

Infants and Toddlers in State and Federal Budgets:
Summary Report from Urban Institute Roundtable

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EXECUTIVE SUMMARY

This report summarizes the roundtable “Infants and Toddlers in State and Federal Budgets: Yesterday’s Choices, Today’s Decisions, Tomorrow’s Options” conducted by the Urban Institute, with support from the A.L. Mailman Family Foundation, on March 30, 2009. The roundtable’s focus grew out of the widely perceived mismatch between sharply limited public investments on infants and toddlers and an accumulated body of research demonstrating the significance of the earliest years of life. We describe the group’s diverse perspectives and wide-ranging discussion of strategies to address this mismatch.

This executive summary highlights selected points from the full report, with a focus on actionable next steps. It summarizes key facts about federal and state expenditures on young children, draws out five themes from the discussion, and identifies selected short-term action steps for each. These action steps were proposed during the discussion but do not necessarily reflect all participants’ views, since the discussion was not designed to reach consensus.

Federal and State Expenditures on Young Children

- Of more than 12 million infants and toddlers in the United States, nearly half live in low-income families, a disproportionate share compared with children in other age groups (Douglas-Hall and Chau 2008).
- Federal spending on infants and toddlers is concentrated in health and nutrition programs, which together account for 38 percent of federal spending on this age group—but only about a quarter of federal spending on all children (Macomber et al. 2009).
- Early care and education programs represent less than 7 percent of federal spending on very young children, compared with 17 percent of federal spending on all children (Macomber et al. 2009). Participants also noted that federal spending in key programs is very small compared to need: for example, even after recently enacted gains, Early Head Start will reach only 6 percent of poor pregnant women, infants, and toddlers.
- Federal spending is likely the large majority of public spending for this age group. Participants noted that state and local expenditures on very young children are relatively small, since the vast majority of state and local spending on children goes toward elementary and secondary education. (At the same time, participants highlighted several states that have recently taken important and innovative approaches to investing in infants and toddlers.)
- The American Recovery and Reinvestment Act of 2009 (ARRA) is more focused on children, including young children, than the federal budget as a whole. Its investments though are set to expire at the end of the period 2009–2011.
- The state fiscal outlook is currently grim, and participants argued that ARRA will not be sufficient to fill the gap.

Five Themes

1. Health and nutrition programs offer opportunities for improving young children's circumstances that have not been fully tapped.

- State early childhood practitioners and advocates should look into the potential role of nutrition programs (including Women Infants and Children [WIC], Supplemental Nutrition Assistance Program [SNAP], and Adult Care Food Program [CACFP]) in their own states as a lever to improve children's early experiences.
- State early childhood and health practitioners and advocates should seek joint opportunities to improve the care of young children. They should
 - i. increase the focus of public health insurance programs on prevention and early intervention for young children,
 - ii. reduce "churning" (young children moving in and out of public coverage),
 - iii. reach out to private insurers and pediatricians, and
 - iv. track key quality of care indicators for young children.

2. Improving infant-toddler services requires better aligning the "Lego set" of programs and funding streams.

- Alternative routes to this goal include investing in
 - i. "systems change," such as revamping professional training across programs, improving data systems, and developing shared program standards and eligibility criteria;
 - ii. programs that already reflect an integrated approach (such as Early Head Start); and
 - iii. system improvements (such as reimbursement changes or quality standards) within one or two programs whose reform would have a large impact (such as Medicaid/CHIP).
- Participants recommended the active use of state early childhood councils or similar groups to develop locally tailored ways to connect programs and funding streams.
- Participants also suggested driving change through the collection of cross-cutting data about infant/toddler outcomes for a geographical area.

3. Services for young children should respond to the whole child and to children's real needs, including children with multiple vulnerabilities.

- States should reorient medical services for babies and toddlers based on a developmental model. For example, they should
 - i. respond to children's need for mental and behavioral health services; and
 - ii. provide services (e.g., a hearing aid) at the moment they are needed developmentally, not after a delay.

- Infant/toddler care and education programs should similarly reflect developmental science. For example, programs should
 - i. provide or link services that support all the domains of development; and
 - ii. build from what babies and toddlers need, rather than adapting from programs for older children.
- Policymakers should understand and respond to the specific needs of babies and toddlers in their communities. For example, they should consider outreach and targeting to overcome the barriers faced by immigrant families.

4. Serving young children requires attention to parents, yet few programs have a two-generational focus.

- Health care for babies and toddlers should include family-oriented services crucial to young children’s development, such as mental health treatment for parents or family support services.
- States should explore community-focused strategies that reduce parental isolation and provide group support for parenting.
- WIC and Early Head Start offer models of two-generational approaches that include parent education and support along with direct services to the infant or toddler.
- States should consider services and supports that help parents care for young children better as part of their infant-toddler discussion. These include parental health coverage and paid family leave.

5. Achieving more public investment in infants and toddlers requires making the public case for it.

- Most participants believed that it is crucial to explain research evidence clearly as part of the public case. Participants disagreed on the value of additional research but agreed on clear communication of existing evidence.
- Participants suggested thoughtful tracking of ARRA implementation—including how its increases have made a difference—to make the case for sustaining investments.
- Some participants proposed a strategy of “naming the problem”—that is, linking together the parts of an infant-toddler agenda that lie buried in different programs.
- Others recommended (as an alternative or in addition) “getting on board with the train that is moving”—that is, infusing a focus on infants and toddlers into health reform and/or school-readiness agendas.

