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Policy Alternatives to Increase Access to Early Childhood Education and Care in Massachusetts

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POLICY ALTERNATIVES TO INCREASE ACCESS TO EARLY CHILDHOOD
EDUCATION AND CARE IN MASSACHUSETTS

A Thesis Presented

by

MEGHAN LEMAY

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ABSTRACT

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FEBRUARY 2013

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Access to early childhood education not only leads to improved social, academic, and health outcomes for children, but can also carry the same benefits into adulthood. Early education and care programs can work against some of the negative effects of social factors such as socioeconomic status, discrimination, social support, and work demands which have been linked to physical and mental health outcomes. Early education programs could intervene not only in the life of a child, but also impact parents, families, and populations. This thesis will review the research showing early childhood education leads to better social and health outcomes and that there is a lack of adequate access to early childhood education for low-income families in Massachusetts. This thesis presents three state-level policy options for making early childhood education more accessible to low-income families in Massachusetts: lengthen the certification period of child care vouchers; reduce the administrative burden on families including eliminating the need for double documentation; dissolve the child care subsidy waiting list by making child care services an entitlement for families at or below 50% State Median Income. These policy options are evaluated based on the criteria of political feasibility, equity and fairness, administrative ease, effectiveness, and cost. Based on this policy analysis, a recommendation is made for Massachusetts to lengthen the certification

period of child care vouchers, as well as reduce the administrative burden on families including eliminating the need for double documentation.

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CHAPTER 1

THE VALUE OF EARLY CHILDHOOD EDUCATION AND CURRENT MASSACHUSETTS POLICIES

A. Introduction and Objective

A connection has been made between early childhood education, family support services, and health outcomes for disadvantaged, low-income families with young children. A significant amount of research has been done over the past forty years suggesting the link between childhood poverty, reduced academic achievement, and subordinate health outcomes. In the public health discipline, social factors such as socioeconomic status, discrimination, social support, and work demands have been linked to physical and mental health outcomes. Early education and care programs have been suggested as a way to work against some of the negative effects of these social factors. Therefore early education could work to combat the ill health outcomes that are associated with negative social factors.

This thesis will explore how early education programs could intervene not only in the life of a child, but also impact parents, families, and populations. This thesis will review the research showing early childhood education leads to better social and health outcomes and how access to early childhood education for low-income families is inadequate in Massachusetts. This thesis will present three state-level policy options for making early childhood education more accessible to low-income families in Massachusetts: lengthen the certification period of child care vouchers; reduce the administrative burden on families including eliminating the need for double documentation; dissolve the child care subsidy waiting list by making child care services

an entitlement for families at or below 50% State Median Income. These policy options will be evaluated based on the criteria of political feasibility, equity and fairness, administrative ease, effectiveness, and cost. Based on this policy analysis, a policy option will be recommended for improving accessibility to early childhood education in Massachusetts.

B. The Link Between Early Childhood Education and Health and Social Outcomes

Studies show that healthy early childhood development and education can positively influence class-based health disparities, as well as success in school and life. The literature on poverty, child development, and education has documented how the early physical and sociolinguistic environment provided by average low-income families can sometimes lead to suboptimal child development (Campbell and Ramney, 1994). Research shows that 54 percent of homeless preschoolers had a major language, gross motor, fine motor, or social developmental delay, “compared to only 16 percent of their housed peers” (McCoy-Roth, Mackintosh, and Murphey, 2012, p. 3). Early childhood intervention is necessary to avoid these and other serious issues correlated with problematic early environments. It is necessary to integrate early education and care with family support services as family needs are often interconnected, for example, over “80 percent of mothers with children experiencing homelessness have previously experienced domestic violence, and their children are more likely to have emotional and behavioral problems” (McCoy-Roth, Mackintosh, and Murphey, 2012, p. 5).

The High/Scope Perry Preschool Project was a landmark study conducted in Michigan in 1962 that produced results which sparked major interest in the issue and led

to decades of further research. The study followed two groups of at-risk children from the age of 3 until they were 27 and was able to show that the group that went through an active learning preschool program out-performed the control group that did not attend a preschool program, in a variety of ways. The program group “on average had completed a significantly higher level of schooling than the no-program group had...the program group significantly outscored on various tests of school achievement and intellectual performance” (Schweinhart and Weikart, 1993, p. 56). In addition, the study showed that more students who did not go through the program had criminal records as adults compared with those who did go through the program. Those who had a preschool education also had a higher monthly income as adults, and a higher percentage of home ownership. This study was able to clearly make the connection between early education and an improved overall quality of life. When young children develop in a healthy early environment, they are more likely to grow into successful adults who can potentially break the cycle of poverty and positively impact communities as a whole.

Follow-up studies have been conducted in recent years to make further conclusions about early intervention programs of the 1960s and 1970s. In 2003 researchers followed up with participants from the Brookline Early Education Project in Massachusetts, “an innovative, community-based program that provided health and developmental services for children and their families from 3 months before birth until entry into kindergarten” (Palfrey et al, 2005, p. 145). This was the first study to focus heavily on the correlation between health-related outcomes and an early education intervention. Participants in this follow-up study were adults who had been enrolled in the Brookline Early Education Project from 1973 to 1978. The program was initially

evaluated by monitoring the children from birth through second grade. Then, decades later, a quasi-experimental causal-comparative study used a survey to gather information on the health, educational, and employment status of the adult participants in the Brookline Early Education Project and compared it to the status of control group members. The survey had a 47 percent response rate. The results of the Brookline Early Education follow-up study showed that participants in the program had on average attained more years of schooling, had higher incomes, and were more likely to have private health insurance, compared with the control group. Sixty-four percent of the participants in the urban early education program reported being in “very good or excellent health,” while only 41.67 percent of the urban control group reported this level of health (Palfrey et al, 2005, p. 150). The study showed that there was a dramatic difference between the urban group and the suburban group regardless of participation in the early education program, meaning that on average children who grew up in suburban neighborhoods were better off in adulthood compared with those who grew up in an urban environment, regardless of participation in the early education program. Despite this, overall participation in the early education program was “associated with higher levels of health efficacy, more positive health behaviors, and less depression than their peers” (Palfrey et al, 2005, p. 150).

A 2010 study used statistics on childhood height to provide evidence that “childhood health influences health and economic status throughout adulthood” (Case and Paxson, 2010, p. 65). With data collected from early to late adulthood on cohort members in five longitudinal data sets, height was found to be uniformly associated with level of employment, income, physical health and cognitive ability. A 2011 retrospective

cohort study examined the link between preschool attendance and adult cardiovascular disease risk. After controlling for potential confounders, the study found that adults with a preschool education were more likely to engage in rigorous physical activity and refrain from smoking. This study discusses the “potential health benefit of interventions outside of the health sector to prevent cardiovascular diseases, which are strongly associated with lifelong social disadvantage” (D’Onise et al, 2011, p. 278). An older systematic review of randomized control trials that examined the health effects of day care discussed how day care leads to “increased employment, lower teenage pregnancy rates, higher socioeconomic status and decreased criminal behavior” yet points out that there was little evidence proving an increase of health outcomes across the spectrum, but that there must be further research (Zoritch, Roberts, and Oakley, 1998, p. 317).

