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# Valuing the Invaluable

Rethinking and respecting caring work in Canada

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Salimah Valiani, PhD  
Policy Analyst, Economist  
Ontario Nurses' Association



# Valuing the Invaluable: Rethinking and respecting caring work in Canada

by Salimah Valiani, PhD\*  
Ontario Nurses' Association

"...a mother with a family is an economist, a nurse, a painter, a diplomat and more."  
– Buchi Emecheta

During the United Nations Decade for Women, from 1975 to 1985, the United Nations (UN) led an unprecedented international effort to collect available evidence of the position of women in countries around the world. These words of Buchi Emecheta are part of the findings of the UN effort published in a book entitled, **Women: A World Report**. Though this volume documenting and analyzing the inequalities faced by women internationally was released over 20 years ago, women around the world continue to face a vast range of inequalities. (UNIFEM: 2011) A good part of the reason for this is the fact that a large portion of the work women do is caring work, and the skills involved in caring work are overlooked in most cultures.

Through the overlooking of skills involved in caring, caring work is undervalued in Canadian and other societies. As Emecheta puts it for the case of mothers, many of the skills applied daily by mothers are overlooked because they are characteristic of roles typically associated with men – the mother's skills as an economist, as a creator, as a diplomat, as a repair person, to mention just a few. Other skills involved in caring work are overlooked completely because they involve abilities which are intangible, and in turn difficult to define. Caring work is thus undervalued at the micro-level in that it is not seen as worthy of pay. At the macro level, it is undervalued in that it is not seen as necessary to include in the tabulation of the gross domestic product of nations.

## **Valuing Care: Unlearning the overlooking**

Care is the raw material for the production of capabilities which are central to human survival. Along with food, care is the basis of physical and mental health. Without care, food cannot be consumed, babies cannot grow, the ill cannot be cured, and the elderly cannot endure. Care is the means by which skills and proclivities crucial to the self and others are taught and learned – skills such as respect, cooperation, empathy, giving, consideration, self-discipline and caring itself.

The concept of *carework* aims to capture the complexity of work carried out mostly but not only by women, both paid and unpaid. Carework involves "a distinctive pattern of thought that can be learned and practiced, but which differs sharply with scientific rationality." (Abel and Nelson: 1990, 9) Though typically seen as coming naturally to

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\* This paper has benefitted from the comments of colleagues at the Ontario Nurses' Association as well as from comments of Dr. Shahra Razavi, Research Coordinator at the United Nations Research Institute for Social Development (UNRISD). The author may be contacted at [salimahv@ona.org](mailto:salimahv@ona.org)

those performing it, carework is a complex activity consisting of technique, effort, time, and skill. (Stelling: 1994; Mellow: 2007)

For analytical purposes, carework may be broken down into instrumental tasks, or *caring for*, and affective labour, or *caring about*. (Abel and Nelson: 1990; Graham: 1983) Due to the different types of care required by human beings, there is a range of skills associated with a range of caregiving roles, each involving varying amounts of practical and theoretical learning. In addition to the caregiving roles of mother and father, there are the roles of registered nurse, personal support worker, grandmother, cook, cleaner, registered practical nurse and child care worker, to mention a few.

### **The Continuum of Undervaluing in the Continuum of Care**

The concept of the *care penalty* underlines the pattern found across countries in which those performing paid carework – whether female or male – earn relatively less than those in non-caring fields. (Razavi and Staab: 2010) In the United States of America, for example, care workers face a wage penalty of five to six per cent for doing carework, regardless of sex, race, or job characteristics. (England, Budig and Folbre: 2002)

In Taiwan, Mexico, the USA, the Russian Federation, Canada, Hungary, Belgium, the Netherlands, Germany, France, Sweden, and Finland, though care workers are more likely to be professionals or/and have comparatively more formal education than non-care workers, the average earnings of care workers are equal to those of non-care workers. (Budig and Misra: 2010)

In South Africa, though professional nurses have four years of university training and thus fall in the same official national occupational category as engineers, professional nurses earn considerably less. At the upper salary band, more than one third of engineers earn 16,000 Rand per month, while only one per cent of professional nurses earn that amount monthly. At the lower salary band, 65 per cent of engineers earn 6,000 Rand per month as compared to 54 per cent of professional nurses. In South Africa, 91 per cent of professional nurses are female and 92 per cent of engineers are male. (Lund and Budlender: 2009)

In the Canadian instance, a continuum of undervaluing can be traced within the continuum of carework. The continuum of carework as conceptualized here includes unpaid and paid carework, both within and beyond the home. (See Figure 1 below) Volunteers providing support and care join mothers in the spectrum of unpaid, undervalued carework in Canada.

