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## Healthcare workers ‘on the move’: making visible the employment-related geographic mobility of healthcare workers

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### ABSTRACT

Many healthcare workers are ‘on the move’ as part of their employment, travelling often great distances to such places as patients’/clients’ homes and community clinics. Healthcare workers’ experiences of this employment-related geographic mobility have been relatively invisible even though mobility is necessary for home and community care. Interviews with professional (e.g. nurses) and paraprofessional (e.g. personal care assistants) healthcare workers in Nova Scotia (Canada) found that mobility includes safety risks, and health and economic costs, although a few professionals had employment contracts that helped to protect them against such risks and costs. Paraprofessionals appear to be most impacted by the economic costs given their lower incomes. Many healthcare workers also experienced travel positively, as time away from fixed sites, and associated this time with freedom. The risks of mobility were understood by some workers as part of a duty to care, but a few suggested that the health and economic costs are an undue burden, pointing to an opening for challenging these conditions. There is a need for regulations to ensure all healthcare workers are safe as they are mobile to and from fixed sites, and do not have to shoulder the health or economic costs of mobility.

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## Introduction

Employment-related geographic mobility, which is defined as the ‘frequent and/or extended travel from places of permanent residence for the purpose of, and as part of, employment’, and which can include extensive mobility in terms of time (e.g. two hours daily travelling) and distance, is not a new phenomenon (Cresswell, Dorrow, & Roseman, 2016, p. 1788). Such mobility is, however, increasingly part of workers’ lives in a wide variety of occupations beyond ‘sales managers, truck drivers or service

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technicians' (Kesselring, 2015, p. 572; Temple Newhook et al., 2011, p. 121). Within the healthcare sector, employment-related geographic mobility has long existed as healthcare workers have travelled often great distances to provide care in patients' homes (Herritt, 2012, p. 175). In the past few decades, however, neoliberal policy reforms have resulted in restructuring and the downsizing of hospitals (Burke, Ng, & Wolpin, 2016, p. 474) which has created a demand for more home and community care, and thus more mobile healthcare workers. In 2015 in the United States, for example, there were 1.7 million direct homecare workers providing personal assistance in clients' homes, which is approximately twice the number of homecare workers that were working in 2005 (Hartmann & Hayes, 2017, p. 88).

In Canada, healthcare restructuring began in the 1970s, and included discharging people from hospitals as quickly as possible, as well as increased community healthcare (Aronson & Neysmith, 1997, p. 40; Heitlinger, 2003, p. 37). Prior to 1970, homecare in Canada focused on professional services and patients with acute care needs (Government of Canada, 1999, p. 1) but since this time, homecare has included services for the frail elderly and individuals with disabilities (Government of Canada, 1999, p. 2). The mobile healthcare workforce, which is female dominated, not only travels to patients' homes but also to other fixed sites such as community clinics and hospitals, and they do so in order to provide care, support and education for the health of individuals and communities.

Our research explored Nova Scotian (Canada) healthcare workers' experiences of the journey to and from fixed sites. The focus on mobility is aligned with the 'new mobilities paradigm' insofar as mobility is in the foreground or central, and the journey is conceptualised as more than instrumental movement from point A to B but as having intrinsic value (Brommelstroet, Nikolaeva, Glaser, Nicolaisen, & Chan, 2017, pp. 2–3; Cresswell et al., 2016, p. 1789). Our interest in exploring the power relations associated with healthcare workers' mobility and immobility is in line with this framework because, as mobilities theorists have noted, mobility is 'infused with power and its distribution' (Cresswell, 2010, p. 21), and there is 'the unequal distribution of choice around mobility' (Cresswell et al., 2016, p. 1791). Much of the mobilities literature (with some exceptions such as Gogia, 2006 and Novoa, 2014) centres on the global elite (Cresswell et al., 2016, p. 1791) but our research included paraprofessionals (i.e. personal care workers) as well as professionals (e.g. nurses), in order to explore potential differences in mobility experiences across two groups with very different social locations in terms of status, income and power.