Introduction

This report summarizes major themes from the roundtable “Infants and Toddlers in State and Federal Budgets: Yesterday’s Choices, Today’s Decisions, Tomorrow’s Options” conducted by The Urban Institute, with support from the A.L. Mailman Family Foundation, on March 30, 2009. The roundtable’s focus grew out of the widely perceived mismatch between sharply limited public investments and an accumulated body of research demonstrating the significance of the earliest years of life.

The timing of the roundtable raised the stakes even higher. The deep economic downturn that began in 2008 poses great risks for families and creates intense budget pressures on states. If states pull back on recent investments in young children as a result of these pressures, the damage to young children could be exacerbated. Yet, the early months of 2009 could represent a moment of opportunity because of enactment of the American Recovery and Reinvestment Act of 2009 (ARRA), which contains significant investments in young children, and because a new Congress and new presidential administration are taking a fresh look at domestic policy.

The unique features of the roundtable included its joint focus on both federal and state budgets and its cross-program focus covering health, nutrition, and early education and family support. Federal and state decisionmakers often have only cursory knowledge of each other’s environments and constraints and few opportunities to reflect on the most important intersections between federal and state budgets regarding young children’s programs. Similarly, experts in health, nutrition, and early education and family support rarely have the opportunity to talk across the different service systems about achievements and failures on behalf of very young children. And experts in one field often do not know of budget, policy, and performance trends in the others.

To achieve this cross-cutting conversation, the roundtable brought state and federal budget experts together with practitioners and policymakers specializing in early childhood and family support programs, health care, and nutrition. The discussion was designed to share information and perspectives in order to engender new insights, not create consensus. In particular, it aimed at three goals:

- assess the evidence about state and federal budget choices that affect young children;
- identify immediate opportunities and risks for young children related to the recession and the economic recovery package; and
- suggest both short- and longer-term next steps to yield better outcomes for children.

The first session, an overview of federal and state investments in infants and toddlers, concentrated on the first goal. Sessions two and three addressed opportunities and risks from the perspective of particular program areas: health and nutrition in session two, and early childhood education and family support in session three. The final session explored possible next steps for policy and research arising from the roundtable.

Infants and Toddlers in State and Federal Budget Processes

The first session grounded the conversation in the latest information about state and federal budgets for infants and toddlers. As context for the question of why public investment might be needed, the first presentation summarized the demographic and socioeconomic characteristics of young children (box 1). According to the National Center for Children in Poverty, there are more than 12 million infants and toddlers in the United States. Nearly half of these children live in low-income families, a disproportionate share compared with children in other age groups (Douglas-Hall and Chau 2008). The ethnic composition of young children has been shifting, and the majority of young children are now nonwhite, with African Americans and Latinos making up the largest proportions. Young children of color are disproportionately likely to be poor and near-poor. Low-income children are also twice as likely to experience housing instability. Together, these findings mean that children in their critical developmental years are economically vulnerable, belong to groups that have typically been on the losing end of disparities in health and well-being, and disproportionately live in families with sharply limited private resources to devote to their needs.

Box 1. Who Are Infants and Toddlers?

- There are more than 12 million infants and toddlers in the United States.
- Many live in low-income (43 percent) or poor families (21 percent).
- The majority (54 percent) of infants and toddlers in low-income families lived with a single parent.
- The majority of infants and toddlers are nonwhite, with African Americans and Latinos making up the largest proportions.
- Young children with immigrant parents are 66 percent more likely to be low income than children of native-born parents (61 percent versus 40 percent).
- Infants and toddlers living in low-income families moved substantially more often than those in higher-income families; 1 million (18 percent) had moved in the past year.

Source: National Center for Children in Poverty.

Federal and State Expenditures on Young Children

Jennifer Macomber of the Urban Institute provided a baseline picture of federal expenditures from the first-ever analysis of the federal budget for infants and toddlers (Macomber et al. 2009).¹ She highlighted three key findings (box 2). The first is that federal spending on infants and toddlers is concentrated in health and nutrition programs. Together, these programs account for an estimated 38 percent of all expenditures to young children, compared with 25 percent of federal spending on all children. The disproportionate share for the youngest children is driven largely by Medicaid, and within

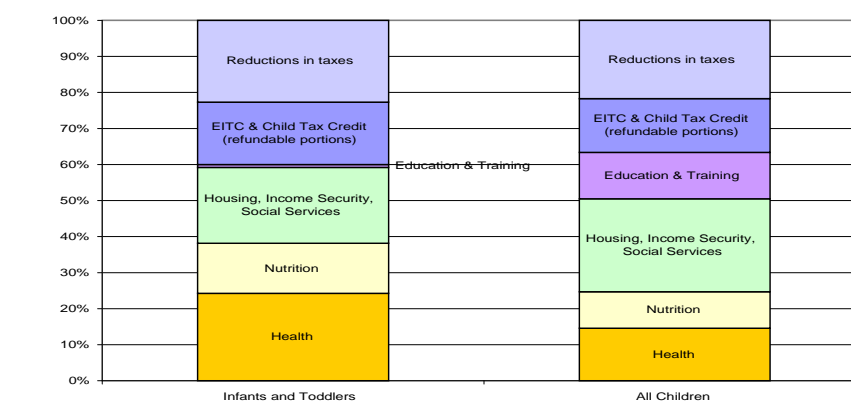
¹ The report, “Federal Expenditures on Infants and Toddlers in 2007,” was produced jointly by the Urban Institute and the Brookings Institution, with funding from the Irving B. Harris Foundation and Buffet Early Childhood Fund. The study defined infants and toddlers as under 3 years old.

