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Voices of child care providers: an exploratory study on the impact of policy changes

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Abstract

In debates about child care and early education, the voices of providers are often missing. In this article, we report findings from a study exploring child care provider perspectives on how regulation and policy changes impact their ability to provide care. Data were collected from interviews and focus groups with home-based providers and center-based administrators ($N = 55$) in rural, urban and suburban New York counties. Four overarching themes emerged: undervaluation of child care providers, challenges faced by providers and the parents of the children they serve, regulatory disconnect, and discretionary implementation of laws and regulations. These findings suggest that without input from providers in the creation of legislation and regulations, policies may have unforeseen, inefficient, or even harmful results, such as an inability to match providers with open slots to families whose children are eligible for and in need of care. Based on these findings, we recommend developing mechanisms to enable and encourage participation of providers in the policymaking process, assisting providers in complying with regulations and providing quality care, and standardizing regulation enforcement and oversight to better align with the needs of families and the day-to-day realities of providing quality care.

Background

The World Health Organization (2004) has recognized the crucial role that caregivers play in early child development (World Health Organization and UNICEF 2014). The majority of US parents with young children are part of the paid labor force (US Department of Labor 2016). While they work, most of their children are cared for by non-parental providers, with 13.5 million children under the age of six receiving care from someone other than their parent on a weekly basis (Laughlin 2013). In an effort to expand access and ensure the quality of care for these children, there has been increased attention to oversight and funding of child care, such as those set out in the Child Care Development Block Grant reauthorization of 2014 and changing Quality Rating and Information Standards (New America Foundation 2014; Palley and Shdaimah 2014). These changes, generally implemented at the state and local level, affect child care providers, a primarily low-wage female workforce, and their ability to earn a livelihood. However, in the conversation about child care and early education policy the voices

of providers are often absent (van Laere and Vandenbroeck 2017), despite the crucial importance of their perspectives (Shulman and Blank 2005).

In the US, child care is low-wage work, with pay that does not match the responsibility and skills of the workforce (Whitebook et al. 2016; National Survey of Early Care and Education Project Team 2013). The child care workforce contends with numerous challenges, including the economic insecurity resulting from poverty-level wages, and salaries and benefits incommensurate with their educational attainment. According to the latest occupational employment statistics, the median annual salary for US child care workers is only $20,320 or $9.77 per hour (Bureau of Labor Statistics 2015). Over 56% have at least some post-secondary education and almost 20% have a bachelor's degree or higher (Bureau of Labor Statistics 2016). Nearly half of this workforce receives income-eligible public benefits themselves (Whitebook et al. 2014). Child care employers experience high rates of turnover due to the low pay and the financial instability of trained workers (Whitebook and Sakai 2003). Low and declining wages have led to a decline in child care workforce qualifications over a 25-year period (Herzenberg et al. 2005). Additional environmental factors, such as workplace stress, further burden child care workers' ability to care for children (Whitaker et al. 2015).

This study explored the perspectives of child care providers in New York State on how recent policy changes affect their perceived ability to provide services. New York State is home to 870,151 children under age six, 72% (627,970) of whom are cared for by 36,510 child care workers—approximately 6% of the US child care workforce (Child Care Aware of America 2017). These workers staff the 4836 child care centers (5% of which are nationally accredited), 12,401 family child care homes, and 2747 school-aged care programs across the state (Child Care Aware of America 2017). New York State provides for two types of regulated home-based care: family and family group. Family child care allows a provider to care for up to six children, or up to eight children if two of the children are school-aged (18 CRR-NY 417.8(j)(1)). There must be "at least one caregiver present for every two children under 2 years of age in attendance" (18 CRR-NY 471.8(j)(2)). Family group providers may care for up to 16 children, depending on the combination of ages of children present at a given time, and the ratio of providers to children. Costs can exceed $14,000 a year for care of one child in New York, resulting in 92,200 children (54,500 families) on average receiving a child care subsidy each month (Early Care and Learning Council 2016).

Just as in the nation at large, New York has developed new policies to improve the oversight and funding for child care. In 2000, the Quality Child Care and Protection Act of 2000 mandated pre-licensure and pre-registration inspections for child daycare programs as well as stronger training requirements and criminal history checks for prospective child care providers, creating a foundation for child care regulations in the state of New York (Laws of 2000, Chapter 416). New York's formal child care policy has been added to and modified through legislation as well as regulations promulgated by the Office of Children and Family Services (Division of Child Care Services 2015). Between 2013 and 2015 alone, at least 104 child care-related bills were introduced in the New York State Legislature (New York State Legislature 2015). Of the significant child care legislation that has passed in the state since 2000, almost two-thirds have been geared toward benefiting families, either through improving quality of care or financial support,

while the remainder are geared toward benefiting providers (e.g., creating a task force to streamline regulations or ensuring timely district payments) or both providers and families. In addition to a focus on quality improvement, a significant amount of the advocacy around early childhood in New York has centered on the state budget, particularly the funding of childcare subsidies and pre-k programs (Center for Children's Initiatives 2015; Winning Beginning 2014).