Our research centred on the journey of healthcare workers to and from fixed sites, within the context of a specific geographical region in Canada, but it is important to note that the movement of healthcare workers ranges across scales from the global to the body. There is an extensive literature on the international migration of healthcare/homecare workers, and migration patterns have been linked to variations in working conditions based on different dimensions of marginality such as race, class, citizenship and language (England & Dyck, 2012; Schwiter, Strauss, & England, 2018). Speaking about migrant homecare workers, England and Dyck (2012) provide an analysis of the different international routes taken to work in Canada, the varied socio-economic backgrounds of the workers, and the body work which workers engage in such as bathing clients. This research highlights mobility across scales from the global to the body.

## Healthcare workers' invisible journey to and from fixed sites

The mobility of healthcare workers to and from fixed sites is invisible labour, just as other types of work engaged in primarily by women have been invisible, including unpaid labour in the home, cleaning and cooking in hospitals, and the caring work of healthcare/homecare workers (Armstrong, Armstrong, & Scott-Dixon, 2008; Bourgeault, Sutherns, MacDonald, & Luce, 2012; Clarke, 2006; Lupton, 2013; Toffoli, Rudge, & Barnes, 2011). Examining mobility through a feminist political economy lens (Armstrong et al., 2008; Roseman, Gardiner Barber, & Neis, 2015), we argue that the journey to and from fixed sites requires skills and responsibilities such as the ability to navigate routes or the skills to operate a vehicle and ensure the safety of oneself and others (Brommelstroet et al., 2017, p. 5). Hatton (2017, p. 337) notes that the wide resonance of the concept of invisible labour is due to its success in drawing attention to labour that has received little attention in popular and scholarly research on employment, and this applies to the mobility of healthcare workers because, with few exceptions (see, for example, Ferguson, 2016), there is little academic literature on healthcare workers' experiences of the journey to and from fixed sites. A fairly substantial body of literature does exist on work in the home or close to the home (Bartoldus, Gillery, & Sturges, 1989; Lyter & Abbott, 2007; Stevenson, McRae, & Mughal, 2008), or workers' experiences of work in hospitals (Armstrong et al., 2008; Toffoli et al., 2011) but research on mobility to and from fixed sites is very limited.

Hatton (2017, p. 337) defines invisible work as labour that is economically devalued through three intersecting mechanisms which 'obscure the fact that work is being performed', and all three mechanisms can be applied to the journey to and from fixed sites for healthcare workers. The *sociospacial* mechanism is in effect when labour is physically separate from a culturally defined worksite (Hatton, 2017, p. 337), and in the case of healthcare workers, their mobility is segregated from such culturally defined fixed workplaces as patients'/clients' homes, community clinics, hospitals and offices. The *sociocultural* mechanism is in effect when labour is devalued through cultural ideologies such as those linked to gender, race, class, age, sexuality and ability (Hatton, 2017, p. 338), and skills minimised as those that just come naturally (Hatton, 2017, pp. 340–341). The conceptualisation of immigrant women of colour as being 'predisposed to domestic labour' (Stiell & England, 1997, p. 343) is an example of the devaluing of work based on gender, race and citizenship. In the case of mobile healthcare workers, their mobility is also devalued because key skills such as driving and managing routes are minimised given the cultural ideology which assumes that if one is an adult and appropriately trained, one can easily manage travel. Work which is invisible through *sociolegal* mechanisms is devalued 'because it is excluded from legal definitions of "employment" and is therefore not monitored and regulated by the state as such' (Hatton, 2017, p. 341). Although healthcare workers' travel may be defined by both employers and workers as part of, or an expectation of, their employment, exactly when travel is part of work and therefore paid with benefits such as workers' compensation, and when it is not part of work (i.e. the workers' own travel time), is variable (Fitzpatrick & Neis, 2015, p. 58). Travel time to and from work fixed sites that is not paid time has significant implications for workers particularly if they are paid a low hourly wage. As UNISON (2019), a large public service union in the UK, points out, there are thousands of homecare workers in

England and Wales who are 'being paid less than the national minimum wage because councils aren't insisting that homecare companies pay for travel time'.