There has been increasing acknowledgement in the scientific, as well as public policy literature that “children from vulnerable families, where there is social disadvantage, parental mental health problems, substance abuse or domestic violence, are at risk of attention, language, learning and behavior problems because of poor attachment and lack of stimulation in the first 5 years” (Gwynne, Blick, and Duffy, 2009, p. 119). In the 2000 book, *From Neurons to Neighborhoods: The Science of Early Child Development*, Jack Shonkoff and Deborah Phillips present evidence on early brain development and the importance of children’s early environment and initial experiences. Children are born ready to learn and need nurturing relationships in order to develop in the optimal way. Children who develop in a stressful environment are more likely to experience emotional disorders, behavior problems, and school failure later (Shonkoff and Phillips, 2000). Infants and children who experience trauma are “most significantly

at-risk because of the effects of cortisol and the early cementing of the Limbic-Hypothalamus-Pituitary-Adrenal axis and autonomic nervous system pathways” (Bolger and Patterson, 2001, p. 549). Early education programs can serve to teach coping skills and reinforce self-esteem for all children, not just those who have experienced trauma (Marmot and Wilkinson, Eds. 2006, p. 46).

Many scientific developments have also furthered the understanding of the “life-course perspective on health,” which “sees a person’s biological status as a marker of their past social position and, through the structured nature of social processes, as liable to selective accumulation of future advantage or disadvantage, a person’s past social experiences become written into the physiology and pathology of their body” (Blane, 2006, p. 54). This perspective is important for understanding how experiences in early life are connected to health and well-being later in life. Social context tends to “structure life chances so that advantages and disadvantages tend to cluster cross-sectionally and accumulate longitudinally” (Blane, 2006, p. 55). Cross-sectionally accumulated advantage could mean, for example, that a person who lives in an environmental hazard-free home is likely to have a higher income and therefore be able to afford a healthier diet, whereas, longitudinally accumulated advantage could mean, for example, if a child attends a high-quality early education program, they are more likely to go to college, become financially stable as an adult, and then retire with a pension. Importantly, interventions can occur throughout the course of one’s life that may alter the trajectory of health and well-being. Early education and care can intercede in the “dynamic of the ongoing process of social accumulation in the continuity of social circumstances from

parental social class to social conditions during childhood and adolescence, and eventually, to adult socioeconomic position” (Blane, 2006, p. 56).

There is ample evidence exposing the link between early childhood education and improved health and social outcomes over the lifespan. Multiple studies have compared the health and well-being of adults who attended an early childhood education program as children, with adults that did not, and the results are clear: early childhood education interventions work to improve health and social outcomes in childhood, adolescence, and adulthood. Studies show that a healthy, educational environment in the first five years of life is crucial to optimal brain development. Early childhood education is vital for all children, but it is especially important for children who are already disadvantaged by poverty or a history of trauma. Early education can improve the educational, social, economic, and health outcomes of the children who receive it. The evidence exists to support the implementation of early childhood education programs as educational, social, and health policy.

C. The Link Between Early Childhood Education and the Health of Parents and Communities

One important way in which early education programs can influence the health of parents, families, and communities is by providing a social network or support system. Access to early education and day care programs can serve to connect parents with social networks and support that they may not have in other aspects of their life. A great deal of theoretical sociological research exists explaining the importance of social integration and social support in how individuals connect to the community. The level of

connectedness to one's community is "vital to an individual's health and well-being as well as to the health and vitality of entire populations" (Berkman and Kawachi, Eds. 2000, p. 137). Health and social support are interrelated in crucial ways, as anthropologists of the 1950s pointed out, "the structural arrangement of social institutions shapes the resources available to the individual and hence that person's behavioral and emotional responses" (Berkman and Kawachi, Eds. 2000, p. 141). In the 1970s a series of studies consistently showed that a shortage of social networks was correlated with higher rates of mortality. Since then, the intricacies of how social integration and networks influence population health have been further explored. The generally accepted conceptual model argues that "networks operate at the behavioral level through four primary pathways: provision of social support, social influence, on social engagement and attachment, and access to resources and material goods" (Berkman and Kawachi, Eds. 2000, p. 144). Parents of children who are enrolled in early care programs may gain greater access to these pathways compared to parents whose young children stay at home until kindergarten. This may be especially important for socially disadvantaged or low-income families who already are at a higher risk for lacking material resources.

Families may further their social networks, and therefore health, by being involved in early education programs. Early education facilities may serve as institutional liaisons. For example, they may connect families with health care or adult education opportunities. Early care programs may also strive to intentionally work on changing the health behaviors of families as, "shared norms around health behaviors are powerful sources of social influence with direct consequences for the behaviors of network members...the social influence which extends from the network's values and norms

constitutes an important and underappreciated pathway through which networks impact health” (Marsden and Friedkin, 1994, p. 5). Within early education institutions, for example, when dental hygiene is enforced in school, parents and children may be taking that health behavior home with them. In addition, social network size is inversely related to unhealthy behaviors. Multiple studies have shown that there is a “steady gradient between increasing social disconnection and the cumulative prevalence of health-damaging behaviors such as tobacco and alcohol consumption, physical inactivity, and consequent obesity” (Berkman and Kawachi, Eds. 2000, p. 149). Social scientists also point out that socially engaging in a community may allow people to feel as though “life acquires a sense of coherence, meaningfulness and interdependence” (Berkman and Kawachi, Eds. 2000, p. 146). This could have a major positive effect on low-income families and communities.

Social capital can be viewed as a subset of social networks or social cohesion and is defined as “features of social structures – such as levels of interpersonal trust and norms of reciprocity and mutual aid- which act as resources for individuals and facilitate collective action” (Coleman, 1990, p. 101). Similar to the effects of social networks, significant social capital can positively impact health. Social capital is specifically important because research shows that even socially isolated individuals enjoy better health and well-being if they live in a cohesive community with significant social capital. If individuals feel trust in their social environment, even if it is just an overall sentiment, they are better off than if they feel nothing towards their neighbors and feel no public responsibility. This research could be used to explain how the sense of community, social support, and connection provided by early education centers can link to better population-

wide health outcomes, even if individual parents continue to struggle with particular, isolated issues. As Berkman and Kawachi say in their publication on social capital, state and federal governments “could do much to directly subsidize local associations that foster social capital, such as neighborhood associations, cooperative childcare, and youth organizations” (2000, p. 188). Public early education centers that include family support services can serve to improve the social capital of a community, especially in areas where social capital is lacking.

Head Start, the federally funded, targeted early education program for families living in poverty lists parental involvement as a specific goal of the program. As a result, some Head Start programs have implemented educational interventions for parents specifically, with the aim of providing parents with more knowledge around child health. However, one outcome of these parental interventions has been to increase the general health knowledge of parents, which in turn may impact the overall health of the parent population. When parents are equipped with new information on healthy living, they may not only apply it to their children, but also to themselves. One study published in 2012 provided an asthma-centered educational intervention for parents of Head Start children and “results showed a statistically significant increase in asthma and healthy home-knowledge ($p < 0.001$) in several areas” (Zuniga et al, 2012, p. 3). Six months after the intervention, 54 percent of participants were contacted and “98.4 percent of them made changes in their households as a result of their training” (Zuniga et al, 2012, p. 3). Other studies have been carried out that test the health knowledge of parents pre- and post-intervention and have shown that workshops for parents around health literacy and

related topics can not only impact how a parent raises their child, but also how they as adults, approach their own health (Helena, 2005).