Box 2. Federal Expenditures on Infants and Toddlers in 2007

1. Federal spending on infants and toddlers (up to age 2) is more concentrated in health and nutrition than federal spending on all children.

- An estimated 38 percent of all federal spending on infants and toddlers is on health and nutrition programs, compared with 25 percent of federal spending on all children under 18.
- The health portion is driven largely by spending on Medicaid, specifically on costs in the first two years of life.
- Twenty-one percent of federal spending on infants and toddlers comes in the Medicaid program alone, compared with 12 percent of spending on all children.

Figure: Federal Expenditures, by Category of Expenditure



Source: The Urban Institute and Brookings Institution, 2008. Authors' estimates based on the *Budget of the United States Government, Fiscal Year 2009* and U.S. Census Bureau, Monthly Postcensal Resident Population: July 2007.

2. Early care and education programs make up a relatively small share of all federal funding on infants and toddlers.

- Spending on Early Head Start, Part C of the Individuals with Disabilities Education Act, and child care assistance under spending and tax programs represent less than 7 percent of all expenditures on infants and toddlers. By comparison, 17 percent of federal expenditures on all children goes to early care and education, and high levels of state spending on education for these older children means that the total public investment is far higher.

3. The federal government spent \$44 billion in outlays and an additional \$13 billion in tax expenditures on infants and toddlers in 2007, likely representing the majority of public investment on this age group since states' spending on children mostly goes towards public education.

- Federal programs serving children tend to be targeted on low-income families, and this is particularly true for expenditures on infants and toddlers; more than two-thirds of expenditures are focused on low-income families.

Medicaid, especially by costs in the first two years of life. In fact, Medicaid alone accounts for 21 percent of all federal spending on infants and toddlers.

The second major finding is that early care and education programs make up a relatively small share of all federal funding on infants and toddlers. They account for only 7 percent of spending, including Early Head Start, Part C of the Individuals with Disabilities Education Act, and child care assistance from both assistance programs and tax aid. This is far less than the 17 percent of federal spending for children of all ages that goes to early care and education.

And third, the federal government spent \$44 billion in outlays and an additional \$13 billion in tax expenditures on young children. This federal spending on infants and toddlers likely represents the vast majority of all public investment in these critical years, as research to date suggests that states spend little on this age group. A Rockefeller Institute study concluded that children's share of state budgets is relatively small, and that 90 percent of state and local spending on children is for elementary and secondary education.

The federal economic stimulus package (ARRA) is more focused on children, including young children, than the federal budget as a whole. Altogether, the stimulus package adds \$143 billion to supplement current federal programs that support children (box 3). This is about a 50 percent increase over the current level, to be spent from 2009 to 2011.

State Fiscal Outlook

The current budget outlook was rounded out by Nick Johnson from the Center on Budget and Policy Priorities, who presented the latest findings on state fiscal conditions and their policy impacts so far (Johnson et al. 2009). The data paint a bleak portrait of state economies, with states facing \$350 billion in shortfalls over the next year, and nearly all (47) states affected. Independent of any federal aid, the state deficits would only be helped by drawing down reserves, increasing revenue, or cutting spending. States have begun to address the gaps by doing all of the above, including cutting programs that serve children. Several states have cut child care programs, programs for disabled children, Head Start, and health services including through the CHIP program. Other steps such as cutting state agency workforces, imposing hiring freezes or mandatory furloughs (time off without pay) can also affect the delivery of children's services, as can cuts in benefits and aid to low-income families.

Johnson stressed that although the federal stimulus package is sizable and will boost states' budgets, it is still "nowhere near enough to fill the gap." While he hopes that the increased federal Medicaid matching rate will take the pressure off general operating funds and shore up health programs, and that states will take advantage of state fiscal stabilization funds to maintain or enhance services to young children, he sees little hope of "a big leap forward" in the near future. Nonetheless, he offered a positive example

from Arizona, which is using federal stimulus dollars to preserve child care slots that otherwise were slated to be cut.

He also argued that states' capacity to make their own investments in young children is constrained by the very structure of state budgets, which hampers recovery in both the short and long run. A huge portion of state budgets is anchored to health care, transportation, and education, and a much smaller portion goes toward human services, leaving little room for additional spending. Over the long run, states will probably have a difficult time replenishing their revenues because their revenue systems are outdated for today's economy, and new federal infusions often require matching funds that they may lack. Sheri Steisel, senior director of human services policy at the National Conference of State Legislatures, was also doubtful that states had much room to act during this economic downturn, adding that this recession is much deeper and more debilitating than the last, so that "the idea that states will create new spending and matches for federal money is less likely."