Here, we report our findings from focus groups and interviews with New York State child care providers. Our respondents described the impact of regulation and policy on their day-to-day workplace challenges. We then suggest policy and workplace recommendations based on their perceptions of their experiences and of the needs of the families they serve. We contextualize these recommendations and suggest the value of additional perspectives in future research.

Methods

Study sites and sample

New York State has one of the largest, most heavily regulated child care systems in the country and has been the site of recent innovative child care policy changes. As a result, it is an ideal location to study how the rollout of new policies affects child care providers. The study sample was chosen to maximize geographic diversity and variation in population density (rural, suburban, and urban) as well as diversity in terms of provider types (center-based, home-based) and role (center director, direct provider). We held two separate focus groups at each site: one for home-based providers and the other for center-based administrators. Our initial research suggested that these two groups faced different concerns in relation to our questions of interest. We also believed that members of these groups were perceived differently by child care providers themselves and outside stakeholders. Table 1 provides a breakdown of participants for each focus group by region type.

While the urban group drew from one city, the suburban and rural groups drew from multiple counties. We supplemented the rural focus group with telephone interviews with six home-based providers. While our goal here was exploratory rather than comparative, where our data revealed differences among home- and center-based administrators or by geographical location or population density, we note these in our findings.

While the home-based providers were both owners and direct care providers, the center-based focus groups comprised administrators who would best be able to provide an overview of the work of their centers and how policies impacted decision-making and

Table 1 Focus group participants by location and type

County	Provider type	# Participants
Suburban	Home-based	8
	Center-based	9
Urban	Home-based	9
	Center-based	10
Rural	Home-based	11
	Center-based	2

care. Many of these administrators began their careers as providers and rose to leadership positions through experience and education. Most were also on site and in the classrooms, substituting for providers when necessary and interacting with parents and teachers. A total of 55 individuals participated in the study: 6 in interviews and 49 in focus groups. Their child care experience ranged from 3 to 33 years. Of those who provided their race or ethnicity, the majority self-identified as white, with the largest minority identifying as black. Home-based providers, as a group, were more diverse than center-based administrators.

We drew on preexisting relationships with child care councils, unions, and activists to recruit study participants. Focus group locations and times were selected based on convenience of the majority of participants. They were held in public libraries, child care centers, and child care council spaces where privacy could be assured. Focus groups lasted between 90 and 120 min and were audio-recorded and transcribed verbatim. Study respondents chose their own pseudonyms, and we did not collect or record any identifying information. Although all respondents participated in an informed consent process, documentation of consent was waived to avoid collecting identifying information. The study was reviewed and approved by the authors' respective IRBs.

Data analysis

The research was designed as an exploratory study to generate descriptive analysis (Sandelowski 2000). We chose this method because of limited knowledge about providers' experiences and the newness of policy changes. This type of analysis can also point to further directions for research and is likely to flag connections and concerns that otherwise might not be readily apparent to policymakers and researchers. We employed the constant comparative method of data analysis (Glaser and Strauss 1967), allowing us to use later focus groups to subject emerging conceptual frameworks to member checking. We took a phenomenological approach (Bevan 2014), which seeks an emic or insider understanding of how respondents apprehend and ascribe meaning (Kvale and Brinkmann 2009). In accordance with this approach, as researchers, we recognize child care providers' subjective understandings and did not attempt to verify or contest child care providers' accounts. In the Discussion section, we raise challenges to respondents' perspectives and understandings and suggest future research to obtain the perspectives of other stakeholders.

After data collection, we conducted thematic analysis (Thomas 2006). In the first step, the first two authors read two initial transcripts to gain an overall sense of the data. These authors then compared the themes and created a coding scheme by consensus. Some codes were derived from sensitizing concepts (Bowen 2006), such as regulatory burden, that we expected to find based on the literature and the first two authors' prior research. Most, however, were emergent codes which arose from our reading of the data (Padgett 2016). All authors then coded the transcripts separately, modifying codes as new understandings emerged. The first two authors further discussed the findings to resolve discrepancies through consensus and finalize the themes. The overarching themes that emerged through this process were the undervaluation of child care providers, challenges faced by both providers and the parents of the children they serve, regulatory disconnect, and discretionary implementation of laws and regulations.

Findings

"I'm Not a Babysitter"

Respondents in all settings emphasized their intimate knowledge of children, often noting that children spent more waking hours with them than with their parents: "We are the primary caregivers for most of these children and that's something a lot of people do not realize…we spend 10–12 h a day with most of these children." As another provider stated, "[w]e are kind of the therapist, the mom, the cafeteria." Their holistic and multifaceted care went well beyond what others have derogatorily referred to as babysitting. Most of the services they provided centered around their roles as educators and family supports.

Providers as educators

While many respondents felt appreciated by the families they served, most believed that people fundamentally misunderstand their expertise and their commitment to care work. They also believed that policymakers failed to recognize the importance of the services they provide, not only to families, but also to the broader society. In all of the focus groups, respondents initiated discussions about what they saw as the value of their overlooked contributions. A rural home-based provider whose quote serves as the subheading to this section, explained.

