with 70.7 percent of eligible parents responding. In comparison, parental response rates in the Peoria County and Southern Seven areas were 56.5 percent and 51.6 percent, respectively.

Table 4-4 provides comparable response rate information for providers. Because of our decision to only interview providers if we first obtained a parent interview completion, the initial sampling pool for providers was considerably smaller; this 401 number is by definition equal to the number of completed parent interviews. Of this number, 10 providers did not qualify to be interviewed when contacted, because they no longer were providing care for the family. This resulted in an adjusted provider sampling pool of 391.

Table 4-2. Summary of Interview Completions by Type of Interview and Study Area

	Total Sample		North & South Lawndale		Peoria County		Southern Seven	
	Number	% of Interviews	Number	% of Interviews	Number	% of Interviews	Number	% of Interviews
Parents:								
Telephone	259	64.6	76	56.3	82	61.2	101	76.5
In-person	142	35.4	59	43.7	52	38.8	31	23.5
Provider:								
Telephone	150	49.5	35	33.7	43	45.7	72	68.6
In-person	153	50.5	69	66.3	51	54.3	33	31.4
Total Interviews								
Telephone	409	58.1	111	46.4	125	54.8	173	73.0
In-person	295	41.9	128	53.6	103	45.2	64	27.0

Table 4-3. Parent Interview Sample, Disposition, and Response Rates by Study Area

	Total Sample	North & South Lawndale	Peoria County	Southern Seven
Sampling Pool				
Initial sample	810	220	300	290
Did not qualify	126	29	63	34
Adjusted sample	684	191	237	256
Disposition				
Could not contact	230	34	84	112
Refusals	53	22	19	12
Interviews completed	401	135	134	132
Response Rate	58.6%	70.7%	56.5%	51.6%

The 303 completed provider interviews resulted in a completion rate of 77.5 percent among eligible providers. As with parents, most non-responses resulted from inability to contact providers as opposed to refusals. Among the 88 provider non-responses, 68 or 77.3 percent were due to inability to contact the provider. The response rates were fairly similar across the three study areas, ranging from 70.1 percent in Peoria County to 77.0 percent in North and South Lawndale to 79.5 percent in the Southern Seven area.

Table 4-4. Provider Interview Sample, Disposition, and Response Rates by Study Area

	Total Sample	North & South Lawndale	Peoria County	Southern Seven
Sampling Pool				
Initial sample	401	135	134	132
Did not qualify	10	3	5	2
Adjusted sample	391	132	129	130
Disposition				
Could not contact	68	17	28	23
Refusals	20	11	7	2
Interviews completed	303	104	94	105
Response Rate	77.5%	77.0%	70.1%	79.5%

Data File Construction

All closed question responses were entered directly into an SPSS data file. Open question responses were entered into text files, and then coded and merged with the closed question responses. The final merged data file includes both the 401 parent and 303 provider survey responses. In this file, a single case record includes both the parent survey responses and the linked provider survey responses, which facilitates analyses comparing parent and provider responses. While we will focus on the 303 complete parent-provider pairs in the subsequent analyses in this report, the public use file to be prepared for the project will contain all 401 parent interviews.

Administrative Data Development and Analysis

The administrative data analyses presented in this report are based on data developed for the project by the Chapin Hall Center for Children at the University of Chicago, using case records from several state agency databases. Three sources of data were used for this purpose.

First, for describing the patterns of CCAP subsidy use, administrative data from the IDHS Child Care Tracking System were used. Second, we utilized the IDHS Client Database to analyze the patterns of other services used by child care subsidy users and providers, such as TANF, Medicaid, and Food Stamps. Third, for the patterns of earnings of the child care subsidy families, Unemployment Insurance (UI) wage records from the Illinois Department of Employment Security were accessed. Below, we describe each data source and the methods employed to link the data records from each system for the study.

Patterns of CCAP Subsidy Use

Chapin Hall receives monthly extracts of the IDHS Child Care Tracking System (CCTS). This database records monthly subsidy payment and service information for subsidy families, as well as their basic characteristics and information about their service providers. The database contains information on child care subsidy receipt on a monthly basis at the individual family and child levels. Using the monthly CCTS extracts, Chapin Hall has created a longitudinal database that tracks information such as months of child care receipt, types of care used, voucher amounts, addresses of parents, types of providers, addresses of providers, and demographic information about families using care. Upon receipt of each data shipment, Chapin Hall extracts the pertinent variables, reformats the data into relational files, and stores them in a relational database (Sybase). The study utilized selected data from July 1998 to January 2003 from this database.

Illinois makes child care subsidy payments through two methods: vouchers and contracts. Vouchers are issued to eligible families to purchase care from providers, while the contracts are negotiated with the providers to serve blocks of eligible children. Prior to December 2000, the CCTS system only contained information on families using voucher subsidies. The contract service system data were added to CCTS beginning in January 2001. Thus, our study only captures a portion of the total subsidy population for the period from July 1998 to December 2000. However, previous research has shown that the vast majority of Illinois children receiving subsidies (about 83 percent) were served through vouchers (Piecyk, Collins, and Kreader, 1999).

TANF, Medicaid, and Food Stamp Use

Chapin Hall receives monthly extracts of the IDHS Client Database. Each extract contains mainly cross-sectional data, with some limited historical information. The Illinois Longitudinal Public Assistance Research Database (IL LPARD) is a longitudinal database of public assistance cases (including AFDC/TANF, Medicaid, and Food Stamp receipt) in Illinois that Chapin Hall built from these monthly extracts. This database currently contains data from February 1989 to the present.

Chapin Hall's purpose in creating the IL LPARD was to structure the IDHS Client Database data in a way that would facilitate longitudinal research. On receipt of each data shipment, Chapin Hall extracts the pertinent variables, reformats the data into relational files, and stores them in a relational database (Sybase). This relational database uses less space than the original hierarchical structure, facilitates a longitudinal design, and provides researchers with more flexibility in their analyses. In addition, by allowing users to track the changes that occur in

the data, the relational structure improves on that of the original data, which required all changes to overwrite existing information. The IL LPARD is updated monthly with new cases from the IDHS system and also updates records that IDHS changed in the past month.

Earnings of Child Care Subsidy Families

Unemployment Insurance (UI) wage records consist of total quarterly earnings reported by employers to state UI agencies for each employee. The database contains information on quarterly earnings, employee Social Security number (SSN), employer SSN or Federal Employer Identification Number (FEIN), and employer address. Any employer paying $1,500 in wages during a calendar quarter is subject to a state UI tax and must report the quarterly amount paid to each employee.

It is generally known that more than 90 percent of a state's employed population is covered. Major types of employment that are not covered include federal government civilian and military employees, U.S. Postal Service employees, railroad employees, employees of some philanthropic and religious organizations, and independent contractors. A potential limitation of the data is that the coverage extends only to a state's borders, so Illinois residents who work in Wisconsin or in Missouri, for example, appear in the UI wage record databases of those jurisdictions. Another limitation of the data is that some persons, especially in low-income populations, work in the "underground" or cash economy, and such cash transactions generally are not reported to the Illinois Department of Employment Security. Both of these limitations lead to some understatement of earnings, and use of this method also does not capture non-earnings sources of income.

Chapin Hall receives Illinois Department of Employment Security (IDES) quarterly wage report data from the IDHS through an interagency data-sharing agreement. The quarterly data are linked over time at the individual level to allow longitudinal analyses of earnings. For this study, the employee records were linked to subsidy records to allow examination of the quarterly earnings for a family receiving subsidies in a given month. For example, the mean and median earnings reported for January 2001 represent the earnings reported in the first quarter of 2001.

Record Linking

Linking data records from the CCTS reliably and accurately to TANF, Medicaid, Food Stamp and UI wage records is a key to being able to describe the service use and earnings patterns of subsidy recipients. The linking process is complicated by the fact that no single variable, even Social Security Number in some cases, can be relied on completely to establish the identity of a client from the records of various agencies. A process called probabilistic record matching, first developed by researchers in the fields of demography and epidemiology, is used by Chapin Hall for these purposes (Newcombe, 1988; Winkler, 1988; Jaro, 1985; 1989). Probabilistic record matching is based on the assumption that no single match between variables common to the source databases will identify a client with complete reliability. Instead, probabilistic record matching calculates the probability that two records belong to the same client, using multiple pieces of identifying information. Such identifying data may include name, Social Security Number, birth date, gender, race/ethnicity, and address of residence. When

multiple pieces of identifying information from two databases are comparable, the probability of a correct match is increased.

Once a match has been determined, a unique number is assigned to the matched record so that each record can be uniquely identified. The end result of computer matching is a new link file, which contains the unique number assigned during matching, the client's identifying data (name, birth date, race/ethnicity, gender, and origin of residence), and all the identification numbers assigned by agencies.

Presentation of Survey Data in the Report

Most of the survey data presented in this report will be expressed as percentage frequency distributions for the total sample and for each of the three study areas. Two conventions will be followed in this respect, with the intent of highlighting the most pertinent study findings and allowing consistent interpretations of results.

First, results often included small numbers of "don't know" or "refused to answer" responses. A decision was made to include such response categories in the tables only if they equaled or exceeded 1 percent of total responses. The actual percentage of all other response categories will be presented in each table unless otherwise indicated in the text or table footnotes, so these categories will total to slightly less than 100 percent in those tables where numbers of "don't know" and "refused to answer" responses do not reach the 1 percent threshold for inclusion in the table. In a small number of tables, it was considered useful to exclude "don't know" responses from the frequency distributions, and the table numbers are adjusted accordingly in these tables.

Second, to simplify data presentation, we first will present findings for the total sample, as well as any related statewide administrative data, in each chapter. Then, a section will discuss statistically significant differences that were found in the survey responses between the three study areas. In addition, this latter section will examine significant differences in responses depending on whether the family was using a related or non-related provider. For selected analyses, differences also will be assessed with respect to the age of the focal child in care.

Chapter 5:
Background Characteristics of Parents Using License-Exempt Care

This chapter describes the characteristics of parents using license-exempt care in the Child Care Assistance Program (CCAP). Two sources of data are used in this analysis. First, limited information on all parents involved in the program is available statewide from administrative records. Second, more detailed data are available for the parents surveyed in the three study areas.

Statewide Profiles of Parents Using Subsidized License-Exempt Care

The Illinois Child Care Tracking System (CCTS) includes limited information on the characteristics of families using the subsidy system. Earned income data of subsidy families also were available through wage reporting data provided by the Illinois Department of Employment Security. In addition, data from the IDHS Client Database were accessed to determine the extent to which subsidy families use selected other means tested programs. Available data were collected at two time points for each year of the study – January and July. These two different months were selected to control for the possibility of seasonal differences in the data.

Overview of Illinois Program Growth and Composition

Figure 5-A illustrates the rapid growth of the CCAP over the period from July 1998 to January 2003. Beginning with a caseload of 53,882 families in July 1998, the number of families using the program monthly increased 63.2 percent to 87,917 by January 2003. The number of children receiving care through the program similarly grew by 57.8 percent during this time, reaching a total of 170,284 in January 2003. As can be seen from Figure 5-A, the growth in program participation was quite rapid during the initial years of the period under study, before stabilizing at the end of the period.

Figure 5-A. Growth of Child Care Assistance Program

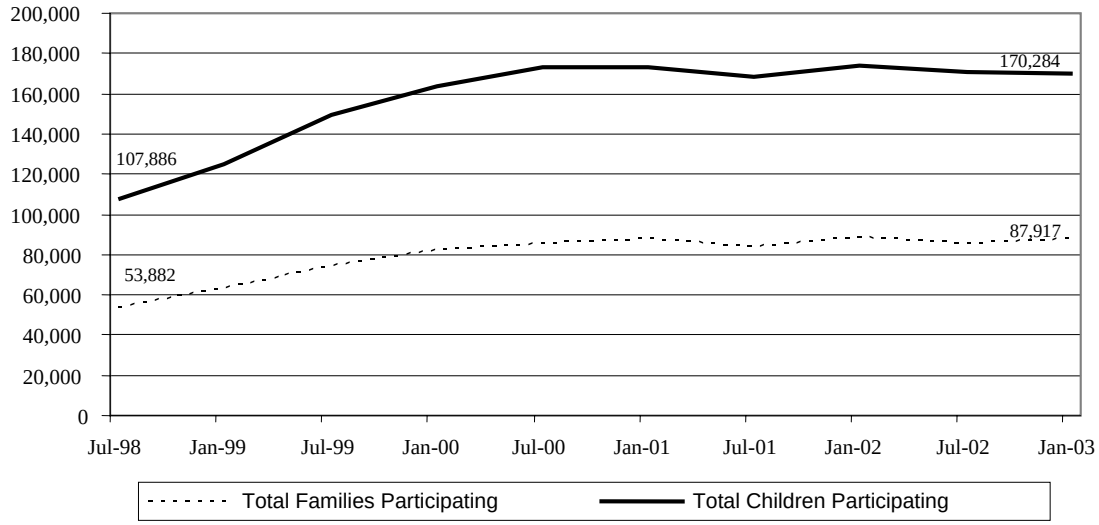


Table 5-1 presents data on the ages of children served by the subsidy program in January 2003. Over 44 percent of children served by the program were age 6 and over[6], while another 34.9 percent were in the 2.5 – <6 age group. A relatively small portion of program services was being provided to children under age 1 (6.5 percent). Analysis of the percentage distribution of care by age for other months revealed only minor variations when compared to the January 2003 percentages. There was a slight decrease over the study period in the proportion of all cases in the 2.5 - <6 age group, with each of the other age groups correspondingly representing a slightly higher percentage of the total caseload.

Table 5–1. Age Composition of Children Receiving Care Through the Illinois Child Care Program: January 2003

	Number	Percent of Total
Under age 1	11,011	6.5%
1 - <2.5	24,533	14.4%
2.5 - <6	59,430	34.9%
6 and Over	75,310	44.2%
Total	**170,284**	**100.0%**

Background Characteristics of Families Receiving Child Care Subsidies

Characteristics of Total Caseload

Table 5-2 presents data on the characteristics of families that were receiving the child care subsidy in the most recent month for which data were available (January 2003). The average age of parents receiving subsidies at that time was 29.5. Slightly over one-half of the parents (51.4 percent) were age 20-29, while 42.9 percent were age 30 and over. Only a small subset of the parents (5.7 percent) was less than 20 years old.

Table 5-2 also shows the number of subsidized children that families had in care, with 42.7 percent having only one subsidized child and 57.3 percent having multiple children in subsidized care. It also can be seen that nearly three-fourths (74.5 percent) of the families had either one or two children in subsidized care. Analysis of data for earlier months during the study period indicates that this one child versus multiple child composition of the caseload was quite stable over the study period.[7]

[6] Because care for children over age 13 is only allowed under special circumstances, nearly all children receiving care in the age 6 and over category are under age 13.

[7] We should note that these figures refer only to children in subsidized care; the administrative data do not include data on any other children the family has who are not receiving subsidies.

Table 5-2. Demographic Characteristics of Household Heads Who Use Illinois Child Care Subsidies: January 2003

		Total Families		Percent Distribution for Families Using:		
		Number (n=87,917)	% of Total	License-Exempt Only (n=40,555)	Licensed Only (n=43,009)	Both Licensed & License-Exempt (n=4,353)
Age of Household Head[1]						
	< 18 years	1,699	2.0	2.5	1.8	0.8
	18 – 19 years	3,101	3.7	3.8	3.9	1.7
	20 – 23 years	21,955	26.5	22.3	30.4	26.0
	24 – 29 years	20,636	24.9	24.4	24.7	31.2
	30 years and over	35,569	42.9	47.1	39.2	40.4
	Mean	29.5 years	-----	30.0 years	29.1 years	29.0 years
Number of Subsidized Children in Family						
	One	37,532	42.7	30.3	57.2	14.8
	Two	27,985	31.8	33.1	29.7	40.8
	Three	14,368	16.3	21.6	10.0	29.2
	Four or more	8,032	9.1	15.0	3.0	15.2
Age of Youngest Subsidized Child						
	<1 year	10,907	12.4	13.0	11.6	15.3
	1 - <2.5 years	22,112	25.2	22.4	27.2	30.9
	2.5 - <6 years	36,388	41.4	32.2	49.2	49.3
	6 years and over	18,510	21.1	32.4	12.1	4.6
Income in First Quarter of 2003						
	< $1,000	32,848	37.4	36.9	38.6	29.9
	$1,000 - $4,999	39,383	44.8	47.4	42.2	46.2
	$5,000 - $9,999	14,269	16.2	14.5	17.3	21.7
	$10,000 and over	1,417	1.6	1.2	2.0	2.2
	Mean (in dollars)	$2,686	-----	$2,551	$2,764	$3,170
	Median (in dollars)	$2,281	-----	$2,201	$2,304	$2,925

[1] The data on age of household head will not add up to the total number of families, because the administrative data on age was missing for 4,957 household heads. Percentages are calculated on the non-missing household head total.

For about two-thirds of families, the youngest subsidized child was either age one to less than two and one-half (25.2 percent) or two and one-half to less than six (41.4 percent). Consistent with the data previously presented on the relatively small number of infants in the program, only 12.4 percent of families had a youngest child under one receiving a subsidy.

Administrative data indicate that parents receiving subsidies typically have incomes well below the maximum levels allowed for program eligibility. For example, as shown in Table 5-2, average quarterly family income during the first quarter of 2003 for those receiving subsidies was only $2,686, and the median income figure for this period was only $2,281. The mean quarterly income figure would equate to an annual income of only $10,744. While, as noted in the methodology section, use of unemployment insurance wage records results in some understatement of incomes from unearned or uncovered earnings sources, it is clear that the CCAP generally serves a population with very low incomes.

Differences in Characteristics among Families Receiving Different Types of Care

Table 5-2 also compares selected characteristics for families receiving subsidies according to the types of care they were using in January 2003: license-exempt only, licensed only, or a mix of licensed and license-exempt care. The size of these care categories differs markedly, with licensed only (43,009) or license-exempt only (40,555) care being used by most families and a smaller number using both types of care in the same month (4,353). We will turn to issues of types of care used in more detail in Chapter 7.

The average age of household heads was very similar for the families regardless of the types of care they were using. Parents using only license-exempt care were more likely to be age 30 and over than parents who used only licensed care (47.1 percent versus 39.2 percent), and they were less likely to fall in the 20-23 age group (22.3 percent versus 30.4 percent).

There were notable differences in number of children receiving subsidies and the age of the youngest child receiving subsidies for the types of care shown in Table 5-2. Families only using licensed care were more likely to have only one child receiving a subsidy than those using license-exempt care only (57.2 percent versus 30.3 percent). Exclusive use of licensed providers also was much more highly concentrated in families with a youngest subsidized child in the 2.5 < 6 age range (49.2 percent versus 32.2 percent of families using on license-exempt care). In comparison, families using only license-exempt care were more likely to have a youngest child age 6 and over (32.4 percent versus 12.1 percent of families using only licensed care).

There were small differences in average quarterly incomes for families using only licensed or only license-exempt care in January 2003 ($2,764 for licensed-only families versus $2,551 for license-exempt only families). The small group of families that used subsidies for both license-exempt and licensed at that time had slightly higher average quarterly incomes of $3,170.

Use of Other Social Services by Subsidy Families

Given the welfare reform context in which child care subsidy programs have developed, the use of other means tested programs by subsidy recipients is of particular interest. Data therefore were analyzed on the use of TANF, Medicaid, and Food Stamps by families receiving subsidies. In addition, comparisons were made of usage patterns by families using license-exempt versus licensed care.

The data reveal several interesting usage patterns by subsidy families. First, as shown in Table 5-3, by January 2003 only 6.2 percent of subsidy families were also receiving TANF. Yet, as also can be seen from this table, over half (51.0 percent) of these families had received TANF within the last five years. This trend is consistent with large numbers of persons transitioning off welfare and using child care subsidies as they did so.

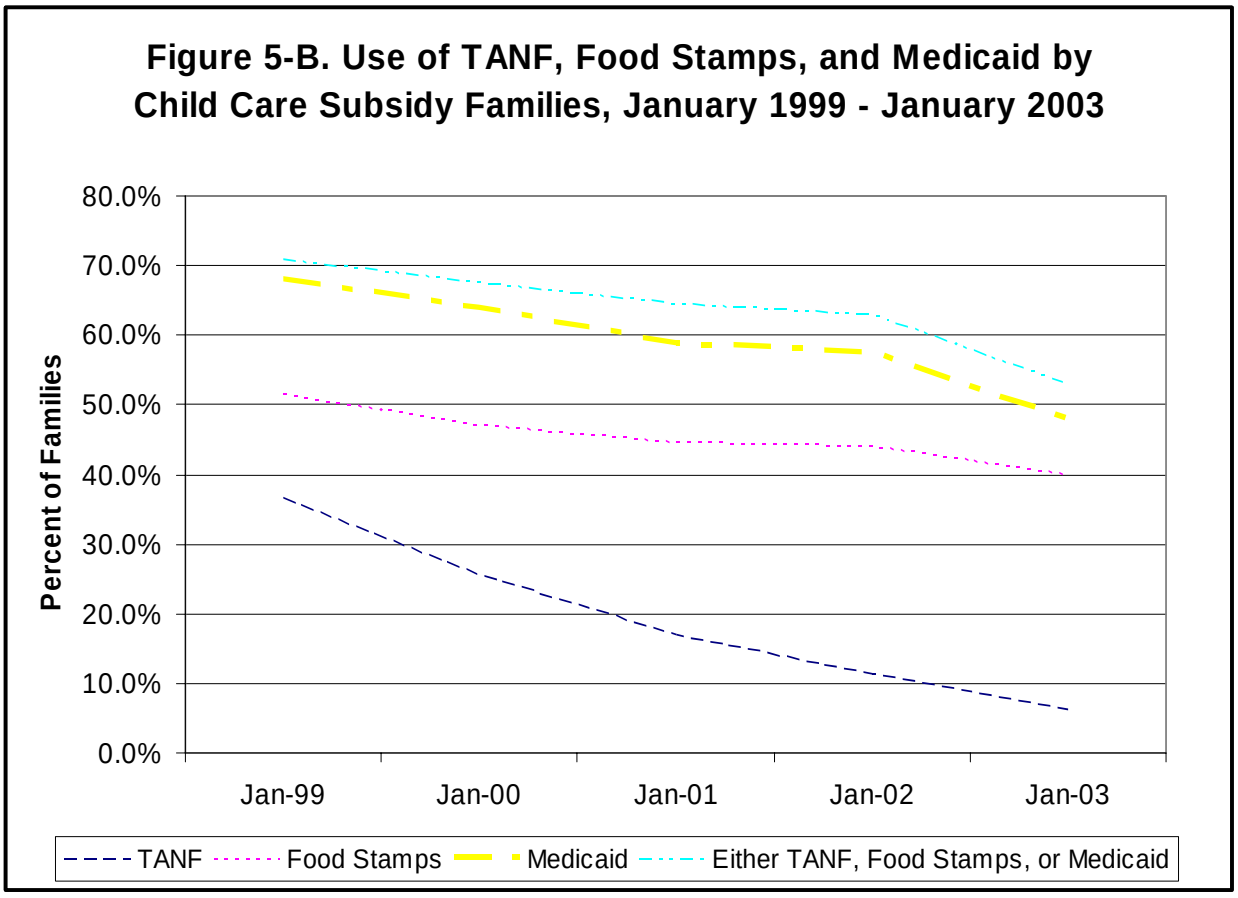
Figure 5-B shows a similar pattern using current use patterns of all subsidy families at different time points. That is, the figure shows that slightly less than 40 percent of the families receiving subsidies in January 1999 also were receiving TANF. However, by January 2003, only 6.2 percent of subsidy families also received TANF.

Although use of TANF has declined substantially, the data also demonstrate the continuing importance of other means tested programs to subsidy families. Table 5-3 shows that 47.9 percent of families that received subsidies in January 2003 were simultaneously receiving Medicaid, and 39.9 percent were using Food Stamps. Over half (53.0 percent) were using TANF, Medicaid, or Food Stamps. The fragile economic circumstances of most subsidy users are further underscored by the fact that 81.6 percent had used either TANF, Food Stamps, or Medicaid at some point in the previous five years.

Table 5-3. Use of Selected Means Tested Programs by Families Receiving Child Care Subsidies in January 2003 (n=87,917)

	Currently Using		Used in Last 2 Years		Used in Last 5 Years	
	Number	% of All Families	Number	% of All Families	Number	% of All Families
TANF	5,476	6.2%	20,614	23.5%	44,810	51.0%
Food Stamps	35,110	39.9%	53,757	61.2%	63,629	72.4%
Medicaid	42,114	47.9%	60,807	69.2%	69,646	79.2%
All of the Above	5,210	5.9%	20,307	23.1%	44,294	50.4%
Any of the Above	46,588	53.0%	64,133	73.0%	71,750	81.6%
None of the Above	41,329	47.0%	23,784	27.1%	16,167	18.4%

As with TANF, use of Medicaid and Food Stamps became less common among subsidy families over the five-year period for which data were analyzed, but the usage declines were less dramatic (Figure 5-B). Overall, use of either TANF, Food Stamps, or Medicaid among subsidy users declined from 70.8 percent in January 1999 to 53.0 percent in January 2003.



Differences in Other Service Use by Families Using Different Types of Child Care

Subsidy families that relied exclusively on license-exempt providers were much more likely to use other means tested programs than families using only licensed providers. For example, in January 2003, 66.1 percent of the families using only license-exempt care were receiving TANF, Food Stamps, or Medicaid, as compared to 40.0 percent of those using only licensed care (Table 5-4). The table also shows that families relying solely on license-exempt care were much more likely to use each of these means tested services than were families that used only licensed care.

In addition, subsidy families that relied on license-exempt providers were more likely to have used other means tested programs in prior years than those who used only licensed providers. For example, 67.7 percent of the January 2003 subsidy families using only license-

exempt care had received TANF within the last five years, as compared to only 34.3 percent of the families using only licensed care (not shown in table). Thus, consistent with the income data in Table 5-2, these data suggest that families relying solely on license-exempt providers may be somewhat more economically disadvantaged than families relying only on licensed caregivers.

Table 5-4. Use of Selected Means Tested Programs by Families Receiving Child Care Subsidies in January 2003, by Type of Child Care Provider Used

	Type of Subsidized Child Care Provider Used by Family:					
	Licensed Only (n=43,009)		License-Exempt Only (n=40,555)		Both Licensed and License-Exempt (n=4,353)	
	Number	% of All Families	Number	% of All Families	Number	% of All Families
TANF	1,298	3.0%	3,916	9.7%	262	6.0%
Food Stamps	11,288	26.2%	21,803	53.8%	2,019	46.4%
Medicaid	15,648	36.4%	24,131	59.5%	2,335	53.6%
All of the Above	1,213	2.8%	3,745	9.2%	252	5.8%
Any of the Above	17,185	40.0%	28,999	66.1%	2,601	59.8%
None of the Above	25,824	60.0%	13,753	33.9%	1,752	40.2%

Characteristics of Parents in Survey Sample

The survey responses provide more detailed information on the demographic, social, and economic characteristics of parents using subsidies in the three study areas. As shown in Table 5-5, nearly all parents responding to the survey were women, and the large majority (94.8 percent) were neither married or living with a partner. In addition, 67.0 percent of the parents had no other adults living with them in their household. Taken together, these background characteristics indicate that our subsequent analyses of subsidy users are most pertinent in the context of single female-headed households, a group that has been of considerable concern to child care policy-makers.

Table 5-5 also presents the age distribution for the parent respondents. The average age of the parents in the sample was 29.3, which closely parallels the age for all parents in the program shown in Table 5-2. Consistent with this average, 63.2 percent of the parents fell in the age 25-29 and age 30-39 age groups. Only 10.3 percent were age 20 or younger.

Table 5-5. Demographic Characteristics of Parents in Survey Sample

	Total Sample (n= 303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Gender				
Female	99.0	100.0	100.0	97.1
Male	1.0	0.0	0.0	2.9
Marital Status				
Never married	80.9	91.4	84.9	66.7
Married or living w/ partner	5.0	1.9	2.2	10.5
Divorced, widowed, or separated	13.9	6.7	12.9	21.9
Adults in Household (other than self and Spouse / partner)				
None	71.0	61.9	71.0	80.0
One	16.8	22.9	18.3	9.5
Two or more	12.2	15.2	10.8	10.5
Has Either Spouse, Partner, or Other Adult in Household				
Yes	33.0	40.0	30.1	28.6
No	67.0	60.0	69.9	71.4
Age				
< 18	2.0	1.9	0.0	3.8
18 – 20	8.3	4.9	6.5	13.5
21 – 24	16.6	15.4	20.4	14.4
25 – 29	28.6	29.8	29.0	26.9
30 – 39	34.6	34.6	36.6	32.7
40 – 49	8.3	12.5	6.5	5.8
50 and over	1.7	1.0	1.1	2.9
Mean age	29.3	30.2	29.0	28.8

Table 5-6 provides data on selected social characteristics of parents in the three study areas. It can be seen that the study population was heavily African American (73.3 percent), and that most other respondents were white (22.1 percent). Despite our inclusion of the heavily Hispanic South Lawndale neighborhood in our North and South Lawndale study area, only 2.3 percent of all parents in the sample and 5.7 percent in North and South Lawndale were Hispanic. Similarly, only 2.3 percent of parents generally spoke a language other than English in their own homes, and only 1.3 percent were born outside of the United States.

The study findings thus are heavily a reflection of African-American parents and provider perspectives, especially in North and South Lawndale and Peoria (for comparable provider

characteristics, see page 56). We cannot ascertain the primary reason for the lower than expected participation of Hispanic parents from South Lawndale. However, community contacts in South Lawndale had informed us during initial community visits that Hispanic program participation tended to be low, especially among recent immigrants. In addition, among those who were receiving child care subsidies, there may have been greater hesitancy to participate in the study for cultural reasons, despite the availability of Spanish-speaking interviewers.

Table 5-6. Social Characteristics of Parents in Survey Sample

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Race / Ethnicity				
White	22.1	1.0	23.7	41.9
African American	73.3	90.5	73.1	56.2
Latino or Hispanic	2.3	5.7	1.1	0.0
Other	1.7	1.0	2.2	1.9
Language Spoken at Home				
English	97.7	94.3	98.9	100.0
Spanish	1.3	2.9	1.1	0.0
Other	1.0	2.9	0.0	0.0
Country of Origin				
United States	98.7	97.1	100.0	99.0
Outside United States	1.3	2.9	0.0	1.0

The parents in the sample varied considerably with respect to their educational backgrounds. Nearly two-thirds (63.6 percent) had at most a high school diploma or GED, and 22.7 percent had not finished high school or obtained a GED (Table 5-7). In comparison, 36.3 percent had attended a community college or four-year college, and most parents in this subgroup had not received a degree. As shown in the table, only 8.9 percent of the entire sample had received an Associates Degree, and only 2.0 percent had completed a Bachelor's Degree.

Most parents in the sample were current or former public assistance recipients. Table 5-7 shows that 38.6 percent of the parents reported receiving TANF at the time they were interviewed. An additional 48.5 percent were not currently receiving TANF but had received cash public assistance in the past, so overall 87.1 percent of respondents either were current or former public assistance recipients. It should be noted that the proportion of sample respondents who were current TANF recipients was much higher than for the program as a whole (see Table 5-3). We were unable to ascertain the reasons for this higher proportion of TANF recipients in the survey sample. However, contributing factors may include higher proportions of TANF

receipt in the study areas compared to the state and regional averages, or a greater interest in TANF recipients in receiving the payment for completing an interview.

Parents also were asked to estimate their pre-tax household incomes for the year prior to the study (2002). As would be expected given the high proportions of respondents who were current or former public assistance recipients, reported incomes were quite low. For example, 38.5 percent of respondents reported annual household incomes of less than $10,000, and 42.1 percent reported incomes of $10,000 – 19,999. While not directly comparable, these income range data are consistent with the statewide earnings data from the administrative records presented in Table 5-2, and again indicate the very low-income status of most program participants.

Table 5-7. Educational and Economic Characteristics of Parents in Survey Sample

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Highest Grade Completed				
< 9th grade	2.6	2.9	1.1	3.8
Some high school	20.1	35.2	16.1	8.6
High school diploma or GED	40.9	42.9	41.9	38.1
Some college	36.3	19.0	40.9	49.5
Received College Degree				
Associates degree	8.9	3.8	7.5	15.2
College degree	2.0	1.0	2.2	2.9
Household Income in 2002				
Less than $ 10,000	38.5	34.3	39.8	41.3
10,000 – 19,999	42.1	42.2	39.8	44.2
20,000 – 29,999	12.7	14.7	16.1	7.7
30,000 – 39,999	2.0	2.9	0.0	2.9
Don't know	3.7	3.9	3.2	3.8
TANF Status				
Currently received	38.6	32.4	43.0	41.0
Received previously	48.5	56.2	44.1	44.8
Never received	12.2	11.4	11.8	13.3

Table 5-8 provides data on the characteristics of the children of the parents interviewed. Parents on average had 2.74 children less than 18 years of age, with an average of 2.43 of these meeting the subsidy eligibility age requirements of being under 13 years of age. Most respondents (58.1 percent) had one or two children who were under age 13, while 35.6 percent had 3-4 children in this age group. Consistent with the state administrative data, relatively few (11.6 percent) survey respondents had a youngest child under one year old. The youngest child in these families was fairly evenly distributed across the other three age groups shown in Table 5-8, with the highest percentage falling into the 2.5 < 6 age category (33.1 percent).

Table 5-8. Characteristics of Children in Survey Sample

	Total Sample (n=303)	**North & South Lawndale (n=105)**	**Peoria County (n=93)**	**Southern Seven (n=105)**
Average Number of Children < 18	2.74	3.05	2.90	2.30
Average Number of Children < 13	2.43	2.67	2.65	1.99
Number of Children Under 13				
1	28.7	23.8	17.2	43.8
2	29.4	26.7	33.3	28.6
3 – 4	35.6	41.9	41.9	23.8
5 or more	6.3	7.6	7.5	3.8
Age of Youngest Child				
< 1	11.6	8.6	14.1	12.4
1 - <2.5	27.5	32.4	21.7	27.6
2.5 - <6	33.1	26.7	38.0	35.2
6 and over	27.8	32.4	26.1	24.8

Differences in Parent Characteristics between Study Areas

Although parents in the three study areas shared many characteristics, there also were interesting differences that illustrate the diverse range of family situations encompassed by a large statewide subsidy program such as CCAP. For example, while a small minority of parents in each study area were married, parents in North and South Lawndale and Peoria County were significantly more likely to never have been married than were Southern Seven parents (91.4 percent in North and South Lawndale and 84.9 percent in Peoria County versus 66.7 percent in the Southern Seven area) (see Table 5-5). In contrast, North and South Lawndale respondents were more likely to have at least one other adult in the household (40.0 percent) than parents in Peoria County (30.1 percent) and the Southern Seven area (28.6 percent). This latter comparison may suggest the differential availability of other adult household members to provide care in these sites, either through subsidized or non-subsidized means.

As would be expected from the general population characteristics, the racial/ethnic composition of respondents in the three areas differed markedly (Table 5-6). North and South Lawndale respondents were largely African American (90.5 percent), as were Peoria County respondents (73.1 percent). In comparison, 56.2 percent of Southern Seven parents were African American, and 41.9 percent were white.

There also were significant differences between parents in the three study areas with respect to education, with Southern Seven and Peoria County respondents generally more educated than those in North and South Lawndale (Table 5-7). For example, 49.5 percent of parents in the Southern Seven area and 40.9 percent in Peoria County had attended some college, as compared to only 19.0 percent in North and South Lawndale. Correspondingly, a much higher percentage of North and South Lawndale parents had not completed high school or received a GED (38.1 percent versus 17.2 percent in Peoria County and 12.4 percent in the Southern Seven area.

Finally, the parents in the study areas differed significantly in the number of children they had (Table 5-8). While the average number of children under 18 was similar for parents in North and South Lawndale and Peoria County (3.05 and 2.90, respectively), Southern Seven respondents had only 2.30 children on average. Differences in the average numbers of children under age 13 were similar. Given these average differences, it is not surprising that Southern Seven parents were much more likely to have only one child under age 13 (43.8 percent versus 23.8 percent in North and South Lawndale and only 17.2 percent in Peoria County).

Chapter 6:
Background Characteristics of License-Exempt Providers

This chapter describes selected background characteristics of license-exempt providers in the study. Because the CCAP administrative data contains limited information on provider characteristics, we focus on the backgrounds of the 303 license-exempt providers with whom linked interviews were conducted. Demographic, social, and economic characteristics of these providers are described, and information on their educational backgrounds is provided. Data on the specific child care training that providers have received, as well as provider and parent perceptions about needed training and resources, are presented in Chapter 13. The IDHS Client Database contains information on the use of means tested programs by child care providers. Because such data are useful in considering the economic circumstances of license-exempt providers statewide, we conclude the chapter with a brief presentation of this information on other service use.

Characteristics of License-Exempt Providers in Survey Sample

Demographic Characteristics

Over four-fifths (84.1 percent) of the license-exempt providers in the sample were women (Table 6-1). Providers were more likely to be married or living with a partner than the parents for whom they provided care, but they nonetheless were a largely unmarried group. Nearly three-fourths (73.1 percent) of providers were not married or living with a partner when interviewed, with 49.5 percent never having been married and 23.6 percent being divorced, widowed, or separated. When coupled with the extremely high percentage of parents who were not married or living with a partner when interviewed, over two-thirds (70.8 percent) of parent-provider pairs consisted of both a parent and a provider not currently living with a spouse or partner.

Although most providers were not living with a spouse or partner, many had at least one other adult living in their household. Slightly over half (54.7 percent) of providers reported having no other adults other than a spouse or partner living in their household, while 29.7 percent lived with one other adult and 15.7 percent lived with two or more adults (Table 6-1). Particularly interesting in this respect was that 30.7 percent of the providers lived with the focal family that they provided care for. In total, slightly over three-fifths of providers (62.3 percent) lived with either a spouse, partner, or other adult.

The mean age for the providers was 42.0. Reflecting the large number of grandparents in the sample (see Chapter 8), 36.5 percent of all providers were age 50 and over (Table 6-1). While much less prevalent than older providers, a substantial minority (27.4 percent) of providers were less than 30 years old.

There has been research interest in the extent to which providers care for their own children while providing paid care to others. We therefore asked providers how many children they had of their own under the age of 13. As shown in Table 6-1, 71.1 percent of providers did not have any children in this age group, and an additional 15.3 percent had only one child.

Table 6-1. Demographic Characteristics of Providers in Survey Sample (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Gender				
Female	84.1	75.7	86.0	90.5
Male	15.6	24.3	12.9	9.5
Marital Status				
Never married	49.5	63.1	52.7	33.3
Married or living w/ partner	26.9	15.5	20.4	43.8
Divorced, widowed, or separated	23.6	21.4	26.9	22.9
Adults in Household (other than self and Spouse / partner)				
None	54.7	42.7	52.7	68.3
One	29.7	32.0	36.6	21.2
Two or more	15.7	25.2	10.8	10.6
Has Either Spouse, Partner, or Other Adult in Household				
Yes	62.3	68.9	54.8	62.5
No	37.7	31.1	45.2	37.5
Lives with Focal Family				
Yes	30.7	39.0	25.8	26.7
No	69.3	61.0	74.2	73.3
Age				
18 – 20	6.7	10.8	3.2	5.7
21 – 24	11.7	14.7	10.8	9.5
25 – 29	9.0	9.8	11.8	5.7
30 – 39	17.0	15.7	12.9	21.9
40 – 49	19.7	15.7	24.7	19.0
50 and over	36.5	33.3	36.6	38.1
Mean age	42.0	40.3	42.5	43.3
Number of Children Under Age 13				
0	71.1	68.9	74.2	70.5
1	15.3	14.6	15.1	16.2
2	6.6	10.7	4.3	4.8
3 or more	6.3	5.8	4.3	8.6

Social and Economic Characteristics

The racial and ethnic composition of providers closely paralleled that of parents. Slightly over three-fourths (75.7 percent) of providers were African American, while 20.6 percent were white and 2.0 percent were Hispanic (Table 6-2). Over 90 percent of parents had a provider of the same racial or ethnic background caring for their children. Most prominently, 70.8 percent of the interview pairs consisted of an African American parent and provider, and 18.3 percent included a white parent and provider. Only 8.0 percent of the interview pairs included a parent and provider with different racial or ethnic characteristics.

