“IT FEELS LIKE SOMEBODY CUT MY LEGS OFF”: PUBLIC TRANSPORTATION AND THE POLITICS OF HEALTH IN SASKATCHEWAN

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By

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ABSTRACT

Background: In May 2017, the Government of Saskatchewan closed the Saskatchewan Transportation Company (STC), a 70-year-old bus company in Saskatchewan, Canada, through an austerity budget that saw many cuts to programs and services. The government justified its decision on budgetary grounds ignoring opponents who cited the possibility of negative impacts of the decision on population health. Little research evidence exists to interrogate the closure and its implications for the health system, population health, health equity and the politics of health.

Methodology: A qualitative case study was conducted to explore the politics, health and health equity implications of the closure of STC. The study drew on 47 days of Parliamentary Hansards, 751 newspaper articles, archival material, six focus group discussions (with activists, Indigenous, health system and social services stakeholders) and 100 interviews (with former STC users). A discourse analysis was conducted on two focus groups, newspaper articles and Parliamentary Hansards. The rest of the data were subjected to a thematic analysis. The study maintained rigour through crystallisation and member checking.

Findings: The closure of STC was facilitated by a neoliberal economic policy paradigm that ignored counter-discourses of resistance from activists and advocates who argued that the bus should be maintained on human rights, climate change and other grounds. The closure of STC has had deleterious impacts on health and this is best understood through a *web of dispossession* whereby the closure affects individual former bus users through missed hospital appointments and other psychosocial impacts, their family members through financial burdens and strained relationships, communities through reduced access to the commons, and the whole of society through inefficiencies in the health system and stress on health and other workers. The closure has had inequitable impacts and has exacerbated the vulnerability of women, low-income populations, Indigenous populations, seniors, newcomers, young adults, people with disabilities and rural and northern populations.

Conclusion: Austerity is bad for health. This transportation case study reveals how it affects health in the Saskatchewan context. New approaches to public policy that prioritise health in all policies (HiAP) are needed to pay attention to the negative impacts of austerity on health and health equity globally and in Saskatchewan.

CO-AUTHORSHIP

This dissertation contains three manuscripts completed and written by Mr. Jacob Albin Korem Alhassan in collaboration with his supervisor, Dr. Lori Hanson from the Department of Community Health and Epidemiology, College of Medicine, University of Saskatchewan and dissertation advisory committee members: Drs. Sylvia Abonyi (Department of Community Health and Epidemiology, College of Medicine, University of Saskatchewan), Cory Neudorf (Department of Community Health and Epidemiology, College of Medicine, University of Saskatchewan) and Charles Smith (Department of Political Studies, St Thomas More College, University of Saskatchewan).

"POLITICS, TRANSPORTATION AND THE PEOPLE'S HEALTH"

Mr. Alhassan conceptualised and designed the study, conducted data collection and management, interpreted the data and prepared and revised the manuscript; Dr. Lori Hanson, Mr. Alhassan's PhD supervisor, contributed to the study conceptualisation, design, data management and interpretation, and reviewed and revised the manuscript; Dr. Charles Smith contributed to the study conceptualisation, results interpretation, and reviewed and revised the manuscript. A shorter version of this manuscript has been published in *Critical Public Health*.

"AUSTERITY AND THE WEB OF DISPOSSESSION"

Mr. Alhassan conceptualised and designed the study, conducted data collection and management, interpreted the data and prepared and revised the manuscript; Dr. Lori Hanson, Mr. Alhassan's PhD supervisor, contributed to the study conceptualisation, design, data management and interpretation, and reviewed and revised the manuscript; Dr. Sylvia Abonyi contributed to the study conceptualisation, results interpretation, and reviewed and revised the manuscript. Dr.

Cory Neudorf contributed to the study conceptualisation, results interpretation, and reviewed and revised the manuscript. A shorter version of this manuscript has been submitted to *Social Science and Medicine*

““FOR A PERSON WITH A DISABILITY AND A PERSON WITH DISABILITY WHO IS ALSO POOR…””

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N:B: Although I (Jacob Albin Korem Alhassan) am the sole author of the dissertation I use the pronouns “we” or “our” in Chapters 5-7 (manuscripts 1-3) and “authors” under tables and figures in these chapters to signify co-authorship.

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DEDICATION

1. To my father on whose shoulders I stand to become tall
2. To the former users of STC: that the stories shared in this project may inspire policy action towards social justice, transportation access and health equity in Saskatchewan
3. To the activists and those who have opposed the closure of STC (sometimes at the risk of arrest), that we may all draw from your well of strength and be inspired to continue to fight for justice and fair access to transportation for people in Saskatchewan
4. To the memory of the Saskatchewan Transportation Company (1946-2017)

"Everything in life is somewhere else, and you get there in a car"

E.B. White

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LIST OF ABBREVIATIONS

CCF	Cooperative Commonwealth Federation
CUFTA	Canada-United States Free Trade Agreement
DA	Discourse Analysis
DALYS	Disability Adjusted Life Years
DOT	Directly Observed Treatment
FGD	Focus Group Discussion
GDP	Gross Domestic Product
HiAP	Health in All Policies
HICS	High Income Countries
IMF	International Monetary Fund
LICS	Low Income Countries
MMIWG	Murdered and Missing Indigenous Women and Girls
MVIS	Motor Vehicle Injuries
NAFTA	North American Free Trade Agreement
NDP	New Democratic Party
OECD	Organisation for Economic Cooperation and Development
PFAS	Patient Family Advisors
P3S	Public Private Partnerships
SAID	Saskatchewan Assured Income and Disability
SAPS	Structural Adjustment Programs
SCPOR	Saskatchewan Centre for Patient Oriented Research
SHA	Saskatchewan Health Authority
STC	Saskatchewan Transportation Company
TRAP	Traffic Related Air Pollution

CHAPTER 1: INTRODUCTION

1.1 Introduction

The abrupt closure of the Saskatchewan Transportation Company (STC)[1] in May 2017 has led to critique of the provincial government's apparent lack of consideration of the social and health impacts of the decision, particularly on vulnerable population groups (women, seniors, northern and Indigenous populations, people with disabilities and rural populations). Such concerns were exacerbated by the Greyhound bus company's decision to end service in all of Western Canada by October 2018 (Mahichi, 2018). The rationale of the Saskatchewan government for the "winding down" of the STC was to reduce its budget deficit and to save $85 million in the next five years (Langenegger, 2017). Some believe, however, that the closure of STC was deeply driven by ideology (Wooldridge, 2017) and rooted in the politics of austerity which are reshaping the institutional structure of the province. Austerity – "drastic but selective public expenditure cuts" (Schrecker & Bambra, 2015, p.69) – is becoming a popular political choice globally, driven by a neoliberal orthodoxy (Basu et al., 2017; Borisch, 2014; McKee et al., 2012; Schrecker, 2016b; Stuckler & Basu, 2013).

The 2008 World Health Organisation (WHO) report on social determinants of health (Commission on the Social Determinants of Health, 2008) provided affirmation at the global level that social factors affect people's health and wellbeing. A prodigious amount of literature from different parts of the world shows that health inequities (unfair health differences) have a

[1] Throughout the thesis I sometimes refer to the STC as "the bus" since that is how many participants referred to it as well.

social and political basis that might sometimes lie beyond the remit of clinicians (Bambra, 2011; Bartley, 2016; Dorling, 2013; Doyal & Pennell, 1979; Greenwood & Leeuw, 2012; Krieger, 2011; Marmot et al., 2008). Among other determinants, transportation and how it is organised has been identified as important for the wellbeing of populations because of its connections to road traffic injuries, access to services and physical activity levels (McCarthy, 2006; Wilkinson & Marmot, 2003).

Although much of the literature that connects transportation and health has done so using a 'downstream' approach (Khreis et al., 2017b), insufficient attention seems to be paid to the more 'upstream'[2] political factors that determine transportation policies themselves. For example, what roles do ideology, politics and public finance (tax cuts versus public investments, running public services for a profit versus a loss) play when considering the transportation-health nexus? Do specific public transportation policies lead to a deterioration of health outcomes? The modalities of the closure of STC (i.e., the politically charged nature of the decision, the age of the company and the sparse distribution of Saskatchewan's population) offer an excellent opportunity to interrogate such issues and to pursue the question of the health implications of politics using a transportation case study.

[2] 'Upstream' and 'downstream' are often used to describe the ways in which macrosocial factors affect social determinants of health. While this conceptualisation is useful it can sometimes be problematic since the path from upstream to downstream determinants are not always linear (Krieger, 2008).

1.2 Purpose of the Study

The overarching goal of this study was to bear witness to history, given the global rise in neoliberal austerity. The study aimed to increase understanding of potential pathways by which austerity policies affect health and health equity. Specifically, this study examined how transportation policies enacted under austerity, inequitably influence the health of several Saskatchewan populations. The study sought to investigate the rationale behind the politics of the closure by examining the discourse that was used to justify the closure of STC and the associated impacts on health and health inequities.

1.3 Research Objectives

The goal of the study was to increase understanding of the ways in which neoliberal austerity impacts health and health equity via public transportation policies. The specific research objectives of the study were:

1. To identify and reveal the political rationale underlying the closure of STC
2. To identify and elucidate the health impacts of the closure of STC
3. To examine how the health impacts differ based on social and geographical locations
4. To advance a theoretical pathway for understanding the effects of austerity on health and health equity (using a transportation case study)

1.4 Research Questions

To achieve these research objectives, the following research questions were employed:

1. What was the political rationale underlying the closure of STC?
2. What are the health impacts of the closure of STC on former bus riders and systems in Saskatchewan?

3. How do impacts of the closure on health differ for people based on social (age, gender, class, disability status and race/ethnicity) and geographical (rural, northern, and urban) locations?
4. What theoretical pathways are suggested between austerity, health and health equity as illustrated by the closure of STC?

1.5 Background to the Problem

An adequate understanding of the closure of STC requires a description of the social, political and economic context within which the closure occurred. In the sections that follow, I trace how neoliberal transformations across time and space have promoted austerity or at least created a climate within which decisions such as the closure of STC could occur.

Following the 2008 global financial crisis, many countries have pursued austerity as a means to economic recovery (Basu et al., 2017). Contemporary austerity bears remarkable resemblance to the Structural Adjustment Programmes (SAPs) of the 1980s where countries of the global south were subjected to debt disciplining mechanisms that detrimentally impacted the health of the poor through the removal of social services (Pfeiffer & Chapman, 2010; Sassen, 2015). Austerity itself is nested within the broader framework of neoliberalisation which is better understood when conceptualised as a process (Peck, 2010). The concept of neoliberalisation is unfortunately not often well understood and is increasingly ill-defined, particularly when used in "totalising and monolithic" ways, to the detriment of health research, (Bell & Green, 2016, p. 240). That notwithstanding, the term "neoliberalism" should not be completely ignored or discarded since it "remains useful as shorthand summarising forms of profit making and regulation in capitalism" (Whiteside, 2020, p. 8).

1.5.1 The Global Neoliberal Turn

The genesis of neoliberalisation can be traced to the Mont Pelerin Society, consisting of previously marginalised (Peck, 2010) Austrian and American academics such as Friedrich von Hayek, Ludwig von Mises and Milton Friedman (of the Chicago school) (Harvey, 2005). For a time, 'neoliberalism' remained marginal in academic and policy circles before the concept's ascendancy to the political and economic zeitgeist of the last half-century. Philosophically based on the assumption that markets are efficient, morally superior to government intervention and promote individual choice (Heywood, 2003), the eclectic idea of neoliberalisation can be conceptualised as: 1) an ideology, 2) a distinct set of policies and programs, 3) a set of institutional forms and 4) normative ideas of agency and responsibility (Schrecker, 2016a; Ward & England, 2007).

According to Wacquant (2012), much of the literature on neoliberalisation can be divided into two. The first is narrowly defined in terms of hegemonic 'market rule' and the second is an overly broad definition informed by Foucauldian ideas of governmentality. Wacquant (2012) proceeds to provide his three *in media res* theses for understanding neoliberalisation: 1) as a political rather than economic project focused on reengineering the state to satisfy markets, 2) as a rightward tilting of the state away from its 'feminine collectivising pole' to its 'rightward individualising pole' and 3) as a glorification of penal systems.

Neoliberalism was developed as an alternative to post-war Keynesian macroeconomic principles[3] (Peck, 2010). The first wholesale implementation/experimentation of neoliberalisation was in Chile in 1973. Following a coup d'état (backed by the USA and local elite) that removed the democratically-elected socialist government of President Salvador Allende, the new president, Augosto Pinochet, invited economists from the Chicago school to restructure the Chilean economy, negotiate International Monetary Fund (IMF) loans and in effect test their neoliberal economic theories (Harvey, 2005; Klein, 2007). Neoliberalism has subsequently spread through its adoption by countries such as China (in 1978), India (in the 1980s) and Sweden (in the 1990s) (Harvey, 2005).

Multiple factors account for the global rise in neoliberalisation. The debt crises of the 1970s (Ibid, 2007) and 'stagflation'- a combination of inflation, slow economic growth and high unemployment (Labonté & Stuckler, 2016) created a perfect economic climate for many countries to try neoliberal policies. Additionally, alliances between banks, international financial institutions and powerful world leaders (notably Margret Thatcher and Ronald Raegan) promoted neoliberalisation (Przeworski, 1995). Such alliances and the power of these leaders led to the implementation of neoliberal policies of trade liberalisation, deregulation and austerity programs either within the respective countries of these leaders or as a new "common sense" approach to policy globally (Jessop, 2004; Marangos, 2013; Schrecker & Bambra, 2015; Scott-Samuel et al., 2014). It is important to add that the fervent pursuit of these policies has been

[3] Keynesianism refers to the economic theories of John Maynard Keynes (1883-1946) which offered an alternative to the neoclassical economic theories of unbridled *laissez faire* capitalism. It advocated for government intervention in markets and was associated with policies of progressive taxation and social protection programs (Heywood, 2003).

associated with crises – up to 200 in the last three decades (Labonté & Stuckler, 2016; Stiglitz, 2000) – requiring neoliberalism to constantly mutate to remain relevant by oscillating between constraining the state from intervening in markets (roll-backs) and crafting and recrafting the state to satisfy markets (roll-outs) (Peck, 2010).

1.5.2 Neoliberalisation in Canada

The rise of a neoliberal orthodoxy also occurred in Canada. Brodie (1997) identifies three main periods of Canadian national policy; the first (1867-1895) involving integrating former British colonies and bringing Canada's west into an unequal union with the east; the second (1950s-1970s) involving a post-war embrace of Keynesianism and social welfare programs; and the third (1980s and beyond) involving an embrace of neoliberalisation enacted through "hemispheric economic integration", the roll-back of social welfare, liberalisation and market-driven economics. Like other high-income countries (HICs), the post-World War II period in Canada saw the creation of a welfare state similar to those found in other 'Liberal' regimes such as the UK, USA and Australia (Esping-Andersen, 1990b). Although the type of welfare state that existed was not as generous as the 'social democratic' welfare states found in countries such as Denmark, Norway and Sweden (Esping-Andersen, 1990b, 1990a), the system was underpinned by a philosophy of social citizenship and universality, and characterised by a system of progressive income taxation, increases in social spending and efforts to promote interregional and interpersonal equity through transfers (Brown, 2002). While these policies were Keynesian, they were not a perfect form (in relation to full employment for example), leading some to conclude that the Canadian form was a "bastard Keynesianism" (McBride & Shields, 1997, p. 40).

Canada's Keynesian era may not have been perfect but the neoliberal turn represented a marked shift in public policy. The shift towards neoliberalisation in Canada has varied by region, with provinces such as Manitoba, Saskatchewan and British Columbia proceeding farther on the neoliberal path than others in the 1980s (Evans & Fanelli, 2018). Data from 1985 onwards show a consistent decline in national total expenditure as a percentage of Gross Domestic Product (GDP) (from 24% in 1985 to 17.1% in 1991), increasing commercialisation within the public sector and "reduced… generosity" in relation to federal social policy programs such as unemployment insurance (McBride, 2001, p .89). Neoliberalisation has also taken the form of privatisation. Some of the largest privatisations of Crown corporations (in transportation, manufacturing and telecommunications) took place between 1987 and 1995 (McBride, 2001, p. 86). Canada's neoliberal turn (in relation to austerity) has been hegemonic, reshaping the idea of the state and its functions. This has sometimes occurred through legislative mechanisms (for example through the Spending Control Act 1991-1995) and by circumscribing policy options during crises; in political discourse on austerity, the question has often been the "degree of austerity and budget restriction, not on broader alternatives" (McBride, 2016, p. 10).

It is useful to add that the turn toward neoliberalisation has generally been by Conservative governments (Conservative Party of Canada (CPC), however, Liberal governments (Liberal Party of Canada) over time have embraced neoliberal ideas such as liberalising trade and pursuing balanced budgets as long-term policy objectives. The creation of the Canada-United States Free Trade Agreement (CUFTA) under former Progressive Conservative Prime Minister Brian Mulroney and the North American Free Trade Agreement (NAFTA) under former Liberal Prime Minister Jean Chrétien demonstrate that Canada's neoliberal turn has been promoted by both Liberal and Conservative political parties (Evans & Smith, 2015). The rise in

neoliberalisation has also involved reductions in federal-to-provincial transfers with most of Canada's deficit reductions in the 1980s and 1990s, for example, achieved through "downloading" or simply transferring social welfare costs to provinces (Brodie, 1997, p. 257).

1.5.3 The Financial Crisis and Austerity in Canada

The 2008 global financial crisis offered an economic climate for the pursuit of neoliberal policies (globally and in Canada) mostly to the detriment of the poor. Driven by its "innate neoliberalism and disinclination to interfere with market forces" (McBride, 2011, p. 397), Canada's response to the global financial crisis was first an official denial and then subsequent minimalism orchestrated by the political elite to create the impression that Canada had escaped relatively unhurt (Ljunggren, 2009). The stimulus package that was eventually adopted consisted of broad-based personal and corporate tax cuts (35% for the latter), with only 4% of tax cuts directed at vulnerable low-income Canadians (Canadian Centre for Policy Alternatives, 2009; McDonald, 2009). This response did little to ease the struggles of the nearly 296,000 people who lost jobs during the period (McDonald, 2009). Recent macroeconomic trends show that neoliberal policies of austerity in Canada have been disequalising, leading to a consistent shift in national income from labour to capital (Sanger, 2013). This is because the pursuit of neoliberal policies has been 'Janus-faced' so that policies of privatisation and tax cuts benefit capital while austerity policies disproportionately affect labour (Fanelli & Hurl, 2011).

1.5.4 Neoliberalisation, Austerity and Health

Under the neoliberal framework, austerity may be pursued in response to crises as in the case of the 2008 global financial crisis or may simply occur as a way of circumscribing the role of the state for the better functioning of markets. Although a few papers have shown that recessions

themselves can be salutogenic (Ruhm, 2000, 2007), a preponderance of research has shown that austerity (in response to crises) is often deleterious to health (Bambra & Garthwaite, 2015; Basu et al., 2017; Borisch, 2014; Kampfner, 2001; Kentikelenis, 2017; Ruckert & Labonté, 2017; Schrecker & Bambra, 2015; Stuckler & Basu, 2013; Taylor-Robinson et al., 2013). The literature on austerity and health suggests that the dynamics of the "austerity epidemic" (Schrecker & Bambra, 2015) have been complex, with multiple pathways through which austerity has affected health.

Across space and time, the negative relationships between austerity policies and health have been widely documented. In settings such as Ghana in the 1990s, for example, cuts to healthcare budgets as part of World Bank and International Monetary Fund (IMF) recommended Structural Adjustment Policies (SAPs) led to drops in hospital visits by about 45%-50% (Konadu-Agyemang, 2000). Research that has used specific health outcomes such as tuberculosis incidence, prevalence, mortality and Directly Observable Treatment (DOT) coverage within 21 post-communist countries has also empirically demonstrated that implementation of IMF conditionalities was associated with 13.9%, 13.2% and 16.6% increases in tuberculosis incidence, prevalence and mortality respectively (Murray & King, 2008; Stuckler et al., 2008).

In terms of the 2008 crisis, although there were some variations in responses, many countries including Latvia, Ireland, Spain, Portugal, Romania, Estonia, Bulgaria and the Czech Republic responded with cuts - some more drastic than others - to the health sector (Mladovsky et al., 2012). These cuts have been associated with health declines. Those that occurred in low-income countries (LICs) in particular have been projected to negatively affect the health of

children and vulnerable populations through reductions in cash transfers and contractions in social spending (Ortiz et al., 2011).

Other recent examples of the health implications of post-crisis austerity have shown associations with declines in physical and mental health through food insecurity, characterised by the rise in food banks in the north-east of England, as the UK government cut assistance to vulnerable populations (Garthwaite et al., 2015). In a Cameroonian and French context, austerity affected health through the rationing of hepatitis C treatment which disproportionately affected vulnerable populations (Chabrol et al., 2017), while in the now (in)famous example of Greece where health budgets were cut by 40% (Kentikelenis et al., 2011), austerity was associated with a rise in HIV infections, suicides, malaria and homelessness as public health and other social service expenditures were cut drastically (Stuckler & Basu, 2013).

In Canada, the crisis led to labour market transformations with increases in precarious employment, housing difficulties (Ruckert & Labonté, 2014) and a rise in food insecurity characterised by rises in foodbank use (Tarasuk et al., 2011). In instances where austerity policies have been pursued, some of the common services governments resort to cutting have been housing, transportation, education and retirement pensions (Basu et al., 2017). Significant changes in these social determinants of health have important implications for health and health inequities.

1.5.5 Saskatchewan's Neoliberal Turn

Saskatchewan has an export-based economy with oil, mining and public services representing significant proportions of GDP, which makes the economy vulnerable to changes in global commodity prices. In 2017 the economy's growth rate was -1% (Government of Saskatchewan,

2017). Poverty rates in the province are higher than the national average; 14.8% compared to 14.4% for all persons in poverty in Canada and 24.6% compared to 18.5% for child poverty in Canada (Gingrich et al., 2016).

Saskatchewan has a unique history that has involved a gradual but steady swing from social democratic principles to a consistent rise in neoliberal policies (Warnock, 2005) which have laid a solid foundation for contemporary austerity. Although the geography of neoliberalisation has typically shown itself to have an important global dimension (Tickel & Peck, 2003), local particularities have played a crucial role in shaping how neoliberalisation is manifested everywhere (Peck, 2010; Wacquant, 2012) and this has been the case of Saskatchewan, too (Conway & Conway, 2015).

The coming to power of the Cooperative Commonwealth Federation (CCF) in Saskatchewan in the 1940s ushered in a wave of social and health-related welfare state programs mostly in favor of the labouring classes (Conway & Conway, 2015). These developments that characterised the foundations of Saskatchewan's social democracy were, however, challenged and to a large extent reversed by the coming to power of the Progressive Conservatives under Grant Devine in the 1980s where neoliberal austerity policies were actively pursued (Smith, 2018). This period was characterised by deregulation, tax breaks for large and small businesses and attacks on labour unions (Pitsula & Rasmussen, 1990). In some cases, the geographies of neoliberal policies pursued in the province were enacted to favor rural Saskatchewan causing a rural-urban polarisation, since the Conservatives had a strong rural base (Conway & Conway, 2015). Several political choices from the 1980s onwards, including privatisation of Crown

coorporations, have created a climate within which decisions such as the closure of STC became possible. The neoliberal turn in Saskatchewan is dealt with more fully in Chapter 4.

The fervent pursuit of neoliberal policies such as austerity have had perverse health impacts as noted earlier, and in the case of Saskatchewan, health researchers warned that the pursuit of austerity policies (particularly following the 2015 economic slump) would have direct and indirect consequences for health and health inequities (Hanson & Hicks, 2017).

1.5.6 The Closure of the Saskatchewan Transportation Company (STC)

It is against this wider global, national and local political background and history that the closure of the Saskatchewan Transportation Company occurred. In May 2017, the STC, a Crown corporation that had been in existence since 1946 was closed by the government to reduce a budget deficit given falling ridership. The company served as a vital mobility link to people before its abrupt closure. Just before the company was closed, it had a fleet of 41 buses, covered 25 routes, connecting about 253 communities and travelling about 2.8 million miles per year (Saskatchewan Transportation Company, 2017). The miles travelled, communities served and routes covered at the time of closure were less than in earlier years. In 2000, for example, there were 28 routes, 276 communities served and 3 million miles travelled per year (Saskatchewan Transportation Company, 2000).

