



US CARE POLICY SCORECARD

ASSESSING FEDERAL UNPAID AND UNDERPAID
CARE POLICIES IN THE US



i-Lab *integration lab*



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AUTHOR INFORMATION AND ACKNOWLEDGEMENTS

The US Care Policy Scorecard and this report were developed by graduate students at the Integration Lab in the Keough School of Global Affairs (KSGA) at the University of Notre Dame (ND-i-Lab), Oxfam America, the National Women's Law Center (NWLC), and the National Partnership for Women & Families (NPWF).

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The authors would like to express their deepest gratitude for the guidance and support of the individuals at the University of Notre Dame, Oxfam America, NWLC, and NPWF who provided inputs and guidance throughout the entire project. These individuals include Katy Henderson, Mike Helms, Paige Castellanos, Patricia Stottlemeyer, Ernesto Archila, Nick Galasso, and Stephanie Smith at Oxfam America; Whitney Pesek and Karen Schulman at NWLC; Vasu Reddy and Jessica Mason at NPWF; Melissa Paulsen, the ND-i-Lab student advisor; Tracy Kijewski-Correa, the lead faculty for the 2022 ND-i-Lab period; and Hanna Murphy, the ND-i-Lab program manager from the ND-i-Lab leadership team.

The authors would like to give special thanks to the editor of this piece, Sara Duvisac, and to the peer reviewers who reviewed and provided feedback on the research terms of reference and draft report: Annette Jacoby, Julie Kashen, Anam Parvez, and Sarah Tuckey.

The authors would also like to thank each and every expert who agreed to be contacted and was able to sit for an interview. These interviews added depth and expertise to the research. These include experts from National Employment Law Project (NELP), National Domestic Workers Alliance (NDWA), NPWF, NWLC, A Better Balance (ABB), Center for Law and Social Policy (CLASP), Department of Labor (DOL), Stanford University, Caring Across Generations, Disability Rights Education and Defense Fund (DREDF), Legal Momentum, Center for WorkLife Law, and Oxfam America.

Finally, our deepest gratitude to the participants of the Care Policy Scorecard validation workshop that was carried out in March 2023, including those who work at: ABB, Caring Across Generations, Center for American Progress, CLASP, Center for Economic and Policy Research (CEPR), The Century Foundation, Cornell University, Family Values at Work, Hand in Hand, Instituto de Estudios sobre Mujeres, Género y Derecho (INTERMUJERES), Institute for Women's Policy and Research (IWPR), Mothering Justice, National Conference on Worker Safety and Health Administration (COSHA), NDWA, NPWF, NWLC, New America, ND-i-Lab, Prosperity Now, and the US federal government.

CONTENTS

INTRODUCTION	2
SECTION I: BACKGROUND	4
SECTION II: RESEARCH OBJECTIVES AND QUESTIONS	8
SECTION III: METHODOLOGY	10
Table 1. Care Policy Scorecard policy areas and indicators for unpaid care work	11
Table 2. Care Policy Scorecard policy areas and indicators for paid care work	11
Table 3. Care Policy Scorecard indicator and assessment criteria sample	12
SECTION IV: SCORECARD RESULTS AND MAIN FINDINGS	16
Table 4. Overall scoring and general trends	16
SECTION 1: UNPAID CARE WORK	18
Table 5. Policy area 1.1: Care-supporting physical infrastructure	19
Table 6. Policy area 1.2: Care services	20
Table 7. Policy area 1.3: Social protection benefits related to care	21
Table 8. Policy area 1.4: Care-supporting workplaces	22
SECTION 2: PAID CARE WORK	22
Table 9. Policy area 2.1: Labor conditions and wage policies	23
Table 10. Policy area 2.2: Workplace environment regulations	23
Table 11. Policy area 2.3: Migrant care workers' protections	24
Table 12. Policy area 2.4: Right to organize	24
STATE BRIGHT SPOTS	25
1. California	25
2. New York	25
3. Washington	25
SECTION V: RECOMMENDATIONS AND CONCLUSION	26
RECOMMENDATIONS	26
CONCLUSION	28
APPENDIX A. DATA COLLECTION APPROACH AND SCORING DECISIONS	34
Data collection approach	34
Scoring decisions	35
APPENDIX B. COMPLETED SCORECARD	36
APPENDIX C. INTERVIEW GUIDE	38
APPENDIX D. LIST OF EXPERT INTERVIEWS	39
APPENDIX E. VALIDATION WORKSHOP	40
APPENDIX F. LIMITATIONS AND RECOMMENDATIONS FOR FUTURE ITERATIONS OF THE US CARE POLICY SCORECARD	41

INTRODUCTION

Unpaid and underpaid care work (UUCW) is critical to the well-being of individuals, families, and societies in the US and around the world. Much of the care work done in our homes and communities is unpaid, and all people engage in and receive unpaid care at some point in their lives. There are also those who work in the care sectors, such as domestic, child care, and elderly care workers, but these jobs are often underpaid and undervalued. UUCW is often divided into two overlapping categories: direct care and indirect care.¹ Direct care work includes direct engagement or contact with the care recipient, such as bathing a child or helping a person with a disability get dressed. Indirect care activities, like cooking or cleaning the home, are activities in which the care recipient isn't directly involved but the activities are still critical for their well-being. In the US, care work is still most often done by women.² The amount of unpaid care work they do is valued at almost \$1.5 trillion annually.³

Care work sustains life. We are all dependent on the caregiving provided by people around us to survive and thrive. It is the way in which we express our humanity, connect with each other, and demonstrate love for our family, friends, and community. Although UUCW in and of itself is valuable and important, it is also a critical part of our economy. UUCW facilitates labor participation and economic production, and unpaid care work should be counted as part of our economy. The cooking, cleaning, and laundry that a domestic worker does for a family is what allows both parents to perform paid work; the education and care a child care worker provides babies and

toddlers means that a single mom can earn a living for her family; the school pickup and drop-off a grandmother does for her grandkids allows their parents to remain employed full time.

The importance of UUCW for the well-being of individuals, communities, and the economy means that it should be recognized and supported through robust public policies. In other words, there must be well-designed, well-funded, and widely accessible government policies and programs in place that facilitate people's ability to give and receive care. These policies include ones that ensure that those in the paid care workforce are protected, paid well, and treated with dignity. This project uses the [Care Policy Scorecard: A tool for assessing country progress towards an enabling policy environment on care](#) (Care Policy Scorecard Tool),⁴ to assess whether the US federal government is supporting working families, caregivers, and care workers through its policies.

In our assessment, the federal UUCW policy environment in the US is far from adequate: the US scores a 43 out of a 100, meeting less than half of all possible criteria when all care policy indicators in the US Care Policy Scorecard are examined and aggregated. This scoring examines whether care policies exist at the federal level; whether existing policies are accessible to the most underserved communities, particularly women of color and immigrants; whether existing policies are adequately funded, monitored, and enforced; how these policies were designed to meet the needs of caregivers; and the impact these policies have on caregiving. As the main findings section of this report will show, the US doesn't score poorly across all these areas nor across every indicator, but this scorecard supports the argument that US federal UUCW policies are severely lacking. This policy assessment indicates that this lack of UUCW policies is mainly because multiple

care policies don't exist at the federal level, and policies and programs that do exist face many issues, including inaccessibility and underfunding.

For anyone in the US who works in the care sector, is aging, has a disability, or has a child or an aging or disabled family member, the US's poor score on its federal UUCW policies is no surprise. Without the existence of basic care policies at the federal level, like paid sick and paid family and medical leave, and with federal programs—like the ones in place for child care and early learning—that only reach a small fraction of people who need them, families in the US have been left with little support from the federal government. While the experience of struggling to juggle caregiving responsibilities with paid work is widespread, this report discusses the ways in which it is women of color and immigrant women who are most harmed by the US's failure to fully support working families, caregivers, and care workers. It is these underserved communities that are most harmed by absent UUCW policies and that are the least likely to access the UUCW policies and programs that do exist. As is discussed in the background section of this report, this is a result of a history of policy making rooted in sexism and racism that makes care work invisible and undervalued.

The real-life impact of the US's failure to meet the needs of working families, caregivers, and care workers includes financial insecurity, inequality, and other hardships for millions of women across the US. For example, because the unpaid care work most often conducted by women in the home is seen as a private matter that doesn't require government support, many women are unable to earn an adequate living or have sufficient time for rest and leisure. Additionally, care workers—who are

overrepresented by women of color and immigrant women—too often live in poverty due to low wages, despite the monumental work they do to care for other people's loved ones. Also, low-wage women workers who can't afford to take off twelve weeks of unpaid parental leave have to return to work just a few weeks after giving birth without sufficient time to bond with their baby or properly heal. These are just a few examples of how the devaluing of care work has played out for millions of women in this country.

Strong care policies are a critical part of a just economy in which everyone is able to thrive. By providing an assessment of how the US federal government addresses—or fails to address—the needs of unpaid caregivers and underpaid care workers, this scorecard also serves as a roadmap for action for advocates and policymakers. We hope that it will be used in this way.

SECTION I: BACKGROUND

CARE WORK, GENDER, RACE, AND IMMIGRATION

UUCW disproportionately falls on women and girls, which is both a cause and a result of gender inequality. In 2018, women in the US spent 2.1 more hours on unpaid care work each day than men, and women ages 35–44 spent 3.6 more hours on unpaid care work than men in the same age range per day.⁵ There is a bigger gap in unpaid care work responsibilities between Hispanic women and men, Black women and men, and Asian women and men, when compared to white women and men,⁶ indicating that gendered differences in unpaid care workloads are racialized. Recent research has shown that even women in the US who earn the same amount or more money than their male spouses still do more care work in the home than their partners.⁷ Globally, the amount of unpaid care work women and girls ages 15 and over do each year equals \$10.8 trillion.⁸ In the US, it's valued at almost \$1.5 trillion annually, when calculated based on a minimum wage.⁹ This unequal share of unpaid care work translates to 4 percent higher poverty rates for women globally, increasing to 22 percent during women's peak productive and reproductive ages.¹⁰ In the US, mothers are estimated to lose almost \$300,000 in lifetime earnings due to caregiving responsibilities.¹¹

The COVID-19 pandemic put a spotlight on the way women's expected responsibility to care for children (compared to their male partners) impacts their economic well-being: although men and women experienced unemployment at the same rates during the beginning of the pandemic, two years after the start of the pandemic, the unemployment rate among women

remained higher than prepandemic levels, while men had recovered all job losses.¹² The US Chamber of Commerce cites lack of access to and/or nonaffordability of child care as one of the main reasons for this discrepancy.¹³ Women's unpaid care work responsibilities can also have negative impacts on their mental health, particularly if they juggle these tasks with paid work.¹⁴ A poll taken at the beginning of the COVID-19 pandemic found that women were more likely to feel anxiety, stress, depression, and a lack of motivation, when compared to men.¹⁵

In the US, sexism and racism play a role in how the underpaid care work sectors are disproportionately occupied by women of color and immigrant women. Ninety-seven percent of child care and early learning workers are women,¹⁶ and this workforce is disproportionately made up of women of color.¹⁷ Furthermore, Black women and Latina child care workers are the most likely to experience poverty compared to child care workers of other races.¹⁸ Also, over 90 percent of domestic workers are women,¹⁹ while over half (52.4 percent) of the female domestic work labor force are Black, Latina, or Asian American/Pacific Islander.²⁰ The median domestic work wage rate is around \$12.01 per hour, as opposed to the \$19.97 median hourly wage of other workers. Domestic workers are on average three times more likely to live in poverty than other workers.²¹ Over 85 percent of all home health aides in the US are women,²² while Black and Latina women—who are overrepresented in the home care sector—are more likely to live in poverty than white women and white men home care workers.²³

Globally, paid care work is increasingly done by migrant and immigrant workers from the Global South, and especially by migrant and immigrant women who are employed through informal channels, including through private households or employment agencies.³⁵ In many countries, the often-informal nature of migrant care work limits access to labor rights offered by the host country as well as to societal and economic protections (social security, pension plans, insurance plans, medical coverage, etc.) that usually come with formal employment.³⁶ Migrant care workers often leave their families behind and their children in the care of other family members. This chain of care is called the “Global Care Chain.”^{37, 38} In the US, much has been written about the experiences of Filipina women in particular, who work as domestic workers in the US and send money to their children back home in the Philippines.^{39, 40, 41}

Immigrants play a key role in the US paid care workforce, and can be disproportionately impacted by the sector’s poor pay and lack of protections. Immigrant child care workers, who make up 18 percent of the child care and early learning workforce, are more likely to live in poverty than US-born child care workers (22 percent vs. 16 percent).⁴² Additionally, while immigrants make up around 17 percent of the entire US workforce,⁴³ 38 percent of home health aides are immigrants,⁴⁴ and 19 percent of workers in nursing homes are immigrants.⁴⁵ Domestic work is also often done by immigrant workers, at a higher rate than many other jobs: in 2015, immigrant women were most likely to work as housekeepers and maids or nursing, psychiatric, or home health aides.⁴⁶