In the area of health care, hospital volunteers provide instrumental and affective care to patients and their families. Hospital volunteers in Alberta, for example, provide emotional support to patients and the family members of patients through such activities as cuddling, talking, spending quiet time, and providing companionship to patients waiting for porters and drivers. (Mellow: 2007, 459) These unpaid care workers lead patients in rehabilitation exercises after patients have been taught exercises by physiotherapists.

Under the direction of nursing staff, unpaid care workers provide physical care to patients in the form of feeding, bathing, and toileting. The work of hospital volunteers in Alberta is defined through job descriptions and assignment guides. These outline the objectives of volunteer roles, desirable skills and qualities, specific tasks, work shifts, training, and persons to whom volunteers must report. (Mellow: 2007, 456)

Returning to the national scale, in Canada in 1997, 22 per cent of volunteers reported being involved in “providing support or care” within organizations. By 2000, this figure had increased to 27 per cent. (Hall et al.: 2001, 41) In 2007, 33 per cent of volunteers reported contributing their time to health, hospital, social service, education/

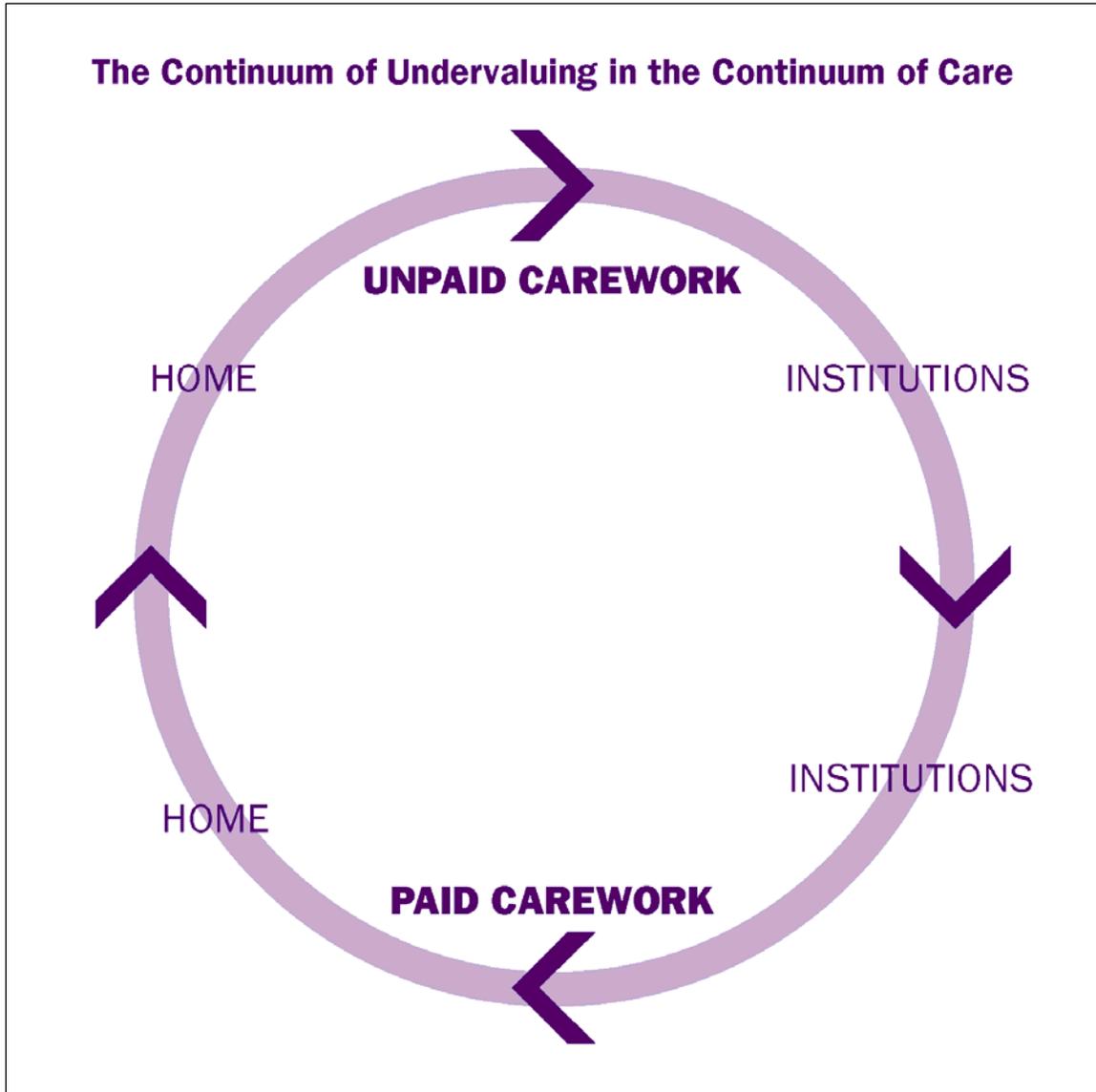


Figure 1

research, and development/housing organizations. (Hall et al.: 2009, 37)<sup>1</sup> In terms of volunteer hours, unpaid caring labour in these areas constituted 40 per cent of total volunteer hours in Canada in 2007. (Hall et al.: 2009, 37)

<sup>1</sup> Given the changes in method of data collection adopted by Statistics Canada for the 2007 Canada Survey of Giving, Volunteering and Participating, a comparison of volunteers involved in “providing support or care” in 2007 with previous years is not possible. The 2007 figure stated here is the closest comparison possible.

In the area of health care, the growing use of volunteer labour in hospitals and other organizations is linked to the fall in nurse to population ratios resulting from the elimination and casualization of registered nursing jobs throughout the country. More specifically, many of the caring tasks performed by hospital volunteers are considered by nurses to be part of nursing work. In the early 1990s, the total registered nurse (RN) to population ratio in Canada was 824 per 100,000 population. (Canadian Institute for Health Information: 2010, 10) By 2009, the ratio had fallen to 789 RNs per 100,000 population.<sup>2</sup> For the province of Ontario, the ratio of direct care RNs to population in 2009 was particularly low: 644 to 100,000 population (Canadian Institute for Health Information: 2010, 10). In the rest of the country in 2009, the average ratio of direct care RNs to population was 785 to 100,000.<sup>3</sup>

