

EXECUTIVE REPORT

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Executive Report

SECTION 1.0: Introduction

The National Institutes of Health (NIH) is one of the world's foremost medical research centers, and the federal focal point for medical research in the United States. The NIH, comprised of 27 separate Institutes and Centers, is one of eight health agencies of the Public Health Service which, in turn, is part of the U.S. Department of Health and Human Services. The Office of Research Services (ORS), one of the departments under the Office of the Director, combined a number of wide-ranging contracted services and programs to create the Worksite Enrichment Programs Branch (WEPB), under the Division of Support Services (DSS). The WEPB is dedicated to providing NIH employees with a variety of services that enrich and enhance their quality of work life. As part of an ongoing commitment to providing a quality work environment for its employees as it relates to child care amenities, the NIH sponsors four licensed child care centers. In order to assess the current and future needs of the NIH population for child care services, the Office of Research Services commissioned this statistically valid Child Care Needs Assessment Survey. The survey included 1441 participants whose demographics reliably mirrored those of the entire NIH population with regard to gender, work site and job category. The following executive report contains a summary of the findings, analyses of those findings, as well as recommendations and conclusions.

SECTION 2.0: Survey Purpose

The Office of Research Services understands the importance of child care to the retention and recruitment of talented people who make up the NIH, and the survey instrument was administered to allow the ORS to assess and determine the child care needs of the NIH community.

The questions were designed for those employees who have children of child care age, or who anticipated placing children in some form of child care services within the next 12 months, and it measured their service priorities, desired future initiatives and recorded demographic data. The survey project was performed on behalf of the ORS by Performance Dynamics, Inc., in partnership with the University of Central Florida, College of Business Administration, BE2000 Technical Team.

SECTION 3.0: Methodology

A three phased approach was undertaken to complete this survey. In the first phase, information gathering, senior consultants reviewed existing NIH public documents pertaining to child care services, conducted small focus group meetings with key stakeholders from the Office of the Director, Office of Research Services, child care staff, users of existing NIH-sponsored services and potential users of these services, which resulted in a pilot survey. In the second phase, pilot survey administration, the initial survey draft was given to select individuals. The data was then collected, analyzed, discussed with the aforementioned stakeholders and then retooled to better meet the needs of the respondents. In the final stage, final survey administration, the agreed upon version was submitted electronically to all NIH employees. Also, the survey was offered in 5 different languages online and 2 different languages on paper.

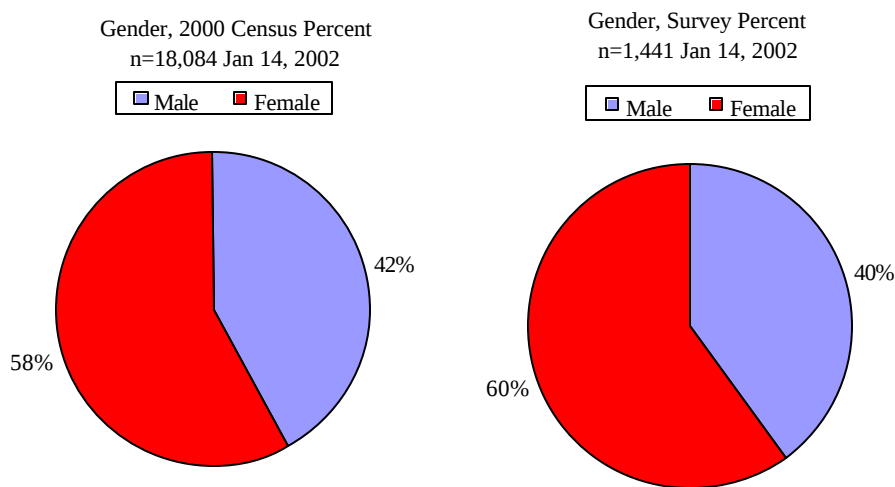
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SECTION 4.0: Survey Sample

The survey sample of the NIH population consisted of 1441 people. As approximately 22,000 people were invited to participate in the survey via electronic mail, this response rate of roughly 6.6 percent is within the ordinarily acceptable response rate range, according to Creative Research Systems.© It is important to note, when viewing this response rate, that only a fraction of the population of the 22,000 invited to participate in the survey have children or direct concerns with child care issues. Furthermore, the survey was administered two weeks following the tragic events of September 11, 2001, and given the many additional responsibilities incumbent on federal employees in the wake of that date, this response rate is considered to be a very good one.

Figures 4.1, 4.2 and 4.3 show that the sample of respondents also adequately represents the demographics of the NIH population. With regard to gender, Figure 4.1 shows that 40 percent of the respondents were men, while 60 percent were women. According to the 2000 census of the NIH population, 42 percent were men, and 58 percent were women. The differences between these two distributions are not considered to be significant.

Figure 4.1: Gender of the NIH Population, Survey Data vs. Census Data

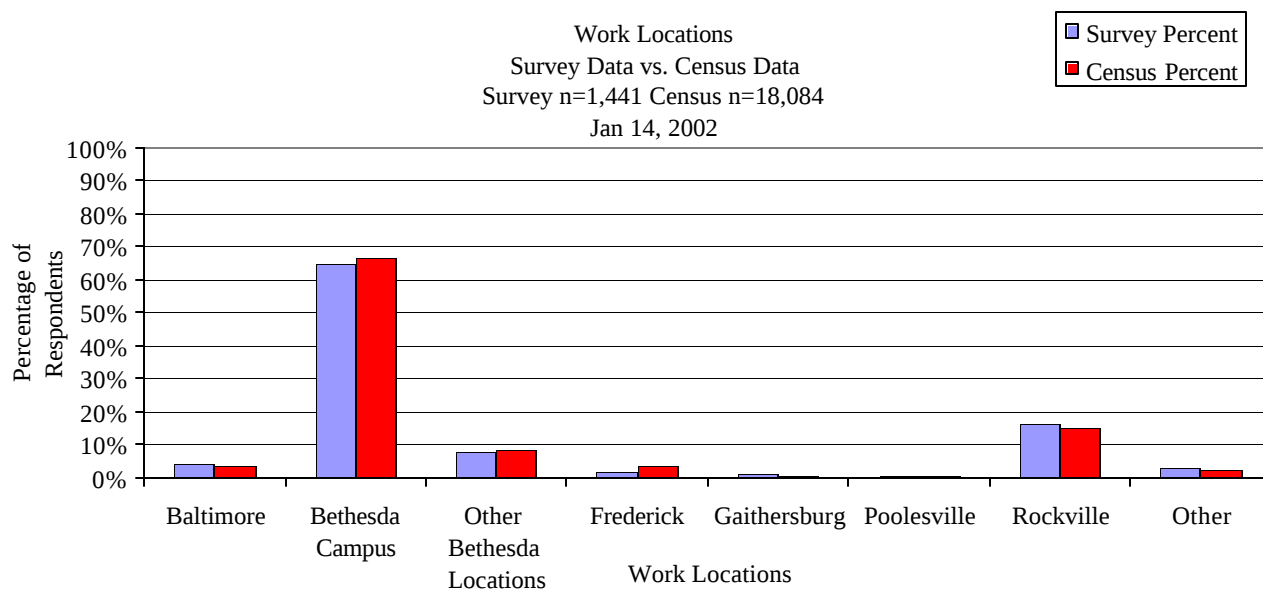


Source: NIH Office of Human Resource Management, Workforce Profiles and NIH Census, Office of Facilities Planning, ORS

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Similarly, respondents were not significantly different from the overall NIH population with respect to work locations. The majority of respondents were from the Bethesda campus. Figure 4.2 compares work locations survey data to the 2000 NIH census. The small marginal differences observed are not considered to be significant.

Figure 4.2: Work Locations, Survey Data vs. Census Data

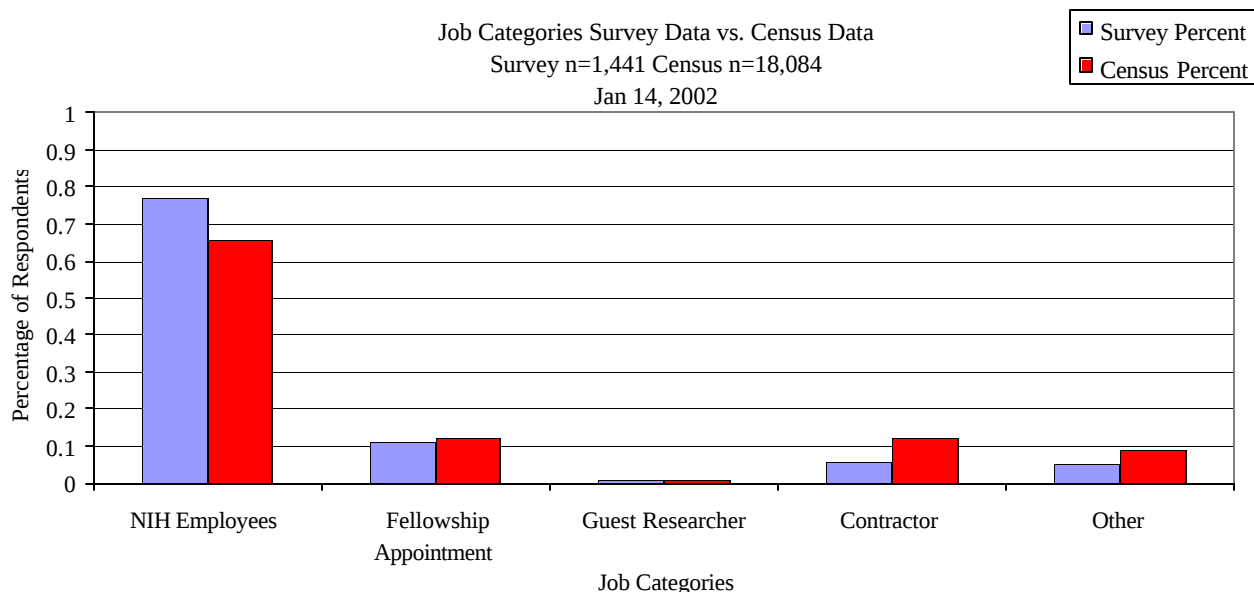


Source: NIH Office of Human Resource Management, Workforce Profiles and NIH Census, Office of Facilities Planning, ORS

The sample of respondents did differ in some degree from the NIH population as a whole in relation to respondents' job categories. Generally speaking, NIH employees were over-represented in the sample, while contractors were under-represented. This can perhaps be accounted for by the fact that, as a practical matter, contractors tend not to be able to access NIH-sponsored child care, as they are accorded a lower priority when open slots are awarded to applicants on wait lists. See Figure 4.3.