A 2006 study was able to successfully evaluate the impact of a one-year early intervention program for at-risk infants and children. The study aimed to look at the effects of center-based care integrated with a home-visiting program and case management. Various measures were used to evaluate “parent, child and family functioning via pre-post test research design” (Gwynne, Blick, and Duffy, 2009, p. 120). Previously-established assessments were used by the researchers to test children and parents at the beginning of the year of the intervention and at the end of the year; these assessments which had already shown reliability and validity through other studies were: “The Parent Stress Index, The Being a Parent Scale, The Child Behavior Checklist, The Brigance Developmental Screen, The Northern Carolina Family Assessment Scale, The Norm Referenced Language Assessments, and The Goal Attainment Scaling” (Gwynne, Blick, and Duffy, 2009, p. 121). The results of this one-year intervention that integrated early education and family support services “indicated large effect size changes ($P < 0.01$) in parent/child interaction; reduced parent stress; parental satisfaction; parent confidence; parental capacity; family interactions; child well-being; and total family functioning” (Gwynne, Blick, and Duffy, 2009, p. 122). These types of outcome measures show how early interventions can influence whole families and communities; the outcomes were able to show that parents greatly benefited from the intervention program. Seventy-one percent of children who initially tested as having clinical developmental delays, tested in the normal range for development, post-intervention. Forty-one percent of children tested significantly higher in language development, post-

intervention. The authors also noted that the center-based aspect of the intervention seemed to have the most dramatic positive outcomes (Gwynne, Blick, and Duffy, 2009). This study also highlighted the importance of early education programs being high-quality and having specific standards. The type of outcome measures used in this study could potentially be used to measure the level of social integration and social support experienced by families whose children are enrolled in early education programs.

In various ways early childhood education programs can lead to better health and social outcomes for parents, as well as whole communities. Parents may find that having their child enrolled in an early childhood education program will provide them with a new social support system. This social support system can connect parents to other resources in the community, as well as lead to positive changes in social or health behaviors.

D. The Implications of Early Childhood Education for Marginalized Populations and Inequality

In the United States, certain populations are institutionally and structurally oppressed or discriminated against, due to the specific history and economic system of the country. The marginalized groups discussed here can be generally categorized as low-income people, women, people of color, and immigrants or non-native English speakers. Early childhood education can have a specific impact on these groups for two reasons. The first reason is that research has shown children from low-income families, children raised by single mothers, children of color, and children who learn English as a second language are more likely to struggle in school and therefore benefit more from early

educational interventions. The second reason early childhood education can specifically impact marginalized populations is that it can work against overall inequality in society by helping parents improve their own lives.

Families who speak English as a second language are part of a marginalized population that may struggle with attaining basic needs in addition to having a hard time dealing with the education system in the United States; having a support system through a day care program could ameliorate some of their struggles. For children, language barriers could lead to difficulties in adjusting to classroom expectations; sometimes these obstacles can lead to social isolation and this can greatly impact a child's chance at social and academic success (Seltzer, 2005). Studies have found that children from low-income families are usually slower to use expressive language, regardless of what language they are speaking, and "results of long-term observations of middle income and lower income families concluded all mothers spent a great deal of time nurturing their infants (e.g., touching, hugging, kissing, and holding), but there were differences in the way they verbally interacted with their children" (Enz et al, 2003, p. 16). Verbal interactions are crucial in stimulating neural synapse networks that foster language development. It seems necessary to intervene and increase the chance at academic success for immigrant children because research also shows that "between 30 and 40 percent of second-language learners read below grade level by the time they reach high school" (Seipel, 2011, p. 4).

The environment children develop in can impact their ability to participate fully in school and new immigrant families may face specific obstacles. New Latino immigrant families often “share overcrowded apartments with other families or extended family; whole families often live in one bedroom where books and age-appropriate toys are scarce and there may be little child-centered language interaction. However...these parents have a drive to succeed and they understand the importance of education” (Seltzer, 2005, p. 73). It is a problem when students enter kindergarten with little or no basic English language, reading, or writing skills. Seltzer discusses how the family unit can be strengthened by supporting parents with a variety of resources, from workshops on parenting strategies to support in finding employment. However, this is most likely to be successful if done through a population-wide intervention.

An important longitudinal study done in 1998 entitled, “Linking Schools, Human Services, and Community: A Puerto Rican Perspective,” talked to Puerto Rican families with children in Boston elementary schools about improving their kids success in school and parents emphasized that “parents should be involved in the education of their children...they noted that the school could make it easier to involve parents by providing social services on the premises, increasing communication, providing workshops on parenting, increasing parent-teacher conferences, initiating festivals for parents and families” (Delgado, 1998, p. 123). Participants in the study also discussed how a school can provide a support system to new immigrant families and help them avoid isolation from social services and their new community. When families with young children have access to good nutrition and health care, the children are more likely to go to school ready to learn, but whole families may also be able to enjoy better health and wellbeing.

This Boston study stresses the importance of having staff with diverse ethnic and racial backgrounds working in schools and social agencies, “indigenous resources, in turn, can serve as referral agents, provide advice or suggestions for activities, or assist in the development of a sociocultural context to better inform linkage programmatic decisions” (Delgado, 1998, p. 124). This not only would serve to provide a better social network for the families, but it may also help combat some of the effects of institutionalized and structural racism, which have been linked to lower health outcomes (Marmot and Wilkinson, Eds. 2006).

On a population level, children living in poverty are less likely to have medical and dental care during their childhood, and they are also less likely to have access to the health care system as they mature into adults. Therefore, if families are made aware of the health care and health insurance available to them due to the guidance of an early education center, this may reduce some of the difficulty of attaining adequate preventative and acute health care. This is crucial, as there is a recognized, direct association between socioeconomic position and health status. As public health scholars have discussed for the last decade, “the effect of the social and economic environment on the health and well-being of persons living in that environment is profound and not adequately recognized by either the lay public or the healthcare system in the U.S.” (Bezruchka, 2009, p. 202). Research shows that adult Americans with low socioeconomic status have higher rates of chronic disease compared with adults with higher incomes. There are many reasons for this, some of which are more straightforward than others. Americans living with a higher socioeconomic status have a greater ability to purchase healthy food, may have more opportunities to exercise healthy habits, and are more likely

to have health insurance. Social environment has been shown to play a major role in one's health. Societies "characterized by high levels of income inequality suffer a depression in life expectancy of up to ten years when compared to low-inequality societies" (Babones, 2009, p. 233). The Gini coefficient of inequality, a commonly-used measure of income inequality, is .469 in the United States. .469 represents an extremely high level of inequality and this number has only increased in the past five years (U.S. Census Bureau, 2010). The United States poverty rate is at its highest since 1993. Income inequality means a lack of equity and egalitarianism overall which is poisonous for the social environment in the United States.

More accessible and affordable or free child care could serve to relieve some of the stress that families living below, at, or near the poverty line deal with on a daily basis. Michael Marmot pioneered the research linking positions in social hierarchy to levels of health. Research has shown how the "organization of work, degree of social isolation, and sense of control over life, could affect the likelihood of developing and dying from chronic diseases" (Marmot and Wilkinson, Eds. 2006, p. 6). Marmot based his research on the concept that the social environment acts upon the biological responses of individuals; a lot of previous research had been based on the inverse of this idea. Marmot, and others since, have been able to provide evidence that the stress faced by those lower on the social hierarchy, poor and working class individuals, is more significant and problematic than the stress faced by those at the top of the social hierarchy. This stress and the biological reactions to it, may have a substantial impact on health and the development of disease. Populations living in industrialized countries are "largely free of the risks of fatal infectious disease, but not of the more subtle exposures which may

repeatedly and frequently activate the fight-or-flight response over a period of decades...financial strain, lack of social support, and monotonous work may produce a low level of psychosocial stress as a feature of daily life” (Marmot and Wilkinson, Eds. 2006, p. 13). This stress is clearly linked to health disparities based on income. Studies have shown that this type of stress not only influences the most impoverished sections of the population, but that there is increasing stress and ill health with every step down the social gradient or hierarchy; people living with middle-income jobs have higher stress levels and are less healthy than those who fall into the upper-middle-class income bracket. This is an important justification for why early education and care programs should be universal and not just offered to those in the lowest income brackets. The fragmented nature of the current early education and care system is not ideal for any segment of the population. Under current economic conditions families often move in and out of different income brackets and therefore become qualified or disqualified for child care subsidies and other benefits fairly frequently. This system is frustrating, stressful, and therefore unhealthy for families in various income brackets.