The journey to and from fixed sites is often conceptualised as time that is not part of healthcare work, although mobility has to happen in order for the work in fixed sites to happen (Smith & Hall, 2016, p. 153). Speaking specifically about social workers, Ferguson (2006, p. 572) argues that what happens between leaving the office or one's home and arriving at the home visit, and the return journey to home or the office, is typically thought of as 'non time' (Ferguson, 2006, p. 572). Other mobile workers such as flight attendants who are paid only when the aircraft is en route, also have certain times designated as non-work time even though during these times they are engaged in tasks necessary for their job. As Murphy's (2016, p. 55) research on the labour history of flight attendants in the United States notes, key tasks are viewed as non-work and thus not paid the hourly wage, but during these times flight attendants are performing some of the most essential and most difficult elements of their jobs such as calming passengers during boarding.

For many healthcare workers, what is counted as work tasks is limited not only to what happens within fixed sites, but also within fixed sites certain skills are counted. Among nurses, for example, much of their work is related to a caring script (Gordon & Nelson, 2005, p. 63) but the clinical skills are what tends to be counted as work, and this obscures nurses' caring tasks (Henry, 2018, p. 347). In a similar manner, healthcare workers' movement to and from fixed sites is obscured by the focus on work in fixed sites, including patient or client care. Those receiving care at a fixed site or those attending meetings do not see, however, the mobility because it happens out of sight or 'behind the scenes' (Laurier & Philo, 2003, p. 86), so the work of healthcare workers is viewed as only that which happens at fixed sites.

There is a need to reconceptualise the work sites of mobile healthcare workers to include the spaces en route to and from the client/patient, or to and from meetings and other job tasks at fixed sites. The workplace needs to be thought of as the many places, spaces, and time along the journey, and not conceptualised as simply fixed sites and the time at fixed sites. Healthcare workers arrive at the traditional places of work or the fixed sites by travelling through spaces (Wood, Smith, & Hall, 2016, p. 141), and their work time begins before they have a patient/client in front of them or before they are at a meeting in a fixed space to talk about the health of individuals or the community. Healthcare workers' mobility happens before or after the various tasks that are associated with healthcare workers such as their clinical tasks or other services and supports for patients and clients, but this mobility is, we argue, work time.

### **Nova Scotia healthcare workers' mobility to and from fixed sites**

Our analysis of Nova Scotia (Canada) healthcare workers' mobility provides a nuanced account of the experiences of professional and paraprofessional healthcare workers as they are mobile to and from fixed sites, as well as the meanings they attach to their mobility. Class differences among healthcare workers are frequently described in terms of professional status (Torrance, 1998, p. 448), and distinctions based on credentials and the types of services the workers provide or skills they possess. Professionals (e.g. physicians, nurses), for example, are licensed and have particular scopes of practice (e.g. provide

clinical assessments) whereas ‘non-professional’ or paraprofessional workers are not licensed, and provide personal care and household services and supports. Differences in professional status translate into significant variations in incomes and benefits although there are some variations in incomes and benefits within both professional and paraprofessional status categories based on employment contracts and, if unionised, collective agreements. There are also significant differences within and across professional status based on privilege and marginality related to citizenship/immigration status, race/ethnicity, country of origin, and language, and such differences impact conditions of work.