Table 6-2. Social Characteristics of License-Exempt Providers in Survey Sample

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Race / Ethnicity				
White	20.6	1.0	20.4	40.0
African American	75.7	93.2	77.4	57.1
Latino or Hispanic	2.0	5.8	0.0	0.0
Other	1.3	0.0	1.1	2.9
Language Spoken at Home				
English	98.3	96.1	100.0	99.0
Spanish	1.0	2.9	0.0	0.0
Other	0.3	1.0	0.0	0.0
Country of Origin				
United States	99.0	97.1	100.0	100.0
Outside United States	1.0	2.9	0.0	0.0

Like the parents they serve, license-exempt providers most often reported low household incomes. For example, Table 6-3 shows that 36.7 percent of providers indicated that their annual household incomes were less than $10,000, and an additional 30.7 percent reported incomes in the $10,000-19,999 range. When considered as pairs, 57.1 percent of parents and their providers both had incomes of less than $20,000, and 17.9 percent both had incomes of less than $10,000.

Providers also were asked if the earnings they received from providing child care were the main source of their household income, as well as of their personal income. As shown in Table 6-3, child care earnings were the main source of household income for only about one-third (32.2 percent) of providers. Such earnings were the main source of personal income for slightly over half (50.8) of the sample.

There was some speculation at the time of welfare reform implementation that many public assistance recipients might become child care providers. We asked providers both whether

they were TANF recipients at the time they were interviewed, and if not, whether they had received public assistance in the past. While only 10.3 percent of providers were receiving TANF when interviewed, 45.5 percent reported receiving TANF or cash public assistance in the past. It should be noted that the proportion of providers in the sample that reported receiving higher was considerably higher than the statewide use of TANF by license-exempt providers (see Table 6-5).

Table 6-3. Household Income and Income Sources for License-Exempt Providers

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Household Income in 2002				
Less than $10,000	36.7	42.7	36.6	30.8
10,000 – 19,999	30.7	31.1	24.7	35.6
20,000 – 29,999	9.0	6.8	10.8	9.6
30,000 – 39,999	8.3	9.7	7.5	7.7
40,000 and over	5.7	2.9	5.4	8.7
Don't know	7.3	3.9	12.9	5.8
Refused	2.3	2.9	2.2	1.9
Child Care Earnings Are Main Source of Personal Income				
Yes	50.8	66.0	45.2	41.0
No	48.8	33.0	54.8	59.0
Child Care Earnings Are Main Source of Household Income				
Yes	32.2	39.8	26.9	29.5
No	67.8	60.2	73.1	70.5
TANF/Public Assistance Status				
Currently Received	10.3	4.9	14.0	12.4
Received Previously (but not currently)	45.5	42.2	46.2	48.6
Never Received	43.9	53.4	39.8	38.1

Educational Background

Table 6-4 presents data on the educational backgrounds of providers. Slightly over 70 percent of providers had at least finished high school or obtained a GED, while 29.5 percent had not. Although a substantial minority (29.6 percent) had attended college, only 15.6 percent had

received any type of degree. Of these, Associates Degrees were most common, with 8.3 percent of providers reporting that they had received such degrees. To determine whether those who attended college may have received some child care specific training at that time, respondents were asked if they had taken any college courses in early childhood education or child development. Only 14.5 percent of providers reported having taken any courses of this nature.

Table 6-4. Educational Background of License-Exempt Providers in Survey Sample

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Highest Grade Completed				
< 9th grade	4.3	4.9	4.3	3.8
Some high school	25.2	38.8	23.7	13.3
High school diploma Or GED	40.9	32.0	43.0	47.6
Some college	29.6	24.3	29.0	35.2
Highest Post-Secondary Degree Earned				
Associates	8.3	7.6	7.5	9.5
Bachelors	3.0	1.9	2.2	4.8
Masters	0.7	1.9	0.0	0.0
Other	3.6	2.9	3.2	4.8
Don't know	2.0	0.0	3.2	2.9
Took Any College Courses in Early Childhood Education or Child Development				
Yes	14.6	10.5	14.0	19.0
No	85.2	89.5	86.0	80.0

Differences in Provider Characteristics between Study Areas

There are several interesting differences between providers in the three study areas with respect to the characteristics described in the previous sections. The marital status and presence of other adults described in Table 6-1 are one such significant difference. Providers in the Southern Seven area were more than twice as likely to be married or living with a partner than those in Peoria County or North and South Lawndale (43.8 percent versus 20.4 percent in Peoria County and 15.5 percent in North and South Lawndale). However, providers in both North and South Lawndale and Peoria County were much more likely to have adults other than a spouse or partner living with them. As a result, the differences between the percentage of providers in the

three areas who live with no other adults were not great (31.1 percent in North and South Lawndale, 37.5 percent in Southern Seven, and 45.2 percent in Peoria County).

As previously discussed, the racial and ethnic characteristics of providers closely followed those of parents, so there were significant differences in the three areas in the racial and ethnic composition of providers (Table 6-2). As with parents, North and South Lawndale providers were predominantly African-American (93.2 percent), with a small representation of Hispanics (5.8 percent). Peoria County providers also largely were African American (77.4 percent), but included a substantial minority of Caucasians (20.4). In comparison, Southern Seven providers included the highest proportion of Caucasian providers (40.0 percent), but African American respondents still were more prevalent (57.1 percent).

While there were not significant differences in reported provider incomes between the three study areas, providers varied with respect to the importance of child care earnings as an income source and in their history of public assistance receipt. North and South Lawndale providers were considerably more reliant on child care earnings as a source of personal and household income than either Peoria County or Southern Seven providers (Table 6-3). North and South Lawndale providers were less likely to have ever received public assistance benefits than providers in the other two areas, although current or former receipt was quite high in all areas (47.1 percent in North and South Lawndale, 60.2 percent in Peoria County, and 61.0 percent in Southern Seven).

Finally, there were significant differences between the three areas in the educational background of providers, with providers in North and South Lawndale being the least educated and those in the Southern Seven area the most educated (Table 6-4). For example, while 43.7 percent of North and South Lawndale providers had not completed high school, this was the case for 28.0 percent in Peoria County and only 17.1 percent in the Southern Seven area. A minority of providers in all three areas had attended any college, with Southern Seven providers the most likely to have done so (35.2 percent in Southern Seven versus 29.0 percent in Peoria County and 24.3 percent in North and South Lawndale).

There also were significant differences in characteristics according to whether or not the provider was related to the focal family. Relative providers were more likely to be female than non-relative providers (88.6 percent versus 68.6 percent), and they were less likely to be single (45.0 percent versus 62.9 percent). Relative providers also were significantly older, with mean ages of 43.8 years as compared to 36.2 for non-relative providers. While current receipt of TANF was similar for both groups, relative providers had considerably more previous experience using TANF. That is, 51.5 percent of relative providers were previous TANF recipients, as compared to 24.3 percent of non-relative providers.

Use of Means Tested Programs by License-Exempt Providers

As for families using subsidies, data on the use of TANF, Food Stamps, and Medicaid by license-exempt providers was obtained from the IDHS Client Database. Table 6-5 presents these data for license-exempt providers who provided subsidized care in January 2003. Only 0.6 percent of these license-exempt providers were currently receiving TANF, but nearly one-fifth

(18.4 percent) had received TANF at some time in the previous five years. This suggests the importance of research on the use of child care as a career path for former welfare recipients.

Use of Food Stamps and Medicaid was slightly higher, with 7.6 percent of January 2003 license-exempt providers using Food Stamps and 11.1 percent using Medicaid. Taken together, 13.6 percent were using either TANF, Food Stamps, or Medicaid. Further, 44.8 percent of the January 2003 license-exempt providers had used one of these programs in the previous five years, which again underscores the fragile economic circumstances of many license-exempt providers.

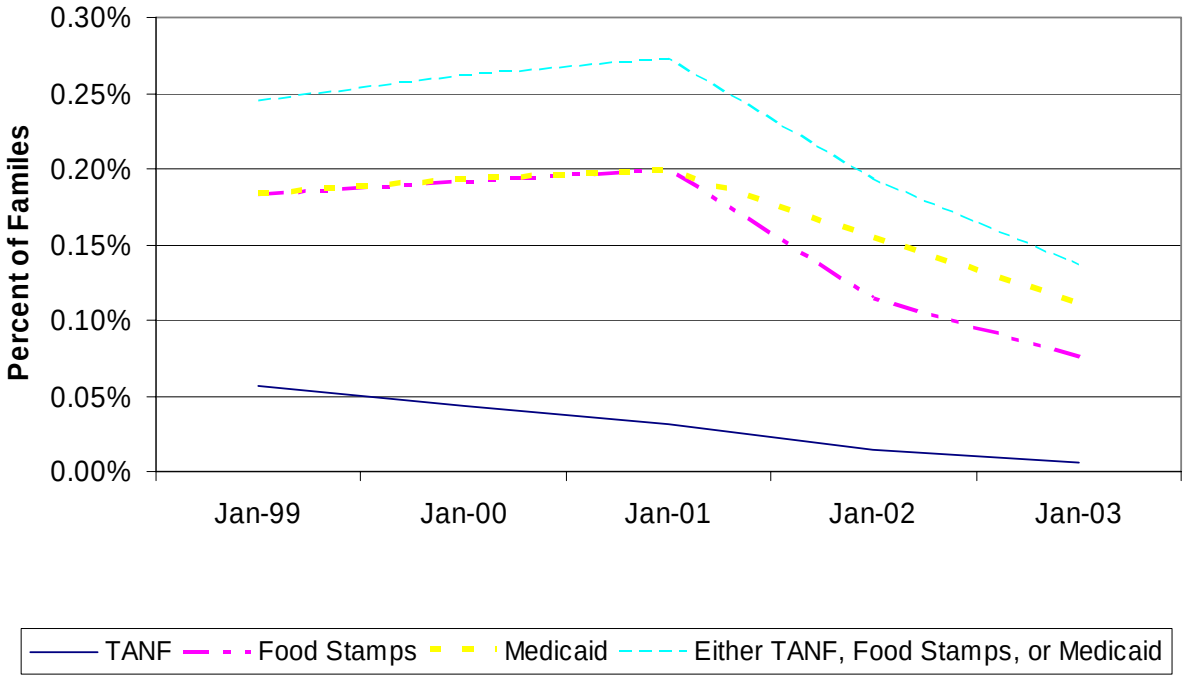
Figure 6-A shows the use of means tested programs by license-exempt providers at different time points during the study period. As was reported for subsidy families in Chapter 5 (see Figure 5-B), the use of means tested programs by license-exempt providers declined over the study period. However, it can be seen from the figure that use of Food Stamps and Medicaid actually rose slightly until January 2001 before subsequently declining, while TANF use fell steadily. This pattern may be partially attributable to the entry of former TANF recipients into the license-exempt workforce, and the continuing use of Food Stamps and Medicaid to support this transition.

Table 6-5. Use of Selected Means Tested Programs by License-Exempt Providers Active in CCAP in January 2003 (N = 50,902)

	Currently Using		**Used in Last 2 Years**		**Used in Last 5 Years**	
	Number	% of LE providers[1]	Number	% of LE providers[1]	Number	% of LE providers[1]
TANF	298	0.6%	2,218	4.4%	9,382	18.4%
Food Stamps	3,849	7.6%	10,187	20.0%	20,232	39.7%
Medicaid	5,629	11.1%	10,810	21.2%	17,471	34.3%
All of the Above	236	0.5%	2,087	4.1%	9,266	18.2%
Any of the Above	6,907	13.6%	14,215	27.9%	22,796	44.8%
None of the Above	43,995	86.4%	36,687	72.1%	28,106	55.2%

[1] LE = License-Exempt

Figure 6-A. Use of TANF, Food Stamps, and Medicaid by License-Exempt Providers, January 1999 - January 2003



Chapter 7:
Patterns of Child Care Use by Parents Using Subsidized License-Exempt Care

This chapter explores various aspects of the caregiving arrangements for parents using license-exempt care in the Illinois program. We begin by providing statewide data that describes the relative use of license-exempt and licensed care in the program. More detailed caregiving patterns and related issues then are examined for the survey sample.

Statewide Use of License-Exempt and Licensed Care

The administrative records used in this study provided only limited data on statewide caregiving patterns of subsidy users. Nonetheless, these data are helpful in illustrating the relative distribution of care between license-exempt and licensed care, and in describing how this distribution varies by the age of the child and by family size. The administrative data also provide useful information on the types of license-exempt care used by families, and cohort data using these records can ascertain broad patterns in terms of the length of time that children receive subsidies and the movement into and out of the subsidy system. We should reiterate that the administrative data are limited in that they only provide information on the subsidized providers used by families and their children; any unsubsidized caregivers therefore are not considered.

Distribution of Subsidy Cases between Licensed and License-Exempt Care

As previously mentioned, the Illinois program is an interesting context to study subsidized license-exempt care provision, because requirements to become a license-exempt provider are minimal and parental co-pays are the same regardless of provider type used. The program therefore may be viewed as providing a fairly open choice by parents between license-exempt and licensed providers.

Point in Time Data

Table 7-1 presents data on the distribution of license-exempt and licensed care among both families and children using subsidies in January 2003, the most recent month for which administrative data were available. The data demonstrate the importance of license-exempt caregiving in the Illinois program, with 51.1 percent of all families in the program using at least one license-exempt provider (derived from Table 7-1). The vast majority of these were receiving subsidies exclusively for license-exempt care (46.1 percent of all families), while a small portion (5.0 percent of all families) were using subsidies for both licensed and license-exempt care.

The table also shows that, regardless of whether families used license-exempt or licensed care, they generally used only one subsidized provider at a given point in time. For example, 91.0 percent of all families were using only one subsidized provider in January 2003 (derived from Table 7-1). Conversely, only 9.1 percent of all families at that time were using subsidies for more than one provider with most of these (5.0 percent) using a combination of license-exempt and licensed providers.

Table 7-1. Distribution of Subsidized Child Care for Children and Families, by Type of Provider Used: January 2003

	Numbers Using Provider Type		Percentage of Total Using Provider Type	
	Families	**Children**	**Families**	**Children**
One License-Exempt	39,741	95,209	45.2%	55.9%
Multiple LE[1]	814	1,205	0.9%	0.7%
One Licensed	40,227	69,325	45.8%	40.7%
Multiple Licensed	2,782	1,251	3.2%	0.7%
Both Licensed & LE	4,353	3,294	5.0%	1.9%
Total	87,917	170,284	100.0%	100.0%

[1] LE = License-Exempt

The prevalence of license-exempt caregiving was even greater when children rather than parents are considered as the unit of analysis. Over 58.5 percent of subsidized children were using at least one license-exempt provider in January 2003, and 55.9 percent were receiving subsidized care from a single license-exempt provider (Table 7-1). This higher proportional use of license-exempt care by children, as compared to families, results from different patterns of license-exempt and licensed care use according to family size. We will describe these patterns in more detail in a following section (see "Differences in License-Exempt and Licensed Care Distribution by Family Size"). It also is noteworthy that it was rare in the program for a child to be receiving subsidized care from more than one caregiver in a single month; only 3.3 percent children in January 2003 had such multiple caregivers (derived from Table 7-1).

The administrative data also suggest a trend toward increased use of licensed care providers over the five years for which data were analyzed (Table 7-2). For example, the proportion of families receiving subsidies that used at least one licensed care provider increased from 39.4 percent in January 1999 to 54.0 percent in January 2003 (derived from table 7-2). In comparison, the proportion of families using at least one license-exempt provider declined from 64.3 percent in January 1999 to 51.1 percent in January 2003. A similar trend may be observed in the types of providers used by children over the same time period (Table 7-2). We should note, however, that beginning in January 2001, site-administered child care data began to be added to the Child Care Tracking System (CCTS). Because all of these sites are licensed, the latter part of the trend shown in Table 7-2 may be based primarily on this change in the data included in the CCTS, as opposed to real movement toward licensed care usage.

Cohort Data

Cohort data provide useful refinements to the point in time data. In particular such longitudinal data allow the analysis of patterns of license-exempt care use by families over time, as well as comparisons of these trends with families using licensed care. Data therefore were developed for a cohort of 45,445 subsidy families that entered the Illinois program for the first time in FY 1999. Subsequent use experience was analyzed for all cohort members for the twelve

quarters (three years) following program entry. For each of these twelve quarters, analyses were completed both on the cumulative subsidy use experiences of all cohort members and on the subset of cohort members who remained active in the program in the given quarter.

Table 7-2. Change in Percentage Distributions of Provider Types Used by Families and Children: January 1999 – January 2003

Families Receiving Subsidy					
	January 1999	**January 2000**	**January 2001**	**January 2002**	**January 2003**
One License-Exempt	59.5%	57.1%	53.4%	48.7%	45.2%
Multiple LE[1]	1.1%	1.1%	0.9%	1.0%	0.9%
One Licensed	34.0%	35.9%	38.7%	42.5%	45.8%
Multiple Licensed	1.7%	2.0%	2.6%	3.0%	3.2%
Both Licensed & License-Exempt	3.7%	4.0%	4.3%	4.9%	5.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%
Children Receiving Subsidy					
	January 1999	**January 2000**	**January 2001**	**January 2002**	**January 2003**
One License-Exempt	68.7%	66.8%	63.9%	59.5%	55.9%
Multiple LE[1]	0.9%	0.8%	0.6%	0.7%	0.7%
One Licensed	28.4%	30.4%	33.3%	37.4%	40.7%
Multiple Licensed	0.4%	0.5%	0.5%	0.6%	0.7%
Both Licensed & LE	1.6%	1.5%	1.6%	1.8%	1.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

[1] LE = License-Exempt

Before turning to data on the types of care use over time, it first is useful to understand the overall level of subsidy use by the cohort as time passes. Figure 7-A shows that subsidy use declined quite quickly in the initial three quarters after program entry, and then more slowly in subsequent quarters. For example, by the end of the third quarter, it can be seen that only two-thirds of entering cohort families remained active in the program. By the end of the twelfth

quarter, or after three years, only 35.8 percent of cohort families were receiving subsidies.[8] This suggests that, for a substantial portion of the subsidy population, the program appears to be meeting child care needs for a short period.

Figure 7-A. Number of Subsidy Families Entering Care in FY 1999 That Remain Active in Subsequent Quarters

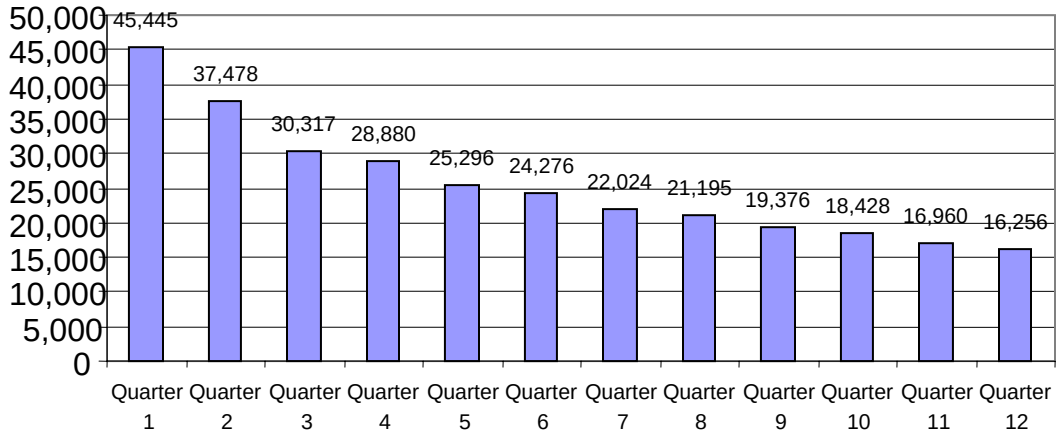


Table 7-3 presents data on licensed and license-exempt care use patterns for all cohort members in the entry quarter and at four, eight, and twelve quarters after program entry. These quarters were selected to approximate care patterns during the entry quarter and at years one, two, and three. The data presented represent cumulative use patterns through the quarter in question, as opposed to use only in that particular quarter. For example, the data provided for quarter twelve indicates the type of providers used by families at any time during the previous twelve quarters. The table includes the experiences of all cohort members, regardless of whether or not they were active in the program during the quarter in question.

Several points can be made from the Table 7-3 data. First of all, the table illustrates the frequent use of multiple subsidized providers over time (See also Figure 7-B). As would be expected, data for the entry quarter correspond closely with the point in time data, with almost 90 percent of families having used a single provider. During this initial quarter, 56.1 percent of families used a single license-exempt provider and 33.7 used a single licensed provider. By the eighth quarter, only a 54.9 percent of families receiving subsidies had used a single provider, with 33.4 percent having relied on one license-exempt provider and 21.5 percent on a single licensed provider. By the twelfth quarter, less than half (48.2 percent) had used a single subsidized provider. This suggests that, while the use of multiple providers was relatively

[8] It should be noted that these percentages over time reflect aggregate trends, as opposed to the experience of individual cohort members. That is, an individual cohort member may have left the subsidy program in a selected quarter, and then become active again in a subsequent quarter. Consequently, the composition of the active cohort cases in any quarter represents a subset of cases that was active continuously since the cohort formation and another subset that had left the program but then returned.

infrequent at a point in time, most subsidy users were faced with the need to change providers at some time within a three-year period after program entry.

Table 7-3. Cumulative Percentage Distribution of Types of Providers Used by Families in Subsequent Quarters After Entering Program: For Families Entering Program in FY 1999

	1st Quarter		4th Quarter		8th Quarter		12th Quarter	
	Number	Percent of Total Families	Number	Percent of Total Families	Number	Percent of Total Families	Number	Percent of Total Families
One License-Exempt	25,486	56.1	19,158	42.2	15,159	33.4	13,193	29.0
Multiple LE[1]	1,473	3.2	5,552	12.2	7,717	17.0	8,558	18.8
One Licensed	15,290	33.7	11,911	26.2	9,749	21.5	8,742	19.2
Multiple Licensed	1,337	2.9	3,283	7.2	4,320	9.5	4,698	10.3
Both Licensed & LE	1,859	4.1	5,541	12.2	8,500	18.7	10,254	22.6
Total	**45,445**	**100.0**	**45,445**	**100.0**	**45,445**	**100.0**	**45,445**	**100.0**

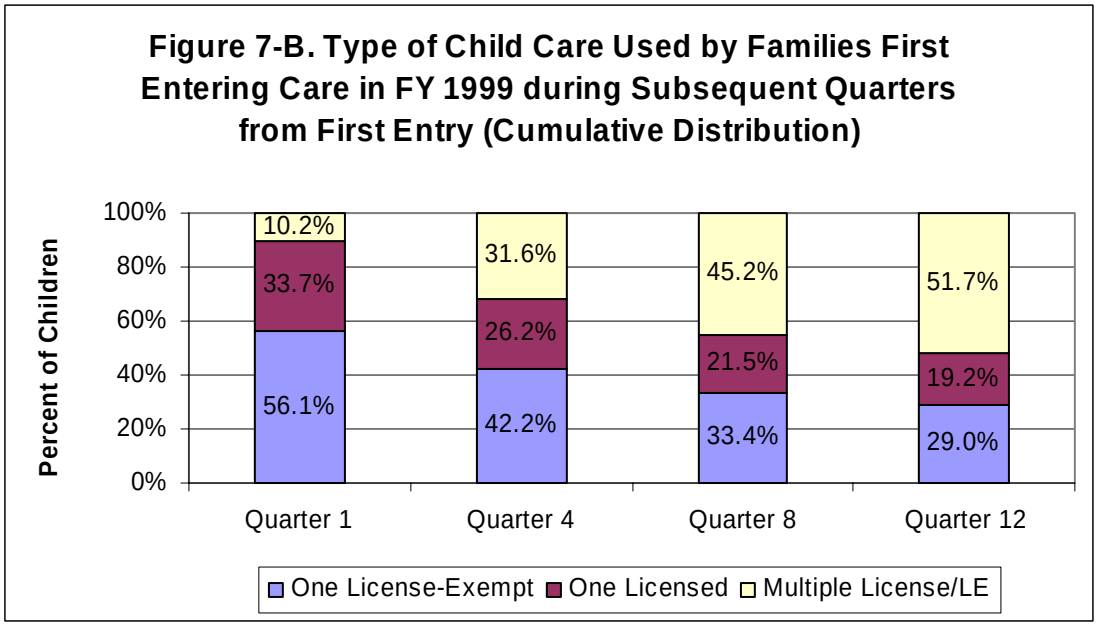
[1] LE = License-Exempt

Second, the cohort data further highlight the common use of license-exempt providers in the Illinois program. Adding together the several categories that include license-exempt caregiving, it can be seen that 63.4 percent of the families had used at least one license-exempt caregiver during their initial quarter in the program, which again corresponds closely to the point in time data. Experience with license-exempt care use had increased to 69.1 percent of the cohort by the eighth quarter and to 70.4 percent by the twelfth quarter. In comparison, 52.1 percent of the cohort had used at least one licensed provider over this three-year period.

Third, the data provide a sense of the extent to which subsidy families relied exclusively on licensed or license-exempt care over the three-year period, as opposed to using both types of care. By quarter twelve, 47.8 percent of families had used only license-exempt providers for subsidized care, while 29.5 percent had used only licensed providers. In comparison, 22.6 percent of families had used both types of providers.

This latter figure illustrates the fairly common use of combinations of licensed and license-exempt providers over time, which is masked by exclusive reliance on point in time data. That is, the 22.6 percent of families that had used both subsidized licensed and license-exempt care within three years represents a substantial increase from the 4.1 percent who had used such combinations of care during their initial quarter in the program. If only those who used some subsidized license-exempt care are considered, nearly one-third of these families also utilized

subsidized licensed care at some point over the three-year period. Therefore, for a substantial portion of subsidy users, licensed and license-exempt care may be viewed as complementary as opposed to alternative care systems.



Differences in License-Exempt and Licensed Care Distributions by Family Size

The previously noted higher prevalence of license-exempt care use by children as compared to families results from interesting differences in use patterns according to the number of children receiving subsidized care in a family (Table 7-4 and Figure 7-C).[9] That is, families with only one child receiving a subsidy were twice as likely to use a single licensed provider as a single license-exempt provider in January 2003 (64.8 percent versus 32.4 percent). In contrast, families with more than one child receiving subsidies were much more likely to use a single license-exempt provider (54.7 percent versus 31.6 percent using a single licensed provider). These families with more than one child receiving subsidies comprised 57.3 percent of all subsidy children and included an average of 2.63 children in subsidized care per family in January 2003. The relatively heavy usage of license-exempt providers within such families thus results in children in the program being more reliant on license-exempt care than would be suggested by the percentages of families that use this form of care.

As would be expected, the use of multiple providers also varies according to the number of children in a family that receive subsidies. Consistent with the previously mentioned data indicating the rare use of multiple providers for a single child, only 2.8 percent of families with one child receiving a subsidy were using multiple subsidized providers in January 2003. In comparison, 13.7 percent of the families with more than one child receiving a subsidy were using

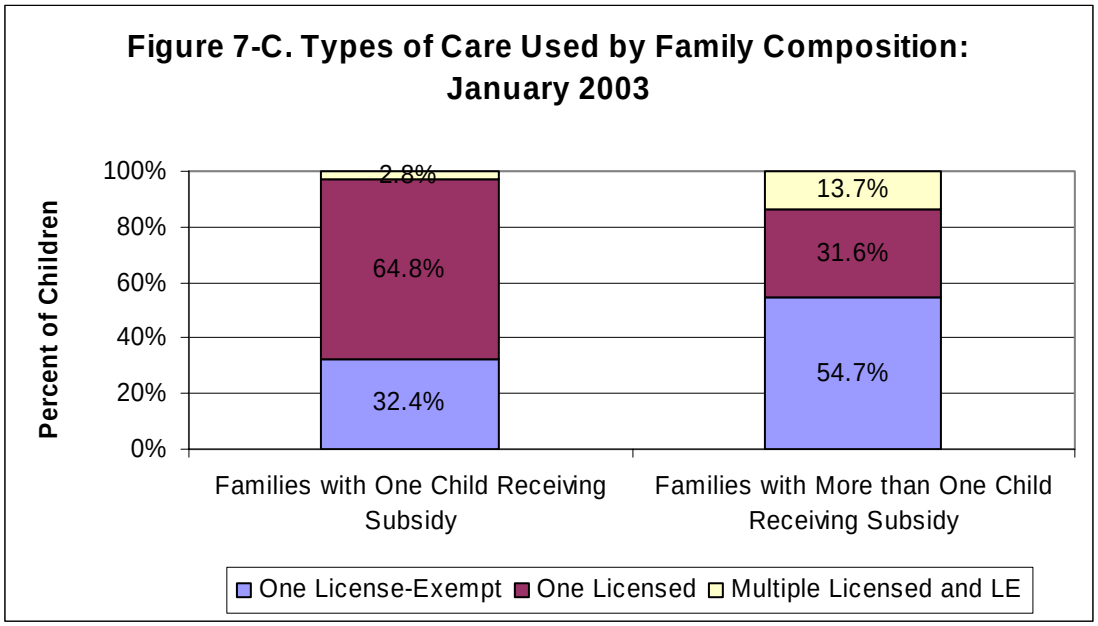
[9] We should remind the reader that the administrative data only allows analysis of those children in a family that are receiving subsidized care. A family may have other children in child care who are not receiving subsidies.

multiple providers (derived from Table 7-4). These data collectively demonstrate that multiple subsidized provider use by families at a point in time in the Illinois program generally results from using multiple providers for different children, as opposed to using multiple providers for the same child.

Table 7-4. Distribution of Subsidized Child Care for Families with One Child or More Than One Child Receiving Subsidy, by Type of Provider Used: January 2003

	Number Using Provider Type		Percentage Using Provider Type	
	Families with One Child Receiving Subsidy	Families with More Than One Child Receiving Subsidy	Families with One Child Receiving Subsidy	Families with More Than One Child Receiving Subsidy
One License-Exempt	12,171	27,570	32.4%	54.7%
Multiple LE[1]	103	711	0.3%	1.4%
One Licensed	24,317	15,910	64.8%	31.6%
Multiple Licensed	297	2,485	0.8%	4.9%
Both Licensed & LE	644	3,709	1.7%	7.4%
Total	**37,532**	**50,385**	**100.0%**	**100.0%**

[1] LE = License-Exempt



Differences in License-Exempt and Licensed Care Distributions by Age of Child

There were substantial variations in the subsidized licensed versus license-exempt distribution of care arrangements used by children in different age groups (Table 7-5 and Figure 7-D). These differences were greatest for children aged six and over, with about three-fourths (74.9 percent) of children in this age group using license-exempt providers in January 2003. Utilization of license-exempt care also was slightly more common than licensed care for infants. In January 2003, for example, 53.2 percent of the children under age 1 in the program received at least some care from license-exempt providers, as compared to 48.7 percent receiving care from licensed providers.[10] While subsidized license-exempt care also was common among children in the 1 – <2.5 and 2.5 – <6 year age groups, the use of licensed care was more prevalent for these children. The use of licensed providers was most common in the 2.5 - <6 age group; 58.9 percent of the children aged 2.5 - <6 received some care from licensed providers in January 2003, as compared to 44.0 percent who used some license-exempt care.

Table 7-5. Number and Percentage of Children in License-Exempt and Licensed Care Arrangements, by Age Group: January 2003

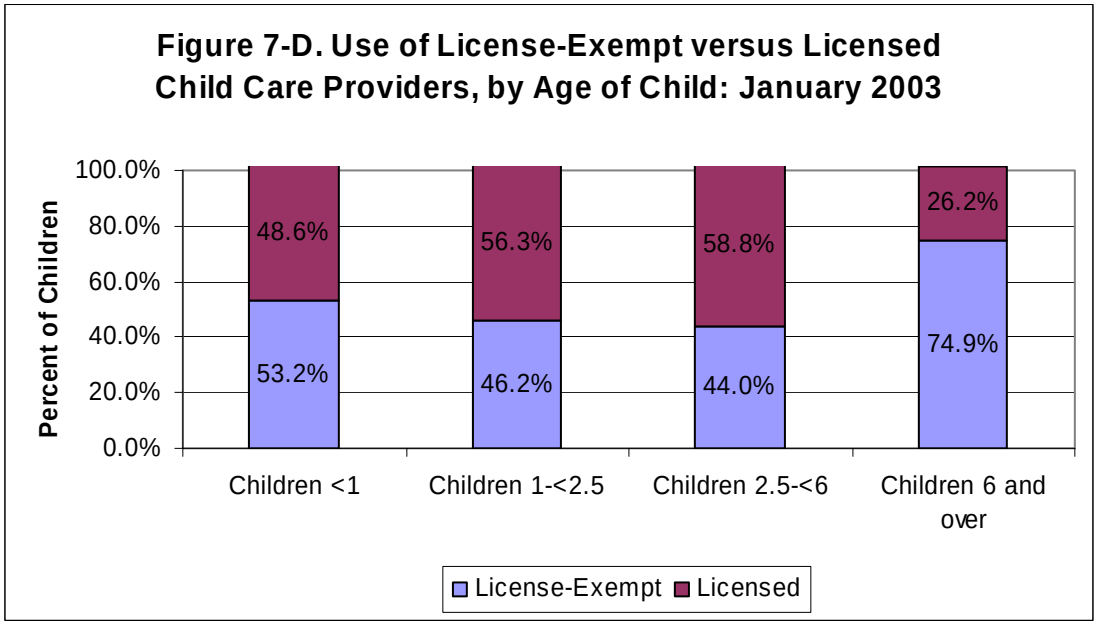
	Children <1		Children 1 - <2.5		Children 2.5 - <6		Children >6	
	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
One License-Exempt	5,575	50.6	10,562	43.1	24,129	40.6	54,943	73.0
Multiple LE[1]	81	0.7	163	0.7	336	0.6	625	0.8
One Licensed	5,068	46.0	13,009	53.0	32,716	55.1	18,532	24.6
Multiple Licensed	83	0.8	196	0.8	577	1.0	395	0.5
Both Licensed & LE	204	1.9	603	2.5	1,672	2.8	815	1.1
Total	**11,001**	**100.0**	**24,533**	**100.0**	**59,430**	**100.0**	**75,310**	**100.0**

Types of License-Exempt Providers Used

The administrative data provide information on the number of families and children that receive care through four types of license-exempt arrangements: relative caregivers in the child's home, relative caregivers outside the child's home, non-relative caregivers in the child's home,

[10] The reader may note that these percentages add up to more than 100 percent, which results from the fact that a small number of children were using both licensed and license-exempt providers.

and license-exempt homes[11]. Several observations can be made from Table 7-6 and Figure 7-E-, which show the distribution of care among these four license-exempt care types for all families and children receiving subsidies in January 2003. First, relatives provided 62.3 percent of subsidized license-exempt care for families in January 2003, with 37.8 percent provided outside the child's home and 24.5 percent in the child's home. Second, 54.6 percent of all subsidized license-exempt care used by families was provided in the child's home; in addition to the 24.5 percent of families that received care from relatives in the home, 30.1 percent received care from non-relatives in the home. Third, only about 8.9 percent of the license-exempt care for families was provided through license-exempt homes. Finally, the distribution of care for children across these four types of license-exempt care is similar to that for families.



Examination of the distribution of these license-exempt care types over the five-year study period revealed only modest changes in the percentage of all license-exempt care falling into each category. The greatest change in this respect involved a slight shift in the percentage of families using license-exempt homes and non-relatives in the child's home. That is, the percentage of families using license-exempt care that had children cared for in license-exempt homes increased from 5.2 percent January 1999 to 8.9 percent in January 2003. Correspondingly, care by non-relatives in the child's home fell from 35.1 percent to 30.1 percent of the families receiving license-exempt care over this period.

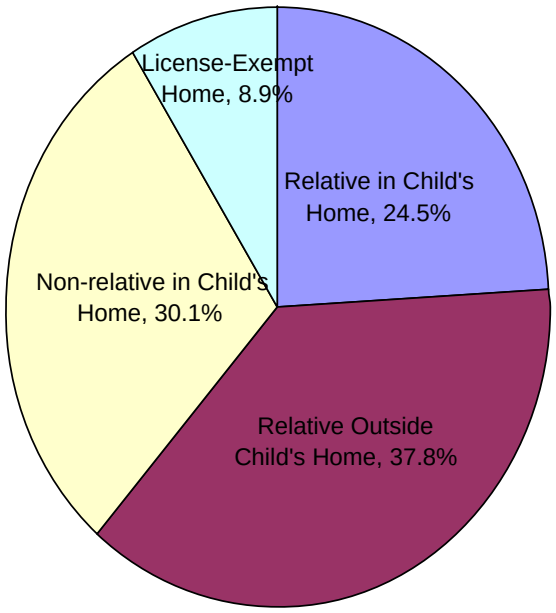
[11] In license-exempt homes, non-relatives care for children in the provider's home.

Table 7-6. Type of License-Exempt Provider Used by Families and Children: January 2003

	Families Using License-Exempt Care		Children Using License-Exempt Care	
	Number	Percent	Number	Percent
Relative in Child's Home	11,022	24.5	25,076	25.2
Relative Outside Child's Home	16,980	37.8	35,606	35.7
Non-relative in Child's Home	13,524	30.1	31,723	31.8
License-Exempt Home	3,980	8.9	8,060	8.1
Total[1]	**44,908**	**101.3**	**99,708**	**100.8**

[1] Percentages total to more than 100 percent, because some families and children use more than one type of license-exempt care.

Figure 7-E. Type of License-Exempt Care Used by Families, January 2003



The distribution of license-exempt care across these four types of care varied slightly according to the number of children receiving subsidies in a family (Table 7-7). In particular, in January 2003, families with more than one child receiving subsidies made greater use than families with one child of non-relative care in the child's home (32.5 percent versus 25.1 percent). In comparison, families with one subsidized child were more likely to have their children cared for outside of the home, either in license-exempt homes or by a relative. Overall, 57.5 percent of the license-exempt care provision for families with more than one subsidized child occurred in the child's home, as compared to 48.7 percent for families with only one subsidized child.