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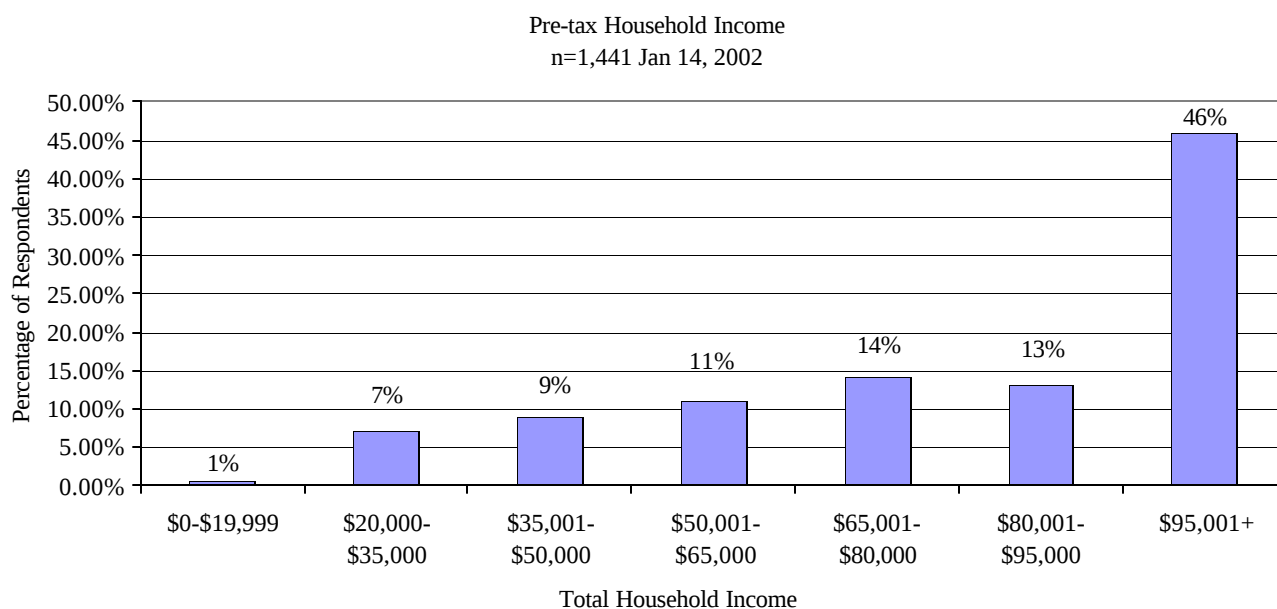
Figure 4.3: Job Categories, Survey Data vs. Census Data



Source: NIH Office of Human Resource Management, Workforce Profiles and NIH Census, Office of Facilities Planning, ORS

Other demographic data were collected on the survey that was not directly collected through the NIH census. For example, survey respondents indicated their levels of pre-tax household income. As can be seen from Figure 4.4, almost half of all survey respondents (46 percent) reported to have pre-tax household income in excess of \$95,000 per year. Distributions of incomes less than \$95,000 per year can be observed in Figure 4.4. Relative affluence of survey respondents are further discussed in Section 5.1F.

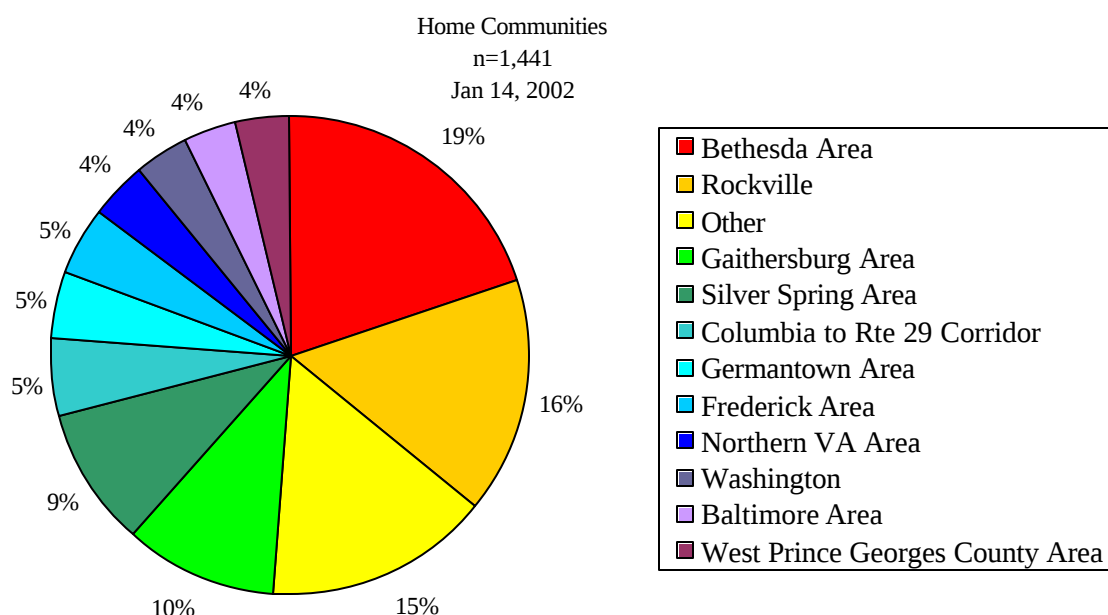
Figure 4.4: Pre-tax Household Income



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In addition, the survey respondents were asked to state their home communities, the towns in which they live. In all, respondents named 104 hometowns. The Bethesda area is where the largest, concentrated group of respondents lived (19 percent). Rockville then claimed the next largest number of concentrated residents (16 percent). Fifty-nine cities comprise the “other” category (15 percent). Community locations, including the municipalities of each category, can be observed in Figure 4.5.

Figure 4.5: Home Communities

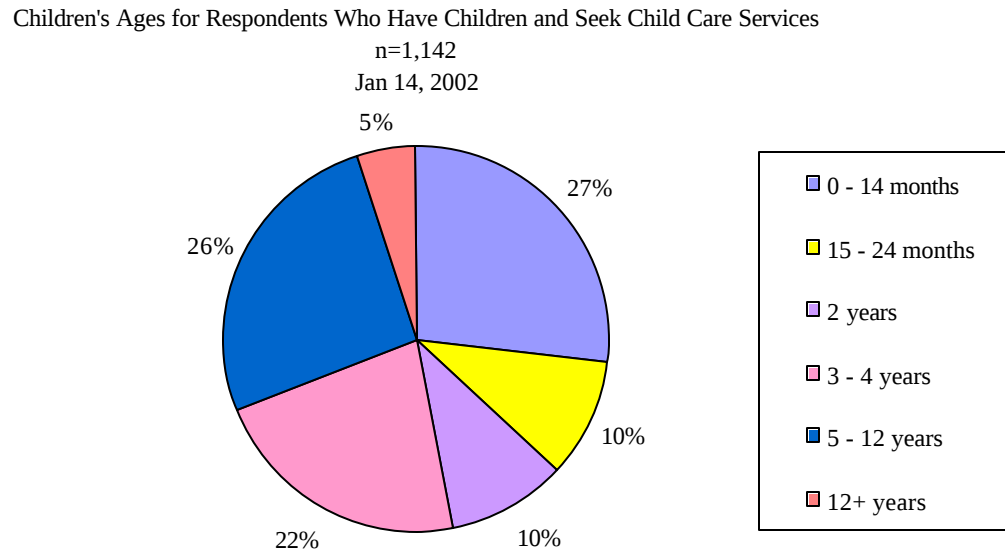


- Bethesda Area: Cabin John, Garrett Park, North Bethesda, Bethesda, Potomac, Chevy Chase, Kensington
- Gaithersburg Area: Gaithersburg, Montgomery Village, and North Potomac
- Germantown Area: Boyds and Germantown
- Frederick Area: Frederick, Brownsville, Ijamsville, Jefferson, New Market, and Walkersville
- Baltimore Area: Baltimore, Baltimore City, Owing ill, Pikesville, and Timonium
- Northern VA Area: Northern VA, Alexandria, Arlington, Fairfax, Falls Church, Reston, Springfield, and Vienna
- West Prince George County: Adelphi, Beltsville, Greenbelt, Hyattsville, and Laurel
- Columbia to Rt 29 Corridor: Columbia, Ellicott City, Burtonsville, Fairland, Highland, Colesville, and Clarkesville
- Silver Spring Area: Silver Spring and Takoma Park

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All respondents were asked to declare the age ranges of their children, and in Figure 4.6, the distribution of those ages is displayed for the population of respondents *who both have children and who seek child care services*.

Figure 4.6: Children's Ages for Respondents Who Have Children and Seek Child Care Services

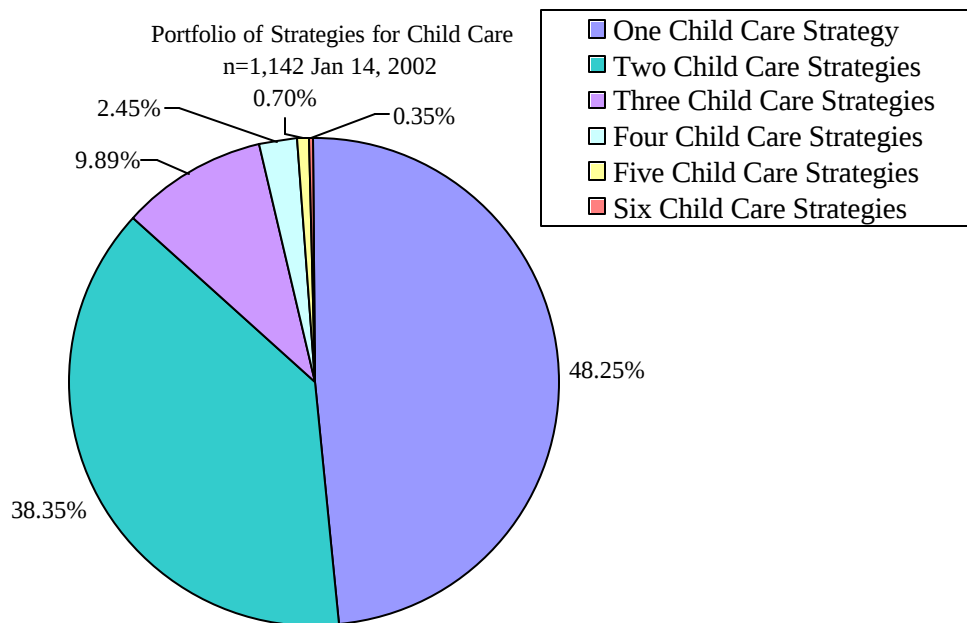


Respondents were also asked to describe the context of the child care services they employ. Respondents tended to use services in the following settings: center-based child care, school-based child care, paid child care services in another person's home, care by relatives or friends, paid child care services in their own homes, and any other settings.