> *It's a lot more than most people [realize]. I always joke around when [someone says] "Oh you're a babysitter." No I'm not a babysitter. I'm not a teenager that's raiding your fridge…I am an early childhood educator. I'm preparing your children for elementary school.*

Respondents frequently cited long tenures in the profession, as well as their formal educational background, often in early education and child development. Most had some post-secondary education, which contributed to their ability to provide appropriate, quality care. The charts below provide a profile of the general levels of education for providers in our sample (Fig. 1), and their education specific to child care and development (Fig. 2).

Some respondents described expertise and training around learning theories, and physical and/or developmental disabilities. Others were trained in specific educational approaches (e.g. Montessori Method), building age-appropriate curricula, and/or preparing children emotionally and academically to enter kindergarten or first grade.

Providers as a family support

Respondents emphasized their role as financial, employment, and social supports for children and families. One urban center director described her holistic view that caring for a child means caring for the family as a whole:

> *It's the community. It's the whole family. You cannot isolate the child. We're taking care of the child. We're taking care of that family. How many fights have you broken up? How many times have you stood in the middle of the boyfriend and the girlfriend with the court papers? Come on. Let's talk about the whole situation. We need to make sure that the funding is there for those of us who will do this work. It's not child care. It's not babysitting. It is family provision of care for the family unit.*

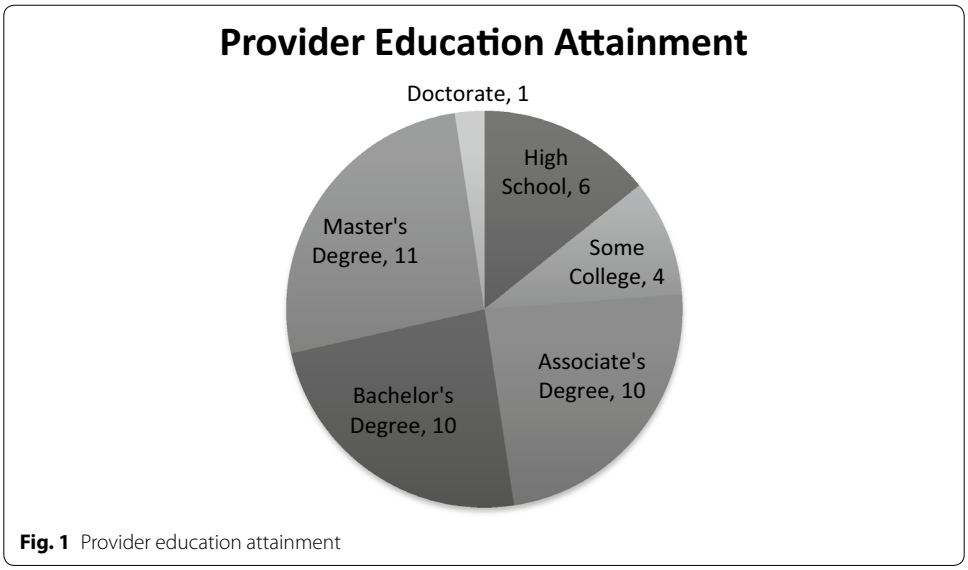

Fig. 1 Provider education attainment

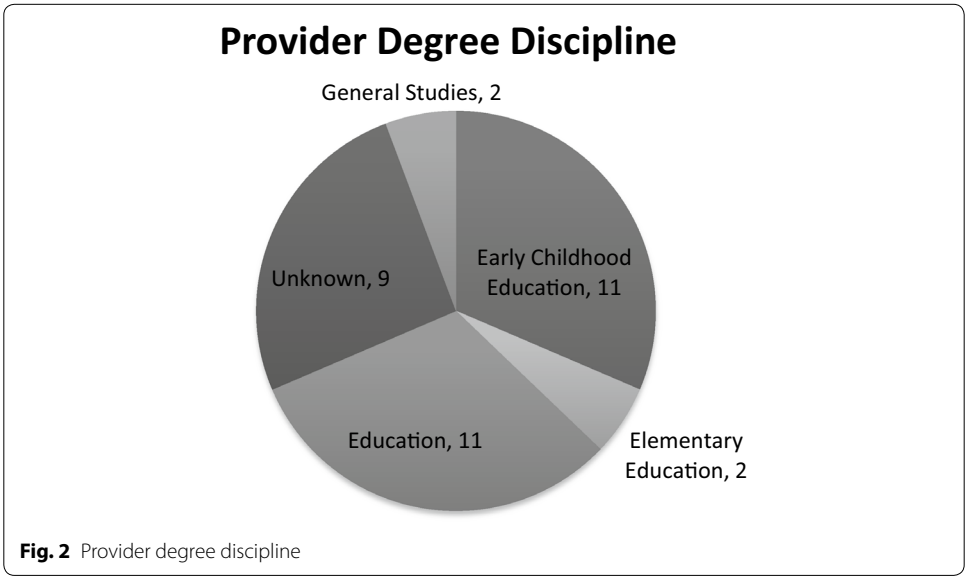

Fig. 2 Provider degree discipline

Home-based providers often worked outside of their regular hours, with many starting as early as 5:30 AM and ending as late as 6:30 PM. Most did not charge overtime for these hours of care, which they provided either on an emergency basis or more regularly. Others waived or lowered fees when parental funds ran low.