**Box 3. Federal Expenditures on Children by the
American Recovery and Reinvestment Act of 2009**

Program	2007 Expenditures on Infants and Toddlers ^a		American Recovery and Reinvestment Act of 2009
	Spending	Percent of program	
Medicaid	\$12 billion	6%	Increases states' FMAP by 6.2 percentage points, among other changes.
WIC	\$3.9 billion	73%	\$500 million to WIC.
Supplemental Nutrition Assistance Program (SNAP)	\$3.5 billion	10%	Increases the maximum benefit of the SNAP program, formerly food stamps; the new maximum benefit will be calculated as 113.6% of the Thrifty Food Plan.
Temporary Assistance to Needy Families (TANF)	\$2.6 billion	16%	Creates a new Emergency Contingency Fund for the TANF program in the amount of \$5 billion for grants for states in three areas: cash assistance caseload increases, non-recurring short-term benefits, and expenditures for subsidized jobs.
Child Care and Development Block Grant (CCDBG)	1.7 billion	33%	\$2 billion for the CCDBG. Of these resources, \$255 million is targeted for quality improvement, of which \$93.6 million are targeted for activities to improve the quality of care for infants and toddlers. The CCDBG requirement to spend a minimum of 4 percent of funds on quality improvement activities also applies.
Head Start / Early Head Start	\$686 million	10%	\$2.1 billion for Head Start, to be split between Head Start (\$1 billion) and Early Head Start (\$1.1 billion).
IDEA Part C	\$434 million	4%	\$500 million for the IDEA infant and toddler program (Part C).

Note: ARRA also allocates \$13 billion for Title I of No Child Left Behind for disadvantaged students; spending on early childhood programs for children from birth through the age of school entry is a permitted use of funds.

^a Estimates are from "Federal Expenditures on Infants and Toddlers in 2007," a report jointly produced by the Urban Institute and the Brookings Institution, May 2009. Infants and toddlers are defined as children up to 2 years old.

Implications: The Budget and Political Context

Robert D. Reischauer, president of the Urban Institute, kicked off a discussion of what it might take to translate the enhanced ARRA investment in young children, scheduled to end in two years, into a long-term uptick in children's spending. He identified several key features of the federal budget process and its political and legislative context. He suggested that regardless of political interest in the issue, federal budget flexibility for permanent investments is hampered by the large size of the deficit. In the end, the deficits will need to be addressed through spending cutbacks or tax increases. Given the way Congress works, young children's programs would need an influential champion for their interests. He saw states as a possibility but echoed other participants' doubts that states are in a position to exercise clout at the moment, given their own fiscal straits.

Reischauer also noted that in the context of the federal legislative process, young children's interests still appear nebulous and hard to identify, so "you can't package it up and say 'here it is.'" Part of the problem is that young children's programs and services are fragmented across federal agencies, and another part is that young children's well-being is affected by so many broader social and economic forces. In effect, said Jerlean Daniels, "you can't put your arms around it and can't be up in arms about it." Daniels and others suggested that "it needs a name so that people can get behind it."

Bruce Lesley commented on another feature of the federal budget: increases in mandatory spending have squeezed out discretionary spending, including children's services, noting that from 2004 until 2008 mandatory spending rose 6 percent but discretionary programs declined 14 percent. Tom Gais added that spending on Medicaid and Medicare account for a sizable portion of the growing mandatory spending but that a lot of this is going to states with growing elderly populations, not to states with more children in need. Similarly, Isabel Sawhill urged the forum's participants to "think about the larger trade-offs, because we do have totally unsustainable budgets here" and in particular to identify reductions in Medicaid, Medicare, and Social Security or in other sections of the budget that could offset increases for children. Taking a different tack, Helen Blank, director of leadership and public policy at the National Women's Law Center, suggested that increases in federal mandatory spending could be explored to increase funding for infant and toddler care.

Participants also discussed the tight time frame created by ARRA's two-year end date, and some argued that programs that can generate visible results within two to three years have a better chance at sustainability. Some noted that aggressive research and data collection could help meet this challenge and thereby convert short-term gains from ARRA into long-term opportunities in the federal budget. While a two-year time frame is far too short to generate new outcome data, particularly since the payoffs for infant-toddler investments come over a number of years, participants pointed out that existing research has already identified effective strategies that improve outcomes. So the more realistic role for short-turnaround research may be to document implementation—in

particular, whether and how the investments have expanded programs already known to be effective and enhanced their quality.

Driving home the importance of what we already know, Melvin Newsome, a Republican state legislator from Kansas who has led in Kansas's early childhood funding efforts, identified the research on brain development in the prenatal period and first years of life as the most convincing argument for legislators in his state. "Neuroscience provides compelling evidence," he said, "that beginning at birth if not prenatally is when services need to be provided and that's when brains develop." In particular, the findings on the early evolution of sensory development and cognitive circuitry resonates with him and has guided his policy thinking. These data, which show "exactly why and how these issues matter," should be more widely publicized, as he believes that policymakers would respond to what science says is best. He often advises state leaders that "we need to never forget that when it comes to kids, earlier is better."

The Role of Health and Nutrition Programs in Serving Infants and Toddlers

Considering the large share of spending that health and nutrition programs make up for infants and toddlers, the discussion turned to the role that these programs play in supporting young children. Genevieve Kenney of the Urban Institute gave an overview of Medicaid and CHIP's expansive reach as well as their limitations. Together, Medicaid and CHIP cover 30 percent of all children from birth to age 3, 60 percent of young children in low-income families, and half of all African American and Hispanic children.

