ONTARIO'S CARE ECONOMY

An assessment of provincial care policy

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ONTARIO NONPROFIT NETWORK

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Acknowledgements

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Introduction

Care work, both paid and unpaid, is a vital yet all too often a minimized aspect of people's lives and society broadly. It functions as a subsidy to the economy when performed for no or too-low wages (Pay Equity Office, 2022).

The care system in Ontario is experiencing ongoing crises, visible across headlines: long wait times for services, increasing privatization of care services, gaps in quality, and staffing shortages. Ontario's care systems are overburdened and the impacts on communities are material. Ontarians are struggling to access healthcare, affordable housing, and seniors care and arts, cultural, and recreational programs are disappearing in communities. At the same time, a growing number of unpaid caregivers are sandwiched between caring for older and younger generations, often while needing care themselves (Statistics Canada, 2024).

Provincial policy and funding are critical determinants of how care is delivered, and the current conditions people face can be linked to both long-standing and recent public policies.

The provincial care landscape, which is evaluated in this report, is shaped by legislation ill-equipped to meet contemporary realities. Employment standards do not reflect the expansion of care work into the gig economy, funding formulas do not reflect the increasing number of people relying on social programming, benefit programs do not reflect the cost of living, and one-size-fits-all policies do not consider how additional barriers compound for equity-denied communities.[1]

1 ONN uses the terms "equity-deserving" and "equity-denied" to refer to groups of people who, because of systemic discrimination, face barriers that prevent them from having the same access to resources and opportunities that are available to other members of society, and that are necessary for them to attain just outcomes. In Canada, groups generally considered to be equity-deserving/denied/seeking include Black, Indigenous, and racialized communities, women, 2SLGBTQI+ community, religious minority groups, and people with disabilities. Throughout this report, "equity-denied" will be used.

What is paid and unpaid care work?

Care work refers to all of the labour that goes into meeting the physical, psychological, and emotional needs of individuals, families, and their communities (Wray et al., 2023).[2]

The **care economy** is the sum of that labour, both paid and unpaid, that is delivered through the public, private, and nonprofit sectors, and within households (International Labour Organization, n.d.).[3] Care work is often carried out by Black, racialized, immigrant, and migrant women (Vancouver and District Labour Council, 2023).

Paid care work is delivered by workers in public, nonprofit, and for-profit settings. Nursing, personal support workers, child care, administration, and custodial work are some examples of paid care work.

Unpaid care work primarily refers to domestic labour that happens within the home such as parenting, cooking, cleaning, and crisis and medical support for loved ones.

2 ONN's definition of care work is adapted from the International Labour Organization and many feminist scholars.

3 ONN also uses the term "social infrastructure" to describe the care economy.

Assessing Ontario's care economy

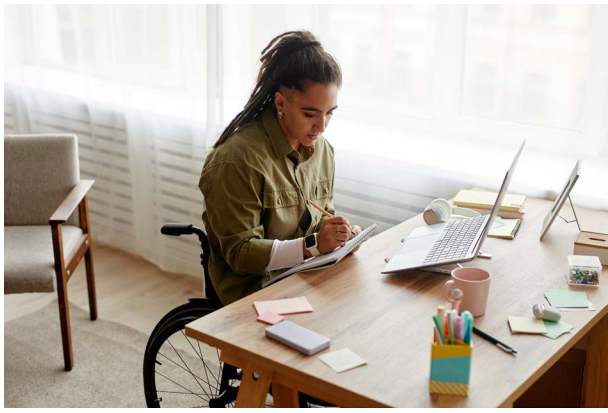
This report is a broad overview of findings about Ontario's care economy based on the adaption of the Care Policy Scorecard, a practical tool designed to measure progress, identify gaps in care policy, and further advocacy to transform the gendered social conditions that hinder care. The scorecard was developed by multiple organizations including Oxfam, International Center for Research on Women (ICRW) Asia, International Domestic Workers Federation, Africa Leadership Forum, UK Women's Budget Group, Ciudadanía Bolivia, Padare Men's Forum Zimbabwe, the Ugandan Women's Network, and Youth Alive! Kenya.

The insights in this report were gathered through research and consultations with sector experts. This research focuses on policies at the provincial level which directly oversee elements of care, such as healthcare and childcare, as well as policies that influence the working and living conditions of care workers. Many of the gaps in care that people experience in their daily lives can be traced back to provincial policy (or the lack thereof). This scorecard places care at the center of policy decisions on service provision, labour standards, and infrastructure projects. The lens the scorecard adopts supports centring care in provincial advocacy efforts.

The Care Scorecard for Ontario includes all scores, explanations, and sources. Detailed information about how the scorecard was adapted and assessed to reflect the Ontario context can be found in the methodology report.

Situating Ontario within the global devaluation of care work

Care is a gendered and feminized issue.[4] From the home to the workplace, the highly skilled emotional and physical labour that women do is dismissed as natural or obligatory, and regarded as easier, less important, and consequently less valuable than men's work (Moser, 2024). The consequences of this devaluation are replicated across every sphere: women perform more unpaid labour in the home than men, wages in women-majority sectors are lower for all workers in those sectors, unpaid overtime and long hours are recast as obligations tied to caring for others, and women receive poorer care in institutional settings (Camargo-Plazas et al., 2022; Pay Equity Office, 2025; Scott, 2024).



4 Throughout this report, ONN and Vivic Research use an inclusive definition of women that includes trans women and 2SLGBTQI+ women. There is a lack of data and research on the specific experiences of gender nonconforming feminized people, thus this report uses the language of women to specifically discuss the experiences of all people who identify or are perceived as women.