Figure 4.7 gives a flavor of the portfolio of strategies that respondents manage when purchasing child care services. The figure shows the numbers of respondents who described employing at least two service options (437 out of 1142 or 38 percent) is significant. When combined with those respondents who employ three or more methods, it is clear that almost half of all respondents who seek child care services employ a variety of services.

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Figure 4.7: Portfolio of Strategies for Child Care



The sample of respondents for all comparisons is considered to be representative of the overall NIH population based on data from the year 2000 NIH census. Additionally, the number of respondents made possible a level of statistical analysis that has yielded highly significant results. *For all findings reported, using tests of analysis of variance (ANOVA), simple t-tests or multiple analyses of variance (MANOVA), as appropriate to each inquiry, a result was considered to be significant if it met an observed significance level of less than or equal to .05 ($p \leq .05$).*

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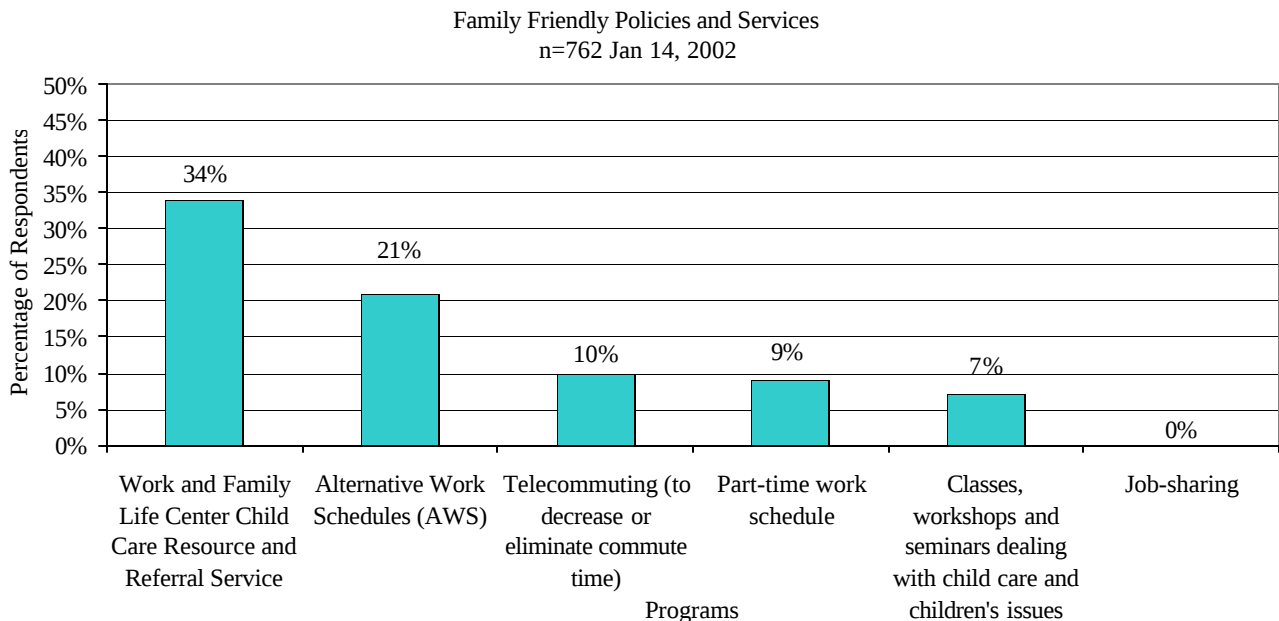
SECTION 5.0: Findings

5.1 Existing Services

A. Family Friendly Policies and Services

Respondents were asked to rate the degree to which they found the following policies and services helpful: the Work and Family Life Center, Child Care Resource and Referral Service; alternative work schedules, telecommuting (to decrease or eliminate commute time); part-time work schedules; classes, workshops and seminars dealing with child care and children's issues; and finally, job sharing. Of the 1441 respondents, 762 expressed some opinion or awareness regarding these services and policies. From this group of those who expressed an opinion, 34 percent, the greatest number, have found the Work and Family Life Center, Child Care Resources and Referral Service to be helpful. For the distribution of other responses, see Figure 5.1A-i.

Figure 5.1A-i: Family Friendly Policies and Services Usage



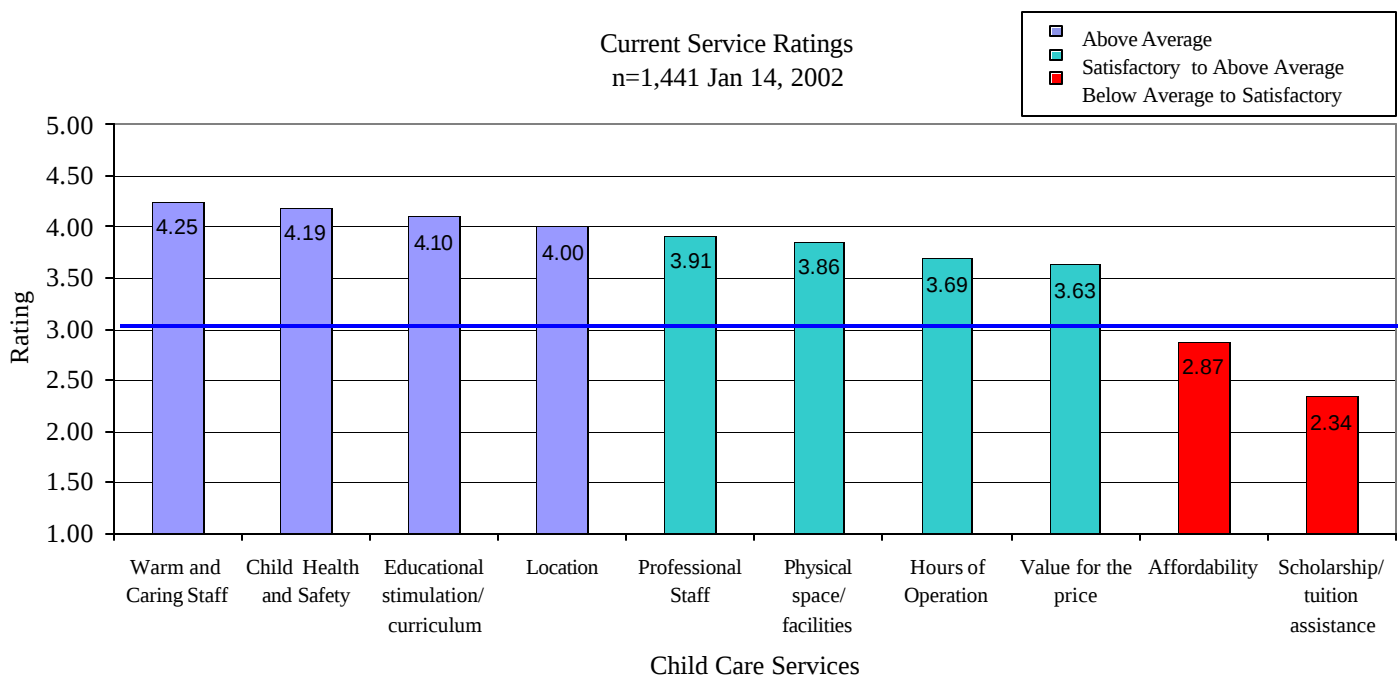
The largest number of people found the Work and Family Life Center, Child Care Resource and Referral Service to be helpful is consistent with findings elsewhere in the survey, which indicates a large demand for child care services and for assistance in the procurement of child care services. The next most popular item endorsed by respondents for this question was the alternative work schedule program, which many parents apparently find helpful as they juggle the difficult and ever-changing time demands involved in raising and caring for children. Although telecommuting is not permitted to be used to facilitate family scheduling, some percentage of respondents do find that telecommuting, to decrease or eliminate commute times, has the ancillary benefit of making their lives easier as they manage their needs for child care. Similarly, part-time work schedules are helpful to some families for the same purposes.

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B. NIH-sponsored Child Care Services

Of the 1441 respondents to the survey, 453 stated that they currently use at least one of the three NIH-sponsored child care facilities, or expected to do so within the next twelve months. These consumers of NIH-sponsored child care services, overall, rated very highly the quality of the services they received (See Figure 5.1B-i below). Respondents were asked to rate various aspects of services on a scale of one through five, where one represented needs improvement, two represented below average, three represented satisfactory, four represented above average and five represented excellent. As can be seen from the graph below, users of NIH-sponsored child care services ranked eight of the ten possible criteria as being at least above average, and what stood out most among these ratings are the factors of *warm and caring staff* and *child health and safety*. Rated below average were the factors of *affordability of services* and the quality of *scholarship/tuition assistance*. **Overall, users of NIH-sponsored child care services find the services to be expensive, but of very high quality.** However, respondents state that they believe they are getting relative value for the price that they pay.