Despite a high demand for paid care work, poor pay and insufficient worker protections contributed to a high turnover rate among care workers even before the pandemic hit (81.6 percent in 2018, and 64.3 percent in 2019).⁴⁷ The COVID-19 pandemic then caused many care workers to lose their jobs or to move to other sectors for better economic security. Economic analyst Julia Wolfe affirmed the pandemic-induced strain on domestic workers by noting that the pandemic “placed the nation’s 2.2 million domestic workers—91.5% of whom are women—in a particularly precarious position,” due to layoffs and limited-to-no protections against COVID-19 at the start of the pandemic.⁴⁸ Relatedly, there are 100,000 fewer child care workers now in the US than there were prepandemic,⁴⁹ while a shortage of home care workers, such as home health aides, assistive care providers, and certified nursing assistants, is leaving many families with aging family members or relatives with disabilities without any support.⁵⁰

QUICK FACTS ON GENDER, RACE, IMMIGRATION, AND CAREGIVING IN THE US

- Women spend 2.1 more hours on unpaid care work than men per day.²⁴
- Women’s unpaid care work was valued at \$1.5 trillion for a single year.²⁵
- Women are more likely to be employed in the underpaid care work sectors: 97 percent of child care workers,²⁶ over 90 percent of domestic workers,²⁷ and over 85 percent of all home health aides²⁸ are women.
- Women of color are overrepresented in the underpaid care work sectors; for example, 52.4 percent of domestic workers are Black, Latina, or Asian American/Pacific Islander.²⁹
- Women of color child care workers,³⁰ domestic workers,³¹ and home health aides³² are more likely to live in poverty than other workers in those sectors and/or the overall workforce.
- Immigrants are overrepresented in the underpaid care work sector, particularly home health aides, where 38 percent of the workforce are immigrants.³³
- Immigrant underpaid care workers are more likely to live in poverty than other workers; for example, 22 percent of immigrant child care workers live in poverty compared to 16 percent of US-born workers in the same sector.³⁴

A BRIEF HISTORY OF FEDERAL CARE POLICIES IN THE US

To understand the care landscape in the US today, tracing historical developments in UUCW policies is imperative. Some scholars and activists have argued that an undervaluing of care work in the US stems from the fact that the original caregivers of white people in the early days of this nation were Black women who were enslaved.^{51, 52} The low wages that many care workers earn and a continued lack of full labor protections for these workers (discussed further in the main findings section) highlight how the legacy of sexism and racism continues to plague the paid care workforce. To illustrate the ways in which sexism and racism have played a role in the US's approach to UUCW policies historically, a quick history of the Fair Labor Standards Act (FLSA) and child care and federal leave policies is briefly discussed below.

The 1938 FLSA was a historic labor bill that created a minimum wage, addressed child labor, and established a 44-hour work week. However, domestic and home care workers were excluded from the protections in the 1938 FLSA and didn't receive Social Security benefits until 1950.⁵³ Nannies and housekeepers didn't gain minimum wage and overtime protections under FLSA until 1974, while home care aides didn't receive these protections until 2013.⁵⁴ The prevalence of Black workers in the sectors originally excluded from FLSA at that time (which also include farmworkers and tipped workers)⁵⁵ highlights how racism played a role in who was originally granted labor protections and rights.

The first and only time the federal government aggressively subsidized child care was during World War II, when white women who were not previously in the paid workforce were encouraged to take on wartime jobs (families who already had two working parents—commonly Black families—still had limited affordable child care options).⁵⁶ This funding abruptly stopped after the war ended, and the government didn't take any steps to substantially fund child care until 1971, when Congress passed the Comprehensive Child Development Act, which would've made child care universal for three- and four-year olds, free for low-income families, and more affordable for middle-income families.⁵⁷ Due in part to influences by opponents who labeled the bill as communist, President Nixon vetoed the bill when it crossed his desk, arguing that the bill would weaken families.⁵⁸

After being introduced by Congress every year since 1984, the Family and Medical Leave Act (FMLA) was signed into law in 1993 by President Bill Clinton, after it had been passed by Congress and vetoed twice (in 1991 and 1992) by President H.W. Bush, who didn't believe "the federal government should order companies to provide a certain benefit."⁵⁹ After the second veto, Democrats were able to override the presidential veto, and the veto-override vote highlighted how gender influenced lawmakers' votes: 79 percent of all women in the House and 73

percent of Republican women in the House voted to override the veto, compared to 58 percent of all men in the House and 21 percent of Republican men in the House.⁶⁰ Now, paid workers are guaranteed up to 12 weeks of unpaid leave for family and medical reasons if they've worked for an employer for a certain number of hours, for at least 12 months, and if the employer has 50 or more employees (among a few other restrictions). These restrictions mean workers of color are least likely to be eligible for FMLA leave, and, because the leave is unpaid, workers of color are the least likely to be able to afford taking FMLA leave.⁶¹ Additionally, the strict definition of family in the FMLA doesn't reflect the reality of many peoples' caregiving responsibilities.⁶²

Decades later, the COVID-19 pandemic era was a temporary bright moment for federal care policies, as many of the pandemic relief bills included provisions on care. For example, the Coronavirus Aid, Relief, and Economic Security (CARES Act) of 2020 provided stimulus payments to families to help them make ends meet.⁶³ The Families First Coronavirus Response Act (FFCRA) required certain employers to provide their employees with paid sick leave and expanded family leave.⁶⁴ Furthermore, the American Rescue Plan Act (ARPA) provided \$39 billion in funding to stabilize the child care industry, while expanding the child tax credit to low-income families and increasing the amount families received per child.⁶⁵ All of these provisions have or will soon expire.

The Biden administration's proposed Build Back Better (BBB) bill was among the most-recent attempts to increase investment in the care sector by including a federal guarantee for paid family and medical leave and increase funding for child care and home- and community-based care.⁶⁶ Notably, while BBB lacked sufficient Congressional support and was unable to pass in the Senate,⁶⁷ Congress was able to pass the Infrastructure Investment and Jobs Act (IIJA, commonly known as the Bipartisan Infrastructure Law) during the pandemic, which included \$1 trillion in funding for physical infrastructure projects such as public transportation, clean water, the Interstate Highway System, and others.⁶⁸ As discussed in more depth later, the failure of BBB and passage of IIJA is illustrative of how in the US policies that are traditionally tied to care, like paid leave and child care, receive a lack of support in Congress, while physical infrastructure projects, which are less likely to be associated with caregiving, aren't as often stymied by political differences. Despite these setbacks, the Biden administration has continued to act on care in ways that don't require Congressional support, such as by including requirements that any company that receives federal funds through the Creating Helpful Incentives to Produce Semiconductors (CHIPS) Act provide affordable child care for their employees⁶⁹ and by signing an Executive Order that includes 50 directives in support of child care and long-term care.⁷⁰ Although actions by the president on care are welcome, legislation passed by Congress is what's needed for long-term, transformational change to the US's care policy landscape.

SITUATING THIS PROJECT WITHIN THE BROADER LITERATURE

This project adds to a rich base of existing literature that highlights the value of care work and the hidden workload on caregivers and care workers who belong predominantly to underserved communities. It does so by providing a comprehensive analysis of the federal UUCW policy landscape. It is the first piece of research that provides scores based on the existence and quality of a wide range of care policies at the federal level in the US.

One unique quality of this research is that it includes policies that may not intuitively be considered “direct care policies.” Specifically, the scorecard tool includes indicators for physical infrastructure (e.g., access to piped water) and labor rights and protection policies (e.g., minimum wage) that are indirectly related to caregiving and care work. The inclusion of these policies is meant to provide a holistic picture of the lives of caregivers and care workers, by showing that there is a wide breadth of policies that impact peoples’ ability to give and receive care. This research will be the first attempt to assess care policies in such a holistic way in the US.

It is important to note that other rankings of care-related policies in the US exist, although these rankings focus on state-level policies. Oxfam America’s yearly Best States to Work Index and Best States for Working Women Index examine a number of care policies, such as paid leave, and breastfeeding and pregnancy accommodations in the workplace, among others, at the state level. Additionally, the Century Foundation’s Care Policy Report Card provides a letter grade for each state based on five major policy areas: child care and early learning; home- and community-based services/long-term care; paid family and medical leave; paid sick and safe days; and fair working conditions for care workers.⁷¹ Other publications on state rankings that look at related policies include “The Status of Women in the States” by IWPR⁷² and “Expecting Better: A State-by-State Analysis of Laws That Help Working Family Caregivers” by NPWF.⁷³ Finally, Oxfam America recently launched “Where Hard Work Doesn’t Pay Off,” a report that compares the US to other Organisation for Economic Co-operation and Development (OECD) countries on many of the same policies that are examined in this report. “Where Hard Work Doesn’t Pay Off” complements this report by showing how the US compares to its economic peer nations on select care policies.⁷⁴



While this project is meant to complement these state-focused research products, this project analyzes care policies at the federal level because federal policies provide baseline requirements for states. While some states go beyond these requirements, others do not, which furthers inequality and negatively impacts the most underserved communities. A deep dive into the federal care policy landscape is crucial for advocates in order to successfully push for changes that apply to everyone in the US. We hope that by shedding light on federal policies, we prompt action.

SECTION II: RESEARCH OBJECTIVES AND QUESTIONS

This research seeks to assess the UUCW policy environment in the US using the Care Policy Scorecard Tool. This tool was developed by nine international organizations⁷⁵ as a practical tool to assess and track the extent to which government policies related to care are adopted, budgeted for, and implemented. The tool aims to serve as a monitoring and advocacy tool for countries to measure their progress on care policies and government commitments to UUCW, particularly in light of the global care crisis experienced during and in the aftermath of the COVID-19 pandemic.⁷⁶ Additionally, this tool was created to recognize UUCW as a critical part of the well-being of our societies and economies.

Taking into consideration the complexity of assessing a country policy landscape and the existence of multiple policies and criteria related to care, the Care Policy Scorecard Tool sought to be flexible in its implementation (design, objectives) and adaptable to different country contexts, at the national or subnational level.⁷⁷

For this project, the US scorecard seeks to assess the US care policy environment at the federal level by adapting and implementing the Care Policy Scorecard Framework and Tool in the US context. Specifically, the first two sections of the scorecard tool, which look at unpaid care work policy areas (care-supporting physical infrastructure, care services, social protection benefits related to care, and care-supporting workplaces) and paid care work policy areas (labor conditions and wage policies, workplace environment regulations, migrant care workers' protections, and rights to organize), were utilized. This research is built on addressing inequalities between men and women related to caregiving activities, since, as mentioned previously, women in the US are largely responsible for UUCW. Furthermore, an

intersectional lens, based mostly on race and immigration, is used to examine the ways in which women of color and immigrant women are particularly affected by the UUCW policy environment in the US.

While the US Care Policy Scorecard cannot tell us how well the US fares in the global context, it does provide an analysis of federal care policies and their impact on caregivers and care workers in the US. It does so by indicating which care policies exist at the federal level, which policies are absent, and the strengths and weaknesses of the policies that do exist. The goal of this project is to create a product that will help caregivers, care workers, advocates, policymakers, and other stakeholders have a better understanding of the federal care policy landscape in the US. Additionally, the scorecard can be used as a resource when policy advocates are pushing for the passage and implementation of missing policies or working to improve existing ones.

The research questions for this project are:

1. What is the US federal policy landscape relating to unpaid and paid care work? How have government policies related to care been designed, adopted, budgeted for, monitored, and implemented at the federal level in the US?
2. How does the design of US federal policies relating to unpaid and paid care work take into consideration the needs and challenges of and barriers faced by the most underserved communities in the design stage? How do these policies affect/impact the most underserved groups and communities?
3. What are some examples of states that passed their own policies to bridge the gap in federal policies?



Scorecard

Time to
Care

SECTION III: METHODOLOGY

OVERVIEW OF THE CARE POLICY SCORECARD

As mentioned above, the US Care Policy Scorecard includes the first two sections of the Care Policy Scorecard Tool, which is divided into three sections: Section 1: Unpaid care work; Section 2: Paid care work; and Section 3: Cross-sectoral policies. Section 3, which covers social norms regulations, was deemed less relevant to the US context and was not included in the US Care Policy Scorecard since some aspects of that section, such as media regulations, would be complicated by the legal context of the US; the US constitution and legal precedent are particularly protective of speech.

The Care Policy Scorecard Tool uses relevant policy areas, policy indicators, and assessment criteria to establish and assess the policy landscape of UUCW. As Tables 1 and 2 on the next page show, each section includes four policy areas. Section 1: Unpaid care work includes care-supporting physical infrastructure, care services, social protection benefits related to care, and care-supporting workplaces. Section 2: Paid care work includes labor conditions and wage policies, workplace environment regulations, migrant care workers' protections, and right to organize. Each policy area includes the assessment of specific policy indicators, with Section 1 containing a total of 20 policy indicators and Section 2 containing a total of 10 policy indicators. While maintaining the same overall structure of the original scorecard tool, the US Care Policy Scorecard was adapted to include two additional policy indicators: 1.4.2: Paid medical leave⁷⁸ and 1.4.7: Pregnancy accommodations.