The undervaluing of unpaid caring labour takes shape in at least two forms. As mentioned above, the carework of mothers and other caregivers within the home is undervalued in that it is not seen as worthy of pay, nor is it considered to be necessary to include in the tabulation of Canada's gross domestic product.<sup>4</sup> The labour of hospital and other caring labour volunteers is undervalued in that it is unpaid despite the essential functions it serves. Coming full circle, the use of hospital volunteers to carry out nursing work is additionally a devaluing of registered nurses in that it denies RNs the ability to provide holistic care to patients, as they are trained to do. Bathing patients, for example, is stressed by RNs as an important task for RNs to perform because it allows them to undertake a full assessment of the condition of patients.

Within the spectrum of paid, undervalued carework in Canada, migrant live-in caregivers figure in one extremity and registered nurses in the other. The undervaluing of migrant live-in caregivers takes shape in the overlooking of skills applied daily to care for children, the elderly and people with disabilities within the home, as in the case of mothers. Additionally, though paid, migrant live-in caregivers are often paid below the provincially mandated minimum wages as stipulated by the federal government, which administers the Live-in Caregiver Program (LCP). (Langevin and Belleau: 2000)

The most common undervaluing of this type is unpaid overtime, wherein live-in caregivers are not paid for carework performed beyond regular working hours. (Arat-Koc: 1992; Pratt: 1999; Arat-Koc: 2001; Stasiulis and Bakan: 2003; Valiani: 2009) This occurs primarily due to the coercion inherent in the employer-migrant caregiver relationship. Workers entering Canada through the LCP are obliged to live in employers' homes and are dependent on employers to maintain their legal status in Canada. Despite this blurring of working and living space, and the abuses likely to occur, employers of live-in caregivers are not monitored by the federal or provincial

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<sup>2</sup> This ratio includes registered nurses working in all areas: direct care, education, and administration.

<sup>3</sup> This ratio was calculated by the author on the basis of CIHI data on regulated nursing workforce and population estimates for all health regions in Canada. (See CIHI: 2009, 132-136)

<sup>4</sup> Statistics Canada includes unpaid carework in the "Satellite account of non-profit institutions and volunteering." The account includes a set of standard economic accounts and a nonmarket extension to put an economic value on unpaid volunteer labour. It is unclear, however, whether or how the satellite account is incorporated into economic policy decision making. For more information on the account see <http://www.statcan.gc.ca/nea-cen/list-liste/npiv-nblb-eng.htm>

governments because in most provincial legislation, the home is considered part of the private sphere and hence beyond the bounds of monitoring. (See Valiani: 2009) The undervaluing of live-in caregiver labour is particularly pronounced in the instance of internationally trained RNs entering Canada through the LCP.