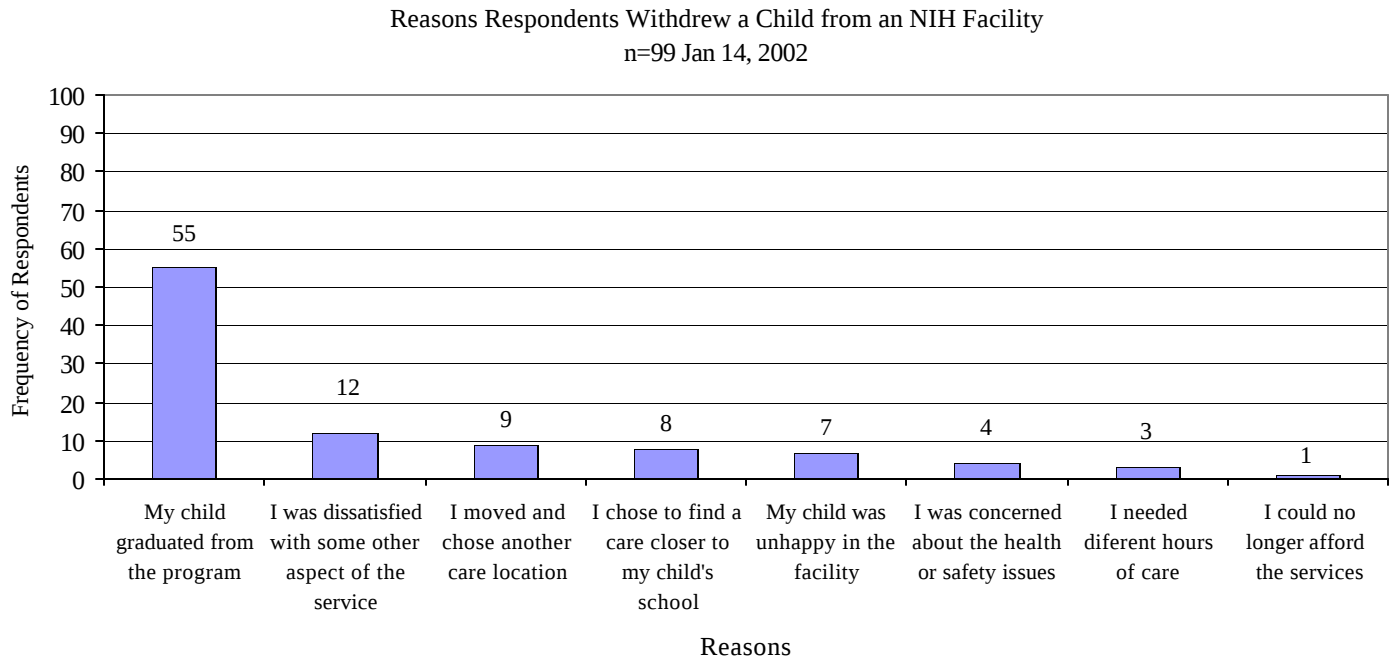
Figure 5.1B-i: Current Service Ratings



Respondents were asked to declare if they had ever withdrawn a child from any NIH-sponsored child care services and were given the option of declaring from which center they had withdrawn a child. Figure 5.1B-ii shows those who withdrew their children from NIH-sponsored child care did so, for the most part, because their children graduated from their selected child care center, or for other reasons that do not imply problems with care or customer satisfaction. Figure 5.1B-iii shows the distribution of the reasons for withdrawal given by respondents among the three NIH-sponsored child care centers. Generally there were no overt concerns about one center versus another with regard to quality or withdrawal issues. As might be expected, ECDC graduated fewer children as it accepts the oldest school aged children for care.

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Figure 5.1B-ii: Reasons Respondents Withdrew a Child from an NIH-sponsored Facility



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Figure 5.1B-iii: Reasons Respondents Withdrew a Child from Individual NIH Facilities

Why Respondents Withdrew from each NIH-sponsored Facility			
n=110 Jan 14, 2002			
	<u>ChildKind</u>	<u>POPI</u>	<u>ECDC</u>
My child graduated from the program	29	22	8
I could no longer afford the services	1	0	0
I moved and chose another care location	4	2	5
I chose to find a care closer to my child's school	0	0	8
I was concerned about the health or safety issues	4	0	2
My child was unhappy in the facility	4	4	0
I needed different hours of care	1	0	2
I was dissatisfied with some other aspect of the service	2	4	8
Total	45	32	33

Many parents or guardians of children who use child care services employ services in more than one setting, and users of NIH-sponsored child care services are no different. Parents or guardians who have children in ChildKind, in POPI, and in ECDC also employ services in other settings. Of the 222 respondents who said they use ChildKind, 214 stated they use some other form of outside care. Of the 135 respondents who said they use POPI, 121 use some other outside care. Similarly, of the 152 respondents who stated they use ECDC, 125 use some other form of outside care. In other words, users of NIH-sponsored child care services are similar to other parents in that they must employ a number of settings in order to meet their family's unique child care needs.

C. Access to Existing Services

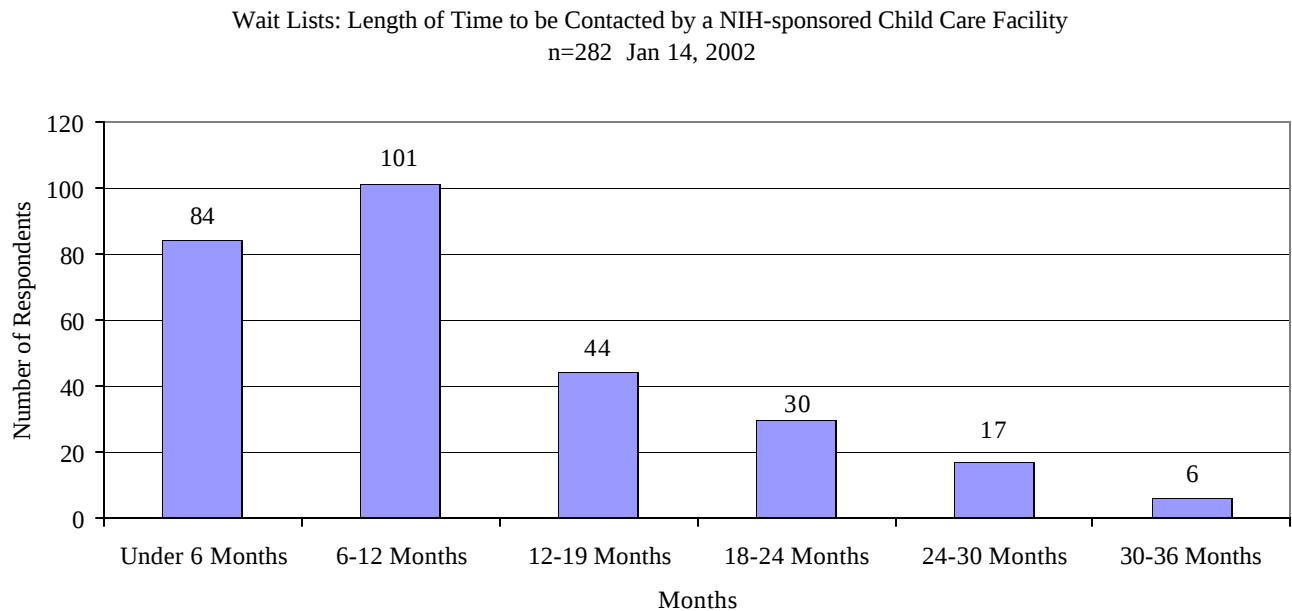
Of the 1197 respondents in the sample who seek child care, 548 or 46 percent reported having placed themselves on a wait list for NIH-sponsored child care services within the last three years. Those who placed themselves on a wait list for NIH-sponsored child care services differed in some significant ways from those who chose not to place their names on a wait list. Specifically, those who did place themselves on a wait list tended to have higher incomes than those who did not. Also, they tended to be more interested on factors such as program *curriculum and education*, the *personal warmth of the provider*, *staff consistency/low turnover* and *staff professionalism and training* when choosing child care services. Also, they preferred services close to their worksites. Those who placed themselves on a wait list for NIH-sponsored child care services also differed from those who did not place themselves on a wait list with regard to the future initiatives that they most highly ranked in the survey. This will be discussed

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in Section 5.1E, the discussion on possible future initiatives.

Survey respondents made clear that by placing themselves on a wait list for NIH sponsored child care services did not mean that they expected to be contacted with regard to the specific facility to which they had applied; rather, they anticipated contact in reference to any one of the facilities upon availability. However, only 51 percent of the people who had placed themselves on a wait list for NIH-sponsored child care services had ever been contacted by a facility within three years of having placed themselves on the wait list, which means the remaining 49 percent (269 out of 548) had never been contacted. Figure 5.1C-i shows how long it took for those 51 percent to be contacted regarding the status of their application by the facility to which they had applied.

Figure 5.1C-i: Wait Lists: Length of Time to be Contacted by an NIH-sponsored Facility



Having been contacted, these parents and guardians then had to determine whether or not they would enroll their child in NIH-sponsored child care services. Of those who had been contacted after placing themselves on a wait list, 59 percent (172 out of 287) of them subsequently enrolled their child. This 59 percent reported to have higher incomes which means that within the pool of the high income people who placed themselves on a wait list, those who ultimately enrolled their children had higher incomes still. And in similar fashion, those who did enroll their children in NIH-sponsored child care services were the ones who most highly valued factors such as the *personal warmth of the provider, staff consistency/low turnover, and staff professionalism and training* when choosing child care services. Furthermore, these people were mostly concerned with finding care close to where they work. Similarly, this group was even less interested in factors such as *affordability and hours of available care*.

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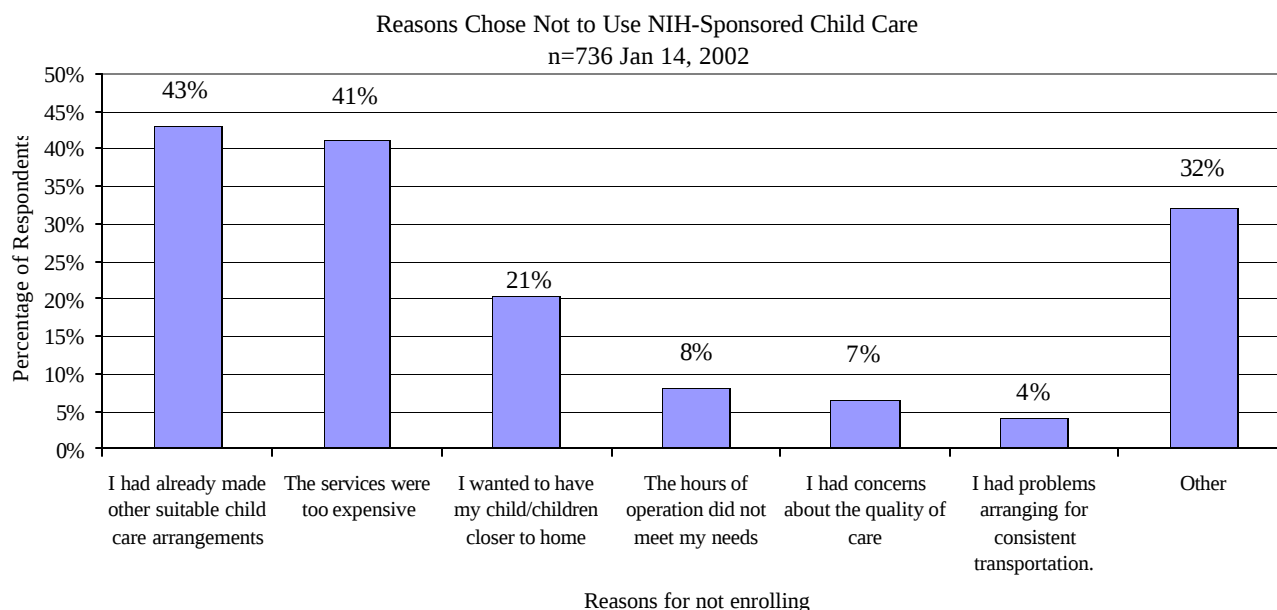
To summarize the path towards enrollment, certain trends are clear.