TABLE 1. CARE POLICY SCORECARD POLICY AREAS AND INDICATORS FOR UNPAID CARE WORK

SECTION 1: UNPAID CARE WORK
POLICY AREA 1.1: CARE-SUPPORTING PHYSICAL INFRASTRUCTURE
1.1.1: Piped water
1.1.2: Household electricity
1.1.3: Sanitation services and facilities
1.1.4: Public transport
1.1.5: Time- and energy-saving equipment and technology
POLICY AREA 1.2: CARE SERVICES
1.2.1: Public healthcare services
1.2.2: Early childhood care and education (ECCE) services
1.2.3: Care services for older people
1.2.4: Care services for people with additional care needs
POLICY AREA 1.3: SOCIAL PROTECTION BENEFITS RELATED TO CARE
1.3.1: Public pension
1.3.2: Cash transfer policies related to care
1.3.3: School-based meals or food vouchers
1.3.4: Care-sensitive public works programs
POLICY AREA 1.4: CARE-SUPPORTING WORKPLACES
1.4.1: Paid sick leave
1.4.2: Paid medical leave*
1.4.3: Equal paid parental leave
1.4.4: Flexible working
1.4.5: Onsite child care
1.4.6: Breastfeeding at work
1.4.7: Pregnancy accommodations*

*New policy indicator for the US Scorecard

TABLE 2. CARE POLICY SCORECARD POLICY AREAS AND INDICATORS FOR PAID CARE WORK

SECTION 2: PAID CARE WORK
POLICY AREA 2.1: LABOR CONDITIONS AND WAGE POLICIES
2.1.1: Minimum wage
2.1.2: Gender wage gap and equal pay for equal work
2.1.3: Working hours
2.1.4: Right to Social Security
2.1.5: Child rights and labor protection
POLICY AREA 2.2: WORKPLACE ENVIRONMENT REGULATIONS
2.2.1: Occupational health and safety in the workplace
2.2.2: Protection against gender-based discrimination, harassment, and violence in the workplace
2.2.3: Workplace inspections and grievance mechanisms
POLICY AREA 2.3: MIGRANT CARE WORKERS' PROTECTIONS
2.3.1: Equal rights and protections for migrant care workers
POLICY AREA 2.4: RIGHT TO ORGANIZE
2.4.1: Right to representation and negotiation, freedom of association, and right to strike

Following the Care Policy Scorecard Tool's structure, each policy indicator is measured by an average of 18 assessment criteria with the aim to determine the existence of the policy as well as to evaluate the performance and progress of the policy in relation to its design, implementation, and impact. As indicated, the first assessment criterion for each policy indicator helps indicate whether a certain policy exists, and then is followed by criteria grouped by topic, including

legislation and ratification (Section 2: Paid care work only); accessibility and reach/inclusivity (Sections 1 and 2); budgeting and administration (Sections 1 and 2); regulation and monitoring (Sections 1 and 2); and design and impact (Sections 1 and 2). Although not all indicators have the exact same number of assessment criteria, there is a general pattern that the scoring system follows. Table 3 below provides an example of the assessment criteria for Indicator 1.2.2: Early childhood care and education (ECCE) services.

TABLE 3. CARE POLICY SCORECARD INDICATOR AND ASSESSMENT CRITERIA SAMPLE

SECTION 1. POLICY INDICATOR 1.2.2: EARLY CHILDHOOD CARE AND EDUCATION (ECCE) SERVICES			
ASSESSMENT CRITERIA	SCORE		
	YES	PARTIAL	NO
There is a national policy or policies for the provision of early childhood care and education (ECCE) services.	1	0.5	0
ACCESSIBILITY AND INCLUSIVITY			
The policy prioritizes underserved and marginalized populations, including informally employed workers.	1	0.5	0
The policy ensures ECCE services are universally available and accessible to everyone.	1	0.5	0
The policy ensures ECCE services are free/affordable for low-income groups.	1	0.5	0
The policy provides for ECCE services for all ages between birth and five years of age.	1	0.5	0
The policy recognizes the importance of ECCE services having operational hours that are practical for the paid working hours of parents and/or are at least eight hours a day.	1	0.5	0
ECCE services under this policy are reaching the most underserved areas and populations, including those likely to be marginalized.	1	0.5	0
BUDGETING AND ADMINISTRATION			
There is a federal budget allocated for this policy and/or a federal mandate for states to allocate resources towards the implementation of this policy.**	1	0.5	0
The budget allocation for this policy has risen (in real terms) since the previous budget cycle.	1	0.5	0
The budget allocated is sufficient to implement the policy (consider both direct implementation and maintenance costs, and indirect costs such as personnel and administrative costs).	1	0.5	0
> 80 percent of the allocated budget for public ECCE services is being spent (consider both direct implementation and maintenance costs, and indirect costs such as personnel and administrative costs).***	1	0.5	0
There is adequate human resources/staff for the implementation of the policy.***	1	0.5	0
ECCE services are primarily (≥ 80 percent) government funded or administered.	1	0.5	0

Following the Care Policy Scorecard Tool recommendations for adapting the scorecard to different contexts, the US Care Policy Scorecard includes assessment criteria that have been adapted as well as new assessment criteria.⁷⁹ As a result of the flexible nature of the Care Policy Scorecard Tool, and the context-specific adaptations made in the US case, the Care Policy Scorecard administered in the US is specific to the US, and can be used as a measure of US care policy landscape through federal policies and programs as well as to track federal policies over time.⁸⁰ That being said, it may still be used in future research that examines care policies at a global scale.

TABLE 3. <i>Continued</i>			
REGULATION AND MONITORING	SCORE		
	YES	PARTIAL	NO
There is a government department/unit/agency responsible for implementing the policy.	1	0.5	0
The policy includes provisions for the oversight and regulation of the quality, accessibility, and affordability of ECCE services.	1	0.5	0
The policy includes mechanisms for complaints and grievance redressal mechanisms in case of noncompliance or lack of quality provision.	1	0.5	0
The government collects and publishes disaggregated data on implementation of the policy, with indicators and targets.	1	0.5	0
The government's monitoring and evaluation system includes the impact of the policy on the well-being of caregivers and care recipients.	1	0.5	0
DESIGN AND IMPACT			
The policy was developed through consultation with representatives from underserved groups/communities [or interest groups] (i.e., women or women's rights organizations from diverse backgrounds, workers' associations, etc.).***	1	0.5	0
The policy explicitly mentions addressing unpaid or underpaid care work in the policy objectives or purpose (either to reduce or redistribute the time, cost, and labor for caregivers, and/or to improve the quality of care received; consider other terms such as domestic workers, parents, care workers for the elderly).***	1	0.5	0
There is evidence of positive impact on the reduction or redistribution of unpaid care work as a result of the policy.***	1	0.5	0
Women are equally (> 50 percent) represented in management of the specific office responsible for the monitoring and implementation of the policy.***	1	0.5	0
SCORE FOR INDICATOR 1.2.2: __/22			

**New assessment criterion for the US Care Policy scorecard.

***New language or wording for the assessment criterion for the US Care Policy Scorecard.

SCORING METHODOLOGY

In accordance with the Care Policy Scorecard Tool guidelines for completing the scorecard, the scoring is determined using a three-point scale: 1, 0.5, and 0. Assessment criteria are scored 1 if the scorer determines the assessment criteria are fully met, 0.5 if the assessment criteria are partially met, and 0 if the assessment criteria are not met. In cases where the assessment criteria were not included in the assessment of the policy landscape of the US context, the score is marked as “N/A,” and for cases where there were insufficient data to be able to score accurately, the score is marked as “INS.” Any assessment criteria marked with “N/A” or “INS” are not included in the final score.⁸¹

The policy analysis and assessment cutoff date was December 31, 2022, meaning that only policies and laws that were in effect by December 31, 2022, were included in the scoring. It is important to note that the Pregnant Workers Fairness Act (which increased protections for pregnant employees) and the Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act (which expands breastfeeding accommodations for nursing employees) were passed in December 2022 but were not or will not be enacted until 2023. Therefore, these laws were not factored into the scoring.⁸² Any future updates to the US Care Policy Scorecard will factor in these two new pieces of legislation.

Each indicator received a total score based on the possible number of points it received for all the assessment criteria over the total points it could have received for all the assessment criteria. Both a fraction and a percentage score are included. Then, all the policy area scores received a percentage score, which is the average of the percentages of each indicator within that policy area. Subsequently, each section received a percentage score, which is the average of the percentages of the policy area scores within that section. Finally, the entire scorecard was given a total percentage score, which is an average of the Section 1 (unpaid care work) and Section 2 (paid care work) percentages.⁸³

The percentage average (and not the number of points) was used to determine the score of the policy areas, Sections 1 and 2, and the overall score for the US Care Policy Scorecard. This method gave equal weight to the policy indicators, policy areas, and Sections 1 and 2. Taking into consideration that the number of potential total points of each assessment criterion may be different by indicator, we considered it inadvisable to compare just the number of points across assessment criteria, so the total points do not influence the weight of the assessment criteria within the indicator.

METHODOLOGY, DATA, AND SOURCE OF VERIFICATION OF THE US CARE POLICY SCORECARD

To score the first two sections of the US Care Policy Scorecard, first, the ND-i-Lab research team employed an iterative research process that primarily relied on desk research of federal databases and official legislative text, and analyses of secondary research sources such as policy briefs, journals, and research reports and published documents from government agencies as well as from credible research institutions not included in the official legislation. Sources of verification and rationale for the chosen score were given for each assessment criterion following the Care Policy Scorecard Tool recommendations on how to document the score (for more details, please see [Final Scorecard Tables](#)).⁸⁴

Second, to triangulate the data and fill any remaining information gaps, qualitative data were collected from interviews with 22 stakeholders and experts in the field. The interviewees were chosen based on Oxfam, NWLC, and NPWF referrals, subsequently followed by a snowball sampling method.⁸⁵ Questions for the interviews centered on assessment criteria that could not be scored through desk research and included other questions surrounding the effects of policies on underrepresented communities and states that serve as exemplars (bright spots) for the successful implementation of care policies (see bright spot section). Interview transcripts and coding were used to analyze the data collected.

Third, to enhance the robustness of the scoring, the US Care Policy Scorecard assessment followed two series of quality checks and revisions by ND-i-Lab and Oxfam America. First, the ND-i-Lab team followed intercoder reliability using a single-blind process. Furthermore, the team at Oxfam America led an internal and external revision process administered by an external consultant. This process assessed the first iteration of the US Care Policy Scorecard (completed by ND-i-Lab) by conducting further desk research and including new sources of verification, which led to a revision of the process and the scoring structure (resulting in the “scoring decisions” outlined in Appendix A), and therefore a revision of the score of some policy indicators. Through this process, the consultant raised scoring questions for internal discussion and helped determine feedback prompts for external stakeholders.

Fourth, after this internal process,⁸⁶ a validation workshop was held in March 2023, to which approximately 30 policy experts from 15 different organizations or institutions were invited. These experts reviewed specific sections of the scorecard and provided their feedback on the scoring. After including the final revisions from the validation workshop, the final report and scorecard went through the Oxfam Research Network peer-review process. (For more detail, please see Appendixes A–E).



LIMITATIONS

As mentioned in different sections of this report, the US Care Policy Scorecard included an adapted version of the Care Policy Scorecard Tool, which was not designed to be context specific but rather is a flexible tool that can be used in different country contexts. The process of this adaptation to the US context created several challenges and limitations, including:

1. Needing to refer to multiple policies for many individual indicators, creating complications when applying assessment criteria to multiple policies. For example, the team faced challenges with how to score when one policy under an indicator fulfills an assessment criterion but another policy that is also relevant to that indicator does not. Additionally, it is a challenge to score individual policies when multiple policies are associated with an indicator. For example, the 1.3.3: School-based meals or food vouchers indicator includes the National School Lunch Program, the Women, Infants and Children (WIC) program, the Child and Adult Care and Food Program (CACFP), the Supplemental Nutrition Assistance Program (SNAP), and others, so the scoring for that indicator applies to all those programs when looked at together, rather than being an evaluation of each individual program separately.
2. A lack of assessment criteria that could have more thoroughly reflected nuances within the US policy landscape. For example, in the US budgets are mandatory or discretionary, which has implications for whether budgets for policies and programs are guaranteed from year to year in the US context. However, the assessment criteria didn't include any questions on discretionary versus mandatory spending, making it necessary to determine a scoring decision on this matter.