Although Medicaid and CHIP serve many infants and toddlers and have generous benefit packages, Kenney emphasized that they are still not reaching many eligible children nor treating the variety of children's basic needs. About 13 percent of infants and toddlers are uninsured despite being eligible for public coverage. Preventive care falls especially short for toddlers from 19 to 35 months, only 56 percent of whom are up to date with immunizations, 37 percent of whom have received the recommended number of well-child visits by 7 months, and 57 percent of whom had not received a developmental assessment by age 3. Only half of children on public insurance have had a dental visit by age 5, added Kenney. And even though Medicaid can be tapped to supplement coverage for children with private insurance, few states are doing so, despite evidence that children with private coverage have significant access problems for basic care.

Jim Weill of Food Research and Action Coalition (FRAC) and Barbara Devaney of MDRC kicked off the discussion of the other big pieces of federal expenditures on infants and toddlers—Supplemental Nutrition Assistance Program (SNAP) and the Women Infants and Children (WIC) program. Both are important anti-poverty programs that, despite their size and success in reaching eligible families, receive little attention. Both also have grown rapidly in recent years, reflective of their capacity to expand participation among eligible families. In addition, the economic recovery package supplements the maximum benefit of the SNAP program and dedicates an additional half-million dollars to WIC.

SNAP serves 4.2 million children age 0 to 4. Weill reported that it has been shown to buffer the health consequences of food insecurity and is as effective as the earned income tax credit at lifting children above the poverty level. As an entitlement program with automatic full federal funding, SNAP can be expected to grow even faster through the economic recession to meet rising need without creating fiscal problems for states. The Congressional Budget Office recently increased its 2010 estimate of SNAP expenditures to \$65 billion, more than double the cost just three years ago, not including the additional funds from the stimulus package.

The WIC nutrition program has also attained wide reach among families with young children and pregnant women. About 9 million pregnant women, mothers, infants, and children are served by WIC every month. More than half of all infants and a quarter of all children receive WIC benefits. Almost three-quarters of WIC spending (73 percent or \$3.9 billion dollars) went to infants and toddlers in 2007 (Macomber et al. 2009). Low-income families disproportionately benefit, including almost all low-income infants, although WIC has a generous income threshold. Use of WIC is especially pervasive among Hispanic families. Barbara Devaney, senior vice president of Mathematica Policy Research, said that WIC is associated with improved birth outcomes, improved iron status of infants, improved dietary patterns, and greater access to use of health care. She called WIC “an integral part of our public health system and well suited to make a difference.”

Implications for Infants, Toddlers, and Their Families

Against this backdrop of significant, successful outreach for young children, participants engaged in a lively debate about the lessons from both success and the substantial remaining gaps in health services for infants and toddlers and their families.

First, even though the health programs serve many infants and toddlers, discontinuous care and gaps in care lead to particular problems for young children. Jane Borst, director of the Maternal and Child Health Program in Iowa, referenced the high level of “churning” in the system—a good portion of which is likely unrelated to changes in eligibility status for public insurance. She also added that even children who just transition from public to private insurance can experience this. Private insurance, as referenced by Kenney, is less likely to cover preventive services, including certain checkups that are recommended as part of a basic care package. So young children who are moved to private insurance coverage after being in the public system often lose access to the relatively comprehensive array of services they had under Medicaid and CHIP.

A second problem is that even children who are served by Medicaid and CHIP may not get good or medically recommended levels of care, especially preventive care. Neal Halfon, director of the UCLA Center for Healthier Children, Families and Communities, argued that both public and private systems are designed to ignore preventive care, resulting in burgeoning health problems and higher costs later on. The current structure of coverage treats problems in lieu of fundamental causes. It ignores, for

example, that most chronic disease problems start at a very young age and can be detected early on.

Other problems in quality of care include health care standards that are not tailored to young children and a bias toward narrowly medical rather than developmental approaches that Matthew Melmed of ZERO TO THREE called the bias towards treating children “from the head down.” Jane Borst gave one example of incomplete coverage through private insurance in her state. In Iowa, private insurance only covers a portion of the cost for hearing aids, based on what they would cover for an elderly person. But many new parents cannot afford to pitch in the additional amount, especially for newborns with bilateral hearing loss. Since uncorrected hearing loss can lead to a host of other problems, the state stepped in and now runs a supplementary insurance program, of which 85 percent of the beneficiaries already had private coverage.

There was general consensus that as a whole, the system of care is not maximizing its potential for meeting the needs of children in the most important developmental years. Neal Halfon argued that what is needed is a comprehensive early childhood system that offers “wraparound care” for all children. Such a system would integrate services from the health, early care and education, and family support sectors, and targeting optimal early childhood development, a shared result that each sector could own. Participants offered different ideas about what this would entail. Greater service coordination and a more fully accessible set of services could be achieved by reaching out to and working with private insurers and pediatric practices, suggested Jane Borst. In her state of Iowa, the new First Five program has achieved better quality and content of care by doing just that—and now, 95 percent of children with coverage receive primary health care and a fuller range of preventive services. Charlie Bruner added that providing training opportunities for private pediatricians to provide better care should also be a priority. Jenny Kenney considered it important to link up to the school system to provide continuous care and coverage in the early years. Only half of children with special needs are diagnosed by the time they enter kindergarten.