Table 7-7. Type of License-Exempt Provider Used by Families with One Child or More Than One Child Receiving Subsidy: January 2003

	Families with One Child Receiving Subsidy		Families with More Than One Child Receiving Subsidy	
	Number	Percent	Number	Percent
Relative in Child's Home	3,368	23.6	7,654	25.0
Relative Outside Child's Home	5,962	41.7	11,018	36.0
Non-relative in Child's Home	3,578	25.1	9,946	32.5
License-Exempt Home	1,459	10.2	2,521	8.2
Total[1]	**14,286**	**100.6**	**30,622**	**101.7**

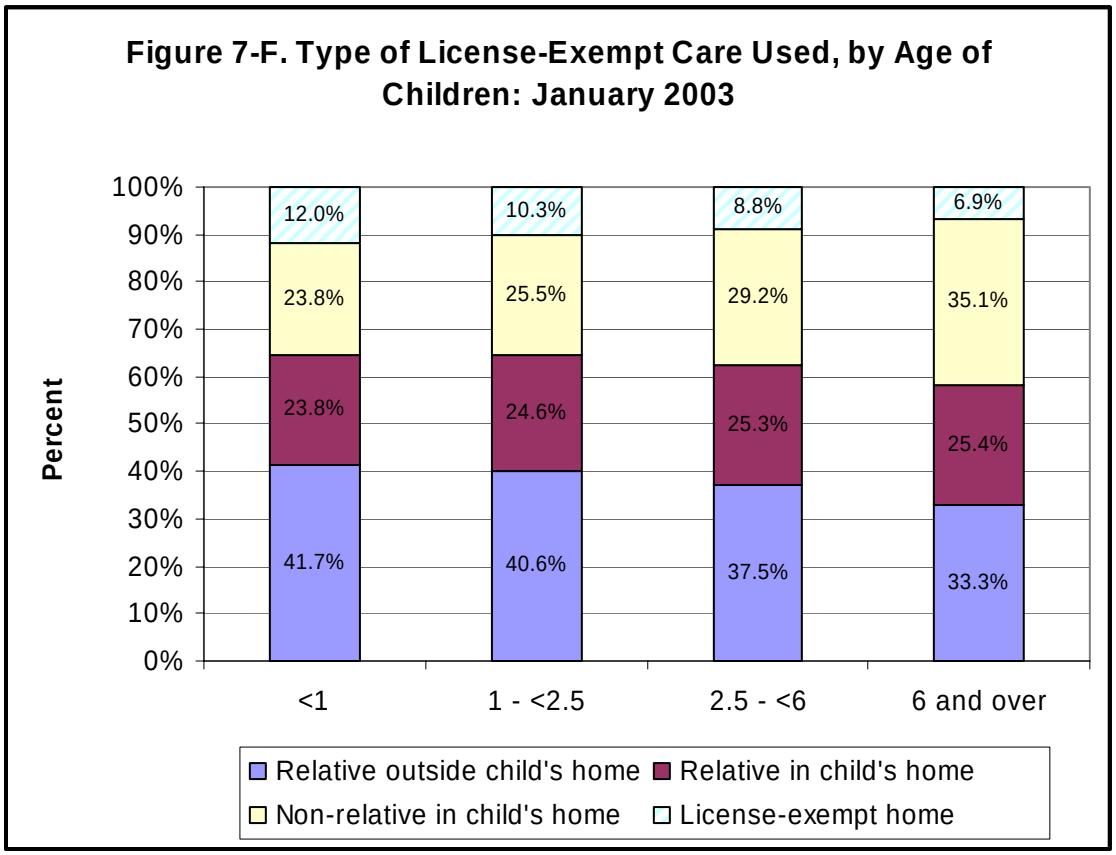
[1] Percentages total to more than 100 percent, because some families use more than one type of license-exempt care.

The January 2003 distribution of license-exempt provider types according to the age of the child is presented in Table 7-8 and Figure 7-F. In general, differences in these provider types across age groups were not striking, although a few differences were notable. For example, young children were slightly more likely than other children to be cared for by a relative. About 65 percent of both infants and children age 1 – <2.5 in license-exempt settings were cared for by a relative, as compared to 58.7 percent of children age 6 and over (derived from Table 7-8). This difference resulted from a lower percentage of relative care outside the child's home in the age 6 and over sub-group (i.e., 33.3 percent for children age 6 and over versus 41.7 percent for children < 1 and 40.6 percent for children age 1 - <2.5). In contrast, the percentage of license-exempt care provided by non-relatives in the child's home increased with age. While only 23.8 percent of the infants receiving subsidies were cared for by a non-relative in the child's home, 35.1 percent of children age six and over received such care. The percentage of care provided through license-exempt homes was relatively low across all age groups, but did decline with age (12.0 percent for infants to 6.9 percent for children age 6 and over).

Table 7-8. Distribution of Children in Various Types of License-Exempt Care, by Age of Child: January 2003

	Distribution for Children Age:							
	< 1		1 – <2.5		2.5 – <6		Age 6 and over	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Relative in Child's Home	1,381	23.8	2,790	24.6	6,611	25.3	14,294	25.4
Relative Outside Child's Home	2,441	41.7	4,599	40.6	9,809	37.5	18,757	33.3
Non-relative in Child's Home	1,395	23.8	2,891	25.5	7,636	29.2	19,801	35.1
License-Exempt Home	700	12.0	1,161	10.3	2,307	8.8	3,892	6.9
Total[1]	**5,860**	**101.0**	**11,328**	**101.0**	**26,137**	**100.9**	**56,383**	**100.6**

[1]Percentage totals more than 100 percent because some families use more than one type of license-exempt care.



The Length of License-Exempt Care Spells

The length of time that child care subsidy cases remain open, and whether there are differences in length of care spells for families that use license-exempt versus licensed care, also are important issues when considering license-exempt care use. Table 7-9 presents data on initial spell lengths for a cohort of families that entered the subsidy program for the first time in fiscal year 1999. The table provides initial spell lengths for this total cohort, as well as for those who used license-exempt, licensed, or a combination of licensed and license-exempt care during the initial spell. It does not take into account any repeat use of the program after the initial spell, which is considered in the following section.

The table shows that the average case in this entry cohort remained open slightly over one year (13.4 months) during the initial care spell.[12] The frequency distribution for length of time cases remained open indicates that nearly half of cases (47.4 percent) closed within six months, while about one-third (33.7 percent) remained open for more than one year (derived from Table 7-9). Only a small minority (16.8 percent) remained open for more than two years.

Table 7-9 also shows that cases that used either licensed or license-exempt care exclusively remained open for very similar lengths of time (average initial spells of 11.9 months for license-exempt and 12.0 months for licensed). Cases that relied exclusively on license-exempt care were somewhat more likely to have relatively short care spells, but these differences were not great. For example, 53.7 percent of the families that used only license-exempt caregivers had initial spells of less than six months, as compared to 48.5 of the families that relied exclusively on licensed care (derived from Table 7-9).

Finally, the small proportion of cases that used a combination of license-exempt and licensed care had the longest initial spell lengths, with an average of 24.9 months. This difference does not necessarily imply that families using such combinations have more stable care patterns. It may simply reflect that families in this group were able to either combine the two types of care, or else change from one to the other, without ever closing their case. This group using a combination of care types also may need subsidized care for longer periods than others, and the use of such multiple care types may be a response to a need to change caregivers as care is required over longer periods. Developing a better understanding of these or other explanations of differences in spell lengths for different types of care is a useful area for further research.

[12] Because some cases in the FY 1999 cohort remained open at the final time point of analysis (January 2003), the mean is sensitive to right censoring. The mean estimated here therefore is somewhat lower than the true mean that will result when all cases in the cohort have closed.

Table 7-9. Length of Time Cases for Families Entering Care in FY 1999 Remained Open, by Type of Provider Used (Cohort of FY 1999 Subsidy Program Users)

	Total	Percent That Remained Open:			
		Total (n=45,445)	LE[1] Only (n=24,945)	Licensed Only (n=15,203)	Mixed LE & Licensed (n=5,297)
< 1 month	2,891	6.4	7.2	7.1	0.3
2 – 3 months	7,865	17.3	19.5	18.5	3.4
4 – 6 months	10,750	23.7	27.0	22.9	10.1
7 – 12 months	8,608	18.9	18.1	20.7	17.7
13 – 24 months	7,680	16.9	14.5	17.6	26.1
25-36 months	3,736	8.2	6.6	7.7	17.5
> 36 months	3,915	8.6	7.1	5.5	24.9
Total	**45,445**	**100.0**	**100.0**	**100.0**	**100.0**
Mean (in months)		13.4	11.9	12.0	24.9

[1] LE = License-Exempt

Repeat Use of the Subsidy Program for Cases that Close

Families may stop receiving child care subsidies for many reasons, such as changes in work patterns, loss of providers, or difficulties in completing required paper work. Repeat use of the program after a case has closed therefore merits attention. IDHS administrative records allow analysis of the extent to which such closed cases receive subsidies in future periods. A cohort of subsidy cases that closed for the first time in FY 2000 therefore was created, and care patterns for this group over the following two years then were assessed.

Table 7-10 presents the results of this repeat use analysis. Roughly two-thirds (65.6 percent) of the 25,475 families whose cases closed for the first time in FY 2000 did not use the subsidy program again within two years. About one-fourth (25.2 percent) had only one subsequent spell within two years, while only 9.3 percent had two or more subsequent spells. This suggests that, although subsequent use of the subsidy program is fairly common among those whose cases close, families do not tend to frequently move in and out of the program over short time periods. The median and mean times that elapse after initial case closures until subsequent spells are three months and 4.8 months, respectively.

Table 7-10. Frequency of Subsequent Spells in Next Two Years for Cases that Closed for First Time in FY 2000

		Type of Care Used During Initial Spell			
		Total	LE[1] Only	Mixed LE & Licensed	Licensed Only
No subsequent spells in following 24 months		16,701	7,620	1,573	7,508
Number	1 subsequent spell	6,413	2,754	1,539	2,120
	2 subsequent spells	1,881	795	618	468
	3 or more subsequent spells	480	205	143	132
Total		**25,475**	**11,374**	**3,873**	**10,228**
Percentage with no subsequent spells in following 24 months		65.6	67.0	40.6	73.4
Percent	1 subsequent spell	25.2	24.2	39.7	20.7
	2 subsequent spells	7.4	7.0	16.0	4.6
	3 or more subsequent spells	1.9	1.8	3.7	1.3
Mean time from initial closing to first subsequent spell		4.8	4.7	5.4	4.4
Median time from initial closing to first subsequent spell		3	3	3	3

[1] LE = License-Exempt

Table 7-10 also provides data on subsequent use of the subsidy program according to the type of provider that the families used during their initial spell (license-exempt only, licensed only, or combination of license-exempt and licensed). Those families who used only licensed providers during their initial spell were less likely to have their cases re-opened within two years (26.6 percent—derived from Table 7-10), followed closely by families who had used only license-exempt providers (33.0 percent). In contrast, about three-fifths of families that had used a combination of license-exempt and licensed providers had subsequent spells of subsidy use during the following two years.

Survey Data on Care Usage Patterns

The survey of parents in the three study areas asked about child care needs and use patterns more generally, and consequently included questions related both to overall child care and care that was subsidized. The survey queried parents about their reasons for needing child care, the specific caregiving arrangements they used, and whether child care problems had caused work or school difficulties. The information on caregiving arrangements was obtained through a subset of questions asked about the care provided to each child under age 13, as well

as those age 13 and over who had special care needs.[13] These age criteria were selected to correspond to the age eligibility requirements for the Illinois CCAP. Information was obtained on each child's age, days of the week and times of day in care, number of hours in care, number of hours in the care of the main provider, the relationship of children to the provider(s), the length of time the main provider had cared for the child, and the type of any special needs that the child had.

Reasons Child Care is Needed

All parents were asked whether each of the following four reasons compatible with Illinois child subsidy eligibility requirements had contributed to their current need for child care: going to school, involved in job training, working, and meeting TANF requirements. A follow-up open-ended question asked if there were any other reasons that the parent needed child care.

Because these reasons are not mutually exclusive, many respondents provided more than one reason. As Table 7-11 shows, 90.4 percent of respondents indicated that they needed care because they were working. The important relationship between child care subsidies and the TANF program is illustrated by the 20.1 percent of respondents who indicated that child care was needed to meet TANF work requirements. Going to school (20.5 percent) or participating in job training (5.3 percent) also were reported by substantial minorities of respondents as contributing to their need for child care.

These four categories of care needs appeared to largely capture the reasons that respondents had for needing care. Only 9.2 percent reported other reasons in the open-ended follow-up question, and all of these respondents also had indicated at least one of the four categorical reasons. These "other" reasons were diffuse, with none being reported by over six respondents. The reasons included job search, going to appointments or running errands, plans to go to school, the lack of the other parent in the child's life, and the need to supervise young children. In addition, although the question was asked about the need for child care in general, some respondents emphasized their inability to afford unsubsidized care as a reason they needed a subsidy.

Hours Worked or In School

In order to obtain an initial sense of the extent of child care needs facing parents, respondents were asked how many hours they had either worked or been in school or job training in the last week. The data in Table 7-11 show that most parents reported being in school or training for the equivalent of a full-time schedule during the previous week. The average reported work or school hours was 36.6, and 83.1 percent of parents indicated that they were engaged in one of these activities for at least 30 hours.[14]

[13] We limited the roster to six children in each family, in order to preserve interviewing time for other questions. In such cases, the six children included were the youngest six in the family. Only three cases in the sample had more than six children under age 13, while eight cases had more than six children under 18.

[14] We should note that the sampling procedures used may have resulted in a sample with higher average work and school hours than is the case for the entire Illinois CCAP population. That is, as described in Chapter 4, we included only parents who indicated that they had a child who was usually cared for by a license-exempt provider for at least 15 hours per week.

Table 7-11. Reasons for Needing Child Care, and Hours in Work and Training for Parents Receiving Subsidies

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Reasons for Needing Child Care				
Going to school	20.5	16.2	16.1	28.6
Involved in job training	5.3	9.5	1.1	4.8
Working	90.4	86.7	97.8	87.6
Meeting TANF work requirements	20.1	19.0	19.4	21.9
Number of Hours Working or in School During Last Week				
< 10	3.7	3.9	2.2	4.9
10 – 19	3.1	2.9	2.2	3.9
20 – 29	10.2	10.8	15.4	4.9
30 – 39	28.5	19.6	24.2	41.2
40 and over	54.6	62.7	56.0	45.1
Mean Hours Worked or in Training	36.6	37.2	37.1	35.5
Travel Time to Work or Training (Round Trip)				
< 30 minutes	18.1	3.9	21.7	28.6
30 – 59 minutes	29.4	12.7	44.6	32.4
60 – 119 minutes	34.4	47.1	25.0	30.5
120 minutes and over	15.7	34.3	6.5	5.7
Don't know	2.3	2.0	2.2	2.9
Mean Time	63.5	95.3	47.4	46.5
Has consistent, work, school, or job training schedule each week				
Yes	81.3	86.3	78.5	78.8
No	18.7	13.7	21.5	21.2

Parents also were questioned about the travel time required to get to and from work and training, including the time it took to get to and from child care. As shown in Table 7-11, such travel times generally were substantial. Average daily round trip travel times were just over an

hour (63.5 minutes), and under one-fifth (18.1 percent) of parents reported traveling less than one-half hour to get to and from work or training.

Finally, because prior research had indicated that inconsistent work or school schedules were a factor in the need parents had for license-exempt care provision, we asked parents whether the hours they worked or were in school or job training usually stayed the same each week. As Table 7-11 shows, about four-fifths (81.3 percent) of parents reported that their hours in these work and training activities generally stayed the same each week. The approximately one-fifth of respondents who indicated that their hours did not stay the same were subsequently asked how hours had changed. The responses typically emphasized the unpredictable nature of variations in work hours, including both changes in the total number of hours worked and the days of the week and times of the day worked. The importance of unpredictable work hours for a subset of subsidy recipients will be explored further in Chapter 9, which assesses the reasons that parents selected their license-exempt caregivers. An important related issue concerns the extent to which parents work non-traditional hours, such as evenings or weekends; this issue will be addressed later in this chapter (see section on "Days of Week and Times of Day in Care").

Hours Children Were in Care

Parents were asked the number of hours that each child under age 13 was in child care during the previous week. Table 7-12 presents information on three different hours of care figures derived from this question. The first shows the total number of hours that parents reported having all of their children in care during the primary week; it may be viewed as an aggregate measure of total child care hours received by the family. The average hours of care received using this measure was 84.6 hours.

This first measure is highly sensitive to the total number of children in care in a family. Consequently, a second measure in Table 7-12 shows the number of hours of care received by the child in the family who received the most care. Using this measure, the average hours in care was 35.8 hours, and nearly two-thirds (64.7 percent) of parents reported having a child that received care for at least 30 hours.

Finally, Table 7-12 presents a blended average for the number of hours that individual children in the family were in care. This average divides the total number of hours that children in a family were in care by the number of children in care. Children were in care an average of 33.9 hours using this measure. It should be noted that this figure corresponds fairly closely to the average of 35.8 hours in care for the child with the greatest hours in care. Such proximity in these measures is consistent with children within a family generally being in care for the same number of hours, which is not surprising.

Use of Multiple Providers

As previously mentioned, the screening criteria used in survey sampling assured that at least one child in each family was receiving paid care for a minimum of 15 hours per week from a license-exempt provider, who was referred to as the "main provider" if the family also used other caregivers. To determine the prominence of this main provider in the total child care used

by the family, the survey asked whether child care also was provided by someone other than the main provider for each child. Table 7-13 shows that 87.5 percent of the parents used only the main license-exempt provider for all of their child care needs. Even among the 33 parents who were using other forms of care, the main provider generally was the predominant caregiver. That is, the main caregiver was providing an average of 76.2 percent of the total child care hours in these families, and only four of the families used more total hours of care from other sources than were rendered by the main provider.

Table 7-12. Average Hours Children Were in Care Last Week

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Number of Hours All Children in a Family Were In Care				
<20	8.0	6.0	5.7	11.9
21 – 40	25.6	18.0	17.0	40.6
41 – 80	29.1	24.0	30.7	32.7
81 and more	37.4	52.0	46.6	14.9
Average	84.6	105.7	91.9	57.4
Number of Hours Child Receiving Most Care Was in Care				
<20	16.6	11.0	17.0	21.8
21 – 30	18.7	16.0	17.0	22.8
31 – 40	33.6	25.0	37.5	38.6
40 and over	31.1	48.0	28.4	16.8
Average	35.8	40.1	35.7	31.6
Average Number of Hours Individual Children Were In Care	33.9	38.3	33.7	29.6

The 33 families who were using multiple providers also were asked to specify who else cared for their children. As shown in Table 7-13, the most common additional provider used was another relative (39.4 percent of those using multiple providers) In addition, 9.1 percent of those using multiple providers used a non-relative in the provider's home as an additional provider, and 3.0 percent used a non-relative in the child's home. When taken together, these data suggest that license-exempt providers were the most frequently used additional providers among respondents.

A small number of parents used child care centers or early education programs in addition to the main provider. For example, 11 parents reported using a day care center, preschool or nursery school, or a before or after school program, and three said that they used Head Start. This represents 42.4 percent of the 33 parents who used additional providers, but only 4.6 percent of the entire sample. Thus, it is clear that the vast majority of parents in our sample relied exclusively on some form of license-exempt care.[15]

Table 7-13. Single vs. Multiple Provider Use by Families, and Types of Secondary Provider Used

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Single Versus Multiple Provider Use				
Used one provider only	87.5	88.6	90.3	83.8
Used multiple providers	10.9	11.4	7.5	13.3
Don't know	1.7	0.0	2.2	2.9
Average percentage of care provided by main provider (for parents using more than one provider) – n=30	76.2	82.9	67.8	75.5
Type of Additional Provider Used (percentage of those using secondary provider) – n=33				
Another relative	39.4	41.7	57.1	28.6
Non-relative in child's home	3.0	8.3	0.0	0.0
Non-relative in provider's home	9.1	8.3	0.0	14.3
Day care center, preschool, nursery school, or before/after school program	33.3	33.3	28.6	35.7
Head Start	9.1	0.0	14.3	14.3
Other	15.2	25.0	14.3	7.1

[15] It should be noted that Illinois has a pre-kindergarten program, as well as a Preschool Initiative sponsored by the Governor's Early Learning Council to promote access to preschool programs for all 3 and 4 year olds. There has been considerable work done to encourage parents to access such preschool programs for at least a portion of the day. As these efforts continue to develop, it is likely that the number of parents using license-exempt providers that access these programs will grow.

Days of Week and Times of Day in Care

Previous research has suggested the importance of license-exempt caregivers in providing care during non-traditional work hours when most child care centers are not open. We will refer to hours that fall outside of a weekday, daytime schedule as "non-traditional" hours; they include any hours of care during the evenings, overnight, or weekends. To develop estimates of the prevalence of such care in this sample, we asked parents which days each of their children was in care during the last week, as well as whether the child was in care during the day (6 a.m. to 6 p.m.), evenings (6 p.m. to 11 p.m.), or overnight (11 p.m. to 6 a.m.).

Table 7-14 summarizes this care schedule information, and underscores the importance of license-exempt care during non-traditional hours. Only 30 percent of the parents in the sample used care exclusively during weekday days, while 70 percent used some care either during evenings, overnights, or weekends. The table further demonstrates that a range of non-traditional hour care periods were used. Non-traditional care most frequently was used during evening hours, with 54 percent of respondents reporting such usage. In comparison, 48.4 percent used weekend care and 16.4 percent used overnight care.

Table 7-14. Days of Week and Times of Day that Care Is Used by Parents Receiving Child Care Subsidies

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Types of Care Hours Used In Last Week (n=290)[1]				
Weekday care during day only	30.0	32.4	25.6	31.6
Either evening, overnight, or weekend care	70.0	67.6	74.4	68.4
Evening care	54.0	51.0	57.3	54.1
Overnight care	16.4	20.0	14.6	14.3
Weekend care	48.4	39.6	54.4	52.0
Percent Ever in Work, School, or Training in the Last 3 Months during:				
Evenings	65.3	64.8	67.7	63.8
Overnight	20.8	24.8	18.3	19.0
Weekends	62.4	58.1	74.2	56.2
Either evenings, overnight, or weekends	79.2	79.0	84.9	74.3

[1] Because of missing data on the variables used to create the data in this particular analysis, the maximum number of cases with complete data was 290.

Finally, to test the possibility that some parents who had not used non-traditional hour care in the last week may have used such care recently, parents were asked if they had ever used evening, overnight, or weekend care during the last three months. Nearly four-fifths (79.2 percent) of respondents had used care during at least one of these non-traditional periods in the last three months (Table 7-14). Evening and weekend care had been used by 65.3 and 62.4 percent of parents, respectively, while overnight care was used much less frequently (20.8 percent).

Special Care Needs

When describing the care their children received, parents were asked whether each child had a special medical problem, special care need, or disability. If needed to prompt a response, the interviewer indicated that such special needs may include asthma, ADHD, a physical or mental disability, behavior problems, or other problems. As shown in Table 7-15, 38.0 percent of parents reported having at least one child with a special care need. Among these parents, a total of 139 children were indicated to have special needs, which represents 18.9 percent of all of the children in the sample.

Table 7-15. Special Needs of Children Receiving Care

	Percentage of Sample (n=303)	Percentage of Families with Special Needs (n=115)[1]
Has at least One Child with Special Care Needs		
Yes	38.0	100.0
No	62.0	0.0
Types of Special Care Needs Reported by Parents		
Asthma or breathing related	26.7	70.4
ADHD	7.9	20.9
Speech	2.6	7.0
Learning disability	2.3	6.1
Sickle cell anemia	2.3	6.1
Seizure disorder/epilepsy	2.0	5.2
Vision or hearing	1.7	4.3
Cardiac	1.7	4.3
Other	6.6	17.4

[1]The percentages in this column will add to more than 100 percent, because families could report more than one special need.

For each child that was indicated as having a special care need, parents were asked to describe the nature of this need. Parents reported 163 specific special needs for the 139 children with special needs. Asthma and other breathing disorders were easily the most commonly mentioned special care need, with 70.4 percent of the families who reported special needs mentioning this problem for at least one child (Table 7-15). This represents over one-quarter (26.7 percent) of all families in the sample. Attention-Deficit/Hyperactivity Disorder (ADHD) was mentioned as a problem by 20.9 percent of those families reporting special needs. No other specific need was mentioned for over seven percent of the families who reported special needs.

Place Where Child Is Cared For

Parents were asked where the main provider usually cared for their children. As shown in Table 7-16, the children in nearly two-thirds (65.3 percent) of the families were cared for in the provider's home, while 32.3 percent were cared for in the parent's home. These percentages were consistent regardless of whether or not the main provider was related to children in the family. We should note that the prevalence of care in the home of the provider is higher than for the statewide license-exempt population shown in Table 7-6 (65.0 percent in sample versus 46.7 percent for the statewide data shown in Table 7-6).

Table 7-16. Usual Place of Care

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
All Families				
Parent's home	32.3	46.7	34.4	16.2
Provider's home	65.3	50.5	63.4	81.9
Someplace else	2.3	2.9	2.2	1.9
Families in Which Relative Is Main Provider (n=230)				
Parent's home	32.6	48.7	32.9	16.5
Provider's home	64.8	47.4	65.8	81.0
Someplace else	2.6	3.8	1.4	2.5
Families in Which Non-Relative Is Main Provider (n=71)				
Parent's home	32.4	40.7	42.1	16.0
Provider's home	66.2	59.3	52.6	84.0
Someplace else	1.4	0.0	5.3	0.0

Relationship between Children and Providers

Parents were asked to specify the relationship between each of their children and the main provider. Table 7-17 presents these results, using the family as the unit of analysis. It can be seen that relatives were easily the most common types of caregivers. The main provider was related to at least one child in 76.4 percent of the families surveyed. Among the remaining 23.6 percent of families using a non-relative caregiver, friends or neighbors were the most common source of care provision. Grandparents were most commonly used among the relative providers, being used by 46.2 percent of all families in the sample and 60.4 percent of those who used relative caregivers. Aunts and uncles (17.9 percent of all families) and siblings (4.7 percent) were used by smaller numbers of the families.

Table 7-17. Relationship between Children and Their Child Care Providers

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Main Provider Related to At Least One Child in Family				
Yes	76.4	74.3	79.3	76.0
No	23.6	25.7	20.7	24.0
Family Has Main Provider Who is Child's:[1]				
Grandparent	46.2	33.3	51.1	54.8
Aunt or uncle	17.9	20.0	17.4	16.3
Brother or sister	4.7	10.5	3.3	0.0
Other relative	9.6	12.4	9.8	6.7
Friend or neighbor	22.6	26.7	20.7	20.2
Other non-relative	2.7	2.9	0.0	4.8
Longest Time Main Provider Has Cared for Child in Family (n=291)				
< 6 months	17.5	13.9	20.2	18.8
6 – 11 months	7.9	5.0	5.6	12.9
12 – 23 months	18.2	21.8	11.2	20.8
24 – 47 months	27.5	28.7	33.7	20.8
48 months and over	28.9	30.7	29.2	26.7
Average	37.1	38.0	40.1	33.5

[1] The percentages under this heading add to more than 100 percent, because a small number of cases had relationships that varied between the main provider and different children in the family.

The length of time that children had been in the care of the main provider was ascertained as another indicator of the relationship between caregivers and children at the time of the interviews. Because this length of time is highly sensitive to the age of the child, we determined the longest time that any child in the family had received care from the main provider. Table 7-17 indicates that the main provider had cared for a child in the family an average of 37.1 months, or slightly over three years, when interviewed. Further, 56.4 percent of the main providers had cared for a child in the family for over two years. Given that parents were interviewed at points in time when care was on-going, it should be emphasized that these figures are not intended as estimates of the length of care spells. Rather, they are intended to provide some context concerning the care relationship parents and providers considered as they responded to various survey questions.

Parental Responses to Child Care Problems

Because license-exempt providers most often work alone, there has been interest in learning what actions parents take when their provider becomes ill or is unavailable for other reasons. We therefore questioned parents about what they did in such circumstances. Parents also were asked more generally whether problems with child care had compromised their ability to meet work and school obligations.

Handling of Child Care When Main Provider Is Unavailable

All parents were asked a series of questions about possible back-up care options they ever had used if their main provider was unavailable, as well as an open-ended follow-up asking if any other options had been used. About 90 percent of parents indicated that they had to make back-up care provisions at some time. As shown in Table 7-18, parents mentioned two actions by far the most often in this respect. First, 66.0 percent suggested that they turned to another relative when their provider was not available. Second, 56.4 percent said they stayed home from work or school.

Because the back-up care options shown in Table 7-18 are not mutually exclusive, parents also were asked which of these they used most often. Having another relative provide care (47.9 percent) and staying home from work or school (32.0 percent) again easily were the most common responses.

Work and School Problems Related to Child Care

The relatively high proportion of parents who said they had ever missed work or school because of the unavailability of their provider raises the question of whether this was a frequent occurrence. Responses to another question on whether parents had experienced selected work or school problems in the last six months sheds some light on this issue. Parents were asked if child care problems had required them to take any of the following actions in the last six months: been late for work or school, missed work or school, quit school, or quit or been fired from a job. As shown in Table 7-19, 29.3 percent of parents reported that they had experienced at least one of these problems during the last six months. However, less than one-fifth indicated that they had

missed work or school (19.9 percent) or been late for work or school (18.9 percent). It is notable that this percentage is considerably lower than the 56.4 percent figure reported in Table 7-18 for ever having stayed home from work or school due to the unavailability of a provider. Table 7-19 also shows that, while the percentages are low, a few parents reported quitting or being fired from their job (2.0 percent) or quitting school (1.0 percent) in the previous six months because of child care problems.

Table 7-18. What Parent Does with Children When Main Provider Is Unavailable to Provide Care

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Does Parent Ever:				
Stay home from work or school	56.4	50.5	57.0	61.9
Take children to work or school	9.2	8.6	9.7	9.5
Have children take care of themselves	2.3	2.9	3.2	1.0
Have another relative watch children	66.0	62.9	62.4	72.4
Take children to another provider	9.6	5.7	11.8	11.4
Make other alternative arrangements	7.3	8.6	4.3	8.6
What Parent Usually Does:				
Stay home from work or school	32.0	30.5	38.7	27.6
Take children to work or school	1.7	2.9	1.1	1.0
Have children take care of themselves	0.3	1.0	0.0	0.0
Have another relative watch children	47.9	43.8	46.2	53.3
Take children to another provider	3.6	1.0	3.2	6.7
Make other alternative arrangements	1.7	1.0	1.1	2.9
Don’t know/refused	12.9	20.0	9.7	8.6

Table 7-19. Parent Reported Problems Related to Child Care in the Last 6 Months

	Total Sample (n=297)[1]	North & South Lawndale (n=102)	Peoria County (n=93)	Southern Seven (n=102)
Because of Child Care Problems, Parent Has:				
Been late for work or school	18.9	16.7	20.4	19.6
Missed work or school	19.9	13.7	20.4	25.5
Quit or been fired from your job	2.0	1.0	4.3	1.0
Quit school	1.0	0.0	1.1	2.0
Experienced at least one of the problems above	29.3	21.6	32.3	34.3

[1]Total cases are slightly lower in this table than other tables due to six system missing cases on all of these questions.

Differences in Care Patterns between Study Areas and Provider Types

The overall care patterns revealed for the survey sample in the preceding sections were quite similar across each of the three study areas. License-exempt care in each area was provided largely by relatives, and it usually served parents involved in full-time work and/or schooling. The main providers typically had a fairly longstanding care relationship with at least one child in the family, and the need for care during non-regular work hours was very high in each area. Despite these similarities on these important aspects of caregiving, a few statistically significant differences in care patterns between the study areas are noteworthy.

One difference pertains to the reasons that parents said child care was needed in the three study areas (Table 7-11). Working was the dominant response, being mentioned by at least 86.7 percent of respondents in each area. However, parents in Peoria County (97.8 percent) were even more likely to mention working than those in the other two study areas, and Southern Seven parents were more likely to indicate that going to school necessitated their need for care (28.6 percent versus 16.2 percent in North and South Lawndale and 16.1 percent in Peoria County).

Although the average hours worked or in school or training approximated full-time in each study area, North and South Lawndale respondents were more likely to be involved in such activities 40 or more hours per week than in the other areas (62.7 percent in North and South Lawndale versus 56.0 percent in Peoria County and 45.1 percent in Southern Seven). In addition, one of the greatest differences between the areas concerned travel time to and from work and child care. In North and South Lawndale, such round-trip travel times averaged 95.3 minutes, or approximately one and one-half hours per day. This was more than double the comparable travel

times in Peoria County and the Southern Seven counties, which averaged 47.4 and 46.5 minutes respectively.

There also were significant differences in the average hours that children received child care across the three areas (Table 7-12). For example, in comparing the length of time in care for the child with the most care, the average was 40.1 hours per week in North and South Lawndale versus 35.7 hours in Peoria County and 31.6 hours in the Southern Seven counties. Comparable geographic differences resulted when the average hours for all children in care were assessed. These differences in average care hours between North and South Lawndale and the Southern Seven counties may be due to several factors. First, work hours were slightly higher for North and South Lawndale parents than for Southern Seven parents, and travel times were significantly greater. Second, Southern Seven parents were more likely to be married (see Chapter 5), which may necessitate fewer hours of non-parental care. Finally, Southern Seven parents had significantly fewer children age 13 and under. While one may argue that this should not affect per child care averages, it is possible that informal arrangements (with friends, for example) are more feasible when fewer children are involved. Peoria County was very similar to North and South Lawndale on each of these factors except travel time, which is consistent with care averages that fell between North and South Lawndale and the Southern Seven counties.

A final significant difference between the study areas pertains to the usual place where child care was provided (Table 7-16). While care in the provider's home was the most common place of care in all three study areas, this was much more the case in the Southern Seven counties than in Peoria County or North and South Lawndale. That is, 81.9 percent of the parents in the Southern Seven counties reported having their children cared for in the provider's home, as compared to 63.4 percent in Peoria County and 50.5 percent in North and South Lawndale.

Only one significance difference of interest was found when comparing provider types. Parents served by non-relative providers were more likely to report one of the work or school related problems shown in Table 7-19 than parents with relative providers were (38.6 percent versus 26.2 percent).

Chapter 8:
Caregiving Patterns among License-Exempt Providers

This chapter describes basic caregiving patterns of license-exempt providers in the Illinois program, relying heavily on the survey data from the three study areas. Because most of the providers in this study are relatives, and non-relative providers are subject to program rules limiting the number of children in care, the provider care patterns are closely related to those detailed for parents in Chapter 6. Nonetheless, provider caregiving patterns extend beyond the focal family in some cases, and there are selected aspects of caregiving on which providers are uniquely qualified to respond.

It is useful to remind the reader of the specific Illinois Subsidy Program rules that pertain to license-exempt caregiving. In particular, these providers include:

- License-exempt family day care homes, in which providers are non-relatives who are at least 18 years of age and who care for no more than 3 children, including their own children, unless all of the other children are from the same household; or,

- Relatives, who are not the parents, stepparents, or legal guardians of the children, either in the relative's or the child's home.

Administrative Data on License-Exempt Provider Caregiving Patterns

Statewide administrative data can provide an overview of the number of children receiving subsidies that license-exempt providers care for at one time, as well as some useful information on the length of time they commonly care for these children. As previously mentioned, the administrative records contain information only on the children in care who are receiving subsidies. Consequently, some providers may be providing care for other children, including their own, who are not receiving subsidies. We will return to this issue in presenting survey results in a later section. However, in considering the administrative data, the reader should keep this limitation in mind.

Number of Children Cared For

Table 8-1 presents data on the number of subsidized children that each license-exempt provider cared for in January 2003, as well as the number cared for by different types of license-exempt providers. Most noteworthy from the table is the relatively small number of children typically cared for by each license-exempt provider. For example, the average number of children receiving subsidies cared for by all license-exempt providers was 2.31. Further, over three-fifths (61.6 percent) of license-exempt providers were caring for either one or two children receiving subsidies, while an additional 22.3 percent were caring for three children.

This pattern of caring for few children at a time was fairly consistent across the license-exempt provider types. The average number of children receiving subsidies in the care of each provider ranged from 2.18 for license-exempt home providers to 2.44 for non-relative caregivers providing care in the child's home. Although the differences between provider types were not

great, the two types of license-exempt providers (relatives and non-relatives) that provided care in the child's home were slightly more likely to be serving four or more children than providers who offered care outside of the children's home. Even among these groups, however, only 18.6 percent of non-relatives and 17.7 percent of relatives who provided care in the child's home were caring for four or more children receiving subsidies in January 2003.

Table 8-1. Number of Subsidized Children Cared for by License-Exempt Providers: January 2003

	Number of License-Exempt Providers Caring For:				
	All License-Exempt Providers	License-Exempt Homes	Relatives Outside Children's Home	Non-Relatives in Children's Home	Relatives in Children's Home
1 child	12,604	1,239	5,284	3,105	2,980
2 children	13,979	1,185	5,246	4,222	3,333
3 children	9,625	764	3,357	3,170	2,335
4 children	4,452	302	1,448	1,547	1,153
5-9 children	2,472	178	738	851	703
10+ children	16	1	9	3	3
Total	**43,148**	**3,669**	**16,082**	**12,898**	**10,507**
Mean	2.31	2.18	2.20	2.44	2.36
	Percentage Distribution of License-Exempt Providers Caring For:				
	All License-Exempt Providers	License-Exempt Homes	Relatives Outside Children's Home	Non-Relatives in Children's Home	Relatives in Children's Home
1 child	29.2	33.8	32.9	24.1	28.4
2 children	32.4	32.3	32.6	32.7	31.7
3 children	22.3	20.8	20.9	24.6	22.2
4 children	10.3	8.2	9.0	12.0	11.0
5-9 children	5.7	4.9	4.6	6.6	6.7
10+ children	0.0	0.0	0.1	0.0	0.0

Length of Time Care Has Been Provided

Another important issue in examining license-exempt caregiving patterns concerns the length of time that providers have cared for families receiving subsidies. There are several perspectives from which this issue may be considered. For example, it is useful to understand

both how long individual children typically are cared for by license-exempt providers, as well as more generally how long license-exempt providers have been providing care for any subsidized children.

To obtain a sense of how long different types of license-exempt providers typically cared for individual children, spell lengths were created for each subsidized child cared for by license-exempt providers at particular points in time.[16] For example, for the data in Table 8-2, spells were created for each subsidized child cared for license-exempt providers in January 2000. These spells establish how long the provider ended up caring for each child in their care at that time. For example, the "< 1 month line" in Table 8-2 shows that 3.1 percent of the providers active in January 2000 cared for at least one child who received subsidized care from that provider for less than one month.

Table 8-2. Length of Time that Providers Cared for Subsidized Children, for Children in Their Care in January 2000

	Percent of Providers Caring for a Child that Remained in Care:[1]				
	All License-Exempt Providers (n = 48,169)	**License-Exempt Home (n = 2,103)**	**Relative Outside Child's Home (n = 17,600)**	**Relative In Child's Home (n = 11,492)**	**Non-relative In Child's Home (n= 17,031)**
< 1 month	3.1	6.0	2.6	3.4	4.4
2 – 3 months	7.4	12.3	6.6	7.5	10.8
4 – 6 months	16.1	23.1	15.6	12.9	16.1
7 – 12 months	21.8	27.8	21.5	18.2	20.1
13 – 24 months	26.6	23.8	26.7	27.2	25.5
> 24 months	30.7	18.7	33.0	34.7	27.6
Mean (in months)[2]	19.7	14.0	20.7	20.9	17.7
Median (in months)[2]	14.0	9.0	15.0	16.0	12.0

[1] Percentages will total to over 100 percent, because some providers cared for children for different lengths of time.
[2] Because the data used to calculate spell lengths only were available through January 2003, some spells still had not been completed. This biases the mean and median spell lengths downward.

[16] Such spells are created by determining a starting service point and an ending service point with the provider for each child, and then calculating the length of time between these points. A spell is considered to have ended if a child ceases to receive care from the provider for at least one month. January 2000 was selected as the month on which to base analysis in order to allow most cases open at that time to have sufficient time to close before the study was completed (data for such analyses only were available through January 2003).

Several observations may be made from the Table 8-2 data. Of the 48,169 license-exempt providers active in the Illinois program in January 2000, 57.3 percent were caring for at least one child that remained in subsidized care with that provider for at least one year. Similarly, short spells were fairly uncommon with these providers, with 3.1 percent caring for a child that remained with them less than one month and 7.4 percent caring for a child 2-3 months. The average length of time that providers cared for these children was 19.7 months, with a median of 14 months.

Turning to the four types of license-exempt care categories, Table 8-2 reveals that the longest average care spells were provided by relatives. The average care spells provided by relatives outside the child's home and by relatives within the child's home both approached 21 months, as compared to 17.7 months for non-relatives providing care in the child's home and 14.0 months in license-exempt homes. Median spell care lengths varied similarly.

Survey Data on License-Exempt Provider Caregiving Patterns

The survey allowed more detailed questioning about the care patterns of license-exempt caregivers in the three study areas. In addition to providing information on a broader range of caregiving issues, the survey allows consideration of all children in the care of license-exempt providers, as opposed to only those receiving subsidies. The following sections present survey results on the number of children cared for and hours of care provided, monetary compensation and sources of payment, non-monetary compensation, places where care is provided, and the availability of back-up care.

Number and Family Composition of Children Cared For

Providers were asked several questions designed to determine the number of children under age 13 that they cared for, as well as how many families they served. An initial set of questions asked about the largest number of children that providers cared for at one time, both including their own children and other children. These questions did not limit respondents to caregiving for which they were paid, as they were intended rather to determine the total number of children that providers were caring for.