The work of paraprofessionals is often invisible within the healthcare system as it is conceptualised in a similar manner to paid reproductive work in the home (Pratt, 1997); work which requires few skills or education and thus poorly paid. Speaking about the increasing demand for live-in homecare workers, Schwiter et al. (2018, p. 463) note that the home is supposed to be an ideal site of care, but a workforce is required that will accept the poor pay offered to such workers as well as the hours of work and other poor conditions of work. Healthcare workers providing homecare are often precarious workers as their work is outside of the standard employment arrangement given that they are not under the direct supervision of their employer, and their work involves non-standard work hours or shift work with particular occupational health and safety issues (e.g. lifting and bathing clients). Precarious work is not new because the standard work arrangement that existed after World War II was restricted primarily to Whites and to men (Kalleberg & Vallas, 2018, p. 6), but there has been a proliferation of precarious work in advanced capitalist countries in recent decades (Kalleberg & Vallas, 2018), and the increasing demand for personal support workers to provide services to an aging population is likely to increase the number of precariously-employed paraprofessionals.

We specifically explored the challenges and opportunities of mobility among professional and paraprofessional workers because the current, albeit limited, literature indicates that mobility for healthcare workers involves different types of experiences. A study of homecare workers in the United States, for example, found that elements of the physical environment such as slow transportation and inclement weather can be stressful for healthcare workers (Bartoldus et al., 1989, p. 206). Equally stressful may be the social environment, as Mumtaz et al. (2013, p. 54) found was the case for Lady Health Workers who provide ‘door-step’ reproductive health services in Pakistan, and who are sometimes ‘stalked by men and even little boys when travelling on the village lanes and roads’. At the same time, there is literature suggesting that mobility can provide certain opportunities or positive experiences. A Canadian study found that relatively poorly paid low status personal care workers who provide services in people’s homes, ‘love’ their work and express ‘great attachment and commitment to their work’ which is largely related to the workers’ autonomy because they are mobile within the city and at a physical distance from their institutional base (Meintel, Fortin, & Cognet, 2006, p. 564).

Our analysis of mobile healthcare workers’ experiences is based on data from 25 interviews with Nova Scotian healthcare workers who were mobile within the province of Nova Scotia (Canada), and, in a few instances, mobile to community clinics within the Maritime provinces. The Maritime provinces include the three provinces which border the Atlantic Ocean: Nova Scotia, Prince Edward Island and New Brunswick. The province of Nova Scotia has the largest population of approximately 950,000 (Statistics Canada, 2017),

and the three Maritime provinces collectively have a total population of approximately 1.8 million (Statistics Canada, 2017). The total land mass of the Maritime provinces is 130,000 km<sup>2</sup> (Statistics Canada, 2005). Winters in the Maritime provinces are long with first snowfalls sometimes in November and continuing well into April, and severe blizzards often occur several times each winter. Nova Scotia is prone to tropical storms and hurricanes in the summer and autumn because the province juts out into the Atlantic Ocean, and Prince Edward Island has some of the most variable day-to-day weather in Canada. Much of the Maritime provinces is considered rural, and the largest urban area in the region is Halifax, Nova Scotia which has a population of approximately 400,000. Nova Scotia is home to the only children/youth hospital in the region, which provides services to the three Maritime provinces. Homecare workers travel throughout the province of Nova Scotia, which includes many rural and remote areas, and as noted by the Canadian Home Care Association (2008), there are various challenges in providing homecare in rural and remote places including that some places have limited cellular coverage. In Nova Scotia, homecare services are offered through local Continuing Care offices or agencies (e.g. Visiting Order of Nurses) and include personal care services as well as nursing care, and there may be a cost to the patient depending on their income (Nova Scotia Health and Wellness, 2019).

One-on-one, semi-structured qualitative interviews were conducted in person or on the telephone with 16 professionals (physicians, nurses and social workers), and nine paraprofessionals (continuing care assistants or personal care workers). Prior to conducting the interviews, ethics approval was obtained from the relevant ethics boards. Interviews were audiotaped and personally identifying information was removed during transcription. Each transcript was read and re-read multiple times by two members of the research team (LJ & AK) to gain familiarity with the interviews, and Atlas Ti was the qualitative software data management program utilised to assist with coding and data management. The interviews asked about various aspects of mobility including a daily or typical work/shift routine, influences of mobility on relationships with clients, family and co-workers, and expectations of mobility. The data were coded according to emerging themes, and compared and contrasted across interviews and professional or paraprofessional status. This paper is based on the codes relevant to the challenges (i.e. negative experiences) and opportunities (i.e. positive experiences) of mobility.