The core business of the company was the delivery of passengers and freight services including an express parcel service (Saskatchewan Transportation Company, 2017). The passenger service provided mobility to a variety of demographics, particularly those without cars. It was an alternative way of travelling around the province. At the time of closure, a large proportion of riders were seniors (defined as 60 years and older) of which about 75% were low-

income seniors (Legislative Assembly of Saskatchewan, 2017). The passenger service made provisions for users with disabilities by providing wheelchair accessible services as well as an attendant program to assist persons with visual impairments (Saskatchewan Transportation Company, 2017).

The company also had a parcel service that shipped “[v]ital goods such as urgent medical supplies [blood and laboratory samples], medical instruments and agricultural parts” (Saskatchewan Transportation Company, 2010). These services linked the economy and served the health and the agricultural sectors. Prior to its closure, the company had consistently received very high approval ratings from customers ranging between 80% and 95% (Saskatchewan Transportation Company, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009 2010, 2011, 2012, 2013, 2014, 2016, 2017).

The primary explanation offered by the government for the closure of STC was that it would save $85 million in the next five years - this translates to roughly 9% of the $685 million which the government hoped to save within that budget (Stansfield, 2017). Other secondary explanations were offered for the closure such as: 1) the decline of intercity bus services throughout Canada, 2) the decline of provincial bus ridership over the last 35 years by 77%, 3) the possibility that closing STC would open up competition for other parcel delivery services and 4) the idea that all attempts at reducing the growth of subsidies had been exhausted (Johnson, 2017).

Expectations that the private sector would step in have mostly not been met. For example, Rider Express, a company that began service after the closure, only operates routes in Saskatchewan’s biggest cities (Saskatoon, Regina and Prince Albert). Another company that was

created in June of 2018, LA Family Shuttle, which operated between Prince Albert and La Ronge was eventually shut down due to low patronage (Cornet, 2018).

The closure of STC is riddled with contradictions. First, the idea of cost reduction which features in arguments for the closure of the company is intriguing because no cost-benefit analysis was conducted by the government and made available to the public. In fact, multiple organisations called for some type of analysis from the government on potential impacts of the closure (Global News, 2018). Another apparent contradiction arises from the fact that the Saskatchewan Party which led the closure has a strong rural base (Smith, 2018), yet a lot of the routes formerly covered by the company were in rural Saskatchewan.

1.6 Conclusion

This chapter has provided a broad overview for understanding the social, economic and political context within which the closure of STC occurred. It has revealed some contradictions inherent in the decision as well as the possible negative impacts of the closure on health and health inequities. Anchored around the research questions, the rest of the dissertation examines the politics of the closure of STC and the health and health equity impacts of the closure.

The rest of the dissertation is presented as follows: Chapter 2 presents a literature review on the connections between transportation, health and health inequities and some theoretical literature on the political economy of health and intersectionality. A vast body of literature exists that considers transportation to be a social determinant of health. While this literature is essential for understanding the etiological pathways from transportation to health outcomes, it is rather apolitical. Chapter 2 therefore attempts to describe the transportation- health literature and to enrich it by connecting it to two other bodies of literature; on the political economy of health and

on social location and intersectionality theory. Drawing on extant frameworks for understanding health inequities, the chapter concludes with a theoretical framework that guided data collection processes and analysis. Chapter 3 describes the methodologies that guided the research process; specifically qualitative health research and case study methodology. The chapter also highlights the Saskatchewan context and provides demographic and contextual information necessary for understanding the politics, health and health equity impacts and implications of the closure of STC. One of the central issues that emerged in arguments around closure of the STC was the question of the company's history and why it was set up in the first place. Chapter 4 draws on archival material to present a historical account on why the STC was created vis-à-vis the reasons offered for its closure. The chapter reveals that the STC *did* have losses in its early days and demonstrates the logic that was used to defend the bus, namely that it existed for the 'public good' and that it was often presented as a 'modern' alternative. The chapter argues that, given contemporary environmental concerns on pollution and climate change, an opportunity to reinvent the bus as a progressive option was missed.

Chapter 5 presents the first manuscript that responds to the question of the political rationale for closing STC. This chapter draws on parliamentary Hansards, focus groups (with activists and Indigenous stakeholders) and media sources to describe the discourses and counter-discourses at the heart of the debate on STC closure. The chapter argues that despite the reasons given for closing the STC, the decision represents a classic case of 'privatising profits and socialising risks' under neoliberal economic policy making. This is because during the period of economic boom the government did not spend more on STC yet at the time of economic decline it ensured that the STC and its former users paid the price for the provincial deficit. The chapter also reveals the anti-evidence approach the government adopted that facilitated the closure and

the important role activists played in presenting counter-disourses to justify why the bus should not be closed. Chapter 6 provides evidence in the context of the ongoing debate on whether or not the closure of STC has had negative impacts on health. Drawing on interviews with former bus riders, I argue that the closure of STC has indeed had many negative health impacts on individuals, families, communities and systems in Saskatchewan. I also argue that these impacts are complex, interconnected and far beyond direct impacts on former bus riders. Finally, I develop a *web of dispossession* to reveal how the closure has unexpected impacts on people who were not necessarily former bus riders.

Chapter 7 presents the third and final manuscript on health equity impacts and implications of the closure. This manuscript draws on intersectionality theory to extend the ideas from Chapter 6 by revealing how the closure of STC is inherently classist, abeleist, racist, sexist and ageist. I argue that the closure of STC has exacerbated the vulnerability of particular members of society and this reveals the necessity for a critical perspective. The evidence from Chapter 7 demonstrates how austerity intersects with a toxic combination of extant vulnerabililities to further marginalise seniors, low-income Indigenous women and people living with disabilities. In this sense, although we are all implicated in austerity's *web of dispossession*, particular groups have been asked to pay a heavier price for the closure of STC than others. Finally, Chapter 8 offers a summative discussion and academic and policy recommendations moving forward. Drawing on the evidence presented throughout the dissertation, Chapter 8 argues that activists need to continue to play a role in presenting discourses that can counter neoliberal arguments often used to justify austerity. The chapter advocates for a Health in All policies (HiAP) framework in Saskatchewan and concludes that through decisions such as the STC closure we can see how politics become embodied in people.

CHAPTER 2: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

This chapter provides an overview of the literature on the connections between transportation and health. It begins by exploring direct relationships between transportation and health outcomes before exploring how transportation might affect health through indirect pathways where the transportation-health nexus is mediated by other social determinants of health. It then draws on two sets of theoretical literature that guided the research process - the political economy of health and intersectionality - before constructing a theoretical framework which helped guide data collection, including the interview guides, participant selection and, later, was used to guide analysis. Although the theoretical literature and the literature on transportation and health often stand on their own, I constructed a framework that unites the two to create room for exploring how neoliberal austerity might affect health and health equity through transportation.

Transportation is one of the social determinants of health, along with income, housing and a host of others (Wilkinson & Marmot, 2003). From the late 1990s onwards, a burgeoning literature has focused on illustrating the relationships between transportation and health. This literature often takes the form of health impact assessments (Dannenberg, 2016). Although this study is not a traditional health impact assessment, an exploration of the transportation literature is essential for understanding *why* and *how* the closure of the STC could have health and health equity impacts and implications. The figure below describes some of the common connections typically explored in studies that attempt to connect transportation and health outcomes. Most research on the transportation-health nexus typically begins with a transportation policy choice (bus closures, fare increases, creation of a new bus line, etc.) and then traces how such public policy changes may affect people's choices for travelling and how these choices may ultimately

be associated with improved or worsened health outcomes. The figure below illustrates an example of the connections between transportation policy changes and health outcomes. In the sections that follow I explore in detail some of the major connections between transportation and health.

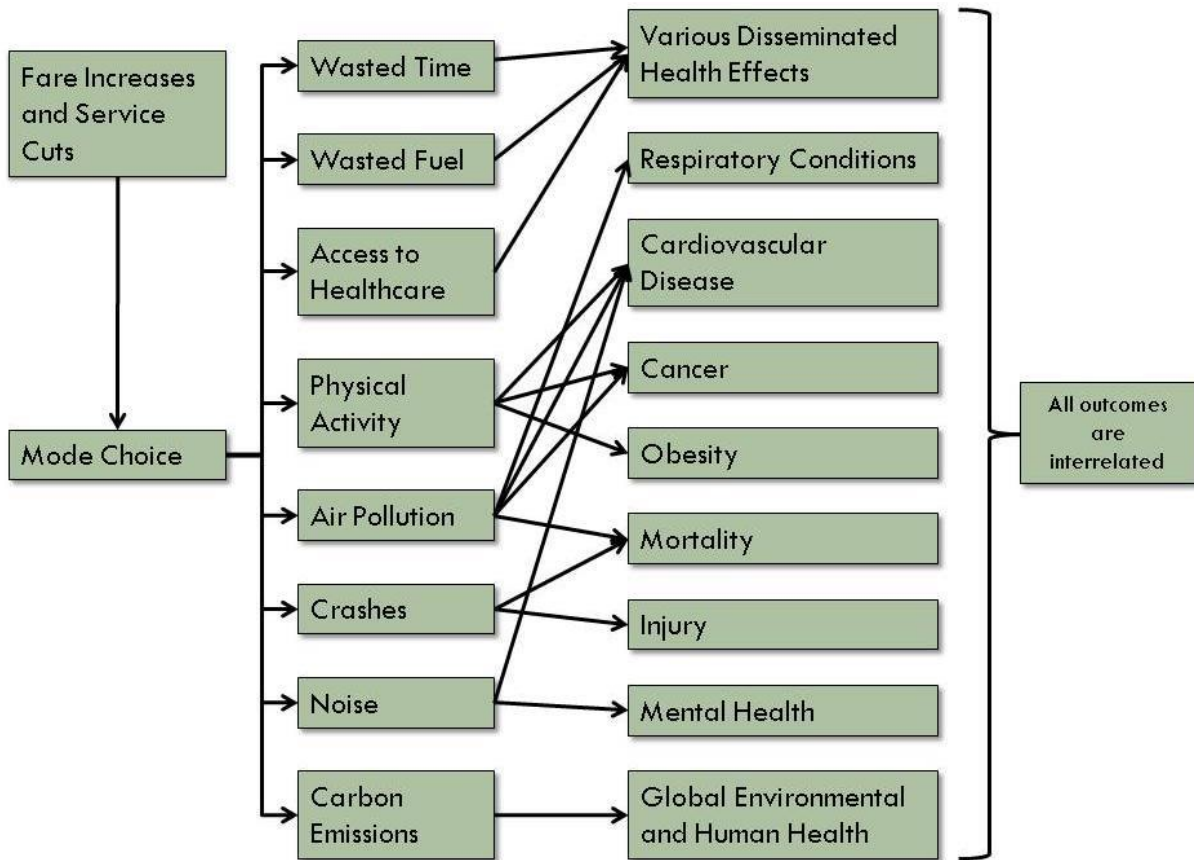

Figure 2.1 Health Impacts of Transportation Policies. Source : (James et al., 2014)

2.2 Direct Connections between Transportation and Health

2.2.1 Crashes and Motor Vehicle Injuries

The most direct connection between transportation and health is via motor vehicle injuries (MVI) (Godlee, 1992). Globally, 1.5 million deaths and close to 80 million years of healthy life are lost through motorised road transport: these exceed deaths from HIV, malaria, or tuberculosis annually (Bhalla et al., 2014). A 2009 comparison of traffic fatalities among 16 Organisation for

Economic Cooperation and Development (OECD) countries ranked Canada fourth, putting it only behind the USA, New Zealand and Ireland (Litman, 2010). The main ways of conceptualising the risk of MVIs involve measuring fatality per distance travelled (e.g., per 100 million kilometers travelled), number of trips taken, number of streets crossed (by pedestrians), amount of time spent travelling, per population (e.g., per 100,000) and per person-trips (e.g., 100 million) (Beck et al., 2007; Litman, 2010; Teschke et al., 2013). Per-population methods are not considered exposure-based as the denominator might include people not at risk of MVIs. The risk of injury and death through transportation varies by mode of travel, with public transportation (transit) shown to be the safest (Beck et al., 2007; Litman, 2010). For example, annual fatal injury rates per 100 million person-trips in the USA in 2007 were as low as 0.4 for bus occupants compared to motorcyclists (536.6), other vehicle occupants (28.4), bicyclists (21.0), pedestrians (13.7) and passenger vehicle occupants (9.2).[4]

2.2.2 Physical (In)activity[5]

The availability of public transportation systems has important implications for people's levels of physical activity (McCarthy, 2006). A preponderance of research has shown that the use of public transportation increases physical activity through increased walking (Durand et al., 2016; Langlois et al., 2016; Morency et al., 2011; Sener et al., 2016; Wasfi et al., 2013). As people walk to and from home to board public transit, they increase their walk time by as much as 19

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[4] Six primary modes of transport were used in this study; passenger vehicle (passenger car, sport utility vehicle, van, or light truck), motorcycle, walking, bicycle (includes tricycle, unicycle), bus, and all other vehicles (e.g., large truck, motor home, taxi, limousine, hotel/airport shuttle) (Beck et al., 2007).

[5] Most of the research that focuses on physical inactivity is typically within the same city as opposed to intercity transport which is the case under study.

minutes per day (Besser & Dannenberg, 2005) or 8.3 minutes/day (expending 25.7-39.0 kcal) (Morency et al., 2011). The additional walk time associated with public transportation use has been linked to reductions in overweight and obesity (Liao et al., 2016), risk of heart disease (Dora, 1999) and health expenditure (Edwards, 2008). Conversely, an Australian study found that although public transportation accessibility increased walk times, it was not necessarily associated with reductions in obesity, diabetes or metabolic syndrome (Barr et al., 2016). Such findings as in this Australian study have not been replicated in Canada.

In Canada, transit-oriented development is associated with increased physical activity (Langlois et al., 2016), with public transit users more likely to achieve the WHO's physical activity recommendation of 30 minutes per day (Wasfi et al., 2013). Several sociodemographic differences exist in these outcomes. Females, people in lower-income households (<$20K) and younger people walk less to and from public transportation (Wasfi et al., 2013). Additionally, data from Montréal, Hamilton and Toronto also show reduced mobility of people from single-parent households, seniors and people on low incomes (Morency et al., 2011).

2.2.3 Environmental Pathways – Air and Noise Pollution and Climate Change

Transportation also affects population health through air pollution, noise pollution and, on a macro level, climate change. Increases in particulate matter as a result of transportation have been shown to increase the risk of myocardial infarctions by as early as hours post exposure (Peters et al., 2001). Among children, Khreis et al. (2017a) have shown, through a meta-analysis and systematic review of 41 studies, that Traffic Related Air Pollution (TRAP) significantly increases the likelihood of the development of asthma. Data from 2005-2010 also show that while 20 of the 34 OECD countries made progress in reducing air pollution, the remaining 14

(including Canada) did not. The health costs of air pollution (of which 50% is due to road transportation) in OECD countries in 2010 was about US$1.7 trillion (OECD, 2014).

Noise created from road traffic has deleterious impacts on population health. Traffic-related noise is a significant stressor leading to sleep disturbance, difficulties in cognitive performance among children (Stansfield et al., 2005), annoyance, cardiovascular diseases (Halonen et al., 2015; Mü Nzel et al., 2014; Recio et al., 2016b, 2016a) and hearing impairment (World Health Organisation, 2000). Conservative estimates of the health impacts of noise using Disability Adjusted Life Years (DALYs) from Europe as of 2010 indicated a total of at least a million years of healthy life lost yearly to conditions such as ischemic heart disease (61,000 years), cognitive impairment in children (903,000 years), sleep disturbance (22,000 years) and tinnitus (654,000 years) (Fritschi et al., 2011). Some of these noise-related outcomes have however been shown to be amenable to health interventions (Brown & van Kamp, 2017; World Health Organisation, 2000).

The heat and gases produced by contemporary modes of transportation have been shown to accelerate climate change and its negative consequences. About 26% of global carbon emissions are transportation-related (Chapman, 2007), with most of these emissions attributable to diesel cars (Marsden & Rye, 2010). Finally, transportation affects health via climate change by increasing carbon emissions which are associated with heatwaves, floods and drought-related deaths (World Health Organisation, 2000).

2.3 Indirect Connections between Transportation and Health

In some cases, the connections between transportation and health are not direct but mediated by other social determinants. In such cases, transportation options (or the lack thereof) affect access

to certain services, resources, or social connections that are necessary for the maintenance of health and wellbeing. Here, social factors such as accessibility, aversion behaviors, public safety, uncertainty of construction and intrinsic journey value and their distributional effects are usually considered (Markovich & Lucas, 2011). Key transportation-related social determinants of health such as poverty, social exclusion and access to services including healthcare are explored below.

2.3.1 Transportation, Poverty and Social Exclusion

Transportation is connected with poverty, social isolation and social exclusion. The connections between transportation and poverty revolve around three main bodies of conceptual and theoretical literature: spatial mismatch and entrapment theory, social exclusion theory and social justice approaches (Titheridge et al., 2014).

First, a lack of adequate and affordable transportation promotes poverty by separating people from economic and life opportunities. In the case of spatial mismatch (more relevant in urban settings), the argument is that poorer people live in neighborhoods with fewer opportunities for employment. Lack of public transportation therefore restricts their ability to search for jobs over a wide area (Blumenberg & Ong, 2001). Employers may also discriminate against such persons in the absence of reliable transportation as they expect that such employees may frequently be late or absent from work (Gobillon et al., 2007). Thus, for such people, transportation represents a vital link to economic opportunities necessary for escaping poverty.

Second, lack of public transportation may increase social exclusion since the most vulnerable members of society may be increasingly unable to participate in social activities such as visiting friends, shopping, education, etc. because of the absence of transportation (Litman, 2003; Lucas, 2004). Social exclusion resulting from the absence of public transportation can lead

to the erosion of social capital, although the interrelationships between social exclusion, social capital and transportation disadvantage are complex and may interact to reinforce one another (Schwanen et al., 2015). For example, potential and actual mobility (motility), a form of social capital, facilitates spatial and social mobility (Kaufmann et al., 2004) and engenders social participation. Therefore, the availability of public transportation options can be a means to build social capital for the transport disadvantaged (Currie & Stanley, 2008). On the other hand, the reason some people are less mobile or have low levels of social capital to begin with is a result of transportation disadvantage (Schwanen et al., 2015).

A third approach to thinking about the relationship between transportation and poverty is the social justice approach. This relates to the question of distributional impacts and externalities arising from transportation policies (Lucas et al., 2016). Here, transportation policy has implications for poverty and, by extension, health, because road traffic injuries and environmental impacts disproportionately affect people with low income, women and other vulnerable members of society (Litman & Brenman, 2012; Lucas et al., 2016; Markovich & Lucas, 2011).

The three bodies of literature demonstrate that the (un)availability of transportation infrastructure and services affect people's access to income, food, employment and other services (Lucas, 2012; Lucas et al., 2016) and that the unavailability of adequate, affordable and accessible transportation might push people further into poverty and to the margins of society. These transportation-poverty relationships are not straightforward and are rendered more complex by social constructs such as class, ethnicity or gender that might modify the relationships between transportation and poverty. In the north-east of England for example, the

availability of public transportation has been shown to significantly affect women's ability to participate and compete in the labour market (Dobbs, 2007). An Australian example showed that poverty resulting from transportation policies affects Indigenous communities disproportionately (Currie & Sendbergs, 2007).

These indirect connections between transportation and health are nevertheless important. Through material and psychosocial pathways (Bartley, 2016), increases in poverty, reduced access to opportunities such as employment and the lack of social support or erosion of social capital that may arise from disadvantages in transportation, can have potentially negative effects on population health and health inequities (Berkman & Krishna, 2014; Litman, 2013).

2.3.2 Access to Healthcare Services

Another pathway from transportation to health is through healthcare access. A review of 61 studies in the USA revealed that people who do not own vehicles (primarily older adults, people of a lower socioeconomic status and ethnic minorities) have disproportionately lower rates of healthcare utilisation because of transportation barriers (Syed et al., 2013). A similar review in Australia found that the unavailability of transportation significantly affects the ability of older people to access health services for chronic conditions such as cancer and asthma (Corcoran et al., 2012). In Saskatchewan, research on the health of rural-dwelling seniors suggests challenges with accessing health services, particularly for those who are unable to drive to medical appointments (Jeffery et al., 2011).

In thinking about the transportation-health nexus, some population groups have been identified as bearing the greatest suffering from the absence of transportation or the negative impacts of transportation decisions. These include low-income or unemployed people, welfare

beneficiaries, youth/children, women, the elderly, people with disabilities, outer urban dwellers and ethnic minorities (Dodson et al., 2004).

2.4 Research Gaps and Opportunities based on Transportation Literature

Gaps exist in the transportation-health literature that could be addressed by the STC case study due to the specific modalities of the closure. First, most transportation-health connections are typically established with little or no attention to political factors that determine how transportation itself is organised. Second, the transportation-health connection is often made with a focus on human travel as opposed to the transportation of non-human products (e.g., medical equipment) which are also connected to health. Finally, the scale and analysis of transportation research is often within one city (intra-urban) as opposed to inter-city transportation (or across a province as was the case of STC). This research aimed to fill these gaps and to broaden the understanding of how politics can affect health via transportation.

2.5 Theoretical Perspectives

2.5.1 Politics, Policies and Health – The Political Economy of Health

The idea that politics significantly determines health inequities is not new. One of the pioneers of clinical pathology, Rudolf Virchow, declared a century ago that “Medicine is a social science and politics is nothing more than medicine on a large scale” (Navarro, 2009, p. 441). Similarly, one of the founders of medical statistics, William Farr, stated a century ago “no variation in the health of the states of Europe is the result of chance; it is the direct result of physical and political conditions in which nations live” (Diderichsen et al., 2001, p. 13). Despite this long history and tradition, many of the contemporary accounts of health inequities have remained apolitical (Bambra et al., 2005). In fact, most debates that connect politics to health inequities

have revolved around the organisation of health systems while ignoring other ways in which politics and health are connected (Bambra et al., 2005; Obeng-Odoom & Bockarie, 2018).

As used in the social sciences, political economy refers simultaneously to an area of study focused on the relationships between politics and economics as well as a methodological approach for understanding institutions, political behaviour and social processes (Weingast & Wittman, 2006). It is the study of ‘totalities’ from a materialist perspective that involves connecting economic, political and cultural/ideological aspects of life to explain how a society produces and reproduces itself while paying attention to inherent contradictions in the process (Clement, 1997). There is a strong tradition of political economy research in Canada, aimed “centrally, to understand the theory, practice, history, and implications of capitalist development and its alternatives – capitalism being primarily oriented around profit, prices, and private property” (Whiteside, 2020, p. 4).

The approach of attempting to understand health inequities through politics and how society is organised is sometimes referred to as the ‘political economy of health’ (Harvey, 2021). While similar to the broader area of political economy theory, in health research the approach stands in stark contrast to other ways of explaining health that rely on biomedical, behavioural and sometimes individual (genetic) differences as fundamental explanations of health inequities (Bambra, 2011b; Birn et al., 2017; Mackenbach, 2012). Some instances where the political economy of health has been used as an analytical lens have yielded remarkable insights into how political and economic systems affect health negatively, such as capitalism and workers’ health (Bambra, 2011a; Doyal & Pennell, 1979), the collapse of the Soviet Union and health inequities

(McKee, 2000) and the impacts of colonialism on poor health in North Africa (Fanon, 1965, pp. 121-147).

At its core, the political economy of health, occasionally refered to as "political epidemiology" (Pega et al., 2013, p. 176), examines the relationships between the individual and society and how political and economic contexts determine people's likelihood of poor health. This approach argues that structural factors are critical for understanding why health inequities occur (Bartley, 2004, 2016; Diderichsen et al., 2001). As Krieger (2011, p. 168) notes, the political economy of health emphasises that those who wish to understand health inequalities pay particular attention to "political and economic structures, processes… that *produce* societal patterns of health, disease and wellbeing via shaping the conditions in which people live and work" (emphasis in original).

Three main approaches exist for conducting research using the political economy of health: the welfare regime approach, the politics approach and the individual policy approach (Pega et al., 2013). The welfare regime approach investigates how politics affects health by comparing health outcomes across welfare regimes (social-democratic, Christian-democratic and liberal) (Muntaner et al., 2011). The politics approach connects politics to health by examining how health is affected by "political traditions and ideology (e.g., neoliberalism), processes (e.g., democratisation, globalisation, corruption, privatisation, trade liberalisation), systems (e.g., democracy versus autocracy) or institutions (e.g., unions, political parties, bureaucracy)" (Pega et al., 2013). The third approach involves examining how specific or individual public policies and political choices affect health and wellbeing of the population (Pega et al., 2013). Aspects of this study fall in the second and third approaches as the study focused on a specific policy decision –

elimination of a provincial bus service – as well as the role of ideology and discourse in the closure.