3. Difficulty in scoring indicators where states have a big role to play in implementing and funding associated policies. For example, the US scorecard was not able to fully capture the fact that the implementation of certain policies (i.e., child care, Medicaid, etc.) varied drastically from state to state because of the freedom states are given in federal program implementation. When applicable, a discussion is included to highlight state discrepancies, but the scores themselves cannot always reflect the realities of how access to and coverage of federal policies and programs is dependent on which state an individual lives in.

To respond to these challenges, the scorecard tool was lightly adapted to better reflect the US context, and some scoring decisions were established to allow for consistent scoring for assessment criteria that became complicated to score (please see full list of scoring decisions and methodology in Appendix A). To preserve the major components of the tool and methodology, a limited number of changes were made.

Additionally, due to the types of policies the organizations leading on this tool work on, the experts invited to participate in interviews and in the validation workshop largely work on issues related to care services, care-related work policies, and other labor laws and protections. This means that we were not able to rely on the same level of external validation and feedback on other policies such as, for example, physical infrastructure policies. Finally, our interviews and validation workshop participants largely came from the civil society and nongovernmental sector.

Please refer to the limitations section in the Appendix F for more details.

SECTION IV: SCORECARD RESULTS AND MAIN FINDINGS

US CARE POLICY SCORECARD RESULTS

OVERALL SCORING AND GENERAL TRENDS

As observed in Table 4, the US receives an aggregate score of 43 percent. Section 1: Unpaid care work obtained a slightly higher score (45 percent) than Section 2: Paid care work (41 percent).

In other words, the US overall meets less than half of all possible criteria when all care policy indicators are examined and aggregated. These percentages don't just take into account the existence of policies, but also their accessibility and reach, budget and administration, regulation and monitoring, and design and impact. These scores paint a grim picture of an inadequate care policy landscape in the US and indicate that the needs of caregivers and care workers are by and large not being met by federal policies.

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Out of the 30 policy indicators within the two sections of the scorecard, 7 scored 0 percent because there were no federal policies associated with those policy indicators at the time of the assessment. All 7 of these policy indicators are in Section 1 (unpaid care work) of the scorecard. When only looking at the

TABLE 4. OVERALL SCORING AND GENERAL TRENDS

SECTION 1: UNPAID CARE WORK	
	AVG. SCORE
Policy area 1.1: Care-supporting physical infrastructure	61%
Policy area 1.2: Care services	59%
Policy area 1.3: Social protection benefits related to care	52%
Policy area 1.4: Care-supporting workplaces	7%
SECTION 1 TOTAL SCORE	45%
SECTION 2: PAID CARE WORK	
Policy area 2.1: Labor conditions and wage policies	51%
Policy area 2.2: Workplace environment regulations	47%
Policy area 2.3: Migrant care workers' protections	24%
Policy area 2.4: Right to organize	43%
SECTION 2 TOTAL SCORE	41%
TOTAL COUNTRY SCORE	43%

existence of federal policies, 12 out of the remaining 23 policy indicators receive a partial score of 0.5,⁸⁷ meaning that there are federal policies that only partially meet these assessment criteria. Out of the 12 that received a partial score, 4 policy indicators are in Section 1 (unpaid care work), and 8 policy indicators are in Section 2 (paid care work). Eleven out of 30 policy indicators receive a full score of 1.⁸⁸ This means policies fully exist for only about one-third of the policy indicators in the US Care Policy Scorecard, while two-thirds of the policy indicators either didn't have any policies associated with them or were only partially met by federal policies. So, even when only examining whether crucial federal UUCW policies exist, it is clear that more needs to be done to pass UUCW policies that fully meet care needs.

When observing the overall scores of the US Care Policy Scorecard by policy areas and related indicators, we can determine that, generally, the US does best in terms of care-supporting infrastructure (61 percent), care services (59 percent), and social protection benefits (52 percent). This means that the federal government has stronger policies tied to ensuring people have access to piped water, electricity, sanitation services, and public transportation and that many of the assessment criteria for care and social protection policies and programs such as Medicare, Medicaid, Title XIX of the Social Security Act, and the National School Lunch and Breakfast Programs were met. With physical infrastructure scoring the highest across the scorecard, it is notable that it is the policy area that is likely least directly associated with caregiving that performs the best in the US. The US scored the worst in terms of policies related to supporting caregivers in the workplace; these policies are extremely limited.

As a trend, for all policy indicators where policies do exist, the US appeared to perform best on the assessment criteria focused on regulation and monitoring, indicating that policies are usually accompanied by government structures to ensure their implementation and monitoring. Moreover, mechanisms for grievance redressal, and data collection and publication for care-supporting programs and policies partially exist.

By contrast, the US appears to score worst on the assessment criteria tied to legislation and ratification (only relevant for Section 2: Paid care work), and accessibility and reach/inclusivity. For unpaid care policies (Section 1: Unpaid care work), this score means that, when policies do exist, they are often not universally accessible, especially for key underserved groups, such as low-income families, informally employed workers, and others. For paid care policies (Section 2), this score is reflective of the fact that federal US labor laws often exclude several types of workers, including some care and all informal workers. As will be examined further in this section, these findings highlight a system of inequity within

HOW DOES THE US COMPARE TO OTHER NATIONS?

The US Care Policy Scorecard doesn't include a comparison of the US's UUCW policies to other nations, but a recently launched Oxfam America report, [*"Where Hard Work Doesn't Pay Off: An Index of US Labor Policies Compared to Peer Nations,"*](#) compares the US to other OECD countries—countries that are considered economic peers—on some of the care policies that are examined in the scorecard. The report shows that, when it comes to wages, workers protections, and rights to organize, the US is at the bottom of the pack.

Under the wages dimension, the report explores a wide set of minimum wage and unemployment support policies. Most relevant to the US Care Policy Scorecard, *"Where Hard Work Doesn't Pay Off"* examines whether a minimum wage exists, whether domestic workers are included in the minimum wage standard, and whether the minimum wage is a livable wage. Across the entire wage pillar, the US ranks 36th out of 38 OECD countries. Under the worker's protections pillar, the policies explored include equal pay, protection from sexual harassment, identity protections, healthcare availability, paid leave, child care support, working schedule protections, and pregnancy accommodations. Across this entire worker's protections dimension, the US ranks dead last. Most notably, the report illustrates how the US doesn't require that workers receive a single day of paid leave, while all other OECD nations measure their paid leave guarantees in weeks. And finally, under the rights to organize dimension, workers' ability to collectively bargain is examined. Under this dimension, the US ranks 32nd out of 38 nations.

Although *"Where Hard Work Doesn't Pay Off"* can't demonstrate how the US compares to other countries on all the indicators examined in the scorecard, it does illustrate the ways in which the US is behind its economic peer nations on passing many federal policies that facilitate people's ability to give and receive care.

	WHERE THE US DOES BEST:	WHERE THE US DOES SOMEWHERE IN THE MIDDLE:	WHERE THE US DOES WORST:
ASSESSMENT CRITERIA	Regulation and monitoring	Budget and administration Design and impact	Legislation and ratification (Section 2: Paid care work) Accessibility and reach/ inclusivity

the US federal care policy landscape that is tied to income, race, and immigration and employment status. The chart above shows how the US performs on various assessment criteria.

Assessment criteria tied to budget and administration, and design and impact receive scores somewhere in the middle. The major gaps under budget and administration are tied to the fact that, for unpaid care policies, not all eligible individuals are able to access care services due to inadequate funding, while for paid care policies, limited budgets and human resourcing prevent the government from fully implementing the policies. Additionally, many of the policies included in the scorecard rely on discretionary funds, meaning that funding amounts are subject to change each year based on who's in power. As opposed to policies funded by mandatory spending, this also means that budgets for these policies aren't set based on need. Lower scores for design and impact assessment criteria indicate that many of these policies were not designed in a consultative manner, or with care needs in mind. Interviewees noted that many of the policies examined in this scorecard were proposed and passed during an era wherein equity concerns were less of a priority. By contrast, in policies passed in recent years, some lawmakers have made more of an effort to consult relevant stakeholders as bills are designed.

SECTION 1: UNPAID CARE WORK

With an average score of 45 percent for all the indicators for unpaid care work policies (Section 1), Section 1 overall performs better than Section 2 (paid care work). Section 1 includes both the highest- and the lowest-scoring indicators for the entire scorecard. The highest scoring policy areas are care-supporting infrastructure (61 percent) and care services (59 percent), and the highest scoring indicators are school-based meals or vouchers (83 percent), public pension (76 percent), and sanitation services and facilities (71 percent).

Despite the higher scores for many of the policy indicators in Section 1 (unpaid care work), the average score for this section was driven down because of the care-supporting workplaces policy area, which received an average score of only 7 percent, making it the worst-performing policy area across the entire

scorecard. Six indicators out of seven within this policy area scored a 0 (policies do not exist), including paid sick leave, paid medical leave, equal paid parental leave, flexible working, onsite child care, and pregnancy accommodations. This finding is a particularly alarming indication that there are few federal protections that allow paid workers to juggle caregiving responsibilities at home and work responsibilities.

Policy indicators in Section 1 (unpaid care work) scored the best among regulation and monitoring assessment criteria and scored the lowest among the accessibility and reach assessment criteria, closely followed by the design and impact, and budget and administration assessment criteria.

1.1. CARE-SUPPORTING PHYSICAL INFRASTRUCTURE

This policy area centers on physical infrastructure policies that impact people's ability to give and receive care. This area includes policies regarding piped water and electricity access, sanitation services, public transport, and time- and energy-saving equipment. Care-supporting physical infrastructure is crucial to reducing the amount of time spent on care, which decreases drudgery and frees up time to be spent on other activities such as working outside of the home, attending school, and leisure.



With a score of 61 percent, this area is the highest-scoring policy area in the scorecard. As Table 5 shows, the highest-scoring policy indicators in this section are sanitation services and facilities (71 percent), piped water (68 percent), and household electricity (66 percent). The lowest-scoring policy indicators are time- and energy-saving equipment and technology (55 percent), and public transport (45 percent). The policies associated with these indicators include the 1974 Safe Drinking Water Act (SDWA), Title 24 Housing and Urban Development of the Code of Federal Regulations (CFR), the 2005 Energy Policy Act, and the 1972 Clean Water Act. The high score for the care-supporting physical infrastructure policy area isn't surprising when considering the most-recent negotiations around BBB and IJA. As mentioned in the background section, the BBB Act, which would have addressed issues such as child care and paid leave, was unable

to pass Congress, while IIJA, a large-scale investment in the US’s physical infrastructure, was. During this bill’s negotiating period, a public debate around what should be considered “infrastructure” arose; care policy advocates and some Democrats argued that child care, paid leave, and long-term care services should count as infrastructure^{89, 90, 91} while many Republicans rejected^{92, 93, 94} — and sometimes even ridiculed⁹⁵—that idea.

All these policies scored highest among the regulation and monitoring, and budget and administration assessment criteria, with accessibility and reach assessment criteria scoring a bit lower. Household electricity and sanitation services and facilities scored particularly high among the accessibility and reach categories, indicating that associated policies and programs have widespread reach. However, the scorecard doesn’t adequately reflect the ways in which there are wide disparities—often based on race and income levels—in access to these services due to municipal and state funding for and implementation of some physical infrastructure services. Perhaps the starkest example of this is the almost decade-long water crisis that occurred in Flint, Michigan, an area of the state that is majority Black,⁹⁶ when the city’s water supply was switched to save costs. After lack of action by the government despite repeated complaints by residents, Michigan state officials were ultimately blamed for inaction,⁹⁷ leading to federal charges against eight state officials and one city official, including for “neglect of duty,” “misconduct in office,” and violating Michigan’s Safe Drinking Water Act.⁹⁸ The Michigan Civil Rights Commission points to systemic racism as a factor in the government’s response to the Flint water crisis.⁹⁹

Public transport scored much lower than the other criteria among the accessibility and reach criteria, likely due to the fact that public transportation projects are concentrated in urban areas, meaning 45 percent of Americans don’t have access to public transportation.¹⁰⁰ Additionally, at the federal level there isn’t any mandate to provide free public

**TABLE 5. POLICY AREA 1.1:
CARE-SUPPORTING PHYSICAL INFRASTRUCTURE**

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
1.1: CARE-SUPPORTING PHYSICAL INFRASTRUCTURE		61%
1.1.1: Piped water	13/19	68%
1.1.2: Household electricity	12.5/19	66%
1.1.3: Sanitation services and facilities	13.5/19	71%
1.1.4: Public transport	8.5/19	45%
1.1.5: Time- and energy-saving equipment and technology	10.5/19	55%

WHY INCLUDE PHYSICAL INFRASTRUCTURE IN THE US CARE POLICY SCORECARD?