> *They took social services away from [a] family because the funds weren't there. And the lady, you know, she was a single mom. And she worked every day, but she just couldn't pay for daycare. And I would just let her not pay for daycare. And then, when she could afford it, she could pay me whatever she could afford. And so, like, I went without that $145/week…I had known her and she was a hard working person. It wasn't like just somebody who lived off of welfare (Rural home-based provider)*

While empathy for parental struggles was a common thread, these kinds of accommodations were primarily the purview of home-based providers, who had more flexibility to set the rules than center-based administrators, who may have to answer to their boards of directors or supervisors. Although home-based providers earned less and seemed more overwhelmed, their close relationships with families created strong bonds with the children and families and a greater willingness to compromise, even to the provider's own detriment.

A number of home-based providers who suspected financial burdens among families provided extra food onsite and sent food home with children in order to help feed their families; some also bought shoes or clothes. While less common than responding to perceived financial struggles, some providers in the suburban home-based provider group watched children over holidays or when parents failed to pick them up. Other respondents noted that if parents retrieving children seemed to be under the influence of drugs or alcohol, they kept children in care, sending the parent home. These respondents felt professional responsibility toward the children and genuine concern for their well-being, going above and beyond legal requirements.

Challenges to providing high-quality care

Providers noted workplace barriers to providing quality care. Most of these related to the cost of providing care, which was often higher than parents and subsidies could cover. Most respondents were unable to fund desired changes to improve facilities, work force, and programming. Their financial status often affected staffing decisions. Low pay and unstable working conditions make it difficult to hire and retain well-trained, experienced workers.

The high cost of providing good care

All respondents were committed to the children and families they served. Home-based providers, who struggled the most financially, often claimed that their love for the children they served and their commitment to these children and their families was the only reason they remained in child care, with several reportedly on the verge of leaving the profession. Respondents raised questions about their ability to comply with quality standards when they operated on slim profit margins. Many expressed concerns about New York's rising minimum wage:

> *Not that I have anything against paying my people more, because they deserve the $15 and then some, but how will it impact us as a program? We're having some serious discussions about how we can set up our organization for success. It's not a reality that we can just go to our families [to ask for additional funding]. (Urban center-based administrator)*

One director, who ran a large, relatively well-funded, multi-site, center-based nonprofit program, was troubled by the impact of rising operating costs resulting from background checks and minimum wage increases on substantive programming. For-profit providers also struggled. They worried about how policy mandates might affect operating costs, what this could mean for paying parents, boards of directors, and payroll, and how to refrain from cutting costs at the expense of quality programming. One

suburban center-based respondent echoed providers in all locations in her worries that higher costs would drive parents away or price them out of the market: "Part of my job is managing how much it's already in the red, and that's constantly being looked at because as much as people want quality, they don't want to pay for it, so it becomes a real problem."

Staffing challenges

High operating costs prevented some respondents from providing optimal care, including hiring the most qualified staff. Center-based administrators and home-based providers struggled to pay their employees a living wage. Low wages often meant hiring workers who had little knowledge of professional workplace norms.

> *I'm thinking about behavior on the job. I spend a fair amount of time working with staff, saying "this is an appropriate behavior to the staff." We're hiring from within the community, and I have to say to the staff that "that cell phone is not appropriate to use when you are working with children." (Urban center-based administrator)*

Others expressed concerns about retaining staff at low wages, particularly when they were unable to provide consistent work schedules. This was especially difficult for those who served families reliant on government child care subsidies, for which providers are only paid for the days the children are in attendance. Staffing challenges were influenced by systemic challenges, such as the precarious nature of low-wage employment. The uncertain work schedules of many parents in low-wage work often translated into reduced workdays for child care staff, who were sometimes sent home when children did not arrive for school.

> Speaker 1: It was really hard to keep retraining staff. They didn't want to work there, why would you? …you couldn't manage your bills, monthly bills, because one week you might work 25 h. The next week, you might work 18. I mean., it was awful. I -.
> Speaker 2: And these—and the wage is not high either.
> Speaker 2: Exactly.
> Speaker 3: I know today, [a child care chain], one of the biggest in the nation, is hiring four-year degreed, certified, early childhood professionals at 13 bucks an hour. (Suburban center-based administrators).

Center-based administrators who were partially funded by employers, such as those connected to universities, were among the few who paid living wages as well as health and in-kind benefits, such as university tuition for employees, children, and spouses. This was so unusual that other focus group participants asked if these centers were hiring.

Respondents who wanted to work with children with disabilities were stymied by high costs and lack of support. Even when children and providers were eligible for subsidies, these often took time to acquire or got lost in a bureaucratic maze.