The frameworks below illustrate the complex pathways from political and social contexts to health outcomes. In both frameworks health is ultimately linked to the social context and the types of policies adopted by governments can influence the conditions in which people live and work and thereby influence their health outcomes.

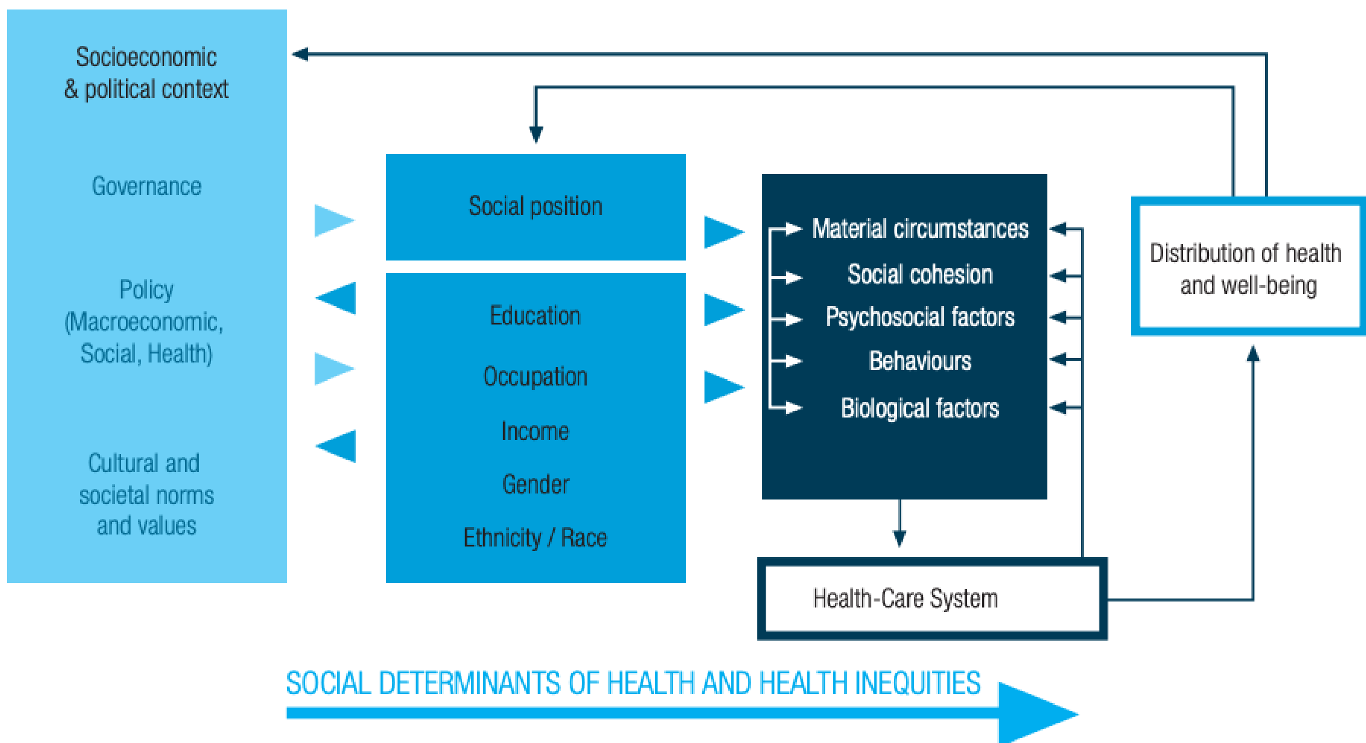


Figure 2.2 Social Determinants of Health and Health Inequities. Source: (World Health Organisation, 2008)

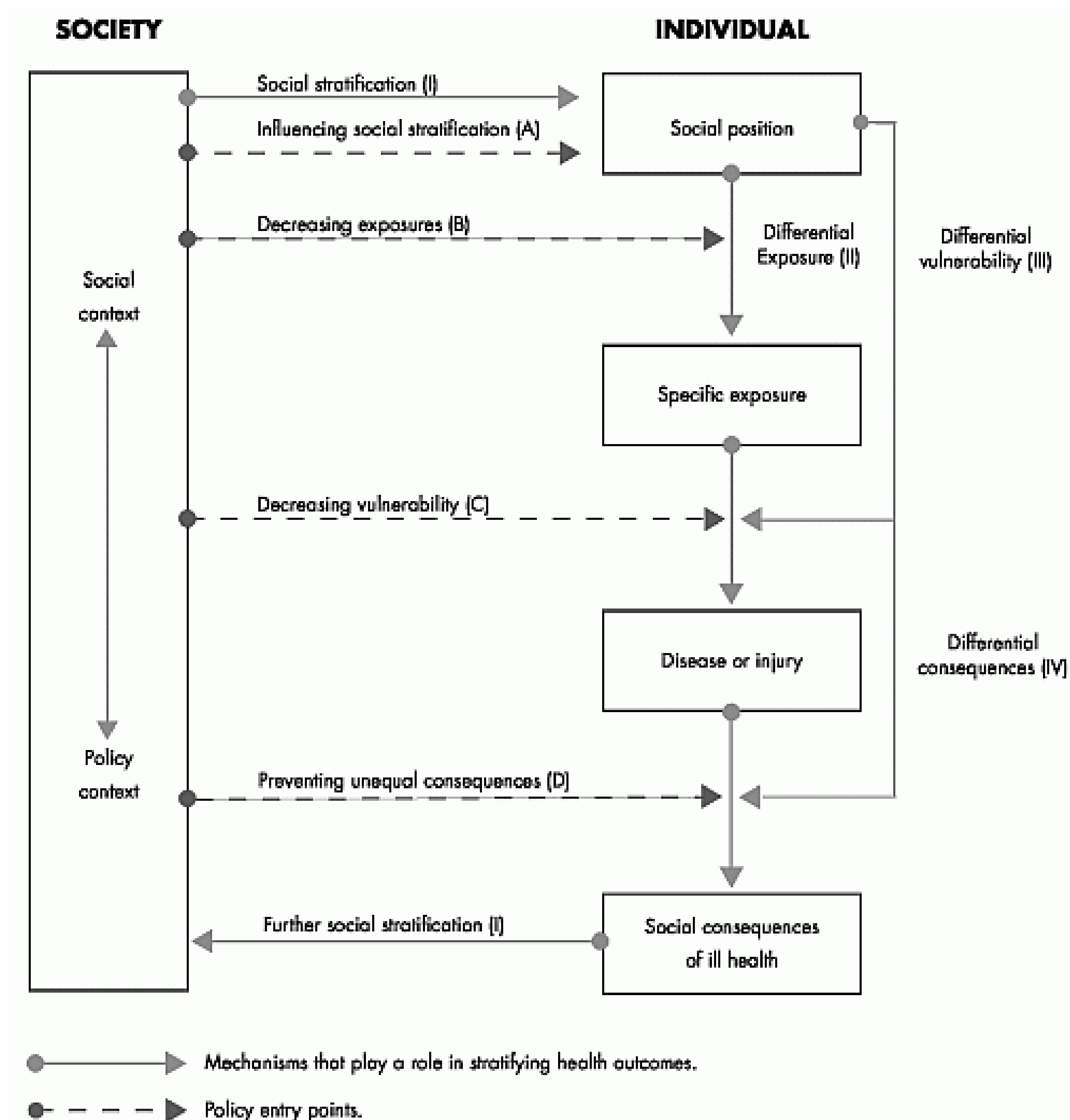


Figure 2.3 The Social Context and Health. Source : (Diderichsen et al., 2001)

2.5.2 Social Location and Intersectionality Theory

The second theoretical perspective and set of assumptions that have guided the conduct of this research and subsequent analysis are the ideas of social location and intersectionality. A person's social location refers to where they stand in society and this is articulated through their experience and background (Daynes, 2007). People's social locations determine the development of their sense of self and their interpretations of their experiences (Zaytoun, 2006). Social location, which is often hierarchical (Anthias, 2013), also affects how people accumulate forms of capital (social, cultural, economic) in a Bourdieausian sense, and all have implications for health (Veenstra, 2007). In a narrower sense, conceptualisations of people's social location are usually through the use of categories such as class, gender, ethnicity, age and a number of variables that affect health differently based on theory and measurement (Canadian Institute of Health Information, 2013; Krieger et al., 1997)

Although these social categories have been useful in analysing and understanding how policies and social inequities affect health, the concept of intersectionality has emerged as a useful theoretical perspective for enriching such analysis (Gkiouleka et al., 2018). The term 'intersectionality' was coined by African American legal scholar and feminist researcher Kimberlé Crenshaw as a result of the inadequacy of race or gender alone in describing experiences of discrimination faced by African American women (Denis, 2008; McCall, 2005). This theoretical perspective which is often employed by feminists and anti-racist researchers (Nash, 2008) has contributed to robust analyses in a number of fields including sociology (Denis, 2008) and health inequalities research (Springer et al., 2012).

Intersectionality posits that because people belong to different social locations (example: gender, class, disability status, etc.) and belonging to each socially disadvantaged group can negatively affect one's life chances, those who simultaneously belong to disadvantaged groups may be multiply oppressed in a syndemic fashion (Crenshaw et al., 1995; Veenstra, 2011). This means that efforts to understand the health impacts of policies as described from the political economy of health approach need to pay attention not only to the unique etiological pathways from politics and policies to health outcomes but also the complex ways in which a toxic combination of disadvantages can syndemically interact to leave marginalised population groups at unique health disadvantages (Hankivsky & Christoffersen, 2008).

Building on intersectional analyses that pay attention to place (Hankivsky et al., 2019), geography was adopted in this case study because of the wide distribution of Saskatchewan's population. There is a rich tradition of research dedicated to the geographies of health and how place can play an important role in affecting people's life chances and access to social determinants of health (Veenstra et al., 2005). Health geography is very similar to epidemiology but places an emphasis on spatiality in a way that may not often be found in epidemiology (Drummer, 2008). Informed by an intersectionality theoretical perspective, my interest here was to understand how living in a rural or urban area in combination with the other markers of social location play a role in how the health impacts of STC closure are experienced by people.

2.6 Theoretical Framework

Drawing on a political economy of health, transportation and health and social determinants of health insights, I created the figure below in order to help organise data collection and identify potential participants. Figure 2.4 describes the anticipated pathways through which austerity might affect health using a transportation case study (STC closure). Some of the potential pathways posited in the framework such as access to health services, motor vehicle injuries, increased costs of transportation, physical activity and pollution are well recorded in the academic literature (Beck et al., 2007; Litman, 2013; Morency et al., 2011; Syed et al., 2013) but others such as hitchhiking, transportation of medical equipment and escape from intimate partner violence were added based on anecdotal evidence (Johnson, 2017; Mattern, 2017; Saskatchewan Transportation Company, 2017). The connections suggested in the framework were explored in data collection (as discussed in Chapter 6).

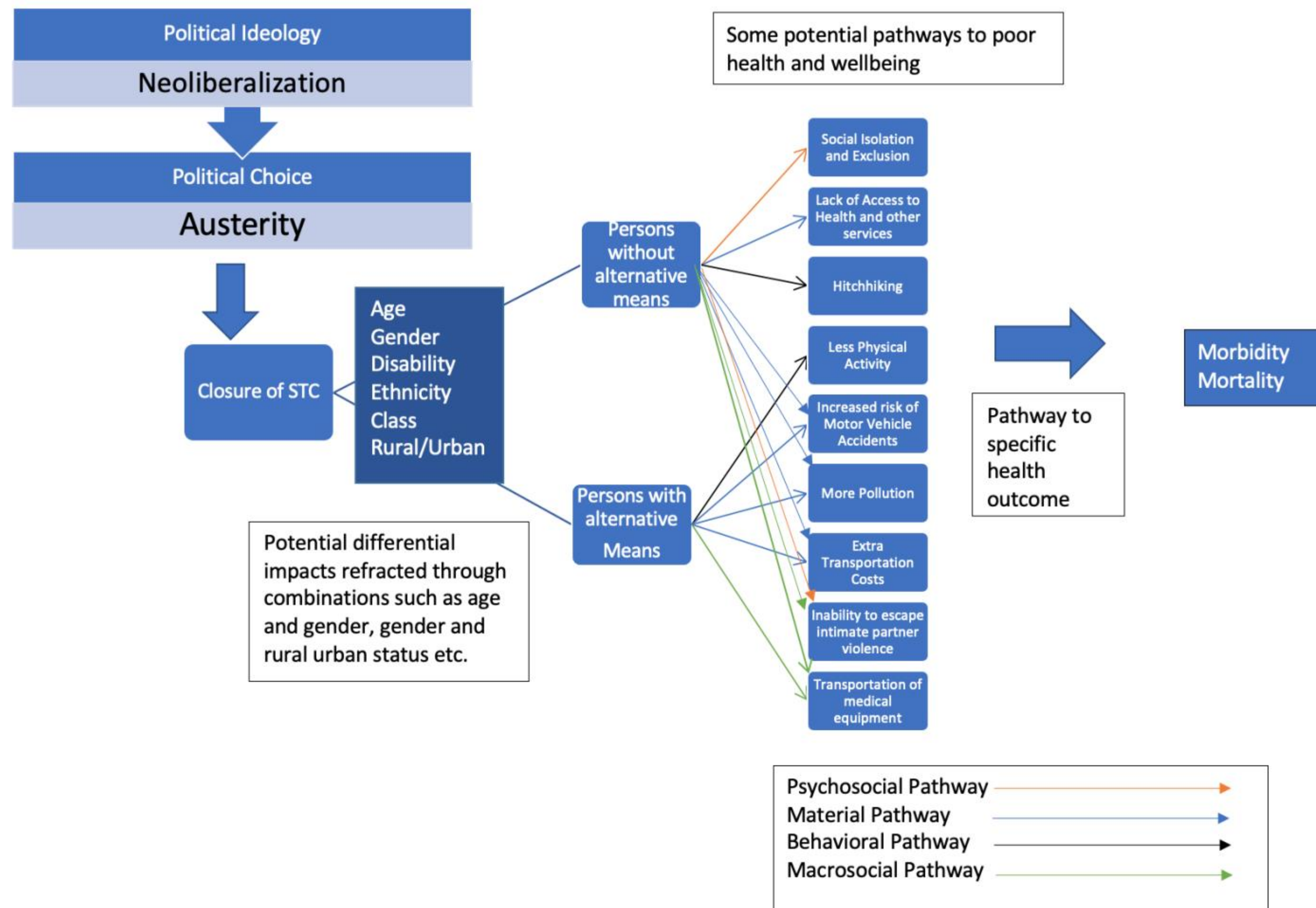


Figure 2.4: Transportation as a Social Determinant of Health- Theoretical Framework for Investigating STC closure and Health. Source: Author

As this research is guided by the political economy of health, the first part of the research (as indicated in the framework) was dedicated to understanding the politics behind the closure of STC. This involved using data from Parliamentary Hansards and media sources to uncover the political ideology that drove the closure and helped meet research objective 1. The second part of the framework is related to the third research objective and was guided by intersectionality theory. This part of the framework guided the selection of participants for the study and also informed the analysis of interviews and focus group data. Attention to people's social and geographical location helped reveal health equity impacts of the closure. The third part of the framework broadly categorised former STC riders into those with alternative means of transportation and those without. This was not a perfect way of categorising; however, it was a useful and broad enough categorisation for identifying participants and to understand the potential for inequitable impacts. The fourth part of the framework traced the specific pathways by which the closure could impact health. The main pathways explored included psychosocial pathways, such as exclusion and isolation arising from the closure as well as other psychological impacts. Inaccessibility of health and other services and increases in transportation costs which has health implications were examined. Hitchhiking (for those without access to cars) was also explored. Finally, health system effects were explored to understand how medical equipment, blood and other laboratory samples previously transported using STC were being transported post-closure. The environmental pollution pathway and the pathway on increased road traffic injuries were not researched directly since such connections are measured most appropriately using quantitative methods.

In summary, the framework was created based on methodological, theoretical and content literature to connect the politics of STC closure to health equity impacts and implications. It

drew on the political economy of health and intersectionality theory to show possibilities for health inequities. It was utilised to guide data collection, participant selection and interview questions. This framework represented the first attempt at responding to research objective 4.

2.7 Conclusion

This chapter has provided a broad overview of traditional connections between transportation and health arising from health research. After identifying some gaps in the literature connecting transportation to health outcomes, it described two theoretical approaches that respond to some of the gaps in the transportation literature and assisted in the creation of a theoretical framework. This framework guided the methodological choices made, as described in the next chapter and the subsequent analysis conducted after primary data collection.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the overall methodology employed in the conduct of the research. It begins by describing the qualitative health research approach that was used and highlights the particulars of case study methodology. It then provides an overview of the study context before describing the methods used (interviews, focus groups and document review) as well as the analytical approaches (discourse and thematic analysis) used to arrive at findings. The chapter ends by describing the axiological aspects of the research project and specific strategies employed to increase the trustworthiness of the research findings.

3.2 Qualitative Research Strategy

The study adopted a qualitative health research approach. Qualitative research is “a situated activity that locates the observer in the world… it consists of a set of interpretive material practices that make the world visible [by turning it] into a series of representations” (Denzin & Lincoln, 2017 p. 45). Qualitative research is a naturalistic (unobtrusive) inquiry where the researcher is a key instrument for the collection of data which are usually interpreted “inductively, recursively and interactively” (Creswell, 2007, p. 38). There are a number of methodologies that can be used in the conduct of qualitative research and the five major ones typically used are phenomenology, case study, narrative inquiry, ethnography and grounded theory (Creswell, 2013).

There are slight differences between qualitative research in general and *qualitative health research*. According to Morse (2012), qualitative health research focuses more on individual experience and patterned group response is considered secondary (Morse, 2012). Qualitative

health researchers also use different techniques to elicit and draw out meaning from research participants in a variety of health-related research areas. Whatever the specific methodology and methods employed, the primary aim is often towards a “moral praxis” (Labonté et al., 2005, p. 14) with the qualitative health researcher striving to humanise research and to be an advocate for participants (Morse, 2012). The point of qualitative health research above all is to help understand research participants’ experiences and causes of poor health outcomes as a means of improving health in society.

3.2.1 Case Study Methodology

Case study methodology is an in-depth study of single or multiple unit(s) to understand a larger class of (similar) units (Gerring, 2004, 2007). Although this methodology is not unique to health research, it has proved invaluable in the study of health issues such as dementia (Kindell et al., 2014), self-harm (Breet & Bantjes, 2017), healthcare access among religious groups such as the Mennonites in Canada (Hall & Kulig, 2004) and a host of others. There are several types of case studies: exploratory, explanatory, descriptive, multiple, intrinsic and instrumental (Baxter & Jack, 2008) that can be used to conduct both qualitative (Stake, 1995, 2008) and quantitative research (Yin, 1999, 2014). To conduct case study research, the researcher defines the case and its context and draws on multiple data sources to help illuminate the multifaceted aspects of the case (Abma & Stake, 2014; Stake, 1995; Yazan, 2015; Yin, 1999).

This was an instrumental case study to investigate how neoliberal austerity affects health via transportation policy decisions (Stake, 1995, 2008). In this kind of study, one studies the case not for its own sake (as in intrinsic case study), but to understand some broader phenomenon. In this instance, the case (the closure of STC) was used to understand the larger context (how

austerity affects health). As recommended for case studies (Baxter & Jack, 2008; Gerring, 2007; Yazan, 2015; Yin, 2003), it involved gathering data from multiple sources to understand the politics and rationale for the closure of STC as well as the health impacts and health equity implications of the decision.

Another characteristic of the case study methodology is the need to tightly define and 'bind' the case. This is done to differentiate the case from others and to clarify what constitutes its context (Baxter & Jack, 2008; Stake, 2008). A case can be bound by time and place (Creswell, 2003), time and activity (Stake, 1995, 2008), or by definition and context (Miles & Huberman, 1994).

For the purposes of this research, the case was defined as the closure of STC thus binding the case temporally to May 2017. Spatially it also binds the case and restricts it to Saskatchewan. As shown in Figure 3.1, although the closure of STC happened at a specific time (May 2017) and in a specific place (Saskatchewan, Canada) there are a host of contextual factors operating at different spatial (global, national and provincial) and temporal (from the past to the present) levels that provided a useful context for understanding the closure. Although no causal arrows are used, the review of literature reveals that a rise in neoliberalisation is a critical part of the context. On the vertical axis, there is space (global, national and Saskatchewan) within which events have occurred and on the horizontal axis, time (1940-2018) which shows when specific events occurred.

The rise in neoliberalisation beginning with its first example in Chile or its dramatic global rise may not have caused the closure of STC but presented neoliberal policies as viable alternatives. Changes in federal-provincial transfers and other neoliberal policies of privatisation

may also not have been proximate causes of the closure of STC but again they reflect a specific policy climate within which the closure of STC occurred and therefore provide context for the study. Thus, in the figure below if one traces the intersection of space and time (Saskatchewan, 2017) one sees the closure of STC but upon stepping back one sees the context. The point of context in case study methodology is to draw clear boundaries to highlight the focus of the research while acknowledging that other factors within the context are important for understanding the case (Baxter & Jack, 2008). (See Chapter 1 for a detailed description of STC closure and Chapter 4 for its historical context. 'LEAN' as shown in the figure refers to a series of cuts and management practices pursued by the Saskatchewan Government to increase efficiency in the health sector (McIntosh, 2016)).

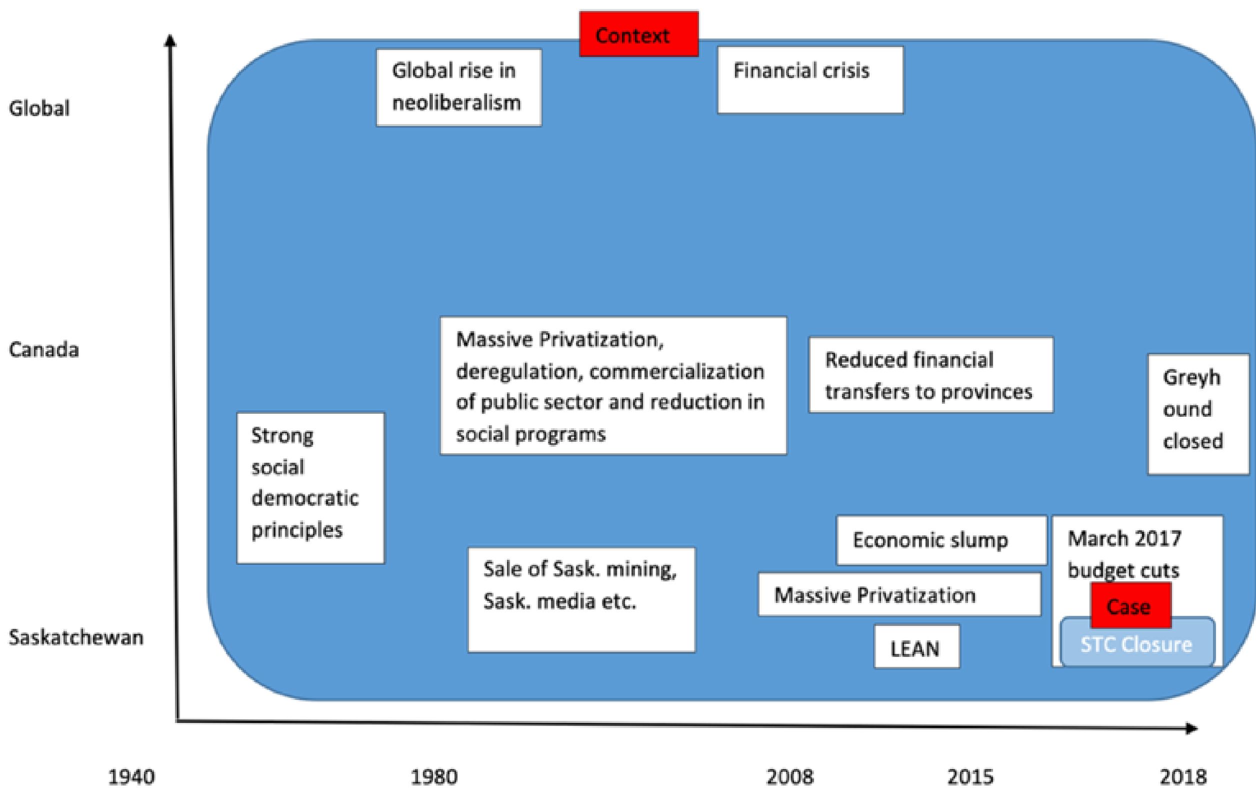


Figure 3.1: Defining the Case and its Context. Source: Author

3.3 Study Context

The closure of STC occurred in the context of major demographic and economic shifts in Saskatchewan, a sparsely populated province of about 1.1 million people (Bureau of statistics-Government of Saskatchewan, 2016). It has an export-based economy and sectors such as oil, mining and public services represent large proportions of GDP (Smith, 2018). Poverty rates for families and children (those under 18) are higher than the national average. The most recent data show that Saskatchewan has the third-highest rate of child poverty in the country at 26.2%, with Manitoba at second (27.9%) and Nunavut (31.2%) in first position (Hunter & Sanchez, 2020). Saskatchewan witnessed rising unemployment especially among the population aged 25-64 (from 4.1% to 6.7%) between 2011 and 2016 (Statistics Canada, 2016a). Figure 3.2 shows the major distribution of the labour force in the province by industry.