Physical infrastructure projects, such as piped water, electricity, and public transportation, are important for reducing the amount of time required for, and the intensity of, many unpaid care work tasks, such as cooking, bathing, taking kids to school, and grocery shopping. The importance of basic physical infrastructure to care and domestic work is widely recognized by different studies, programs, and international agreements and conventions such as the Sustainable Development Goal (SDG) 5 and International Labour Organization (ILO) Convention 156.¹⁰¹ The Care Policy Scorecard Tool acknowledges that this policy area is most relevant for low- and middle-income countries as well as low-income communities in the Global North.¹⁰² Although the US is known as a highly industrialized nation that has a relatively strong physical infrastructure, the inclusion of physical infrastructure policies in the scorecard serves several purposes:

1. It explicitly makes the link between caregiving and physical infrastructure, which are two issue areas that aren’t commonly associated with each other in US care policy advocacy circles.
2. It allows for a discussion around inequality in access to physical infrastructure services, particularly for communities of color, low-income communities, rural populations, and Native Americans.
3. It points to the way in which physical infrastructure is a considerably more popular and more bipartisan policy area compared to other UUCW policy areas.
4. It ensures consistency and accuracy of the assessment of Section 1 (unpaid care work).¹⁰³

transportation for low-income individuals. The area in which these policy indicators underperformed, and even received 0s (public transportation, and time- and energy-saving equipment and technology), was the design and impact section, meaning that infrastructure policies in the US frequently excluded women in their development, they lack a care-centered focus in the policy language, and women were not equally represented in the management and governance structures that are responsible for physical infrastructure policies and programs. As was mentioned earlier, the reason could be that many physical infrastructure policies in the US were designed several decades ago, when consultation and equity in policy design was less of a concern.

1.2 CARE SERVICES

This policy area of the scorecard includes policies surrounding the availability of direct care services, such as public health care, early childhood care and education (ECCE), care services for the elderly, and care services for people with additional care needs. The availability and accessibility of care services are major factors in the redistribution and reduction of care. Ensuring that care is available outside of the home redistributes care from unpaid family members to paid caregivers, who receive training and are compensated for their time.



As observed in Table 6 below, this policy area received a score of 59 percent. The highest-scoring indicators in this section were care services for older people (68 percent) and ECCE services (57 percent), and the lowest-scoring indicator was care services for people with additional care needs (50 percent). Policies associated with these indicators include the Affordable Care Act (ACA), Head Start, Child Care and Development Block Grant (CCDBG), Medicare, and Title XIX of the Social Security Act (Medicaid). Out of all indicators asking about a policy’s existence, the public health care service and the care for older people indicators received less than a full score, since only certain populations (e.g., military veterans) benefit from access to public healthcare in the US and because long-term care is absent from Medicare and not universal under Medicaid. Additionally, as is discussed further below, these scores don’t adequately reflect the ways in which state flexibility in administering federal programs and states’ rights to reject federal funding hinder access, perhaps leading to scores within this policy area that are higher than is warranted.

Overall, the policies in this section scored strongly in regulation and monitoring, and design and impact but had mixed results under accessibility and reach and low results under budget and administration. None of the programs in this section are universally accessible, many only somewhat prioritize underserved groups, and affordability for low-income

groups isn’t always guaranteed. In fact, Policy indicator 1.2.4: Care services for people with additional needs didn’t receive a single point under any of the accessibility and reach criteria. A deeper look at Medicaid, a federal program relied upon by the elderly, people with disabilities, and low-income individuals, can provide insight into how federal programs that are meant to reach the most underserved communities often fall short. Medicaid is jointly funded by the federal and state governments, and states have flexibility in how they administer Medicaid, meaning Medicaid benefits are not uniform across the US.¹⁰⁴ Most notably, there are 10 states that have not adopted the Affordable Care Act Medicaid expansion,¹⁰⁵ which would have given them additional federal funds to provide Medicaid coverage to more low-income individuals.

Interviewees also highlighted lack of adequate funding as a major limitation for many of these policies, including for the ACA, Medicare, Medicaid, and CCDBG. This lack of adequate funding means that many people who are in need of these services can’t access them because there is insufficient funding behind these policies. For example, in 2019, only one in nine eligible kids received CCDBG support,¹⁰⁶ which is why the ECCE indicator scored the lowest under the budget and administration assessment criteria. One additional challenge that is not captured by the scorecard is that lack of adequate pay is causing a labor shortage in these sectors, further limiting accessibility. This is particularly true for the child care and early learning sector¹⁰⁷ and for home health aides¹⁰⁸ who support the elderly and people with disabilities.

TABLE 6. POLICY AREA 1.2: CARE SERVICES

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
1.2: CARE SERVICES		59%
1.2.1: Public healthcare services	11.5/19	61%
1.2.2: Early childhood care and education (ECCE) services	12.5/22	57%
1.2.3: Care services for older people	13.5/20	68%
1.2.4: Care services for people with additional care needs	10/20	50%

CAREGIVING AND ABORTION RIGHTS

There is a question in the scorecard under the public healthcare indicator about whether the existing policy includes the provision of sexual and reproductive healthcare services, but neither the original scorecard tool nor the US Care Policy Scorecard include any stand-alone policies on reproductive and sexual rights. During the research phase of this project, the 1973 Supreme Court decision *Roe v. Wade* was overturned, which rescinded the federal right to an abortion. This decision means that states can and have restricted or even eliminated people's ability to get abortions for unwanted or dangerous pregnancies. As a person's ability to control how many children they have has a tremendous impact on their caregiving responsibilities, it is important to note that this new federal policy decision will have wide-reaching impacts for caregivers now and for years to come. This reality isn't reflected in the current US Care Policy Scorecard. Future iterations of the scorecard should consider adding a stand-alone indicator on federal reproductive and sexual rights protections.

1.3 SOCIAL PROTECTION BENEFITS RELATED TO CARE

This policy area of the scorecard includes policies related to care and social protection benefits, such as public pension policies, cash transfer policies related to care, school-based meals or food vouchers, and care-sensitive public works programs. Social protection benefits are associated with the well-being of both care receivers (in the case of school-based food programs) and caregivers (as is the case with care-sensitive public works programs) as they support people's ability to receive and give care.



This policy area obtains the second-lowest scoring within the unpaid care work section of the US Care Policy Scorecard with an overall score of 52 percent. As observed in Table 7 below, the policy indicator for care-sensitive public works programs scored a 0 percent because no such policies exist at the federal level in the US. The highest-scoring indicator in this section is public pension (76 percent) and school-based meals or food vouchers (83 percent), which focuses on many policies, including the National School Lunch Program, School Breakfast Program, WIC, and SNAP.

However, even for these two indicators, there are some important gaps. For example, the US Social Security program doesn't apply to informal workers,¹⁰⁹ and it wasn't designed to be the only source of income for retired workers.¹¹⁰ The participation rate for SNAP is 74 percent among the working poor according to the US Department of Agriculture (USDA),¹¹¹ while the WIC coverage rate hovers between 50–60 percent, meaning around half of people who are eligible don't participate.¹¹²

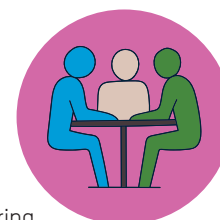
For Policy indicator 1.3.2: Cash transfer policies related to care, which receives a score of 50 percent, the US Scorecard looks at the federal child tax credit (CTC) and the child and dependent care tax credit (CDCTC). The major gaps with these policies, as they relate to the scorecard's assessment criteria, are that these tax credits are not fully refundable, meaning they only apply to families that have a certain amount of income, and the amount of the tax credits does not meet the care costs of families.^{113, 114, 115} These examples help illuminate why this section scored the worst among the accessibility and reach, and design and impact assessment criteria.

TABLE 7. POLICY AREA 1.3: SOCIAL PROTECTION BENEFITS RELATED TO CARE

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
1.3: SOCIAL PROTECTION BENEFITS RELATED TO CARE		52%
1.3.1: Public pension	16/21	76%
1.3.2: Cash transfer policies related to care	10/20	50%
1.3.3: School-based meals or food vouchers	16.5/20	83%
1.3.4: Care-sensitive public works programs	0/22	0%

1.4 CARE-SUPPORTING WORKPLACES

This policy area focuses on workplace benefits, and scores policies focused on paid sick leave, paid medical leave, equal paid parental leave, flexible working, onsite child care, pregnancy accommodations in the workplace, and breastfeeding accommodations. This scoring determines the extent to which workplace policies support employees who are caregivers, particularly people who are able to give birth. Adequate workplace support is crucial to ensuring that paid work doesn't harmfully interfere with people's ability to give care and that those who engage in unpaid caregiving in the home are able to enter and remain in the paid workforce.



This policy area obtained the lowest scores within the unpaid care work section, earning a score of 7 percent. As observed in Table 8 below, out of the seven policy indicators that scored a 0 percent in the scorecard, six of them were part of this policy area. The only indicator that received a score above 0 percent was breastfeeding at work (46 percent). This indicator scored very high among the design and impact, and regulation and monitoring assessment criteria, but very low among the accessibility and reach criteria and didn't receive a point for the one budget and administration criterion that was included.

A lack of federal policies on issues such as paid leave has a detrimental impact on the most underserved groups and further contributes to inequality. Recent research has shown that access to paid leave is lowest among the following groups: low-wage workers, part-time workers, Black workers, and Latinx workers.¹¹⁶ Additionally, workers with access to paid leave are less likely to experience financial hardships.¹¹⁷ This means that federally mandated paid sick and paid family and medical leave would benefit many underserved communities the most.

As mentioned earlier, by the time this report is published, two new policies will have been enacted at the federal level that did not exist when the research for this scorecard was completed: the Providing Urgent Maternal Protections (PUMP) for Nursing Mothers Act, and the Pregnant Workers Fairness Act (PWFA). The PUMP Act—which went into effect on January 1, 2023—requires workplaces to ensure breastfeeding accommodations for employees, while the Pregnant Workers Fairness Act—which went into effect on June 27, 2023—gives pregnant employees rights to reasonable accommodations in the workplace. The scores within this subsection of the scorecard would be higher if these two bills had been in effect before the policy cutoff date for this research.

TABLE 8. POLICY AREA 1.4: CARE-SUPPORTING WORKPLACES

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
1.4: CARE-SUPPORTING WORKPLACES		7%
1.4.1: Paid sick leave	0/21	0%
1.4.2: Paid medical leave	0/21	0%
1.4.3: Equal paid parental leave	0/23	0%
1.4.4: Flexible working	0/16	0%
1.4.5: Onsite child care	0/20	0%
1.4.6: Breastfeeding at work	6.5/14	46%
1.4.7: Pregnancy accommodations	0/16	0%

SECTION 2: PAID CARE WORK

The highest-scoring policy area within Section 2 (paid care work) is labor conditions and wage, with a score of 51 percent. The worst-performing policy area is migrant care workers' protection, which includes a single indicator that receives a 24 percent score. No policy indicator within this section received a score of 0 percent, but, as mentioned previously, 8 out of the 10 policy indicators in this section don't receive full credit for having federal policies that apply to the indicator. In other words, most of the policy indicators' assessment criteria in this section aren't fully reflected in federal policies. This means that paid workers—particularly paid care workers—are not fully protected by federal labor laws, and the scorecard shows the ways in which this is particularly the case for certain workers who are overrepresented by women of color.

Policy indicators in Section 2 scored the best among regulation and monitoring assessment criteria, and scored the lowest among the accessibility and inclusivity, and legislation and ratification assessment criteria.

2.1 LABOR CONDITIONS AND WAGE POLICIES

This policy area includes policies focused on ensuring humane working conditions and wages for all workers, but particularly for paid care workers. The indicators in this section include policies on national minimum wage, equal pay, working hours, Social Security, and child labor protections. Adequate working conditions and wages ensure that the rights of paid care workers are protected and that all workers can receive fair wages and experience labor conditions that support their ability to give care.



As observed in Table 9 below, the highest-scoring indicator is child rights and labor protections (56 percent). This indicator is also the only one within this policy area that receives full credit for having a national policy that's applicable. The remaining four policy indicators have federal policies that are only somewhat applicable. These scores mean that, even though there are federal policies on labor conditions and wages in the US, there are major gaps. Specifically, the policy indicators in this section scored the lowest among the accessibility and inclusivity, and legislation and ratification criteria, highlighting the ways in which care workers are particularly left out of labor conditions and wage policies. For example, although there is a national minimum wage, it doesn't apply to all workers¹¹⁸ and is not considered a living wage.¹¹⁹ Additionally, although there is an equal pay for equal work law, it doesn't cover equal pay for work of equal value, and not all employers are required to

publish pay information.¹²⁰ Moreover, many workers are also left out of policies that guarantee working hour regulations and from receiving Social Security benefits.