It is important to note that much of the research, data, and conversation on care work relies on cis-heteronormative and binary understandings of gender and sex. In reality, global systems of femmephobia, sexism, and transmisogyny intersect to extract care labour from feminized people of all genders.[5]

The same patterns which devalue care work can be observed globally, nationally, and locally. In Ontario, this manifests as a gender segregated workforce where the vast majority of workers in the care economy are women (Canadian Institute for Health Information, 2026). Racialized and immigrant women are disproportionately concentrated in the lowest-paying and most precarious roles within the care economy, in part as a result of Canadian immigration policies that reinforce gendered and racial stereotypes and divisions of labour. Policies which invalidate credentials and classifications of care work, especially domestic work,

5 Femmephobia refers to the systemic devaluation and regulation of femininity in people of all genders and sexes. Transmisogyny refers to the intersection between transphobia and misogyny.

positioning this labour as "low-skill", culminate in the subordination of migrant care workers and pave the way for exploitation (Mooten, 2021). For many racialized, migrant, and low-wage care workers, the line between paid and unpaid care work can be quite blurry when a paid role is so demanding that it ultimately requires the worker to provide significant unpaid care, which collectively adds up to millions of dollars of wage theft (Bedard & Gellatly, 2025). These same patterns appear across all forms of systemic oppression, leading to greater labour precarity for people with disabilities, 2SLGBTQI+ people, and low-income women, with compounded effects for people who experience intersecting forms of oppression.

The context in which paid care operates cannot be disentangled from unpaid care in the home. As poverty rises in Ontario, the demand for services increases while the capacity to provide them shrinks. Many frontline care workers are struggling to afford food, housing, and other necessities while still being expected to work long hours in under-resourced positions (Workers' Action Centre, 2022). Women in caring roles report high levels of burnout; nonetheless, they are also expected to provide unsustainable levels of care for children, partners, and/or aging parents in their homes (Brophy et al., 2024; Luxton, 2021).

Nonprofits within Ontario's care economy

The Ontario government has always relied on nonprofits to fulfill its care responsibilities. Over the past 50 years, the decline of state-run social services has led to a significant expansion in the role of nonprofits as care providers (Baines & Brown, 2025). Nonprofits provide both direct and indirect care services. For instance, arts nonprofits can provide indirect care through events and exhibitions that allow caregivers to see or understand themselves better; environmental nonprofits engage in care for the environment, which in

turn cares for us. Care cannot be confined to one subsector; it is an expansive system.

Decades of government austerity measures, such as divestment of ownership from historically government-owned enterprises, downloading of services to municipalities, and increased emphasis on treating government as a business, versus a public good, have led to the degradation of care (Box, 1999; Hyde, 2023). As a result, nonprofit care services are often not funded adequately despite being an essential part of the care economy. Nonprofit providers are tasked with caring for a rapidly growing and increasingly complex client base, on stagnant budgets. Front-line workers are made to bear the brunt of gaps in care while earning barely livable wages themselves.

While nonprofits want to expand, they are at a disadvantage when competing for government contracts against for-profit service providers, who have more resources. This competition is particularly acute because the expansion of care services, such as child care and long-term care, is increasingly done in marketized ways. Bidding for contracts for service delivery favours private companies who have resources to dedicate to the bidding process, which puts nonprofits of all sizes at a disadvantage during the procurement process.

Many of the nonprofits who provide care for equity-denied communities are faced with challenging political terrain to navigate. Limited, short-term funding forces nonprofits into a constant state of fundraising and draws energy and capacity away from transformative advocacy (Gallagher et al., 2024). Organizations navigate the challenges of working in crisis conditions daily while trying to remain palatable to government and funders.

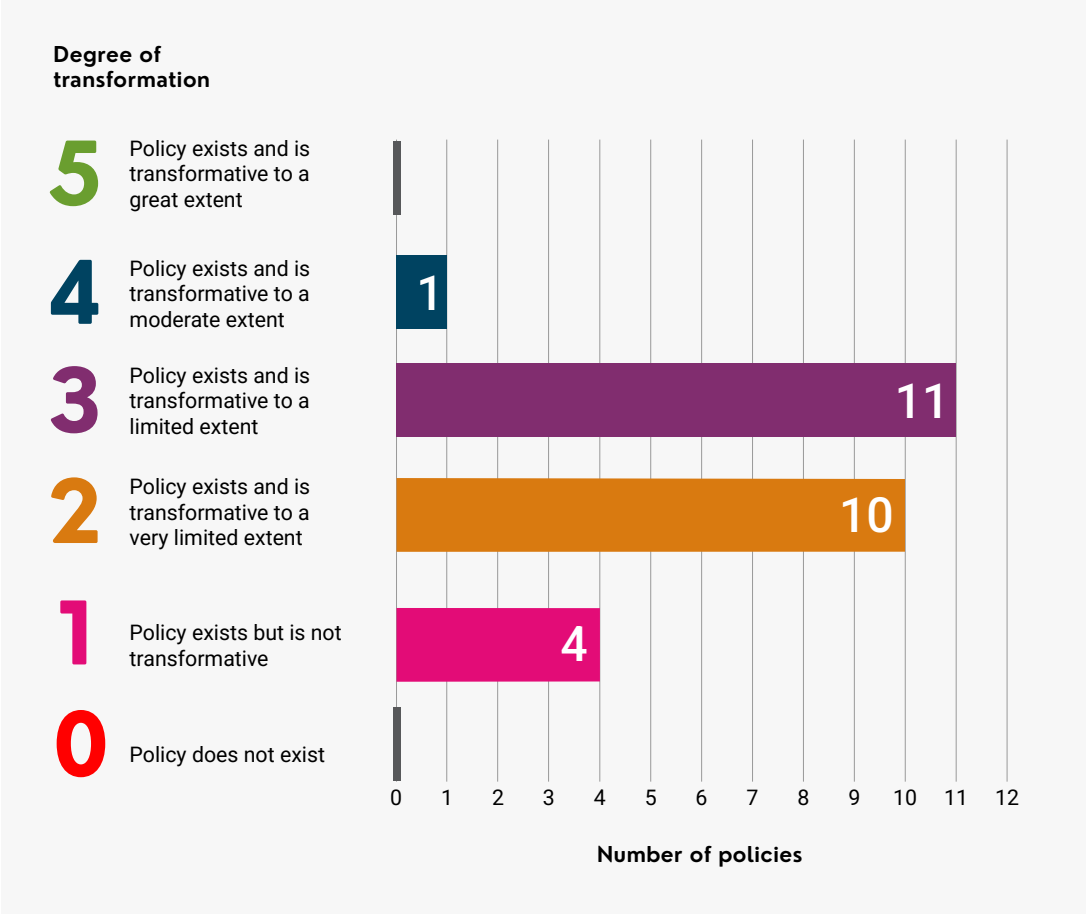
Care scorecard: Ontario care policies get a failing grade