Many scholars in the fields of women’s studies and economics have documented the impact that access to reliable child care has on a woman’s ability to hold a steady job and therefore have a steady income. Women are more often the primary caregivers of their children and therefore are forced to leave or miss work when a child is sick or child care arrangements fall through. The health and well-being of the female population are disproportionately impacted by the fragmented, for-profit child care system in this country (Polakow, 2007). In 2010, 17 million women were living in poverty compared

with 12.6 million men. The likelihood of living in poverty is significantly higher for women of color; the poverty rate for women is 14.5 percent, but the poverty rate for Latina and African American women is 25 percent. The 2010 U.S. Census showed that the wage gap has not improved, “women working full-time year-round continued to be paid only 77 cents for every dollar paid to their male counterparts” (Bennett, 2011, p. 11). Single mothers suffer the most as “more than 40 percent of women who head families are now living in poverty. With more than half of poor children living in female-headed families in 2010, the child poverty rate jumped to 22 percent” (Bennett, 2011, p. 10). Access to early childcare centers could make a significant difference in the socioeconomic status of single mothers. Lack of reliable and affordable child care is the main reason single mothers struggle with finding work, getting an education, or holding a steady job. In the United States, studies “show that the cost, quality, and availability of child care play a major role in a mothers decision to choose work over welfare” (Maurier and Russell, 2003). The importance of mother’s being able to access the job market should not be underestimated, “since families outside the labor market are particularly vulnerable to poverty, unemployment remains the most effective guarantee against both poverty and the ill health with which it is associated” (Marmot and Wilkinson, Eds. 2006, p. 39). A women’s access to education is also crucial, as high levels of education are associated with a lower infant mortality rate. Having consistent access to an early education center that is affordable or free regardless of whether the mother is employed or not, would not only provide peace of mind and a social network and support system to a single mother, but it would also allow her to put more effort into finding a better or full-time job or educational opportunity.

Health science research has also exposed the link between race and health outcomes. In the United States, inequality has influenced the health of African Americans and Latinos to the point that they have higher rates of chronic disease compared to their white counterparts, even when controlling for socioeconomic status and exposure to other known risk factors for disease (Byrd and Clayton, 2002). A powerful example of the health disparities based on race that persist in this country is that white women without a high school diploma have a lower infant mortality rate than black women with a college degree (Nazroo and Williams, 2006, p. 238). Racial inequality is not being addressed at the level it should be as communities in the United States are more racially segregated today than they were in the first half of the twentieth century. This fact is very much connected to why white children are more likely to attend high-quality, early education centers, compared with children of color (Babones, 2009). The way the for-profit early education and day care system runs leads to the concentration of high-quality centers in white, more affluent neighborhoods. This means that parents of color are also struggling with the problems associated with the inability to access reliable child care, while simultaneously not receiving the indirect benefits of being connected to a child care center. Since it has been established that in the United States today race and socioeconomic status in adults are social determinants of health, it follows that better social policy is necessary to improve health outcomes for disadvantaged populations.

Addressing social determinants of poor health is extremely complex and requires societal change. Early education and care could be part of breaking the cycle of poverty and positively influencing the health outcomes of African Americans and Latinos if enrollment of these racial groups is increased (Magnuson et al, 2005). Research has

shown that early education and early health intervention, as social policy, can not only lead to success in childhood, but that the benefits may carry into adulthood. In addition to this, the availability of affordable or free child care may positively influence the socioeconomic status of families, especially single-headed households where a woman is the primary caregiver (Saxonberg, 2009). Inequality in the United States must be combatted in order to see improved health outcomes. Better social policy can improve long-term population health. It follows that policy change must be the next logical step, as it has been established that collective characteristics of communities control population health status. Society cannot simply be viewed as the “sum of individuals- that the factors which determine population well-being cannot be reduced to individual risk factors” (Berkman and Kawachi, Eds. 2000).

E. Current Early Education and Care Programs in Massachusetts

Currently, there is no fully universal, publicly-funded early education or child care system in Massachusetts or in the United States. Massachusetts has a fragmented child care system that includes many private early education and care centers, as well as a limited amount of public programs. Most parents in Massachusetts have no choice but to spend a significant amount of money on private early education and child care programs. Other early education and child care options only exist for low-income families. The federal programs, Head Start and Early Head Start, are targeted and provide early education and day care services to low-income, at-risk children and families who meet the requirements for eligibility. Families must be living at or below the federal poverty level to qualify for Head Start. This means that many families who are living right above the federal poverty level, but are still extremely poor, are not able to access Head Start.

Head Start offers “center-based, family child care, and home visiting options on a part-day, part-year, or full-time basis” (U.S. Department of Health and Human Services, 2011). Head Start programs are free and prioritize children in foster care, children with disabilities, homeless children, and families receiving public assistance. Head Start serves eligible 3 and 4-year-olds, while Early Head Start serves eligible infants, toddlers, and some pregnant women. Head Start was started in 1965 under the Department of Health and Human Services, and has been guided by its mission of providing a range of “comprehensive education, health, nutrition, parent involvement, and family support services” (U.S. Department of Health and Human Services, 2011). Eighty percent of the yearly cost to operate Head Start and Early Head Start programs is funded by the federal government, while the remaining 20 percent of funding must come from local sources. However, funding is limited and in most states, less than half of eligible children are actually enrolled in Head Start or Early Head Start (U.S. Department of Health and Human Services, 2011). Massachusetts “currently contributes \$7.5 million to Head Start, down from \$10 million in fiscal year 2009” (Squires, 2012). In 2006, 11 percent of 4-year-olds in the United States were served by Head Start. In 2009 in Massachusetts, over 15,000 infants, toddlers, and preschool children participated in Head Start and Early Head Start (Massachusetts Department of Early Education and Care, 2011). Due to changes in political support for this federal program, funding is variable despite the pressing need for the program. Of the children enrolled in Head Start or Early Head Start, more than 10 percent have disabilities, one in five have been exposed to violence, and 28 percent are learning English as a second language (Blank, 2004). This federal program is

crucial for public health, as it specifically targets nutrition and other wellness concerns in its programming.

An alternative to Head Start for low-income families is state-subsidized educational child care in the form of vouchers or contracted slots. Child care vouchers are certificates given to families that qualify, that they can use at a child care provider of their choice. These vouchers subsidize the cost of child care and do allow freedom of choice for parents. However, some private child care programs do not accept vouchers. The other option is using a contracted slot. Contracted slots are “spaces set aside for children from low-income families at specific child care programs. The state and the child care provider agree on a rate and the state guarantees payment for the reserved slots” (Massachusetts Department of Early Education and Care, 2011). Child care vouchers and contracted slots are administered with the assistance of regional Child Care Resource and Referral Agencies; these agencies are contracted by the state. Currently, the Department of Early Education and Care provides financial assistance for early education and care programs only if families meet a specific income requirement and a specific activity requirement. Parents not only have to meet income eligibility, but they must also prove that they are working, seeking employment, homeless, or enrolled in an education or training program (Massachusetts Department of Early Education and Care, 2011). To meet income eligibility requirements for a voucher or a contracted slot, families must have an income at or below 50% of the State Median Income upon initial assessment, and may remain eligible if their income remains at or below 85% State Median Income. Families are also eligible for a child care voucher or contracted slot if a child or parent in the family have a documented special need and the family has an income at or below

85% State Median Income upon initial assessment and may remain income eligible up to 100% of State Median Income (Massachusetts Department of Early Education and Care, 2011).