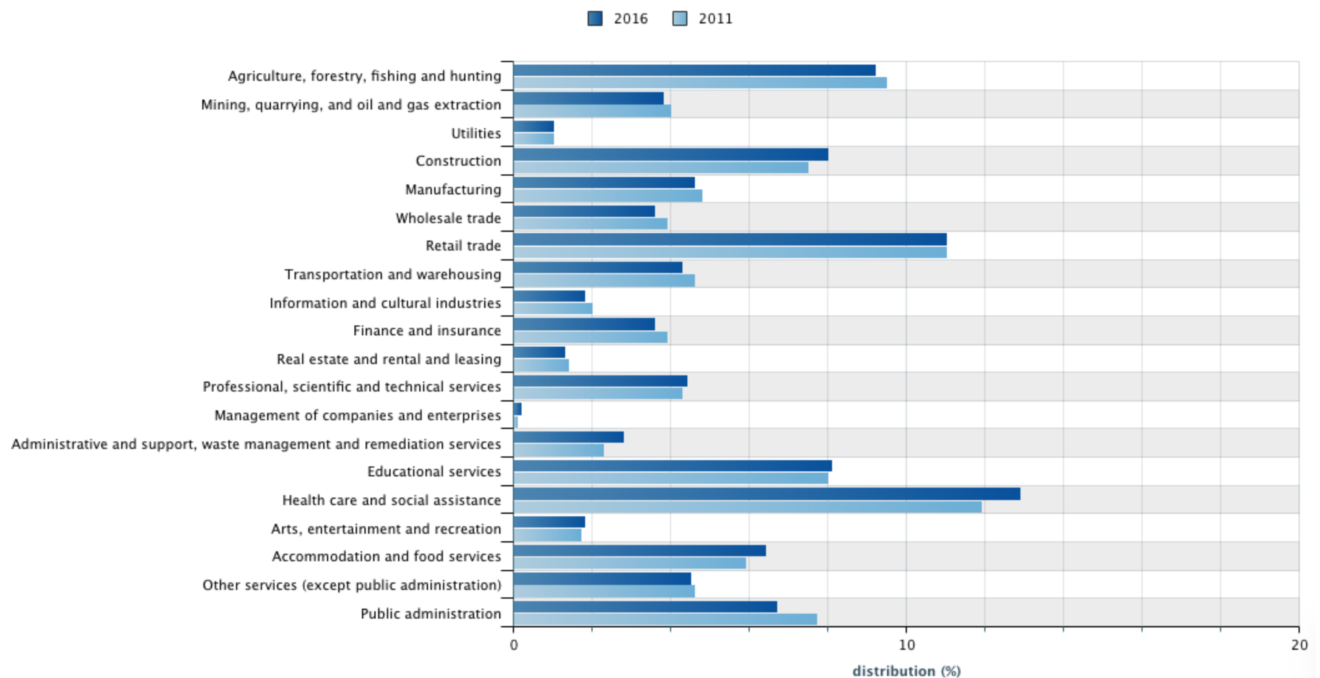
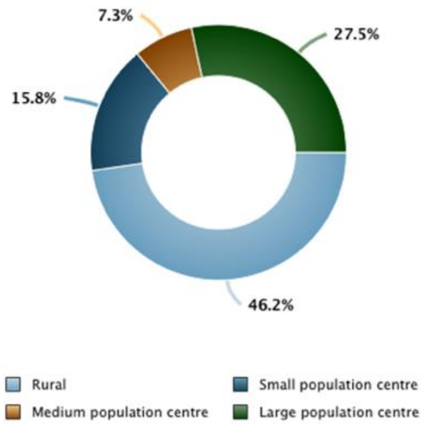


Figure 3.2 Distribution of Saskatchewan's Employed Labour Force Age 15 Years and Above. Source: (Statistics Canada, 2016a)

Saskatchewan has seen a major demographic shift given a rise in its aging population. Compared to 1971 when the proportion of the population aged 65 and above was only 10% of the general population, an estimated 16% of the population in 2020 is aged 65 and above. Figure 3.4 describes the population over the last 50 years. The rise in an aging population has led to a number of concerns including the current capacity of welfare systems to cater for it. For example, evidence on the availability and responsiveness of residential care facilities in Saskatchewan indicate that neoliberal policy shifts towards privatisation and marketisation have left the province's physical infrastructure "eroded" and unprepared for the increasing senior population (Braedley et al., 2019, p. 15). The rise in Saskatchewan's aging population is also gendered and is partly explained by the general trend in population health whereby women typically live longer than men (Bird et al., 2012; Payne, 2006). Figure 3.5 shows the gendered pattern in aging in Saskatchewan. There is a higher proportion of women in the senior population.

Compared to other parts of Canada, Saskatchewan has a high population of Indigenous people. In 2016, the total number of Indigenous people in the province stood at 114,570. Although the total proportion of First Nations in Canada is under 3% of the population, 10.7% of the population of Saskatchewan in 2016 self identified as First Nations (Statistics Canada, 2017b). Saskatchewan also has higher numbers of other Indigenous peoples such as the Métis. As shown in figures 3.3 and 3.6, the Indigenous population, especially those living on reserves, continues to grow although more Indigenous people are moving to urban centres. Saskatchewan's Indigenous population is also younger than the general population as shown in Figure 3.3.



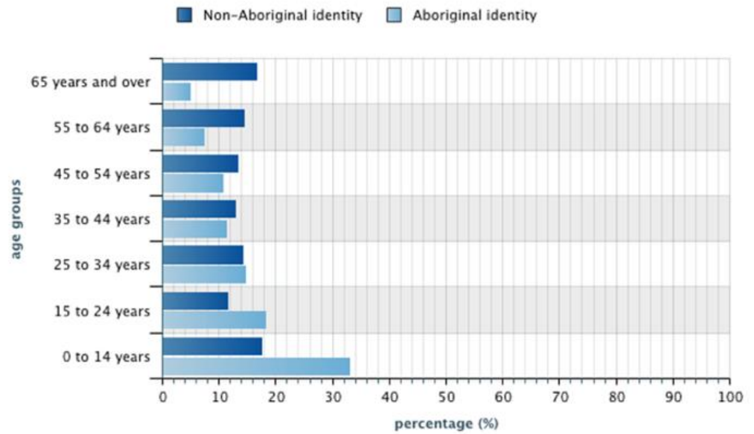


Figure 3.3 Indigenous Population by Geography and Age in Saskatchewan, 2016. Source: (Adapted from Statistics Canada, 2016b)

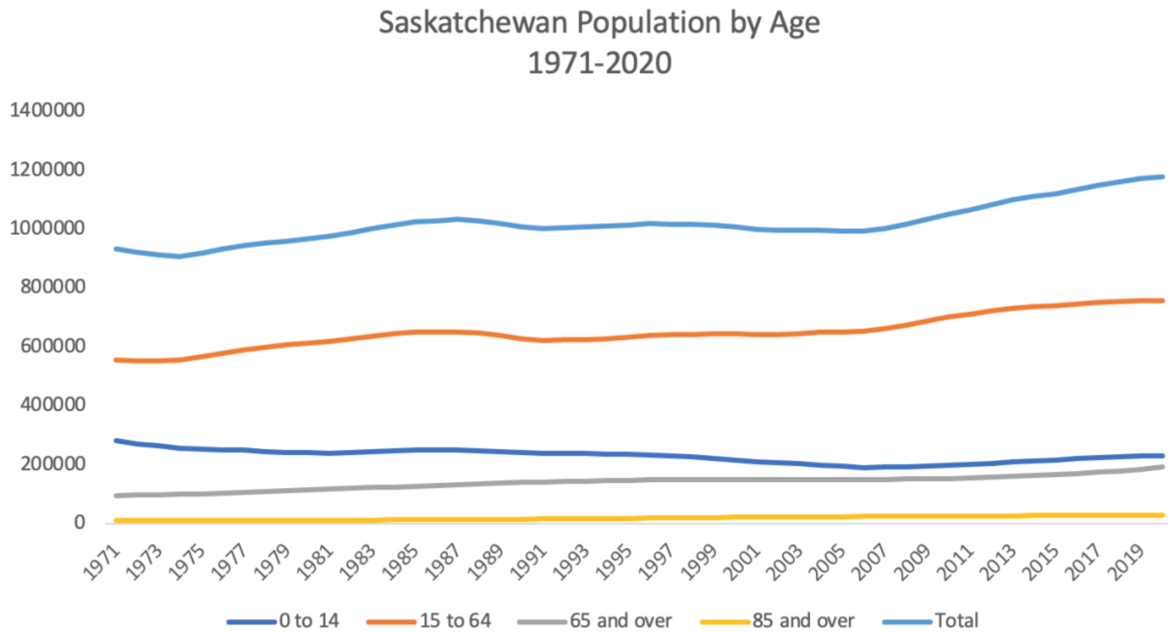


Figure 3.4 Saskatchewan Population by Age. Source: (Author, based on Bureau of statistics-Government of Saskatchewan, 2020)

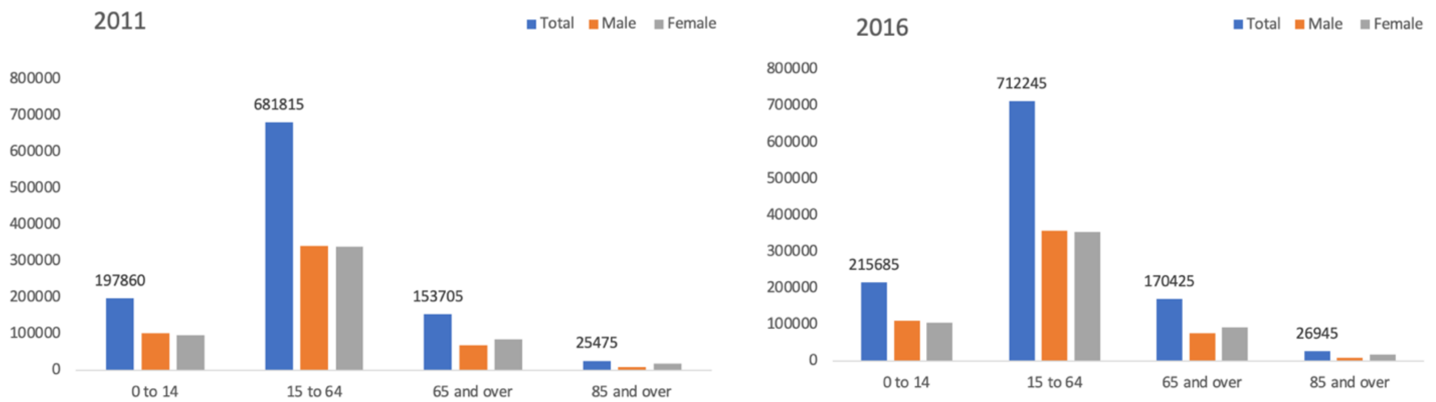


Figure 3.5 Saskatchewan Population by Age and Gender. Source: (Author, based on Bureau of statistics-Government of Saskatchewan, 2020)

In terms of geography, the province has also witnessed important shifts. There has been a decline in rural populations and a rise in the proportion of people living in urban centres. Apart from Indigenous communities and resort villages which have witnessed some population growth over the last four decades, there has been a decline in the proportion of people living in rural municipalities and towns. These changing population dynamics and rural decline are partly explained by poor infrastructure in rural areas and outmigration of young people (Hall & Olfert, 2015) as well as economic shifts including the rise of the service industry - concentrated in urban areas (Stevens, 2014).

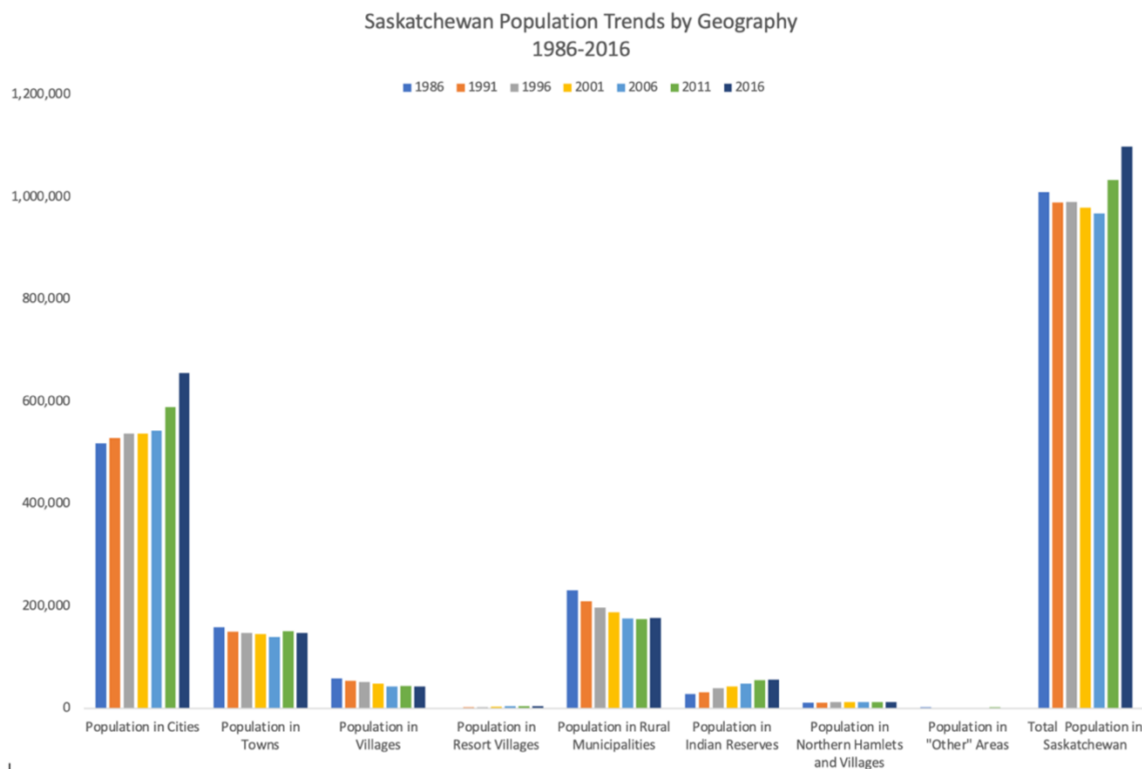


Figure 3.6 Saskatchewan Population by Geographical Location. Source: (Author, based on Bureau of statistics-Government of Saskatchewan, 2020)

For research purposes, there are different ways of geographically dividing the province. For example, some province-wide studies (quantitative) have relied on dividing the province into quadrants (Pahwa et al., 2012). Interview participants in this research were recruited from the northern, central and southern parts of the province. Focus group participants working in the health system were, however, recruited to mirror the current organisation of the health system which is divided into rural, northern and urban Saskatchewan. These analytical choices were made not for the sake of representativeness in an epidemiological and statistical sense but to attempt to respond to the vast and widespread nature of former STC routes and locations of former users of the bus whether they be individuals or those working in health and other systems. At the time of its closure, STC had a fleet of 41 buses, covered 25 routes and connected about

253 communities (Saskatchewan Transportation Company, 2017). Figure 3.7 shows the former routes covered by the STC. As shown in the figure, many communities in the north and some remote parts of the province had no access to bus transportation even when the STC operated because of poor roads.

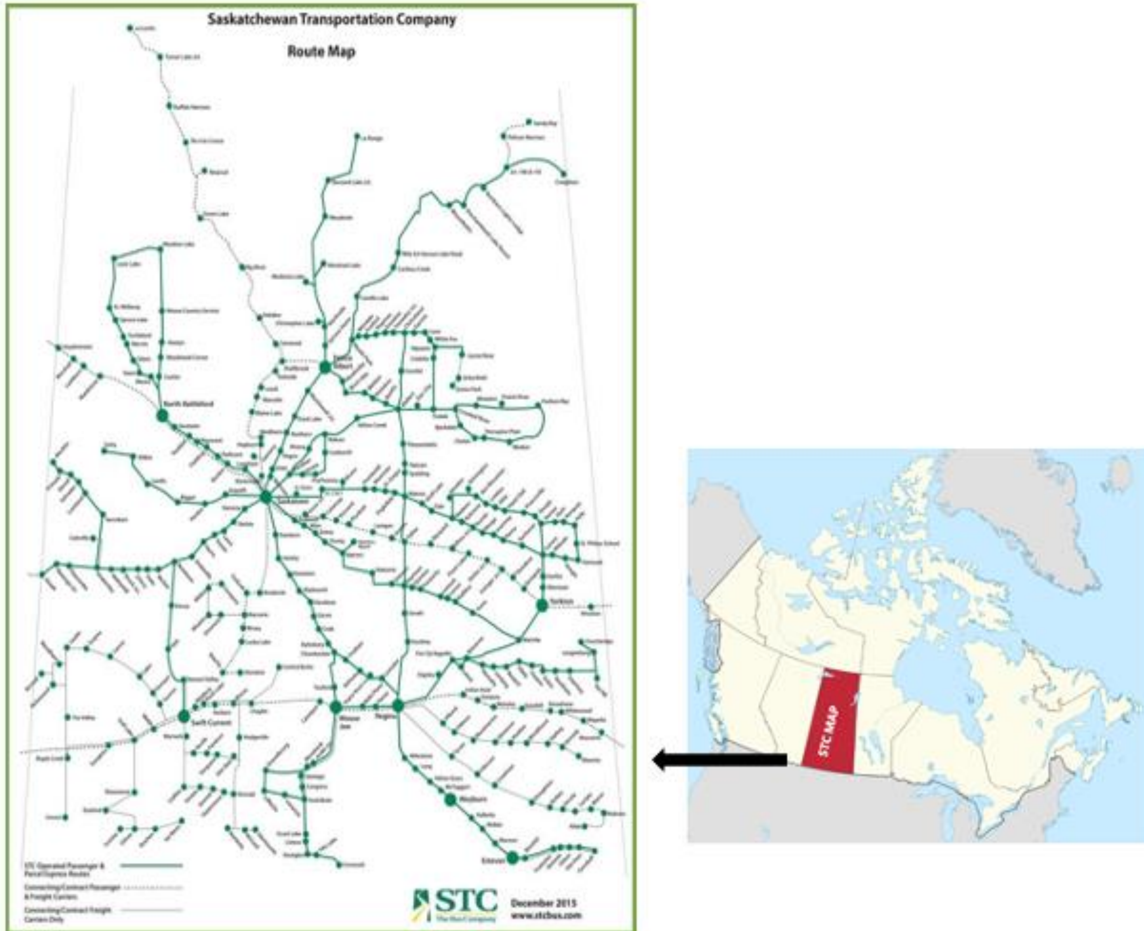


Figure 3.7: Former STC Route Map showing Cities, Towns and Villages in Saskatchewan.

Source: (Adapted from On the World Map, 2012; Saskatchewan Transportation Company, 2017)

3.4 Data Collection

3.4.1 Data Collection Procedures

This study involved primary and secondary data. Data from newspaper articles and Parliamentary Hansards (2014-2019) were extracted systematically and exported for subsequent analysis. Annual reports of the STC were reviewed for contextual information but not analysed. Historical data on why STC was created was also collected from the Saskatchewan Archives and analysed. Primary data were gathered from both the FGDs and semi-structured interviews to understand firsthand the impacts of the closure on health and health services delivery.

3.4.1.1 In-depth Interviews

Semi-structured in-depth interviews were conducted with one hundred former users of STC to gain a better understanding of STC closure impacts on health and wellbeing. Selected participants reflected a diversity of demographic characteristics (age, gender, class, ethnicity and geography). Apart from four interviews conducted by phone, each semi-structured interview was conducted in person and lasted between half an hour and one and a half hours. In most cases, consent forms were sent to participants prior to the interview and at the start of each interview, the form was discussed with the participants and they signed prior to the interview. Where participants had a disability such as visual impairment, the form was read to them before conducting the interview. At the end of each interview, participants were given a $25 gift card as an honorarium. Interviews were audio-recorded and transcribed before importation into NVivo 12 for organisation and analysis. Figure 3.8 shows the geographic distribution of interview participants and Table 3.1 shows participants by demographic characteristics.