Of the 25 healthcare workers, all were women except for one male professional. In some places in Canada and elsewhere, many personal care workers are members of immigrant and racialized communities (Aronson & Neysmith, 1997; Hartmann & Hayes, 2017) but among the paraprofessionals we interviewed, only one indicated that they were a member of a visible minority group and all indicated that they were Canadian citizens. Approximately half ( $n = 12$ ) of the healthcare workers we spoke to were in the 20–49 age range and approximately half ( $n = 13$ ) in the 50–69 range.

Most of the 25 workers typically travelled by car (e.g. personal vehicle, rented vehicle) but a few professionals indicated that they travelled by plane on occasion. Most of the professional healthcare workers spoke about having an office where they worked occasionally or frequently, and their destinations were highly variable as they travelled to patients'/clients' homes, community clinics, offices, hospitals, or other fixed sites in different communities. Not all of the professionals provided direct client or patient care, and at least one was a supervisor. There was significant variability in frequency and destination of travel

among professionals. For example, one nurse (Professional #2 Female) does home visits several times per week both in urban and rural areas, another nurse (Professional #9 Female) travels to community clinics 3 days a week, and yet another (Professional #13 Female) travels to a clinic once a month but travels within the Maritime provinces. One physician (Professional #15 Female) travels to patients' homes about twice a month, up to an hour drive from the hospital, and a social worker (Professional #23 Female) does group education sessions in various towns in rural Nova Scotia and travels about 4 times a week. Another social worker does home visits almost every day and usually goes to the office at least once per day. This professional argued that,

There are occasions if I'm starting with a home visit in the community, I might go straight to the client's residence. Typically, no more than a visit or two per day. Sometimes back and forth [to office]. There may be days that I'm on the road all day. (Professional #26 Female)

Most of the paraprofessionals spoke of being mobile on a daily basis or almost daily during the days when they worked, sometimes visiting multiple patients' or clients' homes in one day. For example, one paraprofessional indicated that she is mobile everyday, and even when training because 'our training is somewhere that we have to go to' (Paraprofessional #12 Female). Another paraprofessional works part-time but is mobile doing homecare in rural Nova Scotia 5 days a month including evenings, doing what she calls 'tuck ins' or helping individuals get ready for bed (Paraprofessional #10).

## Challenges of healthcare workers' mobility

### *Health and safety risks*

Many paraprofessional and professional workers spoke quite extensively about the health and safety risks that they sometimes experienced when they travel. A few workers who travelled with patient-related information (e.g. files) spoke about their concern for the safety of these items, but by far the most significant concerns expressed were related to their own personal health and safety risks. These personal risks were primarily associated with travelling by car, particularly in winter weather conditions. As one paraprofessional worker noted, 'And there was a period of time where, especially the days that it would snow, I was really paranoid ... There's always the worry that something bad could happen and you could really get hurt' (Paraprofessional #4 Female). There were also stories about changing and unpredictable weather patterns that add to the uncertainty when one is travelling, particularly if one is travelling great distances (Professional #27, Female). This concern about safety during poor weather conditions is not surprising given the long winters in the Maritimes, and the frequent temperature changes requiring drivers to contend with rain, ice, sleet and snow. These conditions call for automotive equipment (e.g. snow tires, brushes and scrapers) and driving skills attuned to the conditions. One paraprofessional spoke of the stress that travelling in bad weather can cause but at the same time noted that she tries to keep herself safe by adjusting her driving speed (Paraprofessional #10 Female), and another indicated that, because of the safety concerns, she always keeps her car in good condition and makes certain that her 'tires are good' (Paraprofessional #3 Female). These comments clearly indicate that mobility is not 'dead time', and that in fact workers have to utilise their skills, knowledge, and experience to help ensure their safety on the road.