As shown in Table 8-3, the largest number of children cared for at a time during the last month was relatively small, even when the provider's own children were included. For example, 59.8 percent had cared for at most three children at one time during the past month, and only 16.2 percent had cared for six or more children at one time. The largest number of children cared for at one time by providers averaged 3.51.

Providers also were asked whether any of their own children under age 13 were usually present when they provided care. About one-fourth (24.4 percent) of providers reported usually having their own children present. In subsequent questioning about the largest number of children in care at a time, providers were asked to differentiate between how many of these children were their own and how many were from other families. Table 8-3 shows that 69.3 percent of the providers were caring for three or less children that were not their own. It also can

be seen that, of the average largest number of children in care at one time (3.51), an average of 3.05 were not the provider's children.

Table 8-3. Largest Number of Children Cared for by Provider at One Time in Last Month, and Presence of Own Children in Care (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Provider Usually Has Own Children Under 13 While Providing Care				
Yes	24.4	24.8	21.5	26.7
No	75.3	74.2	78.5	73.3
Largest Number of children in Care at One Time During Last Month (Including own)[1]				
1	15.1	9.9	10.0	25.0
2 – 3	44.7	38.6	55.6	41.0
4 – 5	24.1	33.7	17.8	20.0
6 and over	16.2	17.8	16.7	14.0
Average number of children	3.51	3.79	3.57	3.18
Largest Number of Children in Care at One Time During Last Month (Other than own)[1]				
1	20.4	15.2	13.8	31.9
2 – 3	48.9	43.4	62.1	42.6
4 – 5	20.0	30.3	11.5	17.0
6 and over	10.7	11.1	12.6	8.5
Average number of children	3.05	3.30	3.16	2.69

[1]These analyses include small numbers of missing cases for providers interviewed who recently had stopped providing care. The largest number of missing cases due to this issue was 10. Frequency distributions are calculated on non-missing cases.

A second set of questions focused more narrowly on the paid care that caregivers provided during the previous month (Table 8-4). Nearly three-fourths (72.3 percent) reported providing paid care to three or less children in the past month. An average of 2.95 children were in paid care with the provider in the last month, and only 7.2 percent of the providers were paid to care for six or more children. This paid care in the last month measure is not strictly comparable to the previously described largest number of children in care at a time measure, both because of differences in the consideration of time (single point versus last month) and pay (all care versus paid care). Nonetheless, the close correspondence between the average largest

number of children in care at a time (3.05) and the average number of children in paid care during the last month (2.95) is noteworthy.

The small-scale nature of service provision among study providers is further illustrated by responses about paid care provided to children not in the focal family. Only 19.3 of these providers were caring for children not in the focal family, and only 7.9 percent reported receiving subsidies for such care (Table 8-4). Consequently, it is not surprising that of the average 2.95 children for whom paid care was provided, an average of 2.40 or about 83 percent were from the focal family. Among those who provided paid care to children not in the focal family, the average number of additional families served during the last month was 1.86.

Table 8-4. Number of Children <13 License-Exempt Caregivers Provided Paid Care for during Last Month (Percent Distribution)

	Total Sample (n = 303)	North & South Lawndale (n = 105)	Peoria County (n = 93)	Southern Seven (n = 105)
Number of Children Provided Paid Care for in Past Month				
1	21.6	15.8	14.3	34.0
2 – 3	50.7	48.5	61.5	43.0
4 – 5	20.5	27.7	16.5	17.0
6 and more	7.2	7.9	7.7	6.0
Average number of children	2.95	3.16	2.95	2.75
Average Number of Children Cared for from Focal Family	2.40	2.66	2.60	1.98
Provided Paid Care for Children under 13 Not in Focal Family				
Yes	19.3	17.6	11.8	27.6
No	80.4	81.6	88.2	72.4
Average number of families cared for in non-focal families	1.86	1.76	1.82	1.93
Received Subsidies for Caring for Children Outside The Focal Family				
Yes	7.9	5.7	5.4	12.4
No	92.1	94.3	94.6	87.6

Hours Worked and Care Schedule

Providers were asked how many hours they had provided child care altogether in the last week, as well as how many of these hours were provided for the focal family. Table 8-5 shows that providers generally cared for children at least 30 hours per week, with an average of 35.9 hours.[17] A substantial minority (19.3 percent) had provided care for less than 20 hours in the past week, and a similar percentage (18.0 percent) reported providing care for 50 hours or more.

Given that most providers cared only for children from the focal family, it is not surprising that the hours of care provided to focal family children clearly mirrored the total hours of care provided to all children. As shown in Table 8-5, providers reported caring for children from the focal family an average of 34.9 hours in the past week, as compared to the 35.9 hour average for all children in care. It should further be noted that these averages may be so similar partially because those providers caring for children outside the focal family may do so at the same time they care for focal family children.

Table 8-5. Number of Hours That License-Exempt Caregivers Provided Care During Last Week (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Total Hours Provided Care Last Week				
< 20	19.3	6.8	30.1	22.1
20 – 29	9.0	12.6	6.5	7.7
30 – 39	18.0	14.6	16.1	23.1
40 – 49	30.7	35.0	23.7	32.7
50 and over	18.0	30.1	12.9	10.6
Don't know	5.0	1.0	10.8	3.8
Average number of hours	35.9	41.4	32.2	33.4
Total Hours Provided Care For Focal Family Last Week				
< 20	22.3	8.7	31.2	27.9
20 – 29	10.3	13.6	9.7	7.7
30 – 39	17.0	12.6	15.1	23.1
40 – 49	31.3	37.9	23.7	31.7
50 and over	13.3	25.2	8.6	5.8
Don't know	5.0	1.9	10.8	2.9
Average number of hours	34.9	39.6	33.0	31.7

[17] We again should remind the reader that, compared to all license-exempt caregivers in the Illinois program, these hours of care provided estimates may be biased upward. This stems from the fact that we limited sampling to parents who had been using the provider at least 15 hours.

As was reported by parents (see Chapter 7), caregivers typically provided some care during non-traditional work hours (Table 8-6). Less than one-third (30.6 percent) provided care exclusively during the day on Monday through Friday, while 66.1 percent provided some evening, overnight, or weekend care during the last week. Among these non-traditional care hours, evening care (51.5 percent) and weekend care (41.5 percent) were most commonly reported, followed by overnight care (18.6 percent).

Table 8-6. Days of Week and Times of Day That License-Exempt Caregivers Provide Care (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Types of Care Hours Provided In Last Week				
Weekday care during day only	30.6	34.0	22.7	37.0
Either evening, overnight, or weekend care	66.1	66.0	72.0	61.0
Evening care	51.5	51.5	54.8	48.6
Overnight care	18.6	20.4	16.1	19.0
Weekend care	41.5	36.9	46.2	41.9
Don't know/missing[1]	3.3	0.0	5.4	4.8
In Last 3 Months, Ever Provided Care During:				
Either evenings, overnight, or weekends	84.1	82.5	90.3	80.0
Evenings	73.1	74.8	74.2	70.5
Overnight	37.5	34.0	37.6	41.0
Weekends	69.1	63.1	79.6	65.7

[1]This category includes a small number of cases in which respondent did not remember all times of care provision, or else provided inconsistent responses to the several questions used to construct this measure.

To further explore the non-traditional hours of care provision, providers also were asked if they ever had cared for children during evenings, overnight, or weekends during the last three months (Table 8-6). Over 84 percent had provided non-traditional hour care at some point during this period. Evening (73.1 percent) and weekend (69.1 percent) care again were most commonly reported, followed by overnight care (37.5 percent).

Usual Place of Care and Back-Up Care Provisions

Over three-fourths (75.4 percent) of providers reported that they usually cared for children in the provider's home, while 22.9 percent indicated that care was provided in the child's home (Table 8-7). This percentage of caregiving reported in the provider's home is

slightly higher than the 65.0 percent of parents who reported receiving care in the provider's home.[18]

Table 8-7. Usual Place of Care and Back-Up Care Provisions for License-Exempt Providers (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Usual Place of Caregiving				
Provider's home	75.4	61.2	75.3	89.5
Child's home	22.9	38.8	21.5	8.6
Other	1.7	0.0	3.2	1.9
Has Back-up Help Available In Emergency Situations				
Yes	94.7	94.2	94.6	95.2
No	5.3	5.8	5.4	4.8
Has Back-up Caregiver Available If Unable to Provide Care				
Yes	88.7	91.3	87.1	87.6
No	11.3	8.7	12.9	12.4

Because license-exempt caregivers generally work alone and without on-going institutional support and supervision, there has been some concern in the literature with the availability of back-up assistance for these providers. Providers were asked two questions to explore this issue, and they overwhelmingly reported that they did have back-up assistance available. First, 94.7 percent of providers indicated that they would have back-up help available if they were faced with an emergency situation. Second, 88.7 percent stated that they had a back-up caregiver available if they were unable to provide care due to circumstances such as illnesses or vacations.

Child Care Earnings and the Provision of Unpaid Care

All providers were asked how much they earned from providing child care in a typical month, as well as how much of these earnings were received from the focal family. There was

[18] Although we cannot directly assess the reasons for this difference, there are several possibilities. First, parents were asked the usual place where care for their children was provided, while providers were asked where they usually provided care. For the subset of providers who cared for children from multiple families, it is possible that some usually provided care in their own home while caring for the focal family children in the child's home. Second, because of lag times between the parent and provider interviews, the usual place of care location actually may have changed between interviews in some cases. Finally, subsequent analysis showed that 43 percent of the parent-provider pairs that differed in reported "usual place of care" lived together. In these cases, parents may have considered this place to be the "child's home", while providers simultaneously could view it as their own home.

substantial missing data on these items, almost totally because many providers said that they did not know. As a result, 260 providers reported usable estimates of total monthly child care income, and 271 provided usable earnings data from the focal family.

Table 8-8 presents these earnings estimates for those cases with usable information. The vast majority of providers (94.2 percent) reported earning less than $1,000 from child care in a typical month, with average earnings of $476.28. Earnings received from the focal family averaged $420.43. This fairly close correspondence between average total child care earnings and average earnings from the focal family is to be expected, given that only 19.3 percent of caregivers provided paid care for children not in the focal family (see Table 8-4).

Table 8-8. Payment Amounts and Sources of Payments Received by License-Exempt Providers for Care in Typical Month (Percent Distribution)

	Total Sample	North & South Lawndale	Peoria County	Southern Seven
Amount Received from All Sources for Child Care in Typical Month	**(n=260)**	**(n=91)**	**(n=80)**	**(n=89)**
0 – 249	27.3	19.8	26.3	36.0
250 – 499	35.4	28.6	37.5	40.4
500 – 999	31.5	45.1	30.0	19.1
1,000 – 1,999	5.0	6.6	5.0	3.4
2,000 and over	0.8	0.0	1.3	1.1
Average amount	$476.28	$557.64	$472.44	$396.53
Received for Care of Focal Family Children in Typical Month	**(n=271)**	**(n=96)**	**(n=82)**	**(n=93)**
0 – 249	32.5	24.0	26.8	46.2
250 – 499	36.5	32.3	41.5	36.6
500 – 999	27.3	40.6	26.8	14.0
1,000 – 1,999	3.3	3.1	4.9	2.2
2,000 and over	0.4	0.0	0.0	1.1
Average amount	$420.43	$499.12	$428.06	$332.47

Providers also were asked if they provided unpaid care or received non-monetary compensation for any of the children they cared for. Nearly one-third (30.2 percent) of providers reported receiving some non-monetary compensation for care (Table 8-9). Similarly, just over one-fourth (25.9 percent) provided some unpaid care. Taken together, 46.5 percent of providers indicated that they provided unpaid care and/or care for non-monetary compensation, with 9.6 percent reporting that they did both.

Differences in Provider Care Patterns between Study Areas

While the overall care patterns for license-exempt providers in the three study areas generally were similar, there were several interesting differences. In particular, Southern Seven providers tended to care for fewer children, and in turn to make less money from child care than providers in the other two areas. For example, as shown in Table 8-4, Southern Seven providers were likely to have cared for fewer children in the past month than North and South Lawndale and Peoria providers, largely because a larger portion of them provided care for only one child (34.0 percent of Southern Seven providers, versus 15.8 percent in North and South Lawndale and 14.3 percent in Peoria). This difference in number of children cared for resulted from the provision of care to fewer children within the focal family by Southern Seven providers, as they actually were slightly more likely than North and South Lawndale and Peoria providers to care for children not in the focal family (Table 8-4).

Table 8-9. Provision of Unpaid Care and Care for Non-Monetary Compensation by License-Exempt Providers (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Provide Some Unpaid Care for Children				
Yes	25.9	27.2	23.7	26.7
No	73.1	71.8	75.3	72.4
Don't know/refused	1.0	1.0	1.1	1.0
Received Some Non-Monetary Compensation for Care Provided				
Yes	30.2	46.6	20.4	22.9
No	67.1	50.5	76.3	75.2
Don't know/refused	2.6	2.9	3.2	1.9

The average earnings received from child care in a typical month differed significantly between the three areas, with the highest earnings in North and South Lawndale ($557.64) followed by Peoria ($472.44) and the Southern Seven area ($396.53). Similar average earnings differences from the focal family also were found (see Table 8-8). These differences are consistent with the higher reported work by North & South Lawndale providers (Table 8-5), as well as the lower average number of children cared for by Southern Seven providers (Table 8-4).

Although the percentage of providers who reported providing some unpaid child care was similar across the three areas, North and South Lawndale providers were significantly more

likely to provide care in return for non-monetary compensation. As shown in Table 8-9, 46.6 percent of North and South Lawndale providers reported some caregiving for non-monetary compensation, as compared to 22.9 percent in the Southern Seven area and 20.4 percent in Peoria County. Over three-fifths (60.2 percent) of North and South Lawndale caregivers reported providing some care either for free or for non-monetary compensation.

Finally, there were significant differences between providers in the three areas with respect to the place that child care usually was provided. Providers in all three areas most often reported caring for children in the provider's home (Table 8-7). Nonetheless, Southern Seven providers were much more likely to provide care in their own homes than provider's in the other two areas. Nearly ninety percent of Southern Seven providers reported their own home as the usual place of care, as compared to 75.3 percent in Peoria County and 61.2 percent in North and South Lawndale. We should note that these differences are not due to variations in the proportions of relative and non-relative license-exempt providers in the three study areas.

Chapter 9: Parental Decision-Making on Child Care Arrangements

Parental decision-making related to the choice of child care providers has received considerable attention in previous literature. This issue is of paramount importance when considering parents using license-exempt care, because of concerns that choices of this form of care may be the undesirable consequence of supply and cost constraints facing parents. Nonetheless, previous research also has indicated that more positive factors, such as the trusting relationships that parents often enjoy with relative caregivers, are important in parental decision-making.

We asked several questions to ascertain the factors that were most pertinent to the selection of license-exempt providers by parents in our sample. In particular, parents were asked to indicate which of a list of eight factors had been most important in selecting their current license-exempt caregivers, and also to provide information about why these factors were important. Additional questions were included to assess the extent to which parents had considered and would desire child care options other than those they had selected. Because child care arrangements and related decision-making factors may vary for different children within a family, all of these questions were asked about a randomly selected focal child. We also included limited questioning on the quality of neighborhoods in which parents lived, due to concerns that perceptions about neighborhood quality could affect the factors parents considered most important when selecting child care providers.

Factors Influencing Child Care Decisions

Most Important Factors Influencing Choice

Respondents were presented with a list of the following eight factors that previous literature and our initial focus groups had suggested were important in child care selection: affordability/cost, schedule, convenience/location, trust, health/safety, individual attention, learning opportunities, and the age of the child. They were asked to indicate which three of these factors had been most important when choosing their current license-exempt provider. To guard against possible list ordering effects, the order of these factors was varied randomly in each interview.

Table 9-1 summarizes the factors considered most important by respondents. Trust was easily the most often selected factor, with 85.4 percent of parents mentioning trust among their top three choice factors. Convenience/location (55.1 percent), health/safety (43.9 percent), schedule (31.2 percent), and affordability/cost (30.2 percent) each was mentioned by at least 30 percent of the parents. In contrast, learning opportunities (12.0 percent) and the age of the child (10.6 percent) were mentioned by relatively few parents.

Exploration of Choice Factors

Factors such as trust and affordability/cost are quite broad, and previous literature generally has not clearly defined their dimensions. In addition, discussions of some choice factors in our focus groups suggested that concepts such as safety may include dimensions not

traditionally considered in regulated settings. Parents therefore were asked to define what they meant by each of the three factors they had identified as being most influential in choosing a child care provider. These open-ended responses then were coded to determine the dimensions of each factor that parents articulated. The following sections elaborate upon each of these choice factors based on these parental responses, with quotes from parents also presented to illustrate various responses types.

Table 9-1. Reasons Parents Reported for Selecting Current License-Exempt Care Provider to Care for Focal Child (Percentage Distribution)

	One of Top Three Reasons for Selecting Current Arrangement:*			
	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Affordability / cost	30.2	27.9	41.9	22.1
Schedule	31.2	36.5	29.0	27.9
Convenience / location	55.1	60.6	47.3	56.7
Trust	85.4	83.7	82.8	89.4
Health / safety	43.9	41.3	40.9	49.0
Individual attention	26.6	25.0	24.7	29.8
Learning opportunities	12.0	9.6	20.4	6.7
Age of child	10.6	8.7	8.6	14.4

*Note: The reasons add to well over 100 percent, because parents could identify three reasons for selecting their main provider.

Trust

As previously mentioned, trust was easily the factor most often mentioned by parents as influencing their child care selection. While parents offered many variations in explaining what they meant by trust, these reasons typically hinged on close familiarity with the caregiver. In particular, 45.1 percent of those parents who cited trust as a decision-making factor specifically mentioned that the provider was a relative. In general, knowledge that a relative was caring for the children provided confidence that the children would be safe and well cared for. A few quotes are illustrative:

"I know it's someone who will take care of my kids as a family member."

"I trust my mom more than I would a stranger. I know she loves him and other people don't really care because it's not theirs."

"I know she will do nothing to harm them. She is my cousin."

Aside from the specific mention of relatives, parents most often noted four other types of comments when discussing trust. Most common among these were generic expressions that the parent trusted the provider or believed that the provider would care for the children well. Such general statements were made by 22.1 percent of those citing trust. A second group was very similar to the relative group in that trust was stressed in terms of familiarity; the only difference was that the parents were not related to the parents in these cases. These comments often emphasized long-time personal friendships or lasting family ties, such as the following: "I've know him all my life and he's really good with kids, so he's just the perfect person."

A third group, mentioned by 18.6 percent of all parents who cited trust as a factor, specifically linked trust to confidence that the provider would protect the children's safety and/or health. Many of these comments reflected very basic concerns for the safety of their children while in care, as suggested by the following:

"I trust him to keep them from harming themselves and him not to harm them."

"I trust him not to molest my daughter, and to feed them and keep them clean and safe."

"I trust they will be OK, safe, they won't run in the street, and he won't hurt them."

Finally, these concerns about trusting providers to safeguard children sometimes extended to parents comparing their provider with some non-selected alternative, such as a child care centers or someone who was less well known to the parent. This fourth group of comments, mentioned by 12.6 percent of those who selected trust as a decision-making factor, included statements such as:

"I don't trust many people with my child."

"There are centers where you can't trust people… I like her to be around people that she trusts."

"I can trust her more than day care. I've had my kids in day care. She won't do anything to hurt my kids."

Convenience / Location

Over half (54.8 percent) of parents selected convenience/location as one of the three factors most influential in selecting their license-exempt caregiver. In elaborating what they meant by convenience/location, the vast majority of responses fell into one of three closely related categories. These responses all emphasized how the location of the provider saved the

parent time or costs. First, parents most often noted that the caregiver lived nearby (45.0 percent of parents selecting convenience/location). Second, consistent with the large number of parents in the sample that were living with the provider, parents emphasized the benefits of living with the provider or having the provider come to their home to provide care (30.0 percent of those offering convenience/location responses). Finally, a smaller subset of those mentioning convenience/location (12.5 percent) indicated that the provider lived close to the parent's work or school location, or else was on the way to one of these. The following comments illustrate each of these concerns.

Provider Lives Nearby

"I can walk if my car breaks down."

"I can walk to take my kids to her."

"Because if I was running late, this would be OK. She is close."

"She lives very close to me, and my job is an overnight job."

"She lives near, and she will come to my house if she needs to."

Lives with Provider or Provider Comes to Home

"He'll come here and watch them for me and I don't have to travel way out to his place."

"The kids can stay home and don't have to travel."

"They are at home and not out late at night when I get off work."

"It's here at my house. He can put them to bed."

"The children stay in their own home, so I don't have to take them out in bad weather."

Close to Work/School or on Travel Route

"She lives in a town I have to go to every day."

"She is on the way to my job and school."

"It's very close to my job … I don't have to go out of my way."

Health and Safety

Health and safety was the third most frequently cited factor by parents in considering their choice of the license-exempt provider. In explaining what they meant by health and safety, parents mentioned both general and more specific concerns. Over half of these respondents offered comments that reflected general confidence that their children would be well cared for, or else that the provider would protect their children's health and safety. As with the consideration of trust, a substantial subset of these responses (16.9 of parents who mentioned health/safety) made specific reference to the relative when discussing what they meant by health and safety. The following comments are illustrative of general confidence that parents expressed in terms of providers assuring health and safety.

"She's their grandma … she won't hurt my kids."

"Because my mom will watch my child and keep her safe."

"That's my mom. I know that she is not going to do anything to my kids."

"I know they are safe … she pays closer attention than a stranger might."

One other fairly large subgroup (20.8 percent) of the parents mentioning health and safety pointed to some specific health-related aspect of the care offered by the provider. These include issues such as the provider's willingness and ability to look after children when they were sick, to take children to the doctor, and to administer medications. In addition, consistent with the large number of parents who indicated that their children had special care needs (see Chapter 6), some of these parents spoke of their confidence in the provider being able to respond to asthma or other special care needs.

"When they are sick, she knows what to do, especially with my child with asthma."

"As far as health, like with doctor's visits, my mom can step in."

"She has taken them to the doctor for me. They are in good hands."

"She knows what to look for as far as injuries, etc."

Finally, smaller numbers of parents emphasized some other specific aspect of care in discussing these health and safety concerns. Among the most prevalent in this respect were mentions of the cleanliness of the house or the provider, the provider's cooking and feeding of the children, and the close supervision that was provided.

Schedule

Nearly one-third (31.4 percent) of parents selected "schedule" among the three most important factors influencing their choice of care arrangements. While some of these spoke generally of a good fit between their schedules and the availability of the provider, they much more often stressed that the provider could work with their unusual, bad, or shifting work schedules (47.3 percent of cases mentioning schedule). An additional 18.3 percent of these parents referenced the provider's flexibility in providing care, and these cases seemed to overlap considerably with those mentioning specific unusual scheduling needs. Both of these response categories are consistent with the previously referenced large number of parents using care during non-traditional work hours (see Chapter 7). Finally, a smaller number of parents (6.5 percents of cases mentioning schedule) referred to not having to worry about being late to pick up the child in the case of unforeseen circumstances. These cases may be viewed as a specific example of provider flexibility in response to parents' scheduling issues. Following are selected examples of each of these response types.

"If I am late getting off work, it is not a big deal … she is very flexible."

"The schedule … I was going to school, and I wouldn't have made it home in time to pick them up from day care."

"It don't matter what hours I work – the provider is there to watch the kids."

"I work second and third shifts, and there are no day cares that will offer hours."

"I can't find anyone else to keep them these hours."

"He works with my changing schedule."

"My schedule flip flops a lot, and the day cares prefer to be on a specific schedule."

Affordability/Cost

Thirty (30.0) percent of parents mentioned affordability/cost as one of the three factors most influential in their child care provider selection. This group typically cited one of three related factors in discussing the importance of affordability. Most either mentioned the general low cost of their care option or of their co-payment amount, and many of these also considered this cost in comparison to other options. Following are some examples.

"She's not going to charge me an outrageous price, because I'm her daughter."

"It is cheaper for her to watch than day cares and stuff."

"My co-pay is not so high; I can afford it."

"My co-pay is less than if I used a day care center."

"It's much cheaper for a relative to watch a child than to pay someone else."

"The rate is lower, because she is not licensed."

What is most noteworthy about many of these responses is that they appear to reflect a misunderstanding of Illinois subsidy policy. That is, the co-pay that is required of parents by the program is the same whether or not the parent uses a licensed or license-exempt provider. However, this is a fairly complicated issue in practice, both because some child care centers may not be willing to care for children for the amount that the subsidy program pays, and also because some license-exempt providers may waive or be flexible in when they collect the co-payment.

This concern with flexibility in charging was mentioned by substantial subsets of the parents in discussing why they emphasized affordability/cost when selecting their license-exempt provider. For example, 17.8 percent referred to the provider's flexibility with respect to how much they charged the parent, and an additional 17.8 percent mentioned provider flexibility in terms of when the payments were collected. Examples of both of these concerns are provided below.

Flexibility in Charging

"When I am behind on my bills, she just takes a decrease in pay."

"He agreed with a certain amount of money that I could afford."

"I can adjust my payment a little, where at day care I couldn't."

"I have leeway on my co-payment. My mom tries to help me out."

Flexibility in the Timing of Payments

"It's very affordable. If I'm not able to pay the co-pay right away, then she's very understandable about that."

"If I tell him that I don't have the co-payment this month but I will pay next month, he's O.K. with it."

"If I didn't have the money to pay, mom would wait for the money. A day care would kick your kid out."

Individual Attention

Slightly over one-fourth (26.7 percent) of parents selected individual attention as one of the three factors most influential in selecting their license-exempt provider. Most of these respondents emphasized that their children received one-on-one attention, special attention, or were cared for in a very small group. These positive aspects of care frequently were contrasted with the type of care perceived to be provided in child care centers.

"She is not grouped with 30 other children."

"Because she's not caring for any other children right now, and she has a lot of time for [child's name]."

"The only other [available] provider cared for 12 kids – that's too many."

"She can give one-on-one they wouldn't get in day care."

"My kids get a lot of special attention. They're loved and made to feel welcome."

Smaller numbers of these parents mentioned a particular aspect of the individual attention that was especially important to them, with the provision of learning activities or help with homework most commonly mentioned in this respect. Some also emphasized that the provider was related to the child, and that this stimulated greater individual attention than otherwise would be provided. Finally, a small subset of these parents focused upon specific characteristics of the provider that were viewed as fostering individual attention, such as their attentiveness, patience, or love for children.

Learning Opportunities

Among the relatively small number (11.9 percent of parents) who selected learning opportunities as one of their three most important choice factors, parents most often simply indicated that the providers were good at teaching or guiding the children in their care. In addition, some parents specifically referenced help that providers offered with school or homework, as well as ABC and numbers training with younger children.

"She teaches the children and helps them with homework."

"There are things that [provider's name] can guide [child's name] in. He will be more likely to take his brother's advice."

"She spends more time doing school work one on one with each child. She is very good at stressing school to the kids."

"She teaches him stuff – numbers, ABCs, potty training."

Age of Child

The age of the child was least often selected by parents as among the three most influential factors in their child care choice (10.6 percent). This small subset of respondents most often referred to the child being an infant or very young when describing why this factor was important to them. In addition, some parents indicated that their children would tell them if they were mistreated by the license-exempt provider. In contrast, some were less confident that their child would speak up if mistreated in other settings.

> "Nobody really wants to put their child in care at an early age, so it's important to get someone good."

> "They're so little I don't want them to go anywhere else."

> "I have young children, and I want them watched closely."

> "I would not put my kids with anyone until they were old enough to tell me what is going on."

> "Because he can speak if he was to be mistreated."

Consideration of Other Child Care Options

Another issue concerns the extent to which parents using license-exempt care explore other types of caregivers for their children. All parents consequently were asked if they had considered any other child care options when they selected their current license-exempt provider to care for the focal child. As shown in Table 9-2, 29.8 percent of the parents interviewed had considered other options. This group of 90 parents in turn was asked which of the seven common provider types listed in Table 9-2 they had considered. Child care centers were easily the most often considered option reported among this group, with 64.4 percent of parents who considered other caregiving alternatives mentioning this possibility. The only other option mentioned by at least one-fifth of this group was another relative (21.1 percent).

Because of concerns that cost issues may constrain the range of child care options considered by low-income parents, we also asked all parents if they would choose an alternative to their current child care arrangements if cost was not a factor. As shown in Table 9-3, 94.7 percent of parents stated that they still would choose the main provider.

Those few (n=14) parents who indicated they would not choose their current main provider if cost was not a concern were asked what other types of providers they would choose. Day care centers were the most commonly preferred option for this group, with 10 of the 14 parents indicating this would be their choice. The only other type of care preferred by more than two of these respondents was preschools or nurseries. This small set of parents that would desire a change in providers also was asked to identify the main barriers that prevented them from

getting the type of arrangement they desired. Cost was the most often mentioned barrier, with eight of the 14 respondents mentioning cost. Schedule, transportation, and the lack of availability of the desired type of care each were mentioned by at least three respondents.

The discussion above strongly suggests that, at least in this sample, the choice of license-exempt providers by parents largely was a positive one. This further was underscored by a question asking parents how satisfied they were with the having the main provider care for their child. Fully 98.7 percent of respondents indicated they were very satisfied, and only one respondent expressed dissatisfaction. Although there may be reluctance among some respondents to criticize arrangements that they have been responsible for initiating, the strength of expressed satisfaction for these arrangements nonetheless is striking.

Table 9-2. Other Care Options Considered When Current License-Exempt Provider was selected

	Total Sample (n= 303)	**North & South Lawndale (n= 105)**	**Peoria County (n=93)**	**Southern Seven (n= 105)**
Considered Other Arrangements (Percentage Of All Parents)				
Yes	29.8	25.0	31.2	33.3
No	69.5	74.0	67.7	66.7
Other Types of Arrangements Considered (Percentage of Parents that Considered Other Options)	**(n=90)**	**(n=26)**	**(n=29)**	**(n=35)**
Another relative	21.1	19.2	16.7	25.7
Non-relative In parent's home	7.8	0.0	3.4	17.1
Non-relative In provider's home	11.1	3.8	10.3	17.1
Child care center, preschool, or nursery school	64.4	61.5	65.5	65.7
Before/after school program	13.3	7.7	13.8	17.1
Head start	7.8	3.8	0.0	17.1

Knowledge about Subsidy Support for Other Care Options

While the selection of license-exempt caregivers appeared to be driven largely by positive motivations, we also wondered if parents fully understood the range of child care options that would be supported through the subsidy program. A final question therefore asked parents whether the CCAP would help pay for other types of child care, such as child care centers or licensed day care home providers. As shown in Table 9-3, about one-third of parents either thought that the program would not allow other care options (15.8 percent) or else did not know (17.2 percent).

Given this lack of recognition of basic rules on allowable child care options among a substantial minority of respondents, a related question is whether parents fully understand the subsidy cost implications of selecting a license-exempt versus licensed provider. We will return to this question in Chapter 14, which considers cost issues related to license-exempt care provision.

Table 9-3. Preferred Child Care Options if Cost Were Not a Factor, and Knowledge about Other Subsidized Alternatives (Percent Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Would Still Choose Current License-Exempt Provider If Cost Was Not a Factor				
Yes	94.7	92.4	94.6	97.1
No	4.3	5.7	5.4	1.9
Don't know	1.0	1.9	0.0	1.0
Subsidy Program Allows Use Of Other Child Care Options				
Yes	66.3	52.4	83.9	64.8
No	15.8	23.8	7.5	15.2
Don't know	17.2	23.8	7.5	19.0

Neighborhood Effects on Selection of Child Care Arrangements

In the focus groups conducted during the first year of the project, several parents made comments suggesting that the nature of the neighborhoods in which they lived affected their child care decision-making. In particular, some parents were concerned that their neighborhoods were dangerous or susceptible to bad influences on children. We therefore asked survey respondents to rate the quality of their neighborhoods, and to indicate whether their neighborhood had any effect on their choice of caregiving arrangements. As shown in Table 9-4, the ratings of neighborhood quality were fairly evenly split between those who indicated their

neighborhoods were excellent or good (51.9 percent), and those who reported that their neighborhoods were fair or poor (47.9 percent).

Despite these often negative perceptions of neighborhood quality, 82.8 percent stated that their neighborhood had not affected the type of child care arrangements they had chosen. The 16.8 percent of parents who did cite such neighborhood effects were asked to specify how the neighborhood had made a difference. Responses most often referred to the relative safety of the neighborhood in which the care was provided. For example, 10 respondents indicated that the provider's neighborhood was better than their own, and 14 made other comments suggesting safety concerns. It should be stressed that these comments often painted stark pictures of the difficult neighborhoods in which parents resided, which provides important challenges for the development of child care programs. A few quotes from respondents are illustrative:

"I want my kids out of this environment. At least they can stay outside at my mom's."

"I wouldn't leave them with any of the crazy people around here."

"I would not send them out in this neighborhood … the provider's neighborhood is better."

Other than safety issues, comments about neighborhood effects on child care choice were disparate. Several respondents referred to the convenience of the provider location, and a few mentioned positive aspects of the provider neighborhood such as the presence of other children, parks, or churches.

Table 9-4. Neighborhoods Effects on Parental Selection of Current License-Exempt Care Arrangements

	Total Sample (n=303	North & South Lawndale (n=105)	Peoria County (n= 93)	Southern Seven (n=105)
Parent's Rating of Neighborhood Quality				
Excellent	14.9	4.8	18.3	21.9
Good	37.0	22.9	39.8	48.6
Fair	36.0	51.4	33.3	22.9
Poor	11.9	21.0	7.5	6.7
Neighborhood Has Made a Difference in the Selection Of Care Arrangements				
Yes	16.8	16.2	17.2	17.1
No	82.8	83.8	82.8	81.9

Finally, it should be noted that neighborhood effects on child care selection were not confined to those living in less desirable neighborhoods, although those living in poor neighborhoods were significantly more likely to report such effects. For example, of those parents who rated the neighborhood in which they lived as poor, 38.9 percent said the neighborhood affected their child care decisions. In comparison, only 13.3 percent of those in excellent neighborhoods and 12.6 percent in good neighborhoods indicated neighborhood effects on child care decisions. Further, parents who cited neighborhood effects in these better neighborhoods were more likely to emphasize aspects of the neighborhood that made them desirable as a caregiving location.

Differences between Study Areas and Types of Providers

The patterns of choice factors were quite similar across the three study areas, particularly in the emphasis given to trust as a choice factor. However, three differences between the areas are worth noting. First, there was considerable variation in the importance placed on affordability/cost, which may reflect differences in available child care supply at reasonable cost in different locations. For example, while only 22.1 percent of the Southern Seven respondents mentioned affordability/cost as a choice factor, nearly twice that percentage (41.9 percent) of Peoria County respondents did so (Table 9-1). Second, learning opportunities were reported as a choice factor by over 20.4 percent of Peoria County respondents, as compared to only 9.6 percent of North and South Lawndale and 6.7 percent of Southern Seven respondents. Finally, schedule and convenience/location were most often mentioned by North and South Lawndale respondents, although differences with the other study areas were not great.

Another difference between the study areas concerns parental perceptions about neighborhood quality. Parents in the North and South Lawndale area were significantly more likely to report living in fair or poor areas than those in the other study areas. For example, 72.4 percent of North and South Lawndale respondents rated their neighborhood as fair or poor, as compared to 40.8 percent in Peoria County and 29.6 percent in the Southern Seven area. The areas did not differ significantly in terms of the percentage of parents indicating that their neighborhoods influenced their choice of caregiving arrangements (i.e., 16.2–17.2 percent reported such effects in the three areas, see Table 9-4). Nonetheless, the very high percentages of parents indicating neighborhoods concerns, especially in North and South Lawndale, suggests the difficult neighborhood contexts in which many low-income subsidy users often contemplate child care choices.

There was only one significant difference between parents using relative versus non-relative providers with respect to the issues discussed in this chapter. That is, parents using relative providers were significantly less likely to have considered other options when choosing their current license-exempt provider (26.2 versus 42.3 percent for parents using non-relative providers).

Chapter 10: License-Exempt Provider Motivations for Caregiving

There has been considerable interest in understanding the primary caregiving motivations of license-exempt providers, but only limited information in this respect has been available from large scale surveys. We explored caregiving motivations in detail through a series of open and closed questions asked of all providers. The closed questions asked whether selected factors identified by previous literature and by our first-year research activities were important motivators in provider caregiving for the focal family. The open questions asked more generally what providers liked best about caring for children other than their own, and also what they found to be hardest about such caregiving.

Most Important Reasons for Providing Care to the Focal Family

Table 10-1 presents closed question responses on factors that providers considered important in motivating them to care for the focal family. Three reasons were easily the most prominently mentioned as "major" by these providers: want to help out the focal family (89.4 percent), enjoy caring for focal family's children (88.8 percent), and enjoy helping children in the focal family learn (87.5 percent). The desire to help out the focal family was most often accompanied by other positive family and child-centered caregiving motivations, as opposed to perceived pressures to help the family. That is, in addition to the high numbers who enjoyed caring for the focal family's children, nearly two-thirds (65.7 percent) cited wanting the focal family's children cared for by a family member as a major reason for caregiving. In comparison, only 6.9 percent of providers said that pressure from the family to provide care was a major influence for their caregiving.

A majority of providers also mentioned three more specific and closely related child-centered care motivators as important influences. Three-fifths (60.7 percent) of providers indicated that serving as a role model for the focal family's children was a major reason for caregiving, and an additional 30.8 percent said it was somewhat of a reason. Further, 56.1 percent indicated that wanting to provide structure and discipline for focal family children was a major motivation for care, and 54.5 percent wanted the children raised in a manner that the provider thought was desirable.

These high levels of both family and child-centered helping motivations stood in sharp contrast to care reasons that focused upon provider employment needs or desires. Slightly over one-fourth (26.7 percent) cited needing to earn money as a major reason for providing care, and 36.0 percent said this was somewhat of a reason. However, the idea that providing care for the focal family was the only job available was seen as a major or somewhat of a reason for caregiving by only one-fifth (20.2 percent) of respondents. In addition, only one-tenth (10.2 percent) cited the need to find a job because of TANF or welfare work requirements as a major or somewhat important reason for caregiving.

A substantial minority of respondents did mention motives related to child care as a profession or their own family needs as being important in their decisions to provide care. For example, slightly over two-fifths (41.3 percent) indicated that wanting to explore a new career direction had been at least somewhat of a reason they became involved in caregiving for the

focal family, with 17.2 percent considering this a major reason. In addition, about one-third (32.7 percent) said the fact that they already were caring for children in other families when they began providing care for the focal family was influential. One-fourth (25.1 percent) reported that being able to stay home with their own children was a major reason for caregiving, and an additional 11.6 percent indicated that this was somewhat of a reason.

Table 10-1. Reasons Providers Decided to Provide Care for Focal Family (Percentage Distribution) – n=303

	Major Reason	Somewhat of a Reason	Not a Reason
Wanted to help out focal family	89.7	8.6	1.7
Enjoy caring for focal family children	88.8	8.9	2.3
Enjoy helping children in focal family learn	87.5	10.9	1.7
Wanted focal family's children cared for by a family member	65.9	12.2	21.8
Expected to be role model for focal family's children	60.7	30.7	8.3
Wanted to provide structure and discipline for focal family's children	56.1	30.0	13.5
Wanted focal family's child raised as provider thought desirable	54.5	25.4	19.8
Needed to earn money	26.7	36.0	37.0
Allowed provider to stay home with own children	25.1	11.6	63.0
Already caring for children in other families	17.5	15.2	66.7
Wanted to explore new career direction	17.2	24.1	58.1
Only job provider could find	7.3	12.9	79.9
Felt pressure from focal family to help out	6.9	8.9	84.2
Needed a job because of TANF or welfare work requirements	4.3	5.9	89.4

Respondents also were asked which of the motivations they had reported as major reasons for caregiving was the most important. While the results presented in Table 10-2 suggest a fairly disparate set of most important reasons, they nonetheless are consistent with the themes of helping families and their children in various ways. A desire to help out the focal family was reported as most important by 19.8 percent of providers, followed by 15.5 percent who emphasized wanting the focal family children to be cared for by a family member. Five child-centered reasons were mentioned as most important by 5-12 percent of respondents: enjoy helping children in the focal family learn (11.9 percent), enjoy caring for focal family's children

(9.9 percent), wanted to provide structure and discipline (9.9 percent), expected to be a role model for the focal family's children (8.3 percent), and wanted the child raised in the manner the provider thought was desirable (5.0 percent). Taken together, one of these seven family or child-centered motives was mentioned as the most important caregiving reason by 80.3 percent of respondents.