> *For example, one of the autistic children I have, he's not very stable at all, he only comes in the afternoon sometimes, but going down the stairs, now I would have to make modifications to [my] railing, but then you have to get documentation. This*

stuff is already documented…They're supposed to give you money for that special needs child, and they don't. You're making all these modifications which is costing you more money to get an extra staff for that person, and these are the guidelines that need to be looked at, because there's a lot of children now being diagnosed with autism….I can't choose and say "Oh, I'm going to choose this apple and not this one." (Urban home-based provider)

Like this provider, a number of others were willing to provide care for children with disabilities, and home-based care was often a good setting for personalized programming. However, lack of financial and/or training resources impeded their ability to do so. Similarly, respondents were often the first to identify children with developmental delays or learning disabilities. They sometimes encountered resistance when trying to persuad parents to obtain a professional evaluation of these children. Even when parents were willing to follow through and request evaluations, it was often difficult for them to get the evaluations and recieve services in a timely way.

Regulatory disconnect

All study participants understood the need for rules and regulations, but many found some regulations, to be so onerous and rigid as to interfere with their ability to provide what they saw as optimal care. A wide variety of examples were provided, from duplicative paperwork to impractical supervision requirements, some of which are shared in the following sections. It is important to note that while different regulations impact providers differently, each example helps illustrate the overall theme observed and the unintended consequence of the example regulation. Providers complained that laws and regulations were disconnected from the actual job of caring for and educating children, and that they had little to no voice in the regulatory process. Providers also discussed the unrecognized cost burdens that came with unfunded policy mandates.

Policies and procedures that interfere with care work

When asked about the regulations and changes over the course of their careers, one suburban center-based administrator echoed a sentiment heard across all focus groups:

Yeah, they depersonalized a lot of the care that we provide. A lot of the human service aspect of the child care industry has become more administrative and paper-pushing, like [Peggy] stated, the teachers are overwhelmed with it. They are trying to do what they need to do, but they are really torn between what sound early childhood practices tells us [about] social/emotional development in children, meeting young children and their families' needs, and then doing the regulatory work—and the regulatory work just gets harder and harder with no resources.

Others gave more specific examples of how documentation requirements interfered with their jobs, creating a conflict between providing quality care and meeting bureaucratic regulatory demands. Required documentation included logs of who entered and left the facility (including family members of home-based providers who were already present in their home); inventories of how each child was feeling and any signs of discomfort or illness; notations of times of entry and exit of children; and records of health concerns or injuries that arose throughout the day. These were accompanied by other,

less routine procedures, such as registering scheduled vacations (for home-based providers) and bi-annual shelter-in-place drills in the wake of Hurricane Sandy (in addition to regular fire drills) that required setting up beds, calling all emergency numbers, bringing children to a safe location, and inventory review of emergency supplies. When a suburban home-based provider described paperwork requirements, others nodded in agreement, which is noted in brackets:

> *We spend a good portion of our day doing paperwork [mhm]. For either the food program, for DSS, which has two separate forms [yeah, uh huh] that are sign-in sheets, the State, which has yet another sign-in sheet [mhm] for the children and then another sheet that we have to sign in, and we have to make sure that all of these things are done on a daily basis because if licensing or the food program happens to come in, they're looking for consistencies with our paperwork and then if it's not done we run the risk of getting violations.*

Many routine forms and regulations, while logical in theory, were practically difficult. For example, providers may be inundated with parents who are simultaneously rushing to work, handing over children, and sharing information. Home-based providers and center-based administrators in all sites opined that legislatively predetermined and scripted encounters, particularly at the moment of "hand-off", interfered with their ability to provide parents and children a more genuine and effective encounter. Many home-based providers, who are alone with their charges, criticized policies regarding eye contact with children at all times.

> *I want to talk about something, a policy on supervision, 15.1, I think dash one, where it says when you go to the bathroom, you're supposed to take kids with you. Who in their right mind developed this policy, and what were they thinking? It's just wrong on so many levels. (Urban home-based provider).*

Respondents across the State underscored that the cumulative impact of seemingly superficial or routine processes, by virtue of their sheer number and minute specificity, interfered with providers' morale, relationships with families, and child care duties.

Respondents described an implementation and regulatory process characterized by illogical rigidity in light of families' changing needs.

> *So in my particular instance, I had three different families, all moms were pregnant. The older children had all been with me since six, eight weeks, whatever. These moms are all pregnant and due within six months of each other. And I am told one of these families have to be cut loose. In the olden days I would have been able to apply for a waiver and gotten the waiver, and kept the families intact and the children with the siblings. So it was a nightmare, it ended up one grandmother took one child on Monday, another grandma took one on Tuesday, one mom stayed home on Wednesday, and they just rotated days. I would look at my chart, which five kids am I going to have today. For almost two full years, until the kids aged out to the over two. It was extremely difficult for me and the parents. I just saw no reason for any of that. (Rural home-based provider)*

Respondents complained about the lack of flexibility, noting that it left them and families in difficult situations especially if there were few providers within a certain geographic area.