One of the key meanings associated with health and safety risks, for some paraprofessionals and professionals, was that it is part of one's duty to care. One paraprofessional noted that she sometimes travels despite the objections of her family members who are worried about her safety (Paraprofessional #12 Female). Care and concern for patients or clients was clearly top of their mind when deciding to travel, and this emphasis on the duty to care is not surprising given that caring is a key part of healthcare work, even if it is not counted as work, and that most workers we spoke to were women who are socialised to be caregivers.

Although many workers spoke about travelling in poor weather conditions, a few paraprofessionals and professionals indicated that there were times when they would not personally risk driving in bad weather conditions. A couple of professionals, however, had alternative mobility options available to them if they did not want to drive. One professional, for example, indicated that she had the option of hiring a taxi driver to drive in poor weather (Professional #14 Female) which meant that the risks of driving were transferred from her to someone who she believed was better skilled at driving in poor weather. A couple of professionals also noted that they had the option of travelling by plane if driving was dangerous, and they could do so because they were travelling great distances and their employment contract paid for this method of transportation. None of the paraprofessionals reported having these options nor some of the professionals. Such differences among the workers in terms of options for reducing risks associated with personally driving highlight differences in power or control over this aspect of mobility. Some have the choice of taking a taxi or plane which others do not.

### ***The health and economic costs of mobility (and immobility)***

Professional and paraprofessional workers alike, especially those who drive daily or frequently and/or drive long distances, noted that 'time behind the wheel' is tiresome. One paraprofessional indicated that sometimes she has to stop her car for periods of time and have a nap in order to gain the rest her body needs to drive again (Paraprofessional #21 Female). A professional noted that, if she could do it all over again, she would not take a job that involves extensive driving because it drains one's energy (Professional #30 Female), and according to another professional, not only is the job stressful but the travelling is very time consuming and tiring. This worker takes a bus to and from a work fixed site, and at the fixed site accesses a work fleet vehicle to be used for travelling during the day (Professional #29 Male).

One paraprofessional who has been involved in mobile healthcare for years spoke about how difficult it has been to be on the road a lot, but she still has a strong commitment to, and even 'love' for, her clients and 'wouldn't give it up' which indicates a strong duty to care (#4, Paraprofessional Female). For one professional, however, the meaning given to the health costs was that of an unfair burden, and it was suggested that if more workers were hired to cover large geographic regions, there would be less travel required and, as a result, healthcare workers' 'physical [and] emotional wellbeing would be improved' (Professional #27 Female).

Concerns about the economic costs of using one's personal vehicle were not shared by all, and in a few instances, there was no discussion of economic costs, or costs were represented as 'normal costs' of any employment as stated by one paraprofessional

(Paraprofessional #19, Female), but a few paraprofessionals and professionals did speak about the economic costs associated with mobility as an undue burden. For these individuals the mileage compensation that they received from their employers for use of their personal vehicle did not cover all of the economic costs, and as one professional worker explained:

The compensation for the wear and tear on our vehicles is outrageous ... For example, on my vehicle, my new winter tires will cost me between \$1,000 and \$1,200. And then I have, because I drive so often, I have more frequent oil changes ... So I think there needs to be some modifications to what we're compensated for in terms of our mileage. (Professional #27, Female)

Some professionals and paraprofessionals also noted that they experienced costs related to *immobility* or not being able to travel because of poor weather. One paraprofessional indicated that if she decided not to travel due to weather conditions and cancelled her clients, she would not be paid (Paraprofessional #20 Female), and a professional pointed out that if she did not travel because of bad weather she would take a vacation day because travel was expected since her work was considered an essential service or a service that had to be provided. This worker commented that she could not remember the last time summer arrived and she had many vacation days left (Professional #30 Female). A few professionals, in contrast, did not indicate experiencing any economic costs related to their immobility as they continued to work at their 'home base' fixed site. One professional also noted that if she was travelling and the weather became dangerous when at a distance from the regular fixed site she could stay the night in the local community and the costs of accommodation (or her immobility) would be covered given the nature of her employment contract (Professional #15 Female).