Table 10-2 also compares the motivations of providers who were related to a child in the focal family or not. As would be expected the greatest difference was in the large number of related providers (20.0 percent) who said their most important motivation was wanting the focal family's children cared for by a family member. The distribution of other motives between these two provider types was quite similar. The greatest differences were that non-relative providers were slightly more likely to report motives of wanting to help out the focal family, enjoying helping children in the focal family learn, and enjoying caring for the focal family children.

Table 10-2. Most Important Reasons License-Exempt Providers Reported for Caring for Focal Family Children, by Relationship to Family (Percent Distribution)

	Percentage of:		
	All Providers (n=303)	**Relative Providers (n=230)**	**Non-Relative Providers (n=71)**
Wanted to help out focal family	19.8	18.7	22.5
Wanted children cared for by family member	15.5	20.0	1.4
Enjoy helping children in focal family learn	11.9	10.9	15.5
Enjoy caring for focal family children	9.9	8.7	12.7
Wanted to provide structure and discipline for focal family's children	9.9	10.0	9.9
Expected to be role model for focal family's children	8.3	8.3	8.5
Needed to earn money	5.6	5.2	7.0
Wanted focal family's child raised as provider thought desirable	5.0	4.8	5.6
Allowed provider to stay home with own children	4.0	3.5	5.6
Felt pressure from focal family to help out	1.7	1.7	1.4
Wanted to explore new career direction	1.0	0.9	1.4
Already caring for children in other families	0.7	0.9	0.0
Only job provider could find	0.3	0.0	1.4
Needed a job because of TANF/welfare requirements	0.0	0.0	0.0

General Reasons for Caregiving

Providers were asked more broadly what it was that they liked best about caring for children other than their own. The nature of this questioning differed in two important respects from the questions on which analyses in the previous section were based. First, questions on general caregiving motivations were not specific to the focal family, with the intent to obtain more general caregiving perspectives. Second, the questions were asked in an open-ended manner, which allows the presentation of greater depth of response on caregiving motivations in the respondents own words.

These open-ended responses were coded, and the most frequent response categories are presented in Table 10-3. Providers most often offered general statements about the enjoyment they experienced through caring for children, with 46.9 percent making such references. The following examples reflect the positive feelings that this large group of providers had with respect to caregiving.

"I just love working with kids."

"They are just a delight."

"I just love being around kids – just the enjoyment they give."

"You learn a lot from them."

"The time spent with other children is a joy."

Table 10-3. What Providers Liked Best About Caring For Children Other Than Their Own

	Percentage of All Providers
Enjoy caring for children –general	46.9
Want to help out families or their children/provide proper care	39.1
Interested in teaching or working with children	28.6
Provider work-related or personal needs	11.9
Personal fulfillment or companionship	9.5
Other	11.9

Note: Percentages total to over 100 percent, because providers could offer more than one reason.

Two other most positive aspects of caregiving were most often mentioned. Nearly two-fifths (39.1 percent) of providers offered statements indicating a desire to help families, or else to

assure that children were well cared for. Most prominent among this group were those who indicted positive aspects of caring for a related child or helping out a related family member (21.4 percent of all providers). A smaller subset (9.5 percent of providers) more generally expressed satisfaction in helping families in need while others stressed their role in providing proper care for children (8.2 percent of providers). This latter group mentioned factors such as providing a safe environment or a home-like setting. In some cases, concerns with properly caring for children appeared to be elevated by the fact that the caregiver was related to the family member receiving care. Following are illustrations of each of these most liked aspects of caregiving.

Helping Out Related Family or Caring for Related Child

> "Being able to help my mom so she feels comfortable and has no worries while at work."
>
> "Helping my sister out so that she can keep her job."
>
> "I get to care for my grandchildren, while my daughter betters herself to provide for her children. It helps people provide for their kids."
>
> "The fact that I know I am helping my sister succeed in life."
>
> "They are my grandkids, and I get to see them and spend time with them."

Helping Families in Need

> "[I'm] doing it to help mothers who have trouble finding day care."
>
> "I like it because it gives parents time to do what they need to do."
>
> "Helping people who are trying to complete something in their life."
>
> "I like to help women or parents that need child care for their children. I enjoy helping out with parents that are working or in school. I enjoy helping out others."
>
> "I will be able to help a struggling young mother who is trying to help herself and her babies."

Proper Care for Children

> "I feel that it is hard for young parents to find safe environments for kids to stay in, and she can do that [with me]."
>
> "I like knowing that the children are not being mistreated."
>
> "This is my first grandbaby, and I don't want anything to happen to her."
>
> "I wanted my grandchildren raised right – like I did their mother."

Another large group (28.6 percent of providers) offered a response that indicated an interest in working with or teaching children. Many of these responses stressed the opportunity

to engage children one-on-one. Common developmental concerns such as teaching children the alphabet or numbers or helping children with homework were included among these comments. However, providers also frequently spoke about broader aspects of teaching children, such as helping children learn about their neighborhoods or providing positive role modeling for children.

"I love to see how they develop and grow … I like teaching them."

"I like kids. They listen to me. I like helping them with their homework."

"I like helping them with their homework and teaching them about the neighborhood."

"Raising them to be good people and being in a loving household."

"I am a good father figure for the kids."

"[I have] the chance to teach them ABCs and 123s."

Two additional best-liked aspects of caregiving were reported by about one-tenth of providers. First, 11.9 percent cited caregiving reasons related to their own work-related or family needs. Most prevalent in this group were the 5.4 percent of providers who simply indicated that caregiving had provided them with a needed job. Smaller numbers mentioned being able to provide care in their own home, as well as the opportunity to have their own children interact with other children while they provided care.

"The extra money helps me pay my bills on time."

"I am going to keep my children so they can be well cared for."

"I know how to do it well and I can do it at home."

"It's a job, and I love teaching my cousins about schooling and respect, and it gives me time for my own child."

"[You get to] spend time with your own children while keeping them."

"Besides the pay the kids get along with my kids and have each other to play with."

Finally, 9.5 percent of providers emphasized that caregiving offered some type of personal fulfillment. Included in this group were those who spoke of caregiving in terms of fulfilling a need to keep busy. In addition, small numbers of providers mentioned the satisfying companionship that caring for children offered.

"I've been taking care of children for 40 years and I love it. It keeps me feeling young and energetic."

"I like being around children – they make me feel young."

"Kids keep me active – I like being around kids. Kids keep me up to date on life."

"Since my kids are grown now, it makes me miss taking care of younger ones."

"I always did like kids, and being around them keeps me busy."

Differences between Study Areas and Provider Types

Few significant differences in the provider motivations were found either study areas. North and South Lawndale providers were much more likely to report feeling pressure to help out the focal family as a reason for providing care. That is, 32.3 percent reported this as a "major" or "somewhat" of a reason, as compared to 11.8 percent in Peoria County and 15.8 percent in the Southern Seven area. North and South Lawndale providers also were significantly more likely to indicate that care provision was the only job they could find (28.6 percent versus 22.6 percent in Peoria County and 10.5 percent in the Southern Seven area). Given the economically distressed nature of the North and South Lawndale communities, these findings suggest the need for further investigation of the impact of community economic circumstances on the supply and motivations of caregivers.

Only one significant difference of interest was found by provider type. As expected, relative caregivers were much more likely to suggest that the most important reason they provided care was to assure that the focal family's children were cared for by a family member. One-fifth of relative providers cited this as their most important caregiving motivation.

Chapter 11:
Parent and Provider Perceptions About Child Care Goals and Quality Issues

Past research has found that providers' beliefs about children's learning and the role they play in supporting those beliefs are related to the quality of care they provide. However, child care quality factors often are quite broad and multi-dimensional, and neither the relative importance of individual beliefs nor the dimensions of particular beliefs have been well-established. Therefore, we asked parents to indicate which of seven quality factors identified in previous literature, and which comprise many global quality ratings scales, were most important to them in assuring that the focal child was well-cared for. We also asked parents to explain what each quality factor that they identified as most important meant to them.

Even less is known about license-exempt provider beliefs on quality care factors. Consequently, we asked providers the same questions on caregiving quality factors, with respect to the focal child. This allowed analysis of provider perspectives on this important aspect of care, as well as comparisons between parent and provider perspectives in relation to the same child. In addition, we asked provider questions about the goals they had in supporting the development and learning of the focal child in their care.

Parent and Provider Quality of Care Concerns

Qualities Selected as Most Important

Parents and providers were asked which three of the following seven qualities were most important to them in assuring that the focal child was well cared for: safety, health, learning activities, positive relationships with other children, positive parent-provider relationships, positive child-provider relationships, and caregiver training or experience. To guard against potential list order effects, the order in which these seven qualities was presented to respondents was randomized.

Table 11-1 presents parental and provider responses regarding most important quality of care concerns. A positive relationship between the provider and the child (68.3 percent of parents) and safety (67.6 percent) were the most commonly emphasized qualities by parents. The only other quality selected among the most three most important by over 50 percent of parents was a positive relationship between the parent and the provider (54.4 percent). Interestingly, two qualities often stressed as important for child outcomes in the child care literature – learning activities and the training and experience of caregivers – were among those qualities selected least often (28.6 percent and 23.7 percent, respectively).

Providers as a group similarly emphasized safety as an important concern, with 76.9 percent selecting this quality as one of the three most important. However, they were considerably less inclined to choose either positive parent-provider relationships or positive child-provider relationships as one of the three most important qualities. For example, 42.8 percent of providers selected a positive child-provider relationship (compared to 68.3 percent of parents), while 37.2 percent chose a positive parent-provider relationship (compared to 54.4 percent of parents). In contrast, they were more likely than parents to select health concerns (45.2

percent versus 30.0 percent of parents), learning activities (36.6 percent versus 28.6 percent of parents), and a positive relationship with other children (37.6 percent versus 22.3 percent of parents). They were similar to parents in the lack of emphasis they placed on training and experience, with only 17.2 percent selecting this quality among their three most important.

While the preceding discussion has centered on the importance of these qualities to parents and providers as separate groups, a related issue concerns the extent to which parents and providers agree on these qualities when considering care for the same child. The right hand columns in Table 11-1 consequently present information on the percentage of the parent and provider survey pairs who were in agreement in terms of selecting these qualities among their three most important when considering care for a common focal child. The "total agreement" column considers parents and providers to have agreed if both selected the quality among their three most important or if neither did. The "both selected" and "neither selected" columns are subsets of the "total agreement" column, with the former indicating that both parent and provider selected the quality among their three most important and the latter indicating that neither did.

Table 11-1. Parent and Provider Perceptions on Qualities Considered Most Important for Assuring Focal Child Is Well Cared For (Percentage Distribution)

	Selected As One of Three Most Important Qualities by:		Percentage Agreement by Parent-Provider Pairs (n=286)[1]		
	Parents (n=287)[1]	Providers (n=290)[1]	Total Agreement[2]	Both Selected[2]	Neither Selected[2]
Positive child-provider relationships	68.3	42.8	51.4	31.1	20.3
Safety	67.6	76.9	62.6	53.5	9.1
Positive parent-provider relationships	54.4	37.2	53.5	22.7	30.8
Health	30.0	45.2	54.2	14.7	39.5
Learning activities	28.6	36.6	61.2	13.3	47.9
Caregiver training/ experience	23.7	17.2	66.4	3.8	62.6
Positive relationships with other children	22.3	37.6	54.9	7.3	47.6

[1] The number of cases for this analysis is slightly less than for other tables due to missing cases associated with problems in matching the focal child for parents and providers. In addition a small number of parents and providers did not reveal their three most important preferences.

[2] The "Total Agreement" percentage is based on the percentage of all parent and provider pairs that agreed whether the quality in question was or was not one of the three most important. The "Both Selected" and "Neither Selected" columns add up to this "Total Agreement" percentage.

As shown in Table 11-1, parent-provider agreement with respect to whether or not a quality was selected among the top three most important exceeded 50 percent for each of the qualities. Agreement was highest with respect to caregiver training and experience, with 66.4 percent of the parent-provider pairs in agreement on this quality. As can be seen from the "both selected" and "neither selected" columns, this agreement stems largely from the fact that neither the parent or provider in the pair selected this quality as most important (62.6 percent of pairs). Over three-fifths of the provider-parent pairs also were in agreement with respect to safety (62.6 percent) and learning activities (61.2 percent).

Further examination of the "both selected" and "neither selected" columns in Table 11-1 provides useful insights into the nature of parent and provider agreement on the care qualities. For example, the table shows that safety was the only quality that a majority (53.5 percent) of the parents and providers each selected among their three most important. The only other qualities that at least one-fifth of providers and parents both selected among their top three choices were positive child-provider relationships (selected by 31.1 percent of parent-provider pairs) and positive parent-provider relationships (22.7 percent).

Given the national policy debates on the importance of provider training and experience and learning activities for children in order to promote positive developmental outcomes for children, the findings on the relative importance of these factors to parents and providers are especially interesting. Only 3.8 percent of the parent-provider pairs each selected caregiver training and experience among their three most important care qualities, while 13.3 percent both selected learning activities. While this does not necessarily suggest that parents and providers consider these care attributes unimportant, it is clear that large numbers of those surveyed viewed these qualities as subsidiary to more basic safety and personal relationship issues.

Differences in Quality Ratings by Region, Age of Focal Child, and Provider Relationships

Separate analyses were conducted to determine if the results on quality concerns varied significantly by selected sample characteristics. Few regional differences in the selected quality indicators were significant. Among parents, learning activities were selected significantly less often in the Southern Seven area (17.3 percent selected versus 31.0 percent in Peoria County and 38.5 percent in North and South Lawndale). In contrast, the importance of positive relationships between the focal child and the provider was emphasized more often in the Southern Seven area (77.9 percent versus 69.0 percent in Peoria County and 57.3 percent in North and South Lawndale). Among providers, learning activities were selected more often in the North and South Lawndale region (46.3 percent versus 35.2 percent in the Southern Seven area and 27.8 percent in Peoria County).

The qualities selected also were analyzed according to whether or not the provider was related to the children in care. For parents, the percentages selecting various qualities varied significantly for only two qualities. Parents using non-related providers were significantly more likely to select learning activities among their top three quality concerns (41.5 percent versus 24.4 percent for those using a relative provider). They also were more likely to emphasize the importance of positive relationships with other children (35.4 percent versus 18.6 percent).

It is notable that neither of these two differences were significant when examined from the provider perspective. In fact, only one quality was significant in terms of whether the provider questioned was related to the children in care or not. That is, providers related to children in care were significantly more likely to select positive relationships between the parent and provider than those not related to children in care (40.3 percent versus 25.4 percent).

Finally, differences in the qualities selected were examined according to the age of the focal child, with the ages <1, 1 < 2.5, 2.5 < 6, and 6 and over used as categories. Only the selection of safety among parents approached significance with respect to these age of child categories (p=.057). The percentage of parents who selected safety as a concern increased with age, from a low of 43.8 percent for infants to a high of 73.3 percent for those age six and over.

Among providers, there was only one significant difference with respect to the age of the focal child. Providers were significantly less likely to select learning activities as a quality concern for children under age one. While none of the providers serving the 16 focal children under age one selected learning activities among their top three quality concerns, over a third of providers serving all other age groups did so (36.0 percent for focal children age one to less than two and one-half, 39.1 percent for focal children age two and one-half to less than six, and 40.6 percent for focal children age six and over).

Overall, these differences according to selected sample characteristics seem quite minimal. In addition to the lack of any significant differences on the vast majority of items, no single quality differed significantly from both the parent and provider perspective. In this sense, the findings on quality issues appear fairly stable in terms of region, age of focal child, and whether or not the provider was a relative. The one limitation that should be noted in this respect is the relatively small number of infants included in the sample.

Exploration of the Qualities Considered Most Important

As previously mentioned, broad qualities such as safety and health may have many dimensions, so both parents and providers were asked to explain what they meant by each of the three qualities they selected as most important. These open-ended responses then were coded to categorize the aspects of each quality that parents and providers articulated. The following sections elaborate upon each of these qualities based on these parental and provider responses, with quotes from parents presented to illustrate the most common response types.

It should be mentioned that some respondents discussed these qualities in terms of what they thought was most important or desirable, while others personalized these qualities to practices actually carried out by their current provider. Because coding distinctions between such desired and actual practices often were difficult to make, we coded responses substantively as desirable practices/attributes without trying to distinguish the extent to which these were occurring in the current care situation. Further discussion of parent and provider perspectives on the actual care situation in which they were mutually engaged is provided in the following chapter (Chapter 12).

Safety

Among the seven child care qualities presented to parents and providers, safety was given the greatest emphasis as a child care quality (see Table 11-1). In discussing what they meant by safety, parents and providers specified many different dimensions, with both general and specific safety concerns receiving some prominence

Parents and providers most often offered general comments about the importance of safety or about their confidence that the child was being cared for safely. In these cases, specific details on aspects of safety considered most important were not mentioned. However, especially among parents, these comments often included references to the fact that the provider was a relative and/or that the parent trusted the caregiver to keep the child safe. Consequently, while the comments do not emphasize specific safety related issues, they generally reflect confidence in the provider's inclination and ability to safely care for the child. Following are selected comments illustrating such broad safety concerns.

Parents

"I know with my provider, my kids won't get hurt and will be safe away from danger."

"Safety is very important when I leave my children. I know my mother will keep them safe from harm."

"I want them in a safe environment – free of harm."

"It is my mom caring for them, so I trust her to keep him safe."

Providers

"I keep them from being around what could hurt them. I know they are safe."

"Keeping him safe from harm is a major goal a provider should have."

"I am her [parent's] mother, and she knows her kids will be safe. She knows they are well taken care of."

Another group of respondents also was quite general in talking about safety issues, except that they emphasized the importance of provider attentiveness in preventing harm to children. These parents and providers generally spoke of how closely the provider watched the child, and of how such attention was necessary to assure safety.

Parents

"She is more individually watched, so she does not get into harmful situations."

"She makes sure nothing happens to them – keeps a close eye on them."

"The children can do outside things because the provider watches them."

Providers

"I make sure they are safe at all times by continuing to watch them."

"I stay focused on the child and am careful where they play."

"I watch them like a hawk, so they don't do anything silly or get hurt."

More specific safety concerns generally fell into two categories. First, one group of parents and providers emphasized the importance of protecting children from specific dangers in the household or immediate outside surroundings, as opposed to dangers presented by other persons. These comments addressed issues such as the physical safety of the home or the need to protect children from getting into things that could be harmful. Following are a few examples of these types of concerns.

"You know a lot of people, sometimes their houses have stuff that kids can get into and get into trouble, like poisons and stuff. My mom's house is childproofed." (parent)

"The house is safe – nothing they can get into. They know their boundaries." (parent)

"Keep kids away from things in the house, [such as] electrical outlets, and keep them out of the street and remind them of their surroundings." (provider)

"Making sure things are out of the way – cigarette lighters, knives, etc. [Have] gate at the bottom of the stairs. Make environment safe." (provider)

A second group mentioning specific safety concerns emphasized the need to protect children from other people, or more generally from bad influences. These comments included concerns about protecting children from providers who might somehow harm them, as well as other dangerous persons. In addition, several respondents mentioned the quality of the neighborhood as being important in protecting children from such bad influences. Examples of each of these concerns follows.

"He needs to be kept away from people doing drugs." (provider)

"To ensure that they are not with strangers. I watch them when they are outside."(provider)

"Someone to help my sons stay away from peer pressure and to watch my girls." (parent)

"I don't trust day care type programs, because there are too many children. The caregivers are strangers." (parent)

Although the specific safety concerns noted by parents and providers followed similar patterns, one area of difference is notable. That is, a sizable subset of providers (11.0 percent of those selecting safety as a quality concern) talked about the role they played in teaching children about how to be safe, while such a teaching role was mentioned by only a few parents.

Health

Health was the second most often selected quality concern by providers, and the fourth most frequently selected issue by parents. In discussing what they meant by the importance of health while the child was in care, three types of response were most common. First, many parents and providers spoke generally of the provider's role in protecting children from illness or injury, through the care that they provided. Second, others similarly mentioned the preventive role that providers played in protecting children's health, but spoke of more specific personal care practices in this respect. Providing children with proper food and nutrition was most often mentioned in this respect, and some respondents also noted the importance of cleanliness and grooming. Selected examples of responses falling into each of these categories follow.

General Health

"I know my child's health and well-being is fine with my mom." (parent)

"She would do anything she can to keep her well." (parent)

"Anytime you give child care, you want to make sure their health is first and foremost." (provider)

"I don't want to see her down or unhealthy. Health is the most important thing." (provider)

Personal Care

"Whatever he sees, he eats. So I need to make sure that he eats better and he's really energetic." (provider)

"Making sure [child] gets nutritional needs and takes care of herself – exercise and proper rest." (provider)

"Eating right, wearing proper clothing, making sure kids are not climbing all over the place." (provider)

"She takes care of them – fed, bathed – everything I do she does." (parents)

The third common type of health response focused more specifically upon what the provider did or should do to care for children experiencing health problems. A wide array of responses fell into this category. For example, some respondents spoke generally about how the provider must understand the child's health problems or needs, and/or must know how to

respond to whatever health problems the child may have. Others emphasized the role of the provider in taking care of children when they were sick, taking them to the doctor, knowing what to do if a health emergency occurred, and communicating with parents about the nature of any illnesses or injuries they observed. Following are some examples of this type of response.

> "He knows their medical history and what to do in an emergency." (parent)
>
> "If they are sick or anything, she calls me right away and lets me know I need to get medicine if she has run out of it. And I trust her with their health since she raised me." (parent)
>
> "Anytime [the child] is sick or anything, she calls me right away or lets me know." (parent)
>
> "My kids have asthma and take medicine daily. He sees that they get their medication." (parent)
>
> "If he gets sick, we care enough to take care of him." (parent)
>
> "I think its important when they [parents] are younger to be surrounded by someone who will take care of their immunizations and other things." (parent)

Only four other types of response were mentioned by at least five parents or five providers. The importance of a clean and healthy house or environment, or of the provider being clean, was mentioned most often among these four categories. Though rarely mentioned by providers, eight parents stated that the health of the provider was an important issue when considering health as a quality issue. Some parents also mentioned non health-related provider qualities in their discussions of health quality, such as trustworthiness or responsibility. Finally, a small subset of providers stressed their role in talking with children about their health or in teaching them about sanitation and keeping clean.

Learning Activities

Learning activities were selected as one of the three most important quality concerns by 28.6 percent of parents and 36.6 percent of providers. About one-third of these parents and a smaller subset of these providers made general statements indicating the importance of the child learning while in care or of the provider teaching the child. In these cases, specific learning goals or activities were not specified.

> "I want him with someone who is also interested in teaching him." (parent)
>
> "It is important because she gets to learn with her provider. Some places don't teach." (parent)
>
> "He helps him learn a lot of new things, and this is important today." (parent)
>
> "They are at the stage that they need to be exposed to as many activities as possible." (provider).

More commonly, parents and providers referred to specific learning activities or goals. For example, over a fourth of those mentioning learning activities stressed the role that providers played in helping children with homework or school-related activities. Similar numbers referred to work that was done with younger children, such as teaching them how to read and write, count and do math, identify concepts, develop motor skills, walk, and dress themselves. Following are some examples.

School-Aged Learning Activities

"She helps them with their homework better than I can." (parent)

"He teaches them. He has cards that he goes over with them and helps them with homework and stuff." (parent)

"It's important to learn to function in school. I help with homework." (provider)

"I teach them how to prepare for school and how to do homework." (provider)

Preschool-Aged Learning Activities

"She works with them – teaches them to read and write. She reads and plays games with them." (parent)

"She teaches the youngest the alphabet, colors, shapes, sizes, and math." (parent)

"Learning his ABCs and how to count, riding a tricycle, and throw a ball." (provider)

"Helping the child learn by teaching him how to count and read. Also, the child should be taught how to play well." (provider)

Another large subgroup spoke of educational and recreational opportunities and resources that were provided to children in care. These included specific references to activities and resources that were viewed as educational, such as books, learning games, and computers. This group also referenced activities that appeared to be more recreational in nature, but which often also had an educational component. Examples of these activities include working with children to develop hobbies, providing games and toys, taking children to parks, teaching or helping children participate in sports, providing videos, and engaging children in art or music.

"I help them learn how to play sports and have hobbies." (provider)

"We play learning games to challenge the kids." (provider)

"Just have different games and a computer [child] can play on." (parent)

"The kids have games to help them to count, read, and spell – she helps them." (parent)

A smaller group of both parents and providers viewed learning activities in terms of the roles that providers played in teaching children about values, morals, and life skills. A few examples are illustrative in this respect.

"My mom teaches them life skills." (parent)

"She is teaching the kids great morals (parent)

"I teach them discipline and respect for others." (provider).

"I try to instill good qualities that will help them out in life – courtesy, respect." (provider)

One notable difference in the parent and provider responses concerned the greater frequency with which providers referenced the need to prepare children for school and learning. Comments including such references were made by over one-fourth of providers who mentioned learning activities, but by relatively few parents. It is possible that parents simply assumed that this was a reason for stressing learning activities when making general comments about their importance, but the greater expressed importance in preparing children for school among providers nonetheless was interesting.

"It is important to me that she be prepared to succeed in school." (provider)

"Preparing [child] to get in the habit of doing things she will need to do in school." (provider)

"Learning for the beginning of preschool and to be advanced so he can keep up with other kids going in." (provider)

Positive Child-Provider Relationships

The existence of a positive relationship between the provider and the child was the most frequently mentioned quality care concern of parents (68.3 percent). This attribute was less commonly mentioned by providers (42.8 percent), but nonetheless was the third most frequently selected quality among this group. Both parents and providers mentioning this quality concern most often spoke generally of the importance of the provider and the child interacting well together or "getting along". Approximately three-fifths of each group noted such general considerations when speaking about the importance of child and provider relationships. While these comments most often were framed in terms of a mutual interaction, some focused more upon the need for the child to be comfortable with or to like the provider. In some cases, these respondents suggested that such relationships were a prerequisite to the child benefiting from being in care. The following comments are typical of those who offered general comments on providers and children getting along well.

Parents

"She knows more about them than strangers. They love and trust her."

"My kids know they are loved. The provider makes them feel very comfortable in her home."

"My kids love her, and they really get along well with her and her children."

"The positive relationship shows in the children's behavior. It helps them get into learning. It helps them learn."

"They love being at her house, and this makes me feel good."

"My mom has a good relationship with the kids. She's very understanding and active with them – even for 50 some years old. She loves them."

Provider

"The child has to have a good relationship with the provider or they will not be willing to obey or feel loved."

"It's important they know I really care about them."

"He doesn't have to be afraid of being harmed or anything."

"I want to assure him that he is in good hands with grandma."

"If the child doesn't like you, it will be damaging to both parties, especially in the formative years. I don't want the child to have a negative reaction to adults."

Another large subgroup of parents referenced child and provider relationships more specifically in terms of the preexisting relationships between them, which often were seen as providing a positive comfort level for children as they entered care. Most prominent in this respect were the one-fourth of parents mentioning child-provider relationships who stressed that the provider was related to the child. Other parents noted that the provider and child knew each other before the provider became a caregiver for the child. Providers noted this attribute of provider and child relationships much less frequently.

A final aspect of child and provider relationships, which was noted more often by providers than by parents, concerned the role of providers in teaching respect or discipline or in serving as role models for the children in their care. Closely related to such a teaching role was a small subset of responses that indicated that the child looked up to the provider. Collectively, about one-fifth of providers offered a comment on some aspect of teaching or role modeling, while parents offered such comments much less frequently.

Parent-Provider Relationships

Parent and provider relationships were selected as one of the three most important quality concerns by 54.4 percent of parents and 37.2 percent of providers. In discussing how such relationships were important in the context of child care quality, general comments about how positive relationships were needed to foster good care for the child were most common among

both parents and providers. Parents often framed their comments in terms of a positive relationship serving as the foundation for trusting the provider to care for the child well. Parents also frequently noted that the provider was a relative, while such references were less common among providers. The following examples are illustrative of comments on the general importance of positive relationships between parents and providers.

> "Because we have a good relationship, I know everything will be all right there." (parent)

> "She understands me and I feel we have always been close, and I trust her more than anyone else." (parent)

> "As long as we have a positive relationship, I know he'll care for my children well." (parent)

> "I feel it is very important for us to get along. We have an open relationship. She will tell me anything about the kids." (parent)

> "We were raised in the same household together and trust each other." (provider)

Providers were much more likely to specifically mention the importance of communications between parents and providers to the care of the child, with nearly two-fifths of providers who selected positive parent-provider relationships describing aspects of communications. Practices such as agreeing to a plan for caring for the child, being consistent in the way that parents and providers respond to the child, supporting each other's decisions with respect to the child, and talking about any care issues that arose all were included in this communications category.

> "The parent gets a report on what the child did during the week – she can talk to me at any time." (provider)

> "She and I discuss everything about her child, [such as] moods and disposition." (provider)

> "If the parent and the provider get along really well and talk about the child's needs, this would work out better for the child." (provider)

> "You and the parent have to have a relationship. Those are her children and the two of you must agree on their care." (provider)

> "If there is a problem, we will both know what is going on." (provider)

Finally, a smaller subset of respondents thought that the child benefited from observing a positive relationship between parents and providers. In some of these cases, the perceived benefit

of the positive relationship was that the child would feel more comfortable while in care. In other cases, which generally involved relative care, the positive parent-provider relationship was viewed as promoting a positive model of family relationships for the child.

> "It is more comfortable for the children to be there if they know we get along." (parent)

> "If he sees his mother and I have a positive relationship, it will show him that he can have a positive relationship with others as well." (provider)

> "If the parent and provider can get along, we can show her some family life is needed." (provider)

Positive Relationships with Other Children

Positive relationships with other children was among the least often selected qualities, but nonetheless was chosen among the top three by 22.3 percent of parents and 37.6 percent of providers. In discussing such relationships, most parents and providers spoke generally of the importance of children being able to interact with and get along with other children. In addition, specific values perceived to be gained from interactions among children sometimes were mentioned. These included practices such as learning to share with other children, to respect others, to appreciate different ethnic backgrounds, and to help others. A sizable subset of providers also emphasized the importance of children learning not to fight with others or to control their tempers. Finally, the need for children to develop friendships and to bond with others also occasionally was mentioned when discussing positive interactions among children. The following comments illustrate these concerns.

> "She [the provider] has other children, and kids are taught to get along together." (parent)

> "My mother teaches them to play well with other children – how to share and take turns." (parent)

> "Since there are other children to play with, it teaches them sharing and respect." (parent)

> "I want to teach him to play well, and have fun with other children." (provider)

> "He must learn to socialize so he can get along with people all through his life." (provider)

> "The way they interact with children now is the way they will react when they are older, so they need to be taught how to react with them now." (provider)

> "You want the children to be able to play and not fight with other children; children need to interact and share." (provider)

"To learn to play positive, learn to share, and not fight over toys." (provider)

Training/Experience

Training and experience was the least often selected quality by providers, and the second least often selected quality by parents. Even among this relatively small subset of respondents, what is most notable about the open-ended responses is how few parents and providers mentioned any type of professional training and experience. For example, of those parents who mentioned training and experience as a quality concern, only about 14 percent offered a response that could be interpreted as emphasizing professional experience and only 6 percent mentioned either child care training or higher education. Similarly, only about one-tenth of providers who selected experience and training among their most important quality concerns described any type of professional experience or training in their open-ended descriptions.

Much more common was reference to the fact that providers had considerable experience in caring for children. About two-fifths of the parents and providers who selected training and experience offered a response that suggested that providers had or should have experience in caring for other children, or that providers knew how to care for children well. Some of these cases may have involved care in licensed settings, although this could not be discerned from the responses. Following are selected comments in this respect.

"My sister has taken care of children for a long time, so I know she is good with kids." (parent)

"She has had many children before, raised three children of her own, and is older." (parent)

"I have been babysitting for over 50 years. I know what patience and caregiving is needed for children." (provider)

"I have real good education and experience in child care. I've kept kids all my life." (provider)

Two related response categories were offered by substantial numbers of the subset of parents and providers who selected training and experience. First, over one-fifth of these parents and one-tenth of these providers indicated that the provider had their own children or else already had raised their own children. Second, nearly a fifth of these parents indicated that the provider had raised either them or another family member, or that the parent had raised the provider. Following are some examples of these perspectives.

"My mother has raised three children, and I think she is well experienced." (parent)

"My mom did a great job with me, so I know how much experience she has – I turned out O.K." (parent)

"My mom has a lot of knowledge about kids – she raised six of us." (parent)

Collectively, these responses indicate that formal training and experience did not rate very highly among the quality concerns raised by parents and providers. Even among the relatively small group who selected this attribute as one of their three most important quality concerns, attention tended to focus on experience in caring for their own or other children. Nonetheless, this does not necessarily suggest that parents using license-exempt care and their providers are not amenable to child care training, an issue to which we will turn in Chapter 13.

Provider's Role in Supporting Developmental Goals for the Focal Child

Providers were asked a series of 11 questions that have been used in other studies to assess family child care provider beliefs about their role in supporting the developmental goals of children. Each question asked providers to use a five-point scale to rate how important each development goal was for them to support when caring for the focal child, with 1 being most important to 5 being least important.

Table 11-2 shows that the average provider ratings on each of these 11 questions were between 1.11 and 1.63, indicating that providers typically viewed each of these developmental goals as very important. The two most highly rated developmental goals were to keep the child safe from harm and to make the child feel loved (1.11 and 1.13 average scores, respectively). Four qualities pertaining to the child's self esteem and interactions with others received average ratings of 1.22 to 1.28. These included help the child learn to obey adults, help the child learn to get along with other children, encourage the child to like himself or herself, and help the child learn to get along with adults. Helping the child learn skills to encourage school success also received an average score of 1.22.

Providers rated helping children understand their own cultures and backgrounds, as well as appreciating other ethnic and cultural groups, slightly lower (1.44 and 1.49 average scores, respectively). Giving the child a home away from home similarly received an average rating of 1.49. Finally, the lowest average rating was given to helping children learn to take care of toys and other things (1.63).

Providers were reminded by the interviewer of each of the developmental goals they rated the most highly (i.e., given a score of 1), and then asked to select which one they considered most important. As shown in Table 11-2, making the child feel loved was easily the most often selected developmental goal (36.1 percent of providers). Four other developmental goals were selected as most important by at least 8 percent of providers: keep the child safe from harm (14.2 percent), help the child learn skills that will encourage school success (10.6 percent), help the child learn to obey adults (8.6 percent), and encourage the child to like himself or herself (8.3 percent).

Differences in Provider Care Developmental Goals by Region, Age of Focal Child, and Provider Relationships

As for the quality of care concerns discussed earlier, separate analyses were conducted to determine if the provider developmental goals differed significantly by region, age of focal child, and whether or not the provider was related to the child. These tests revealed no significant

differences with respect to the average score ratings on any of the provider care developmental goals according to these characteristics. Comparable analyses based on the ranking of the single most important developmental goal resulted in significant differences only according to whether the provider was a relative or not. Relative caregivers were more likely than non-relative providers to rank making the child feel loved as their most important developmental goal (38.0 percent versus 29.6 percent), while non-relative providers more often selected keeping the child safe from harm as their most important care developmental goal (23.9 percent versus 10.9 percent).

Table 11-2. Provider Developmental Goals for Focal Child While in Care

	Average Score[1] (n=303)	Percentage Ranking This Developmental Goal as the Most Important (n=303)
Keep child safe from harm	1.11	14.2
Make child feel loved	1.13	36.1
Help child learn skills that will encourage school success	1.22	10.6
Help child learn to obey adults	1.22	8.6
Help child learn to get along with other children	1.25	4.6
Encourage child to like himself/herself	1.26	8.3
Help child learn to get along with adults	1.28	4.6
Help child appreciate own culture, religion, or family background	1.44	0.7
Give child a home away from home	1.49	4.3
Help child appreciate other ethnic/cultural groups	1.49	3.3
Help child learn to take care of toys/other things	1.63	0.3
Don't know/refused	NA	4.3

[1]Questions were asked using a 1-5 Likert scale, with 1 denoting most important developmental goal. Therefore, lower average scores represent higher levels of importance.

Chapter 12:
Relationships Between Parents and License-Exempt Caregivers

Relatively little research has been conducted about the nature of interactions between parents and license-exempt providers in the caregiving context. Yet, it sometimes has been speculated that the less formal nature of these caregiving arrangements may result in strains in relationships between parents and caregivers. Even less is known about the frequency and nature of disagreements that parents and caregivers may experience, or about how any such differences may be resolved.

This chapter examines perceptions about relationships between the family and provider related to the care of the focal child. We begin by providing parent perspectives on their satisfaction with the focal child's care by the provider, and correspondingly present provider satisfaction levels with this caregiving situation. Both parent and provider views on the most positive and negative aspects of caregiving for the focal child also are assessed. We then examine parent and provider views on how the caregiving interaction has affected their relationship, as well as their responses to questions on care-related disagreements.

Overall Satisfaction with Caregiving for Focal Child

Both parents and providers were asked how satisfied they were with the main provider's caregiving for the focal child – very satisfied, somewhat satisfied, somewhat dissatisfied, or very dissatisfied. Reported satisfaction was extremely high for both parents and providers (Table 12-1). Over 98 percent of parents indicated that they were very satisfied with the care being provided to the focal child by the main provider. The providers were only slightly less satisfied, with 94.5 percent stating that they were very satisfied. Taken together, in 93.1 percent of the parent and provider pairs, both the parent and the provider indicated that they were very satisfied with the caregiving situation with respect to the focal child. In an additional 6.2 percent of the pairs, either the parent or the provider was very satisfied and the other was somewhat satisfied.

These extremely high levels of parent and provider satisfaction raise obvious questions with respect to possible selection effects in our sample or to the presence of social desirability response biases. That is, it is possible that parents and providers with higher than average levels of satisfaction with care were more likely to respond to our interview requests. Likewise, there may be reticence among both parents and providers to express dissatisfaction with a caregiving situation even if they in fact are dissatisfied. It is not possible to ascertain the extent to which these problems existed in the sample, although we should note that many parents and providers who rated care highly nonetheless openly pointed out negative aspects of the caregiving situation (see following sections).

Positive and Negative Aspects of the Caregiving Situation

Two open-ended questions were asked to determine aspects of caregiving for the focal child that parents and providers viewed positively or negatively. Consistent with the positive overall assessments of the caregiving situation described above, both parents and providers were much more likely to mention positive than negative aspects of caregiving. For example, in

response to the question on most positive aspects of caregiving, 98.0 percent of parents and 95.0 percent of providers offered at least one most positive aspect of having the main provider care for the focal child. In response to a comparable question on most negative aspects of care, only 23.4 percent of parents and 37.3 percent of providers suggested any negative aspect of care.

Table 12-1 Parent and Provider Satisfaction with Caregiving for Focal Child

	Parents (n=291)[1]	Providers (n=291)[1]	Parent-Provider Pairs (n=290)[1]
Providers and Parents			
Very satisfied	98.6	94.5	
Somewhat satisfied	1.0	5.2	- - -
Somewhat dissatisfied	0.3	0.0	- - -
Very dissatisfied	0.0	0.0	- - -
Provider-Parent Pairs			
Both very satisfied	- - -	- - -	93.1
One very satisfied – One somewhat satisfied	- - -	- - -	6.2
Both somewhat or very Dissatisfied	- - -	- - -	0.0

[1] The number of cases for this analysis is slightly less than for other tables due to missing cases associated with problems in matching the focal child for parents and providers.