- First, those who place themselves on a wait list for NIH-sponsored child care services are more likely to have high incomes. Accordingly, these people have somewhat different priorities when choosing child care than those with lower incomes do, consistent with the general income trends observed in the survey.
- Second, only about half of the people who place themselves on a wait list for NIH-sponsored child care services are ever contacted within a three-year period by the center to which they had applied.
- Third, among those who are contacted to enroll their child, those who do choose to enroll their child tend to be the wealthiest of the already more wealthy subset of people who have chosen to place their names on a wait list for NIH-sponsored services.

As a result, it would appear that existing NIH-sponsored child care services most clearly serve a high-end market segment – relative to the entire NIH population seeking child care. Existing NIH-sponsored child care services do a very good job in catering to the needs of high-end income consumers within the NIH population.

Of the 1441 respondents within the sample, 736 cited at least one reason for their decision not to enroll a child in NIH-sponsored child care services, whether they had entered a wait list or not. Figure 5.1C-ii shows the reasons why people stated they did not choose to enroll a child in NIH-sponsored child care services (Note: Respondents were allowed to choose more than one reason, so total percentages will add to more than 100).

Figure 5.1C-ii: Reasons Chosen Not to Use NIH-sponsored Child Care



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The most common reason respondents cited for not enrolling a child in NIH-sponsored child care services was that they had already made other suitable child care arrangements. It is important to note that this option includes people who had already made other arrangements by the time they were contacted, if they had ever placed themselves on a wait list. So, in part, this category includes people who became frustrated by the length of time they had to wait on a wait list. The second more commonly cited objection for entering a child in NIH-sponsored child care services was that the services were too expensive. While the next most common objection, at a significantly lower rate, was that parents or guardians wanted to have their children closer to home. It is noteworthy to observe that 32 percent (265 respondents) of people cited “other” reasons for not enrolling their children in NIH-sponsored child care services.

When respondents checked “other,” they were afforded an opportunity to enter comments of which there were 151 entries. Of all the comments entered, nearly half, or 47 percent of the comments, cited the length of time on the wait list or having never been contacted after placing themselves on the wait list for NIH-sponsored child care services. Comments entered in this section tended to be lengthy and sometimes forceful in their answer, and no other pattern of responding within the “other” category was nearly as strong as the pattern of responding related to the wait list issue.

The next most common category of responses related to issues of location, including the desire to have child care services closer to home. Seven percent of the respondents who entered comments in the “other” section stated they had been unaware of the existence of available services, and a similar seven percent stated that the hours of available services, in one way or another, did not meet their needs. Five percent of the comments in this “other” section related to complaints of various kinds related to the staff and management of the centers. “Other” reasons given can be seen in the Figure 5.1C-iii (note that in this figure, comments are listed in language as close to the original wording as possible, given space limitations).

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Figure 5.1C-iii: Comments Regarding Wait List

Comments for Question 6, Section 1 n=151 Jan 14, 2002	Number of Responses	Percent
Waiting list/Never Contacted by Facility (71 responses)		47%
Waiting list too long/ been on list for awhile	43	
Never contacted by staff / No follow up	11	
No spaces available	10	
Unsuccessful attempts to get in program	4	
Gave slot away	2	
Told should have gotten on waiting list before we conceived	1	
Location (15 responses)		10%
No child care available in Baltimore	5	
Facility not near my child's school	4	
Facility not near my place of work / inconvenient	3	
No child care available in Poolesville	2	
No child care available for Bayview Campus	1	
Unaware of the existence of services (11 responses)		7%
Did not know services existed	9	
Not enough information about programs is available	2	
Hours of available service didn't meet needs (11 responses)		7%
Need part time care	6	
Facility opens after I have to be at work	2	
Hours not suitable for shift workers	1	
No after school program at the main campus	1	
Need summer care	1	
Staff and Management of Centers(7 responses)		5%
Director of NIH facility was cold and not confidence in their ability	3	
Staff unfriendly (ex. to non-English speakers)	2	
Management is irresponsible	1	
Nepotism evident in facility	1	
Other (36 responses)		18%
Safety/security concerns-Do not want my child in a government facility (	6	4%
Care costs too much	4	3%
Spouse stays home with children	4	3%
No transportation between school and child care facility	3	2%
Found available spaces somewhere else	3	2%
Age restrictions prevent me from using the care	3	2%
Facility too cramped / not nice	2	1%
Don't believe in child care	2	1%
Need sick child care	1	*
Child has special needs that can't be met	1	*
Didn't want child to have to adjust to a new facility	1	*
Can't pick up and drop off child	1	*
Work part time so my spot wasn't guaranteed	1	*
Contractor so care isn't provided but would like it to be	1	*
ECDC uses buses with seatbelts	1	*
Don't know about young teenage programs	1	*
Prefer smaller day care environment	1	*

Note: "*" represents a percentage that is less than 1%

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To summarize, the survey indicated that NIH-sponsored child care services are inaccessible to most of the NIH population for two reasons:

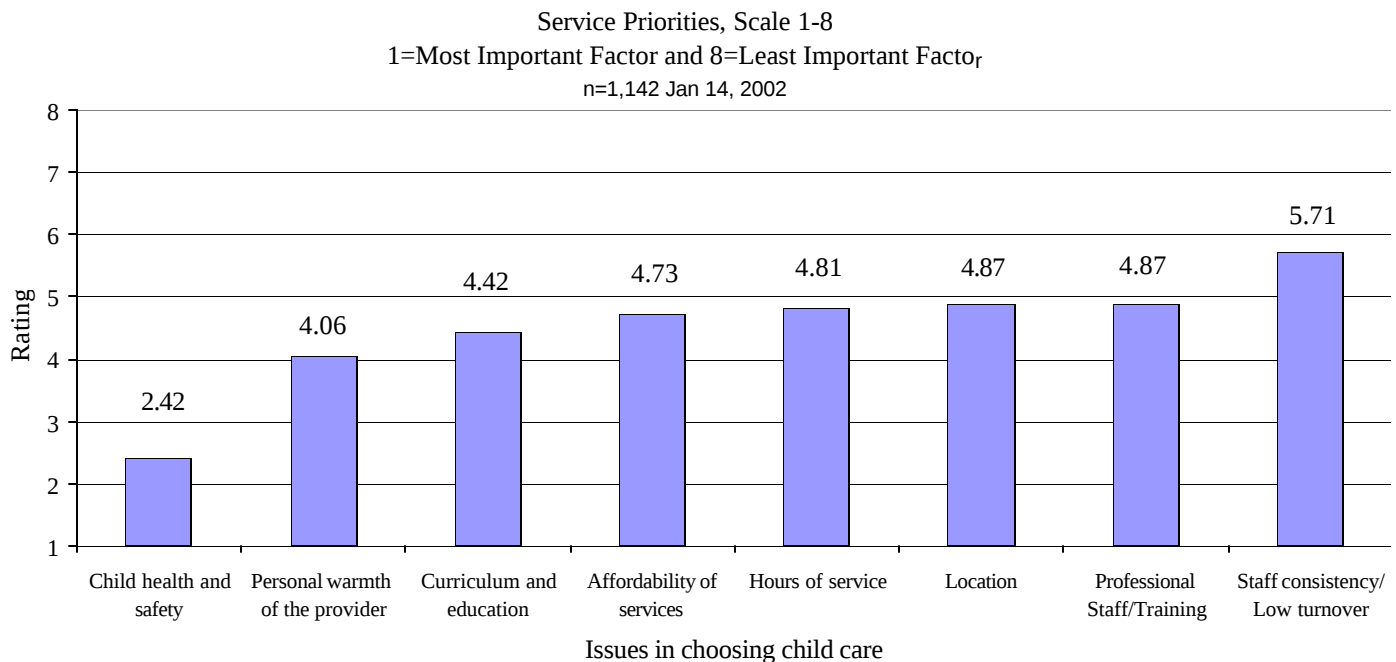
- First, there are not enough slots available to accommodate the needs of all applicants, and many people are never contacted who have placed their names on a wait list.
- Second, the services are regarded as expensive, and they cater most effectively to the highest income members of the NIH community.

Given these results, NIH-sponsored child care services are a scarce commodity within the NIH population, and so consistent with the laws of supply and demand, the services are more expensive, and therefore most accessible to the highest income members of the population. These same two critical concerns of survey respondents - the scarcity of available child care services and the high cost of those services - are apparent when respondents discuss what future initiatives they would most like to see pursued in the NIH community, as will be discussed in Section 5.1E.

D. Service Priorities

Respondents were asked to rank a series of factors that they weigh when choosing child care in order of their importance. Figure 5.1D-i shows the average ranking of each priority and presents those priorities in their order of importance from left to right.

Figure 5.1D-i: Service Priorities



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The priority that was most important to respondents was ranked as priority number one. The second most priority was number two, and so on through eight available options. Accordingly, the most important priority for all respondents was children's health and safety, with a mean ranking of 2.42. The least important priority for all respondents was staff consistency/low turnover, with a mean or average ranking of 5.71 out of a possible eight slots. Rankings four through seven, including the factors affordability of service, hours of service, location, and staff professionalism/training, were all given, cumulatively, somewhat equivalent weights – the differences between them are more minute. While these factors changed their relative order of rankings to some degree based on income (See Section 5.1F on income), for the most part, rankings four through six are indistinguishable from each other in the degree of importance respondents placed on them.