The scorecard evaluates indicators by assigning each assessment criteria a score of 0, 0.5, or 1. These criteria generally fit into four overarching categories: accessibility and reach, design and impact, regulation and monitoring, and budget and administration.[6] The total score for each indicator, listed as a percentage, is then assigned a score for the degree of transformation, between 1 and 5 (see Figure 1).

No policies scored higher than a four on the transformation scale, showing that no care policies in Ontario were assessed to be transformative to a great extent. This means that the policies do not transform the unequal and gendered distribution of care work or correct the devaluation of care and care work. While policies might still meet an immediate need, they were not designed to change or redress issues of gender inequality, gaps in care, and systemic exclusion of equity-denied communities.

6 A complete version of the scorecard is available by contacting ONN at admin@theonn.ca

Figure 1: How Ontario care indicators scored by their degree of transformation

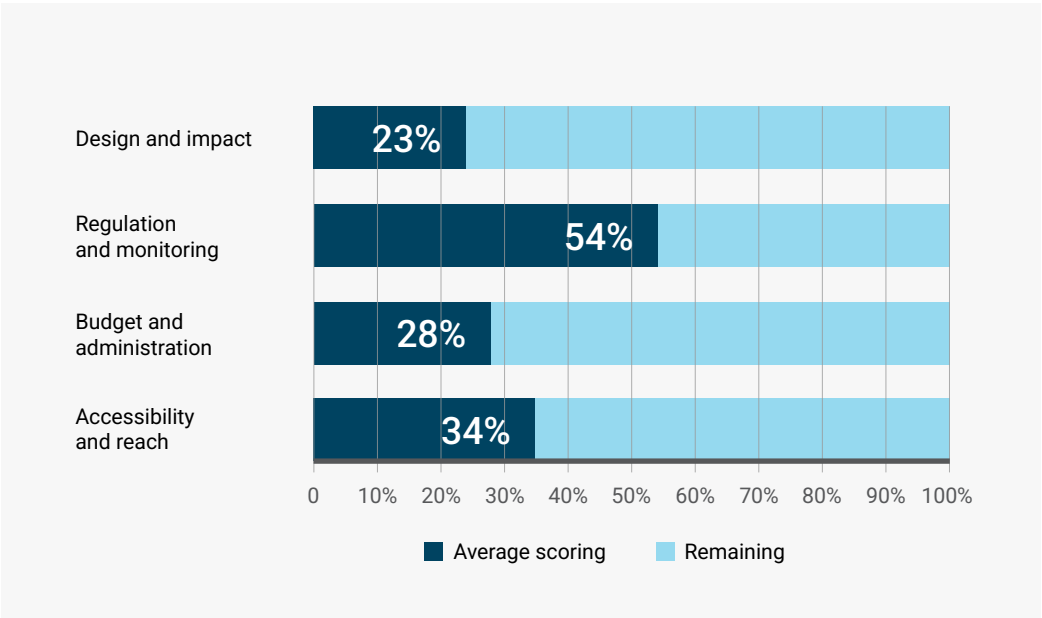


The findings from this research highlight that care policies in Ontario are not transformative, in large part due to their inability to reach all demographics because of costs, citizenship status, wait times, and/or restrictive eligibility criteria.

Access to care was further impeded by systemic barriers such as racism, sexism, transmisogyny, and ableism that can make it unsafe for people to seek help. This was true across policies, including for direct care services where individuals may fear criminalization, to employment policies, where fear of employer retaliation and low wages keep care workers working paycheck to paycheck, making it too risky to speak out or take action.

Much of Ontario's care policy is weak, outdated, and does not go far enough to meet care needs. In the most concerning cases, public policies are being passed and implemented in ways that actively undermine access to high-quality care (Ali et al., 2025; Armstrong & Armstrong, 2023). Where legislation is in place, there are rarely provisions to protect against privatization, profitization, or deregulation (Ontario Nurses' Association, 2023; Yalnizyan & Armstrong, 2023). Policies scored the highest when assessed for regulation and monitoring, which reflects the existence of complaints-based reporting mechanisms. The limitations of complaints-based reporting mechanisms are subsequently reflected in the low scores for design and impact.