Unpaid overtime is also a growing phenomenon for RNs in Canada. Between 1997 and 2008, the annual aggregate unpaid overtime worked by public sector registered nurses virtually doubled, rising from 51,200 to 99,000 hours. (Lasota: 2009, 28) Including both unpaid and paid overtime, the number of overtime hours worked weekly by RNs quadrupled between the late 1980s and 2008. In 1987, RNs worked 144,600 overtime hours per week, while in 2008, RNs worked 412,200 hours per week. (Lasota: 2009, 28) Within Ontario, it is due to the high number of paid overtime hours worked by nurses, rather than excessive salaries or generous recognition of professional service provided, that over 1,000 RNs as well as some registered practical nurses (RPNs) figured in the "Sunshine list", or the list of public sector employees earning over 100,000 CAD annually.

Not unrelated to excess levels of unpaid and paid overtime, among all health care workers, public sector RNs have the highest rate of absenteeism due to illness and disability in Canada. In 2008, 10.1 per cent of public sector RNs working 30 hours or more per week were absent due to illness or disability, an increase of 2.2 per cent from 2005. (Lasota: 2009, 1) In Ontario, RN absenteeism due to illness or disability doubled between 1987 and 2008, from 4.2 per cent to 8.8 per cent. (Lasota: 2009, 34) All of this is rooted in the fall in nurse to population ratios resulting from the elimination and casualization of registered nursing jobs in provinces and territories throughout Canada. The elimination and casualization of RN jobs has been implemented despite numerous studies demonstrating that hospital patient outcomes improve when the proportion of care hours provided by RNs is raised. (Weiss et al.: 2011; Needleman et al.: 2011; Dall et al.: 2009; Aiken et al. 2002) Weiss et al. (2011), for example, found in a study of four hospitals in the Midwestern USA that the larger the number of RNs working in a hospital surgical units at a given time, the lower the number of patients readmitted to the hospital or re-entering via the emergency unit. The same study found that a reduction of RN overtime hours also contributed to a fall in the number of patients readmitted.

Returning to the issue of unpaid overtime, regardless of the salary level or skill category of care workers, unpaid overtime is an undervaluing of carework identical to the undervaluing of unpaid care workers – all of whom fall within the continuum of undervaluing in the continuum of care in Canada.

### **The Continuum of Undervalued Carework in Ontario**

An examination of salaries in Ontario demonstrates that the care penalty exists in varying degrees for care workers across skills levels, regardless of sex and whether occupations are female or male dominated.

**Table 1. Hourly Wages by Occupation, Ontario, 2009, Canadian Dollars (CAD)**

Occupation*	Average Wage	High Wage	Low Wage
<i>NOC A - PROFESSIONAL</i>			
Architects (only Toronto, 2005)**	35.10	N/A	
<b>Registered Nurses ♀</b>	<b>34.70</b>	<b>40.50</b>	<b>25.75</b>
Electrical and Electronics Engineers	33.85	49.65	22.00
Mechanical Engineers	31.35	44.05	20.60
Industrial/Manufacturing Engineers	28.95	38.50	20.65
<i>NOC B - PARAPROFESSIONAL</i>			
Police Officers (not commissioned)	32.25	39.10	19.25
Steamfitters, Pipefitters, Sprinkler System Installers	31.60	38.25	18.75
Industrial Electricians	28.75	36.40	20.50
Electricians (except industrial and power system)	26.00	37.10	14.00
Industrial Instrument Technicians and Mechanics	25.90	36.70	16.90
<b>Licensed Practical Nurses ♀</b>	<b>23.40</b>	<b>26.15</b>	<b>19.55</b>
Chemical Technologist/Technician	21.40	29.65	14.85
Legal Secretary ♀	18.95	27.35	12.00
<b>Medical Secretaries ♀</b>	<b>18.05</b>	<b>23.30</b>	<b>12.00</b>
<b>Chefs</b>	<b>15.55</b>	<b>22.60</b>	<b>10.25</b>
<b>Cooks</b>	<b>11.85</b>	<b>16.50</b>	<b>10.25</b>
<i>NOC C – INTERMEDIATE OCCUPATION</i>			
Aircraft Mechanics and Aircraft Inspectors	24.75	34.00	14.00
Heavy Equipment Operators (except crane)	23.70	32.65	16.20
Truck Drivers	19.05	24.85	15.00
<b>Nurse Aides, Orderlies, Patient Service Associates</b>	<b>17.40</b>	<b>21.25</b>	<b>12.00</b>
<b>Other Assisting Occupations in Support of Health Services</b>	<b>15.80</b>	<b>23.35</b>	<b>10.50</b>
<b>Visiting Homemakers, Housekeepers and Related*** ♀</b>	<b>15.00</b>	<b>19.40</b>	<b>10.35</b>
<b>Babysitters, Nannies, Parents' Helpers ♀</b>	<b>11.80</b>	<b>16.00</b>	<b>10.25</b>