Another regulation designed to protect children that created a burden on families was restriction on the administration of all medication, including those available over the counter, regardless of parental and/or medical consent. This rural home-based focus group exchange detailed providers' frustration with regulations many felt had gone too far:

> Speaker 1: One thing I would like to see change, remember back in the day if the doctor, and the parent, and the daycare provider signed, you could give them Tylenol? Now you have to go have [Medical Assistance] training. And then we took all these hours. But we never signed on because then you would have to have a nurse in your home and all that. If a child is teething, I would like to be able to give them Tylenol. I would like to see the medication [regulation] change. If the doctor says you can, and the parent says you can, and the daycare provider is willing, then you should be able to give that dose of Amoxicillin or Tylenol. You should be able to do that.
> Speaker 2: Just document it like everything else, and you should be able to do it.
> Speaker 3: That is a big gripe of parents, because they have to go find somebody to go give that child, their grandparent, "oh here is your Tylenol."

Unfunded mandates

Center-based administrators and home-based providers alike struggled with the cost of unfunded regulatory requirements. These included criminal background checks, safety regulations (e.g., changes in outdoor surface areas, playground equipment, and fencing), and training (e.g., mandatory CPR or the State's $360 Medical Administration Training (MAT), which is required of any provider administering any medication). It is important to note that respondents did not object to the mandates per se, but often found it difficult to comply due to the time it took to complete them or to their cost. Criminal background checks, which are required for all employees and for residents of home-based family providers' homes (New York State Office of Children and Family Services, n.d.), were a frequent topic of discussion. These could be costly, particularly for home-based providers who live week-to-week on their fees. Center-based administrators, especially for large providers, raised concerns about the cumulative cost for large numbers of employees. Costs for all providers are magnified by high turnover rates, which necessitate additional background checks. In addition to the cost, in some parts of the State, background checks could take up to 3 weeks to process. The lag time posed a particular challenge for providers with employees, as all described high turnover rates, often with little advanced resignation notice. When this causes providers to become temporarily understaffed, they may lose child care slots due to mandated ratios. While a small number of respondents received grants from unions or child care councils to defray some costs, not all were able to access these funds at all, or in a timely manner.

Both home-based providers and center-based administrators served low- and middle-income families who left the labor market, thus removing their children from child care, because they could not sustain the cost of care on their salaries. Many of the home-based

providers had themselves left other careers partially as a result of the cost of child care. One rural center-based director suggested to her board that they only recruit high-income families because the middle-income families did not tend to keep their children in care for long.

Payment delays for children receiving state subsidies were another common burden. Absent unusual delays, providers received payments a month after providing care. Respondents assumed if they accepted children eligible for subsidies, they would eventually get paid. However, recent changes to the law require providers to obtain a formal letter of approval, a process that takes 2 months, before they can bill for services. During this time, providers cannot fill the slot for the subsidized child nor do they receive payment.

> Speaker 1: [The state agency] will call us and say, "We have a family, can you take this child?" And we'll say yes. They'll send the parent to us; we'll talk to them; we accept them. We get a written letter from those two agencies that are under the umbrella of DSS…[but] they don't go on the billing systems! [murmurs of agreement]. Sometimes for months.
> Speaker 2: We don't have no money.
> Speaker 1: I'm talking two to six months. And to get them on the billing system by calling DSS? Again, we may as well just be trying to do brain surgery. (Suburban home-based focus group).

Even when respondents received subsidies for certain children, they did not cover the full time those children actually spent in care. If parents of subsidized children had long commutes, which was often the case as these parents were more likely to rely on public transportation, respondents were not fully compensated for the child's time in care. Hourly employment subsidy calculations also meant that although the provider had to hold a subsidized child's spot open all day for 5 days a week in order to retain that child, they did not get their full weekly wage when parents' employers cut the parents' hours in a given week.

Differential use of discretion in implementation

Respondents in all groups experienced conflicting or arbitrary interpretations of regulations by local licensors and inspectors who conducted frequent, unannounced, onsite regulatory visits. These varied interpretations resulted in frustration and a sense of unfairness.

> *I have three friends that are directors in other counties, local counties. Their licensors' interpretation is entirely different from each other, so somebody is getting violated for something, and I get a call from this director and she says, "Did you know such and such?" and I'm like, "No, I did not," and she goes, "I just got violated on that. What does your licensor say on that?" "Nothing." We are dependent on the licensor's interpretation of what the reg[ulation]s mean and where your licensor is going to, for lack of a better word, bend the rules or enforce them above and beyond… It's okay for one to do one thing, but it's not okay for another to do another thing… We have nothing to stand on to go to somebody to say, "Ah, listen, you guys need to all be on the same page," (Urban center-based administrator)*

One rural center-based administrator noted that even though licensors conflicting interpretations caused stress for them and their staff, but they were hesitant to question:

> *In the beginning, I did not feel like I could ask her, "well, why is this wrong? It was totally [her] interpretation. It is not there [in the regulations]. That confuses staff too. It makes them more and more afraid. Can we do bubbles with the kids? Is shaving cream okay? These are all things that kids love to do but they did not know.*

A suburban center-based administrator noted a four-time turnover of licensors during the preceding 19 months required changes of practice each time.