The design and impact, and budget and administration assessment criteria received mixed results; first, indicating that these policies weren't designed with care workers and caregivers in mind, and second, highlighting the need to put more funding and human resources behind these policies. For example, interviews revealed that underfunding of the Equal Employment Opportunities Commission (EEOC) has prevented it from enforcing equal pay for equal work laws and that the DOL's Wage and Hour Division (WHD) received significantly less money than it sought in 2022.¹²¹

**TABLE 9. POLICY AREA 2.1:
LABOR CONDITIONS AND WAGE POLICIES**

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
2.1: LABOR CONDITIONS AND WAGE POLICIES		51%
2.1.1: Minimum wage	9/18	50%
2.1.2: Gender wage gap and equal pay for equal work	7/15	47%
2.1.3: Working hours	8.5/16	53%
2.1.4: Right to Social Security	10/20	50%
2.1.5: Child rights and labor protection	9/16	56%

2.2 WORKPLACE ENVIRONMENT REGULATIONS

This policy area focuses on workplace environment regulations such as occupational health and safety in the workplace, protection against gender-based discrimination, harassment, and violence, and inspection and grievance mechanisms. Like labor conditions, stringent workplace regulations provide legal protections for paid care workers and make legal avenues available for workers to advocate for their rights if an employer violates them.



As Table 10 indicates, this policy area scored 47 percent. All three policy indicators in this section received similar scores that range from 43 percent to 53 percent. Indicators in this section focused on the 1970 Occupational Safety and Health Act and Title VII of the 1964 Civil Rights Act. These policies scored best in regulation and monitoring and scored low on

budgeting and administration, and accessibility and inclusivity assessment criteria. This scoring signifies that budgets for policies surrounding workplace regulations are inadequate. This conclusion was confirmed in interviews conducted, where the Occupational Safety and Health Administration (OSHA) under the Department of Labor was particularly mentioned as an entity that was underresourced. In 2021, there were only 1,719 OSHA inspectors to inspect over 10 million workplaces,¹²² which means it would take over 160 years for OSHA to visit all workplaces.¹²³

Additionally, for the accessibility and inclusivity assessment criteria, all the policy indicators in this section scored a 0 for the assessment criterion on whether the policy applied to all workers. OSHA doesn't apply to self-employed workers, independent contractors, and informal workers.¹²⁴ Notably, self-employed workers and contractors are most likely to be Black and Hispanic/Latinx rather than white and slightly more likely to be women.¹²⁵ Additionally, Title VII only applies to workers who work for employers with 15 or more employees.¹²⁶ This scoring highlights that the US's current workplace regulation laws are not designed to meet the needs of the most underserved communities.

**TABLE 10. POLICY AREA 2.2:
WORKPLACE ENVIRONMENT REGULATIONS**

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
2.2: WORKPLACE ENVIRONMENT REGULATIONS		47%
2.2.1: Occupational health and safety in the workplace	8/18	44%
2.2.2: Protection against gender-based discrimination, harassment, and violence in the workplace	10/19	53%
2.2.3: Workplace inspections and grievance mechanisms	6.5/15	43%

2.3 MIGRANT CARE WORKERS' PROTECTIONS

This policy area includes only one policy indicator, focused on equal rights and protections for migrant care workers. Many household care workers in the US are migrants, so analyzing policies that protect migrant workers is integral to understanding whether the care landscape is equitable.



The sole policy indicator in this section, 2.3.1: Equal rights and protections for migrant care workers, received a score of 24 percent. This indicator is associated with the Immigration and Nationality Act, OSHA, FLSA, and the DOL Migrant and Seasonal Agricultural Worker Protection Act (MSPA). This policy indicator scored the best in regulation and monitoring and the worst in accessibility and inclusivity, and legislation and ratification. No credit was given for any of the indicators under the latter two assessment criteria. This is in part because the Immigration and Nationality Act doesn't have special language for migrant care workers, and OSHA and FLSA do not apply to informal or self-employed migrant care workers.¹²⁷ Additionally, work authorization under the Immigration and Nationality Act is issued pursuant to an individual's immigration status; workers whose immigration status is work-related must often depend on individual employers for their work permits.¹²⁸ This policy indicator also scored very low among design and impact, and budget and administration assessment criteria. Recent requests by the Biden administration for funding for caseload and backlog reductions¹²⁹ indicate that funding thus far to implement this policy has been insufficient. The scores for this policy indicator show that no policies exist that provide adequate protection for migrant care workers. See Table 11 for scores for this indicator.

TABLE 11. POLICY AREA 2.3: MIGRANT CARE WORKERS' PROTECTIONS

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
2.3: MIGRANT CARE WORKERS' PROTECTIONS		24%
2.3.1: Equal rights and protections for migrant care workers	4/17	24%

2.4 RIGHT TO ORGANIZE

This final policy area also includes only one policy indicator, focused on allowing all workers the right to organize. The policies that protect this right grant care workers access to the leverage needed to pressure employers into meeting the needs of their workers and to bargain for collective action in case of workplace discrimination.



The sole policy indicator, 2.4.1: Right to representation and negotiation, freedom of association, and right to strike, scored 43 percent. This section focused on the 1935 National Labor Relations Act (NLRA), which was given only partial credit for being a federal policy that gives all workers the right to join co-operatives, trade unions, and workers associations. The policy scored the best in regulation and monitoring and the worst in accessibility and inclusivity, and legislation and ratification. No credit was given for any assessment criteria under these latter two categories. This is in large part because the NLRA excludes a lot of workers. Often these are workers who are already marginalized, including domestic workers not employed through an agency and other self-employed workers.¹³⁰ The impact of the deficiencies of this policy play out in the fact that men workers are more likely to be union members than women workers, and Asian and Hispanic workers are least likely to be union members.¹³¹ Additionally, the NLRA lacks intention to address discrimination around the right to representation, and the National Labor Relations Board (NLRB), which is responsible for implementing the NLRA, does not include equal representation of women in management. Importantly, Congress hasn't increased funding for the NLRB since 2014, and the number of staffers in the agency has dropped by 30 percent since 2010.¹³² This lack of financial and human resourcing threatens the NLRB's ability to enforce the NLRA, which is further indication that right-to-organizing laws in the US must be strengthened and well-funded. See Table 12 for scoring for this indicator.

TABLE 12. POLICY AREA 2.4: RIGHT TO ORGANIZE

POLICY AREA/POLICY INDICATOR	NUMERIC SCORE	PERCENTAGE SCORE
2.4: RIGHT TO ORGANIZE		43%
2.4.1: Right to representation and negotiation, freedom of association, and right to strike	6.5/15	43%

STATE BRIGHT SPOTS

The third research question explored in this project pertains to the ways in which US states have passed their own care policies in response to inadequate or absent federal care policies. While there are many states that serve as examples, this section will focus on California, New York, and Washington.¹³³ These three states also rank high in Oxfam America's 2022 Best State to Work Index¹³⁴ and the 2022 Best States for Working Women Index,¹³⁵ which both look at several of the same policies as the US Care Policy Scorecard. Additionally, these three states received among the top grades the Century Foundation's care report card¹³⁶ and NPWF's working caregiver's state scorecard.¹³⁷

It is important to note that this focus on states does not mean the role of the federal government within this sphere should be overlooked. A lack of federal government leadership on key policies further exacerbates inequality across the nation, as not everyone is protected and supported by the same laws. Additionally, many of the state care policies and programs are at least partially supported by federal funding. For example, Michigan, New Mexico, New York, North Carolina, Ohio, Utah, and Vermont were able to implement more transformative child care policies using federal child care funding. Thus, synergy and coordination between states and the federal government is key for creating and implementing transformative care policies.

1. California

California has strong state-level policies for a wide range of areas examined by the scorecard. For piped water, California is the first state to attempt to enshrine the right to water within its constitution, which ensures access to potable, affordable piped water to everyone in the state.¹³⁸ California also has a paid family leave policy that provides up to eight weeks of paid leave to caregivers caring for a sick child, bonding with a new child, or other qualifying events.¹³⁹ Payment includes up to 70 percent of a caregiver's pay, which is lower than the 100 percent recommended by most paid leave advocates but certainly better than the nonexistent federal paid leave policy.¹⁴⁰ California's approach to child care is comprehensive in its consideration of children from different backgrounds, including children who are unhoused, children whose native language is not English, and children whose families have been impacted by the justice system.¹⁴¹ Additionally, California has moved towards intentional employment of multilingual child care workers.¹⁴² The state also has its own Department on Aging, which recently released its state master plan on aging, which includes a goal on "caregiving that works."¹⁴³ A target within that goal is to have one million high-quality caregiving jobs.¹⁴⁴ Additionally, unionization in California has increased in the last 10 years, with a 2022 rate of 16.1 percent, which is higher than the average across the US.¹⁴⁵

2. New York

New York is a bright spot in OSHA and home-based care legislation, reflected in New York's Consumer Directed Personal Assistance Program (CDPAP), which allows people requiring home-based care services to hire caregivers of their choice, including family members or friends.¹⁴⁶ This program means that family members or friends who traditionally fulfilled unpaid care work needs can be compensated for their services. New York has also passed a bill of rights for domestic workers and has developed a fact sheet on these rights in 16 different languages.¹⁴⁷ It is also one of only three states (including California) that provides supplemental credits for CTC and CDCTC, and one of only two states that offer full refundability for these tax credits.¹⁴⁸ Along with several other states, New York has passed legislation that requires employers to provide reasonable accommodations for pregnant workers and breastfeeding workers that go beyond federal legislation (prior to the passage of the PWFA and PUMP Act).¹⁴⁹

3. Washington

Washington State has the only state-based Long-Term Services and Supports (LTSS) policy, also known as the Washington Cares Fund, for aging adults. It's a payroll tax that everyone pays into and can then access for long-term elderly care support. The premium rate is 0.58 percent or 58 cents per \$100 of earnings, and the employer must collect these premiums from employees through payroll deductions and remit the amounts collected to the Employment Security Department (ESD).¹⁵⁰ Workers' contribution to the fund can earn them a lifetime benefit of up to \$36,500 (adjusted for annual inflation).¹⁵¹ Washington is also ranked as the best state for child care wages, when ranked by cost of living.¹⁵² Alongside California, it's one of six states that has eliminated the tipped minimum wage,¹⁵³ meaning tipped employees in Washington make a minimum of \$14.49 per hour, the same as other workers in the state.¹⁵⁴ Furthermore, Washington has the highest wage-to-cost-of-living ratio, and wages are automatically increased each year to match inflation.¹⁵⁵ Finally, along with many other states, local governments can set minimum wages at a rate higher than the state standard.¹⁵⁶

SECTION V: RECOMMENDATIONS AND CONCLUSION

RECOMMENDATIONS

The US Care Policy Scorecard exposes the ways US federal policies fail to meet the needs of all working families, caregivers, and care workers. This section includes recommendations for how to improve the care policy landscape at the federal level in the US. The following recommendations do not address all the policy areas and policy indicators that are included in the scorecard—rather, they reflect the policy areas that are priorities for Oxfam America, NWLC, and NPWF and are seen as most critical for supportive caregiving and care work.

Broadly, we recommend that all US federal policies center the most underserved communities, particularly women of color and immigrant women. When policies are developed for those who have historically been excluded or overlooked, we have a greater chance of tackling the injustices of poverty, inequality, racism, and sexism. Below are more specific steps the US federal government should take to support caregivers and care workers. These recommendations serve as a roadmap for policymakers and civil society organizations hoping to support caregiving and care work in the US.

Pass federal policies that support caregivers in the workplace: paid sick leave, paid parental leave, paid medical leave, and flexible working.

The scorecard revealed that the US does the worst in terms of policies that support caregivers in the workplace, highlighted by the fact that there is no form of paid leave at the federal level. In order to ensure that individuals who work outside the home are able to provide care for themselves and their families, the US must pass paid sick leave, paid medical leave, and paid parental leave legislation. Existing paid leave bills that would help fill these gaps include the **Family and Medical Insurance**

Leave (FAMILY Act), the **Healthy Families Act**, and the **Building an Economy for Families Act**.

Caregiving is also supported by allowing workers to have fixed but flexible work schedules and accommodations. Last-minute changes in schedules can interrupt caregiving responsibilities, like school or child care pickup, meal preparation, and attending medical appointments. Policies that guarantee both consistency and flexibility in the workplace allow workers to fulfill their caregiving responsibilities at home while also making a living. An example of a bill that would help give workers control and flexibility in their work schedules and accommodations is the **Schedules That Work Act**.

Pass laws that strengthen, increase funding for, and increase accessibility of child care, elder care, and care for people with disabilities.

Care services, such as child care, care for the elderly, and care for people with disabilities, exist in the US, but lack sufficient funding. The design of these laws means that not everyone who should be able to access these services can. In fact, current laws are leaving millions of people behind. Additionally, the lack of funding for these services means that the care workforce in these sectors is underpaid, which needs to be addressed in legislation. For child care, there are several proposed laws that would both increase the accessibility and affordability of child care and increase pay for child care workers and early learning educators. These include: the **Child Care for Working Families Act (CCWFA)** and the **Child Care for Every Community (CCEC) Act**. For increasing care services for the elderly and people with disabilities, both groups that rely on Medicaid's home- and community-based services, existing bills include the **Better Care Better Jobs (BCBJ) Act** and the **Home and Community Based Services Access Act (HAA)**.

Strengthen, increase, and expand social protection policies and programs such as the child tax credit, school lunches, SNAP, and WIC.