Figure 2: Average scores by main assessment criteria categories



Care Scorecard for Ontario snapshot

Section 1:
Unpaid care work

Policy areas	Indicators	%	DOT*	Policies assessed	Description
1.1 Care-supporting physical infrastructure	1.1.1 Clean Water	47	3	Safe Drinking Water Act, 2002	There are provincial regulations around clean water, however numerous bills were introduced in 2025 which amended the Safe Drinking Water Act.
	1.1.2 Clean air	9	1	There is no central policy on clear air in Ontario	There is no central policy on clear air in Ontario, but there are some regulations that apply from the Occupational Health and Safety Act and the Ontario Building Code.
	1.1.3 Household electricity	62	4	Ontario Energy Board Act, 1998 & Ontario Fair Hydro Plan Act, 2017	The province regulates energy boards, and subsidizes access to electricity through income-tested programs.
	1.1.4 Connectivity infrastructure	0	0	Excluded from the Scorecard - See Methodology Report	The federal government generally has jurisdiction over connectivity infrastructure.
	1.1.5 Public transportation	21	2	Municipal Act, 2001	The province downloaded the provision of public transit to municipalities alongside coordination through two provincial agencies.
	1.1.6 Housing	0	0	Excluded from the Scorecard - See Methodology Report	Housing policies spans all levels of government and is largely controled by the private market, and regulated through policies that govern zoning and tenant protections.
1.2 Care services	1.2.1 Public health care services	50	3	Primary Care Act, 2025	The provincial government established a set of objectives to ensure Ontarians have access to primary care practioners, it does not establish implementation strategies to address gaps in primary care practioners.
	1.2.2 Early Childhood Care and Education (ECCE) services	52	3	Child Care and Early Years Act, 2014 & Canada-Ontario Early Learning and Child Care Agreement	Provincial policy on childcare, in conjunction with the federal government, has lowered the cost of childcare for people who access subsidized childcare spaces but shortcomings in its implementaiton has resulted in long waitlists and high worker turnover.

DOT = Degree of Transformation

0 Policy does not exist **1** Policy exists but is not transformative **2** Policy exists and is transformative to a very limited extent

3 Policy exists and is transformative to a limited extent **4** Policy exists and is transformative to a moderate extent

5 Policy exists and is transformative to a great extent

Section 1:
Unpaid care work

Policy areas	Indicators	%	DOT*	Policies assessed	Description
1.2 Care services (cont.)	1.2.3 Residential Long-Term Care	20	1	Fixing Long Term Care Act, 2021	The province regulates and funds increasingly privatized long-term care facilites on a per diem, income tested basis.
	1.2.4 Homecare	28	2	Connecting People to Home and Community Care Act, 2020 & Convenient Care at Home Act, 2023	The province funds access to some forms of nonprofit and private home care through the Ontario Health Insurance Plan.
	1.2.5 Developmental disability services	52	3	Services and Supports to Promote the Social Inclusion of Persons with Developmental Disabilities Act, 2008	The province funds residential, employment, and recreation services, which are delivered by nonprofit transfer-payment agencies, along with direct funding system through the provincial Passport program.
	1.2.6 Mental health and psychiatric services	17	1	Mental Health Act, 2011	The province governs and funds access to publicly funded psychiatric facilities and wards.
	1.2.7 Physical disability services	33	2	Direct Funding Program	The province includes access to the Direct Funding Program through the wider home care system.
	1.2.8 Gender-based violence services	33	2	Ontario-STANDS: Standing Together Against gender-based violence Now through Decisive actions, prevention, empowerment and Support & Sexual Violence and Harassment Action Plan Act (Supporting Survivors and Challenging Sexual Violence and Harassment), 2016	The province regulates and funds access to some emergency, nonprofit domestic violence shelters and services, however, the demand far outpaces the services.

DOT = Degree of Transformation

Section 1:
Unpaid care work

Policy areas	Indicators	%	DOT*	Policies assessed	Description
1.2 Care services (cont.)	1.2.9 Homelessness and housing services	23	2	Housing Services Act, 2011	Provincial policies and programs contain provisions for low-income people, and can include emergency provisions, however, there is a lack of access to low-income housing, and increasingly harmful policies towards unhoused people.
	1.2.10 Addiction services	27	2	Ontario Health Insurance Plan, 1990 & Community Care and Recovery Act, 2024	Recent provincial policies have restricted access to harm reduction services, despite already long wait-times for existing services.
1.3 Care-related social protection benefits	1.3.1 Cash transfer policies related to care: Caregiver Benefit	0	0	Excluded from the Scorecard - See Methodology Report	There is no provincial caregiver benefit in Ontario, but some benefits can be accessed federally through Employment Insurance or as a tax credit.
	1.3.2 Cash transfer policies related to care: ODSP	43	3	Ontario Disability Support Program Act, 1997	The provincial government provides disability support to eligible Ontario residents who are unable to work due to the nature of their impairment, however the benefit rates remain below the Official Poverty Line.
1. 4 Care-supporting workplaces	1.4.1 Paid sick leave	35	2	Employment Standards Act, 2000	Provincial legislation guarantees three days of job-protected unpaid sick leave.
	1.4.2 Equal paid parental leave	48	3	Employment Standards Act, 2000	Provincial legislation guarantees job-protected unpaid pregancy and parental leave.
	1.4.3 Flexible working	37	2	Ontario Human Rights Code, 1990	The Ontario Human Rights Code guarantees the duty to accommodate, which includes accommodation of caregiving duties.