> *Licensor one comes in, "Okay, this is how we interpret that-this and this is what you should do." "Fine, we'll comply." Licenser two comes in: "Well, you can't have this [laughing]." Okay, "Well we only [did it] this [way] because licenser one said this was their interpretation [continued laughing]." "No, that's not how I interpret it, do this." Okay. Licenser three comes in: "Well, why are you doing this?"*

As these quotes illustrate, respondents do not take issue with the idea of being regulated. However, they seek consistency and fairness in application of the regulations.

Respondents across groups noted callousness regarding the impact of inspection demands upon children. One suburban home-based provider shared the most emotional story:

> *My kids [were at] nap time… I have 18 months old, 6 weeks; my daycare is in a cottage in the back…It was snowing. My licensor was [at] the gate…She was calling and calling. I say, just give me a minute, the kids are in nap time. [pause] "Wake them up!" [several gasps] My heart [pause] went [pause] [like that]. I can open the door. I have monitor with TV. I can open the door and run to the gate, open the door and run back. You don't think that policy is ridiculous? They cannot not leave them…I had to wake them up, put [on] their jackets. My 18 months-old, my 6 months-old, she was crying hysterical. She couldn't go back to sleep. It was snowing, and she made me wake them up.*

Examples reported in other groups included licensors demanding providers' attention to review charts or respond to questions while children needed comfort or attention and what respondents viewed as inappropriate interactions with children by the licensors or inspectors.

Many respondents noted that inspectors and licensors often lacked child care experience. Although respondents usually had reasons for their own rules and procedures, they reported little to no room for discussion or reconsideration when they experienced a conflict with a licensor's or inspector's interpretations of regulations. Most resigned themselves to accept that inspectors simply must be placated in order to avoid sanctions, and that there was no place for their input or questioning as a provider.

> *She heard me say, "Please be quiet, you're going to choke; you have food in your mouth please don't talk."…and she said, "Did you just tell the children to be quiet, that they couldn't talk while they're eating?" And I said, "Yes", and she said, "You can't do that." I go, "You can't do that?" And she says, "Nope it's a regulation…this is a time when they socialize." And I said, "Socialize, they socialize all morning long…*

wouldn't you think it would be better for children to not talk while they're eating so that they don't accidentally choke on their food?" And she said, "It's a regulation." So I went back out there and I said, "You can talk." So she cited me for it, but she wrote, "Corrected onsite"... when licensors come in, it's like "what you're going to cite me for today?" I just think sometimes they look for stuff...there are people doing day care out there that are child molesters and homes are filthy and you come in my place and you just try to find something wrong. (Rural home-based provider)

The above quote refers to another aspect of respondents' complaints, which is the need for context in assessing sanctions. Like other respondents, this provider prided herself on being competent. Respondents saw many of the rules, often designed after extreme incidents such as child deaths or injuries, as driven by the proverbial few bad apples. They felt providers with good records should be treated as partners rather than adversaries, and that the State should take a more open and educational rather than punitive approach to alleged violations. Some of the rigid regulations that cited safety did not allow for reasonable professional differences of opinion. For example, one group of respondents questioned whether mandated hand sanitizer was warranted in light of research regarding the need for children to develop their immune systems.

Respondents who were found to be out of compliance were written up for violations, even when corrected immediately. Violations, which are made publicly available via state websites and posted onsite, often fall under disproportionately negative categorical designations that create unnecessary concern among current and prospective parents. For example: "I think we didn't have the hot water working in one of our toddler rooms and [our violation] came under the [category] sewage." (Suburban center-based administrator). A relatively egregious example of both the impact of multiple regulations and of the discretionary role of the licensor was provided by a suburban home-based provider. She explained that she had reported one of her employees for suspected child abuse. Even though she had immediately fired the employee and initiated the complaint, her former employee continued to work with another provider while a child abuse violation was placed on *her* record that remained publically available online for the next two years.

Discussion and conclusions

New York and other states have created regulatory frameworks around child care in an attempt to protect children when not in the care of their parents. The clear need for regulation, guidance, and oversight is well-grounded in documented incidents of child care tragedies (Bowes 2017; Fenton 2017) and is the well-accepted and growing body of literature on the crucial impact of quality care on child development (Shonkoff and Philips 2000). Early child care and education regulations focus on risk reduction and quality improvement as defined through evidence-based practices that can be applied and quantified, but may be a poor fit for the dynamic and relational nature of caring for infants and young children (Urban 2012). This mismatch may impede reconciling the important goals of child care and early education policy with the everyday realities of children and families. Our study respondents did not dispute the underlying need for regulation so much as express their frustration with lack of transparency and consistency in regulation and oversight, and the failure of policies (as implemented) to engage

with and plan for the normal contingencies of providing intimate care. Many child care providers are also frustrated by the economic realities of providing care, particularly to struggling families. Regulatory requirements often compound these challenges by creating additional expenses and hurdles for providers to overcome in order to provide quality care without providing additional financial assistance for providers or families. Many providers feel that policymakers do not understand children's needs and the practical implications of the regulatory requirements on care, nor do they seek input from providers in order to better understand the realities of child care provision.