A third gap identified by participants was the system’s disregard of the links between children’s health and well-being and their parents’ health. Several participants suggested that the health service system for infants and toddlers ought to target whole families, and mothers in particular, not just the babies. Parents’ unmet health needs, whether physical impairment or mental health illness, often have adverse consequences on their young children, according to Jenny Kenney. Yet, Medicaid and CHIP provide very limited coverage for adults, and fully a third of infants and toddlers have an uninsured parent. This poses a particular barrier for low-income mothers, she added, who have disproportionate levels of depression and mental health problems. Jane Borst noted that half of all women on Medicaid are on psychotropic medication. Matthew Melmed added that Medicaid rarely pays for dyadic therapy, a mental health intervention designed to heal the broken parent-child emotional bond.

In thinking about promoting the health of caretakers alongside young children, Charlie Bruner pointed to the advantage of the WIC model for successfully connecting

with parents and expectant parents. WIC brings the intervention directly to the most important caretakers and often uses group settings, which he sees as particularly valuable. Bringing parents together as a group cuts down on social isolation, especially among disadvantaged populations, and helps parents learn about their children.

The conversation on the existing service system for infants and toddlers led participants to reflect on strategies for systems change. For example, participants debated the role of broad, large-scale changes versus smaller, incremental steps like building better links between the systems. Some proposed creating special settings like the Nemours project, represented by Anne De Biasi, that draw together major service systems on behalf of particular communities or families. Others wanted to reform the large service systems, although Harriet Meyer, director of the Ounce of Prevention Fund, warned of the daunting challenges involved in reforming the funding, management and accountability structures of the “medical industrial complex.” Still others argued for fundamental, “game-changing strategies” that do not look to marry the existing systems and programs but to create a new, innovative structure. Recognizing the possibility of major health reform under a new administration, Halfon proposed that young children’s advocates and budget experts alike “take advantage of that [reform] to make sure children are central in the health agenda.”

One strategy that some participants suggested for systems change was to learn from the successes so far in the nutrition programs, both in terms of their reach and the content of services offered, particularly in WIC. Jim Weill and Helen Blank also called participants’ attention to the potentially important role of another nutrition program besides SNAP and WIC, the Child and Adult Care Food Program (CACFP), an entitlement program that provides funding for meals in child care settings. Beyond its importance to nutrition, it offers a way in for policymakers who are seeking to enhance quality in informal child care settings, which is extremely important for the many low-income children in family, friend, and neighbor care.

As the session concluded, participants noted that even given the imbalances, gaps, and weaknesses of the major health and nutrition programs for infants and toddlers, there exists enormous potential for both incremental, small positive steps as well as an innovative broader strategy at the state or national level. Federal-to-state coordination is essential to help achieve reform. And experts and advocates must “keep [their] eyes on what a transformed system will look like.”

The Role of Early Care and Education Programs in Serving Infants and Toddlers

Matthew Melmed, director of ZERO TO THREE, began this session by describing this moment as “the best of times and the worst of times” for investments in early care and education. The best can be measured by the new Obama administration’s commitment to improve early care and education and make it a higher funding priority. The administration made good on its promise for increased funding beginning with the economic recovery package. Although none of the early care programs is as large as the

major health and nutrition programs, the potential for growth is large in relation to current program size. The “worst of times” arises from state cutbacks as a result of fiscal crisis.

Melmed also argued that “we have a long way to go in providing proven services to all who need them.” Even with the federal enhancements in ARRA, a huge gap remains in current investments relative to need. Achieving comprehensive access to quality care will require a much larger infusion of federal and state money beyond current levels. For example, the increase in Early Head Start, which more than doubles the number of slots, will only reach up to 6 percent of eligible infants, toddlers, and pregnant women. Finally, he argued for three conclusions about the types of services that ought to be funded. First, developmental science demonstrates that “we must look at the whole child, in the context of his or her family,” rather than investing solely in one dimension such as health or housing. Second, investments should be designed “from the bottom up,” to be developmentally appropriate for the youngest children, rather than designed for the education of older children and imposed downwards. Third, investments should target the most vulnerable among young children, because of the extraordinary stressors that they and their families face.

Harriet Meyer rounded up state strategies and programs, since federal momentum builds on the rising popularity of early care and education programs in the states. Many states have used Early Head Start as a model for their own programs, a positive trend since it was designed with a developmental focus, not as a work support or compensatory education program. States’ programs tend to combine federal-state funding streams with private funds, and several focus on reaching the most disadvantaged young children. For example, under Governor Kathleen Sebelius, Kansas developed a block grant for early care and education with a 30 percent set-aside for infants and toddlers; Nebraska started an early childhood endowment fund that combines public and private-sector funds into a state grant program, and Oklahoma supplemented its pre-K program with a pilot program that also combines public and private-sector funds to expand services to children under age 4. Meyer added, however, that even with the supplemental support from state efforts, the existing programs are “far from serving all at-risk children or ensuring quality of care.”

Miriam Calderon, vice president of early childhood and immigration policy at First Focus, noted the particular issues faced by immigrant and Latino young children. Altogether, two-thirds of Hispanic toddlers have an immigrant parent, but the vast majority are themselves U.S. citizens. The mixed status of such a high proportion of these families raises access issues for children whose parents are less likely to be connected to a range of public services, less likely to speak English, and less likely to come across and learn about programs that could benefit their children in those critical early years. She suggested that early care programs should look to WIC as a model program for its success in reaching Latinos and children of immigrants and engaging Latina mothers. The program’s liberal eligibility guidelines, irrespective of residency or citizenship status, facilitate access for Latinos. This nearly universal structure also makes WIC less threatening for immigrant parents fearful of becoming labeled a public charge.