In Massachusetts, the financial assistance policies of the Department of Early Education and Care impact the ability of families to keep their children consistently in education and care programs. Because Massachusetts legislators decided that early education programs prepare children for “greater financial and personal success in their adult lives while providing a strong foundation for the development of human capital and states’ economic growth,” they passed a bill that encourages the implementation of educational child care programming that prioritizes disadvantaged children (Washington and Reed, 2008, p. 202). However, this 2004 bill has yet to be universally implemented. Massachusetts has the costliest private preschool programs in the country, and unfortunately for those who cannot afford the cost, “the demand for funding supports far exceeds the supply” (Washington and Reed, 2008, p. 203). The Department of Early Education and Care is currently “funded at \$495.16 million, down from \$570.58 million in fiscal year 2009” (Squires, 2012). Despite the existence of regional Resource and Referral agencies placed all over the state, with the sole purpose of administering child care subsidies, 75 percent of families in Massachusetts still report that the “administrative aspects of the voucher system were very stressful” (Washington et al, 2006). The bureaucratic eligibility structure and immense amount of burdensome paperwork, continues to paralyze families, as studies have found that “the high number of eligible families in need of child care assistance, but not served, could not be explained through lack of funding alone,” but that the need for double documentation and general

administrative confusion lead to families “giving up” on the system (Washington et al, 2006). The need for double documentation occurs when a family has already produced the necessary paperwork to qualify for state support through the Department of Transitional Assistance, but must reproduce the same documentation for child care Resource and Referral agencies.

The activity requirement policy, which necessitates that both parents are either employed, seeking employment, or in school leads to significant problems and complications regarding stable early education and care. Under this funding policy, children may experience discontinuity of care if, for example, their parent wasn't able to prove that they were seeking work that month. Children's learning and development may be disrupted when they are pulled out of a program for a few weeks or a month due to a parent's inability to qualify or pay. A 2006 study of the Massachusetts child care voucher system found that two-thirds of vouchers are issued for less than six months and that the average length of the given voucher was 114 days. The study also found that 90 percent of voucher administrators agreed that “the voucher system focused on monitoring parents' continuing service need, at the expense of children's continuity of care” (Washington et al, 2006). There are also extremely long waiting lists for financial assistance, even after a family has proven their eligibility. According to the Massachusetts Department of Early Education and Care, as of July 2012, Massachusetts had 36,500 children on a waiting list for financial assistance and the numbers are not improving, the wait list has only increased. The waiting list in Massachusetts is significantly longer than many other states. This means that if, for example, a single mother attains a low-paying job, she could be on the waiting list for two or three years

before she receives subsidized child care. Children are categorized within a child priority status when placed on the waiting list. From the Massachusetts Department of Early Education and Care 2011 Financial Assistance Policy Guide, the child priority status code is as follows, beginning with the top priority code:

1. Child in foster care, referred by Department of Children and Families
2. Child of homeless family, family must meet income requirement
3. Child of military personnel, where family meets income requirement
4. Child of teen parent, parent must meet income and activity requirement
5. Child who is in the legal temporary or permanent custody of a grandparent
6. Parent with special needs, family exempt from activity requirement
7. Child with special needs, family exempt from activity requirement
8. General priority, a child who does not meet any of the specific child priority status criteria listed above, family must meet income and activity requirements

Once a family receives a voucher or contracted slot, according to 2011 numbers, a family with an income at the poverty level, \$18,530 a year in Massachusetts, receiving subsidies for child care still had to pay \$141 per month, or 9 percent of its income in copayments (Schulman and Blank, 2011). In addition, “Massachusetts’s reimbursement rates for child care providers serving families receiving child care assistance were below the federally recommended level” (Schulman and Blank, 2011, p. 1).

The current child care financing system in Massachusetts is a major challenge to the success of children and parents who are forced to face it. Underfunded programs,

such as the voucher program, have led to an impossibly long waiting list for such a basic need: child care. Head Start only covers families suffering in the worst poverty. The system is fragmented and is causing families to resort to desperate measures. Forcing parents to constantly battle with child care voucher policies is only negatively impacting their health and well-being.

CHAPTER II

METHODS

In order to address the problem of limited access to early childhood education and care for low-income families in Massachusetts, policy alternatives were identified. These policy alternatives were formulated by reviewing a combination of scholarly articles, interest group recommendations, Massachusetts-based studies, and the policies and legislation of other states. Google was used to do a broad search around policy alternatives and further information was gathered from state websites. The similarities and differences between Massachusetts and other states were compared in order to evaluate how different policy options would work for Massachusetts.

Specifically, a lot of guidance came from reviewing Rhode Island's transition to the Family Independence Program, which completely eliminated the child care waiting list in Rhode Island. After reviewing Rhode Island's policy, a version of this policy was selected for Massachusetts because it would have the most significant impact on the goal of increasing accessibility to early childhood education. Some of the recommendations here are based on a 2006 study of the Massachusetts Child Care Voucher System, funded by the Bessie Tart Wilson Children's Foundation. This study tracked 3,295 vouchers for children in care at 30 different centers over 12 months. The study involved conducting in-depth interviews and surveys with child care directors, families, and Resource and Referral agencies. This study showed the negative impact of short-term vouchers and administrative burden on families in Massachusetts. The changes made in Massachusetts since the 2006 study were investigated and current information was gathered from the

Massachusetts Department of Early Education and Care. The policy alternatives to lengthen the certification period of child care vouchers and to reduce the administrative burden on families were selected based on this study and other best practices studies.

The policy alternatives were evaluated and compared based on the criteria of political feasibility, equity and fairness, administrative ease, effectiveness, and cost. According to Eugene Bardach's *A Practical Guide for Policy Analysis: The Eightfold Path to More Effective Problem Solving*, political feasibility is political viability which may be based on too much opposition to the policy or a lack of support. Equity and fairness is about whether the policy would impact all people equally and fairly. Effectiveness is measured by how many children would benefit from the policy. The administrative ease of a policy option includes how simple or complicated the implementation of the new policy would be. It was necessary to consider the "inflexible administrative systems and bureaucratic interests of the state" when examining a potential change in policy (Bardach, 2009, p. 35). The financial cost of each policy option was also estimated and used in the comparison and analysis.

CHAPTER III

POLICY ALTERNATIVES

In order to address the problem of limited access to early childhood education and care for low-income families in Massachusetts, I will describe three different policy alternatives that could potentially be implemented as a way to improve access to early childhood education and care. The three alternative policy suggestions are:

- Option A: Lengthen the certification period of child care vouchers.
- Option B: Reduce the administrative burden on families including eliminating the need for double documentation.
- Option C: Dissolve the child care subsidy waiting list by making child care services an entitlement for families at or below 50% State Median Income.