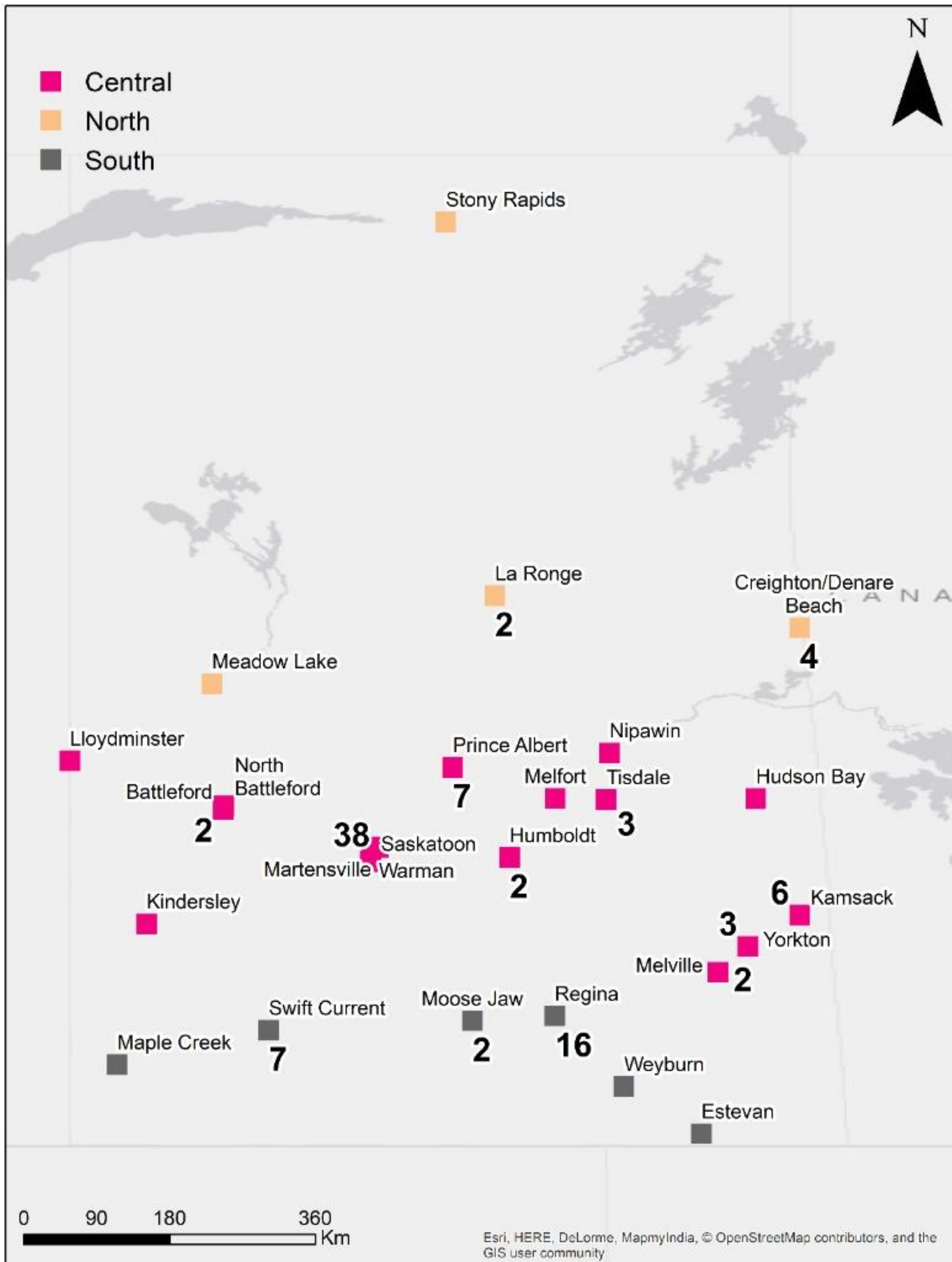


Figure 3.8: Interviewees Geographic Distribution. Source: Author

Table 3.1: Detailed Interview Participant Demographics by Car Ownership

Variable	No car (%) 40 (%)	Owns Car (%) 60 (%)	Total number (%)
Age			
21-29	2 (5.0)	4 (6.7)	6 (6).0
30-39	11 (27.5)	7 (11.7)	18 (18.0)
40-49	8 (20.0)	3 (5.0)	11 (11.0)
50-59	7 (17.5)	10 (16.7)	17 (17.0)
60-69	7 (17.5)	17 (28.3)	24 (24.0)
70-79	4 (10.0)	10 (16.7)	14 (14.0)
80-89	1 (2.5)	8 (13.3)	9 (9.0)
90+	0 (0.0)	1 (1.7)	1 (1.0)
Gender			
Female	28 (70.0)	40 (66.67)	68 (68.0)
Male	11 (27.5)	20 (33.33)	31 (31.0)
Transgender Female	1 (2.5)	0 (0.00)	1 (1.0)
Self-identified ancestry			
African	0 (0.0)	1 (1.7)	1 (1.0)
Caucasian	21 (52.5)	54 (90.0)	75 (75.0)
First Nations	11 (27.5)	3 (5.0)	14 (14.0)
Métis	5 (12.5)	1 (1.7)	6 (6.0)
South American	1 (1.7)	0 (0.0)	1 (1.0)
South Asian	2 (5.0)	1 (1.7)	3 (3.0)
General location			
Northern Saskatchewan	4 (10.0)	12 (20.00)	16 (16.0)
Central Saskatchewan	24 (60.0)	34 (56.67)	58 (58.0)
Southern Saskatchewan	12 (30.0)	14 (23.33)	26 (26.0)
City/Town/Village			
Saskatoon	20 (50.0)	18 (30.00)	38 (38.0)
Regina	9 (22.5)	7 (11.67)	16 (16.0)
Swift Current	2 (5.0)	5 (8.33)	7 (7.0)
Prince Albert	2 (5.0)	5 (8.33)	7 (7.0)
Kamsack	0 (0.0)	6 (10.00)	6 (6.0)
Tisdale	1 (2.5)	2 (3.33)	3 (3.0)
Yorkton	1 (2.5)	1 (1.67)	3 (3.0)
Creighton/Denare Beach	1 (2.5)	3 (5.00)	4 (4.0)
Humboldt	0 (0.0)	2 (3.33)	2 (2.0)
North Battleford	1 (2.5)	1 (1.67)	2 (2.0)
Moose Jaw	1 (2.5)	1 (1.67)	2 (2.0)
Melville	1 (2.5)	1 (1.67)	2 (2.0)
La Ronge	0 (0.0)	2 (3.33)	2 (2.0)
Other	1 (2.5)	5 (8.33)	6 (6.0)
Education completed			
Grade School	18 (45.0)	17 (28.3)	35 (35.0)
Post-secondary training and trades	8 (20.0)	20 (33.3)	28 (28.0)
University	9 (22.5)	14 (23.3)	23 (23.0)
Postgraduate	5 (12.5)	9 (15.0)	14 (14.0)

Source: Author

3.4.1.2 Focus Group Discussions

Six FGDs were conducted, audio-recorded and transcribed using similar procedures to the interviews. Participants consisted of stakeholders from northern, rural and urban Saskatchewan. For northern Saskatchewan, one FGD was held with five participants made up of four health workers from an Indigenous health organisation (two nurses, a homecare worker and a benefits navigator) and one program manager from the Saskatchewan Health Authority (SHA). A second FGD was held with four stakeholders from rural Saskatchewan (a pharmacist, an executive director of a program, a community relations officer for a women's shelter and an outreach worker for a public health program). A third FGD was held with four stakeholders from urban Saskatchewan. This group was made up of a medical doctor, two social workers (clinical oncology and mental health/addictions) and a program manager. The fourth FGD was conducted in an urban centre with two program managers from a mental health and addictions program. The fifth FGD was conducted with two Indigenous stakeholders (one from an Indigenous government and the other a manager of an Indigenous program for vulnerable populations). The sixth FGD was held with seven people who were advocates and/or activists (a person in charge of a meal program, a director of women's shelters, an activist-academic, a disability rights advocate and three other activists from organisations that opposed the closure of STC or were currently advocating for its return). Members of the first four FGDs spoke about health system impacts and populations that had become more vulnerable following the closure, while those from the last two focused on the politics of the closure. In every FGD, participants were asked to describe the ongoing impacts of the closure on their clients and, where appropriate, to comment on the political rationale for the closure. Table 3.2 provides a summary of focus group participants.

Table 3.2: Focus Group Discussion Participants

Characteristic	Number
Profession	
Academic	1
Physician	1
Clerical staff	4
Nurse	2
Other	5
Pharmacist	1
Program Manager	8
Social Worker	2
Location	
Northern	5
Rural	4
Urban	15
Sector	
Community Based Organisation/Program	5
Indigenous Organisation	6
Health System	8
Activist	5
Total	24

Source: Author

3.4.1.3 Document Review

The study drew on four main types of documents. The first was STC Annual Reports. These were reviewed for context on STC service delivery, former users, subsidies received from the government and other relevant information and statistics. The second was newspaper articles. Grey literature search site "Factiva" was searched with the keyword "Saskatchewan Transportation Company" from December 2014 to December 2019. This yielded 712 newspaper articles and was supplemented by hand searches of other news sites culminating in 751 articles. The third type was Legislative Assembly Hansards. The "Saskatchewan Transportation Company" subject area of the Saskatchewan Legislative Assembly Hansard was downloaded and consisted of closure debates in the Legislative Assembly immediately before, during and after

the closure. The fourth type was the earliest annual reports of the STC, memos and other historical material retrieved from the Saskatchewan Archives. Table 3.3 presents a summary of documentary sources used in the research.

Table 3.3: Summary of Data Sources used for Document Analysis

Source	Time frame	Description	Data on…
Parliamentary Hansards	2016-18	Hansards from the Saskatchewan Legislative Assembly (Dec 2016 - June 2018)	Discourses and counter-discourses on the closure of STC
Media Reports	2014-19	Newspaper articles retrieved from FACTIVA and other websites	Citizen concerns and discourses on why the company was closed
STC Annual Reports	2000-17	Annual Reports on STC service users, services delivered and statistics	Former users of STC, routes covered, services rendered
Archives	1946-60	Earliest STC reports, memos, correspondence	Why STC was formed, evidence on earliest operations

Source: Author

3.4.2 Participant Recruitment

The study involved a total of 124 participants from across Saskatchewan. This was made up of one hundred people who participated in interviews and twenty-four who participated in Focus Group Discussions (FGDs). After gaining approval to proceed with data collection, a research poster approved by the University of Saskatchewan Research Ethics Board (REB) was circulated on social media (Facebook and Twitter), on the University of Saskatchewan announcement website and at hospitals in the Saskatchewan Health Authority (Appendix 1). Physical research posters were put up in hospitals by me and with help from four Patient Family Advisors (PFAs) recruited from the Saskatchewan Centre for Patient Oriented Research (SCPOR). Patient Family Advisors are advocates from SCPOR who work with researchers and health professionals on

patient rights and often help to bridge the gap between researchers/practitioners and patients/research participants. At the beginning of the study, the PFAs were recruited and consulted to help refine interview questions. They offered advice and support throughout data collection and dissemination.

After research posters were posted in hospitals and shared on social media, interested participants called or emailed me or my supervisor and an interview date, time and place was arranged. In a few cases where efforts to meet with participants were unsuccessful, interviews were conducted by phone. Participants were selected purposively based on their former use of STC and their knowledge of the impacts of the closure on health and health services delivery.

3.5 Data Analysis Procedures

All data (from archives, interviews, FGDs, newspapers and Hansards) were organised using NVivo 12 software and subjected to coding and analysis. Two main forms of analyses (thematic and discourse) were conducted on the data. Both types of analyses produced complementary and multifaceted understandings of the closure and have helped create a better understanding of the underlying ideology that drove the closure of STC, and the health and health equity impacts of the closure.

3.5.1 Thematic Analysis

Thematic analysis exists on a higher level of abstraction than content analysis. It involves trying to make sense of the major themes and ideas in a given text. It is more contextualised than content analysis and its aim is less quantitative (e.g. word counts) (Vaismoradi et al., 2013). Transcripts of the interviews and FGDs as well as archival material were subjected to a thematic analysis. After listening to each recorded interview, a prepared codebook based on the theoretical

framework (Figure 2.1) was used to deductively code the impacts of the closure. This was followed by inductively coding for new impacts unaccounted for by the initial framework. Codes were categorised and read through multiple times for emerging themes (Saldaña, 2013). Guided by the research questions, themes on closure impacts were carefully reviewed, refined and named (Vaismoradi et al., 2013). Inductive approaches were used to understand how themes were connected and to compare closure impacts for different vulnerable groups to understand inequities in them. Chapters 6 and 7 rely on this type of analysis.

3.5.2 Discourse Analysis

Discourse refers to "any sound, word, image or object which functions as a sign and is organised with other signs into a system which is capable of carrying meaning" (Hall, 2009, p. 19). Discourse analysis (DA) offers an opportunity to understand how discourse creates reality and has been used by health researchers to understand topics ranging from how the social determinants of health literature are framed (Raphael, 2011) to how medical students undertaking global health electives in resource-constrained settings frame their experiences (Hanson & Cheng, 2018). Hansards, newspaper data and FGDs involving activists and Indigenous non-health stakeholders were subjected to discourse analysis, and Chapter 5 relies on this type. The six-step approach suggested by Willig (2013) was employed:

1. Discursive constructions (examining how the STC and its former users were constructed)
2. Identifying discourses (how different actors: MLAs [members of the Legislative Assembly], activists and the public constructed discourses on the bus closure)
3. Action orientation (reflecting on what was gained by each type of construction)

4. Subject positions (exploring what positions became available to subjects such as former bus users)
5. Practice (what became permissible to be done based on 1-4)
6. Subjectivity (examining what reality was created based on 1-5).

3.6 Strategies for Ensuring Trustworthiness of Findings

Qualitative research has been critiqued for lacking validity and reliability. Such criticisms have received responses and led to the development of approaches that show how qualitative research can be conducted in a high quality and trustworthy manner (Boffa et al., 2013; Cohen & Crabtree, 2008; Morse, 2012; Morse, 2006). Approaches such as triangulation (theory, investigator and data source) (Stake, 1995), member checking (Lindlof & Taylor, 2002) and crystallisation (Tracy, 2010) are major ways of ensuring the trustworthiness of qualitative research results. Crystallisation and member checking were used in this project to ensure trustworthiness.

3.6.1 Crystallisation

Crystallisation is a technique for ensuring the trustworthiness of qualitative research and is similar to triangulation where different data sources are analysed to see convergence (Stake, 1995). Unlike triangulation, however, crystallisation does not aim for convergence but allows for multiple perspectives (Tracy, 2010). In the conduct of this research, multiple data sources were used to gain a multifaceted understanding of the politics, health and health equity impacts of STC closure. There were several cases where interview data and information from newspaper sources were confirmed in focus groups and vice versa. Crystallisation allowed me to see multiple realities and meanings which did not necessarily always agree but which formed

different and unique ways of understanding STC closure impacts. The emergence of multiple discourses reflects the different ways in which different actors (government, former bus riders and activists) have understood the closure. There is also a variety of ways in which research participants represented closure impacts on them, from one participant out of the hundred interviewees who thought the closure was a good decision to the ninety-nine who shared varied stories of negative impacts.

3.6.2 Member Checking

A second way of increasing the trustworthiness of the findings of this study was through member checking; the process of discussing with participants what they said in a previous interview to ensure that one is correctly reporting what they said (Creswell, 2013). There are several ways of conducting member checking such as 1) returning interview transcripts to participants, 2) a member-check interview (where ideas from the first interview are revisited in a second for modifications), 3) a member check focus group and 4) a member check of synthesised analysed data (Birt et al., 2016). A synthesised member checking exercise was conducted with 15 research participants recruited from interviews and focus groups. Drawing on Birt et al. (2016), this involved presenting analysed emerging themes to participants followed by a one-hour discussion in which participants commented on and made suggestions on major findings. A public research ‘town hall’ was also organised to share the findings of the research with the wider Saskatchewan community. Seventy-five (75) participants attended the virtual town hall and an opportunity was given for comments on research findings and for people to describe if and how findings resonated with their experiences.

3.7 Role of the Researcher

The axiological (value-driven) aspects of research argue that researchers bring their values, experiences and world views into research and this impacts how the research is conducted and findings interpreted (Creswell, 2013). By stating these values frankly, the qualitative researcher offers readers the opportunity to understand why the research is framed the way it is and why researchers make some of the methodological choices they make (Tracy, 2010).

Throughout the research process one of the main questions participants asked was “why are *you* conducting the research?”. The emphasis on “you” was likely because I am an African person with an accent (that gives me away) who was asking questions about a deeply Saskatchewan topic. To make matters worse (or more comical) my companion who drove me around during data collection was a fellow international PhD student from Russia (with a thick accent, too). He drove me because I do not have a driver’s license; I have never learnt to drive or owned a vehicle. The irony that even the “big shot” researcher from the university needed a bus to conduct research on the absence of public transportation was not lost on participants who often joked about this. It also provided me - in a phenomenological sense- with an embodied lived experience that shaped how I thought about the STC closure and deepened my solidarity; I learned that I was more like my participants than I realised.

Indeed, apart from the fact that I could not drive, my PhD student status came with constraints that shaped my research experience. About two weeks after I started data collection it became clear that the number of people who wanted to be interviewed was far more than I had anticipated. Unfortunately, the research project was not part of a major grant and so my supervisor, Dr. Lori Hanson, and committee member, Dr. Sylvia Abonyi, met with me to discuss

the way forward. Dr. Abonyi generously offered some of her own grant funds and my supervisor collaborated with the department to make special financial provisions to cover research costs. These processes shaped my thinking on STC and demonstrated that although powerful actors such as the government had shut down the bus, ordinary people have the resilience and solidarity required to carry out a project that challenges the decision.

The decision to undertake this study began with an invitation by my supervisor Dr. Lori Hanson to a meeting of academics and community members organising against austerity in Saskatchewan. I spent the next few years participating in anti-austerity meetings and learning about contextual aspects of the decision to close STC. I grew up in a society with poor infrastructure (including the absence of publicly funded transportation) which negatively affected me. Such experiences have inspired in me a passion for social justice and health equity. My philosophical orientation toward cosmopolitanism allowed me to feel confident that the struggle of low-income people, women, Indigenous people, people with disabilities, etc. whether in North America or in Africa is my struggle.

This research was conducted in solidarity with former bus users and activists. Throughout my time in Saskatchewan, I have participated in activist work involving researchers and other community members fighting austerity and this research, however modest, is my main contribution to the struggle for social justice in the province. I hope through this research to help deepen our understanding of the pathways from austerity to health.

There are multiple ontological and epistemological paradigms that can inform the conduct of qualitative research. This research is situated in the critical tradition and aims above all to expose social injustice and reveal structural inequalities associated with the STC closure

(Creswell & Poth, 2018). Researchers who adopt a critical perspective assume that reality consists of and is "shaped by a congeries of social, political, cultural, economic, ethnic, and gender factors" that often crystalise into structures that oppress and marginalise segments of the population (Guba & Lincoln, 1994, p. 110). Combining these critical presuppositions with a political economy of health approach is essential for understanding health inequities since the combined approach helps identify power structures responsible for social and health inequities (McGibbon & Hallstrom, 2012; Schrecker, 2018).

My ontological and epistemological positions inform my choice of theoretical approach, methodology and methods. Aligning ontologies, epistemologies, theoretical perspectives, methodologies and methods shows methodological congruence which is an essential component in the conduct of high-quality qualitative research (Boffa et al., 2013; Cohen & Crabtree, 2008; Tracy, 2010).

3.8 Knowledge Translation

The research findings have been shared with health workers, the media and activists. Through a research town hall, opinion pieces in Saskatchewan newspapers, an advocacy brief (Appendix 7), a video and a podcast, the findings have been widely shared to maintain a spirit of integrated knowledge translation especially since some of the research occurred in real time as debates on the closure evolved. Appendix 11 includes newspaper publications covering the research.

3.9 Research Ethics

The study received ethics approval from the University of Saskatchewan Research Ethics Board (BEH 1219). The study also received operational approval from the Saskatchewan Health Authority (SHA) under file number OA-UofS-1219. Other forms of ethics have informed the

conduct of the research such as relational ethics where I journaled during data collection and was reciprocal with research participants, and situational ethics where I was always willing to be patient with research participants and to adapt to their disabilities, needs and challenges during the research process (Tracy, 2010).

3.10 Limitations and Strengths of the Research

There are a number of limitations of the research worth mentioning. First, although the STC served over 250 communities, research participants were recruited from less than 20 communities. This means that the views and analyses presented in the study represent only a fraction of the reality and lived experiences of former bus users. It would have been impossible to interview people from all communities formerly served by the STC and it is hoped that this study will serve as a springboard for future research to ask new and nuanced questions about the closure of STC in more communities.

Second, the Factiva searches that formed the basis of newspaper sources did not include all newspapers as the search site only captures some news outlets. That notwithstanding, the fact that the final sample of news articles obtained was over 750 (given hand searches to supplement Factiva sources) served to mitigate this limitation and provide a robust sample of papers to explore discourses surrounding the closure of STC. A similar limitation relates to the Parliamentary Hansards used for the analysis. Parliamentary Hansards were downloaded in December of 2019 and so any further discussions on the STC that may have occurred in the Legislative Assembly would not have been included in the final analysis that formed the basis for the first manuscript (Chapter 5). However, given that the searches were conducted two years

after the closure, it is highly unlikely that any major discussions of the STC (in ways that differ from the discourses) have occurred after December 2019 when searches were conducted.

Finally, although in a few cases a driver and some former STC employees were interviewed, former STC employees were not directly sought because the company no longer existed at the time of the research. Specifically interviewing former employees could have yielded useful insights into the politics of the closure from their perspective. This is because former employees would likely have known more about the company's operations and could help interrogate some of the closure discourses.

Despite the limitations, the research has several strengths that are worth mentioning. First, it represents the first and only large-scale attempt since the closure of the STC to systematically explore the impacts of the decision. Many of the findings revealed in this dissertation will therefore play a critical role in extending knowledge on the connections between austerity, transportation and health locally (as in the case of STC) and elsewhere.

Second, the majority of research on transportation as a social determinant of health is apolitical and does not apply a political economy of health approach. By explicitly connecting the politics of STC closure to its health impacts, this dissertation highlights a major gap in transportation -health research through its explicitly political approach.

A third major strength of this research has been the maintenance of a high level of rigour through reliance on sources (including parliamentary sources that are not commonly used in health research) and the use of multiple procedures such as member checking to ensure that findings resonate with the lived experiences of participants.

Finally, the knowledge translation carried out throughout this research (Appendix 11) has sought to move the findings beyond mere academic curiosity to possible social change, by making much-needed evidence available to activists, advocates and many others who need this evidence for policy action.

CHAPTER 4: DRIVING DOWN MEMORY LANE: THE STC IN HISTORICAL CONTEXT[6]

4.1 Introduction

The decision of the conservative Saskatchewan Party to shut down the Saskatchewan Transportation Company (STC) in 2017 was controversial for several reasons, and the discourses surrounding the closure are explored in detail in Chapter 5. This controversial nature hinges on many issues including the sheer number of years the bus had been in existence (Pacholik, 2017), which made the abruptness of the decision unconscionable to its opponents (Wooldridge, 2017). Beyond this, a historical question has arisen: while proponents of the closure forcefully advocated for the decision on financial grounds, some opponents questioned this reasoning and critiqued it for being ahistorical in the context of the original intent for creating the company (CBC Saskatoon, 2019).

This brief chapter draws on archival sources to explore the main reasons why the STC was created and the historical context within which it was created. It also reflects on how issues such as profits, losses and falling ridership, which featured prominently in closure debates, were addressed by the CCF government of Tommy Douglas in the early days of the company. This chapter provides a useful historical context, while drawing on new evidence as well, to gain a better appreciation of closure politics and the health and health equity dimensions of the closure.

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[6] STC Annual Reports referenced in this chapter were obtained from the Provincial Archives although many do not have call numbers. See Appendix 3 for archival sources used in this chapter.

The chapter reveals that in the early days of the STC, the purpose of the company was not to make profits (although some early records show a desire to avoid losses) and that ridership falls and financial non-viability which featured prominently in STC closure debates demonstrated an ahistorical understanding of the original purpose of the company. This is because such issues emerged in the formative stages of the company and were dealt with through the branding of the company as a modern alternative and an essential service to the community.

4.2 Saskatchewan – A Brief Political History

Like comparator Canadian provinces, contemporary Saskatchewan was incorporated into Canada after historical policies and events that decimated local Indigenous populations and consigned surviving locals to literal and metaphorical peripheries of Saskatchewan (Daschuk, 2013). The province became part of Canada to satisfy the exigencies of a particular form of prairie capitalism whereby Saskatchewan and other western provinces would be built around capitalist agriculture and based on a "capital intensive, export oriented economy" feeding industries in central Canada (Conway & Conway, 2015, p. 227).

After some oscillation between Liberal and Conservative rule, the 1944 electoral victory of the CCF under Tommy Douglas represented a paradigmatic shift in prairie politics and beyond and his election created the first social democratic government in all of North America (Warnock, 2005). The Douglas government emerged in the context of the immediate period after the 'Wheat Boom' of 1896-1913 where western Canada was increasingly considered "a producer of natural resource commodities for export into international markets through a marketing system dominated by large corporations…guaranteed by federal and provincial governments

dedicated to ‘creating conditions in which private enterprise might thrive’” (Conway & Conway, 2015, p. 227).

In such a context, then, provinces such as Saskatchewan enjoyed less infrastructural development and instead experienced a sense of alienation from the rest of the country. The period was also rife with economic exploitation and created discontent among the working classes. The sense of alienation engendered a spirit of cooperation especially among the working classes to demand social welfare policies (calling for inoculation, the establishment of scholarhips for farmer’s children etc.). As McGrane (2008, p. 182) has argued, it is not difficult to appreciate “the confluence of social democracy and feminism” in these movements as women also led protests and made demands for improved living conditions.

In this context of the influence of large corporations and other such actors, the CCF emerged from local political mobilisation among farmers, the organised working class, some small local businesses and other workers with common class interests. These mobilisations were aimed at resisting the emerging political and economic trend of western subservience and thus maintained a “radical, populist and even socialist” tinge coalescing into the CCF which would come to be the ultimate “party of the working class” in Saskatchewan (Conway & Conway, 2015, p. 228; Warnock, 2005, p. 82). Given this background, the CCF and later New Democratic Party (NDP) governments (under Woodrow Lloyd) ruling between 1944-1964 pursued an aggressive social democratic program based on “Keynesian style economic diversification through large scale infrastructural developments, rural electrification” and a host of social programs including the introduction of a universal Medicare system in 1961 (Smith, 2018, p. 75).

Crown corporations such as the Saskatchewan Transportation Company were formed in this context and, given this logic of large-scale development, under government ownership. These policies continued steadily even during the tenure of Allan Blakeney (1971-1982), the last of the CCF-NDP pioneers, only to be broken by the election of the Progressive Conservatives under Grant Devine who pursued austerity policies (Smith, 2018). This neoliberal turn was in keeping with neoliberalisation and the popularisation of market fundamentalism across other Canadian jurisdictions and in other countries such as the UK, USA, Germany and many others (Harvey, 2005; Peck, 2010). In Saskatchewan, the period was characterised by deregulation, tax breaks (and sometimes loans) for large and small businesses as well as attacks on labour unions (Pitsula & Rasmussen, 1990). In some cases, the geography of neoliberal policies favoured rural Saskatchewan leading to rural-urban polarisation, since the Progressive Conservatives had a strong rural base (Conway & Conway, 2015).