Source: Human Resources and Skills Development Canada, Labour Market Information, Wages and Salaries, <http://www.labourmarketinformation.ca> (Accessed April 19, 2011)

\*For the occupational categories of Head Nurses and Supervisors, Nursing Assistants, Physiotherapists and Occupational Therapists, 2009 data were not available for the province of Ontario.

\*\*Data was not available for the province of Ontario for 2009.

\*\*\*Personal Support Workers fall in this occupational category of the NOC system.

Using official categories of the National Occupation Classification system (NOC), Table 1 lists wages for professional occupations requiring university training (NOC A), paraprofessional occupations requiring two to three years of college training or two to five years of apprenticeship training (NOC B), and intermediate occupations requiring one to four years of secondary school education (NOC C and D). Carework occupations appear in bold characters and occupations dominated by female workers carry the symbol ♀.

Among professionals requiring four years of university training (“NOC A - Professional” in Table 1), though the average hourly wage of registered nurses in Ontario is higher than that of several male-dominated occupations, it is unclear this would be so if male-dominated professional occupations were unionized to the degree that RNs are unionized. Based on 2010-2011 data of the Ontario Nurses' Association (ONA) and the College of Nurses of Ontario – including some 1,600 RNs of the Trillium Health Centre who recently joined ONA – union density of RNs is 73 per cent. Unionization reduces the care penalty due to the greater relative wages achieved through collective bargaining. Nevertheless, despite high union density and the redistributive power of collective bargaining, RNs fall below workers in male-dominated occupations in terms of upper-level hourly wages.

Among paraprofessionals (NOC B occupations), the average wage of licensed practical nurses (RPNs in Ontario) is below that of several male-dominated occupations. The hourly wage gap between RPNs and police officers – a male-dominated occupation with high union density – is significant, at almost 10 CAD. RPN wages are below those of at least one male-dominated occupation requiring less training – that of aircraft mechanics and inspectors, which figure in NOC C, or one skill level below RPNs. As in the instance of the RN category, upper-wage levels in the RPN category, despite relatively high union density, are lower than upper-level wages of non-caring paraprofessional occupations including that of legal secretaries, which is female dominated. Finally, paraprofessional care workers employed as medical secretaries, cooks and chefs earn less than legal secretaries and far less than most paraprofessionals.

In terms of intermediate occupations (NOC C), average weekly wages of all care workers fall below the wages of all non-carework occupations of the same skill level. Most stark is the care penalty faced by babysitters, nannies, and parents' helpers, the paid caring occupations with characteristics most closely resembling those of unpaid carework within the home. Average wages of these care workers are less than half of those of the non-care workers in the categories of aircraft mechanics/inspectors and heavy equipment operators.

### **Valuing Carework: Redistributing to value the invaluable**

The following recommendations envision a redistribution of resources to begin undoing the undervaluing of carework. ONA calls on provincial and federal elected officials, organizations, and residents of Ontario to consider these recommendations in honour of Mother's Day, 2011.