Our findings suggest numerous changes which could help to improve the ability of child care providers to offer quality child care. Providers, especially those who support low-income children and families, should be given more government financial and educational support. This may include free or subsidized continuing education and degree programs, financial assistance or sliding scale fees for child abuse clearances, and guidance and financial assistance in making safety and education upgrades. Making compliance financially less burdensome may improve morale, relationships with local and state agencies, and ensure the economic viability of providing optimal care for children. In addition, our findings show that increased child care resources and financial supports for low-income families in the labor market are necessary. Despite working for wages, low-income families remain economically vulnerable and may not be able to meet their children's basic needs or afford satisfactory child care even though it is a crucial work support. This vulnerability is heightened by the fact that bureaucratic hurdles result in delayed payments, which can put families' employment and child care provision in jeopardy. Providers serve as a safety net for such families, and their knowledge provides a window on parental hardships.

Our findings indicate that more transparency regarding the qualifications and authority of licensors and inspectors may foster providers' understanding of and respect for rules and regulations without necessarily compromising licensors' regulatory role. Regulation and oversight should also be implemented in a manner that better enables compliance. Rules should be clearly described and disseminated widely; basic trainings or question hotlines should be made available to providers at no or reduced cost. Inspectors and licensors should have increased training to improve consistency of regulation implementation and enforcement. Training should also include ways to collaborate with, educate, and support providers rather than to operate in a punitive manner. When providers are found to be out of compliance with regulations, a more collaborative and remedial approach, tailored to the gravity and frequency of the non-compliance, might be appropriate. This could include opportunities warning notices and allowances to rectify non-compliance, particularly if they are minor, before they are considered violations and prior to publications or fines.

Forums for discussion as well as publicized, accessible, and transparent processes for raising providers' individual and collective concerns may also foster collaboration and problem solving toward shared goals. For example, some of the concerns raised by providers, such as licensors' interactions with children or the need for home-based family providers to take unattended children with them to the bathroom, may benefit from brainstorming of solutions that satisfy safety concerns while allowing for providers to attend to the needs of the children they care for, as well as their own. Augmenting

opportunities for providers to participate in regulatory debates and rule-making may also counterbalance their perception that their expertise and commitment to children are devalued, which may positively influence attitudes toward regulation (Stamopoulos 2012). Perhaps most importantly, policymakers and regulators should consult with child care providers to better understand the context in which prospective laws and regulations will be implemented so that regulations will better support child care, early learning, and child safety. Provider participation in the regulatory process could reduce unintended negative consequences and conflicting mandates, and increase provider understanding and buy-in of any changes. It could also help to identify supports child care providers might need to implement changes and provide the highest level of care. Any mechanisms for input, such as workgroups, hearings, or representation on committees, should include both home-based providers and center-based administrators.

One limitation of this study is the small sample size, and the fact that regulations and regulatory regimes differ across jurisdictions. Future research should consider the extent to which our findings are generalizable to other states and contexts and explore how challenges faced by providers differ. A survey tool could be developed to evaluate this and/or interviews and focus groups could be completed in other parts of the country. Another limitation of this research is the method and its use with one stakeholder group. While a phenomenological approach is useful for exploring in depth, subjective understanding of a phenomenon, in this case, regulation of child care in New York State it is incomplete. Our research augments the already existing literature on regulation by exploring an often absent voice. Future research should triangulate these perspectives by adding the experiences of licensors, inspectors, teachers, or parents, to provide us with a fuller picture. Furthermore, a review of best practices across the United States and internationally would provide a beneficial context with which to compare these various perspectives. Given the concerns expressed by providers in our study, it is also important to evaluate whether the regulations actually make children safer by comparing reports of abuse or injury while children are in care before and after specific regulations are put into effect. One final limitation is that we do not know the relative quality of the programs that providers in our study offered. It is possible that the types of issues reported were influenced by whether they were involved in high- or low-quality programs. It is possible that the quality of the care provided also influenced their perceptions of how difficult it is to meet new standards or regulations. This factor should be explored in future studies that combine emic or insider perspectives with additional data such as quality ratings and regulatory and/or parent perspectives.

Child care is a crucial work support for parents. We know that the children's socio-emotional and educational development are influenced by their experiences in the earliest stages of life, and it is in our best interest as a society that children are safe and well-cared for during this period (Center on the Developing Child at Harvard University 2016; Heckman et al. 2006). Child care providers need to be seen as partners with parents who enable social and economic well-being of children, families, employers, and broader society.

Authors' contributions

CS and EP conceived of and designed the study collected and analyzed the data, and drafted the manuscript in equal parts. AM assisted with review of the literature, data collection, transcription, and data analysis, and helped to draft the manuscript. All authors read and approved the final manuscript.

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The authors declare that they have no competing interests.

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The content of the manuscript has not been published, or submitted for publication elsewhere.

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