It is important to note that this presentation of relative rankings includes the priorities only of those respondents to the survey who stated that they had children. This is because the 248 respondents to the survey who did not state that they had children responded in significantly different ways. The purpose of this section of the survey was to develop an understanding of the priorities of people who make choices about care. Therefore, the responses of those without children were excluded from the current analysis.

The concluding factor derived from these data is that *child health and safety* is paramount for all parents when making choices about child care, while the actual sorting of subsequent priorities was seen to vary by income.

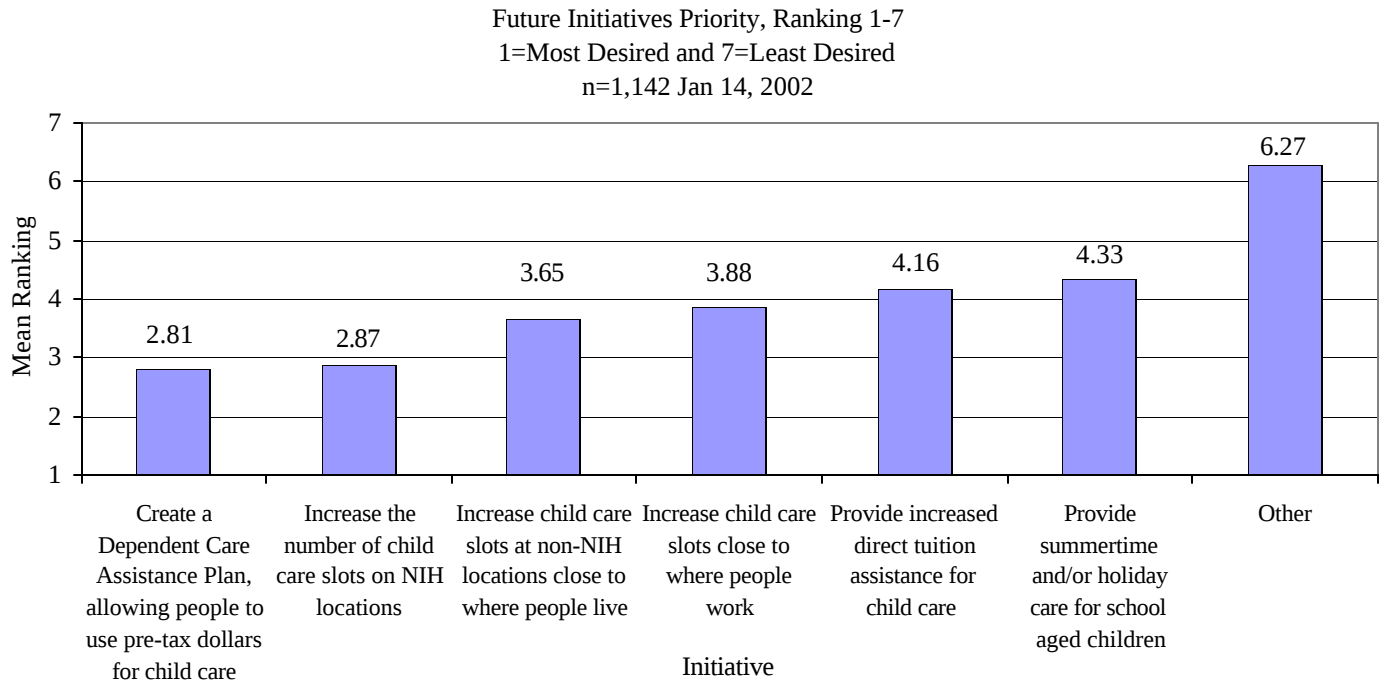
E. Possible Future Initiatives

Respondents were also asked to rank a series of possible future initiatives that could be undertaken by the NIH in order to meet the needs of parents or guardians who seek child care. Note again, that for the purposes of this analysis, the data discussed below reflect the initiatives preferred by parents or guardians who have children, because those who stated they do not have children responded in significantly different ways when making these rankings.

As can be seen from Figure 5.1E-i, the most important priority for the future would be for the NIH to develop a Dependant Care Assistance Plan. A plan that would allow individuals to elect a certain portion of their pay to be set aside before taxes, dedicated to an individual fund that can be used to pay for child care throughout the course of a year. Such Dependent Care Assistance Plans are common in the private sector. The second most highly ranked priority, and one for which respondents placed almost as high emphasis, involved increasing the number of child care available spaces on existing NIH locations. **Together, these two priorities represented the most highly desired possible future initiatives: that respondents within the NIH community strongly desire assistance in ways that they can pay for these services and an increased number of slots within the existing framework.**

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Figure 5.1E-i: Future Initiatives Priority Ranking



The least preferred option came from the space wherein respondents could enter some “other” idea, that perhaps they had regarding a possible future initiative. However, an examination of the comments entered to explain the choice of “other,” did not reveal any consistent pattern of new ideas. For the most part, those who chose the “other” option or entered any comments used these comments to amplify their preferences already expressed through the existing options ranked.

F. Income Influences

Figure 4.4 on page 4 shows that almost half of survey respondents reported total annual before tax household income of over \$95,000. Differences based on income can be seen in three principle areas: in the preferences people expressed for service priorities that they most highly value when choosing child care, in the future initiatives respondents endorsed for the future of the NIH and in the decision to pursue and then enroll in NIH-sponsored child care services. The following analyses are based on the responses of those who reported they have children.

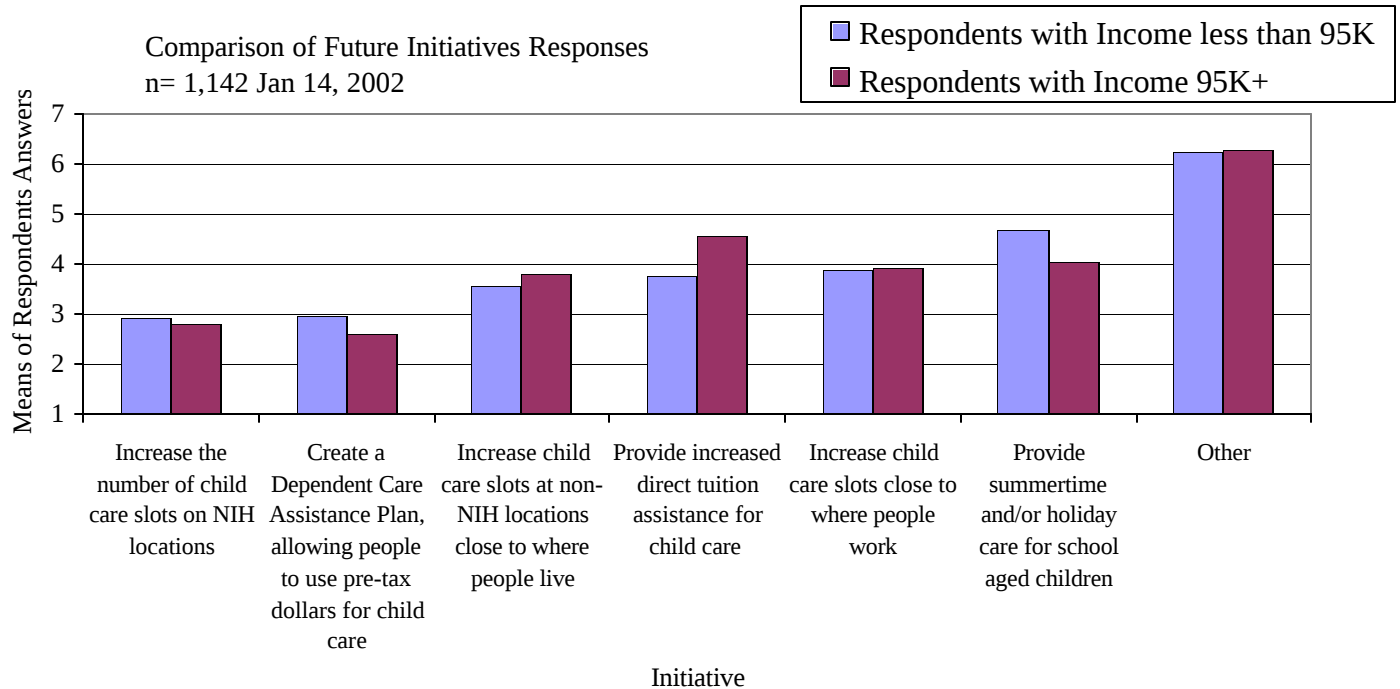
Income significantly affected the service priorities that respondents highlight when searching for and choosing child care. In general, lower income respondents tended to value more highly practical matters, such as *affordability* or, to some degree, the *hours of available care*. Higher income consumers of child care services placed more emphasis on issues such as *staff consistency/low turnover* and *staff professionalism/training*. Nevertheless, commonalities still remain. For example, all respondents highly valued *child health and safety* as their first priority.

Respondents’ income also influences rankings of possible future initiatives. One way of examining these is to divide the respondent pool roughly in half, between those whose annual pre-tax household income is \$95,000 or more (46 percent of respondents), and those whose

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income is less than \$95,000 (54 percent of respondents). Figure 5.1F-i shows a comparison of the priorities of these two groups as they ranked future initiatives.

Figure 5.1F-i: Comparison of Future Initiative Responses



For this figure, a low number represents a higher ranking, as respondents ranked their highest priority as number one, and so on through seven available options, including the optional “other” category. From left to right in the figure, the future initiatives are listed in the order that they were ranked by the lower income group, that is, the income group of less than \$95,000 per year. Had the items been ranked according to the preferences of those whose income exceeded \$95,000 per year, the second option, the creation of a Dependent Care Assistance Plan would have been first. The third option, an increase in child care slots at NIH locations close to where people live, would have remained in place, while the fourth option for respondents with income over \$95,000 would have been an increase in child care slots close to where people work – which is the fifth option for respondents with income less than \$95,000. In fact, the fourth option for those of the lower income group – provision of increased direct tuition assistance based on income – would be dropped to the sixth highest priority for the higher income group.

From this it can be derived that lower income respondents significantly valued an increase in direct tuition assistance more highly than did their higher income counterparts, as might have been expected. Still, it is important to note that among the income assistance options chosen, the creation of a Dependent Care Assistance Plan was still the number one option for higher income respondents.