A. Extending the Length of Child Care Vouchers

One strategy that could work to improve access to early education and care services would be to prohibit the disruption of continuity of care for children by providing one-year child care vouchers regardless of changing parental circumstances. Making all child care vouchers one year in length would provide a stable, educational environment for the child, despite disruptions that may be occurring in the work or social life of the parent. Currently, some families do receive one-year vouchers, but many do not, due to changes in eligibility. For families where both parents are employed in a full-time job, securing a one-year voucher is likely (after possibly years on the wait list); however, for parents who are students or are categorized as seeking employment, the

voucher system is more treacherous. Under the current policy, a parent may receive a voucher for a maximum of 8 weeks of child care while they are seeking employment (Massachusetts Department of Early Education and Care, 2011). This current policy does not serve low-income families adequately, as it does not reflect the reality that they face. According to the U.S. Labor Department, the average unemployed person in the United States has been looking for work for 39.7 weeks (Rampell, 2011). Parents who are living in poverty and have limited educational background have a harder time finding secure employment. According to the study on the Massachusetts Child Care Voucher System, “the nature of low-wage work and the condition of poverty make the circumstances of the respondents’ lives quite challenging” (Washington et al, 2006). The time involved in maintaining government benefits such as child care subsidies can lead to challenges between parents and their employers, making long-term job retention difficult. Extending the length of vouchers could also prevent the unfortunate scenario of very young children being handed around in inappropriate, unstable, or unsafe babysitting environments, while their parents switch jobs or schools. According to the study on the voucher system, child care center directors “saw short-term vouchers as detrimental to the children. Several young children displayed great difficulty with transitions” (Washington et al, 2006). Children living in poverty are already at a disadvantage educationally and developmentally, they do not deserve to be pulled out of a socially and educationally beneficial environment because of a change in the life of a parent. Children who remain in stable, educational care settings performed better on cognitive proficiency tests (Loeb et al, 2004).

This strategy would also serve to ease some of the administrative burden of the short-term child care subsidy system. Currently, early education and child care providers also suffer under funding instability and administrative burdens. Children, parents, providers, and Resource and Referral agencies would benefit if all child care vouchers were one-year in length. Other states such as New Jersey, Maryland, and Washington D.C. have already successfully implemented this simple policy change. Extending the length of childcare vouchers for parents who are seeking employment or who are students would only require a small administrative change. Approximately 20,000 children in Massachusetts are currently receiving vouchers that are for less than one year (Washington et al, 2006). If these 20,000 vouchers were lengthened to one year, I estimate that it would cost the state of Massachusetts about \$48,080,000. I arrived at this estimate after averaging the length of time that the average voucher would need to be increased, using the average rate of \$823 a month. I then subtracted an estimated \$500,000 that could potentially be saved in administrative costs through this policy. This was based on similar cost-savings estimates by other states that enacted this policy change (Adams et al, 2008).

B. Reduce the Administrative Burden on Families

One strategy that could work to improve access to early education and care services would be to reduce the administrative burden of applying for and maintaining child care subsidies including vouchers and contracted slots. A policy alternative to the status quo would include eliminating the need for double documentation and reducing paperwork. Families who qualify for child care assistance are often receiving other government benefits, such as food stamps, monetary assistance, housing subsidies, or

Medicaid, and therefore are producing the same documents and proof of eligibility for many different agencies of the state, even when the eligibility is the same (Zedlewski et al, 2006). State agencies should coordinate their policies and application process. Once families receive their child care subsidy, they must fill out another stack of papers, including a lot of the same information, for the child care center. Information should be allowed to flow more freely between government agencies, Child Care Resource and Referral agencies, and child care centers. Parents report that administrative barriers often prevent them from applying for child care subsidies (Adams et al, 2008). Since eligibility for child care subsidies is determined based on income, as well as the working status and school engagement of the parent, families must produce a lot of documentation in order to apply for a subsidy. Families must show:

- Proof of income, including four to six pay stubs, or an employer letter if they have a new employer.
- Proof of residency such as a utility bill or property tax bill.
- Proof of citizenship or immigration status.
- Social Security numbers for themselves and all children, or sign a form stating they will apply for one.
- Relationship to the children- birth certificates.
- All allowable income verification, such as child support or rental.
- Employer identification numbers and small business certification
(Massachusetts Department of Early Education and Care, 2011).

If a family is already receiving Temporary Assistance for Needy Families, they should not have to submit documentation again to Resource and Referral agencies to

determine child care eligibility. TANF eligibility is most closely connected to child care because TANF has some work requirements and therefore recipients need child care to comply with TANF. As the policy stands now, parents can receive certification for a child care voucher directly from TANF, but they must still then go to a child care Resource and Referral agency to confirm their eligibility, receive more details about the administration of vouchers, produce more paperwork, and find a child care provider (Washington et al, 2006). Currently, the Massachusetts Department of Early Education and Care and Resource and Referral agencies use what is called the Electronic Child Care Information Management System to manage the child care benefits of individual families. Unfortunately, they cannot access the Management Information Systems of other state agencies. This report suggests as a policy alternative, that child care Resource and Referral agency staff be able to access the Management Information Systems of TANF and Medicaid in order to gain needed information about the clients they serve. Michigan, Minnesota, Connecticut, Louisiana, and Oregon have enacted this policy and report that it has “clear benefits for parents, who only have to report their information once, and for the agencies in both reduced workload and fewer improper payments” (Adams et al, 2008, p. 23). These states also report that efficiency increases, while fraud does not increase (Zedlewski et al, 2006). Pennsylvania reports having a “seamless transfer process for TANF/Food Stamp/General Assistance families into child care database and the Child Care Information System agency” (Adams et al, 2008, p. 51).

In Massachusetts, implementation of this policy would mean parents would not have to go into the child care resource and referral agency to review their eligibility and show documentation, they could simply call the Resource and Referral agency for help

with finding a child care center. Staff at the Resource and Referral agency would know whether the family was eligible for a child care subsidy just by logging onto the Management Information System of another government agency and reviewing their personal information and documentation. The Resource and Referral agency would be able to put a child on the waiting list for a voucher or a contracted slot without having to meet with the family in person. The option for families to meet with personnel in the child care Resource and Referral agencies should still be available.

The policy suggestion of allowing Resource and Referral agencies to access the Management Information Systems of other government agencies in order to retrieve information on families looking for child care subsidies, would only ease the burden for families who do receive other services such as TANF. In Massachusetts, the families of 64,900 children receive TANF benefits (National Center for Children in Poverty, 2012). I calculated that about 15,000 children out of the 64,900 children receiving TANF are under the age of 5 and would qualify for child care subsidies. Therefore this policy change could potentially affect 15,000 children. I estimate that the implementation of this policy change would cost about \$1,000,000 because of the need to update the Management Information Systems of TANF and Medicaid so that employees of the Resource and Referral agencies could access them. I arrived at this estimate after reviewing multiple state budgets and observing how much states are forced to spend on Management Information System updates. This cost estimate also includes any costs associated with some minimal employee training needed for the transition to this new policy. Illinois, Wisconsin, and Pennsylvania have developed one Management Information System that is shared by two or more government agencies that handle

benefits; this policy change has been extremely useful, however, creating a completely new Management Information System would be too costly and complicated to implement in Massachusetts today.

C. Dissolve the Child Care Subsidy Waiting List

The policy alternative that would most dramatically improve access to early education and care services would be dissolve the child care subsidy waiting list by making child care services an entitlement for families at or below 50% State Median Income, who also satisfy the activity requirement. As stated in Chapter I, currently there are 36,500 children on the waiting list for a child care voucher or contracted slot in Massachusetts. Massachusetts should look to the major policy change that Rhode Island adopted in 1996. Rhode Island made child care services an entitlement for families with incomes up to 185% of the Federal Poverty Level (later increasing eligibility to 250% of the Federal Poverty Level); this took child care services out of the discretionary budget competition in Rhode Island, entitling all eligible families to subsidized child care, and made a child care subsidy waiting list illegal. This policy change was a tremendous step forward for the state of Rhode Island, allowing thousands of families to access affordable early education and care for the first time. Similar to Massachusetts, Rhode Island provides child care subsidies to families in the form of vouchers and contracted slots, and also enforces an activity requirement. Rhode Island enacted this major policy change when the 1996 federal welfare reform, the Personal Responsibility and Work Opportunity Reconciliation Act, eliminated Aid to Families with Dependent Children and replaced it with Temporary Assistance to Needy Families and gave states a lot more authority in

determining how to use TANF funds. The Temporary Assistance to Needy Families legislation imposed more restrictions and punitive policies on poor families, including new work requirements. National policymakers determined that child care assistance was necessary for the success of the work requirements and therefore created the Child Care and Development Fund. The Child Care and Development Fund is a single block grant that gives funding to the states and allows them flexibility in how they spend this money (Witte et al, 2001). In addition to using the federal Child Care and Development Fund on child care, Rhode Island chooses to spend part of its TANF federal funds on child care. Rhode Island also contributes more general state revenue to child care subsidies in order to cover all eligible families (Washington et al, 2006).