Several neoliberal political choices from the 1980s onwards including privatisations and austerity measures that negatively affected Crown corporations created a climate within which decisions such as the closure of STC became possible. Examples of such choices include the partial or full sale of Crown corporations such as Saskatchewan Mining Development Company, SaskMedia, Prince Albert Pulp Company, Saskatchewan Fur Marketing Corporation, significant portions of Saskatchewan Potash Corporation and Sask Oil (Smith, 2018). Most of the decisions to privatise and sell off Crown corporations which began with premier Grant Devine of the Progressive Conservative Party of Saskatchewan in the 1980s were completed by a dramatically reconstituted and right-leaning NDP under premiers Roy Romanow, and later, Lorne Calvert. Romanow, for example, finalised the processes for privatising the Saskatchewan Potash Corporation and sold off the province's shares in companies such as Crown Life Insurance

Company ($150 million) and Lloydminster Upgrader ($308 million) (Conway & Conway, 2015). Lorne Calvert, who succeeded Romanow, pursued similar neoliberal policies, succumbing to business interests, reducing royalty rates and lowering corporate taxes from 17% to 14% (Conway & Conway, 2015; Smith, 2018). In general, this premiership saw a gradual shift to third way politics (McGrane, 2006) which was being followed by other left-wing parties in continental Europe (Giddens, 1998).

The next political party to rule Saskatchewan and push the neoliberal agenda has been the Saskatchewan Party that was formed in 1997 after corruption and scandals derailed and virtually destroyed the former ruling Progressive Conservatives. In an attempt to build a big-tent anti-NDP coalition, disgruntled Liberals and Progressive Conservatives formed the ambiguously named Saskatchewan Party, which came into power in 2007 after defeating the NDP (Rayner & Beaudry-Mellor, 2009). The party came to power first under the Premiership of Brad Wall, a protégé of Grant Devine (Conway & Conway, 2015) who was later succeeded by Premier Scott Moe.

Although the Saskatchewan Party came to power at the time of the global financial crisis which saw rises in unemployment globally and in Canada (Ruckert & Labonté, 2012), Saskatchewan enjoyed growth and opportunities for job creation at the time because of its dependence on oil and gas extraction. The Saskatchewan Party also benefited from the global demand for food and fertilizer, both of which were in abundance in the province (Smith, 2018). Riding on the economic boom in the province at the time, the Saskatchewan Party pursued free market capitalist policies of low taxes to businesses and, generally, low spending in various sectors (Enoch, 2016). Under the rubric of "transformative change" and creating a "'new'

Saskatchewan" although deeply informed by political ideology (Enoch, 2016, p. 1; Smith, 2018, p. 81), the Saskatchewan Party government pursued policies that have pushed the province further down the neoliberal path.

One of the overarching principles followed by the party was its aim to reduce the government's "footprint" and to increase efficiency by cutting public services by up to 15% (Ministry of Finance, 2010). As part of the 2010 budget, for example, through its 'SaskFirst policy', an inward-looking policy of targeting Saskatchewan businesses only, the government advocated that key Crown corporations such as SaskTel, SaskEnergy and SaskPower "sell non-core out-of-province assets to support required capital investment" (Ministry of Finance, 2010, p. 25). The government also turned to public-private partnerships (P3s) and privatisation of Crown corporations and assets in keeping with the party's general neoliberal ethos (Canadian Centre for Policy Alternatives, 2017). Such decisions reduced the ability of these Crown corporations to grow and endangered the province's fiscal capacity (Smith, 2018). Additionally, in the health sector, the government pursued a policy called 'LEAN' which draws on manufacturing processes of the private sector (Toyota) and requires as key elements 1) continuous quality improvement, 2) setting strategic priorities, 3) elimination of waste and 4) employee engagement in quality control (McIntosh, 2016). This policy which fits perfectly with neoliberal ideas of New Public Management[7] (Smith, 2018) undermined the ability of health workers to deliver quality health

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[7] New Public Management refers to a set of ideas about public administration that became popularised in the 1980s. Its key doctrines are 1) expectations of entrepreneurial management from public administrators, 2) explicit standards and measures of performance, 3) greater emphasis on output controls, 4) shifts to disaggregation of units in the public sector, 5) shifts to competition in the public sector, 6) stress on private sector style of management practice, 7) stress on greater discipline and parsimony in resource use (Hood, 1991).

services (Saskatchewan Union of Nurses, 2014) and possibly created new costs as has been the case elsewhere (Scott-Samuel et al., 2014). Other austerity measures and neoliberal policies carried out by the government including forms of incremental privatisation[8] (e.g., sale of shares of Saskatchewan Fertilizer Corporation worth $75-million), assaults on labour and public-private partnerships (P3) are recorded elsewhere (Smith, 2018, pp. 85-92).

The STC was closed as part of the March 2017 budget that introduced cuts and should therefore be understood and interpreted in the context of the political developments described above. The rationale for the closure and its politics are explored in detail in the next chapter; simply stated, however, the entire budget was aimed at closing a $685-million budget deficit with the STC closure saving $85 million. The figure below summarises the broader political and historical context in which the closure occurred. In the sections that follow, I examine the history of the STC itself in order to understand the reasons for its formation, and why the Saskatchewan Party's reasons for closing the STC, namely that it was not making a profit and was experiencing ridership decline, had actually been recognised by the CCF but never seen as a justification for shutting down the company.

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[8] A full list of partial and full privatisations that occurred in the last decade (2007-17); can be found from Canadian Centre for Policy Alternatives (2017).

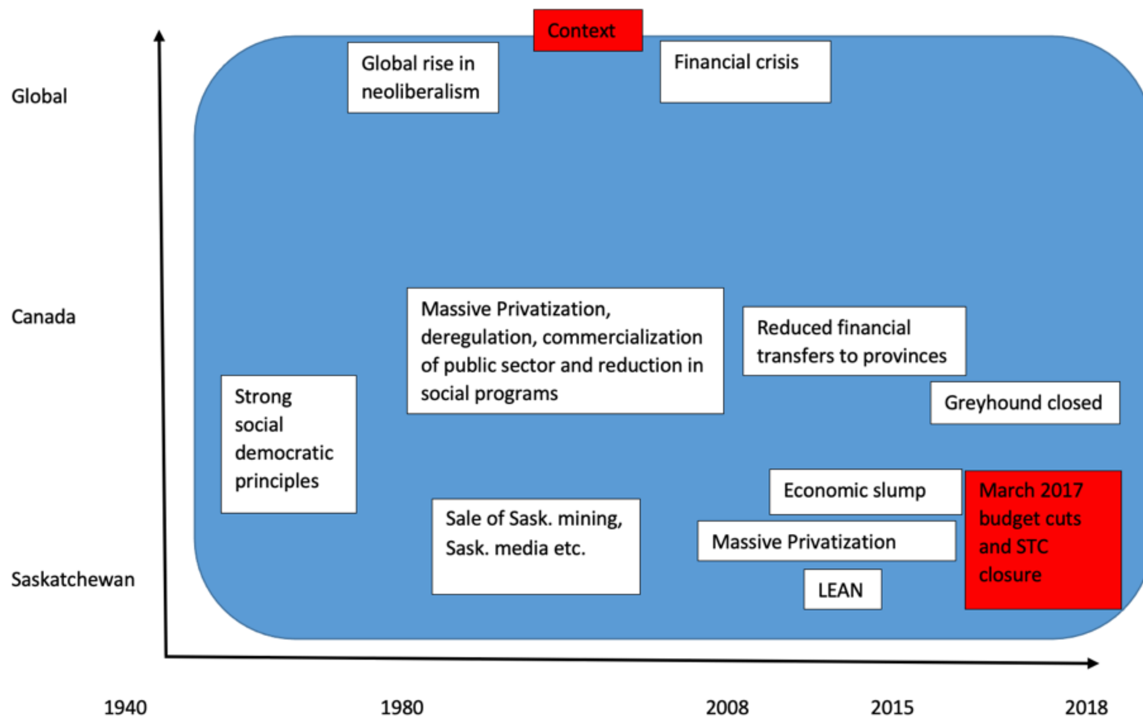

Figure 4.1: The Closure of STC in Context. Source: Author

4.3 Brief History of Saskatchewan Transportation Company

The first STC buses to run in the province began operations on 1 April 1946, a date which has led some contemporary commentators to remark that it was "a prophetically inaugural, bumpy ride" (Pacholik, 2017). The STC was not the first bus company created in the province; private companies "including greyhound," and "11 private bus companies" were operating in the province (The Leader-Post, 1945, p. 12). Most of these companies operated on a small scale in different parts of Saskatchewan, as the Greyhound Company was the main transportation player in the industry. The Greyhound Bus Company had 26 buses and eight lines, traversing Alberta, Saskatchewan and Manitoba. This explains, at least in part, why initial offers by Saskatchewan premier, Tommy Douglas, on "possibilities of taking over and operating the Greyhound bus lines

in Saskatchewan... came to a standstill as the company refused to consider government offers" (The Leader-Post, 1945, p.12).

In the context of Greyhound's rejection of the government's offer, an Order in Council (O.C 168/46) was signed on 29 January 1946 for the creation of the Saskatchewan Transportation Company. Three main aims are listed in the Company's first annual report:

1. To give the travelling public the best possible service
2. To operate wherever and whenever it is possible to do so without actual loss
3. To extend services where they are needed but not to parallel existing services resulting only in wasteful duplication (Saskatchewan Transportation Company, 1947, pp. 2-3)

The operation of the Company began with seven buses and this number rose steadily to fifty-one by the end of its first year of operation. The first bus depots were established in Saskatoon and Regina (Saskatchewan's most populous centres), with the Saskatoon depot doubling as a location for some government departments. The bus quickly became an integral part of life in Saskatchewan. It provided transportation for government services in the province's vast north region; communication services and the transportation of newspapers and people from social clubs throughout the province (Saskatchewan Transportation Company, 1947). The idea that the bus had become an integral part of prairie life is referenced in many company annual reports and other sources. In 1951, the company reported that: "The province-wide bus system operated by the company has now become an established factor in the social and economic life of Saskatchewan" (Saskatchewan Transportation Company, 1951, p. 1). This sentiment survived into the 1980s where on the occasion of the STC's 40th anniversary the following description was made:

> Prairie life for Saskatchewan early pioneers was a secluded existence. Farmsteads were scattered and long distances separated them from the few small settlements where essential goods and services could be obtained…The story of the Saskatchewan Transportation Company is a proud history of service to the people of Saskatchewan. On the threshold of the Corporation's 40th Anniversary, STC is proud to remember its roots – formed out of prairie necessity and part of Saskatchewan's heritage. (Saskatchewan Transportation Company, 1986)

Descriptions of the STC as an important part of prairie life recur through most annual reports well into the early 2000s: "In our province, there are thousands of reasons for needing the service. The one constant is that STC will be there to provide you with safe, reliable, affordable, courteous service" (Saskatchewan Transportation Company, 2000, p. 3).

Given the fact that some private transportation services existed prior to the establishment of the STC, a fundamental question that arises is: what was different about the company to warrant a public option? Is there any sense in which it was possibly a duplication or were there important justifying factors at least in the minds of the CCF pioneers that explained the necessity for its creation?

4.4 What was Different about the STC?

Although not exhaustive, the points described below are recurrent themes in the archival record. These themes contrast the STC with the private alternatives that existed at the time of the company's creation.

One of the most prominent reasons for the creation of the STC was the idea that it would be a company established for the "public good", a concept that clearly differentiated the

STC from its private competitors. The phrases "public good" or "on behalf of the province" appear six times throughout the Order in Council, a two-page document (Government of Saskatchewan, 1946). In 1954 when a consultant from San Francisco, Colonel Marmion D. Mills, an internationally-renowned transportation expert, evaluated the operations of the STC, he agreed that such a company could only be operated for the public good and stated: "quite firmly" that the STC was "doing much better for our public than a privately-owned bus line could or would do, under the circumstances" and that "private operation cannot be expected to be of much help in the development of so thinly settled an area as Saskatchewan" (Government of Saskatchewan, 1954).

This description differentiating the STC from private companies in existence at the time is in consonance with the assertion of Honourable John T. Douglas, the first minister for STC and then Minister of Highways and Transportation, who stated in 1946 immediately prior to the creation of the STC that:

> The [STC] project will be a socially owned enterprise and will be managed in the same way as the government's industries. It will provide employment for Saskatchewan citizens and give the province an efficient bus system operated not for financial profit but for the good of the whole people (The Leader-Post, 1945, p. 12).

In addition to the idea of the STC as an important public good for the people of the province, the company was always described as a 'modern' enterprise compared to existing companies. In a 1945 *Leader-Post* article, the STC buses were described as "[t]hirty modern type buses [that] have been ordered and all deliveries will be made before April 1" (The Leader-Post, 1945, p. 1). While "the Greyhound bus line [had] been unable to obtain new equipment since

1941 because of wartime restrictions" the government was able to obtain "new buses for its government"; smaller options that could hold 28 passengers and bigger buses that could accommodate 41 passengers (The Leader-Post, 1945, p. 12). These 41-seater buses were "larger than the buses operated by the Greyhound bus lines on the Winnipeg to Calgary route" (The Leader-Post, 1945, p.12). The description of the buses as "modern" appears across STC reports throughout the postwar period. For instance, the 1960 annual report stated that; "the Saskatchewan Transportation Company was established in 1946 to provide a modern bus transportation system for the people of the province" (Saskatchewan Transportation Company, 1960, p. 1). Other aspects of the company such as its depots were described in similar terms. A good example is seen in the 1950 report that stated:

> [D]uring the year, the new depot at Moose Jaw was completed and officially opened on December 20, 1950. Its central location and modern depot and lunchroom facilities have enabled a higher order of service to be rendered to the travelling public. (Saskatchewan Transportation Company, 1951, p. 4)

Furthermore, the bus was consistently and intentionally interwoven into Saskatchewan's social and political life. References are made to the company's contribution either financially or in kind, to aspects of social life. Apart from transportation service to the public, annual reports mention other avenues through which the bus was making an important contribution. For example, the role of the bus company which "was again able to come to the assistance of the citizens of the city of Regina in providing emergency transportation facilities after the city's disastrous car barn fire on January 23, 1949, until March 16, 1949" (Saskatchewan Transportation Company, 1949, p. 4). The company is also said to have "continued to operate its

freight service between Prince Albert and Lac La Ronge and thus provide[d] needed transportation link for this fast-developing region of the province" (Saskatchewan Transportation Company, 1950, p. 3).

Finally, the bus was seen as an integral part of government operations. One of the earlier reports stated that the company had taken on the responsibility to operate between Waskesiu and Lac La Ronge, mainly to carry freight for the Saskatchewan Fish Board, the Department of Natural Resources and Saskatchewan Government Airways (Saskatchewan Transportation Company, 1947, p. 7). Moreover, the specific financial contribution of the company was frequently highlighted. For example, the 1959 report stated:

> In addition to the surplus paid to the provincial treasurer, the company paid $28,031 in fuel tax to the provincial government, $5,006 in Educational and Hospitalisation taxes and $19,255 in license fee for buses, cars and trucks. $34,299 was paid as grants to municipalities in lieu of taxes. (Saskatchewan Transportation Company, 1959, p. 6)

These references demonstrate the important role the company played in contributing to government operations and to aspects of the social, economic and political life of people in Saskatchewan. In the section that follows, I examine one of the most contentious and controversial aspects of the decision to close the company which relates to questions of ridership and the place of profits/losses in the operations of the bus company.

4.5 Ridership and the Place of Profits and Losses in the Operations of STC

One of the main reasons offered by the Saskatchewan Party in 2017 for shutting down the STC was to save a total of $85 million over a five-year period, a logic which some opponents have argued is a deviation from the STC's initial mandate (James, 2017). An initial reading of the

historical literature on the operation of the company presents a somewhat ambivalent picture of the place of profits and losses in the operations of the company. For example, whereas J.T. Douglas's statement in the *The Leader-Post* publication of 1945 categorically stated that the STC was meant to provide "the province an efficient bus system operated *not for financial profit* but for the good of the whole people" (emphasis mine, The Leader-Post, 1945, p. 12). The "second basic principle" for the establishment of the company as stated in the 1947 annual report was "[t]o operate wherever and whenever it is possible to do so without actual loss" (Saskatchewan Transportation Company, 1947, pp. 2-3). This apparent contradiction might be resolved in two ways: first by reflecting on what is meant by "actual loss" or indeed interrogating the need to qualify "losses" with "actual" and, second, to carefully review how losses were portrayed and dealt with by the company.

Evidence from STC's first annual report indicates that the company ran at a loss that recurred in the second year where it had "heavy financial losses" (Saskatchewan Transportation Company, 1948, p. 3). The company's report signed by J.T. Douglas did not appear to bemoan these losses but expressed pride in them. The first annual report stated:

> Following the principle of providing services wherever possible and despite conditions which might deter other organisations whose sole motive is the earning of profits, the Saskatchewan Transportation Company is very proud of its record during the severe winter of 1946-47 when buses were kept running at a considerable loss until weather conditions made further operation impossible. (Saskatchewan Transportation Company, 1947, pp. 4-5)

The fact that the company had financial losses appeared again in the following year's report and, again, the company pointed to the unpredictability of prairie weather conditions which made operations impossible. The report stated that "the majority of the runs could not be operated regularly for the five months preceding May 15 [and] heavy financial losses were incurred during these months", and that the company continued to operate in these months "without resorting to any request for increase in fares" (Saskatchewan Transportation Company, 1948, p. 3). The representation of certain financial losses as something to take pride in appears in subsequent reports and is explained in 1950. In this report, it was made clear that profit was not a priority of the company. The report explained:

> The year has seen some decrease in passenger traffic and this, coupled with increasing costs of operation with no corresponding increase in fares, has narrowed the net operating profit. It is the view of the company that a publicly owned transportation system should, wherever possible, avoid increasing the rates charged to the travelling public and consequently, in spite of rising costs, no increase in fares has been put in effect since April 1949. (Saskatchewan Transportation Company, 1950, p. 3)

The "ridership falls" issue which was used by the Saskatchewan Party government to justify STC closure is not a new phenomenon. The problem of a decrease in ridership existed as early as the 1950s. A major social change of the period appears to have been that more people in Saskatchewan and North America were starting to own private vehicles which affected bus businesses. The 1954 report stated:

> For several years past, major problems have faced us. These problems have arisen out of changing conditions. The growing number of people using their own cars rather than buses

> or trains has hit bus operators all over the continent. The most recent interstate commerce commission figures for the United States show that in most companies, passenger traffic and revenue have dropped a great deal. This hit us also, although less than most companies. (Saskatchewan Transportation Company, 1954, p. 1)

This shows that most of the reasons offered for closing the company were not necessarily new or unique but had been experienced even in the earliest days of the company. Indeed STC annual reports from the last two decades regularly presented evidence on the 'public policy' role of the company, suggesting that was one of the main reasons for maintaining the company over the years (Saskatchewan Transportation Company, 2000). In the company's annual reports from 2000-2017 a 'balance scorecard' was regularly used to report on measures such as customer satisfaction, environmental considerations and safety. It is these factors that were often used to judge the company although it consistently aimed to minimise the capital and operating grants it received from the government. The contradictions surrounding the reasons for the establishement of the STC, the metrics it was often judged by and the rationale offered for its closing necessitate not only the explicit stating of historical facts on why the company was established but a deeper exposition (as will be done in the next chapter) to explore the political rationale for closing the STC.

4.6 Conclusion: A Reflection on the Historical Record

The evidence parsed from the archival records reveals that the primary purpose for the creation of the STC was to serve the sparsely distributed population of Saskatchewan and do so as effectively as possible. Wherever possible, the company was to be used as a means to make life easier for the people and the government. The bus was supposed to represent a modern

alternative to existing private companies. The company had a certain drive for modernity and was always quick to adapt to emerging trends either by changes to equipment and facilities or operations as a means of remaining relevant and integral to life in the prairies. The drive for modernity and interest in solving social problems suggests that if the architects of the company had lived during the 2017 budget deficit, they might have seen the problem of rising subsidies as an opportunity to reimagine the company and to adapt it to the practical realities of modern life. Perhaps, for example, current interest in reducing carbon emissions and promoting environmental protection would have been capitalised on by these actors to present and advertise the bus as a 'modern' and progressive alternative.

Finally, most of the reasons offered for closing STC such as falls in ridership, financial unviability and the idea that the private sector would step in to serve people in Saskatchewan represent an ahistorical account of events as most of these challenges had been previously encountered by the company and its creators often resorted to new solutions rather than simply ending the company and its operations. In this sense, the closure of STC was not based on sound public policy but driven by ideology, as will be seen in the next chapter. An important conclusion that might be drawn based on the archival evidence is that the STC had always faced challenges due to weather or changes in the social context. Throughout its history, such changes were seen as an opportunity to modernise and be responsive. Failure to make a profit, or the cost of operating the STC was never seen as a reason to end operations.

CHAPTER 5: POLITICS, TRANSPORTATION AND THE PEOPLE'S HEALTH: A SOCIO-POLITICAL AUTOPSY OF THE DEMISE OF A 70-YEAR-OLD BUS COMPANY (MANUSCRIPT I)[9]

5.1 Background

In May 2017, the Saskatchewan Transportation Company (STC), a Crown corporation established in 1946, was abruptly closed by the Saskatchewan government as part of an austerity budget designed to reduce the deficit. The company was a vital mobility link for the province's sparsely distributed population. At the time of closure, the company had a fleet of 41 buses and covered 25 routes, connecting about 253 communities and travelling about 2.8 million miles per year (Saskatchewan Transportation Company, 2017). The decision to close the bus was announced as part of the province's March 2017 budget that saw the implementation of several austerity measures including cuts to libraries and post-secondary institutions (although a few of these were later reversed following public outcry).

The primary reasons given by the government for the closure of the company were 1) to reduce the province's budget deficit, 2) because intercity bus services were in decline throughout Canada, 3) provincial bus ridership had declined by 77% over 35 years, 4) closing STC would open up competition for the private sector and 5) all efforts to reduce the provincial subsidy for the company had been exhausted (Johnson, 2017). The March 2017 budget in general and the closure of the bus in particular garnered significant local resistance involving protests by activist groups. The heavily contested nature of the decision to close the company and the general

[9] A full list of Hansards and newspapers cited in this chapter is presented in Appendix 12.

austerity regime under which it was closed have critical implications for the larger politics of health, as many former riders used the bus to attend medical appointments in bigger centres and the health system relied on the bus to transport "urgent medical supplies (blood) [and] medical instruments…" (Saskatchewan Transportation Company, 2010, p. 3). The closure provides a useful opportunity to advance knowledge of the political economy of transportation and health.

Our aim in this paper is to describe the discourses and counter-discourses that were used to justify or denounce the STC closure. The analysis of discourses suggests answers to the questions of how the closure was justified (or not) by the government and activists, though it does not explain why the closure happened when it did. We offer some preliminary theories on why the government shut down the STC. We begin the analysis by presenting the discourses that were used by the government to justify the STC closure followed by counter-discourses presented by the media, activists and members of the public to defend the STC. We argue that the closure represented the most basic form of neoliberal capitalism's tendency to socialise risks and privatise profits to the detriment of human wellbeing (Peck, 2014). Given capitalism's tendency towards crises (Albo, 2010), a period of boom in 2007 yielded a significant surplus to the Saskatchewan government which did not benefit ordinary people such as former bus riders yet during the period of crisis, the poor paid the price. Combining evidence on the discourses used to justify and/or deny STC closure with the material realities on why it was closed is an essential first step to understanding the political rationale for the STC closure.

5.2 The Political Economy of Health

The idea that politics significantly determine health inequities is not new; clinical pathology pioneer, Rudolf Virchow, declared a century ago that "[m]edicine is a social science and politics

is nothing but medicine on a large scale" (Navarro, 2009, p. 441). Despite this long tradition, most contemporary accounts of health inequities remain apolitical (Bambra et al., 2005). Indeed, debates on the relationship between politics and health inequities often revolve around the organisation of health systems while ignoring other ways politics affect health (Bambra et al., 2005).

Political economy studies "totalities understood from a materialist perspective" (Clement, 1997, p. 5). This involves connecting economic, political and cultural/ideological aspects of life to explain how societies reproduce themselves and the contradictions inherent in this process (Clement, 1997). The application of political economy to the study of health inequities – 'the political economy of health' is a theoretical approach at significant variance with other ways of explaining health inequities that rely on biomedical, behavioral and sometimes individual (genetic) differences as fundamental explanations (Birn et al., 2017; Schrecker, 2018). Political economy of health research has yielded remarkable insights into how political and economic systems such as capitalism affect health, and how they have depleted health through unhealthy working conditions historically and presently (Bambra, 2016; Doyal & Pennell, 1979) or the collapse of the Soviet Union and its connection to reduced life expectancy through increased alcohol consumption and other risk factors (McKee, 2000).