It can be further deduced from the figure that respondents with higher incomes placed a higher relative value on the provision of summertime and/or holiday care for school-aged children,

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relative to the preferences expressed by lower income respondents. This in part reflects that higher income respondents are more likely to have older children.

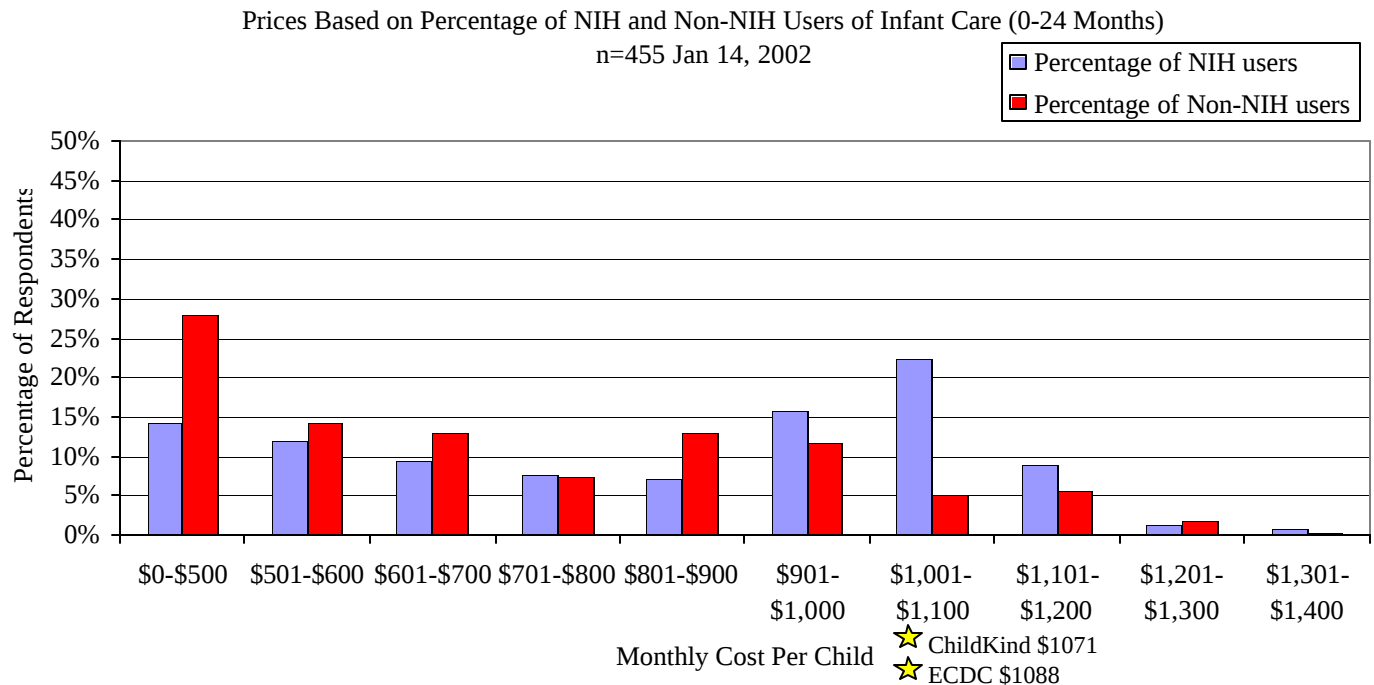
The figure furthermore shows that the common pattern seen throughout the survey still holds – that the overwhelming priority for the NIH is to provide more available child care services along with a provision of some cost relief, preferably through a Dependent Care Assistance Plan.

5.2 Prices Paid for Care

A. Infant Care

The distribution of prices paid for infant care both by users of NIH-sponsored care and by all other users of care, can be seen in Figure 5.2A-i.

Figure 5.2A-i: Prices Based on Percentage of NIH and Non-NIH Users of Infant Care



It is important to note when viewing this figure that the first interval, the zero to \$500 per month range, represents a larger interval than those seen throughout the rest of the graph, as each subsequent interval covers a \$100 range.

Based on this data, it can be seen immediately that those who purchase NIH-sponsored care are typically users of ECDC or ChildKind, whose prices fall into the \$1,001-\$1,100 range. It is also clear, as has been observed and discussed under the Sections 5.1B and 5.1F, that users of NIH-sponsored care are more likely to purchase more costly care services of whatever variety, consistent with their relative affluence among members of the sample population. Alternatively, the plurality of respondents who do not purchase some form of NIH-sponsored care pay between zero and \$500 per month for infant care, representing a low cost market of care often provided

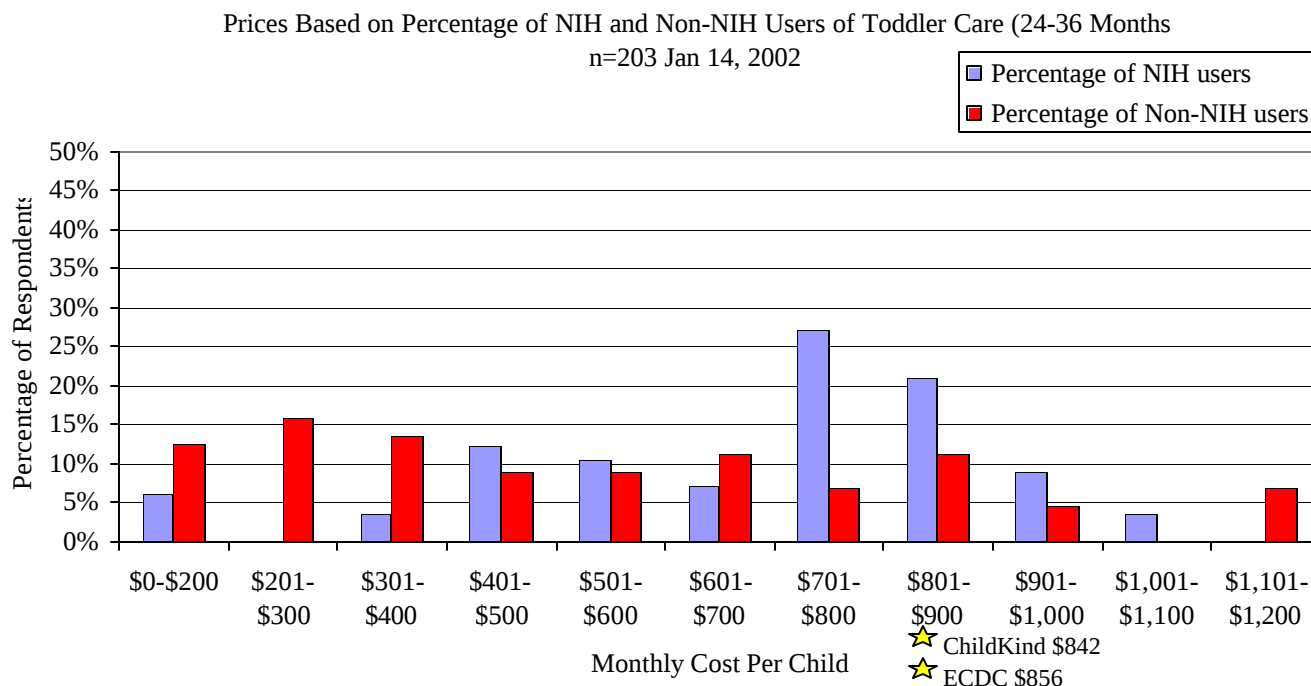
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by friends or relatives, in some cases for free. Aside from the differences between the purchasing patterns of NIH versus non-NIH consumers, both sample groups give evidence that there are essentially two broad markets for care, roughly divided at the point of the \$701-\$800 per month range: one of lower cost, including various home-based care options, and one of higher cost, comprised essentially of center-based care.

B. Toddler Care

Figure 5.2B-i shows the prices paid for toddler care, or children in the age ranges of 24 to 36 months. Again, in this figure, the zero to \$200 range, to the far left, represents a range double the size of the \$100 ranges that fill out the rest of the graph.

Figure 5.2B-i: Prices Based on Percentage of NIH and Non-NIH Users of Toddler Care



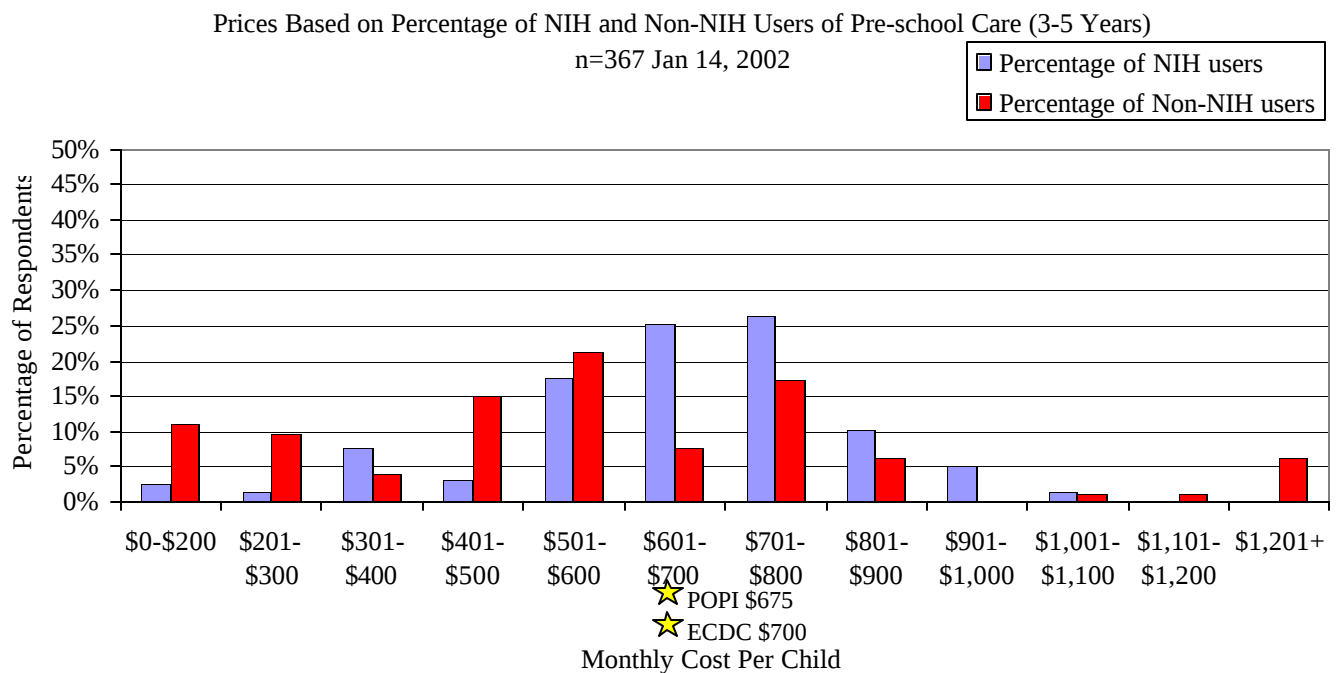
This figure shows once again that purchasers of NIH-sponsored child care services typically pay more for whatever child care services they procure, and they are most likely to pay between \$701-\$900 per month for children in this age range. Both ChildKind and ECDC fall in the upper limits of this higher range, with prices noted in the figure. Alternatively, those who do not purchase NIH-sponsored child care services are more likely to find care services that cost significantly less, in settings other than center-based care. Finally, the split market pattern more clearly represented in Figure 5.2A-i is suggested, but less clearly evident here: for both NIH and non-NIH care consumers, there seems to be a higher cost market comprised of center-based care and a lower cost market comprised of various other options, roughly divided by the \$600 per month cost figure.