It is important to highlight these differences in economic costs and how they are variously distributed among workers because one rationale for increasing home and community care is that it provides cost savings. Our research indicates, however, that some healthcare savings are shouldered by at least some mobile workers who have little power over these costs given the nature of their employment and employment contracts. Both professionals and paraprofessionals spoke about economic costs related to mobility and immobility, but we suggest that the differences in incomes between professionals and paraprofessionals mean that the actual toll of the economic costs is likely very different between these two groups, with paraprofessionals experiencing the greatest economic impacts.

## Opportunities of healthcare workers' mobility

### *Time and space away*

Many of the mobile healthcare workers, both paraprofessional and professional, experienced mobility as having advantages. Specifically, they spoke of the opportunity for 'time and space away' from a fixed site or from roles and tasks undertaken at the fixed site. Some workers had either previously worked in an institutional setting, or were currently doing so some of the time, and they spoke about time and space away from an institutional setting as providing a break from an environment of routine. One professional commented that mobility provides time 'to get out of the office', suggesting that the

office is in some manner limiting (Professional #23 Female), and for another professional, working only in one fixed site creates ‘tunnel vision’ because one cannot see or experience different environments (Professional #16 Female). Mobility was also described by a paraprofessional as allowing one to get away from the constraints imposed by institutions because working in a ‘regimented setting at the long term care facility, it is so physically and mentally draining’ because you have to deal with ‘policies, procedures and workload that they keep putting on you that need to get done’ (Paraprofessional #10 Female).

Although both professionals and paraprofessionals alike represented the time away as freedom, the sense of freedom may be especially important for paraprofessionals given their lower status and that they are often more highly scrutinised or under greater supervision and control when working in an institutional setting. At the same time, however, it is important to note that the sense of freedom they experience while mobile is only relative given that, for many, their mobility is tightly scheduled and tracked.

For healthcare workers who typically travel daily or frequently, this time and movement between fixed sites was also characterised as time away from the work of direct care or meetings. In these short periods of time, one can have a break, as described by one professional: ‘Oh, it’s [travelling] freedom. It’s something I really enjoy, even in the winter if the weather isn’t too bad ... it can be a real nice mental break in a busy day’ (Professional #25 Female). Professionals and paraprofessionals alike pointed to experiences of enjoyment and relaxation, and a couple of paraprofessionals spoke about the time travelling between clients as time to refresh one’s mind and body in order to continue on to the next client or patient. The association of mobility with a ‘comfort zone’ has been documented in research with social workers (Ferguson, 2006, p. 573), and using mobile time to prepare for the next client or patient highlights how the time is valuable as it allows for reflection or preparation for upcoming tasks in a fixed site.

## Discussion

There has been relatively little research on healthcare workers’ journey to and from fixed sites as this has typically been viewed as what happens prior to, or after, the ‘real’ healthcare work that happens in fixed sites. In this paper, we have argued that there is a need to make visible this mobility, and to re-conceptualize this time as work time which has value, and which is a necessary part of the labour process because without it, healthcare tasks in fixed sites would not happen.

A number of challenges of the journey to and from fixed sites were identified by mobile healthcare workers including health and safety risks, and economic costs of both mobility and ‘forced’ immobility due to the weather. There were differences among the workers in their experiences of the risks and costs because of variable power over, or choices concerning, mobility and immobility. This highlights the need for labour regulations to ensure that *all* workers are protected from risks and costs, not just those whose employment and employment contracts help to ensure health and safety, and cover economic costs. Regulations are needed, for example, to protect workers from losing pay or having to take vacation days if they are unable to travel due to poor weather. Such a regulation might include paid weather days that would operate in a similar manner to paid sick days insofar as workers would be able to stop mobility during poor weather without economic consequences. Weather policies that require employers to stop mobile work when

travelling is too risky is another possible intervention to address safety risks, but it would have to include full wages during periods of immobility to ensure workers were not subject to any economic losses as a result of the policies. Proper re-imburement for all vehicle-related costs is an equally important change that is needed, or employer vehicles (where they do not currently exist) that are fitted with the appropriate equipment (e.g. snow tires) and are properly maintained (e.g. oil changes).