DOT = Degree of Transformation

Section 2

Paid care work

Policy areas	Indicators	%	DOT*	Policies assessed	Description
2.1 Labour conditions	2.1.1 Minimum wages for paid care workers	43	3	Employment Standards Act, 2000	Minimum wage in Ontario is $17.60, below the living wage in all jurisdictions in Ontario. Many care workers work in minimum wage positions.
	2.1.2 Gender wage gap and equal pay for equal work	33	2	Employment Standards Act, 2000 & Ontario Pay Equity Act, 1990	The provincial government legislates pay equity and discrimination on the basis of sex and gender is prohibited, yet wages remain depressed in women-majority sectors of the economy.
	2.1.3 Working hours	38	2	Employment Standards Act, 2000	Provincial legislation on working hours does not reach many care workers and reports of overtime, including unpaid overtime, are extremely common in the healthcare and social services sector.
2.2 Workplace regulations	2.2.1 Health and safety in the workplace	57	3	Occupational Health and Safety Act, 1990	Provincial health and safety legislation applies to most workplaces in Ontario, with the notable exeption of private residences.
	2.2.2 Gender-based discrimination, harassment and violence in the workplace	47	3	Occupational Health and Safety Act, 1990 & Ontario Human Rights Code, 1990	Provincial health and safety legislation downloadds the responsible to individual workplaces to implement policies on gender-based discrimination.
	2.2.3 Workplace inspections and grievance mechanisms	54	3	Occupational Health and Safety Act, 1990	The Ontario Health and Safety Act regulates proative and reactive workplace inspections and provides a complaint-based mechanism for workers to follow if their rights have been violated.
2.3 Migrant care workers' protections	2.3.1 Equal rights and protections for migrant domestic workers	20	1	Employment Protection for Foreign Nationals Act, 2009	The Employment Protection for Foreign Nationals Act applies specifically to temporary foreign workers. Other policies such as the ESA and OHSA apply if the worker is an employee working in a covered workplace.
2.4 Right to organize	2.4.1 Right to representation and negotiation, freedom of association and right to strike	59	3	Labour Relations Act, 1995	The Labour Relations Act guarantees the right to organize, however, there are numerous provisions which restrict the ability for certain workers to strike.

DOT = Degree of Transformation

Key findings

1 Care systems are operating at unsustainable levels

Across the care economy, frontline workers serving equity-denied communities and who themselves often live at the intersection of multiple axes of oppression, face the most strain on resources. Care workers, particularly those in the most precarious social and employment positions, such as migrant personal support workers, are forced to work in unsafe conditions where sexual harassment and abuse, threats of deportation, and racism and discrimination are rampant (Amnesty International, 2025). Many of the struggles that care workers feel in their professional lives – being overworked and under-resourced – are mirrored in their home lives.

The core cost drivers for healthcare, including population growth and age, inflation, and poverty and inequality, are trending upwards while investments in the care sector are not keeping pace (Financial Accountability Office of Ontario, 2025). Chronic and significant government underfunding has led to debt and deficits, service cuts, and longer wait times. Multi-year funding for operational costs for healthcare and social service providers offer greater benefits than one-time spending announcements that cannot guarantee stability or sustainability of a service (Gallagher et al., 2024; McWhinney, 2024).

Without a strong foundation of primary care, people either forgo care, depend on unpaid caregivers, or are pushed towards emergency care services, including emergency rooms and shelters (Canadian Institute for Health Information, 2024). Access to primary care is critical for access to various supportive services and housing providers, which can interrupt cycles of homelessness. Yet, in Ontario, more than three million people do not have a primary care provider, and even those who are rostered to a family doctor often cannot access timely and convenient primary care (Registered Nurses' Association of Ontario, 2025). Meanwhile, staffing shortages and dangerously long wait times for specialized services for people with developmental disabilities, older adults, and people with mental health needs are just some examples of the concurrent gaps in care (Community Living Ontario, 2024). Nonprofits are at their breaking point, and the overflow of needs converges in emergency rooms and on the streets. For years, care workers and unions have sounded the alarm on the lack of investments into preventative and community-based care, which has pushed emergency responses far beyond their capacity, into a state of perpetual crisis.

2 Housing precarity and cost of living create high care needs that cannot be met by the current system

Housing is often thought of as distinct from the care economy, yet conversations with policy experts and frontline workers in the care sector reveal housing and homelessness are the central concerns affecting the entire sector. High rental prices in the commodified housing market drives up homelessness rates (Falvo, 2024; School of Cities, 2025). Despite this, the availability of non-market housing has steadily decreased over the past three decades, and homelessness has emerged as a visible crisis that is overwhelming frontline services. There is no level of service delivery or care that can outweigh the negative health and social impacts of being homeless (Harris et al., 2019; Wiens et al., 2021). Stable housing enables greater stability in individual's lives which contributes to decreased reliance on emergency services.

In the private market, renters' needs come second to profit. The need for more rent-geared-to income housing, transitional, and supportive housing is well documented (Tamarack Institute, 2025). Income and strong tenant protections are equally essential components to keep people housed, yet are currently being eroded (Advocacy Centre for Tenants Ontario, 2025). Although solutions are well known, housing reforms proposed in Bill 60 (Fighting Delays, Building Faster Act, 2025) and Bill 10 (Protect Ontario Through Safer Streets and Stronger Communities Act, 2025) represent a step backward from their stated goals, with experts warning they may increase discrimination and evictions among tenants (Canadian Mental Health Association, Ontario, 2025; Canadian Mortgage and Housing Corporation, 2025).

3 Strong physical infrastructure enables good care, but deregulating and privatizing it creates a greater burden of care

Utility infrastructure is foundational to care because it determines the time and intensity of the efforts needed to carry out household labour. Gaps become increasingly visible in moments of generalized insecurity, such as extreme weather events and pandemics. Lack of clean water in First Nations under boil water advisories not only increases the labour required to meet care needs, but is directly linked to mental health crises

(Casey, 2025). Following the Walkerton Inquest, regulations were created in Ontario to maintain and oversee safe drinking water (Kwofie, 2025). However, access to clean and safe drinking water is not protected by law, and forthcoming changes to the Clean Water Act puts Ontario's drinking water at risk of privatization and deregulation. The privatization of Hydro One is a poignant example of that trajectory that unfolded under multiple subsequent provincial governments (Canadian Union of Public Employees, 2015; PressProgress, 2015).

Failures to fund and maintain care enabling infrastructure at the provincial and federal levels, such as public transportation and housing, shift responsibilities onto municipalities and households. These gaps create opportunities for the private sector to encroach on the delivery of public goods through public-private partnerships in transit and the proliferation of financial firms in the housing market (August, 2022; CUPE, 2024).