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C. Pre-School Care

Figure 5.2C-i depicts the comparison of prices paid for care by both users of NIH-sponsored child care services and those who do not purchase such services. The figure shows that purchasers of NIH-sponsored care most commonly pay between \$601-\$800 for children in this age range of 3-5 years, consistent with the prices charged by both POPI and ECDC as noted in the figure. The overall distribution of prices paid for care by NIH versus non-NIH consumers is less distinct for this age range than it was for the previous age ranges examined, though non-NIH care consumers are still more likely to take advantage of various low cost care opportunities in the marketplace. They are also less likely to pay prices equivalent to those charged by the available NIH service providers for this age range, in this case, prices in the range \$601-\$700 per month. Finally, it is less clear from this data that there is a significant alternative market for very low cost care purchased by respondents in the survey, as had been observed in the preceding two analyses.

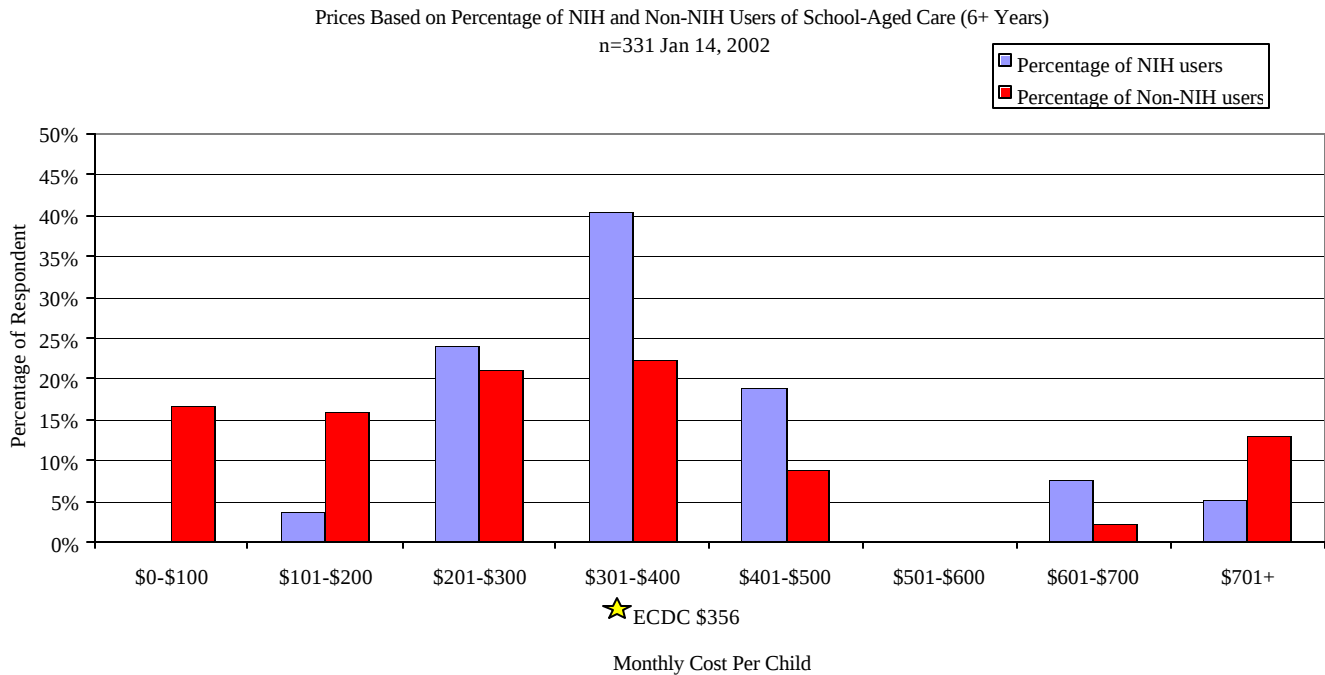
Figure 5.2C-i: Prices Based on Percentage of NIH and Non-NIH Users of Pre-School Care

**D. School-aged Care**

Pluralities of respondents who purchase both NIH-sponsored care and those who do not, reported that they most commonly pay between \$301 and \$400 for care for before or after school care for school-aged children. However, those who do not purchase NIH-sponsored care were also more likely to obtain services through other, lower cost options, as has been shown to be the case for all other age groups as discussed above. The only NIH-sponsored child care facility providing care for this age group is ECDC, and the price paid for in this setting falls within that most commonly paid range. See Figure 5.2D-i.

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Figure 5.2D-i: Prices Based on Percentage of NIH and Non-NIH Users of School-aged Care



E. Summary of Prices Paid for Care

Generally speaking, there is evidence of a bifurcated market for care based on cost, and based on the setting through which care is provided. This is particularly true for care for children under two years of age, and for care provided to children between two and three year of age. Center-based care tends to be more expensive, while other alternatives, including care provided in other people's homes or in the homes directly of respondents tends to be of lower cost. NIH-sponsored child care services tend to fall within the upper ranges of center-based care.

5.3 Qualitative Findings

Qualitative data derived from the research process come from focus groups and from the many comments respondents entered throughout the course of completing the survey. All of these data amplify the degree to which the population strongly desires the provision of more services, with some cost relief. In addition, members of focus groups shared many stories about their frustrations in dealing with wait lists for each center. Members of the community reported their perceptions of access to the centers as:

- arbitrary, and
- those who enter the wait list may not be contacted if they don't know the "right people" within the centers, or
- if they do not have enough income, or
- if they're not somehow directly related to people within the centers (note: the terminology used by respondents include "elitism" and "nepotism").

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Comments both in the focus groups and in the survey represent that there is a significant pool of resentment and frustration regarding the way services are delivered or made accessible to the NIH population, which all tend to focus on the management of the wait list process. The resulting perception is that the NIH does not care about its people: precisely the opposite effect that the NIH wishes to create when using child care services as a tool to attract and retain the best and brightest researchers and professionals in pursuit of its mission and work force goals.

SECTION 6.0: CONCLUSIONS AND RECOMMENDATIONS

Respondents to the survey present two overwhelming concerns: first, respondents strongly desire the provision of more services for child care, and second, respondents desire some form of income assistance or relief to help them pay for child care services. Child care services provided by NIH-sponsored child care facilities most adequately cater to the needs of upper income respondents, and lower income respondents tend not to pursue those services at all. Current NIH-sponsored child care services appear to be overwhelmed by the amount of a demand for services. The wait lists for these services seem not to be well managed. At the very least, respondents express a great degree of frustration and even resentment regarding the wait list process. In particular, they note how infrequently they are contacted once they enter their names on a wait list. Accordingly, in order to meet the needs of the NIH population with regard to child care services, the following measures are recommended:

1. The NIH community would benefit from an increase in the capacity of child care services on or near NIH worksites, especially in Bethesda and, to a lesser degree, Rockville. Bethesda and Rockville are highlighted here because this is where most of the respondents work, and overall, respondents tended to prefer care close to where they work, rather than close to where they live. While it may not be possible in the near term to increase available NIH child care slots directly on NIH worksites, if it is possible to arrange for reserved slots at other center-based service providers near the Bethesda Campus and the Rockville worksite area, this would represent a meaningful and helpful alternative route toward the provision of child care services based on the expressed needs of respondents.
2. The NIH may find it advantageous to pursue legislative authority to create a Dependent Care Assistance Plan, allowing respondents to dedicate pre-tax dollars toward an annual individual fund that can be used to pay for child care services.
3. Given that it may be difficult in the immediate term to gain the legislative authorization to create a Dependent Care Assistance Plan, a reasonable intermediate strategy would be to explore targeted ways to expand programs for direct tuition assistance, especially tuition assistance based on income. Even in the longer term, it may be desirable to create more direct care assistance programs for lower income members of the community, or members of the community who are not compensated through a salary structure and who therefore might not be eligible for a Dependent Care Assistance Plan even if one were to be created. This would be especially true for various kinds of researchers within the NIH whom the organization wishes to attract and retain, consistent with its mission and workforce goals.

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4. The NIH would gain from a thorough examination on the manner in which child care services promote its mission and the accomplishment of its workforce goals. In particular, it might be helpful to examine the degrees to which the provision of child care services influences people's decisions either to join the NIH or to remain with the NIH. It might be interesting to learn the differential retention rates of NIH researchers or employees who use NIH-sponsored child care services versus those who do not, or even to undertake a more broad study of the factors that influence attraction and retention for the NIH.
5. The NIH would most be served by examining and reengineering the wait list process. The existing wait list processes are individual for each existing center, although the NIH population tends to find it difficult to navigate these three unique systems. Even before it may be possible to provide more services, which would of course reduce the length of wait lists, in the immediate term it might be helpful to cap wait lists so that all those who enter a list can and will be contacted regarding their status within a designated, short-term period of time. In addition, since the Work and Family Life Center, Child Care Resource and Referral Service appears to be highly successful and valued by those who use it, efforts should be made to ensure that any individual placing his or name on a wait list should be contacted or directly networked into that resource and referral service. In this way, the NIH could show an integrated concern and response for the needs of its community members who pursue child care services.