Social protection programs should be designed to ensure that the most underserved communities are able to get by. The US has many social protection programs in place, but the issues lie in funding for and accessibility of these programs. As issues like inflation continue to impact low- and middle-income families, funding for programs like school lunches, SNAP, WIC, and others should be prioritized, while access should be expanded to include more qualifying families. Currently, there is an opportunity to strengthen and expand SNAP in the 2023 Farm Bill.

As we saw during the COVID-19 pandemic, the expansion of the CTC was a lifeline for many families. Evidence of the benefits of the expanded CTC include that 2.9 million children were lifted out of poverty.¹⁵⁷ Thus, a permanent expansion of the CTC—including an increase in amount for each child as well as full refundability for the credit—is critical. The aforementioned **Building an Economy for Families Act** includes language on expanding the CTC.

Increase the federal minimum wage for all workers, and strengthen equal pay for comparable work laws.

The federal minimum wage has not been increased since 2009, and last year, the real value of the minimum wage reached the lowest point in over half a century.¹⁵⁸ Women of color are disproportionately represented among workers who make only \$7.25 an hour, and millions of minimum wage workers are parents.¹⁵⁹ Additionally, there are currently certain workers who can legally be paid less than the minimum wage, including student workers, agricultural workers, workers with disabilities, and tipped workers. This puts them in an even more precarious economic situation than other workers, and opens them up to wage theft from employers and sexual harassment. One example of proposed legislation that would both increase the federal minimum wage and help eliminate subminimum wages is the **Raise the Wage Act**. This bill would also raise the minimum wage of two million care workers.¹⁶⁰

Additionally, despite the Equal Pay Act of 1963, pay gaps based on gender and race still exist. Legislation should be passed to close loopholes in the Equal Pay Act, while strengthening the protections for workers who are trying to make sure they're getting paid a fair wage. An example of an existing bill that bolsters the right to equal pay for equal work is the **Paycheck Fairness Act**.

Pass laws that strengthen workers' protections and rights, expand these rights and protections to all workers, and increase funding to allow government enforcement.

The scorecard highlights the many ways existing laws leave out many workers, are unenforced, and are underfunded. These include laws around workplace protections and rights related

to health and safety, workplace inspections and grievance mechanisms, prevention of discrimination and harassment, working hours, and rights to organize. Government agencies and divisions—including DOL's WHD and OSHA—must be funded sufficiently to be able to enforce laws that do exist. Additionally, existing federal labor laws should be extended to all workers, including informal workers, contractors, and employees of companies with 15 or fewer employees.

Domestic workers are often unprotected due to the nature of their work. Although some states have passed legislation to support domestic workers, national legislation is needed to ensure domestic workers are protected across the entire country. One example of such proposed legislation is the **Domestic Workers Bill of Rights Act**, which presents an overarching framework for the rights and protections of domestic workers, and includes provisions such as paid leave, safety precautions, and fair and fixed scheduling. Moreover, if passed, the **Part-Time Worker Bill of Rights Act** would provide a wide range of protections and rights to part-time employees, including those who work for employers with 15 or fewer employees. The bill prevents employers from setting different standards for part-time employees around pensions, promotions, access to family and medical leave, and other rights. Additionally, discrimination and harassment in the workforce is a serious issue for women and LGBTQIA+ individuals, and protections need to be strengthened. The **Bringing an End to Harassment by Enhancing Accountability and Rejecting Discrimination in the Workplace Act (BE HEARD Act)** is a comprehensive bill that increases these protections in several ways, including by prohibiting mandatory arbitration predispute nondisclosure agreements in employment contracts, expanding protections to domestic workers, eliminating the tipped minimum wage, and ensuring businesses have the resources they need to prevent harassment and discrimination.

Additionally, under this umbrella of improving workers' rights, the federal government must ensure that all workers have the right to collectively bargain. Unionized workers are more likely to have higher wages, better retirement, paid leave, and fair schedules.¹⁶¹ One bill that would strengthen workers' rights to organize and collectively bargain is the **Protecting Rights to Organize (PRO) Act**.

Finally, the recently passed **PWFA and PUMP Act** are both important bills that support pregnant and postpartum workers. Although millions of workers will be covered by these laws, expanding coverage to all workers—such as for flight crew members, who were left out of the PUMP Act, and employees who work for employers with fewer than 15 employees, who were left out of the PWFA—should be a next step for advocates and lawmakers.

CONCLUSION

The US Care Policy Scorecard shows that there is much more that needs to be done at the federal level to support caregivers and care workers. Several crucial policies, particularly those around care-supporting workplaces—and most notably those around paid leave—do not yet exist federally in the US, which is detrimental to individuals’ ability to care for themselves and their families. For policies that do exist, the scorecard highlights issues such as program underfunding, unequal access to programs, lack of coverage of policies for all workers, and insufficient resourcing for implementation and enforcement of policies. While many states implement care programs and policies that go beyond the support offered through federal programs and policies, the vast majority of states do not, which deepens inequality from state to state and highlights the need for the federal government to prioritize care policies. Caregivers should be sufficiently recognized and supported everywhere in the US regardless of the state they reside in or their social, economic, or cultural background.

The importance of care to society’s well-being and functioning makes this federal lack of recognition and resourcing unjust and unsustainable. First, policies that are completely absent at the federal level need to be passed. Second, almost all existing care policies need to be strengthened, expanded, better funded, and redesigned in an inclusive manner. Fortunately, many advocates and lawmakers have already worked to introduce bills that would contribute to a more transformative care environment in the US. Whether it’s through these existing bills or newly introduced legislation, the current administration and Congress need to work together to better meet the needs of caregivers and care workers in the US.



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APPENDIX A. DATA COLLECTION APPROACH AND SCORING DECISIONS

This appendix presents the research process described in the third section of this report in more detail.

DATA COLLECTION APPROACH

During the desk research, led by the ND-i-Lab, the 30 scorecard indicators were divided equally among the four team members. Each team member first used Google to search for the relevant policy and federal agency associated with each indicator. Once the agency responsible for the policy was identified, the team member searched the relevant online database to evaluate the scorecard. The majority of the information was taken from the policies themselves, annual reports, congressional budget requests, fiscal year reports, and program monitoring and evaluation reports. While the federal databases provided much of the information needed to confidently score the majority of the assessment criteria, gaps still existed. To fill these gaps, the team gathered supplemental information from relevant academic journals and news articles. To ensure an accurate score, the team mandated each assessment criteria to be scored with a minimum of five sources corroborating the reasoning behind the assigned score. The ND-i-Lab team conducted key informant interviews (KIIs) with care policy experts in an effort to fill these gaps. Upon the conclusion of the desk research, the ND-i-Lab team began identifying and soliciting care policy experts to participate in KIIs, noting experts mentioned in the policy hearings. The ND-i-Lab team also leveraged the Oxfam team's suggestions, resources, contacts, and partners to identify additional experts to interview. Finally, the ND-i-Lab team utilized a Google search to identify experts for the indicators where Oxfam was not able to identify experts. KII participants were solicited via email or, if email was not available, via LinkedIn. At this point, the ND-i-Lab team created an interview script that included the purpose of the project, risks of interview participation and risk mitigation, and consent for recording. Following creation of the script, the team created a set of interview questions for each interview (See Appendix C). The questions were created by pulling assessment criteria from the scorecard and putting them into question format. In conjunction with the Oxfam team, the ND-i-Lab team created an additional set of qualitative questions to ask experts. These qualitative questions shape the qualitative analysis and narratives included in this report. Despite the ND-i-Lab team's best efforts, COVID-19 impacted KII participants' willingness to be interviewed in person. Consequently, interviews were conducted via Zoom. Ultimately, the ND-i-Lab team was able to cover 30 indicators through interviews.

The US Care Policy Scorecard assessment followed two series of quality checks and revisions by ND-i-Lab and Oxfam America. The ND-i-Lab team conducted a single-blind scoring for reli-

ability purposes. In this stage, the team members created a list of indicators that each team member scored. Each team member then adopted a different team member's indicator for scoring. The method of determination for which team member received which list was a process of elimination. If a team member's original list of indicators included any that were similar to another team member's indicator(s), they were precluded from adopting the similar team member's indicators.

During this process, the ND-i-Lab team identified assessment criteria that were particularly difficult to score. Vague wording was one of the main reasons for the difficulty in scoring. In response, Oxfam revisited the language used in the assessment criteria in a panel conducted with representatives from Oxfam, NWLC, NPWF, and ND-i-Lab. The Oxfam team used the responses of this panel in conjunction with their own internal review to amend some assessment criteria, which were included in the final scorecard.

From this process, the Oxfam and ND-i-Lab teams also decided to include two new assessment criteria. For all policy indicators, a new budget and administration assessment criterion, "There is a federal budget allocated for this policy/and or a federal mandate for states to allocate resources towards the implementation of this policy," was added. For policy indicator 2.1.4 Right to Social Security, "Unpaid caregivers can receive Social Security benefits when having to leave the workforce or reduce working hours due to care-related responsibilities," was added.

In order to ensure accurate data collection from the KIIs, each interview was audio recorded, with participants' consent. The team recorded interviews using their personal cell phones or, where that was not possible, using Zoom's audio record function. The audio recordings were then collected and stored on the ND-i-Lab team's Google Drive, and transferred to the transcription software, Trint.ai, for transcription. Upon transcription, the team members cleaned the transcripts and included the relevant information in the scoring of their indicators.

As indicated in the methodology section, once the ND-i-Lab finalized the first iteration of the US Care Policy Scorecard scoring, Oxfam America assessed the first iteration of the US Care Policy Scorecard (completed by ND-i-Lab) by conducting further desk research and including new sources of verification. During this process the team, led by an external consultant, made the scoring decisions listed below, which resulted in an improved scoring version.

Finally, Oxfam hosted a validation workshop with external partners. Feedback received at the workshop was incorporated in the third and last scoring of the US Care Policy Scorecard (see Appendix E).

SCORING DECISIONS

1. STANDARDIZING ACROSS INDICATORS

- a) The standard format in each indicator: “key” policies are listed in first row of each indicator, and all following assessment criteria elaborate on how those key policies are made accessible, funded, administered, etc.
 - i) Score explanations attempt to address all “key” policies in all criteria. However, if not all key policies are addressed in each criterion, the score is considered to reflect the set of policies, with some policies outweighing others in importance in formulating the score.
 - ii) When the lead criterion says “national” or “public,” as in the case of health care, then the policy score needs to assess whether that policy is truly national or public (score is 1) or whether it only applies to a subset of people/ doesn’t strive for universality/is not public. For example:
 - (1) ACA is largely a private-oriented system, leading to criterion scores of .5.
 - (2) Minimum wage doesn’t apply to some major subsets of workers, leading to criterion scores of .5.
- b) Timeline
 - i) Assessment is based on policies currently in place during time of assessment (June–December 2022).
 - ii) Budget assessment is based on 2022 as the current year and 2021 as the prior year.
- c) Binary question scoring
 - i) In the case of binary assessment criteria, when the criterion asserts a policy is “> x%”: the score is 0 if > 10 percentage points away from the criterion goal, the score is .5 if < 10 percentage points away from the criterion goal, and 1 if the policy meets the criterion goal.
- d) Office/agency employment by reported gender
 - i) Binary question scoring mainly applies to this criterion.
 - ii) Score and assessment are based on management-level employment, and data are for the specific office that administers the policy (when available) or for the agency (when office data are not available).
- e) Criteria for accessibility and reach
 - i) Difficult to standardize across indicators, but generally if the criterion states something “for all ...” and there are clear omissions and exclusions in the policy, the score is 0. If it doesn’t say “for all ...,” then if the policy extends to 50 percent or less of the target population, the score is 0.
- f) Criterion for whether there is a budget for the program
 - i) Score is 1 if there is a budget and it is mandatory. It’s also 1 if there are multiple programs listed and at least one budget is mandatory.
 - ii) Score is .5 if there is a budget and it is discretionary, or if there are multiple programs and all have discretionary budgets.
- g) Criteria that include assessment of marginalized groups
 - i) Score is 1 if the intention of the policy is clearly aimed at reducing disparities or achieving universality in standards or service; .5 if there is either a clear emphasis on eliminating/reducing disparities OR if there is a goal of achieving universality in standards or service; 0 if neither are true.
- h) Criteria that include assessment of disaggregated data
 - i) Score is 1 if there are disaggregated data by demographic and other specific groups listed in the criterion, .5 if there are data by other “groups,” e.g., geographic or income, but not for all groups listed in the criterion, 0 if there is no clear attempt to track any stated indicators.
- i) Criteria that include assessment of inclusion of interest groups in policy process
 - i) Score is 1 if there is a clear, robust effort to include multiple stakeholder/interest groups in the policy process (or if there was upon original development of the policy), .5 if there has been any effort to include any stakeholder/interest groups, 0 if there was no attempt found.