Infrastructure policy has not kept pace with the growth of virtual care and digital technology needs in care settings (Fierlbeck & Wyonch, 2025). Increased reliance on virtual healthcare services has not been matched by policies that improve connectivity in Northern Ontario or prioritize affordable broadband access. Instead, private virtual care services have expanded alongside public options, while persistent barriers to equity continue to disproportionately affect older adults, people living in poverty, Black, Indigenous, and racialized communities, precariously housed or people experiencing homelessness, and newcomers (Public Health Ontario, 2023). People living in institutions, including long-term care homes and hospitals, also face high Wi-Fi costs and content restrictions, despite internet access being integral to social connection, access to services, and a recognized social determinant of health (Ghonaim, 2021).

4 Privatization of care services undermines the essential delivery of nonprofit services

Across many care services, unregulated private care options have expanded, including for addiction treatment services, mental health services, group homes, long-term care, child care, surgical services, staffing agencies, and more. At a time where public and nonprofit care systems are under tremendous strain, a growing portion of tax dollars are diverted to private companies seeking to profit off medical and social needs (Longhurst, 2023, 2025).

Gaps in care create a market for for-profit providers to offer services that are inaccessible to many and operate without accountability or oversight (D'Souza et al., 2025). The result is a two-tiered care sector, where those who can afford to pay might opt for private services while others are limited to a public system. While the expansion of for-profit care might give the illusion of reducing caseloads in the public sector, research demonstrates that it has the opposite

effect (Angell, 2008). For-profit care diverts public funding towards private companies, exacerbates staff shortages by drawing workers from the public healthcare system, and is proven to yield worse care outcomes (Ontario Health Coalition, 2024).

Further, the quality of care provided by the private sector is inconsistent and offers no guarantees of high-quality care than the public sector, with little transparency of standards or management. Private sector interests extend into public sector institutions through the use of private staffing agencies to fill staff shortages in hospitals and other care spaces (Longhurst, 2025). While agencies profit, workers in the agencies have little power and often experience exploitation and wage theft with limited resources (Bedard & Gellatly, 2025). In care settings, any money extracted as profit can be understood as money directly diverted away from the provision of care.

5 Punishment and criminalization are the response to care needs when the appropriate services and support are not available

As a growing number of individuals are left behind by under-resourced care services, they are met with policies and procedures that make it increasingly difficult to access the care they need. The closure of safe consumption sites as a result of Bill 223 (Safer Streets, Stronger Communities Act, 2024) is a clear illustration of a policy that makes it more difficult for people who use drugs to access support and increases public drug use, preventable harm, and drug poisoning deaths (Ontario Drug Policy Research Network, 2025).

Continued experiences of systemic neglect ignite the conditions for crisis, and in the absence of the appropriate care services and infrastructure, people are more likely to come into contact with policing and punishment. Bill 6 (Safer Municipalities Act, 2025), is just one example of a policy that increases contact between police and encampment residents (Pitawanakwat et al., 2025). The risks of arrest leading to incarceration or institutionalization are disproportionately heightened for people who are likely to experience crises in public spaces (O'Grady & Simpson, 2024; Pitawanakwat et al., 2025). This includes people experiencing homelessness, as well as people in social and supportive housing, youth, Black, Indigenous, and racialized people, and refugees and asylum-seekers.

Social stigma rooted in ableism, classism, and racism promotes the belief that people in crisis do not have agency and legitimatizes violence and coercion through logics of surveillance, punishment, pathologization, and confinement as acceptable features within care (Mannoe, 2023; Rozinskis & Rourke, 2024). Evidence proves that those features undermine care and fail to produce safety for anyone and will disproportionately

impact Indigenous, Black, and racialized people (DuBois et al., 2025). These ideas are already embedded into Ontario policy through the Mental Health Act which enables involuntary apprehension and treatment (Centre for Addiction and Mental Health, 2025).

6 Weak employment legislation leaves care workers vulnerable to workplace abuse and exploitation

Employment laws and protections like the Employment Standards Act, the Employment Protections for Foreign Nationals Act, and the Ontario Health and Safety Act all share the common stated goal of ensuring safe working conditions, free of abuse and exploitation. In practice, these legislations prove to be weak and ineffective remedies when workplace violations do occur, and care workers in the gig economy are entirely unprotected by these laws (Hopwood et al., 2024; Ziegler et al., 2020). Employers and recruiters by-pass legislation through commonly used loopholes like misclassifying workers, or attracting migrant workers with tourist visas rather than work permits (Migrant Workers Alliance for Change et al., 2023).

Insufficient funding and prioritization have led to a drastic reduction in preventative inspections, leaving the entire burden of addressing labour conditions on workers themselves. Complaints-based mechanisms are an ineffective tool when workers are living paycheck to paycheck or their employer has (or claims to have) power over their immigration status (Yang & Liu, 2021). Even when workers organize to bring forward complaints, there is little recourse for them and next to no consequence for employers (Bedard & Gellatly, 2025). The pervasive nature of worker exploitation in Ontario's care economy highlights that it is not an issue of "bad employers" but a systemic and structural issue (Amnesty International, 2025). These issues stem from social hierarchies that attribute unequal values to workers and from employment, immigration, and care policies that reinforce these forms of oppression.

Ontario's care economy is in a precarious position

The Ontario scorecard shines a light on the limits of Ontario's care policy. Care is being overlooked and undervalued and as a result Ontarians are navigating a policy landscape devoid of care. While limited policies exist, they are not keeping up given lack of adequate review or investment. Rather than using a care-informed approach, public policy is going in the opposite direction by reviving traditional economic policies focused on resource extraction and bolstering male-dominated sectors.

The current moment is defined by care services and workers pushed to crisis points, despite sector experts, advocates, frontline workers, and labour unions having sounded the alarm for years as the situation worsened. The underfunded and under-resourced care economy cannot keep pace with care needs, and the responsibility to fill those needs continues to fall on unpaid caregivers.

As grim as it is, there is an opportunity to seize the moment for transformation. The health of the care economy impacts everyone, and it will take a collective effort to chart new pathways that deliver on a careFULL Ontario.