Regulations are also needed to address the personal health costs experienced by mobile healthcare workers. Other researchers have pointed to the ways in which the manual labour of healthcare workers, and in particular personal care workers' labour, affects their body (England & Dyck, 2012, p. 1082), and, for those who are mobile, there are additional health risks linked to long periods of being sedentary while driving. Personal health risks, like the economic costs of mobility, are distributed unevenly among healthcare workers, and those workers who travel frequently and long distances, and are subject to health risks due to personal care work (e.g. lifting and bathing of patients) are likely most at risk. There are potentially long-term economic costs to the healthcare system if increasing numbers of mobile healthcare workers, especially paraprofessionals, require healthcare to address their own health problems but such costs could be significantly prevented by implementing regulations such as caps on distance travelled in a vehicle per day, and the scheduling of frequent breaks when travelling long distances.

Implementing regulations to reduce workers' risks and costs of mobility will, of course, be challenging particularly in a context where some workers accept the risks and costs as part of their duty to care. The experience of a sense of freedom through mobility may also mitigate against any movement to change although, as noted by other researchers, such freedom or sense of autonomy is within a particular context that may also be constraining. Speaking about the information and communication technology sector, for example, Gregg (2008, p. 285) notes that the experience of being able to work from home is represented as freedom because one is away from 'the banality of the traditional office', but the flexibility in both working hours and location afforded by working from home means one has to always be ready and available to work. Live-in migrant home care workers also experience some agency because of the possibility of intermittent work which allows them to return to their home country for regular and extended periods of time, but at the same time they are constrained in their employment options and may experience poor working conditions (e.g. lack of respect). These workers are what Schwiter et al. (2018, p. 473) refer to as 'constrained agents', and this term may also apply to many mobile healthcare workers because, even as they have a sense of freedom through mobility, there are work constraints, particularly for paraprofessionals who often have highly scheduled work with little control over their schedule, and sometimes poor working conditions in fixed sites (e.g. abusive or rude patients).

For some healthcare workers the sense of freedom provided through mobility is linked to the time to focus on oneself, and this is similar to the 'my time' which Bailey and Madden (2017, p. 12) note refuse collectors speak about when distinguishing between time that belongs to their employer, and their time. For healthcare workers, this mobile time is their time because, at least for a short period of time, they experience some autonomy as they are away from the roles and responsibilities when one is in a fixed site. A focus on 'me' may operate against any movement to collective action to address the challenges associated with travel, but at the same time there are indications that there is an opening

for resistance and change. A couple of healthcare workers, for example, represented health and economic costs as an unfair burden, and if such a representation is connected to other areas of healthcare workers' discontent, change is possible. In the case of Nova Scotia nurses, for example, the risks and costs of mobility could be linked to their recent labour unrest (e.g. wildcat strikes) over provincial essential services legislation which impacts their right to strike, as well as their discontent related to low staffing levels and inflexible schedules (Taber, 2018). Creating an alliance between professional and paraprofessional healthcare workers on common areas of discontent such as the risks and costs of mobility, could also be a significant catalyst for change. Kalleberg and Vallas (2018, p. 21) argue that when precarious workers give a voice to their opposition around the conditions of work, such opposition is 'often a prelude to political action in the electoral domain' and this can lead to government policies to help alleviate workers' risks. With the growing number of mobile healthcare workers in Nova Scotia and elsewhere in Canada, particularly precariously-employed paraprofessionals, time may be ripe for strong voices calling for a recognition of mobility, the risks and costs of mobility, and the need for regulations to address the risks and costs for all healthcare workers.

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