1. In March 2011 in the state of New York, legislation was introduced to limit annual executive salaries in publically financed hospitals to 250,000 US dollars. (New York Times, March 15, 2011) This is far below what several Ontario hospital executives collected in wages and other benefits in 2010, including those who were not employed for the full year due to resignation or layoff. The average total remuneration (including salary and benefits) collected by chief executive officers or/and presidents of Ontario's major 10 hospitals in 2010 was 538,148.36 CAD.<sup>5</sup> If a cap on the remuneration of hospital executives in Ontario was legislated to the level proposed in New York state, this would constitute considerable savings within Ontario hospitals. These savings could

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<sup>5</sup> Calculation by author based on data in “Public Sector Salary Disclosure 2011”, Ontario Ministry of Finance, <http://www.fin.gov.on.ca/en/publications/salarydisclosure/2011> (accessed March 31, 2011).

then be directed toward the goal of eliminating the care penalty for hospital cleaners and others falling within the NOC category, “Other Assisting Occupations in Support of Health Services”. This goal should be legislated and enforced by the Ontario government so as to assure that all hospital service workers within this category benefit from the elimination of the care penalty, including where services have been contracted to private firms. Additional funds required in the public sector to meet this goal should be allocated and designated by the government to demonstrate respect for the crucial role of these service workers in curing illness within Ontario hospitals.

2. The Ontario government’s decision to support the federal government’s corporate tax policy by reducing Ontario tax rates on large corporations to 10 per cent is estimated to reduce Ontario’s fiscal capacity by 2.5 billion CAD by 2012-2013. (Mackenzie: 2011) If this tax policy were reversed in Ontario, these revenues could be used to begin addressing two pressing issues within the continuum of undervalued carework in Ontario: the extremely low RN to population ratios, and the rising impoverishment of sole female-headed households. As a matter of priority, the renewed fiscal capacity resulting from the reversal of corporate tax cuts should be used to: 1) create new permanent, full-time equivalent RN positions, and 2) provide a living wage to all those working within the home as full-time care workers, including family members. Accounting for regional variations and adjusted regularly relative to inflation, the living wage should consist of an income enabling a full-time worker to meet the basic needs of one adult and one child, as well as to save for the future. The savings measure should be determined with the participation of unions and community organizations.

3. Given that 73 per cent of women with children under the age of 16, and 64 per cent of women with children under the age of three are employed in Canada (Statistics Canada: 2010) a federally funded, non-profit, provincially regulated child care system is fundamental to allow women to increase their well-being through paid employment while raising children. Such a system should include national standards assuring quality care for children. Provinces should be required to conform to these standards in order to qualify for ongoing financing. This financing should be adequate to assure living wages (as defined above) for child care and early learning workers so as to demonstrate cultural value for the invaluable work of caring for children in Canada.

4. As the aging population increases in Canada, a comprehensive approach to homecare and long-term care for the elderly is required. A publically funded, non-profit, regulated homecare system should be created including adequate funding for living wages for personal support workers, and living wages for family caregivers. In terms of long-term care, a minimum staffing standard must be funded and regulated at an average of 3.5 worked hours of nursing and personal care per resident, per day, including .68 RN hours per patient per day. In recognition of the vital role they play, like hospital RNs, RNs in the homecare and long-term care sectors should be remunerated at a wage level equal to that of hospital RNs in Ontario. Through these measures, the entire continuum of carework for the elderly within and outside of the home would be adequately regulated and fully remunerated. This approach is far more comprehensive than measures currently proposed, including temporary employment leave for workers caring for the elderly through the Employment Insurance system, or/and tax credits for families with unpaid caregivers working within the home.

5. In recognition of the crucial role played by public health nurses in maternal, prenatal and postnatal care, disease prevention, and health education, public health nurses

should be remunerated at the same level as hospital RNs, and public health programs should be adequately funded and regulated by provincial standards.

6. Given the growing global shortage of RNs, and Canada's ongoing absorption of RNs from countries of the global South facing yet greater shortages than that in Ontario, resources must be dedicated by the federal and provincial governments to create more spaces for nursing learners in Ontario universities. Within the Ontario context, as RNs are in pronounced shortage in northern and rural Ontario, a program should be created to recruit and support low-income nursing students already based in rural and northern Ontario. This program should include study and childcare subsidies. To increase the number of aboriginal RNs – particularly important for the delivery of appropriate care to aboriginal people in rural as well as urban settings – moral and career support during training and upon employment should be included as part of RN education programs targeting aboriginal students. (ONA: 2011) Along with increasing the number of seats bridging registered practical nurse to RN education programs, this should be a major element of a province-wide RN labour force development strategy. In formulating such a strategy, Ontario could take the lead in orienting a pan-Canadian health labour force development strategy forming part of the 2014 Health Accord.

7. Following the implementation of these recommendations, where internationally trained care workers of various skill levels are still required, these workers should enter Canada as permanent residents and be assured a living wage as defined above. Finally, permanent resident status should be accorded immediately to all temporary migrant live-in caregivers currently employed in Canada.

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