A careFULL Ontario is possible

How to build a careFULL Ontario

Emerging evidence across jurisdictions demonstrates that levelling up the care sector has significant social, economic, and ecological benefits. It is good for people, especially women as they predominantly rely on and work in care, good for the economy, good for the environment, and good for government revenues as it is certain to pay large dividends in improving the well-being of Ontarians.

Building a careFULL Ontario requires public policy to be care-informed and care-centred, including policies focused on the care economy itself.

Below are our principle recommendations:

Move away from criminalization and towards public policy that centres care

- Prioritize investment in care systems and services over criminalization, by repealing legislation that makes behaviours and survival strategies that stem from unmet care needs illegal.

Recognize care-enabling physical infrastructure as a key component of care

- Recognize utility and social infrastructure as essential components of paid and unpaid care by involving care advocates in policy decisions.
- Invest in Rent-Geared-to-Income housing and tenant protections to ensure that people can access housing and stay housed.
- Implement free transit services, beginning with unpaid and paid careworkers, people on Ontario Disability Program (ODSP) and Ontario Works, older adults, and youth.

Decent work for care workers

- Pay competitive wages to care workers to take meaningful steps towards reaching pay equity in Ontario.
- Raise employment standards to meet a decent work floor and expand the scope of employment legislation to reflect the changing landscape of care work.
- Grant permanent resident status to all current migrant workers and future migrant workers upon arrival to reduce vulnerability to exploitation.
- Prioritize preventative workplace safety measures rather than relying on workers to report concerns through complaints-based mechanisms.

Bolster the care economy

- Invest in public and nonprofit care systems, from primary care and home care to safe consumption sites and mental healthcare, to reduce reliance on emergency services and ensure care is accessible to all.

Take profit out of care

- End privatization of all care services and make for-profit actors obsolete by redirecting public money allocated to for-profit providers back into the public sector to offer high-quality, accessible care services.
- Amend care-related legislation to prohibit privatization and deregulation.

Continues next page

Take profit out of care (Continued)

- Reverse the decades-long pattern of inadequate healthcare and social service funding by moving toward long-term core funding models.

Create better conditions for unpaid care

- Acknowledge the dependency on unpaid care and work towards social change by measuring the impact care policies have on unpaid caregivers.
- Implement a basic income to ensure that benefits are universal and not dependent on employment, immigration status, or marital status.

Conclusion

Nonprofits and their workers are a core part of the care economy. Often, nonprofits are the organizations providing specialized care to people who are excluded from inaccessible and expensive private sector services. Nonprofit workers have unpaid care responsibilities in their home that they do on top of providing emotionally and physically demanding care work, often for little pay and with limited resources. All nonprofits should be invested in strengthening the care economy and transforming the conditions of care for themselves and the people they work alongside and those they support.

The scorecard includes evaluation frameworks for how policies impact unpaid care, a consideration that is rarely afforded in most policy-making in Ontario. By bringing into focus how all care, both paid and unpaid, is interconnected, the scorecard can be used to remind us that everyone relies on care work. The efforts to improve the conditions of care impact all of us.

The scorecard is a vital advocacy tool. It not only highlights gaps in care policy but also identifies the government actors responsible for oversight and regulation. By clearly outlining which policies are limited and who is accountable for their outcomes, the scorecard helps guide more focused and effective advocacy efforts. The recommendations put forward in this report serve as a call to action for all to continue this multi-sectoral advocacy work. Intentionally high-level, they recognize the multitude of pathways out of crisis that exist when the core intention of the work centers care equity for all.

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Appendix

Methodology for adapting and scoring the Care Scorecard for Ontario

The scorecard functions as a practical tool to evaluate policy that shapes paid and unpaid care at a national or sub-national level. It is intended to measure progress, identify gaps in care policy, and to be used as a political advocacy tool to transform social conditions that hinder care and disproportionately impact women, girls, and gender diverse people.

The Care Scorecard for Ontario is an adaptation of the care policy scorecard designed by multiple organizations including Oxfam, International Center for Research on Women (ICRW) Asia, International Domestic Workers Federation, Africa Leadership Forum, UK Women's Budget Group, Ciudadanía Bolivia, Padare Men's Forum Zimbabwe, the Ugandan Women's Network, and Youth Alive! Kenya. The original materials produced included a scoring guide, and a scorecard template.

The Care Scorecard for Ontario includes two sections, paid and unpaid care, split into policy areas. Each policy area is further broken down into indicators, with each indicator representing a specific policy. Indicators were evaluated using assessment criteria, generally there are 13-20 criteria per indicator.

The research team that led this scorecard adaptation and scoring was composed of Inez Hillel and Jay Piotrowski of Vivic Research.

Adapting the scorecard template to Ontario

For this project, the scorecard template was adapted to assess care in Ontario. All indicators were adapted to the provincial level, and indicators where the policy was within federal or municipal jurisdiction were excluded. A small number of indicators were also excluded to narrow the focus of the scorecard due to budget and time constraints. These changes were made following preliminary conversations with researchers and policy experts in the Ontario/Canada care economy.

Two group consultation sessions were held to familiarize people with the scorecard and to gather feedback on key issues in Ontario's care economy. Feedback was incorporated into the revisions of the edits in the form of adding or removing indicators, and in some cases was used to refine assessment criteria.

Adding/removing indicators

Twelve indicators from the scorecard template were excluded in the Ontario adaptation:

1. Sanitation services and facilities
2. School-based meals and/or food vouchers
3. Care-sensitive public works programmes
4. Onsite childcare
5. Breastfeeding at work
6. Social security benefits for workers
7. Prohibition of child labour
8. Advertising standards and media representations prohibiting gender stereotypes
9. Government awareness-raising campaigns that aims to value and recognize care work and/or shift gender norms around care
10. Education policy that addresses gender stereotypes
11. Measurement framework that captures and monitors progress against well-being
12. Time use data and surveys.