A recent offshoot of political economy of health research has been a wide range of studies interrogating the relationship between austerity and health. Austerity – "drastic but selective public expenditure cuts" (Schrecker & Bambra, 2015, p. 69) – is becoming a popular political choice globally, driven by a neoliberal orthodoxy. Studies on the health effects of austerity (which do not necessarily explore the discourses that justify austerity decisions) have

been critical in illuminating austerity's negative impacts in varied domains such as food insecurity, housing, public health budgets (particularly following the 2007 global financial crisis) and the disequalising effects of World Bank-led structural adjustment policies on health and health systems in countries of the global south (Alhassan & Castelli, 2020; Garthwaite, 2016; Kentikelenis et al., 2011; Ruckert & Labonté, 2014).

While these studies illuminate the relationship between politics and health under conditions of austerity, there remain critical gaps in current understandings of the role of discourse in justifying austerity decisions. How does austerity become socially acceptable? What types of local resistance are available to challenge austerity and within what discourses? How do such dynamics relate to transportation and health?

5.3 The Transportation-Health Nexus

Public transportation is a social and structural determinant of health. One of the earliest connections between transportation and health was made by Godlee (1992) who highlighted that transportation affects health through motor vehicle injuries. Since then, a wide range of literature has been published, anchored around transportation as a social determinant of health (McCarthy, 2006). Previous research shows that transportation affects health through physical (in)activity (Morency et al., 2011), annoyance and noise pollution (Stansfield et al., 2005), and, on a wider scale, climate change (Chapman, 2007). This body of literature has endeavoured to differentiate between public and private vehicle usage, consistently showing that public transportation options are associated with lower risks of motor vehicle injuries (Beck et al, 2007) and from an environmental perspective, contribute less to climate change (Woodcock et al., 2009).

Unfortunately, transportation-health research has focused on downstream connections without necessarily engaging with the political economy of transportation policy decisions. That notwithstanding, some literature has connected transportation and other structural issues such as poverty and social isolation (Lucas, 2004; Titheridge et al., 2014). While these are not necessarily from the political economy of health literature they provide, if in a limited fashion, ways of conceptualising how structural factors such as poverty – which are often a function of politics – might affect health via transportation policy choices. A sparse body of political economy literature has also specifically focused on transportation policy choices and argued that in the capitalist economy, dismantling public transportation increases car dependency, creating enormous wealth for oil companies since "the transport sector depends on oil for 96% of its energy" (Dellheim, 2018, p. 21).

5.4 Saskatchewan and the Closure of STC

Saskatchewan has an export-based economy with oil, mining and public services representing significant proportions of GDP, which makes the economy vulnerable to changes in global commodity prices. In 2017, the economy grew at -1% (Government of Saskatchewan, 2017). Saskatchewan has a unique history involving a gradual but steady swing from being the cradle of North American social democracy to a consistent rise in conservatism and was one of the first Canadian provinces to adopt aggressive neoliberal policies in the 1980s (Pitsula & Rasmussen, 1990; Warnock, 2005). This has laid a solid political foundation for contemporary austerity.

The coming to power of the Corporative Commonwealth Federation (CCF) in Saskatchewan in 1944 ushered in a wave of social and health-related welfare state programs (one of these being the STC) mostly in favor of the laboring classes (Conway & Conway, 2015).

These welfare state policies were however largely reversed by the coming to power of the Conservatives under Premier Grant Devine in the 1980s where neoliberal policies were actively pursued (Smith, 2018). The period was characterised by deregulation, tax breaks for large and small businesses and attacks on labor unions leading sometimes to a rural-urban polarisation. Since then, the Conservatives have maintained a strong base in rural Saskatchewan, especially from the 1990s (Conway & Conway, 2015). The Saskatchewan Party, firmly cemented on the conservative side of the political spectrum, was elected around the time of the global financial crisis and oversaw the STC closure. While this was a period characterised by rising unemployment globally and in Canada (Ruckert & Labonté, 2012), Saskatchewan enjoyed growth and opportunities for job creation, given global demand for food and oil and gas (Smith, 2018). Figure 5.1 shows the deficit history of the province.

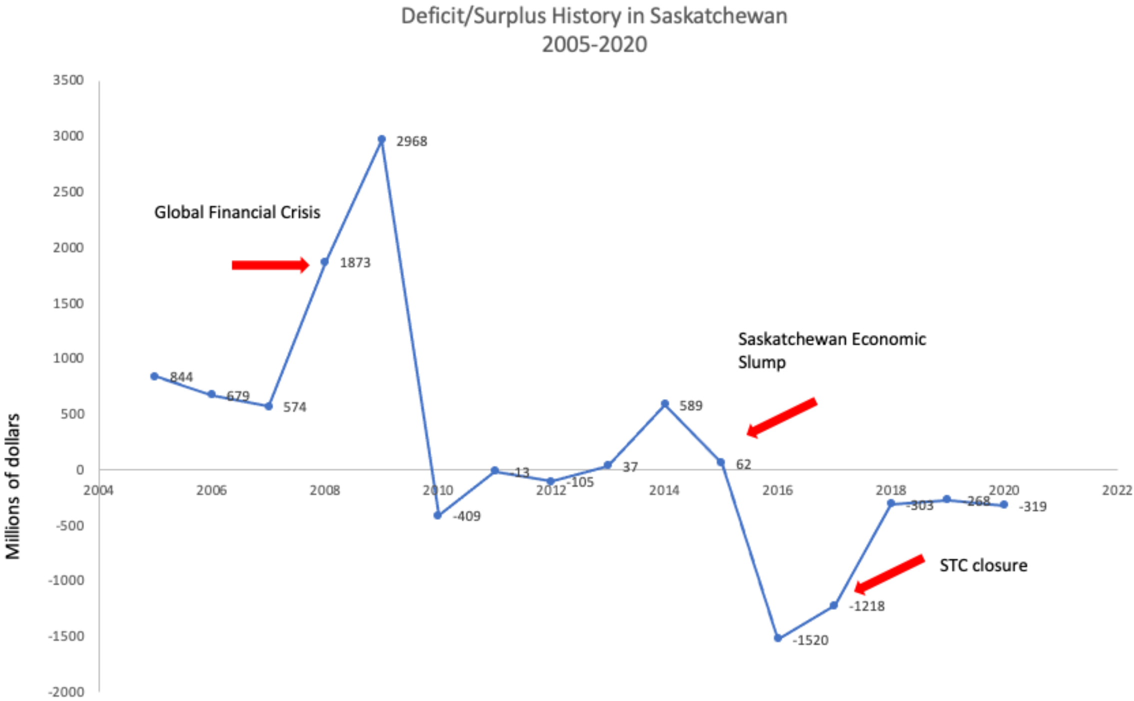

Figure 5.1 Saskatchewan Economic Deficit/Surplus History 2005-2020. Source: (Authors, based on Government of Saskatchewan, 2021)

Riding the commodities boom, the Saskatchewan Party pursued free market policies of low taxes to businesses and generally low spending in the public sector (see Figure 5.2) under the rubric of "transformative change" and creating a "new" Saskatchewan (Enoch, 2016, p. 1; Smith, 2018, p. 81). There was also a strong desire to reduce the government's "footprint" and to increase efficiency by reducing the public service by up to 15% while selling "non-core out of province assets" (Ministry of Finance, 2010, p. 25).

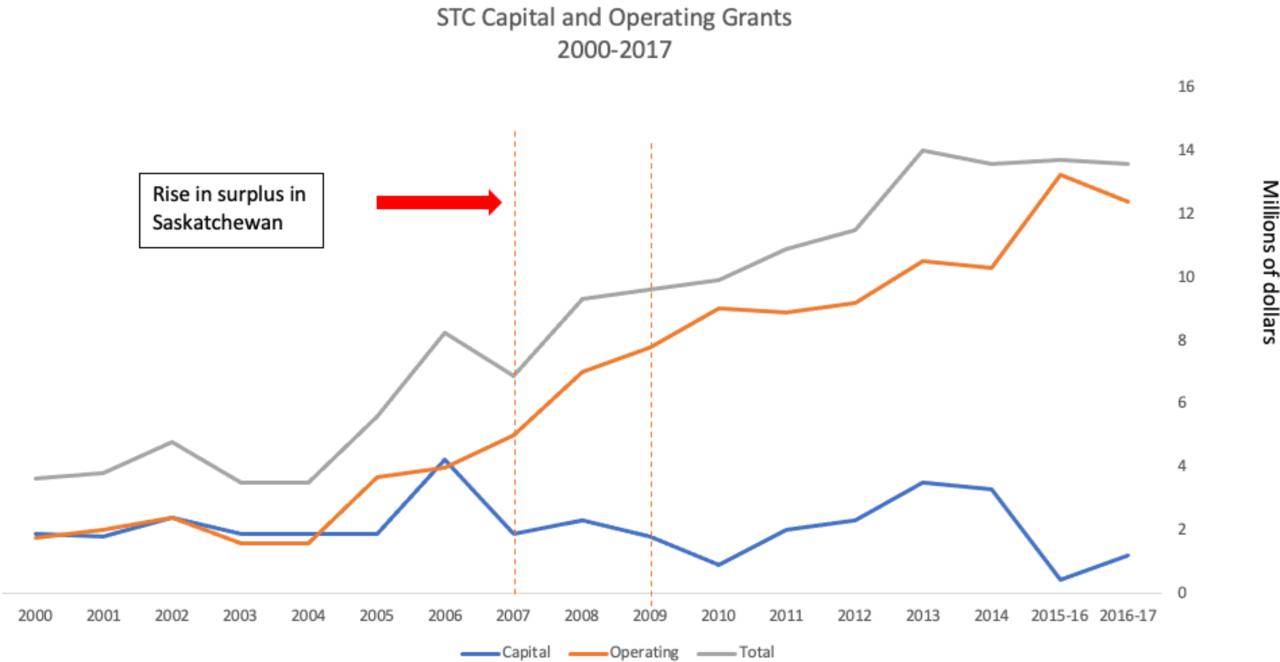

Figure 5.2 STC Annual Subsidies, 2000-2017. Source: Authors, based on STC Annual Reports

The evidence from the the government's public accounts and STC annual reports highlight two things. First, although STC was shut down to reduce the government's deficit in 2017, the government had run into the deficit from 2010 and only enjoyed a surplus in 2014 and 2015. Second, during the period of economic prosperity public services such as the STC did not receive extra funding and even experienced some cuts (see Figure 5.2). It is against this wider

contextual background, albeit with some suddenness, that the 70-year-old STC was shut down in the March 2017 budget. Although this manuscript contributes to current understandings of the connections between austerity, public transportation and health, it primarily focuses on the politics of the STC closure as a health equity issue, especially for vulnerable populations in Saskatchewan.

5.5 Methodology

This manuscript forms part of a large-scale qualitative study on the politics, health and health equity impacts of the closure of STC conducted between 2017 and 2020. The study received research ethics approval from the University of Saskatchewan Research Ethics Board (BEH 1219). The findings reported here are based on a discourse analysis of Parliamentary Hansards, newspaper articles and a subset of the focus group discussions (containing data related to the political underpinnings of the closure and activists' understandings of it). Other focus group data were not included in this analysis as they focused specifically on impacts of STC closure rather than closure politics.

The 'Saskatchewan Transportation Company' subject area of the Saskatchewan Legislative Assembly Hansard was downloaded. Grey literature search site Factiva was searched with the keywords 'Saskatchewan Transportation Company' from December 2014 to December 2019, yielding 712 newspaper articles and supplemented by hand searches of other news sites, totalling 751 articles. Title screening showed 230 repeated titles and full-text screening revealed another 212 republished articles (under different titles). Finally, two focus group discussions (FGD) were conducted with activists (seven members) and Indigenous stakeholders (two members) on the politics of the closure of STC and transcribed verbatim. These FGDs explored

activists' and Indigenous stakeholders' understandings of the political rationale for STC closure. In the presentation of findings, quotes from FGD data are presented as 'FGD Activists' and 'FGD Indigenous'. Data from the three sources were imported into NVivo 12 software for analysis. Table 5.1 and Figure 5.3 summarise data sources used and newspaper sources from which articles were extracted and analysed. As shown in Figure 5.3 *Postmedia Breaking News*, *Regina Leader-Post*, *Saskatoon Star Phoenix* and *The Canadian Press* were the four main sources of newspaper articles.

Table 5.1: Sources of Data included in Analysis

Data Source	Details
Parliamentary Hansard	The data is drawn from 47 days of Parliamentary Hansards between 1 December 2016 and 27 June 2018. It contains debates between the New Democratic Party (NDP) and Saskatchewan Party Members of the Legislative Assembly (MLAs). The Hansard also contains information such as petitions by members of the public like Nigel Fernandez (29 March 2017) and Gary Tinker (17 May 2017) attempting to influence the decision to close or not close the STC.
Newspaper Sources	A total of 751 newspaper articles were reviewed, including newspaper articles from 3 November 2013 to 30 October 2019. This data contains media reportage on the closure, including public opinions and perceptions of the closure.
Focus Group Discussions	Data from two focus group discussions with activists (religious leaders, women's and disability organisations) and Indigenous stakeholders conducted between January and March 2020. The first focus group involved seven people and the second had two participants. This data source includes the opinions and interpretations of these stakeholders on the politics of STC closure.

Source: Authors

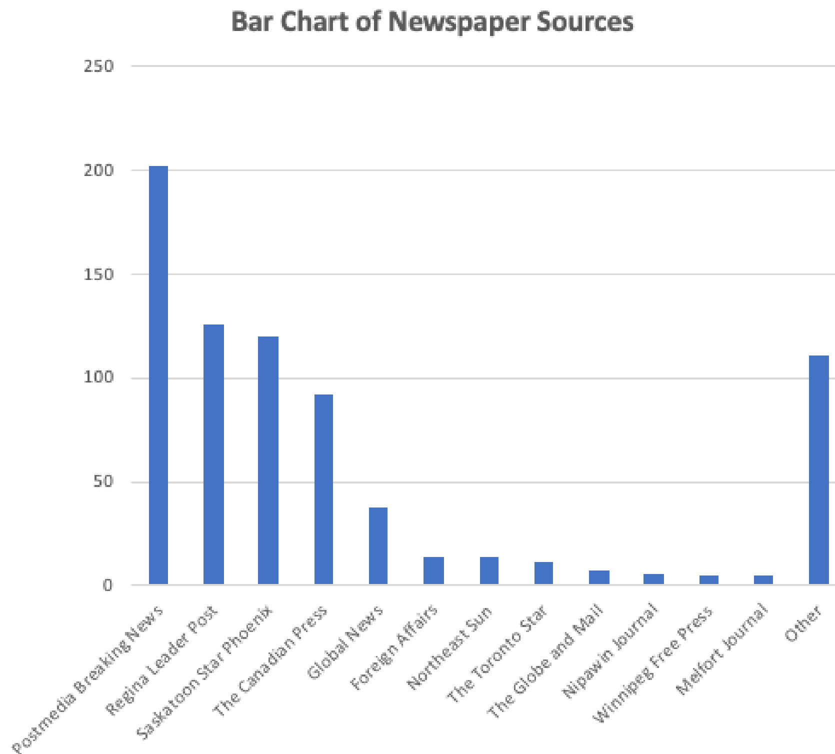

Figure 5.3: Bar Chart of Newspaper Sources. Source: Authors

5.5.1 Data Analysis

Data from the three sources were subjected to a discourse analysis (DA). DA does not treat language as a neutral means of transmitting information but pays attention to its role in the "constitution of social life" (Willig, 2013, p. 380). Language can be a tool for privileging one version of events to "order reality in a certain way…enable and constrain the production of knowledge... to allow for certain ways of thinking about reality while excluding others" (Cheek, 2004, p. 1142). These constructions of reality can help maintain existing power relationships through specific portrayals of subjects and objects of discourse (Hanson & Cheng, 2018). To operationalise our analysis, we employed the six-step process suggested by Willig (2013) for analysing discourse. This involves:

1. Discursive constructions (examining how the STC and its former users were constructed)

2. Identifying discourses (how different actors: MLAs [Members of the Legislative Assembly], activists and the public constructed discourses on the bus closure)
3. Action orientation (reflecting on what is gained by each type of construction)
4. Subject positions (exploring what positions became available to subjects such as former bus users)
5. Practice (what became permissible to be done based on 1-4)
6. Subjectivity (examining what reality was created based on 1-5).

Guided by these theoretical and operational frames, the data were coded to understand the (il)logic that underpinned arguments for keeping or closing STC. Data from each source was analysed individually and all three were subjected to an integrative analysis to understand the politics of the closure.

Findings are presented according to discourses and counter-discourses instead of using Willig's (2013) six steps, to allow room for engaging with the discourses and counter-discourses since these reveal how the state, activists, the media and members of the public defend or deny the need for public services such as the STC. Under the disourse - counter-discourse rubric however, the insights from Willig's (2013) six-step process are highlighted such as how STC and its former users were constructed, what was gained by each construction, what became possible through such constructions, and the types of realities and subjectivities created by such constructions.

5.5.2 Methodological Considerations and Reflexivity

We approached this research from a critical ontological position (Schrecker, 2018) which considers reality as a function of historically contigent power relations crystalised into

oppressive social, political and economic structures. Our methodological choices have been guided by these presuppositions and rooted in the need for a 'moral praxis', where health research challenges power and advocates for the vulnerable (Labonté et al., 2005; Morse, 2012).

5.6 Findings

In the sections that follow we describe the discourses that facilitated the closure of STC and how such discourses framed the closure as a 'victimless decision' justified on economic grounds. We also describe counter-discourses of resistance, how such discourses were framed and their implications for the larger politics of health. As shown in Figure 5.2, there was a rapid evolution, especially by proponents of the closure, from representing STC as an important institution that was safe from closure and held up as a more efficient transportation company than others, to its vilification and the complete normalisation of the decision to close it. We first explore discourses for STC closure followed by their counter-discourses.

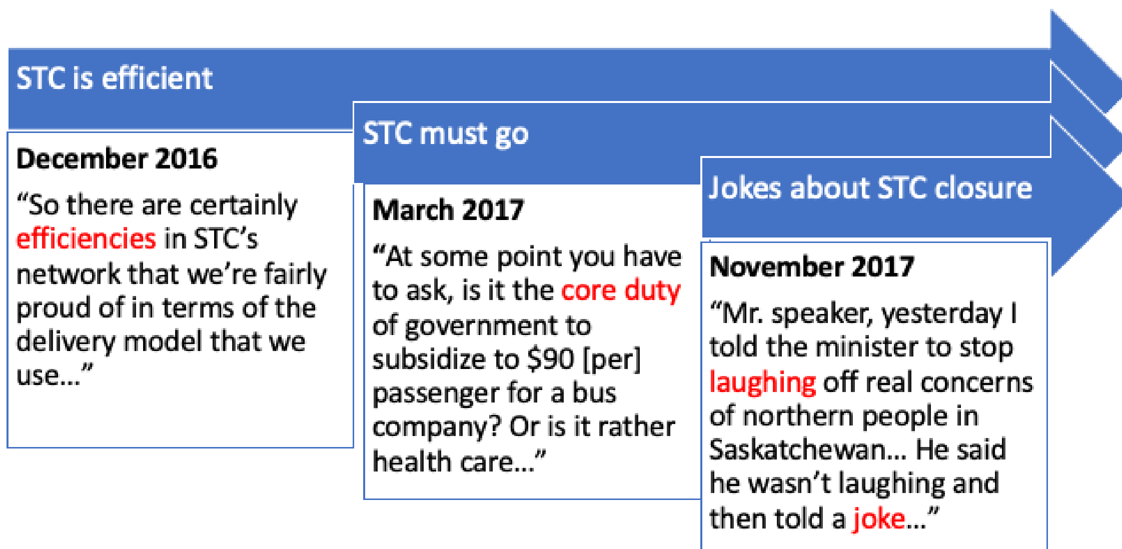

Figure 5.4: The Evolution of Discourses on STC closure in Hansards. Source: Authors, based on Parliamentary Hansard

5.7 Discourses

Economic Rationalisation: The primary logic offered by the Saskatchewan Party for "winding down" STC was an economic argument that claimed it was an unsustainable business venture that "has only been able to continue operating with a large annual subsidy from taxpayers" (Doherty, 2017, p. 1840). This economic logic depoliticised an intensely political decision, perpetuating other discourses that ignored the fact that the original purpose of the company was "not for financial profit, but for the good of the whole people" (The Leader-Post, 1945, p. 12). This discourse of describing the STC as an unprofitable business appeared throughout contemporary media sources with phrases such as "perennial white elephant" (Kosior, 2015), "money losing" (appearing 41 times in Factiva sources) and "money draining" (Robertson, 2017) used to describe the STC. In one case, a right-wing libertarian organisation, the Canadian Taxpayers' Federation, described the STC as "a failing operation… It's not that STC had a few bad years; they were all bad years" (MacPherson, 2017a). Although the March 2017 budget saw cuts to different social services and programs, the government claimed that savings from the failing STC could be spent on other social programs. As a Saskatchewan Party MLA noted "they keep talking about, we need more funds for social services… education. We need more funds for healthcare. Well, Mr. Speaker, I think that 85 to $100 million could well be used in those other needs and those other priorities of the government" (Hargrave, 2017b, p. 2163).

Minimisation and Negation: This discourse involved the essentialisation, minimisation and outright negation of the value of the bus system to its thousands of former users. The discourse emphasised STC's "ridership decline" over the years (Wall, 2017, p.1860; Hargrave 2017a, p. 1947), dismissed claims by opposition MLAs that the closure could have negative consequences as "scare tactics" (Reiter, 2017, p. 2747) and claimed the closure would mainly affect former

employees and their pensions. The idea that the closure would primarily affect former STC employees was repeated throughout parliamentary debates, with a Saskatchewan Party MLA stating for example “[w]e don’t think it’s a laughing matter because we know that the lives of 250 or so valued public servants changed significantly” (Wall, 2017, p. 1860). By denying the existence of the almost 200,000 former riders of STC (from its final year of operation alone) and considering the potential effects of the closure as creating “some inconvenience for people” (Graham, 2017a), proposed post-closure solutions appeared adequate.

As the minister in charge of STC noted, the solutions to any service gaps created by the closure would be for “non-profit organisations, service clubs, people, friends and neighbours… just like people do in Saskatchewan [to] help out their friends and neighbours” (Hargrave, 2017a, p. 1948). Here the retreat of the state and shift of responsibility to individuals was represented as an opportunity for ‘neighbourliness’. Beyond the minimisation of potential effects on individual former users, potential systemic (health, small business, agriculture) effects were treated similarly, with ministers (without evidence per se) claiming the closure would be innocuous. For example, the minister in charge noted “the wind down of STC has had no impact on our child and family services” (Merriman, 2018, p. 640)

The STC as Burden and Relic: A third discourse, more evident in media sources than the Hansards relied on, represented the STC as a relic of a socialist past and a burden that had outlived its usefulness. Here the bus was not described as a modern transportation system with WiFi and other modern technologies. A story from the *Regina Leader-Post* (Pacholik, 2017a) included a description by a member of the public referring to STC as: “[An] albatross, at last, after subsidising it for hundreds of millions of dollars over the years…Tommy Douglas’s

Socialist idea of a public run bus line is going on the trash heap of history". Drawing on logics of the bus as antiquarian and obsolete, a Saskatchewan Party MLA described the closure as a mere fulfillment of the wishes of Saskatchewan people who saw the bus as a burden long before it was closed. The MLA noted: "We just made the final decision, but the people of Saskatchewan decided individually that they weren't going to use the buses. They were the ones that made the decision that they weren't going to use it" (Santos, 2017). In these descriptions, the bus is portrayed as a burden, a service no longer needed in Saskatchewan.