If Massachusetts dissolved the child care waiting list and made early education and child care services an entitlement for families at or below 50% State Median Income, it would mean paying for child care services for an additional 36,500 children. I recommend making child care an entitlement for families at or below 50% State Median Income, because that is the current marker for eligibility for a child care subsidy. As of now the federal government pays for about 80% of the child care subsidy system, including vouchers and contracted slots, while Massachusetts pays about 20%. Some of the funding from the federal government is earmarked for child care; this funding comes through the Child Care Development Block Grant. Some funding from the federal government must be matched by the state. The federal government also provides discretionary social services funding, as well as funding for TANF and Massachusetts chooses to spend some TANF funding on child care. For fiscal year 2012, the federal Child Care and Development Fund allocation to Massachusetts, which includes

discretionary, mandatory, and matching funds was \$101,691,144. For fiscal year 2012, the federal TANF transfer to the Child Care and Development Fund was \$91,874,224 and the direct federal TANF spending on Child Care was \$200,528,249 in Massachusetts (Child Care and Development Fund Plan for Massachusetts FY 2012- 2012). The state Child Care and Development Maintenance- of- Effort (MOE) funds was \$44,973,368; the MOE is a requirement “that a state must spend at least a specified amount of state funds for benefits and services for members of needy families each year” (Greenberg, 2002, p. 1). The state matching funds for fiscal year 2012 was \$31,541,727 (Child Care and Development Fund Plan for Massachusetts FY 2012- 2013). Therefore, in total, from the federal and state government, Massachusetts had \$470,608,712 to devote to child care and development in 2012.

In order to approximate how much dissolving the child care subsidy waiting list and providing an additional 36,500 children with child care subsidies would cost, I began by reviewing the Massachusetts Department of Early Education and Care’s maximum standard daily reimbursement rates to child care providers for fiscal year 2012 (Massachusetts Department of Early Education and Care, 2012). I took the average maximum daily reimbursement between center-based care and family-based care and between the daily reimbursement for infants, toddlers, and children 3 to 5 years of age; this average was \$38.00 per day. I used this average daily reimbursement rate to calculate that it would cost the state \$9,880 a year for the early education and care of one child on the subsidy waiting list. Therefore to cover all of the 36,500 children on the child care subsidy waiting list for one year, the cost would be approximately, \$360,620,000. This estimate is high because it is based on the maximum daily reimbursement rate for

providers and the state often does not pay the maximum rate. The estimate is also high because many families on the waiting list would not want a full-time, full-year subsidy. Regardless, the cost is still extremely high in comparison to how much total funding currently goes to early education and care in Massachusetts. Although, “under federal regulations and under most states’ rules, child care subsidies are available only to the extent that funds are available,” Massachusetts could choose to follow in the footsteps of Rhode Island and guarantee child care subsidies to all eligible families, but it would be at a high cost (Witte et al, 2001, p. 7).

CHAPTER IV

COMPARISON OF POLICY ALTERNATIVES

The purpose of this chapter is to assess and compare the three policy alternatives described in the previous chapter.

- Option A: Lengthen the certification period of child care vouchers.
- Option B: Reduce the administrative burden on families including eliminating the need for double documentation.
- Option C: Dissolve the child care subsidy waiting list by making child care services an entitlement for families at or below 50% State Median Income.

To guide the comparison, the following criteria have been used: political feasibility, equity and fairness, administrative ease, effectiveness, and cost. The table below provides a summary of the results of this analysis, while the descriptions below provide a more detailed analysis.

Increase Access to Early Childhood Education and Care in Massachusetts: Options Assessment

Options Criteria	Option A Extend Length Of Vouchers	Option B Eliminate Double Documentation	Option C Dissolve Waiting List
Political Feasibility	High	High	Low
Equity and Fairness	Medium	High	High
Administrative Ease	High	Medium	Low
Cost	Medium (\$48 million)	Low (\$1 million)	High (\$360 million)
Effectiveness	Medium (20,000 children)	Medium (15,000 children)	High (36,500 children)

The policy alternatives of lengthening the certification period of child care vouchers (Option A) or eliminating the need for double documentation (Option B) are significantly more politically feasible than dissolving the child care subsidy waiting list by making child care an entitlement for families at or below 50% State Median Income (Option C). This is mostly due to the extremely high cost of Option C. As one public policy scholar put it, “the current recession and deficit-averse political environment necessitates budget-neutral or low-cost policies” (Marynak, 2010). The only negative aspect of Option C is the cost. Option A would cost a considerably smaller amount of money because a large portion of families already receive one-year child care vouchers, and this policy alternative would mostly only impact parents who are categorized as seeking employment or are students. Lengthening the certification period of child care vouchers for these families would not strain the overall early education and care budget. The cost of Option B would be marginal and even less than Option A. States that have

eliminated the need for double documentation and allowed child care Resource and Referral agencies to access the Management Information Systems of other state agencies, such as, TANF report minimal costs (Adams et al, 2008). This option may cost the state of Massachusetts some low upfront funding required to train Resource and Referral agency staff to use new Management Information Systems and prepare new account log-ins for the staff who will need to access the systems. However, since this option does not mean creating new, integrated Management Information Systems and will be utilizing existing systems, it is efficient, as well as politically feasible.

Overall, all three policy alternatives discussed here should be politically feasible in that early childhood education as a broad issue, is not controversial or partisan. In 2004, the vast majority of state legislators in Massachusetts voted for a bill that vowed to expand public preschool programs over a ten year period (Washington and Reed, 2008). Although this project is expensive, it received overwhelming bipartisan support. In general, the political climate in Massachusetts is more supportive of publicly funded programs than other states. Option C, or making child care an entitlement for families at or below 50% State Median Income, might be somewhat more politically divisive because entitlement programs tend to be seen as problematic by more fiscally conservative politicians. Option C would also require major legislative change, whereas Options A and B would not. However, there are some strong nonprofit advocacy groups in Massachusetts, such as Early Education for All, that could help garner political support for this entitlement program.

Politicians may not be open to the idea, for example, of raising taxes, in order to improve access to early education for low-income families, which all 3 policy

alternatives address, but they may be interested in how mainstream economists have pointed to early education as a way to improve economic efficiency. James Heckman, a distinguished economist, discusses how “early interventions that partially remediate the effects of adverse environments can reverse some of the harm of disadvantage and have a high economic return. They benefit not only the children themselves, but also their children, as well as society at large” (2007, p. 447). Evidence shows that interventions later in life, such as, public job trainings or General Educational Development (GED) are not only very costly, but also cannot usually make up for an educational disadvantage suffered in childhood (Heckman, 2007, p. 448). Although crime rates have decreased over the past decade, \$1.3 trillion is the net cost of crime per year in the United States if an estimated valuation of life and health is included; the net cost of crime is over \$600 billion per year if a valuation of life is not included (Anderson, 1999, p. 611). Some academics argue that if early education and care interventions were better funded, many children would be able to develop better emotionally and cognitively and would therefore be less likely to commit crime as adults. There is an established link between high school graduation rates and crime reduction, and now this evidence is being connected to optimal early learning environments (Lochner and Moretti, 2004, p. 158). Evidence supplied by researchers showing that children who complete child care programs with a strong educational component are more likely to earn a higher income as adults and own a home also supports this notion that investing in early education will actually save tax dollars in the future (Schweinhart and Weikart, 1993). If health outcomes are also improved at a population level as a result of early education programs, this would also be financially advantageous. Heckman argues that putting “funds toward the early years is a

sound investment in the productivity and safety of American society, and also removes a powerful source of inequality” (Heckman, 2007, p. 456).