Parents

Positive Aspects of Caregiving Situation

Parents provided very diverse reasons when discussing the most positive aspects of the care arrangement for the focal child. The most prevalent of these are summarized in Table 12-2. Parents most often offered comments that suggested their comfort with or confidence in the provider. For example, 18.8 percent referenced the fact that the provider was a relative, and 6.5 percent mentioned their familiarity with the provider. In addition, 14.4 percent indicated that their children were safe with the provider, or that they did not have to worry about their children while they were in care. Collectively, comments in these three categories were reported by nearly two-fifths of the parents who provided positive comments about their caregiving situation. In addition, a category of responses that appeared closely related pertained to positive characteristics of the provider that were likely to stimulate confidence in and satisfaction with care. That is, 19.2 percent of parents spoke of positive provider attributes such as trustworthiness, dependability, and reliability.

Another large subset of parents (20.9 percent) offered general comments about the provider's quality of caregiving. These comments usually made simple references about the provider being good with children or the belief that the provider cared for children well. Parents also sometimes spoke of the love for the children that their provider had.

Smaller subsets of parents mentioned specific aspects of the caregiving situation that they considered important. About 8 percent of the parents referred to learning-related caregiving features, such as helping the child with school or early learning or providing educational resources. Relatively few parents specifically referenced one-on-one attention (2.1 percent) or disciplining the child well (1.7 percent) when discussing the most positive aspect of care.

Table 12-2. Most Frequent Positive Aspects of Provider Care of Focal Child Mentioned by Parents – Open-end Question Responses

Most Positive Aspect of Provider Care for Focal Child	Number of Comments	Percentage of Those Parents Who Offered Positive Comments (n=292)
Cares well for children/loves children	61	20.9
Provider attributes (reliable, dependable, trustworthy)	56	19.2
Family member/relative	55	18.8
Children are safe/don't have to worry	42	14.4
Helps child with learning or schools/provide educational resources	24	8.2
Familiarity with provider	19	6.5
Provider is role model/father figure	16	5.5
Good relationship between children and provider	13	4.5
Convenience	13	4.4
Children can get closer to grandparent	6	2.1
One on one care or watches closely	6	2.1
Disciplines well	5	1.7
Flexibility in care hours/availability	9	3.1
Care is provided in parent's home	6	2.1

Another group stressed relationship dimensions of caregiving. For example, 4.5 percent reported a good relationship between the provider and focal child as the most positive care attribute, and 2.1 percent referred to the chance for children to become closer to their grandparents. In addition, 5.5 percent considered the provider to be a positive role model or father figure for the focal child.

Finally, small minorities of parents mentioned aspects of care not directly related to the caregiving interaction as being most important. The references generally pertained to the convenience of the caregiving arrangement for the parent (4.4 percent), or to the flexibility of the provider with respect to the times or hours available to care for the focal child (3.1 percent).

Negative Aspects of Caregiving Situation

As previously mentioned, only 23.4 percent of parents offered at least one response when asked about the most negative aspect of the provider's care for the focal child (Table 12-3). Comments most often referenced dissatisfaction with a specific aspect of the provider's caregiving. Easily the most often mentioned in this respect were concerns that the provider spoiled the child (15.7 percent of parents who offered negative comments), or that the parent disagreed with how the provider disciplined the child (12.9 percent). A smaller number of parents (5.7 percent) noted other personal care attributes with which they were dissatisfied, such as the child spending too much time in the house or the provider not always serving nutritious meals. Another small group (7.1 percent) referred to unsatisfactory features of the caregiving environment, such as the home or neighborhood where care was provided or the absence of other children in care with the provider.

Table 12-3. Most Frequent Negative Aspects of Provider Care of Focal Child Mentioned by Parents – Open-end Question Responses

Most Negative Aspect of Provider Care for Focal Child	Number of Comments	Percentage of Those Parents Who Offered Negative Comments (n=70)
Provider spoils child	11	15.7
Discipline issues	9	12.9
Pay issues for provider/co-pay issues	9	12.9
Child too attached/parent guilty about leaving child	8	11.4
Lack of privacy for parent/too much time with provider	8	11.4
Attributes of caregiving environment	5	7.1
Personal care related	4	5.7

Another set of responses reflected parental concerns about their own relationships with their children, or about their children's relationship with their provider (11.4 percent). In particular, some parents indicated that they thought the focal child had become too attached to the provider. A smaller number expressed that they wished they were able to spend more time with their own children.

Two remaining sets of comments were not focused on the care received by the child. First, 11.4 percent of the parents who made negative comments felt the caregiving situation deprived them of their privacy or resulted in them spending too much time with the provider. Second, 12.9 percent spoke of payment issues, usually on behalf of their provider. These payment issues most commonly suggested that the providers were not paid enough. Other payment problems mentioned included the parent co-payment, the fact that providers had to pay taxes on their child care earnings, and late payments from the subsidy program to the provider.

Providers

Positive Aspects of Caregiving Situation

While providers reported many different positive aspects of caring for the focal child, several were predominant (Table 12-4). Nearly 30 percent of providers offered general statements indicating satisfaction with providing care. These included references to the being positive about the focal child being safe or well cared for (21.0 percent of those caregivers who provided positive comments), as well as indications that they loved caring for children (8.4 percent).

Close relationships with both the children and their parents also were frequently suggested as the most positive aspect of caring for the focal child. For example, 23.8 percent of the providers who made positive comments referenced being able to care for related children, and 1.4 percent mentioned being more involved in the focal child's life. Further, 27.3 percent of parents cited being able to help out the parent as a most positive aspect of caring for the focal child, and 1.7 percent indicated that caregiving had allowed them to get to know the family better.

A final fairly large subset of providers (11.9 percent) mentioned some aspect of teaching or training children as being the most positive part of their caregiving. In addition, a smaller number (2.8 percent) expressed satisfaction with watching children grow and develop, even though they did not speak about their role in guiding this development.

Negative Aspects of Caregiving Situation

Slightly under two-fifths (37.3 percent) of providers reported at least one negative aspect of caring for the focal child, with the most frequent responses summarized in Table 12-5. Two types of problems were mentioned most often. First, nearly one-fifth of providers talked about difficulties in getting children to obey them (12.4 percent) or in disciplining children (7.1 percent). Second, about one-fifth spoke of how providing care affected their lives in negative

ways. This included caregiving sometimes conflicting with their time available for other activities (12.4 percent), as well as caregiving being tiring or stressful (9.7 percent).

A smaller subset of providers reported problems related to their attachment to the focal child, or the focal child's attachment to them. For example, 10.6 percent made comments about how they did not have enough time to spend with the children, or about how they had become too attached to the children. A smaller number indicated that the focal child had become too reliant upon them.

Slightly over one-tenth of providers making negative comments referenced issues in interacting with the focal child's parents. Included in these were 7.1 percent who cited parent behavior, such as being late to pick up the child or being irresponsible from the provider's perspective. In addition, 5.3 percent mentioned disagreements that they had with the parents, or inconsistent practices that the provider and parent exercised in caring for the focal child.

Table 12-4. Most Frequent Positive Aspects of Caring of Focal Child Mentioned by Providers – Open-end Question Responses

Most Positive Aspect of Providing Care for Focal Child	Number of Comments	Percentage of Those Providers Who Offered Positive Comment (n = 286)
Able to help out parent	78	27.3
Able to care for related children	68	23.8
Assuring that child is safe/well cared for	60	21.0
Teach or train children/provide experiences for them	34	11.9
Loves caring for children – general	24	8.4
Watching children grow and develop	8	2.8
Child likes or trusts provider	5	1.7
Getting to know family better	5	1.7
Personal growth or contribution to society	5	1.7
More involved in child's life	4	1.4
Provider learns about caregiving	4	1.4
Child is cared for with provider's or other children	4	1.4
Parent is responsible	4	1.4

Finally, 8.8 percent of the providers referenced payment issues as the most negative aspect of caring for the focal child. These included such complaints as not being paid enough and being paid late, as well as systems problems in the processing of payments.

Table 12-5. Most Frequent Negative Aspects of Caring for the Focal Child Mentioned by Providers – Open-end Question Responses

Most Negative Aspect of Providing Care for the Focal Child	Number of Comments	Percentage of Those Providers Who Offered Negative Comments (n = 113)
Getting children to obey	14	12.4
Restrictions on provider time/activities	14	12.4
Not enough time with children/getting too attached	12	10.6
Stress on provider/tires provider	11	9.7
Payment issues	10	8.8
Disciplining children	8	7.1
Problems with parent behavior	8	7.1
Disagreements with parents/inconsistent parent and provider care practices	6	5.3
Children becomes too reliant on	3	2.7

Parent and License-Exempt Provider Disagreements

Both parents and providers were asked a series of questions intended to determine the frequency with which selected caregiving disagreements were perceived to occur. Table 12-6 presents these results. For each of nine types of disagreement on which respondents were questioned, the table shows the percentage of both parents and providers who indicated the problem occurred often, sometimes, rarely, or never.

Several observations can be made from the Table 12-6 data. Foremost among these is the relative infrequency of disagreements reported by both parents and providers. For example, for seven of the nine questions, over 88 percent of parents reported never having a disagreement with their provider. Similarly, at least 87 percent of providers reported never disagreeing with the parent on six of the nine disagreement questions. The response patterns for parents and providers with respect to each type of disagreement likewise are very similar.

Given this general lack of reported disagreements, only a few areas of dispute reported slightly more often are noteworthy. First, disagreements with respect to how the provider should discipline the children in care were most prevalent; 14.6 percent of providers and 11.5 percent of

parents reported that such disagreements often or sometimes occurred. The second most frequently mentioned disagreement pertained to the best way for the parents to care for their children, with 13.6 percent of providers and 8.9 percent of parents reporting this type of dispute as often or sometimes occurring. Finally, 10.9 percent of providers reported disagreements with parents about being late to drop off or pick up children as occurring often or sometimes, as compared to 5.3 percent of parents. It also should be noted that parent and provider perspectives differed from each other the most on these latter two issues, but even here the response patterns were very similar.

Table 12-6. Percentages of Parents and License-Exempt Providers Reporting Selected Caregiving Disagreements

	Percentage of Parents Reporting Disagreements (n=303)				**Percentage of Providers Reporting Disagreements (n=303)**			
	Often	Sometime	Rarely	Never	Often	Sometime	Rarely	Never
Amount of payment for child care	1.3	4.3	5.3	89.1	1.0	4.3	4.3	90.4
Paying the co-payment	0.7	3.6	5.6	89.8	2.3	3.3	6.0	88.4
Paying the provider on time	0.7	4.3	6.3	88.4	2.0	4.0	5.6	88.1
Problems meeting parent's care schedule	0.7	4.6	5.9	88.8	0.7	6.0	6.3	87.1
Being late to drop off or pick up children	0.3	5.0	6.6	87.8	2.0	8.9	5.3	83.1
Best way for provider to care for children	1.3	3.0	6.9	88.8	0.3	5.3	7.0	87.4
Best way for parent to care for children	1.3	7.6	7.6	83.5	1.0	12.6	8.3	77.5
How provider should discipline children	2.3	9.2	9.9	77.9	1.7	12.9	6.3	78.8
Issues related to caregiving supplies	0.7	3.0	4.0	91.7	1.7	5.3	5.0	88.1

The less formal caregiving relationships between parents and license-exempt providers also may affect how any disputes are resolved. For example, in many agency-based service contexts, the existence of a service contract or other written descriptions of mutual responsibilities serves to structure the resolution of disputes. Yet, when asked if they had a written contract or agreement with the focal family that described agreed upon care schedules and payment arrangements, only 24.8 percent of the providers in our sample replied affirmatively. Interestingly, the likelihood of having such a contract did not differ significantly

according to whether or not the provider was related to the children in care (24.0 percent of related providers versus 28.2 percent of non-related providers).

In this service context characterized by lack of written care agreements, both parents an providers who indicated having disagreements about caregiving were asked open-ended questions concerning how such disputes were resolved. Nearly all of the responses from both parents and providers suggested that discussion between the two parties occurred when problems arose. For example, 98.2 percent of the parents and 93.6 percent of the providers who cited disagreements reported talking about or communicating about the problem as the mechanism for resolution. This approach usually was reflected by general comments such as "We just talk about it" or "We talk it over". In a small subset of these cases, the parent or provider further indicated that they reached a compromise or came to an agreement. The common thread across all of these cases was that there was no indication of demanding behavior by either party, or the sense that one party occupied a dominant role in the discussion. In this sense, these cases typically seemed to indicate a perspective of fairly friendly or mutually agreeable interaction in resolving conflicts.

Among the small number of cases not falling into the above general discussion category, the only one mentioned by over five parents and providers suggested a more dominant role by providers in dispute resolutions. For example, 3.3 percent of the providers citing disagreements stated that they set rules with or expressed their opinion to parents, and 2.1 percent of parents indicated that they yielded to the provider in such disagreements. Nonetheless, the small number of cases falling into this category should be emphasized, and even fewer comments were made about arguing or threatening to terminate the caregiving situation.

Impact of Caregiving on Parent and Provider Relationship

Except for insights provided by small qualitative studies, little is known about how caregiving relationships between parents and providers may affect any pre-existing relationship they had. For example, it is unknown whether such relationship effects are more likely to be positive or negative, and both possibilities are plausible. That is, the demands of caregiving may strain relationships, or conversely interactions around caregiving may strengthen existing bonds. This is an especially important issue with respect to caregiving by family members, and so this sample is a useful vehicle for examining possible relationship effects with a fairly large sample.

To explore these possibilities, we first asked parents if they had known the main provider before that person began caring for their children, and similarly whether providers knew the focal family before they began providing care. Over 96 percent of parents indicated that they knew the main provider before caregiving began, and similarly 97.4 percent of providers reported they already knew the focal family (Table 12-7). Further, although non-relatives were significantly less likely than relatives to know each other, approximately 90 percent of the non-related parents and providers in the sample indicated that they know each other before caregiving began.

Parents who reported knowing their main provider before caregiving began, as well as providers who said they already knew the focal family for whom they provided care, were asked

if the caregiving experience had changed the nature of these pre-existing relationships. Table 12-7 summarizes responses to this question for both parents and providers. A slight majority of both parents (59.9 percent) and providers (51.0 percent) indicated that their relationships had not changed as the result of caregiving. Nearly all of the remaining respondents stated that their relationships had improved (39.4 percent of parents and 48.0 percent of providers). Further examination of parent-provider pairs revealed that nearly three-fifths of the pairs reported the same perspective on the relationship effects of caregiving; 23.5 percent agreed that their relationship had improved and 34.6 percent said that their relationships had not changed. In nearly all of the remaining parent-provider pairs (40.2 percent), one of the parties indicated that the relationship had improved and the other said the relationship had stayed the same.

Table 12-7. Effect of Caregiving on Parent-Provider Relationships

	Percentage of Parents (n=303)	Percentage of Providers (n=302)
Knew Parent/Provider Before Caregiving		
Yes	96.4	97.4
No	3.6	2.6
Among Those Who Knew Each Other, Caring for Focal Child Has (n=292):		
Changed parent-provider relationship for better	39.4	48.0
Changed parent-provider relationship for worse	0.7	0.0
No change parent-provider relationship	59.9	51.0
Don't know	0.0	1.0

An open-ended follow-up question was asked to further explore the nature of such relationship changes. Because all but two of the respondents reporting changes indicated that the relationship had changed for the better, these comments centered on positive ways in which caregiving had affected parent and provider interactions. The most common comments offered by parents and providers are shown in Table 12-8.

The response patterns in general were quite similar for both parents and providers. In particular, both groups most often mentioned three closely related ways in which relationships had changed for the better. The most common response for both groups was that caregiving had resulted in the development of a stronger relationship between the two parties (47.4 percent of parents and 47.1 percent of providers who reported changes). Respondents who commented along these lines typically spoke of becoming closer, developing a friendship or stronger bond,

or getting along better. Second, both parents and providers also often made references to talking more or communicating better as the result of being engaged in the caregiving relationship (31.9 percent of parents and 17.6 percent of providers). Third, 9.5 percent of the parents and 17.6 percent of the providers reporting changes mentioned spending more time or doing more things together.

Table 12-8. Most Frequent Relationship Changes Resulting from Caregiving Reported by Parents and Providers

Type of Relationship Change	**Number of Comments**	**Percentage of Parents Who Reported Changes (n=116)**
Developed better relationship with provider	55	47.4
Communicate better or talk more	37	31.9
Spend more time or do more things with provider	11	9.5
Children have better relationship with provider	6	5.2
Provider spends more time with children	4	3.4
Provider has helped to be a better parent	4	3.4
	Number of Comments	**Percentage of Providers Who Reported Changes (n=136)**
Developed better relationship with parent	64	47.1
Communicate better or talk more	24	17.6
Spend more time or do more things together	24	17.6
Became closer to children in care	10	7.5
Spend more time with children	8	5.9
Talk with parent about or set goals for children	7	5.1
Parent relies on or respects provider more	6	4.4
Parent and provider help each other more	5	3.7
Provider shares experiences/teaches about raising children	4	2.9

The remaining response categories in Table 12-8 all were mentioned by small numbers of parents and/or parents. These included spending more time with or developing a better relationship with children in care, as well as the provider giving advice or teaching the parent about raising children.

Differences by Region and Relationship of Parent and Provider

Separate analyses were performed to determine if there were differences in these findings based on region and on provider relationship to the parent. With respect to overall satisfaction with the caregiving arrangement, no significant differences were found for either of these factors.

Two significant differences were found in relationship changes reported to result from caregiving. First, parents were significantly more likely to report positive changes if the provider was a relative (42.7 percent if provider was relative versus 25.4 percent if provider was non-relative). However, this difference was not revealed from the provider perspective. Second, positive changes in relationships were less likely to be reported among North and South Lawndale respondents than among respondents from the other two study areas. Among parents, these differences were statistically significant; 57.1 percent of Peoria County, 40.0 percent of Southern Seven, and 22.8 percent of North and South Lawndale parents indicated relationship improvements. Among providers, there also were lower reported positive relationship changes in North and South Lawndale, but these did not reach significance (51.5 percent in Southern Seven versus 51.6 percent in Peoria County and 41.2 percent in North and South Lawndale).

As previously mentioned, only about one-quarter of respondents reported having written care agreements for child care provided to the focal family. However, nearly half (47.1 percent) of North and South Lawndale providers said they had written contracts, as compared to 18.3 percent in Peoria County and only 8.6 percent in the Southern Seven area. Given that there were no significant differences in the existence of such contracts according to whether or not the provider was related to the parent, we have no obvious explanation for these substantial regional differences.

Finally, it seems plausible that the nature of disagreements between parents and providers may be affected by whether or not these parties are related, so such comparisons were made on each of the nine disagreement questions. While no significant differences were found, several were intriguing. For example, parents using related caregivers were less likely than those using non-related providers to report disagreements about meeting the parent's scheduling needs. However, they were more likely to report disagreements with related providers concerning being late for picking up or dropping off the child, the best way for the parent to care for their children, and how best to discipline the children. Providers who were related to the parent similarly were more likely to report disagreements about disciplining children and the best way for the parent to care for their children, as well as the best way for the provider to care for children.

The differences in disagreements about scheduling needs are not especially surprising, as it is conceivable that relative caregivers are more flexible than non-relative caregivers in this regard. This same flexibility also may stimulate disagreements when parents are late. The other disagreements noted (discipline, how the parent and provider care for child) are interesting in

that each involves a more intimate nature of care provision. It may be that closer and less formalized relationships between parents and relative providers lead to more disagreements on these issues. The data from this study do not allow evaluation of this possibility, but such relationship differences are an interesting area for further study.

Chapter 13:
Training Received by License-Exempt Providers, and Perceptions about Training and Resource Needs

There has been considerable interest in learning about the types and amounts of training and experience that license-exempt providers have, as well as their perspectives regarding what if any training and resources they would like to receive. A related issue concerns the extent to which these providers want to become licensed, or if not interested in licensing, the reasons that this is the case. In addition, because license-exempt providers frequently work alone and during non-traditional hours, questions have been raised concerning the best means of providing any desired training.

In this chapter, we present provider perspectives on training and resources. In addition, parent responses regarding resources and training that would be useful to their providers are discussed.

Previous Child Care Training and Experience Among License-Exempt Providers

All providers were asked how long they had been taking care of any children for pay, both through the subsidy system and any other payment mechanisms. As shown in Table 13-1, nearly half (48.6) of the providers stated that they had cared for children for pay for at least five years, and nearly two-thirds (63.2 percent) had provided paid care for at least three years. Correspondingly, only 9.9 percent of providers had been taking care of children for pay for less than one year.

A series of questions was asked to determine the extent to which providers had received any kind of formal child care training. Given that only 29.6 percent of the providers in the sample had any college education (see Chapter 6), it is not surprising that only 14.6 percent of providers reported ever having taken a college course in early childhood education or child development.

Providers also were asked whether they ever had attended several different types of training activities. Nearly two-thirds (64.5 percent) had attended at least one of the types of training shown in Table 13-1, or else another type of child care training that they specified. The two most commonly reported training activities were CPR (52.6 percent) and first aid (50.0 percent). In addition, about one-third of providers indicated that they had attended classes or workshops on parenting education, early childhood education, or child development. Finally, 15.2 percent reported attending training on other topics. Training related to foster care was the most frequently mentioned other training, followed by nursing or health care, child abuse and neglect, child behavior, and various special needs topics.

A related issue concerns how recently providers may have received training. Providers consequently were asked to specify the number of hours of child care training of any kind they had attended in the last year. About one-fifth (21.1 percent) of providers had attended any training during this period. As a result, the average number of hours attended by the group was

Table 13-1. Child Care Experience and Child Care Training Received by License-Exempt Providers (Percentage Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Length of Time Has Taken Care of Children for Pay (n=294)				
< 1 year	9.9	8.7	10.2	10.8
1 – <3 years	25.9	34.6	14.8	26.5
3 – <5 years	14.6	14.4	13.6	15.7
5 years and over	48.6	41.3	61.4	45.1
Don't know	1.0	1.0	0.0	1.0
Has Taken College Courses In Early Childhood Education Or Child Development				
Yes	14.6	10.7	14.0	19.0
No	85.0	89.3	86.0	80.0
Has Ever Attended Training Activities on:				
Parenting education	31.1	28.8	36.6	28.6
Early childhood education or development	33.4	30.8	37.6	32.4
CPR	52.6	30.8	64.5	63.8
First Aid	50.0	34.6	61.3	55.2
Other	15.2	13.5	24.7	8.6
At least one of the above training activities	64.5	45.6	74.2	74.3
Average Hours of Child Care Training Attended in Last 12 Months	3.6 hrs.	4.7 hrs.	3.0 hrs.	2.9 hrs.
Ever Viewed Videotapes about Caring for Children				
Yes	47.0	49.0	48.4	43.8
No	53.0	51.0	51.6	56.2

very low at 3.6 hours for the year. Among the subset of providers who reported receiving any training during the year, the average received was 16.8 hours.

Finally, providers were asked if they ever viewed videotapes about caring for children. Slightly under half (47.0 percent) reported watching such videotapes.

Provider Interest in Training

Providers were asked if they were interested in receiving training on topics commonly emphasized in the child care field. Nearly three fourths of the providers (75.2 percent) were interested in receiving training on at least one of the topics listed in Table 13-2, or another topic that they specified. No single desired training topic predominated, with interest ranging from 44.4 percent for how to discipline and communicate with children to 55.0 percent for CPR training. Among the small subset of providers who suggested an interest in other topics, no single topic was mentioned by over five respondents. The topics mentioned included specific training on newborn or young child care, health or behavior issues, teaching children or preparing them for school, and licensing or starting a child care business.

The approximate one-quarter of providers who were not interested in any type of training subsequently were asked if they would be interested in attending training if their compensation increased as a result. As shown in Table 13-2, 39.2 percent of these providers said they would be interested in training if it was tied to compensation increases.

The lack of desire among some providers to receive each of the six topics of training specified in Table 13-2 resulted partially from the fact that providers indicated they already had received training on the topic. For example, the percentage of providers who said they already had received training and therefore were not interested ranged from 6.6 percent to 21.2 percent for the six topics of training (not shown in table).

A series of closed questions further explored whether providers thought they would get more child care training if not for each of the reasons shown in Table 13-3. Slightly over two-fifths (41.7 percent) of respondents indicated that they did not see the need for more training. Nonetheless, 84.2 percent nonetheless suggested that they would receive more training if not for at least one of the other reasons shown in the table.

The most frequently mentioned barrier to training was a lack of knowledge about what training was available, with 60.9 percent of providers agreeing that they would get more training if they knew what was available. This finding on lack of knowledge about training options was reinforced by the unusually high number of “don’t know” responses on two other questions. That is, 28.1 percent responded “don’t know” when asked if the cost of training inhibited them from receiving more training, and 23.8 percent did not know whether the times when training was offered constituted a barrier to training receipt (not shown in table). It seems plausible that a large portion of these “don’t know” responses resulted from the provider having insufficient knowledge about training costs or training times to evaluate whether either was a barrier to training receipt.

The reasons for lack of training knowledge could not be determined from our survey. All CCR&Rs offer training in basic child development, CPR and first aid, and this training is not restricted to licensed providers. However, most license-exempt providers are not registered on the CCR&R database used as the primary means of disseminating information about training, which may be one important factor limiting their knowledge about and participation in training.

Substantial numbers of providers also suggested that training receipt was inhibited by obstacles related to family or work. Over one-third (34.8 percent) of providers agreed they would obtain more training if doing so did not take time away from their family, and 20.9 percent cited not having care available for their children while attending training. Similarly, one-third of providers suggested that taking time away from work would prevent them from receiving more training. Finally, transportation was seen as a barrier to training by 27.5 percent of providers.

Table 13-2. Provider Interest in Receiving Child Care Related Training (Percentage Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Topics of Training Interested in Receiving				
CPR	55.0	43.3	60.2	61.9
First Aid	54.3	47.1	54.8	61.0
Activities for Children	52.0	42.3	54.8	59.0
Child development	50.7	38.5	59.1	55.2
Health and Nutrition	46.4	37.5	51.6	50.5
How to discipline and communicate with children	44.0	35.6	47.3	50.5
Other	11.6	11.7	15.6	7.9
Interested in at least one type of training	75.2	64.4	80.6	81.0
Interest in Training If Compensation Increased as a Result (of those not interested in training – n=75)				
Yes	39.2	40.5	41.2	35.0
No	50.0	54.1	52.9	40.0
Maybe	10.8	5.4	5.9	25.0

Table 13-3. Selected Reasons That Licensed-Exempt Providers Were Not Interested in Getting More Training

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Percentage of Providers Who Agreed That:				
They did not know what training was available	60.9	64.4	54.8	62.9
They don't see need for more training	41.7	41.3	44.1	40.0
Training takes times away from their family	34.8	24.0	36.6	43.8
Training takes time away from their work	33.4	26.0	32.3	41.9
Training is offered at the wrong times	32.8	19.2	32.3	46.7
Transportation is a problem	27.5	20.2	29.0	33.3
Training costs too much	22.5	19.2	18.3	29.5
They don't have care for own children while attending training	20.9	29.8	11.8	20.0

Providers were asked if there were any other reasons they were not interested in training, and only a few types of responses not shown in Table 13-3 were offered. Most were variations of not knowing what training was available, such as providers who said that no training was offered in their area or who did not know where training was provided. The other most prominent "other" responses pertained to providers reporting that they only were caring for children on a temporary basis, only cared for one family or child, or else planned to phase out of care provision in the near future.

Parent Interest In and Satisfaction with Training for Their Providers

Parents were queried about the types of training they thought were important for providers to have, as well as whether they thought their current provider had sufficient training. In addition, the reasons that some parents thought that training for license-exempt providers was not needed were explored.

An initial question asked parents whether, in general, they thought that people who provide license-exempt child care should have training in taking care of children. About two-thirds (65.7 percent) of parents responded that license-exempt caregivers should receive training, while 32.0 percent indicated that training was not needed.

For the 199 parents who said that license-exempt providers needed child care training, follow-up questions explored which types of training they thought were needed and whether they thought their provider was adequately trained in such areas. Table 13-4 presents these results. The first column shows what percentage of these providers thought selected types of training were important. For those providers who thought a specific type of training was important, the second column then shows what percentage thought their provider was adequately trained in this area.

The table shows that parents who generally thought training was important also reported that each of the six training topics were important, with the importance of CPR and first aid most frequently cited (97.0 and 96.5 percent). There also was widespread agreement that providers had enough training in the specific content areas parents had designated as important. The greatest satisfaction with training was in the topic area of how to discipline and communicate with children, with 93.2 percent of parents who said such training was important suggesting that their provider had enough. The topic areas about which the most parents were dissatisfied with the training of their provider were CPR (75.1 percent satisfied) and child development (80.2 percent satisfied).

Table 13-4. Parental Perspectives on Needed Training and the Adequacy Training for Their Provider (Percentage Distribution for Parents Who Viewed Training as Important)

	This Type of Training Is Important (n=199)	**Provider Has Enough of This Type of Training (among those who said this training was important)**
CPR	97.0	75.1
First aid	96.5	88.5
Health and nutrition	89.4	86.0
Child development	88.9	80.2
How to discipline and communicate with children	88.9	93.2
Activities for children	86.4	87.2

While these levels of parental satisfaction with training are consistently high, it should be emphasized that this does not suggest that providers actually are well-trained or particularly

knowledgeable in these areas. For example, we analyzed whether providers with whom parents expressed satisfaction about training in selected areas reported ever having received training in that content area. With respect to training on child development, 58.5 percent of the providers about whom parents expressed satisfaction with training said they had never attended classes or workshops on this topic (not shown in table). Smaller but still substantial numbers of the providers with whom parents were satisfied with respect to CPR and first aid training also stated they had not received training in these areas (31.0 and 42.4 percent, respectively). In addition, at least half of the providers with whom parents expressed satisfaction with training indicated they would be interested in receiving further training in these areas.

The subset of 97 parents who responded that they did not think that license-exempt providers generally needed to receive child care training were asked a series of follow-up questions designed to explore the reasons for this belief. As shown in Table 13-5, easily the most often expressed reason for a lack of need for child care was that the providers already were experienced in caregiving (64.9 percent). About a quarter of the parents also thought that providers only needed common sense and patience (24.7 percent) and that parents trusted these providers (26.8 percent).

Table 13-5. Parental Perspectives on Why License-Exempt Providers Do Not Need Training (Percentage Distribution among Parents Indicating Training Was Not Needed)

	Total Sample (n=97)	North & South Lawndale (n=49)	Peoria County (n=24)	Southern Seven (n=24)
Already experienced in caregiving	64.9	59.2	75.0	66.7
Parents trust these providers	26.8	38.8	20.8	8.3
Only need common sense and patience	24.7	20.4	33.3	25.0
They usually are relatives	15.5	14.3	16.7	16.7
These providers already have children	14.4	18.4	12.5	8.3

Interest in Resources to Assist in Child Care

In addition to the specific training topics presented in Table 13-2, providers were asked whether a number of informational and tangible resources would be helpful to them in providing

child care. Parents likewise were asked if they thought these same resources would be useful to their provider, so that we could compare their perspectives on resource needs with those of providers.

Several observations can be made from the provider and parent responses summarized in table 13-6. First, the specific resources that providers most often selected as being "very helpful" were similar for both groups. In particular, six resources were reported as being very useful by at least three-fifths of providers and one-half of parents. These resources centered on safety, learning and other resources for children, and emergency help and back-up care provision for providers. They included safety equipment (76.7 percent of providers and 70.5 percent of parents); resources to help children learn (77.7 percent of providers and 69.2 percent of parents); access to recreational or community activities (65.7 percent of providers and 57.0 percent of parents); outdoor recreational equipment (61.7 percent of providers and 54.5 percent of parents); assistance when problems occur in child care (63.9 percent of providers and 50.0 percent of parents); and short-term back-up when the provider is unavailable (61.5 percent of providers and 55.5 percent of parents).

The diverse range of resources that most providers thought would be at least somewhat helpful also is notable. Of the 14 types of resources specified in Table 13-6, only three were considered not helpful by over 30 percent of providers: equipment for the providers home (38.5 percent indicated not helpful); opportunities to meet with other providers (32.9 percent); and information on business management (30.8 percent). Even on these items, more providers indicated that the resources would be "very helpful" than "not helpful".

Finally, although parents also typically thought the resources listed would be quite helpful to their caregivers, higher percentages of providers thought each resource would be useful than did parents. In general, however, these differences were not striking. The greatest differences between providers and parents in terms of their ratings of resources as "very helpful" occurred with respect to help with caring for special needs children (57.1 percent of providers versus 40.0 percent of parents); equipment for the provider's home (46.5 percent of providers versus 32.0 percent of parents); someone for the provider to call when child care problems occur (63.9 percent of providers versus 50.0 percent of parents); information on caring for children (54.2 percent of providers versus 40.5 percent of parents); and information on business management (41.5 percent of providers versus 28.6 percent of parents).

To determine which among this large number of possible resources were considered most important, providers were asked to select two resources from among all of those they had indicated would be "very helpful". Table 13-7 summarizes the results from this question. Consistent with the Table 13-6 results, providers emphasized two resources as the most important. First, 34.7 percent of respondents selected resources to help children learn as one of their two most important resources. Second, 30.7 percent selected safety equipment such as first aid kits, fire extinguishers, and smoke detectors.

Table 13-6. Parent and Provider Views on Resources That Would Be Helpful In Caring for Children

	Parents (n=303)			Providers (n=303)		
	Very Helpful	Somewhat Helpful	Not Helpful	Very Helpful	Somewhat Helpful	Not Helpful
Safety equipment, such as first aid kits, fire extinguishers, and smoke detectors	70.5	13.2	16.2	76.7	9.3	14.0
Resources to help children learn	69.2	20.5	10.3	77.7	14.3	8.0
Access to recreational or community activities for children	57.0	28.5	14.6	65.7	24.7	9.7
Short-term backup when provider is unable to provide care	55.5	24.4	20.1	61.5	22.1	16.4
Outdoor recreational equipment	54.5	26.1	19.5	61.7	22.0	16.3
Someone for provider to call when problem occurs during child care	50.0	20.6	29.4	63.9	16.4	19.7
Health screenings and immunizations	46.8	19.5	33.7	54.7	20.0	25.3
Nutrition classes or access to food programs	44.0	29.0	27.0	55.0	24.0	21.0
Information on caring for children	40.5	27.6	31.9	54.2	21.9	23.9
Information/resources to help care for children with special needs	40.0	22.7	37.3	57.1	16.6	26.2
Information about communicating with parents	36.2	26.9	36.9	47.8	25.6	26.6
Equipment for provider's home, such as cribs/strollers/charging tables	32.0	15.3	52.7	46.5	15.0	38.5
Opportunities to meet with other providers	29.4	33.8	36.8	35.2	31.9	32.9
Information on business management	28.6	24.8	46.6	41.5	27.8	30.8

Note: "Don't know responses varied for each question, but did not exceed 3 percent. Percentage distributions exclude these "don't know" responses.

Table 13-7. Resources That Providers Thought Were Most Important in Caring for Children

	Selected As One of Two Most Important Resources:			
	Total (n=303)	**North and South Lawndale (n=105)**	**Peoria County (n=93)**	**Southern Seven (n=105)**
Resources to help children learn	34.7	35.9	39.8	29.5
Safety equipment such as first aid kits, fire extinguishers, and smoke detectors	30.7	41.7	21.5	28.6
Access to recreational or community activities for children	17.3	15.5	23.7	13.3
Information on caring for children	15.9	12.6	16.1	19.0
Short-term backup when provider is unable to provide care	12.2	12.6	18.3	6.7
Information/resources to help care for children with special needs	10.6	13.6	7.5	10.5
Someone for provider to call when problem occurs during child care	10.2	14.6	9.7	6.7
Health screenings and immunizations	8.9	10.7	7.5	8.6
Nutrition classes or access to food programs	8.6	5.8	5.4	14.3
Information about communicating with parents	8.0	9.7	8.6	5.7
Outdoor recreational equipment	7.3	3.9	6.5	11.4
Equipment for provider's home, such as cribs/strollers/charging tables	4.3	4.9	3.2	4.8
Information on business management	3.3	1.9	4.3	3.8
Opportunities to meet with other providers	2.0	0.0	2.2	3.8

Provider Interest in Becoming Licensed

There has been considerable uncertainty in the child care field regarding whether license-exempt providers commonly have an interest in becoming licensed. In Illinois, licensed providers receive much higher reimbursement rates, so they appear to have solid incentives to become licensed (see pay rate table on page 20). On the other hand, while there are no fees associated with becoming licensed, there are educational requirements. In addition, licensed providers must meet environmental standards such as square footage, play area, and health and safety requirements. Such requirements may inhibit some license-exempt providers from becoming licensed.

To explore interest in licensing, we first asked all providers if they were "very interested", "somewhat interested", or "not interested" in becoming licensed. Table 13-8 shows that interest in becoming licensed among the providers was fairly high, with 34.2 percent saying they were very interested and 23.4 percent saying they were somewhat interested.

Providers also were asked whether selected reasons had contributed to them not becoming licensed. Lack of knowledge again appeared to be very important in this respect, with 52.7 percent of providers indicating that they did not know what was involved in getting licensed. The high number of "don't know" responses on several other items further suggests the importance of knowledge deficiencies when considering why many providers do not pursue becoming licensed. For example, 23.8 percent of providers responded "don't know" when asked if costs were a reason they had not become a licensed provider (not shown in table). Similarly, "don't know" responses were quite high with respect to "takes too long" (17.8 percent), "no benefit" to becoming licensed (11.6 percent), "housing is not adequate" (7.9 percent), and "too much hassle" (6.6 percent).

Providers most often stressed two other reasons why they had not become licensed. First, 51.4 percent indicated that they only wanted to care for family members or the children of close friends. Second, 36.8 percent said they had not become licensed because they only were providing child care on a temporary basis.

A follow-up question asked providers to consider all of the reasons they had reported for not becoming licensed, and to select the one that they considered most influential. Knowledge and family related reasons again dominated the responses. Over one-fourth (28.4 percent) of respondents said that not knowing what is involved in getting licensed was the single most important reason, and 23.4 percent reported that they only wanted to take care of the children of a family member or close friend (not shown in table). The only other reason mentioned by over 10 percent of providers was that they only were providing care on a temporary basis (12.2 percent).

Providers also were asked whether they were licensed to provide foster care, and a substantial subset had experience in this respect. In addition to the 6.6 percent of providers who said they currently were licensed foster care providers, 5.6 percent said that they had been licensed in the past.

Table 13-8. Provider Interest in Becoming Licensed, and Reasons for Not Becoming Licensed

	Total Sample (n=295)	North & South Lawndale (n=104)	Peoria County (n=90)	Southern Seven (n=101)
Interested in Becoming Licensed				
Very	34.2	40.4	31.1	30.7
Somewhat	23.4	16.3	36.7	18.8
Not interested	42.4	43.3	32.2	50.5
Reasons Have Not Become Licensed				
Don't know what's involved in getting licensed	52.7	52.4	50.0	55.4
Only want to take for family members/ friends	51.4	49.5	50.0	54.5
Only providing child care on temporary basis	36.8	37.9	39.1	33.7
Too much hassle	22.0	19.4	20.7	25.7
Housing is not adequate	16.6	10.7	14.1	24.8
Costs too much	13.2	8.7	12.0	18.8
No benefit in being licensed	13.2	7.8	15.2	16.8
Takes too long	11.1	6.8	14.1	12.9
Don't want government in home for visits or background checks	10.1	1.9	17.4	11.9
Other reasons	17.2	15.5	18.5	17.8
Licensed as Foster Care Provider				
Yes	6.6	2.9	15.1	2.9
Used to be	5.6	4.8	11.8	1.0
No, never have been	87.7	92.3	73.1	96.2

Note: 5 respondents reported that they had become licensed, and so were excluded from the analysis along with 3 other cases with missing information.