Participants continued their conversation from the previous session about how to build more integrated service systems. Charlie Bruner, director of the Child and Family Policy Center in Iowa, noted that the expansion of early care and education nationally and in the states has revolved around the development and growth of new or existing individual programs, each with their own individual goals, eligibility cutoffs, and funding structures. Yet even in the most innovative states, and especially at the federal level, there has been much less focus on building cohesive systems that leverage each other's resources and enhance access across programs. The result is an array of disconnected state and federal programs. Harriet Meyer agreed and added that the momentum and resources from the early care and education programs in the states and the expansion of Early Head Start can be used to build an early care infrastructure across the different silos. Melmed suggested that the Early Learning Challenge grants proposed in the president's budget and the State Early Learning Councils created in the Head Start Act now funded through ARRA can be used to support state systems-building. On the other hand, Helen Blank noted that focusing too much on the perfect system could lead to neglect of immediate legislative initiative. She thought it important to recognize that no single program will provide "the silver bullet" or ideal structure for financing or implementing innovative services for babies and toddlers.

Participants also discussed the entrenched disconnect between K–12 education, the early education field, and experts and advocates for infant and toddler development. Meyer observed that over the years, "infants and toddlers have been largely left out of both K through 12 discussions and pre-K discussions." She suggested that this contributes to disparities in children's school readiness and later school achievement for children from disadvantaged backgrounds.

Key Insights

Five key insights emerged from the discussion as a whole.

1. Health and nutrition programs offer opportunities for improving young children's circumstances that have not been fully tapped.

While participants were generally aware that health and nutrition programs represented large public investments, many had not fully appreciated their scale or the potential opportunities they present for serving infants and toddlers. For early care and education experts, an important take-away lesson was to explore the possibilities in their own state for better use of nutrition programs as a lever to improve children's early experiences (including improving the quality of child care settings) and to get more involved in the conversation about health care financing, access, and services. For health and nutrition experts, the corresponding lesson was to pay attention to the evidence from research and practice about the particular needs, developmental trajectories, and circumstances of babies and toddlers and their families. Participants reflected that the health debate can be so focused on the elderly, whose need for care typically drives costs, that experts on

infant and toddler development cannot get a hearing. Although this is sometimes an advantage, since program improvements can be put in place under the radar screen, it can also be a serious hindrance to improving young children's care.

2. Improving infant-toddler services requires better aligning the “Lego set” of programs and funding streams.

Throughout the meeting, participants grappled with how to promote the developmental needs of infants and toddlers within a “Lego set” of options, not a cohesive system. While most had come into the day already familiar with the fragmentation of programs within their specialty area, their frustration only grew when they examined health, nutrition, and early care and education programs together and saw even greater disjunctions. The lack of fit between programs hinders good services—as when children lose public health insurance and arbitrarily lose access to preventive care, or when standards of quality vary widely across early childhood care settings. It also, participants argued, hinders the development of public will and the investment of needed public resources, since there is no single “it” to build support for.

Beyond diagnosing the problem, participants went some way towards solving it. They articulated several different strategies:

- Focus attention on “system-level” barriers to coherent services, such as funding structures, professional training, and disparate eligibility criteria. Some participants, proposing the strongest version of this recommendation, wanted to marry several programs into one cohesive system of care that provides comprehensive services for all children's basic needs. Advocates for this strategy argued that it requires painstaking attention to restructuring, not just expanding, services. As Gerrit Westervelt of The Build Initiative said, “If systems change is a big part of the answer, we should invest in it.”
- Focus on expanding services and increasing investments as a starting point, not on systems change. Some argued that this more pragmatic approach can nonetheless help improve the system, once the added resources are in hand. For example, since ARRA doubles the number of children in Early Head Start while also increasing child care resources, those expansions could help build cross-cutting quality supports as well as expanding slots.
- Improve and expand a few major programs in a way that optimizes their capacity to serve infants and toddlers. For example, revamp Medicaid so it reflects existing knowledge about the developmental needs of babies and toddlers, and expand Early Head Start so all eligible babies and toddlers can be served by its comprehensive services platform. Lessons from Food Stamps and WIC were sometimes cited as useful for improving the other systems.
- Maintain separate services for most children and families, but create special settings for the most vulnerable, who are least able to overcome access barriers,

so they can get a tailored package that works for them. Early Head Start was offered as one example of this strategy, as was the Nemours health program.

- Create processes for program leaders themselves to work through the differences among state and national programs. Examples include “connecting” councils that include representatives of the various programs and using other incentive mechanisms, including the administration’s proposed early childhood challenge grants.
- 3. *Services for young children should respond to the whole child and to children’s real needs, including children with multiple vulnerabilities.***

Another theme that arose throughout the session was the importance of supporting “the whole child,” consistent with the research evidence. To set children on an optimal trajectory in those crucial first years, the system(s) of care should respond to children’s biological, mental, social, physical, cognitive, and relational needs, and children should experience continuous care as they grow and develop. Services should not be designed on the false epidemiological assumption that “90 percent of children are healthy and [only] a small subset need help”; Neal Halfon and others argued that in fact, given the demographic and family circumstances of young children, far more need substantial early help to put them on the right track.