Out of the policy alternatives, Options A and B are more administratively simple to implement than Option C. Option A, extending the length of all child care vouchers to one year, would be simple to implement in that the system of administering vouchers is already in place. The voucher system would not change at all, except for those parents who, under the current system, would lose their voucher due to an employment change or some other unfortunate factor. Under Option A, all parents would receive a one-year voucher if they were eligible and they desired one. Once Option A was implemented it would actually be administratively simpler and easier to understand than the current voucher system, both for families and child care providers. Option B would be slightly more complicated to implement than Option A, as it would require Resource and Referral personnel to train in using the Management Information System of TANF and Medicaid in order to look up the information and personal documents of families who want to receive a child care subsidy. Option B may require updating the systems of TANF and Medicaid so that Resource and Referral agencies may easily access them. The goal of Option B is to ease the administrative burden for families applying for child care subsidies, because it has been documented that eligible families see the process as a barrier to services. The implementation of Option B should allow families to avoid producing documents at multiple government agencies and to prevent them from needing to attend in-person meetings at child care Resource and Referral centers. As other states have noted in justifying linking information systems of different government benefit agencies, “minimizing in-person visit requirements or making them easier for parents is

important. In-person visits can mean taking time off from work—something that may be very difficult since low-income workers are less likely to have paid leave or workplace flexibility than higher-income workers” (Adams et al, 2008). Option B should also ease the administrative burden of Resource and Referral center personnel, once implemented. Option C would be administratively difficult to implement, not only because of the necessary legislative change, but also because providing child care subsidies to 36,500 more children would require some logistics management and an increase in staff at Resource and Referral agencies. Resource and Referral agencies, as well as child care providers would need to have the capacity to deal with the increase in volume.

In terms of equity and fairness of these 3 policy alternatives, Option C would most equitably improve the circumstances of the greatest number of low-income families in Massachusetts. Option C would provide child care subsidies to 36,500 more children and their families, as well as eliminate the waiting list for all future families who may need child care subsidies. Option C would have the most impressive and predictable outcome, providing early education and opportunity to 36,500 children and their families. Option C could be seen as unfair, because it excludes lower-middle class families, who continue to struggle with financing child care. Many middle-income families are forced to pay a large portion of their incomes to cover child care services and they generally receive no support from targeted government programs that only help families categorized as low-income.

Option A may have some unfairness built into it, because it would only improve access to early education and care for a relatively small number of families. If Option A was implemented, it would only lengthen the certification period of child care vouchers

for approximately 20,000 children because it would only impact those who don't already have a one-year voucher (Washington et al, 2006). Therefore, this policy option does not impact all low-income families equally. In addition, it could actually lead to an increase in the number of children, and the time they wait on the child care subsidy waiting list, if the waiting list is not dissolved, because providing one-year vouchers to all eligible families would mean less vouchers available to new families waiting for subsidies. This is a significant drawback of Option A. Option A would have the important outcome of increasing access to early childhood education for approximately 20,000 children and allow them to enjoy a stable, healthy, educational environment for a whole year. The state of Maryland has one-year child care vouchers and reports that although "families were usually going from job to job, most were remaining eligible, and even if a family had a major job change, it was an important work support to allow the family to have child care for a few extra months to provide stability as the parent segued into a new job" (Adams et al, 2008).

Option B would impact the population fairly, because it would simply ease the administrative burden on families who would like to receive child care subsidies. Option B does not have any negative trade-offs. Although, Option B would only decrease the administrative burden and eliminate double documentation for families who are already receiving other government benefits such as TANF. This could potentially positively impact about 15,000 children. The best outcome from the implementation of Option B would be that more families who already receive other government benefits would be less reluctant to go through the process of attaining a child care subsidy, therefore increasing

access to early education and care for those families. Option B would have less of an overall impact.

CHAPTER V

RECOMMENDATIONS AND LIMITATIONS

After carefully researching 3 policy alternatives that could improve access to early childhood education for low-income families in Massachusetts, I recommend the implementation of Option A, lengthen the certification period of child care vouchers, and the implementation of Option B, reduce the administrative burden on families by eliminating the need for double documentation when attaining child care subsidies. It is politically feasible to implement both of these options, without significant cost to the state of Massachusetts. In conjunction, Options A and B would work well together to improve access to early education and care for low-income families. These policy alternatives together would work to combat the barriers that low-income families face in attaining adequate child care. Option B would make the lives of already struggling parents much simpler for very little cost. Option A would require a small increase in funding but would provide full-year child care subsidies to approximately 20,000 hard-working families.

Unfortunately, neither Option A, nor, B, would come close to achieving the positive outcomes that Option C would have. Dissolving the child care subsidy waiting list and making child care an entitlement for eligible, low-income families, would allow 36,500 more children to be enrolled in crucial early childhood education. Unfortunately, at this time, I think implementation of Option C would be an insurmountable task. The trade-off in cost acts as too great a barrier. When only \$470,608,712 in total from the state and federal government is dedicated to early childhood education and care in Massachusetts, the cost of covering all eligible children, \$360,620,000, would seem

unreasonable to many politicians. Bureaucratic stakeholders likely do not see early childhood education as a priority. The implementation of Options A and B would help struggling families of Massachusetts attain early education and care, and therefore secure the futures of their children.

Massachusetts must seriously consider the link between childhood poverty, reduced academic achievement, and subordinate health outcomes and create policies that reflect these social problems. The state must invest in public health measures including vastly improving access to early childhood education, in order to combat social factors such as, low socioeconomic status and discrimination, that are linked to poor physical and mental health outcomes. Investing in education programs for children would lead to cost savings years later through the reduced need for special education and remediation, social services, and correctional services. The United States could afford to put more public funding toward early education and care, especially with the implementation of a more progressive income tax rate. A more progressive tax rate is essential to decreasing disparities in health and income and increasing social equality. As Salvatore Babones writes in his 2009 book, *Social Inequality and Public Health*,: “what the public needs to know about social inequality and public health is that the obvious policy solutions, however unlikely they may seem on the surface, should actually be quite easy to implement in democratic societies. They are policies that would benefit an overwhelming majority of the electorate to the detriment of very small minorities that are very well positioned to bear the costs” (Babones, 2009, p. 234). Educators, parents, supporters, and experts from fields such as public health, must join together and make the argument for

investing in early education and care, pointing out the major positive impact it could have on population health and well-being.

One of the main limitations inherent to this thesis is that the policy alternatives identified here are mostly short-term, partial resolutions. These policy alternatives will not lead to universal access to free or affordable early childhood education in Massachusetts. Instead of laying out an ideal child care policy for Massachusetts, policy modifications or alternatives are described that could be practically implemented in the state. However, the evidence around the impact of early childhood education suggests the need for a much more dramatic policy change, where all families, regardless of demographics, would be entitled to free early childhood education. Another important limitation to this thesis is that it does not describe the full impact of these policy alternatives on providers of early childhood education; the focus is on children, families, and communities.

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