In addition, the following three indicators were added:

+ Clean air infrastructure
+ Connectivity infrastructure (Discussed further in Limitations and Strengths section)
+ Housing infrastructure (Discussed further in Limitations and Strengths section).

The scorecard template includes the indicator **care services for people with additional needs**, and specifies that the assessment questions should be scored for need-specific services separately. The following six areas of care services were scored to reflect what is within the scope of care policy at the provincial level:

+ People with developmental disabilities
+ People with mental health needs
+ People with physical disabilities
+ People experiencing gender-based violence
+ People experiencing homelessness
+ People with addictions.

The indicator **care services for older people**, in the scorecard template, was split into two indicators, **residential long-term care** and **homecare**.

Two policy areas, **caregiver benefits** and **Ontario Disability Support Program (ODSP)**, were scored for the indicator **cash transfers related to care**.

Refining scorecard indicators and assessment criteria

Minor changes were made to indicators and assessment criteria to capture specific elements of the Ontario care economy:

Changes

- Language in the scorecard was changed to reflect that policy at the provincial level was being evaluated.
- For indicator 1.2.1: Public healthcare, the focus was narrowed to primary care, based on the scoring guide, which recommends picking one aspect of the broader indicator to score.
- The time horizon for the budget allocation assessment criterion was changed to cover spending since 2015, rather than the previous budget cycle, to avoid comparing current expenditures with the non-representative funding increases that occurred during the height of the COVID-19 pandemic.

Additions

- An assessment criterion to evaluate if care was consent-based was added.
- An assessment criterion to evaluate if culturally relevant care options were available was added.
- An assessment criterion to evaluate if the evolution of the policy reflected carceral logics was added. For this evaluation, we defined carceral logics as the mindset, policies, and practices that are rooted and shaped by logics of punishment and imprisonment. We relied on this assessment criterion to explore how surveillance, punishment, and control can be embedded into care policy.
- An assessment criterion to evaluate trends in privatization over the last decade was added.

Removals

- Assessment criteria that were specific to federal capacity (e.g. ratifying international treaties) was removed.

Methodology for scoring

The Care Scorecard for Ontario is a snapshot of the state of the care economy at a specific point in time; scoring and the validation sessions took place from July to December 2025.

Each assessment criteria were scored using the scoring guide developed alongside the scorecard template. Each assessment criteria is assigned a score of 0, 0.5 or 1. Assessment criteria were scored a 0.5 in instances where the response to the criterion was neither yes or no to the full question, and does not necessarily reflect a halfway point.

In many cases, there were multiple policies, action plans, programs, and frameworks that guided the delivery of care services/infrastructures for a single indicator. Vivic Research tried to narrow down a single policy whenever possible, but in cases where it was not possible the team has listed each document considered in the scoring. When possible, scoring legislation was emphasized over action plans and other non-legislative policy documents.

Vivic Research's team members both scored each indicator independently and then compared their results to work through any discrepancies in the scores. Sources used for scoring include Ontario statutes and regulations, bills, budget documents, research reports from nonprofits and other advocacy groups, policy briefs, and news articles. In addition to desktop research, scores were determined based on validation sessions with care policy and sector experts, coordinated through ONN's network.

Limitations and strengths

In two instances, Vivic Research was unable to complete the scoring for indicators that were added to the Ontario scorecard: connectivity infrastructure and housing infrastructure. In both cases, a scored indicator was not included but rather a short explanation about their role in the care economy at the provincial level.

Connectivity infrastructure was initially included due to the rapid expansion in virtual health services to ensure that links are made between connectivity infrastructure and access to care, but conversations with policy experts led Vivic Research to understand that connectivity infrastructure was primarily a federal responsibility. The inclusion of housing as care infrastructure also proved challenging within the context of the scorecard, as housing infrastructure policy is currently deeply entrenched in the private sector. Land use policy and tenancy

acts provide some legislative guidance on housing, but when considering housing as infrastructure, government policy is sparse. While housing infrastructure policy was not scored, provincial policy on social housing was scored through indicator 1.2.9 Homelessness and housing services.

A second challenge the research team encountered while scoring was reconciling different expert perspectives heard during the validation sessions. In consultations with care policy and sector experts, perspectives differed based on the primary populations they were serving, particularly in relation to assessment criteria around access barriers and outcomes of the policy. To remain consistent in the scoring, an intersectional lens was used to understand how policies impacted people living at the intersection of multiple axes of oppression, recognizing that the final scores would not necessarily reflect everyone's experience with care systems. Perspectives around the design of the policy, such as whether consultations occurred in the policies' development, were likely to differ by organization.

Furthermore, the original scorecard is designed in a way that favours the existence of legislated guidelines that dictate how care should be delivered. This assumption was challenged during the validation sessions with advocates in the gender-based violence (GBV) sector, which highlighted that survivor-centred organizations benefit from the ability to approach service delivery from a survivor-led perspective rather than through a top-down model. This feedback was incorporated by excluding assessment criteria from the total score that would have penalized a practice that is a positive reflection of grassroots feminist organizing.

A main strength of the Ontario scorecard is its ability to identify which policies can be attributed to the gaps in care that people experience. The scorecard identifies specific legislation, and reveals which government offices are responsible for their implementation. Consultations were essential in forming the research team's understanding of how policy was translated into care, as policies were much more comprehensive in theory than in practice.

While the scorecard is divided into paid care and unpaid care sections, there are assessment criteria in each indicator that consider how policy impacts unpaid caregivers. By breaking down the siloes between paid and unpaid care, the scorecard highlights and reminds advocates how all care is interconnected, opening up avenues for deeper advocacy, and opportunities for solidarity across all kinds of care work.

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