Drawing on their different experiences, participants spoke to mismatches of services and real needs within each major program. In the health and nutrition world, examples included churning in Medicaid, with its effect on the continuity of care for young children; the lack of or high cost of mental and behavioral health services in either public or private insurance; the mismatch between a medical framework aimed at responding to problems and a developmental framework aimed at providing preventive care and early intervention; and the resulting lack of developmental screenings and services even for children already enrolled in Medicaid and CHIP. In early childhood care and education programs, participants spoke of the enormous disconnect between the number of children who need very high quality and comprehensive services and the number reached even after the ARRA investments.

Participants also briefly addressed how to tailor services so they will be effective for children of different backgrounds and circumstances and so they will engage parents. Matching children’s needs to services may mean some level of restructuring or targeting. For example, certain outreach strategies have been shown more effective at reaching children of immigrants, and especially children in language-minority or mixed status households.

- 4. *Serving young children requires attention to parents, yet few programs have a two-generational focus.***

Throughout the conversation, participants sourced many of children’s problems and strengths to family circumstances, characteristics, and level of parental support. Low

levels of parental support are often related to parents' own physical and mental health and parental stress, but also to household poverty, job instability, unmet child care needs, and other factors. As one participant summed it up, "the key to closing the gap [between needs and services] is supporting families."

Yet few existing programs are designed with this two-generational lens. For example, many young children have public health insurance, but their parents have none, inhibiting treatment for parental or family problems even when they place children at risk.

Participants proposed several programmatic improvements to address this gap. Some argued for replicating WIC's approach to targeting the intervention through parent education and support or pointed to similar features of the Head Start model. Others said that health, nutrition and early care, and education programs need to be tailored to communities and build community cohesiveness so families are less isolated, more child-centered, and educated about children's needs. Participants also suggested devoting more resources to ensuring parents can better care for their own children, for example with better family leave options and coverage. There was also mention of buttressing parental insurance coverage and connecting low-income and poor parents to economic help as a way to improve the quality of life for the child.

5. Achieving more public investment in infants and toddlers requires making the public case for it.

Some of the most lively debates occurred over how to make the public case for children more powerfully. The first session set one challenge for the day by asking how infants and toddlers would compete for public resources during an economic downturn—and how any progress achieved through ARRA resources could be maintained once the Act ends in two years.

Consistent with Representative Newman's experience in Kansas, most participants believed in the value of research evidence showing the long-term payoffs of early investment in children. However, participants disagreed sharply on whether sufficient evidence exists now. Some felt that existing research is sufficient and simply needs to be conveyed persuasively to policymakers. These participants argued that the call for additional research is sometimes a red herring, since more evidence exists for early childhood interventions than for many other purposes routinely funded by the federal government. Other participants argued that while a small number of interventions have been rigorously tested, many have not, leaving large gaps in our knowledge. These participants sought more evidence about which potentially promising interventions have impacts, how large the impacts are, and the characteristics of interventions that work compared to those that do not.

Several people throughout the day argued for asking for a large infusion of public money to create and implement a truly effective plan. They thought that "being honest," or articulating what level of investment is needed for good early care, is essential to

having a serious public conversation. One person argued that the early childhood community must “wake up and say we need it.” Another countered that advocates must think more broadly about trade-offs between this and other portions of the budget before making large demands on public resources.

The fragmentation of programs described throughout the session poses public engagement as well as operational difficulties, most participants thought. With young children’s programs hidden in larger programs and rarely having an identity of their own, one participant said, the public rarely has an opportunity to weigh in on an issue that directly affects young children. Potentially, “naming the problem” could help create a constituency in support of an infant and toddler agenda.

On the other hand, some participants argued not for a new effort but for “getting on board with the train that’s moving.” These participants saw opportunities to infuse a focus on infants and toddlers into other current reform efforts. The two opportunities cited were national health care reform, and the focus on early education and school readiness shared by the Obama administration and many states.

Next Steps

As participants deliberated about next steps, in the meeting itself and in follow-up communications, many saw a critical moment of opportunity for setting more young children on a positive developmental course. Some participants highlighted next steps that they planned to take to seize this opportunity: for example, several identified new ways they could build or expand on relationships with other leaders in their home states across the different policy silos to promote infant and toddler needs. Others said that they realized the untapped potential of existing delivery systems, such as health or nutrition. Participants also talked about the importance of creating state forums and processes to facilitate these collaborations.

Participants asked for specific help in accomplishing these state-by-state goals. Several wanted infant and toddler budgets developed for their home states because they saw real value in explicitly identifying the dollar amounts funneled through the different programs. Others asked for future roundtable forums similar to this but focusing on how states are implementing the ARRA funds for young children, so they could exchange information and learn lessons for mid-term corrections. And others wanted the chance for a dialogue with federal administrators, arguing that federal openness to flexibility in how states deploy and connect services will be necessary to improve results for children. Still others identified the need for new, integrated data systems, perhaps keyed to small geographical areas such as neighborhoods, to measure real change for infants and toddlers rather than siloed program-by-program accountability measures.

Nationally, participants saw two areas of focus. First, while strategies differed, most participants thought it very important that future federal budgets build on the ARRA investments in programs for young children. Second, participants urged each other,

fundings, and decisionmakers to keep a focus on infant and toddler issues as part of the broader national dialogue around health and education reform. While it is easy for infant-toddler experts to be on the edge of these discussions, the forum made a powerful case that they ought to push their way in, to maximize the opportunities for better lifetime results and to raise the most useful and richest questions for research and policy.

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