Preferred Modes of Training Delivery

Another issue in providing training for license-exempt caregivers concerns the best mechanisms for training delivery. We consequently asked those providers who expressed an interest in training their opinions about how convenient selected training delivery approaches would be. Books (63.0 percent) and videotapes (61.1 percent) were most often mentioned as being very convenient, and correspondingly the least often reported as being not convenient (Table 13-9). While group meetings such as workshops or support groups were less likely to be viewed as very convenient, the relatively low percentages of providers who viewed such modes of training delivery as not convenient also is notable (15.1 percent and 17.5 percent of providers, respectively). E-mail or internet provision was viewed as the least convenient training mode, with 44.7 percent of providers indicating that this form was not convenient. This may be related to computer access problems among the largely low-income providers in our sample, as well as the high proportion of grandparents, who may have less experience using computers.

Table 13-9. Relative Convenience for Providers of Selected Child Care Training Delivery Approaches

	How Convenient for Provider (n=256)[1]:			
	Very	**Somewhat**	**Not**	**Don't Know**
Books	63.0	20.2	8.2	8.2
Videotapes	61.1	24.9	5.8	7.8
Newsletters	52.1	28.4	10.9	8.2
Visits to provider's home	42.4	29.6	19.5	7.8
Workshop, conference, or class	35.3	37.6	15.1	11.2
Support group or meeting with other providers	31.1	40.1	17.5	10.9
E-mail or the Internet	27.6	17.9	44.7	9.3

[1]These questions only were asked of respondents who indicated having some interest in receiving training.

The desirability of providing home-based visits and delivering resources to license-exempt providers has received some attention, largely because of the perceived difficulty in getting these providers to attend traditional training sessions. A large percentage of providers in this sample seemed amenable to such home visits. As shown in Table 13-9, 42.7 percent said home visits would be very convenient, and 29.6 percent reported that home visits would be somewhat convenient. We also asked providers more directly if they would be willing to have child care resources and training materials brought to their homes, and 72.9 percent said that they would be (not shown in table). A follow-up question asked the 73 providers who expressed

unwillingness to receive home visits for this purpose if they would be willing to have such visits if higher subsidies resulted. Only 20.5 percent responded affirmatively, suggesting that reluctance for home visits among this subset would be unlikely to be affected much by higher subsidy payment incentives.

Differences by Region and Relationship of Parent and Provider

Regional Differences

There were several differences between regions in response patterns on training background and interests. Differences in the length of time that providers reported caring for children did not reach statistical significance (p=.06), but Peoria County providers were more likely to have cared for children for over five years (61.4 percent versus 45.1 percent in the Southern Seven area and 41.3 percent in North and South Lawndale). North and South Lawndale respondents were significantly less likely to have attended CPR training than respondents in the other two areas (30.8 percent versus 63.7 percent in Southern Seven and 64.5 percent in Peoria County), as well as training on first aid (34.6 percent versus 55.2 percent in Southern Seven and 61.3 percent in Peoria County).

North and South Lawndale providers likewise were significantly less likely to have expressed an interest in receiving each of the six types of training shown in Table 13-2 (CPR, first aid, child development, health and nutrition, activities for children, and disciplining and communicating with children). In contrast, response patterns on these training interest questions were similar for Peoria County and Southern Seven area providers.

Regional differences in the views of parents about the training needed by providers followed the same pattern as for providers, with North and South Lawndale parents significantly less likely to report training needs in each of the six content areas. In response to the general question on whether informal care providers generally need training, North and South Lawndale parents also were significantly less likely to respond affirmatively (52.9 percent versus 73.0 percent in Peoria County and 76.7 percent in the Southern Seven area). In follow-up questions on why these providers do not need training, North and South Lawndale parents were significantly more likely to emphasize that they trusted the providers (38.8 percent versus 20.8 in Peoria County and 8.3 percent in Southern Seven), which may partially explain their higher likelihood of believing that training was not needed.

As previously discussed, the subset of providers who were uninterested in any training were asked why they did not want more training, and there were significant regional differences in responses. North and South Lawndale providers were more likely to emphasize not having child care for their own children (29.8 percent versus 20.9 percent in Southern Seven and 11.8 percent in Peoria County). Southern Seven respondents were more likely to indicate that training would take time from their family (43.8 percent versus 36.6 percent in Peoria County and 24.0 percent in North and South Lawndale), or else was offered at the wrong times (46.7 percent in Southern Seven versus 32.3 percent in Peoria County and 19.2 percent in North and South Lawndale).

There also were a few significant differences with respect to how providers viewed the convenience of various training delivery methods. Providers in North and South Lawndale were more likely to prefer books and videotapes as a means of receiving training. In contrast, they were significantly less likely to prefer e-mail or the internet. Finally, while providers in all areas were likely to indicate that they were willing to have child care resources delivered to their homes, providers in the Southern Seven area were especially likely to find this form of provision desirable (77.9 percent versus 69.3 percent in Peoria County and 67.6 percent in North and South Lawndale).

Somewhat paradoxically, while North and South Lawndale providers and parents were less interested in training, they were significantly more interested in the provision of information on caregiving and tangible resources than their counterparts in the other two study areas. That is, North and South Lawndale parents were significantly more likely to consider 11 of the 14 resources shown in Table 13-6 as very helpful, and parents in this area were significantly more likely to view 12 of these 14 resources as being very helpful (regional details not shown in table). While the differences typically were small, Peoria County parents and providers generally were more likely to indicate that the resources shown in Table 13-6 would be very helpful than were their Southern Seven area counterparts.

Finally, North and South Lawndale providers were significantly more likely to express being very interested in getting licensed than providers in the other two areas (40.4 percent versus 31.1 percent in Peoria County and 30.7 percent in Southern Seven). There were several significant differences in the follow-up questions on why providers did not get licensed. North and South Lawndale respondents were less likely to emphasize costs, lack of benefits, taking too long, inadequate housing, or government intrusion as reasons for not becoming licensed (see regional details in Table 13-8).

Differences According to Whether or Not Provider Is Related

There were few significant differences in response patterns according to whether or not the provider was related to the focal family. There were no significant differences between these two groups with respect to perceived training needs. Parents with relative providers were more likely to believe their providers had adequate CPR and child development training than the parents with non-relative providers. However, these differences were not particularly striking.

There likewise were no significant differences between these provider groups in terms of perceived resource needs. However, parents being served by non-relative providers were significantly more likely to express several specific resource needs. These included access to recreational or community activities, information on caring for children, someone for the provider to call when there are problems, and information and resources on caring for children with special needs.

A final area of difference between these provider types concerned licensing. In discussing reasons for not becoming licensed, relative providers were significantly more likely to agree they only were caring for family members or close friends (55.8 percent versus 38.2 percent for non-relative providers), and also that their housing was inadequate (19.5 percent versus 7.4 percent of

non-relative providers). In contrast, non-relative providers were more likely to emphasize not knowing what is involved in becoming licensed (67.6 percent versus 48.7 percent for relatives). These differences similarly were reflected in responses to questions on the main reasons that providers said they had not become licensed. Relative caregivers were much more likely to indicate that they only were caring for family members or close friends as their main reason (30.7 percent versus 14.1 percent for non-relative providers), while non-relative providers more often mentioned not knowing what was involved in becoming licensed (50.0 percent versus 26.7 percent for relative providers)

Chapter 14: Cost-Related Issues for License-Exempt Subsidy Users

Although all of the parents interviewed in this study were receiving child care subsidies, issues of out-of-pocket costs and subsidy co-payments nonetheless are important in assessing license-exempt caregiving. Parents consequently were asked about their monthly out-of-pocket costs, as well as a series of questions about subsidy co-payment amounts and other provider reimbursement issues.[19] They also were asked if they ever exchanged goods and services with providers in return for child care.

Out-of-Pocket Costs for Subsidy Users

All parents were asked how much they paid each month out of their own pockets for child care for all of their children. In responding to this question, parents were asked to include both payments they made as well as payments that their spouse or partner made. Table 14-1 shows that parents reported average monthly out-of-pocket costs of $86.29. Those parents using more than one provider also reported how much of these costs were for care rendered by the main provider. Given that 88.9 percent of parents were using only one license-exempt provider (see Table 7-14), it is not surprising that overall nearly 96.2 percent or an average of $83.05 of these monthly out-of-pocket payments were being made to the main provider. With respect to cost ranges, 30.8 percent of the families reported paying under $50 dollars per month in out-of-pocket costs, while 37.7 percent were paying $50.00 - $99.99. Slightly under one-fifth (17.3 percent) reported paying $150 a month or more.

Table 14-1 also presents information on average monthly out-of-pocket costs for families with different numbers of children under age 18. As would be expected, average monthly out-of-pocket costs were substantially greater for parents with two children under age 18 when compared to those with only one child under age 18 ($107.67 versus $51.87). However, average out-of-pocket costs were slightly lower for those with 3-4 children ($94.40) than for those with two children, and even lower for those with 5 or more children ($64.94). It should be noted that usable out-of-pocket cost information only was available for 18 families with 5 or more children, so the relatively low average costs for these families may be a sampling anomaly.

Subsidy Co-Payment Issues

Co-Payment Amounts

All parents who receive subsidies are required to make co-payments for the care provided, with the amount of the co-payments based on the number of children receiving

[19] We originally intended to ask respondents about the total costs of caring for their children, including both out-of-pocket costs and subsidized amounts. However, because subsidy payments are made directly to providers, parental reports on subsidy amounts were not considered reliable. In addition, lag times between parent and provider interviews raised reliability issues if we had relied on the parent to indicate out-of-pocket costs and the caregiver to provide information on subsidy amounts received.

subsidies and the family's income. In all cases, the co-payments are made by the parent directly to the provider, with the provider also receiving the subsidy amount from the state.

Table 14-1. Monthly Out-of-Pocket Child Care Costs for Families

	Total Sample (n=289)[1]	North & South Lawndale (n=101)	Peoria County (n=90)	Southern Seven (n=98)
All Families				
Average monthly costs	$86.29	$89.72	$97.85	$72.13
Average monthly payments to main providers	$83.05	$85.97	$94.28	$69.72
Out-of-Pocket Cost Ranges (percent distribution)				
$0 - $49.99	30.8	34.7	21.1	35.7
$50.00 - $99.99	37.7	26.7	42.2	44.9
$100.00 - $149.99	14.2	16.8	15.6	10.2
$150.00 - $199.99	10.0	13.9	13.3	3.1
$200 and over	7.3	7.9	7.8	6.1
Number of Children under Age 18 in Family				
Average monthly costs if:				
1 child (n=82)	$51.87	$50.66	$72.10	$46.49
2 children (n=84)	$107.67	$121.27	$99.38	$104.98
3-4 children (n=105)	$94.40	$90.26	$110.41	$73.05
5 or more children (n=18)	$64.94	$80.97	$52.83	$51.00

[1]Because of recall issues, or inconsistencies in the information provided, there were 14 cases that provided information not considered reliable. These cases are excluded.

Because most of the license-exempt care provided through the Illinois subsidy program involves arrangements between relatives, friends, and neighbors, there has been considerable speculation concerning how the co-payment process works in practice for families using license-exempt care. In particular, because there is no monitoring of the co-payment process, little is

known about the amount of co-payments actually made or about the degree of flexibility parents may enjoy in making any such payments. Likewise, the extent to which parents and providers understand the co-payment requirements is unclear.

Parents and their license-exempt providers were asked a series of questions on these issues. Parents first were asked whether the Illinois Child Care Program required them to make a co-payment to the main provider for the care their children received. As shown in Table 14-2, 94.7 percent of parents recognized that a co-payment was required.

Parents aware of the co-payment subsequently were asked how much they were required to pay in a typical month. Those who could identify an amount then were asked how much they actually paid in a typical month. Table 14-2 provides these responses for the subset of parents who provided numerical responses for both the amount required and amount paid questions (n=259). Among this subset of respondents, the average co-pay amount required was reported as $79.45, and the average amount actually paid as $76.10. This represents nearly 96 percent of the required amount for these parents. However, we should reiterate that 44 parents (14.5 percent of sample) either did not know about the co-payment or else provided incomplete information on required amounts and payments made. It seems likely that a high proportion of these cases were not making all, if any, of the required co-payment.

Table 14-2 also provides a frequency distribution that further illustrates the proportion of required co-payments parents made. The data reveal that 92.7 percent of parents reported typically fully paying required co-payments, while only 2.3 percent reported usually making less than half of the co-payment amount. Again, however, the proportion of all cases that were paying less than half their co-payment could be as high as 15-20 percent, given the previously mentioned cases with lack of co-pay knowledge or incomplete reporting. It also is likely that there is some social desirability bias in reporting that full co-payments are made.

Flexibility in Co-Payment Timing

Previous research has suggested that some parents may choose license-exempt care arrangements partially because license-exempt providers are more flexible regarding when payments are made. This may be especially important to families on austere budgets and to those who work irregularly. We consequently asked all parents who indicated that they typically made co-payments how much flexibility they had with respect to when the co-payments were made. Table 14-2 indicates that 50.2 percent of these parents said they had a lot of flexibility as to when payments were made, while 35.1 percent reported having some flexibility and only 13.1 percent had no flexibility. Given that licensed child care arrangements often cannot offer such flexibility in payment schedules, this finding that over 85 percent of parents reported at least some flexibility in paying their license-exempt providers is striking.

Table 14-2. Knowledge of Co-Payment Requirements, and Payments Actually Made

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Illinois Child Care Program Requires Co-Payment to Main Provider				
Yes	94.7	93.2	98.9	92.4
No	5.3	6.8	1.1	7.6
Average amount of co-payment required in typical month for all children (n=259)[1]	$79.45	$70.90	$95.60	$73.55
Average amount of co-payment actually made in a typical month (n=259)[1]	$76.10	$70.79	$88.75	$70.09
Percentage of required co-payment reported as being made (n=259)[1]				
0 % - 49.9%	2.3	2.2	3.8	1.1
50.0 % - 99.9%	5.0	2.2	7.5	5.6
100 %	92.7	95.5	88.8	93.3
Flexibility in Making Co-Payments (n=267)[2]				
A lot	50.2	33.7	56.3	61.1
Some	35.1	46.1	35.0	24.4
None	13.1	19.1	7.5	12.2
Don't know	1.5	1.1	1.3	2.2

[1] Only those parents with usable information on both the amount of co-payments required and actually made are included.

[2] Only those parents who indicated that they made co-pays were asked about co-payment flexibility.

Exchange of Goods and Services in Return for Child Care

Another issue related to payment flexibility concerns the form of payments that parents make for their child care. In particular, while cash payments almost always are required by child care centers and other licensed providers, it has been argued that parents sometimes can exchange goods or services with license-exempt providers in return for child care. We consequently asked parents if they provided goods or services to the main provider in return for child care, and 30.7 percent reported doing so (Table 14-3). This subset of parents detailed a wide range of services in response to an open-ended follow-up question (Table 14-3). Food was the most common among these, with 51.6 percent of those who exchanged goods and services mentioning the provision of food. Transportation or taking the provider places (24.7 percent) and doing housework for the provider (12.9 percent) were mentioned the next most frequently.

Table 14-3. Parent Reported Exchanges of Services with License-Exempt Providers in Return for Care

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Exchange Services with Main Provider in Return For Child Care				
Yes	30.7	28.6	30.1	33.3
No	68.6	69.5	69.9	66.7
Selected Types of Services Provided by Parents In Return for Child Care	**(n=93)**	**(n=30)**	**(n=28)**	**(n=35)**
Food	51.6	53.3	42.9	57.1
Transportation/takes places	24.7	16.7	28.6	28.6
Housework	12.9	3.3	25.0	11.4
Loans/extra money	5.4	16.7	0.0	0.0
Buys clothing	5.4	13.3	0.0	2.9
Buys cigarettes	5.4	10.0	0.0	5.7
Help in any way provider needs	5.4	0.0	3.6	11.4
Cooks for provider	4.3	3.3	7.1	2.9
Helps pay bills	4.3	6.7	3.6	2.9

Differences by Region and Relationship of Parent and Provider

There were few statistically significant regional differences in the cost and co-payment information presented in this chapter, and no significant differences with respect to whether or not the provider was related to the focal family. One significant regional difference concerned reported average monthly care costs, which were highest in Peoria County ($97.85), followed by North and South Lawndale ($89.72) and the Southern Seven area ($72.13). Similarly, reported average required co-payment amounts were significantly higher in Peoria County ($95.60) than in the other two study areas ($73.55 in Southern Seven and $70.90 in North and South Lawndale).

A final area of significant regional difference involved the flexibility that parents reported having in the timing of co-payments. As shown in Table 14-2, North and South Lawndale parents were much less likely to report having a lot of flexibility in when they made co-payments than were Peoria County and Southern Seven area respondents (33.7 percent in North and South Lawndale versus 56.3 percent in Peoria County and 61.1 percent in the Southern Seven area).

Chapter 15:
Parent and Provider Perceptions about Subsidy Policies and Program Impacts

The specific context in which child care takes place is of obvious importance in assessing how parents and providers view license-exempt care and the impacts it may have. Because the policies and procedures associated with subsidy programs constitute an important part of this caregiving context, we questioned both parents and license-exempt providers concerning their views about the Child Care Assistance Program (CCAP). Our intent was to gain a better understanding of their perspectives on both the strengths and weaknesses of this subsidized license-exempt caregiving context, and also to explore their views about the impacts of subsidies on caregiving practices.

We turn to these issues in this chapter. Respondent perceptions about various aspects of the Illinois program are presented first. We discuss how parents and providers learned about the program, what they viewed as positive program aspects and areas in need of change, and how they assessed program functioning in selected respects. We then examine how the care provided to respondents' children may differ in the absence of the subsidies, and also discuss how subsidies may affect the quality of license-exempt care provided.

Learning about the Subsidy Program

Consistent with the goals of the CCDF, the CCAP is a parent-driven system where parents are responsible for selecting their child care providers before they can submit a subsidy application. While the Child Care Resource and Referral (CCR&R) agencies will assist parents in locating a legal provider if requested, most license-exempt caregivers are not listed in the databases that the CCR&Rs use for this purpose. Thus, license-exempt providers most likely learn about the CCAP from the parents seeking care or through other informal sources. However, the extent to which this is true has not been previously examined, and little is known about how parents learn about the CCAP.

Table 15-1 presents parent and provider responses to a question asking how they had heard about the CCAP. The data reveal that parents most often learned about the program through IDHS. Over 44 percent of the parents had learned about the program from their IDHS caseworker, and an additional 10.6 percent responded to flyers, posters, or mailings distributed by IDHS. Follow-up questions were not included to determine how these parents became involved with IDHS caseworkers. However, the high numbers of parents in the sample who were current or former TANF recipients suggest the likelihood that these parents commonly became linked to the child care program through their TANF experiences (see Table 5-7).

Informal sources of information dissemination also were common. Over one-fourth of parents reporting that they learned about the program from friends (18.5 percent) or a relative (9.6 percent).

As expected, providers were much more likely to have found out about the program through the focal family, with 37.3 percent of providers mentioning this source. In addition, 24.1 percent learned about the program from other relatives and 19.8 percent learned about it from

friends. Taken together, 81.2 percent of providers had learned about the program from one of these three sources.

Table 15-1. How Parents and Providers Learned about the Child Care Assistance Program

	Total Sample (n= 303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Parents Heard about Program from:				
IDHS caseworker	44.6	38.1	46.2	49.5
Friend	18.5	19.0	22.6	14.3
IDHS flyer, poster, or mailing	10.6	18.1	5.4	7.6
Relative	9.6	6.7	9.7	12.4
Child Care Resource and Referral Agency	2.6	5.7	1.1	1.0
Other	12.9	11.4	12.9	14.3
Don't know	1.3	1.0	2.2	1.0
Providers Heard about Program from:				
Focal family	37.3	22.9	53.8	37.1
Other relative	24.1	38.1	8.6	23.8
Friend	19.8	27.6	16.1	15.2
Caseworker	6.9	6.7	3.2	10.5
Child Care Resource and Referral	1.7	1.0	2.2	1.9
IDHS mailing, poster, or flyer	1.3	2.0	0.0	1.9
Other	7.9	1.9	12.9	9.5
Don't know	1.0	0.0	3.2	0.0

Assessments of Program Strengths and Needed Improvements

Most Positive Aspects of CCAP

All parents and providers were asked what they liked best about the CCAP. Ninety-eight (98.0) percent of parents and 95.0 percent of providers identified at least one most positive aspect of the program. Table 15-2 describes the most frequently mentioned responses for parents.

Parents most often referenced how the program provided financial help or help with child care costs as the most positive aspect of the CCAP; 42.8 percent of those with positive comments mentioned this attribute. In addition, 7.4 percent indicated that the program provided help to low-income or single parents, and 12.8 percent made broad but non-financially specific references to

the help they had received through the program. Nearly 11 percent emphasized that the program was important in allowing them to work or attend school.

Table 15-2. Parental Perceptions about Most Positive Aspects of the Child Care Assistance Program

	Number of Comments	Percentage of All Parents Offering Positive Comments (n=297)
Helps financially/helps with child care costs	127	42.8
Helps generally	38	12.8
Staff helpfulness or availability	36	12.1
Helps parents go to work or attend school	32	10.8
Helps single or low-income parents	22	7.4
Program efficiency or timeliness of actions	20	6.7
Low required co-payment	11	3.7
Convenience	11	3.7
Parent can choose desired care arrangements	10	3.4
Ability to use relative caregivers	10	3.4
Knows children will be well cared for/safe	6	2.0
Provider receives income	6	2.0
Helps parents save money	6	2.0
Ease of application or paperwork	5	1.7

Many respondents also referenced specific features of the CCAP or its operation in discussing the most positive program features. Positive comments about the helpfulness or availability of staff were reported most often (12.1 percent of those offering positive comments). In addition, 6.7 percent mentioned various aspects of program efficiency or timeliness of response, and 1.7 percent cited the ease of the application process or of program paperwork. The perceived low level of required co-payments was emphasized 3.7 percent of those parents offering positive comments. Finally, many parents stressed the provision of parental choice in

the program, with 3.4 percent indicating that parents can choose the care arrangements they desire and 3.4 percent citing their ability to use relative caregivers.

Table 15-3 summarizes the most frequent provider responses to the same open-ended question on most positive program aspects. Providers most often mentioned that the program provided help to parents and families (28.7 percent of those offering positive comments). In many cases, these comments added that this help allowed parents to work or to better themselves. The next most frequent type of positive response pertained to how the program provided jobs or pay. These included both general references by the provider to getting paid or getting a job (17.5 percent), as well as comments that also suggested satisfaction in being able to care for children for pay or in being involved in productive work (10.1 percent).

Many providers also mentioned particular aspects of the program or how it operates as most positive. These included references to the fact that the program allowed caregiving by relatives (14.3 percent of those with positive comments); positive comments about how program staff answered their questions or provided useful program information (12.9 percent); and positive treatment in their interactions with staff (6.6 percent). In addition, 12.2 percent referred to the timeliness with which their payments for child care were received from the program.

Table 15-3. License-Exempt Provider Perceptions about Most Positive Aspects of the Child Care Assistance Program

	Number of Comments	Percentage of All Providers Offering Positive Comments (n=286)
Helps the parents/families that receive child care	82	28.7
Provides pay or jobs	50	17.5
Allows caregiving by relatives	41	14.3
Staff answers questions/provide information	37	12.9
Timeliness of payments	35	12.2
Get paid for caring for children or productive work	29	10.1
Positive treatment by staff	19	6.6
Able to stay home and/or watch own child	15	5.2
Provider can use pay to help children in care	7	2.4
Helps children	5	1.7

Needed Changes in the CCAP

All parents and providers were asked what most needed to be changed about the CCAP. Slightly over half of the parents (53.1 percent) and 44.2 percent of providers responded that no changes were needed. Another 1.7 percent of parents and 3.6 percent of providers indicated that they did not know of any needed changes.

Table 15-4 describes the most commonly offered recommendations for program changes made by parents. Payment-related issues were the most frequently recommended program changes. Nearly one-fifth (17.8 percent) of parents who mentioned at least one needed program change recommended increasing provider pay rates, and 11.9 percent suggested that parental co-pays should be lowered. In addition, 14.1 percent of these respondents indicated that either the frequency of payments or the speed with which payments were processed should be improved. For example, some respondents suggested that providers be paid every two weeks, as opposed to the current monthly payment system. Several respondents also recommended pay enhancements for particular circumstances. These included suggestions such as pay increments based on the age of the child, weekend and holiday pay, and overtime pay. It should be noted that some such comments reflected confusion about the existing system, as both holiday and weekend pay are allowed if the parent is working or in school.

Table 15-4. Parental Perceptions about Aspects of the Child Care Assistance Program That Need To Be Changed

	Number of Comments	Percentage of All Providers Offering Change Comments (n=135)
Paperwork/application process improvements	29	21.5
Increase provider pay	24	17.8
Increase speed/frequency of provider payments	19	14.1
Lower parent co-payment	16	11.9
Expand eligibility or care resources	11	8.1
Caseworker access or attitudes	11	8.1
Pay enhancements (non-general)	9	6.7
Agency access	7	5.2

Many parents also recommended non-payment related changes in the operation of the program. Slightly over one-fifth (21.5 percent) of those suggesting program changes mentioned various improvements in program paperwork or application procedures. These comments generally referred to a desire for faster processing of applications or other paperwork, as well as to a general desire for less paperwork. Fairly small subsets of parents also cited issues related to caseworker accessibility or attitudes (8.1 percent), as well as more structurally related agency access issues (5.2 percent). These latter responses included parents who found the agency location difficult to access, or who complained about understaffing or staff turnover. Finally, 8.1 percent of the parents recommending changes suggested eligibility expansions, including higher income eligibility standards and eligibility for children age 13 and over.

Table 15-5 provides comparable responses to the most needed program changes question from the provider perspective. Increasing the rate of pay was easily the most often suggested program change; nearly two-fifths (37.3 percent) of those providers mentioning program changes recommended pay rate increases. In addition, 8.9 percent of these respondents cited the need for improving the speed of payment processing, and 7.6 percent desired changes in the payment schedules. As with parents, these scheduling recommendations generally referenced shorter periods between pay issuances, such as biweekly. A small subset of providers (3.2 percent of those suggesting changes) sought changes in the way taxes were treated in the current system, with a preference among some to institute tax withholding. Because child care providers are considered self-employed, the program does not withhold income taxes, and some providers found this troubling when taxes came due.

Table 15-5. License-Exempt Provider Perceptions about Aspects of the Child Care Program That Need To Be Changed

	Number of Comments	Percentage of All Providers Offering Comments (n=158)
Increase pay	59	37.3
Improve paper processing/information dissemination	27	17.1
Improve payment processing	14	8.9
Improve staff availability/caseworker performance	14	8.9
Change timing of payments	12	7.6
Lower parent co-pays	10	6.3
Improve training/educational opportunities	6	3.8
Eligibility expansions	6	3.8
Taxation issues	5	3.2

Among non-payment related provider issues, improving paperwork processing or information about the program was most often noted as an area of needed improvement (17.1 percent of providers suggesting program changes). Improving the availability of staff or other aspects of caseworker performance were mentioned by 8.9 percent, and lowering the co-payments required of parents was mentioned by 6.3 percent. Finally, a small number of providers recommended program eligibility expansions, with all of these comments pertaining either to raising the income eligibility level or allowing care for children age 13 and over.

Perceptions about Selected Aspects of CCAP Performance

Parents were asked whether they had experienced five types of problems with the CCAP. These included paperwork difficulties, trouble in getting applications approved, lack of helpfulness by program staff, trouble reaching program staff, and lack of enough information about the program. While 35.0 percent of parents indicated that they had experienced at least one of these problems, only 15.5 percent stated they had encountered more than one of these problems. No specific problem was mentioned by even one-fifth of respondents (Table 15-6). Parents most commonly mentioned problems in reaching CCAP program staff, with 16.8 percent of parents indicating that this was a problem.

Parents also were asked if they had experienced any other problems with the CCAP, and if so, to identify the nature of these problems. About 16 percent of parents stated that they had encountered other problems, and these problems tended to be quite diverse. The most commonly cited among these was delays in payments, which were mentioned by 5.0 percent of parents. It should be noted that subsidy payments are sent directly to the providers, so it is likely that these comments reflect complaints that parents received from their providers. Lost paperwork was mentioned as a problem by 3.3 percent of parents, and paperwork delays were noted by 1.7 percent of parents.

Providers were less likely than parents to indicate that each of the program issues shown in Table 15-6 had been a problem for them. About one-fourth (25.4 percent) had experienced at least one of the five problems, and only 11.2 percent had experienced more than one of these. Having trouble reaching program staff and not receiving enough information about the program were the only specific problems mentioned by over one-tenth of providers (11.2 percent and 11.6 percent respectively).

Providers were slightly more likely than parents to mention other types of problems with the CCCP, with 19.1 percent suggesting at least one problem not specifically referenced in Table 15-6. Among those mentioning other types of problems, concerns about late payments or slowness in processing payments were most prevalent (6.6 percent of all providers). General complaints about paperwork burdens being too great were referenced by 3.3 percent of providers. Finally, about 6 percent of providers referenced some problem with caseworker performance in disseminating information, losing documents, or incorrectly calculating payment amounts.

Table 15-6. Parent and License-Exempt Provider Reports of Selected Problems with the Child Care Assistance Program

	Percent of Indicating Each Problem:			
	Total Sample (n=303)	**North & South Lawndale (n=105)**	**Peoria County (n=93)**	**Southern Seven (n=105)**
Parents:				
Paperwork was hard to complete	11.2	11.4	11.8	10.5
Had trouble getting application approved	11.2	11.4	7.5	14.3
Program staff have not been helpful	10.6	12.4	9.7	9.5
Have had trouble reaching program staff	16.8	18.1	20.4	12.4
Did not receive enough information	11.9	17.1	11.8	6.7
Other problems	16.2	21.9	16.1	10.5
Providers:				
Paperwork was hard to complete	6.9	2.9	14.0	4.8
Had trouble getting application approved	7.6	7.6	8.6	6.7
Program staff have not been helpful	6.5	6.7	7.5	5.7
Have had trouble reaching program staff	11.2	9.5	15.6	9.5
Did not receive enough information	11.6	16.2	11.8	6.7
Other problems	19.1	24.8	25.8	7.6

The Impact of the CCAP on License-Exempt Caregiving

An important issue in assessing subsidized license-exempt caregiving concerns how the subsidies may affect either the nature or the quality of the care that is provided. Given that such a large proportion of license-exempt caregivers is relatives, a particular public policy concern revolves around the extent to which subsidies supplement rather than supplant care that otherwise may be provided informally without public cost. We asked parents and providers several questions intended to clarify this and related issues concerning subsidy impacts.

Provision of Care Prior to Subsidy Receipt

One interesting question in terms of subsidy impact concerns the extent to which parents already were using license-exempt caregivers before they received a subsidy. Such prior care does not necessarily imply that parents do not need financial assistance, or that the duration or consistency of care are unaffected by subsidies. Nonetheless, prior non-subsidized care receipt can provide a crude indication of whether subsidies are stimulating new caregiving arrangements as opposed to adjustments in existing relationships. It also may signal the existence of strong ties with providers, which have been argued to be a major strength of license-exempt care.

We asked all parents if the main provider had been caring for any of their children before they began receiving subsidy payments for this care. As shown in Table 15-7, nearly two-thirds of parents stated that the main provider already had been providing care for at least one of their children. A follow-up question asked how long those providers who already were providing care had cared for any child in the family before subsidy receipt began. There was considerable variation in these responses, with a range from 1 month to 12 years. The median length of time in care prior to subsidy receipt was six months.

Continued License-Exempt Care Provision If Subsidy Ended

Parents also were asked to assess whether they would continue to use the main provider to care for the focal child if subsidy receipt ended. Nearly 93 percent of parents indicated that they would do so, while only 5.0 percent said that they would not (Table 15-7). Those 15 parents who stated that they would no longer use the main provider without a subsidy also were questioned as to why this would be the case. These respondents most commonly indicated that they would not be able to afford to pay the provider, or that the provider would no longer be willing to provide care.

Providers correspondingly were asked whether they would continue to provide care for the focal child if a subsidy no longer was available. Consistent with parental responses, 96.4 percent of the providers stated that they would continue caring for the focal child. Taken together, 90.4 percent of the paired responses were in agreement that care by the main provider would continue even if the subsidy was not available.

Changes in Schedule and Payments If Subsidy Ended

Even in the event that parents would continue using their license-exempt providers if subsidies were not available, it is conceivable that they would have to change their care schedules or reduce the amount they paid for care. We therefore asked those parents who said they would continue to use the main provider in the absence of subsidies if corresponding schedule or payment changes would be required.

Table 15-7. Use of Main Provider before Subsidy Receipt, and Perceived Future Use of Main Provider if Subsidy Ended

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Main Provider Cared for Focal Child in Family Before Subsidy Receipt				
Yes	65.7	65.7	75.3	57.1
No	34.3	34.3	24.7	42.9
Parent Would Continue to Use Main Provider if Subsidy Receipt Ended				
Yes	92.7	89.5	93.5	95.2
No	5.0	7.6	3.2	3.8
Don't know	4.3	2.9	3.2	1.0
Provider Would Continue Caring for Focal Child if Subsidy Receipt Ended				
Yes	96.4	94.3	97.8	97.1
No	3.3	5.7	1.1	2.9

Table 15-8 presents these results. Nearly 92 percent of those parents who would continue using the main provider indicated that they could maintain their current child care schedule. The 4.3 percent who said that schedule changes would be necessary were asked to specify how their schedules would change. The most common responses among this small subset of parents were that they would stop going to school or change their work hours.

Parents were asked if they would continue to pay the main provider and 85.8 percent of all parents said that they would. However, only 45.0 percent of those parents who would continue paying indicated that they would pay the same amount as currently. The 46.2 percent who said they would pay a different amount were asked how this amount would differ, and responses varied considerably. Respondents typically stated that they would not be able to pay the provider as much as the subsidy amount, and some suggested that they only could afford the co-payment amount. The need to develop special payment plans or schedules or to pay when the parent could afford it also was suggested by many respondents. Others recognized that they would be forced to pay higher out-of-pocket costs, or else simply indicated that they would pay as much as they could.

Providers who indicated they would continue caring for the focal child correspondingly were asked how the lack of subsidies would affect the payment they received for caregiving. As

shown in Table 15-9, only 42.8 percent of these providers said that they would be paid by the parent for providing care. In addition, only 36.8 percent of those who said they would be paid by the parent thought that they would be paid the same amount as under the subsidy program. Therefore, only 15.2 percent of the providers indicated that they both would continue to provide care for the focal child and would expect to receive the same pay that they currently were receiving.

Taken together, these findings suggest that considerable caregiving would likely continue among the parent and provider pairs in this sample even if subsidies were not available. However, both parent and provider responses suggested that payments for care would be disrupted in most of these cases. This raises serious questions about the stability of such care arrangements over time in the absence of subsidized payments.

Table 15-8. Perceived Schedule and Payment Changes Among Parents Who Would Continue to Use Main Provider If Subsidy Ended

	Total Sample (n=281)	North & South Lawndale (n=94)	Peoria County (n=87)	Southern Seven (n=100)
Would Continue Using Same Schedule as Currently				
Yes	91.8	89.4	95.4	91.0
No	4.3	6.4	2.3	4.0
Don't know	3.9	4.3	2.3	5.0
Would Pay the Same Amount to Main Provider As Currently (for those who still would pay main provider)	**(n=260)**	**(n=84)**	**(n=83)**	**(n=93)**
Yes	45.0	35.7	41.0	57.0
No	46.2	53.6	50.6	35.5
Don't know	8.8	10.7	8.4	7.5

Table 15-9. Expected Payment Changes Among Providers Who Would Continue to Care for Focal Child If Subsidy Ended

	Total Sample (n=292)	North & South Lawndale (n=99)	Peoria County (n=91)	Southern Seven (n=102)
Would Expect To Be Paid by Parent				
Yes	42.8	42.4	49.5	37.3
No	53.1	52.5	45.1	60.8
Don't know	3.8	5.1	4.4	2.0
Would Expect To Be Paid the Same Amount As Currently (for those expecting to be paid)	**(n=125)**	**(n=42)**	**(n=45)**	**(n=38)**
Yes	36.8	33.3	42.2	34.2
No	56.0	59.5	53.3	55.3
Don't know	7.2	7.1	4.4	10.5

Impact of Subsidies on Caregiving Practices

Some participants in our initial project focus groups argued that the subsidy allowed license-exempt providers to do things for children in care that they otherwise could not. We therefore asked both parents and providers about this possibility. Table 15-10 shows that 74.9 percent of parents and 71.9 percent of providers thought that the subsidies allowed providers to do things for the focal child that otherwise would not be possible.

Those parents and providers who indicated that the subsidy allowed the provider to do additional things were asked what it was that the provider did. The most common responses to this open-ended question are summarized in Table 15-11. In most cases, the response patterns for parents and providers were similar. About two-fifths of each group indicated that the subsidies allowed the provider to take the focal child on more outings or to more activities, such as museums, zoos, or parks. Purchasing food or taking children out to eat was mentioned by over half of the parents (53.6 percent) and by one-third (32.9 percent) of the providers. Nearly one-fourth of each group referred to purchases of toys, games, or recreational equipment, and clothing purchases also were cited by many. Perhaps not adequately reflected in the numbers was the fairly basic nature of many of these purchases. For example, even when talking about taking children out to eat, inexpensive restaurants such as McDonalds most often were noted.

Table 15-10. Impact of Subsidy Payment on Caregiving Practices with Focal Child (Percentage Distribution)

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
Subsidy Has Allowed Caregiving Practices that Otherwise Would Not Occur				
Parents				
Yes	74.9	73.3	79.6	73.3
No	21.1	24.8	16.1	21.9
Don't know	4.0	1.9	4.3	5.7
Providers				
Yes	71.9	72.4	83.9	61.0
No	27.4	25.7	16.1	39.0

Table 15-11. Most Common Parent and Provider Responses on Additional Things Subsidies Allow Providers to Do for Focal Child (Percentages of Those Who Indicated Subsidies Allow Additional Practices)

	Percentage of Parents (n=224)	Percentage of Providers (n=213)
Purchase food or take out to eat	53.6	32.9
Take to activities (i.e., museum, zoo)	41.5	39.0
Purchase toys/games/recreational equipment	24.6	23.5
Purchase clothes	14.7	22.1
Buy books or educational materials	10.3	18.8
Purchase pampers/diapers	5.8	5.2
Purchase presents/treats – general	5.4	9.9

Perceived Co-Payment Differences If Licensed Care Was Used

A final area of subsidy impact we considered concerns the possible effects on parental care choices of having comparable co-payments for licensed and license-exempt care. Such equal co-payments in theory should minimize cost considerations during the process of provider choice. Yet, focus group discussions with parents during the initial stages of this project suggested that many parents did not understand that required co-payments would be the same regardless of the provider selected (see Anderson, Ramsburg, and Rothbaum (2002) for further discussion). In addition, parents indicated that centers sometimes had rates higher than the allowable CCCP levels, or else charged one-time application or other fees. To the extent that these practices occurred, the total costs facing parents who chose such arrangements would be higher even if the required co-payments were the same.

Two questions were included to test the extent to which parents perceived cost differences between licensed and license-exempt providers. Parents first were asked whether their co-payment amounts required by the CCAP would be different if they used a child care center or licensed home provider instead of their current license-exempt provider. As shown in Table 15-12, despite the program policy of co-payment neutrality regardless of provider type, only 17.5 percent of parents thought their co-payment would be the same if they used a child care center or licensed home provider. Most parents indicated that their co-payment costs would be higher if licensed arrangements were used, with 39.3 percent suggesting that these costs would be much higher and 11.9 reporting they would be somewhat higher. A sizable subset (29.3 percent) said they did not know how co-payments would be affected if licensed providers were used.

A second question asked if overall cost differences would occur if licensed providers were used rather than the current license-exempt provider. The response patterns to this question were similar to the co-pay question, with most parents indicating that costs would be higher or that they did not know. The similarity in responses between these two questions suggests that the principal reason that parents perceived cost differences in these two types of care was related to their belief that co-payments would be higher in licensed settings, or else their lack of knowledge about co-payments.

Differences by Region and Relationship of Parent and Provider

Very few statistically significant differences emerged among the geographic areas or provider types with respect to the issues discussed in this chapter. As might be expected, relative caregivers were significantly more likely to have provided care before subsidy receipt (69.6 percent for relatives versus 53.5 percent for non-relatives). They also were slightly more likely to indicate that they would continue providing care if the subsidy ended, but these differences did not quite reach statistical significance.