2. AGGREGATE SCORING METHODOLOGY

- a) All indicator scores are a total of the points earned, over the total number of points possible (excluding any INS or N/A scores).
- b) All indicator scores also receive a percentage score.
- c) All policy area scores receive a percentage score, which is the average of the percentages of each indicator within that policy area.
- d) Each section (Section 1 (unpaid care work) and Section 2 (paid care work)) receives a percentage score, which is the average of the percentages of the policy area scores within that section.
- e) The scorecard receives a percentage score, which is an average of the Section 1 (unpaid care work) and Section 2 (paid care work) percentage scores.

APPENDIX B. COMPLETED SCORECARD

SECTION 1: UNPAID CARE WORK	NUMERIC SCORE	AVERAGE PERCENTAGES
POLICY AREA 1.1: CARE-SUPPORTING PHYSICAL INFRASTRUCTURE		61%
1.1.1: Piped water	13/19	68%
1.1.2: Household electricity	12.5/19	66%
1.1.3: Sanitation services and facilities	13.5/19	71%
1.1.4: Public transport	8.5/19	45%
1.1.5: Time- and energy-saving equipment and technology	10.5/19	55%
POLICY AREA 1.2: CARE SERVICES		59%
1.2.1: Public healthcare services	11.5/19	61%
1.2.2: Early childhood care and education (ECCE) services	12.5/22	57%
1.2.3: Care services for older people	13.5/20	68%
1.2.4: Care services for people with additional care needs	10/20	50%
POLICY AREA 1.3: SOCIAL PROTECTION BENEFITS RELATED TO CARE		52%
1.3.1: Public pension	16/21	76%
1.3.2: Cash transfer policies related to care	10/20	50%
1.3.3: School-based meals or food vouchers	16.5/20	83%
1.3.4: Care-sensitive public works programs	0/22	0%
POLICY AREA 1.4: CARE-SUPPORTING WORKPLACES		7%
1.4.1: Paid sick leave	0/21	0%
1.4.2: Paid medical leave	0/21	0%
1.4.3: Equal paid parental leave	0/23	0%
1.4.4: Flexible working	0/16	0%
1.4.5: Onsite child care	0/20	0%
1.4.6: Breastfeeding at work	6.5/14	46%
1.4.7: Pregnancy accommodations	0/16	0%
SECTION 1 TOTAL SCORE	45%	

SECTION 2: PAID CARE WORK	NUMERIC SCORE	AVERAGE PERCENTAGES
POLICY AREA 2.1: LABOR CONDITIONS AND WAGE POLICIES		51%
2.1.1: Minimum wage	9/18	50%
2.1.2: Gender wage gap and equal pay for equal work	7/15	47%
2.1.3: Working hours	8.5/16	53%
2.1.4: Right to Social Security	10/20	50%
2.1.5: Child rights and labor protection	9/16	56%
POLICY AREA 2.2: WORKPLACE ENVIRONMENT REGULATIONS		47%
2.2.1: Occupational Health and safety in the workplace	8/18	44%
2.2.2: Protection against gender-based discrimination, harassment, and violence in the workplace	10/19	53%
2.2.3: Workplace inspections and grievance mechanisms	6.5/15	43%
POLICY AREA 2.3: MIGRANT CARE WORKERS' PROTECTIONS		24%
2.3.1: Equal rights and protections for migrant care workers	4/17	24%
2.4: RIGHT TO ORGANIZE		43%
2.4.1: Right to representation and negotiation, freedom of association, and right to strike	6.5/15	43%
SECTION 2 TOTAL SCORE	41%	
TOTAL COUNTRY SCORE	43%	

APPENDIX C. INTERVIEW GUIDE

Strategy for interview questions is based on the type of stakeholder being interviewed. The interview guide was developed by the ND-i-Lab team.

INTRODUCTION

Our overarching strategy for interviews follows the guidelines of a “semi-structured interview” wherein open-ended questions shall be posed but the interviewee will have the freedom to determine the course of the conversation. Accordingly, we will adapt our subsequent questions to enable a free-flowing conversation. That being said, our interviews shall have a list of key questions/themes that shall be posed to each interviewee depending on their domain of expertise. They are provided below.

QUESTIONS

1) POLICYMAKERS, US GOVERNMENT DEPARTMENT REPRESENTATIVES, AND SENATORS IN WASHINGTON, DC

- a) Main questions lifted from the scorecard: Questions for legislators and policymakers will be the ones asked in email templates following each indicator. So the questions were directly lifted from the scorecard.

The scorecard questions will be revisited once the team starts liaising with policymakers.

- b) One additional question for senators/Congress members: “What are the reasons behind the failure in passing a care-supporting bill like the bill formerly known as Build Back Better?”

i) What we mean to ask is, “What changes could be made so that such a bill could pass?”

2) CIVIL SOCIETY (THINK TANKS, NONGOVERNMENTAL ORGANIZATIONS, EXPERTS AND RESEARCHERS, WOMEN’S RIGHTS ORGANIZATIONS (WROS), HUMAN RIGHTS ORGANIZATIONS (HROS))

- a) “Do you know if federal policymakers consult researchers and think tanks while deliberating upon policies on unpaid work? Why or why not?”

i) “Do you know if policymakers consulted WROs or HROs from diverse backgrounds, including migrant representatives, LGBTQIA+, and BIPOC, in the writing of the policy?”

- b) “What role does your organization play in making the voices of those it represents heard (especially those affected by care work policies) to members of Congress in DC?”

i) “What should experts, advocates, and researchers do to amplify the voices of marginalized communities pertaining to their access to unpaid care policies?”

- c) “What implementation challenges prevent the policy from fulfilling its objectives?”
 - i) “Any specific challenges for different demographic groups? Such as problems for women? For BIPOC? For migrants? For LGBTQIA+?”
- d) “What are the reasons behind the failure in passing a care-supporting bill like the bill formerly known as Build Back Better?”
 - i) What we mean to ask is, “What changes could be made so that such a bill can pass?”
- e) “How do you assess the impact of unpaid care work on the mental health of affected communities in the US?”
 - i) “Do any of the data collected provide evidence on the well-being of UUCW?”
 - ii) “If so, do they show that UUCW is differently impacted by the policies based on their demographic characteristics (LGBTQIA+, women, migrants, low-income, BIPOC)?”
- f) End of interview question: “Finally, how does the current policy climate surrounding UUCW affect marginalized communities? What changes need to be made to better support unpaid and underpaid care workers in these communities?”

DEBRIEF

1. “Thank you very much for talking to me today. It has really helped us understand some of the policy dimensions, challenges, and aspects that affect UUCW.”
2. “As we stated in the beginning of the interview, everything you said in the interview is private; ”
3. “We will only use the things you told us to provide context to our scorecard and our qualitative analysis of the UUCW schema in the US, and the policies affecting them.”
4. “As part of our research process, we periodically report our findings. All identifying information is removed from these reports.”
5. “We may include some quotes, but we will never attribute names to quotes to ensure anonymity.”
6. “Do you have any questions about this interview, or about what we do with the information you gave us?”
7. “If any question or concern comes to your mind later on and you would like to talk to someone, you can contact our teams at Oxfam America or at the Keough School of Global Affairs, University of Notre Dame.”

APPENDIX D. LIST OF EXPERT INTERVIEWS

1	Workplace health and safety expert
2	Domestic worker expert
3	Labor protections laws and workplace equality expert
4	Paid leave, pregnancy accommodations, and breastfeeding in the workplace expert
5	Public healthcare expert
6	Paid family and medical leave expert
7	Domestic worker expert
8	Early childhood care and education expert
9	Early childhood care and education expert
10	Wage laws and OSHA expert
11	Social Security expert
12	Piped water and sanitation expert
13	Harassment in the workplace and workplace equality expert
14	Wage and overtime pay and fair scheduling policies expert
15	Workplace gender equality, pregnancy and breastfeeding protections, and employment discrimination expert
16	Care advocacy and coalition-building expert
17	Gender analysis in economics expert
18	Americans with Disabilities (ADA) and Medicaid expert
19	Piped water expert
20	Trade unions expert
21	Gender equity and workplace harassment and paid leave expert
22	Paid leave expert

APPENDIX E. VALIDATION WORKSHOP

As indicated in methodology section of this report, a validation workshop was carried out on March 9, 2023. The objectives of this workshop were: first, bring diverse partners and stakeholder group representatives together to share the first US Care Policy Scorecard Assessment Tool; and second, seek feedback from care experts and advocates. The workshop was organized and led by Oxfam America team and an external consultant via Zoom. The workshop had the presence of representatives of the ND-i-Lab, NWLC, NPWF, and 30 participants from 15 organizations.

THE WORKSHOP AGENDA AND METHODOLOGY

1. Introduction from Oxfam's team, and the project background, goals, and process
2. Introduction from NWLC. Reflections on the use of this tool in the advocacy and research space
3. Overview of the Care Policy Scorecard's structure and scoring, sample indicator sections, and findings by consultant
4. Breakout groups discussion on specific policy indicators:
 - Child care and early learning and onsite child care, elderly care and people with additional care needs, health care;
 - Paid sick leave, equal paid parental leave, paid medical leave, flexible work, workplace safety, working hours, workplace inspection and grievance mechanisms, breastfeeding, pregnancy accommodations;
 - Labor/workplace rights, regulations. Right to Social Security, public pension, minimum wage, equal pay, right to organize, migrant workers, protections against gender-based violence (GBV)/discrimination;
 - General feedback.

Each group:

- Took five minutes to review two to three indicators' criteria, scoring, and explanation;
- Discussed the following questions:
 - o Do the answers and scores make sense to you; is there anything that stands out as potentially inaccurate or unjustified?
 - o Is there anything missing in the scores or explanations, any policies that are foundational that were in place in the assessment timeframe that we've overlooked?
- Participants included their written feedback on a Google sheet.

5. Plenary: breakout group findings
6. Plenary: Q+A
7. Conclusions and next steps

Feedback from participants was recorded in writing and served as an input for a third and last revision of the scoring.

APPENDIX F. LIMITATIONS AND RECOMMENDATIONS FOR FUTURE ITERATIONS OF THE US CARE POLICY SCORECARD

In addition to the limitations faced when implementing the Care Policy Scorecard Tool in the US included in the third section of the report, this section presents in more detail some of the challenges faced during the research process, as well as some recommendations for future iterations of the Care Policy Scorecard Tool in the US and other country contexts.

IMPORTANCE OF CLEAR DEFINITIONS OF THE ASSESSMENT CRITERIA

Some of the assessment criteria in the Care Policy Scorecard Tool comprised general wording that, if not defined in each country context, can be subject to multiple interpretations and might lead to coder bias. Examples of such terms are the following: “management and governance structure,” “adequate,” and “positive impact,” to mention just a few. These terms could be interpreted in different ways. In these instances, it is advisable for the research team to develop clear definitions in the planning process before populating the tool factors contributing to them and their implications for the diverse community of care workers.

ACCESSING INFORMATION ON POLICY DESIGN AND CONSULTATION

Assessment criteria asking about specific issues like consulting with WRDs or asking about budgetary change like “budget has risen in real terms” were challenging to evaluate. While “real terms” means accounting for inflation, most of the fiscal year’s reports do not dissect the budget in such a manner. Most reports mention that they accounted for inflation in some of their reports and not all of them. It is thus difficult to find the related information responding to these specific terms. While most of the information on legislative action, steps, content, budget, and personnel is found online on governmental websites or in op-ed pieces published by major policy think tanks, there is rarely any information about the design process. Information on consultations of specific experts, intersectionality, and diversity in consulting WRDs, civil society organizations (CSOs), unions, and HROs is largely lacking. The scorecard specifically asks for information on impact and design regarding consultation of women’s rights organizations and the inclusion of UUCW in their design. Given the paucity of information on these topics, the researchers should include these design-related questions in the qualitative interviews with experts to be able to assign a score to the relevant criteria.

OVERLAPPING ASSESSMENT CRITERIA

Given the complexity of care-related policies, it is not surprising that some criteria included in the Care Policy Scorecard Tool overlap. In this situation, it is important that the research team clarify each criterion, refining the assessment criteria (keeping track of clarification as well as maintaining a list of decisions made when scoring could be helpful to avoid confusion). Conducting robustness checks like factor analysis or some form of reliability test can make the scorecard clearer and avoid the issues of subjectivity that seemed to have emerged in this iteration of the tool.

To address the challenges and limitations encountered in implementing the US Care Policy Scorecard, the team bolstered the analysis via KIs and the internal revision processes with the development of a scoring decisions guide. The team also carried out external validation with key experts and advocates to receive feedback and identify any data gaps or redlines. These processes helped to get a deeper understanding of the US care landscape, factors contributing to it, and their implications for the diverse community of care workers residing in the US.



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Oxfam is a global organization that fights inequality to end poverty and injustice. We offer lifesaving support in times of crisis and advocate for economic justice, gender equality, and climate action. We demand equal rights and equal treatment so that everyone can thrive, not just survive. The future is equal. Join us.

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