Parent respondents in Peoria County were more likely to report that their providers cared for the focal child before subsidy receipt (75.3 percent versus 65.7 percent in North and South Lawndale and 57.1 percent in the Southern Seven area). Peoria County providers likewise were significantly more likely to report that the subsidies allowed them to do additional things for the

focal child (83.9 percent versus 72.4 percent in North and South Lawndale and 61.0 percent in the Southern Seven area). It may be that these longer pre-existing care arrangements in Peoria County predisposed providers to more frequently use subsidy payments to do additional things for children in their care.

Table 15-12. Parent Perceptions about the Impact of Licensed versus License-Exempt Care Choice on Co-payment Levels and Overall Costs

	Total Sample (n=303)	North & South Lawndale (n=105)	Peoria County (n=93)	Southern Seven (n=105)
If Parent Used Child Care Center or Licensed Home Provider, Co-payments Would Be:				
Much higher	39.3	44.8	32.3	40.0
A little higher	11.9	14.3	11.8	9.5
The same	17.5	11.4	17.2	23.8
A little lower	1.3	1.0	3.2	0.0
Much lower	0.3	0.0	0.0	1.0
Don't know	29.4	28.6	35.5	24.8
If Parent Used Child Care Center or Licensed Home Provider, Overall Child Care Costs Would Be:				
Much higher	43.9	50.5	37.6	42.9
A little higher	12.2	12.4	11.8	12.4
The same	15.5	9.5	16.1	21.0
A little lower	1.0	1.0	1.1	1.0
Much lower	0.7	1.0	1.1	0.0
Don't know	26.4	25.7	32.3	21.9

Finally, there were significant geographic differences on two of the questions on problems with the CCAP. First, providers in Peoria County were more likely to report finding the paperwork hard to complete than those in the other two areas (12.9 percent in Peoria County versus 2.9 percent in both North and South Lawndale and the Southern Seven area). Second, parents in Peoria County and in North and South Lawndale were more likely to report difficulties in reaching staff than Southern Seven parents were (24.2 percent in Peoria County, 21.5 percent in North and South Lawndale, and 12.1 percent in the Southern Seven area).

Chapter 16: Conclusions and Recommendations

As subsidized child care programs continue to evolve, license-exempt caregiving will play a central role in policy debates regarding how to best stimulate both access to and quality of care. This study has sought to illuminate a range of issues related to license-exempt caregiving by focusing on one large state program where this is a principal form of care. The development of a large linked random sample of parents and their license-exempt caregivers offers parental and provider perspectives on a scale not previously presented in subsidized license-exempt caregiving environments.

This concluding chapter integrates and highlights the study findings that appear most pertinent as policymakers consider whether and under what circumstances to support this type of care. We also offer selected policy recommendations based on these findings. In addition, further areas of research that are potentially fruitful are identified, and limitations of study results are discussed.

We first should clearly state our overarching conclusion that the choice of license-exempt providers by parents, the motivations of caregivers in providing care, and the satisfaction with care arrangements among parents and providers in this study all were highly positive. There is little evidence from any of these findings to suggest that license-exempt care generally results from a desire for other forms of care by most parents, although the non-traditional and sometimes irregular hours that many subsidy recipients work do place practical constraints on using licensed options.

Our recommendations therefore focus on how public policies and programs can best support this form of care provision, as opposed to arguing that public support for license-exempt care should be significantly constrained. Further, to the extent that one argues that public programs should target limited resources solely on licensed care provision to ensure a minimum standard of care provision; our findings suggest that a broad public education effort would be needed to convince many low-income parents about the advantages of licensed care.

The Prevalence of License-Exempt Care and Comparisons with Licensed Care Provision

The degree to which parents are offered choice in the selection of caregivers is an important and complicated one. The Illinois CCAP is grounded in the CCDF principle of promoting parental choice of care, in that it has instituted only minimal requirements for license-exempt providers and has equalized the co-payments parents pay for licensed or license-exempt providers. In this program environment of open choice, statewide administrative data analysis revealed that 51.1 percent of families selected license-exempt providers in January 2003, and 58.5 percent of children in the CCAP were receiving care from a license-exempt provider at that time. Further, the vast majority of families were solely using either license-exempt care or licensed providers at single points in time, as opposed to multiple providers.

The use of license-exempt care in the program was considerably higher over time. Analyzing a cohort of 45,445 subsidy families that entered the CCAP for the first time in FY 1999, we found that 70.4 percent of these families had used at least one license-exempt provider

within three years in the program. This analysis further demonstrated that nearly one-fourth (22.6 percent) of families had used both licensed and license-exempt providers within three years of subsidy receipt. Thus, while the combined use of licensed and license-exempt care at single points was uncommon, it was not unusual for families to utilize both types of care over time.

Types of License-Exempt Providers Used

The subsidized care provided through the CCAP most often is provided by relatives, and also usually occurs in the child's home. For example, relatives provided 62.3 percent of subsidized license-exempt care for families in January 2003, and 54.6 percent of all subsidized license-exempt care used by families in the same month occurred in the child's home. In addition, our survey data revealed that sizable numbers of families benefiting from subsidized child care live in the same household as their license-exempt caregivers. These findings suggest the close relationships that families typically enjoy with their caregivers, as well as again indicating the convenience of many of these caregiving relationships.

Characteristics of Families Using Licensed versus License-Exempt Care

Administrative records allowed selected comparisons of the characteristics of families using subsidies for licensed versus license-exempt care. Interesting differences were found in licensed and license-exempt care patterns according to family size and age of children. In particular, while families with one child were much more likely to use a licensed than license-exempt provider in January 2003 (64.8 percent versus 32.4 percent), those with more than one child were more likely to use a single license-exempt provider (54.7 versus 31.6 percent). This suggests that families with multiple children may experience difficulties in finding slots in the same licensed setting, or in juggling school or other schedules of different children. Given that parents reported the importance of convenience and location in their child care choices, license-exempt providers appear to provide a relatively convenient option for such families (see following section).

Administrative data analysis also demonstrated that among children under age 13 receiving subsidies, license-exempt care easily was most prevalent among children age 6 and over. For example, 74.9 percent of children in this age group were using license-exempt providers in January 2003. Use of license-exempt care was next most common among children under age 1, while licensed provision was most common among those age $1 < 2.5$ and those age $2.5 < 6$. While we should note that license-exempt care remained prevalent even in these age groups, this trend is consistent with numerous other studies that find the predominant use of center-based settings during the preschool years after infancy, followed by a strong use of license-exempt care after children enter school.

The age of the CCAP household heads was very similar in families using subsidies for licensed versus license-exempt care (29.1 years for licensed versus 30.0 years for license-exempt). Slightly higher proportions of parents using license-exempt care were in the 30 and over age group, while parents using licensed care were more likely to fall in the 20-23 age group.

The CCAP serves a very low-income population, with average quarterly household incomes of only $2,686 in January 2003. The importance of the program in the implementation of welfare reforms also is illustrated by the high numbers of subsidy families who either currently or formerly received TANF.

Average and median incomes for households using only license-exempt care were slightly lower than for households using only licensed care. These average differences were only $213 per quarter, or approximately $850 per year. Nonetheless, parents interviewed in our survey often assumed that out-of-pocket licensed care costs would be higher than their current license-exempt costs. Consequently, further research that carefully controls for the effects of income and costs on parental choices of subsidized licensed versus license-exempt caregivers is needed. The design of such research is complicated by differences in actual versus perceived costs, as was illustrated by the lack of knowledge about co-payment requirements for different kinds of care among our respondents (see following section on "Factors Leading Parents to Choose License-Exempt Care").

Lengths of Care Spells and Repeat Subsidy Use

Administrative data analysis for the cohort of subsidy families entering care for the first time in FY 1999 showed that such cases remained open for slightly over one year on average (13.4 months). There was virtually no difference in these initial spell lengths for families that relied exclusively on license-exempt versus licensed care, while those who used combinations of both types of care had substantially longer spell lengths.

About two-thirds (65.6 percent) of the subsidy cases that closed for the first time in FY 2000 did not use the CCAP again within two years of this case closing. The differences in subsequent use among families that had relied strictly on license-exempt or licensed care were not great, with 67.0 percent of the license-exempt only and 73.4 percent of the licensed only cases not using the program again within two years. In contrast, the much smaller number of cases that used both licensed and license-exempt care during their initial spell were less likely to not use the program again within the two year period analyzed (40.6 percent). Although our data do not allow a definitive answer as to the reason for this difference, one possibility is that those mixing care are more likely to have complex care needs requiring a variety of supports, including repeat use of the subsidy program.

Factors Leading Parents to Choose License-Exempt Care

The common selection of license-exempt providers in the CCAP could be driven by a variety of factors, including constraints such as expected costs and licensed child care supply issues. However, interviews with parents suggested that positive attributes of license-exempt caregiving generally were more dominant in the provider selection process in this program. The dominance of trust as a parental decision-making factor, which is consistent with numerous prior national and state studies, is particularly striking in this respect. In selecting their three primary reasons for choosing their current license-exempt provider, 85.4 percent of parents in this sample selected trust. The fact that nearly 95 percent of parents in our sample indicated that they would choose their current license-exempt provider even if cost was not a factor also is notable, as is

the extremely high level of reported parental satisfaction with caregiving. Correspondingly, two out of three parents indicated that they had not considered any other option in making their child care decision.

The importance of license-exempt caregiving in terms of convenience, location, and scheduling also was underscored by parents. Over half (55.1 percent) of parents reported convenience or location as one of the three most important reasons for selecting their license-exempt caregiver, and 31.2 percent mentioned scheduling. These assessments are reinforced by the large amount of care during non-regular hours reported both by parents and providers. For example, 70.0 percent of parents reported using child care during evening, overnight, or weekend periods *during the last week*, and 79.2 percent had required care during such non-traditional hours in the previous three months. Inconsistent work or school schedules appeared to be less of a difficulty, but nonetheless were noted by 18.7 percent of parents. When coupled with the fact that study respondents generally worked or were in school full-time, the important role that license-exempt caregiving played in supporting low-income parents facing shifting and non-traditional work schedules was apparent.

The extent to which these convenience and scheduling factors should be considered as positive choice features versus constraints deriving from the lack of child care centers during non-traditional hours is difficult to ascertain. However, even if the supply of non-traditional hour center care was increased dramatically, it appeared likely that many parents would opt for the safety and comfort of their own or a relative's home during evening or overnight hours. The flexibility in terms of emergency care, last minute scheduling changes, or being late to drop off or pick up children also is difficult to replicate in licensed settings. In addition, it must be underscored that such non-traditional care hours will continue to be needed by large segments of the low-income work force on which this study focused. For example, employment instability has been widely reported in studies of parents who leave welfare for work, as have the rotating shift and non-traditional hour schedules of many low-wage workers (see, for example, Anderson, Halter, Julnes, & Schuldt, 2000; Henly & Lyons, 2000). As pressures for low-income parents to become self-sufficient mount in the current post-welfare reform era, the need for child care during non-traditional hours is unlikely to diminish.

The relatively limited role that learning opportunities appeared to play in the decision-making process of most parents in this sample contrasts with the growing focus on school readiness in the child care field. Only 12.0 percent of parents selected learning opportunities among their three most important child care selection factors. Nor were learning opportunities prominently selected by parents when discussing the most important aspects of care quality for their children. This should not imply that parents in these settings are uninterested in learning opportunities for their children while in care. However, learning activities often may be secondary to more basic concerns such as trust in the caregiver and the extent to which care meets the demands of parental work or school schedules. If these more basic needs can be met and supported, it appears that most subsidy recipients also would be amenable to well-focused efforts to improve learning in whatever child care setting the parent selected.

There also has been insufficient attention in most research studies, including our own, to the extent to which parental caregiver choices are affected by community environmental factors.

For example, 47.9 percent of the parents in this sample lived in neighborhoods that they considered fair or poor. While only 16.8 percent of parents stated that their neighborhoods affected their child care choices, significantly higher numbers of parents in neighborhoods perceived as poor did so.

More research attention likewise is needed with respect to how neighborhood and surrounding community factors might influence child care quality across all types of child care settings. That is, in some neighborhoods the quality of all available child care options may fall below even the average or "mediocre" standard in most program environmental rating scales. Realistic concerns about safety also may be prevalent in many of these same neighborhoods. The sense of comfort that parents express for familiar caregivers therefore may be quite understandable if compared to an unfamiliar licensed setting of questionable quality.

Although only 30.2 percent of parents reported that affordability or cost was among their three most important considerations in selecting their current license-exempt provider, continuing attention to the role of cost in care selection is needed. Survey responses suggested that not many of these parents would switch to licensed settings even if reasonably priced licensed options were available nearby. However, there also was considerable confusion about the cost implications of using a licensed versus license-exempt provider, despite the efforts of the CCAP to make such choices cost neutral. That is, while subsidy co-payment levels are the same in the CCAP whether a licensed or license-exempt provider is used, only 17.5 percent of parents recognized this fact. In addition, the flexibility parents noted in the timing of payments to license-exempt providers further underscores that what appears to be a cost neutral choice often was not in practice.

Although not frequently mentioned by survey respondents as a factor in care selection, the large proportion of parents indicating that they had a child with special needs is noteworthy. Nearly two-fifths (38.0 percent) reported having at least one child with special needs. Asthma or other breathing-related issues were most commonly mentioned, followed by ADHD. Further research on how such special problems may affect child care choices, as well as the extent to which care in both licensed and license-exempt settings is responsive to such needs, would be useful given these reported high incidence levels.

License-Exempt Provider Characteristics, Care Patterns, and Motivations

Relatives were the most common type of license-exempt care providers used in the Illinois Child Care Assistance Program (CCAP), with 62.3 percent of all license-exempt care in July 2003 provided by relatives. Likewise, most license-exempt care statewide (54.6 percent) occurred in the child's home. Our survey respondents were even more likely to be relatives, with 76.4 percent related to at least one child in the focal family. The prevalence of grandparents among these relative caregivers is consistent with earlier studies. Slightly under half (46.2 percent) of all providers surveyed, and 60.6 percent of the relative caregivers, were grandparents. Aunts or uncles were the next most frequent type of relative caregiver, representing 17.9 percent of all providers surveyed.

The demographic and social characteristics of the license-exempt caregivers in many ways mirrored those of the parents they served. Consistent with the high proportion of grandparent providers, caregivers in the survey generally were older than the parents (average age of 42.0 versus 29.3 for parents). Over one-third (36.5 percent) were aged 50 and over. While they were more likely to be currently married and living with a partner than parents were, still only 26.9 percent were in such co-habitating situations. Yet, 62.3 percent had at least one other adult living with them in their household, which is largely attributable to the 30.7 percent who lived with the parent for whom they were providing child care.

The economic circumstances of subsidized license-exempt providers have received relatively little research attention, and yet these characteristics may have important implications for caregiving. In particular, providers in our survey were very likely to have low incomes, with 67.4 percent reporting annual incomes of less than $20,000 and 76.4 percent reporting incomes of less than $30,000. Consistent with these low-income characteristics, 55.8 percent reported a history of cash welfare receipt, although only 10.3 percent were current TANF recipients. Earnings from child care were reported to be the main source of personal income by 50.8 percent of these providers, and the main source of household income for 32.2 percent. The generally impoverished circumstances of both parents and providers may be helpful in interpreting the large numbers of parents and providers who indicated that the subsidies allowed providers to do things for children in care that they otherwise could not. The responses on the types of things that were done often centered on the provision of basic goods like food and clothing, or taking children to activities easily accessible to those with higher incomes.

Provider Care Patterns

Statewide administrative data provided useful information on the general care patterns of license-exempt providers. As intended by CCAP, these providers typically served relatively small numbers of children. For example, in January 2003, license-exempt providers were serving an average of 2.31 subsidized children. License-exempt caregivers provided an average of 19.7 months of care to the children they were serving at that time.

The survey data are consistent with these trends and also allow some useful elaborations in our study areas. First, the survey data allowed analysis of the total number of children in care, as opposed to only those in subsidized care. Using this more inclusive measure, the caregivers reported providing paid care for an average of 2.95 children in the past month. Even when their own children were included, the largest number of children cared for at one time averaged 3.51.

Most caregivers provided paid care solely for the focal family whose parent we also interviewed (80.4 percent). Only 7.9 percent were caring for subsidized children other than those in the focal family. Previous literature has suggested the unique importance of child care as a job that allows caregivers to simultaneously care for their own children, and 24.4 percent of providers in this sample did so.

Consistent with the parent survey data, providers typically provided care full-time (average of 35.9 hours). Likewise, the provision of non-traditional hour care was emphasized, with 66.1 percent indicating that they had provided such care in the last week and 84.1 percent in

the last three months. Most care was provided in the caregiver's home (75.4 percent), and 88.7 percent indicated that they had a back-up caregiver available if they were unable to provide care due to illness or other circumstances.

Provider Motivations for Caregiving

The most notable findings in our exploration of provider caregiving motives concerned the relative prominence of family and altruistic motives and the corresponding infrequency of economic motives. Perhaps this should not be surprising given both the prevalence of relative caregivers in our sample and the low pay levels for license-exempt providers. For example, 19.8 percent of providers indicated that wanting to help out the focal family was their most important reason for caregiving, and 15.5 percent reported their most important reason was a desire to have the focal family's children cared for by a family member. Enjoyment in caring for focal family children (9.9 percent), wanting to provide structure and discipline for the focal family's children (9.9 percent), and expecting to be a role model for the focal family's children (8.3 percent) all were offered as the most important care motivator by substantial numbers of providers. In contrast, needing to earn money was reported as the most important caregiving reason by only 5.6 percent of providers, and only 0.3 percent said they chose this work primarily because it was the only job they could find.

Consistent with previous research, a sizable proportion (25.1 percent) of the providers stated that being able to stay home with their own children was a major reason for providing care for the focal family, although only 4.0 percent said this was the most important reason. The subset of providers that that offered this as a major reason for care corresponds closely to the 24.4 percent of parents who said they were providing such care to their own children when interviewed.

Provider Education, Training, and Experience

As has been found in prior research, license-exempt providers in this study tended to have fairly limited formal education and training related to child care. Only 29.6 percent had attended any college, and a similar number had not finished high school. Only 14.5 percent had ever taken a college course in early childhood education or child development. Training also was quite limited. Nearly two-thirds (64.5 percent) of providers reported receiving some type of child care related training, with CPR and first aid most frequently mentioned. However, both the duration and adequacy of this training were questionable, as only one in five providers reported receiving any training in the last year.

Experience as paid caregivers was more extensive, with 48.6 percent of providers reporting at least five years of paid child care experience and 63.2 percent reporting at least three years of experience. Furthermore, providers often had cared for children for relatively long periods of time, and this care often had taken place prior to the receipt of subsidies. For example, 65.7 percent had cared for the focal child before subsidy receipt began, and providers reported having cared for at least one child in the focal family for an average of over three years (37.1 months).

Interest in Training, Licensing, and Resources

Nearly three-fourths (75.2 percent) of providers surveyed expressed an interest in receiving some type of training. Among these, there were fairly similar levels of interests in topics such as CPR, first aid, child development, and activities for children. Of those not expressing interest in training, 39.2 percent said they would be interested if child care compensation increased as a result. Providers also were asked whether selected reasons contributed to them not receiving more training, and two responses were most prevalent. First, 60.9 percent indicated that they did not know what training was available. Second, 41.7 percent said that they did not see a need for more training.

Large majorities of parents thought that it was important for providers to receive training in each of the following content areas: CPR, first aid, child development, health and nutrition, activities for children, and how to discipline and communicate with children. When asked if their providers had received adequate training in each of these areas, at least 75 percent replied affirmatively in each content area. It consequently is unlikely that impetus for further training for license-exempt caregivers in these families generally will emanate from parents.

Providers expressed less interest in becoming licensed than in receiving training. About one-third (34.2 percent) of providers said they were very interested in becoming licensed, and 23.4 percent were somewhat interested. Responses to a question on why these providers had not already become licensed also were revealing. Over half (52.7 percent) indicated that they did not know what was involved in getting licensed, and 51.4 percent noted that they only took care of family members and friends. A smaller portion (36.8 percent) stated that they only were taking care of children on a temporary basis. These findings are more telling when looking at type of license-exempt caregiver, as we found non-relatives much more likely (67.6 percent) to report they did not know what was involved, whereas relative caregivers were more likely (55.8 percent) to report that they only cared for family members and friends.

It also sometimes has been speculated that license-exempt providers avoid becoming licensed because of a reluctance to become involved with government bureaucracies. Yet, only 10.1 percent of the providers said that they did not become licensed because of a desire to avoid having the government in their homes for visits or background checks. In addition, relatively few providers mentioned either the length of time needed to become licensed or the costs associated with licensing.

There was considerable agreement among parents and providers that a wide range of resources would be helpful in enriching the care that children received. For example, over half of both parents and providers indicated that the following resources would be “very helpful”: safety equipment, resources to help children learn, access to recreational or community activities for children, someone for the provider to call when problems occur during child care, outdoor recreational equipment, and short-term backup when the provider is unable to provide care. When asked to distinguish the most important among these and other resources, it is encouraging to note that resources to help children learn was most often mentioned (34.7 percent of providers). Safety equipment (30.7) was selected the next most often. This further reinforces the

notion that learning opportunities may not play a primary role in the child care decision-making process, but may be important concerns for parents once the child is in care.

License-exempt providers generally work alone, and as our data demonstrated, often provide care during non-traditional work hours. The modes through which training is delivered consequently are an important concern. Providers most often suggested that books (63.6 percent), videotapes (61.1 percent), and newsletters (52.1) were the most convenient modes of receiving training, while workshops or classes (35.3 percent) and meetings with other providers (31.1 percent) received somewhat less support. Slightly over two-fifths of providers (42.4 percent) indicated that visits to their home would be very convenient for training purposes, and another 29.0 percent said such home visits would be somewhat convenient. Taken together, these findings suggest that experimenting with delivery mechanisms such as videotapes or public television programs (as are being developed in northern California)[20] may have considerable potential. Although e-mail or internet provision was less often viewed positively (27.6 percent said such provision would be very convenient), it is likely that the acceptability of this form of provision will grow as the internet continues to permeate households. Experimentation with internet-based training therefore seems a worthwhile area for further study.

One difficulty of videotape, television, and internet provision is monitoring the extent to which these resources are accessed and to which learning occurs. However, technologies do exist examining both take-up rates and learning through these delivery modes, so such research would be useful.

Parent and Provider Perspectives on Quality of Care and Caregiving Relationships

Both parents and providers selected three qualities they considered most important in caring for the focal child, from among eight quality factors linked to child outcomes in previous child care research. Safety was selected most often overall, with 76.9 percent of providers and 67.6 percent of parents choosing safety among their three most important qualities. Positive provider-child relationships were selected the most often by parents (68.3 percent), while health was mentioned second most often after safety by providers (45.2 percent). In contrast, caregiver training and experience was selected least often by providers (17.2 percent) and second least often by parents (23.7 percent). Providers also were asked what their most important developmental goals for the focal child were while providing care. Making the child feel loved and keeping the child safe from harm were noted most often. Helping children learn skills that will encourage school success also was among the most highly rated provider developmental goals, which again suggests the potential receptivity of many providers to training on this topic.

For each of the quality factors selected as most important by parents and providers, respondents were asked to define what this quality meant to them. The resulting open-ended analysis reported Chapter 11 provides a better understanding of the diversity of concerns that often underlie fairly broad quality concepts. For example, safety concerns encompassed both issues related to household safety, such as keeping children from hazards, as well as worries about protecting children from bad influences in the broader community. The latter concern may be a reflection of the poor neighborhoods where respondents lived. Continuing to clarify the

[20] See http://www.kcet.org/kced/index.html for more information.

dimensions of broad child care quality concepts may be especially important in developing effective training and education materials for both parents and providers.

When asked open-ended questions about the most positive and negative aspects of their caregiving situation, both parents and providers were much more likely to stress positive caregiving features. In fact, only 23.4 percent of parents and 37.3 percent of providers cited any negative aspect of their current caregiving situation. The subset of parents who voiced negative concerns most often mentioned the provider spoiling the child, discipline issues, or payment related problems. The negative concerns mentioned most often by providers included getting children to obey and disciplining children, stress on providers and restrictions on their time, getting too attached or not having sufficient time with children, payment issues, and problems with the behavior of parents. It should be emphasized that none of these prevalent areas of dissatisfaction were mentioned by even 15 parents or providers.

In contrast, over 90 percent of parents and providers cited positive aspects of their caregiving situations. Most prominently mentioned by parents were that the caregiver was a relative or that the parent was familiar with the provider, the parent felt that children were safe, and general statements that the provider cared for the child well or had particular positive attributes such as dependability or trustworthiness. Providers most often stressed that they liked being able to help out the parent, caring for related children, assuring that the child was safe or well cared for, and teaching and providing training for children.

Parent and provider perspectives on their caregiver relationships also were largely positive. Reported caregiving disagreements were relatively infrequent between both parties, and over 90 percent of parents and providers who reported disagreements indicated that such disagreements usually were resolved through mutual discussion. There also has been speculation regarding the broader implications of caregiving on relationships between parents and license-exempt providers, and we found these relationships generally to be unaffected or positively influenced by caregiving. For example, among those parents and providers who knew each other before caregiving began, 39.4 percent of parents and 48.0 percent of providers said that their relationships had improved based on the caregiving arrangement, and nearly all others stated that their relationships had not changed. Thus, relationship strains caused by caregiving did not appear to be great in this sample, even though the license-exempt caregivers generally had provided care to the focal family for substantial periods of time.

Parent and Provider Perspectives on the CCAP and the Impact of Subsidies

The overall impressions of both parents and providers about the CCAP generally were positive. When asked what they liked best about the program and what was most in need of change, both parents and providers were much more likely to offer positive comments. Consistent with program goals, most parents mentioned their appreciation of receiving financial help with child care costs, or of receiving help that allowed them to work or attend school. Other than such general statements about program helpfulness, positive comments about the staff or about the efficiency of program operations were most prevalent, followed by positive statements either about parental choice of caregivers or the ability to use relatives for care.

Provider positive comments likewise most often emphasized the help that the program provided for working families, and also stressed that the program provided jobs for them. With respect to jobs, many added that they appreciated being paid to care for children or to be involved in productive work. In addition, positive comments about the CCAP staff were common, as were comments about the timeliness of program payments and about the fact that the program allowed the use of relative caregivers.

Both parent and provider comments on needed changes in the program centered on two sets of issues. First, providers most often mentioned increasing the pay rate, with 37.3 percent of all providers who cited needed program changes suggesting higher pay. Higher pay for providers was the second most often mentioned program change by parents, and many also recommended lower parent co-payments. Second, the most requested area of change by parents and second most requested change by providers concerned various aspects of paperwork or payment processing. While these comments were somewhat diffuse, improving the speed of payments was the most often specifically mentioned needed change.

Questions related to the impact of subsidies on caregiving resulted in interesting findings not emphasized in previous license-exempt care research. In particular, nearly two-thirds (65.7 percent) of parents indicated that their current license-exempt provider already was caring for the focal child before subsidy receipt. Further, 92.7 percent of parents and 96.4 percent of providers indicated that the provider would continue caring for the focal child even if subsidy receipt ended. Nonetheless, both parents and providers emphasized that not receiving the subsidies could compromise both the quality and stability of their caregiving arrangement. For example, only 15.2 percent of providers indicated that they both would continue to provide care for the focal child and would expect to receive the same pay that they currently received. Further, over 70 percent of both providers and parents asserted that the subsidies allowed providers to do things for children in care that they otherwise could not. Open-ended follow-up questions indicated that the subsidies supported such basic provision of care as the purchase of food, clothing, activities for children, and books and educational materials.

License-Exempt Policy Recommendations Based on Study Findings

As indicated at the beginning of this chapter, the overarching conclusion of our study is that license-exempt caregiving in the CCAP program environment generally appears to represent a positive confluence of both parental choice factors and provider care motivations. The broad inclusion of this form of care in the program has facilitated parents' child care choices, and also has allowed the program to serve large numbers of children whose parents work non-traditional schedules. The care environments and needs of states may vary widely, and are properly the subject of considerable state discretion with respect to subsidy program development. Nonetheless, our findings suggest that license-exempt care can play an important role in assuring that a continuum of child care options are offered in such programs. The recommendations that follow therefore focus upon issues that policy makers can address if they opt to include this form of care in subsidized child care programs.

Supporting Informed Choice by Parents in Care Selection

While our study findings clearly demonstrate that the selection of license-exempt care provision in the CCAP generally is a positive and rational one, this does not imply that such choices always are as informed as they should be. There are two broad directions we believe are especially important for policy makers to consider to assure that child care choices in subsidized programs are well-informed.

First, as research increasingly has demonstrated the importance of early brain development and early childhood learning, public policy makers have recognized the importance of child care programs emphasizing activities supportive of these goals. It is important that parents facing child care decisions be as informed as possible about the benefits of early learning and related developmental activities. This may lead some parents to select licensed settings when offered realistic choices. However, the broader goal should be to increase parental understanding of the features and skills that best support children's development and learning, regardless of child care setting.

Continued experimentation on the most effective ways to educate parents about the most supportive caregiving practices therefore is needed. The CCR&Rs obviously can play an important role in such efforts through the many interactions they have with parents considering child care options. States are experimenting with developing child care rating systems in a manner that is digestible for parents with limited expertise in assessing child care quality. A critical need when developing such systems, as well as developing related educational materials on best caregiving practices, is to assure that findings on and advice about care practices and settings are expressed in language easily understandable by parents with relatively little child development education and training. Research is needed to test the effectiveness of such information dissemination strategies on both parental care choices and subsequent caregiving practices.

Second, in subsidized programs, making informed choices about caregivers requires a clear understanding of relevant program rules. In the CCAP, attempts to create a cost neutral care selection environment for parents often were obscured by parent misunderstandings about program rules. In particular, parents often thought that CCAP required co-payments would be higher if they used licensed providers, even though this was not accurate. This finding demonstrates the need for state subsidy programs to educate parents well about program rules. In addition to providing written information, both program orientation sessions for parents and initial individual meetings with program staff are important opportunities to convey such knowledge. Because payment processes in the abstract often are difficult to understand, developing selected case illustrations of the effects of using different forms of care may be useful.

Establishing Standards in License-Exempt Care Settings

By their nature, license-exempt care settings are less regulated than licensed settings, but this should not suggest that no monitoring of such care should occur. In state subsidized programs involving billions of dollars in public funding, it seems that accountability concerns

should demand the establishment of selected basic monitoring standards. The CCAP, for example, requires child abuse and neglect checks of all providers.

As suggested above for parents, we also think the provision of basic orientation sessions for providers prior to the initiation of subsidized care may be useful. Such sessions could clearly inform providers about program features, available resources, and program requirements. These meetings also could be an opportunity to provide information about potential benefits of and requirements associated with licensing, an issue to which we return in the following section.

Although our study was not focused on monitoring caregiving practices, CCR&R staff interviews during our first study year revealed concerns about developing minimal monitoring standards once care provision has begun. Given the large numbers of providers involved in a program such as the CCAP, initiating cost-effective monitoring procedures may be a difficult undertaking. However, some limited follow-up with providers once care provision begins merit consideration if the state is interested in promoting a minimum standard of care across all settings. States might do this through follow-ups with random samples of providers. However, key questions states will need to resolve include what standards of care they consider acceptable and who might most effectively conduct such monitoring visits. Developing viable strategies given resource constraints is an issue best addressed by state program administrators and relevant stakeholders such as CCR&R staff.

While much of the research to date that compares the quality of regulated and license-exempt settings reports higher quality in regulated settings, clear evaluation of such differences has been hindered by the lack of assessment tools for measuring quality in license-exempt settings. For example, most rating tools focus on the environmental aspects of the caregiving arrangement and give limited attention to the relationship and interactions between the child and caregiver – a key characteristic of license-exempt care. Continued development and testing of quality assessment instruments and related observational techniques in license-exempt settings consequently are vital and serve two related purposes. First, such instruments will allow more refined comparison of the relative quality advantages and disadvantages of licensed and license-exempt settings, an issue of critical importance as subsidy programs evolve. Second, increased studies assessing the quality of license-exempt settings can be useful in defining best practices in those settings, and therefore can guide the further development of training for license-exempt providers.

Enhancing Quality in License-Exempt Care Settings

Overall, our findings indicate considerable promise regarding the possibility of enhancing the care offered by license-exempt providers. The frequent long lengths of time providers offered care, their common interest in receiving training, their attachments to children in care, and their interest in teaching children all suggest opportunities for enhancing care if creative strategies are developed. Likewise, we were somewhat surprised by the relatively high level of interest in licensing reported by license-exempt providers, particularly those who were not related to the children the cared for.

None of this is meant to suggest that enhancement of quality among these providers is an easy undertaking. On the contrary, both the limited educational backgrounds of many providers and the unique working conditions under which they provide care offer special challenges for policy makers interested in this issue. Nonetheless, our findings suggest a number of directions that policy makers could usefully consider as they attempt to support the efforts of license-exempt providers.

Pay Levels

Although license-exempt providers in this sample did not generally appear to initiate caregiving primarily for monetary reasons, the issue of license-exempt provider reimbursement rates is important for many reasons. First, income data from both administrative records and survey data indicate the low-income status of most license-exempt providers. This raises reasonable concerns about how these low income levels affect the options that providers have available to enhance the quality of care. A second, closely related point is that roughly three-quarters of parents and providers indicated that the provision of subsidies allowed providers to do things for children that they otherwise could not. Third, providers mentioned pay levels as easily the area of most needed change in a program.

By any standards, pay levels for Illinois license-exempt providers are low. While the issue of optimal pay levels is beyond the scope of this study, initiatives to enhance pay or related care resources for license-exempt providers merit attention. Experimentation with tiered reimbursement systems, where pay levels are incrementally increased as providers complete training or meet other requirements, appears promising in this respect. Assuring that license-exempt providers are eligible to participate in food and nutrition programs is another vehicle for extending tangible resources to providers. For example, through the efforts of many Illinois agencies and child care advocates, a decision was made in 2004 to extend eligibility for the Child and Adult Care Food Program to license-exempt providers. This will allow license-exempt providers to receive reimbursements for meals provided to children in care.

Knowledge about Program Rules and Resources

As with parents, provider knowledge about opportunities that could enhance their caregiving often was quite limited in this study. In particular, providers indicated that not knowing what was involved in getting licensed was among the most important obstacles to pursuit of this option. Likewise, providers often reported that they were unaware of training opportunities that were available.

This is not meant to suggest that simply increasing the information available to providers in itself would lead to major increased pursuits of such opportunities. For example, in our first-year interviews with CCR&R staff, many spoke of minimal license-exempt provider response to mailings or flyers providing information about training. Nonetheless, consistent provision of information on training and resource opportunities may result in incremental improvements in training take-up rates, and even greater increases in involvement seem likely if more aggressive recruiting strategies and creative presentation strategies are developed (see following section).

Basic information provision on program rules also may reduce misunderstanding by providers about program expectations, or disagreements with parents about payment rules or other issues.

Recruiting and Providing Training for License-Exempt Providers

There are several approaches to improving the training provided to license-exempt providers, and more carefully researched comparisons of the relative effectiveness of various approaches are an important need. For example, one approach is to simply require agreed upon minimal levels of training for all providers (as in done in Georgia), while another is to provide financial incentives such as tiered reimbursements based on training completion. In addition, it is unknown the extent to which improved marketing efforts alone may increase provider participation in training, and comparative research on the effectiveness of different training delivery modes also has been lacking.

Testing the effectiveness of meetings with license-exempt providers to discuss expectations and opportunities seems one useful approach for experimentation. As previously mentioned, program orientation sessions (which are required in 14 states) may be a useful vehicle for this purpose. In addition, some locales are experimenting with "welcome visits" to license-exempt providers, where both information and tangible resources are shared. This approach not only provides individualized contact, but also can allow staff to begin building relationships with these caregivers. As they develop rapport through delivery of tangible resources such as books or safety equipment, they can also suggest activities that might enhance care. While such efforts are fairly staff intensive, most providers in our study reported being receptive to home visits. However, since a large percentage of providers cared for children during non-traditional hours, consideration must be given to optimal times for offering home visits.

It would be useful to investigate whether more staff intensive methods as discussed above lead to greater subsequent access of program resources, such as lending libraries or participation in training. It seems likely, based on our interviews with providers as well as first-year project interviews with CCR&R staff, that simply sending mailers or flyers to providers indicating the availability of training is unlikely to result in large training take-up rates. However, such failure to respond may be driven by factors such as the inconvenience of training or fear of classroom settings, for example, as opposed to a lack of interest in training.

Creative programming that utilizes different training delivery modes also is needed. For example, providers in our survey were more likely to prefer books, videotapes, and mailings to group sessions, so research on the effectiveness of these and public television provision would be useful. Likewise, although internet modes were not commonly requested, as the internet continues to grow, some testing of internet options seems desirable.

It is likely that the relatively low preferences among providers for training in traditional group sessions reflects both practical constraints in attending such sessions and in some cases concerns with attending group sessions. Therefore, attempts to provide training at hours that correspond with the needs of providers, as well as to provide supports such as transportation and child care, may improve receptivity to such training modes. It may also be useful to experiment

with including license-exempt providers with other care providers in some training sessions and targeting other sessions strictly to license-exempt providers, and to ascertain whether such variations affect training take-up rates and learning.

Regardless of the training modes used, careful consideration must be given to the educational and training backgrounds of license-exempt providers when developing training materials. In particular, the low levels of formal education found in this sample, consistent with previous studies, indicate the need to develop training materials geared toward audiences with limited reading and comprehension skills. Trainers should also take into account that many providers may have experienced previous classroom difficulties, so efforts to increase the comfort level of providers entering any formal classroom training also merit attention.

Given the range of ages of the children in these caregiving settings, careful consideration should be given to the topics of training offered. Many training efforts tend to be focused on preschool-aged caregiving topics (e.g., helping children learn to read), yet the providers in our study most often cared for school-aged children. Such providers might be more motivated to attend training on such topics as helping children with homework. In addition, keeping in mind the ages of children found in these license-exempt settings might reveal other partners who could assist with outreach. For example, schools might be a natural ally in getting information out to parents and their license-exempt caregivers. Similar consideration should be given to infant-oriented training topics and community partners, given that infants often are cared for in license-exempt settings.

Study Limitations, and Related Further Research

While this study provides the largest linked sample available to date of parents and their license-exempt caregivers in subsidized care arrangements, several limitations should be noted. First, state subsidized care policies vary substantially (see Porter & Kearns, 2005), so caution is advised when considering these Illinois program findings in relation to other state programs. In particular, the Illinois CCAP is a large program offering relatively few constraints on parent choice and requiring no training of license-exempt providers.

Second, our study relied on parent and provider perspectives about care provision and related quality issues without corresponding observations of the child care setting. In some areas, social desirability biases could have result in both parents and providers overestimating the desirability of this form of care. Additional studies are needed that observe caregiving practices in license-exempt settings. Yet, child care observational measures have been developed primarily for regulated care settings and likely do not adequately capture important aspects of home-based, and especially relative, caregiving. Therefore, the continued development and testing of observational measures for use in home-based settings are recommended. Porter and her colleagues have made a promising start in this direction through their development of an instrument for assessing relative caregiving settings.

Third, our survey sample included a high proportion of relative caregivers, and even non-relative caregivers generally had prior relationships with the families for whom they provided care. This may partially explain the relatively minor differences we found in caregiving

perspectives between relative and non-relative providers. While relative caregivers tend to be the most dominant license-exempt caregivers, further research could usefully address differences that may exist when parents are less personally familiar with their license-exempt providers.

Finally, the diverse geographic areas in this study each experienced fairly high levels of poverty, and both the parents and providers interviewed were predominantly low-income. While we included limited questioning on the environmental factors that may affect child care choices and practices in such low-income neighborhoods, further research on these issues is desirable. For example, issues such as whether parental choice of caregivers is affected by perceived neighborhood quality, or by ethnic or other cultural considerations, merit further attention.

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