Government Discretion/Charity: This fourth discourse emerged and became reified through a lawsuit between the Amalgamated Transit Union (ATU) and the government on the closure. The discourse, which was later countered by human rights and democratic deficit counter-discourses, justified the closure by arguing that the government had a right as a matter of policy to decide whether to operate a bus system or not; thus, the closure even if at a whim of a right-wing, pro-market government was presented as legal. One newspaper story described the court case in these terms:

> Most of the arguments [in court] hinged on [the STC's] status as a Crown corporation, legal acts that govern such agencies, and definitions of 'privatisation.'" Robert Leurer, representing STC and the Crown Investments Corporation which manages it, said the government by law is allowed to wind down and dissolve the bus company. He said funding of STC is "completely discretionary" by the government, which can choose to devote those resources elsewhere. (Pacholik, 2017b)

In this discourse, the rights of former users were irrelevant. In fact, most of the debate was reduced to procedural issues and technical definitions of 'privatisation'. The judge, who

ruled in favour of the government in a 45-page ruling on the legality of shutting down STC, noted: “[A]s a matter of law and constitutional principle, a decision respecting the disbursement of public funds is within the authority of the legislature alone and is not justiciable” (*Amalgamated Transit Union Local 1374 v. Saskatchewan (Finance),* 2017, p. 15)

This discourse of STC as an object of government discretion was legitimated through the judiciary as above. The ruling was based on the correct interpretation of the law and reveals the limits of the judiciary in defending public services such as the STC or promoting health equity.

5.8 Counter-discourses

There were discourses of resistance that challenged the closure of STC and offered a different set of justifications for keeping the bus. These counter-discourses were promoted by members of the public and activist groups (e.g., Stop the Cuts, Save STC, Students Mobilising Against Cuts, Colonialism No More etc.) and their mechanisms ranged from writing opinion pieces to mass protests. Some of these latter actions led to arrests (Macpherson, 2017b).

Utility and Practical Necessity: This counter-discourse emerged primarily in response to minimisation discourses by affirming the value of the bus and its former users. The discourse represented the bus as a practical necessity and integral part of life in Saskatchewan’s sparsely distributed geography. Describing the closure, one NDP MLA noted:

> [T]hey’re completely scrapping a Crown corporation that ties our vast province together and, importantly, serves those in need… selling STC is wrong, and it’s desperate. People rely on STC to access education and employment and training… our small businesses, our

> producers — on the parcel service… people access it for healthcare. (Wotherspoon, 2017a, p. 2046)

Here the bus was represented not as an unused service but one that was critical to accessing services in the province. Here also, the complex interconnections between the bus and the health system and the vital role of the bus in linking the province were emphasised. As a member of one focus group noted:

> [W]hen you have one branch of government [Ministry of Health] that says, we have this as our mandate for the good of our entire population while at the same time undercutting the ability for people to access that, [it] is absolutely, absolutely ludicrous. (FGD Activists)

Marginalisation and Victimisation: According to this counter-discourse the STC closure marginalised and victimised specific segments of the population. It was essentially used by the NDP (New Democratic Party) to threaten the ruling Saskatchewan Party with the potential for losing votes among specific subpopulation groups, such as rural people who had "been taken for granted" (Meili, 2017, p. 2702). The groups referenced were victims of domestic violence (women), Indigenous populations, seniors, people with disabilities, former medical pass holders, and "the most vulnerable people in the north" (Belanger, 2017, p. 2564).

In media sources, poignant stories were presented of people with disabilities whose ability to participate in social life had been taken away. A *Global News* (Baxter, 2018) story about a former bus user quoted him as saying "now I can only go when community living will provide transport. My freedom has been taken away...Without STC I am in prison". A similar story from the *Regina Leader-Post* (Modjeski, 2017) described how "seniors travelling to Saskatoon for medical reasons will have to 'beg and borrow' for rides from their families [and

STC closure] may result in more people missing important appointments". In this counter-discourse, the closure of the STC was portrayed as a traumatic societal transition with devastating and inequitable consequences. An NDP MLA described the closure effects on a constituent:

> Shirley's kidneys have completely shut down, and she requires dialysis treatment four times a week. Each treatment is three and a half hours… When the Sask Party destroyed STC, [Shirley and her family] had no choice but to sell their home in Bethune and to move to Regina. The financial costs were enormous, larger mortgage, and house renovations to make it wheelchair accessible. (Wotherspoon, 2018, p. 4402)

STC Closure as Neoliberal and Colonial Ideology: According to opponents, the STC closure was ideological (neoliberalism and colonisation), requiring careful analysis. A member of an activist group noted that the closure "has totally deregulated transportation and the culture of safety that we had under STC" (Martin, 2017). Here the closure was interpreted as a neoliberal decision with the ultimate aim "to transform Saskatchewan into a less-connected, less-functional province" (Fingas, 2017). The closure was also interpreted as a neoliberal decision, where neoliberalism is "an ideology that makes poor people dispensable [leading to] increased polarisation" (FGD Activists).

Additionally, the closure was interpreted as ideological not in an economic sense but as uniquely affecting Indigenous populations, for example, in terms of what it meant for reconciliation and the issue of missing and murdered Indigenous women and girls (MMIWG). The closure was "more problematic when you are talking about Indigenous populations… [and in that sense] there's a structural racism that's in there" (FGD Indigenous). Regarding

Indigenous people and their ability to flourish, the closure was seen as a way to "smack them down and keep them there" (FGD Activists), in this sense "it's a kick in the teeth instead of [a] hand up" (FGD Activists). Ultimately "it's colonialism" (FGD Activists). For Indigenous people as well, the closure and the failure of the government to confer with stakeholders prior to the decision was seen as antithetical to reconciliation. A participant in one focus group quizzed : "When it comes to First Nations populations in particular, like if things like reconciliation mean anything at all, why aren't you having more of a mechanism by which you create spaces where their voices can be heard?" (FGD Indigenous)

Evidence Deficit: The evidence deficit counter-discourse pointed out the absence of or inconsistencies in evidence surrounding the STC closure and the lack of transparency in the process leading to the closure. This discourse was based on two main ideas: first, demands for an evidence trail where others could independently arrive at the $85 million savings the government claimed the decision would bring. As an NDP MLA remarked:

> I want to talk a little bit about math.... And the Premier and other ministers will stand up and quote their numbers. We don't know really where those numbers come from.... You know, I'm an old math teacher, and that's often what we say is show your work. (Forbes, 2017, p. 2635)

In a committee meeting to discuss the closure, an NDP MLA asked if the minister responsible could provide how closure savings figures were arrived at; "anything, correspondence, anything that would be helpful" (Vermette, 2017, p. 371) and the minister referenced "numerous in-person meetings and phone calls" (Hargrave, 2017c, p. 371). This counter-discourse also inculpated the government for intentionally providing misleading

numbers; “the last year of operation, the actual budget was 10 million…they kept saying 85 [million dollars] over five years, but I don’t know about you, but 10 times 5 is 50” (FGD Activists). The other dimension of the discourse challenged the definition of ‘cost’ or ‘savings’ from the closure and called for “a social audit of the real costs [which] would show that people are now spending far more in real dollars to attend appointments, to travel, to visit family or to move blood and medical supplies” (Hanson, 2018).

Democratic Deficit: This counter-discourse challenged the idea that the operation of the bus was based on government discretion and considered the closure an illegitimate and undemocratic decision. Proponents argued that the closure should have been preceded by “a province-wide consultation, provide extra special support for groups or individuals or communities that literally have no voice” (FGD Indigenous). Media sources also referenced how the “the current government did not give any consideration to all the many stakeholders who have been compelled to publicly voice how their lives and businesses will be negatively affected” (Richards, 2017). Here, the lack of consultation was described as depriving people of accessing other public services without any clear opportunity for these members of the public to participate in a decision that has critical implications for their lives.

Human Rights and STC as Ideological Symbol: Closely linked to the democratic deficit counter-discourse was an argument that the closure of STC was an infringement on human rights. This discourse, which was largely absent in the Hansards, minimal in media sources and most evident in the focus group data was rights-based, demanding that the closure be reinterpreted through a human rights lens. The *Regina Leader-Post* ran a story about former STC users appealing for a human rights review of the decision to close STC:

> [T]hrough a letter-writing campaign, a passionate group of former STC passengers are trying to put pressure on the provincial government to create an alternative accessible transportation service in Saskatchewan; the letters are being sent to the Saskatchewan Human Rights Commission (SHRC) [for SHRC to] make an official recommendation to the government… to fill a gap in transportation services especially for people with disabilities. (Ackerman, 2018)

In another story, a Regina woman "filed a human rights complaint against the provincial government, alleging the closure of the Saskatchewan Transportation Company discriminates against her and other Indigenous women" (Graham, 2017b). In the focus groups, a participant noted that "free and accessible transportability I think is a human right" (FGD Activists). In this discourse, the closure showed the government as having "fallen down on the social contract… alienating [and] putting at physical, emotional, spiritual, relational risk those who have no other options – they have beyond fallen between the cracks" (FGD Activists). The closure was also interpreted as violating rights to livelihood, freedom from violence and the right to health (FGD Activists).

Climate Change: This final counter-discourse, again largely non-existent in the Hansards but more prominent in media and focus group discussions, interpreted the closure as a poor decision based on its implications for climate change and the environment. One media source wrote: "The STC efficiently provided passenger and freight services to rural and urban residents alike until Canada's most prominent opponent of climate action, Saskatchewan Premier Brad Wall, shut it down this past summer." (Banks et al., 2018). Another media source described how "without rapid expansion of public transit, we cannot reduce our carbon emissions to mitigate the worst

effects of climate change” (Amalgamated Transit Union, 2019). In this discourse, closing STC meant Saskatchewan was not moving “in the right direction environmentally” (FGD Activists), and the environmental interpretations are necessary because “we can’t for a second think that the elimination of a bus service isn’t linked to increased emissions by cars” (FGD Activists). Environmental discourses thus challenged the idea that STC was unused or expensive and argued for the need to think of STC in very different terms.

Figure 5.5 summarises the main discourses and counter-discourses from the three data sources and contains both the primary (P) and secondary (S) discourses that formed the debate over STC closure. The arrows depict the specific discourses that the counter-discourses were directed at or opposed. Human rights and climate change discourses are shown without any arrows because they were less directed at specific discourses and can be seen as a response to most if not all presented discourses. For example, by asserting that public transportation is a human right, activists were arguing against minimisation and negation (people have a right to use the bus even if they are few), economic rationalisation (economic unviability does not justify the violation of human rights) and government discretion (human rights are inalienable and exist not at governments’ discretion). From the climate change perspective as well, global environmental destruction cannot be justified on economic grounds or any of the other reasons offered in the discourses.

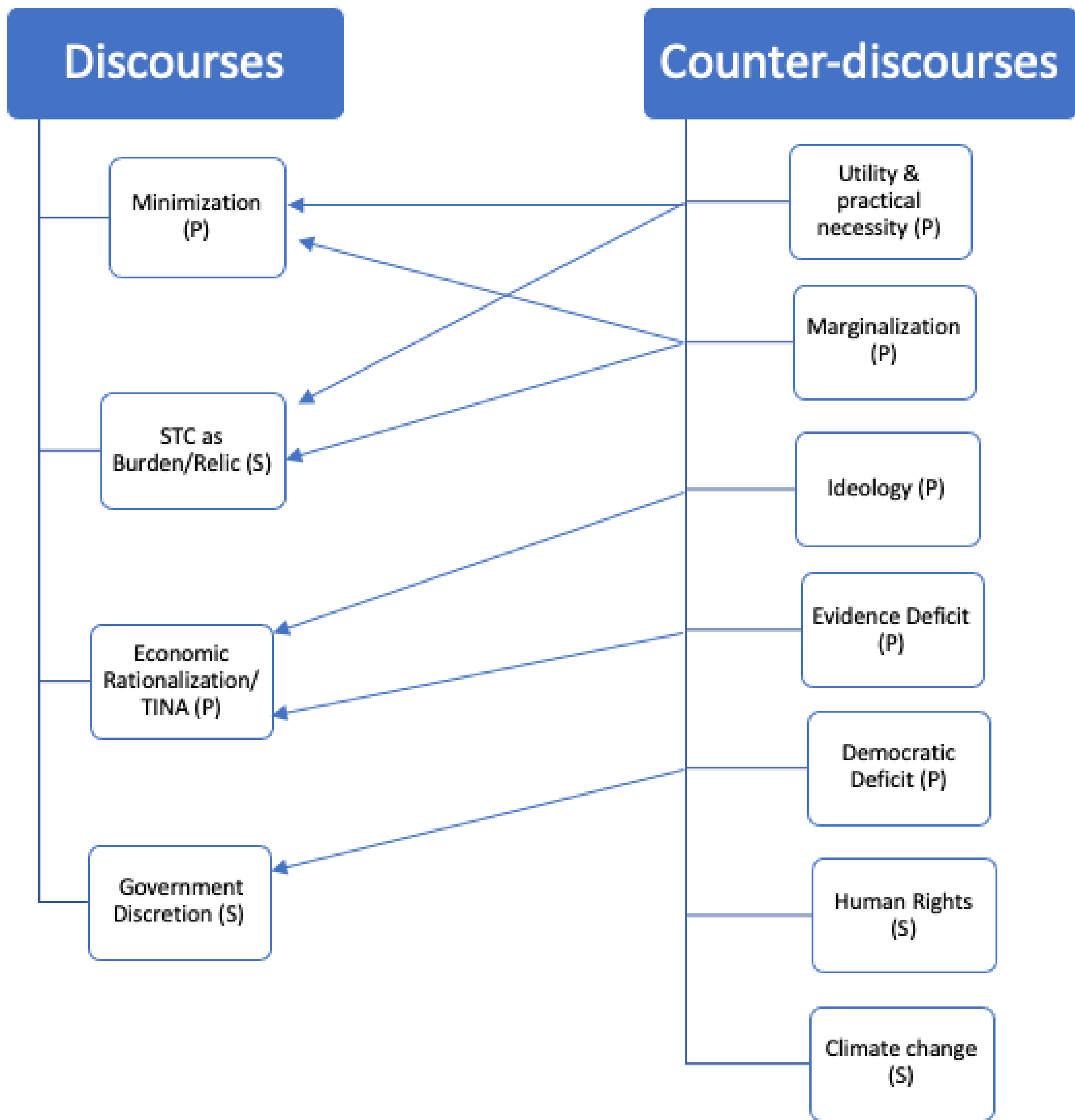

Figure 5.5: Summary of Discourses and Counter-discourses on STC closure. Source: Authors

5.9 Discussion

The discourses above describe *how* the closure of STC was framed and justified although they do not necessarily say *why* the government shut down STC when it did. They reveal that the closure was based on neoliberal ideology. One can therefore hazard some guesses on why the closure

occurred when it did. In a very straightforward way, it was an instrumental decision for economic recovery. Austerity measures of this nature represent a classic neoliberal strategy "to socialise risks and losses and privatise profits" (Asa, 2002, p. 290). One ought to 'denaturalise scarcity' to understand this type of austerity because during economic prosperity the poor do not necessarily receive more investment (Schrecker, 2008). In Saskatchewan's years of economic prosperity the subordinate classes represented in the STC ridership - low income seniors, people living with disabilities and young Indigenous people- did not receive the benefits of this economic boom but suffered budget cuts (see capital grants in Figure 5.2).

Another way to think about why the STC was closed is to 'follow the money' to see who is benefitting from the closure. Emerging evidence suggests that some of the private companies that took over the transportation of medical equipment after the closure were corporate donors to the Saskatchewan Party (Leedham, 2020). In this sense the STC may have been closed to satisfy corporate interests since the corporate elite are a significant source of income for the Saskatchewan Party (Enoch, 2012).

The government's strategy of making cuts to so many programs and services seems to have widened the Overton window[10], such that the closure would be seen as one casualty in a grand neoliberal austerity war against public debt. The fact that most former bus riders were low-income seniors and Indigenous people (Saskatchewan Transportation Company, 2010; 2017) certainly made the company vulnerable. The minimisation discourses, albeit without evidence or

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[10] This refers to a range of policies considered politically acceptable to the general public/mainstream at a given point in time.

facts, were mobilised to discount such former users and reveal the ethos of neoliberal austerity discourses. These construct ‘public problems’ (Gusfield, 1981) or, in this case, usage of public services by vulnerable populations as non-usage, to justify state and corporate actors’ material interests and ideologically based political choices.

The discourses and counter-discourses presented significantly different representations of the STC and reveal extremely different ways of making sense of neoliberal austerity. Austerity’s intellectual history can be traced to such English philosophers as John Locke; “we find austerity’s genesis in the pathological fear of government debt that sits at the heart of economic liberalism” (Blyth, 2013, p. 114). The March 2017 budget which saw austerity measures particularly targeting the poor has altered the entire institutional structure of Saskatchewan and revealed some dynamics of the politics-health relationship that may not always be evident.

Our socio-political autopsy is similar to sociological approaches such as the work of Klinenberg (2015) on structural factors that exacerbated the mortality toll from Chicago’s 1995 heatwave. While similar to ‘root-cause analyses’ (Madzimbamuto et al., 2014), ours departs from the approach of exploring structural causes of one individual’s death to the examination of the death of an institution, a service: a bus. We explored a neoliberal austerity decision that has wide-scale implications for the lives, health and wellbeing of thousands of people, and in the process revealed the discourses used to justify austerity.

This study raises critical questions on the place of evidence, democracy, human rights and health under neoliberal economic policymaking. Indeed, the underlying neoliberalism of the austerity decision to close STC was later made even more evident when the former STC bus

depot in Regina was converted into a police station, signifying the most nuanced manifestation of neoliberalism involving not simply the retreat of the welfare state but the strengthening of the punitive arm of government. In other words, it showed "the systematic tilting of state priorities…from the protective (feminine and collectivising) pole to the disciplinary (masculine and individualising) pole" (Wacquant, 2012, p. 73).

Austerity's health effects have been chronicled in many parts of the world, (Basu et al., 2017; Schrecker & Bambra, 2015). While many researchers have emphasised and debunked the trope of individual responsibility (McBride & Mitrea, 2017) characterised in our data as austerity opening up an opportunity for 'neighbourliness', there is also a powerful democratic deficit, as well as a pernicious negation of the users of public services that appears to be a necessary antecedent in the justification of austerity budgets. In the specific case of the closure of STC, the Courts were used where necessary to justify the neoliberal austerity decision. McBride (2016) provides several examples of how austerity is 'constitutionalised' in Europe and North America. In the context of weakening union power and membership (Smith, 2020), it comes as no surprise that the union that attempted to defend the STC (Amalgamated Transit Union Local 1374) was unsuccessful in court.

In the legislature, arguments on whether to keep or close the STC became solely about technical definitions of 'privatisation' and procedural missteps rather than the possible violation of the human rights of thousands of people who would be left without the ability to move whether for leisure, to access health services or, in the most unfortunate cases, to flee from an abusive partner. This illustrates the role of power in shaping health and health inequities under neoliberal austerity regimes.

In Saskatchewan, as focus group discussants sought to show, the fact that neoliberal austerity dispossesses Indigenous people of access to public services has clear ties to histories of colonisation that involved dispossessing Indigenous peoples of land and other resources (Daschuk, 2013). The destruction of the commons, in this case public transportation, through austerity has several parallels with colonialism not only through dispossession but because the ultimate beneficiaries of such policies have been capitalists; historically through access to land and other resources and contemporarily through car dependency that benefits oil companies and the energy sector (Dellheim, 2018), or possibly a corporate elite in the case of Saskatchewan. Elaborating on these connections and parallels could be a useful and nuanced way of providing counter-discourses to the ideological hegemony of neoliberal austerity. The idea of 'dispossession' is taken up more fully in the next chapter.

It is important to consider the highly marginalised human rights discourse. In the case of people with disabilities, in particular, the Canadian Charter of Rights and Freedoms guarantees the right to mobility under Section 6.[11] Canada also ratified the United Nations Convention on the Rights of Persons with Disabilities which advocates for access to dignified transportation for persons with disabilities. The Saskatchewan Human Rights Commission has advocated for public transportation in the past and cited Supreme Court judgements from as long ago as 1997 (Eaton v Brant County Board of Education) which demand that society "fine tune" its structures, especially those with underlying assumptions that exclude people with disabilities

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[11] See Canada.ca

(Saskatchewan Human Rights Commission, 2010). Yet these laws and provisions did not prevent the closure of STC which violates human rights and was justified on economic grounds.

On the question of evidence and its role in public policy under neoliberal austerity regimes, the vast body of transportation literature that connects the use of private vehicles to climate change (Chapman, 2007; World Health Organisation, 2000) was barely mentioned either in media or parliamentary sources. Thus, important potential effects of a decision that would have global consequences received little attention. A similar issue that received little attention is the idea of the social determinants of health. While transportation is a noted social determinant of health, the phrase "social determinants" neither appears in media sources nor parliamentary discourses and indeed there was a decoupling of the transportation-health connection several times by proponents of the closure with claims that the funds saved from closing the bus system would be redirected to healthcare services (see Figure 5.4).

It would therefore be useful for scholars and practitioners of the social determinants of health to re-politicise health and to engage more seriously with public debates on austerity, especially where it threatens determinants such as transportation. This could be done through writing op-eds and engaging in protests where academics and practitioners use appropriate social determinants of health language. This would bridge the gap between what is known about the social determinants (in the academy and by practitioners) and public debates on austerity decisions that have health implications. It would place more concretely in the public arena, the importance of the social causation of ill health, an idea that is well understood in the academy today (Schrecker & Bambra, 2015). In the STC case, Dr. Hanson and I wrote an advocacy brief and other opinion pieces for local newspapers to share some of the findings of our research. We

believe that such activism coupled with public engagement on the health - depleting effects of austerity could play a useful role in protecting public services and population health.

The important role of activists in defending public services in times of austerity requires more scholarship especially since in the case of the closure of STC, activists not only provided counter-discourses but often put themselves at great personal risk including risk of arrest (by refusing to get off the final bus, for example). Paying more attention to discourse and the politics of health would be a useful addition to our understanding of austerity's dynamics and its implications for health equity.

The interest in conducting this research was to understand the logic behind the closure of STC and associated discourses. The wide array of evidence parsed does not suggest that a specific 'logic' justified the closure of STC, rather undisguised political force won over all arguments and was used to coerce the poor into paying the price for a crisis they did not cause. If health is to be re-politicised, researchers must routinely peruse Parliamentary Hansards to understand the (il)logic that sometimes determines public policy.

5.10 Conclusion

A summative statement about the STC and its closure is that throughout the argumentation, reasoning and discourse around the utility and viability of the bus company, human rights, social determinants of health and environmental discourses remained marginal. In the Saskatchewan context where the ruling government's major support-base is rural, it mobilised discourses of negation of bus users to justify austerity while also relying on an ahistorical economic rationalisation discourse. Understanding these manoeuvres can be important for understanding how neoliberal discourses are mobilised to justify austerity in other parts of Canada and

elsewhere since local particularities can influence how neoliberal discourses are used. The consistent portrayal of the buses as a (taxpayer) burden rather than a right, a symbol of progressiveness, equality and democracy facilitated the closure. It represents, at best, a misunderstanding of the meaning and value of public transportation and, at worst, a retreat of social democracy and the triumph and entrenchment of neoliberalisation in Saskatchewan, the cradle of North American social democracy.

CHAPTER 6: AUSTERITY AND THE WEB OF DISPOSSESSION: HEALTH AND HEALTH SYSTEM IMPACTS OF CLOSURE OF THE SASKATCHEWAN TRANSPORTATION COMPANY (MANUSCRIPT II)

6.1 Introduction

On 31 May 2017, the final bus of the government-owned Saskatchewan Transportation Company (STC) took its last trip from the capital city of Regina after over seventy years of service. The company was shut down by the provincial government as part of a budget that saw several austerity measures (budget cuts) in the province. At the time of closure, the buses served 253 communities, delivering passengers and freight (Saskatchewan Transportation Company, 2017). The company also shipped "[v]ital goods such as urgent medical supplies [blood and laboratory samples], medical instruments, and agricultural parts" (Saskatchewan Transportation Company, 2010, p. 3).

According to the government, the closure would save $85 million over the next five years – this translates to about 9% of the $685 million the government hoped to save within that budget (Stansfield, 2017). The government also offered secondary explanations for the closure such as the decline of intercity bus services throughout Canada, declining provincial bus ridership, and the possibility that closing STC would open up competition for private companies (Johnson, 2017).

At the time of the closure, no analysis was presented to show its potential impacts on individuals, the health system and social services delivery. Additionally, no clear plan to mitigate any potential impacts of the closure was made publicly available. This is the second of three related manuscripts exploring the politics, health impacts and health equity implications of the decision to close STC. The first study revealed a set of neoliberal discourses used to justify the

closure of the company. It connected the closure to a global pattern of austerity and specifically interrogated the discourses that made STC closure possible. The third paper explored the health equity implications of the closure of STC and revealed the disproportionate burden of closure impacts on women, rural and northern populations, people living with disabilities and Indigenous communities.

A major controversy with the STC closure has been the government's claim that closing the bus company would have little to no impact. In fact, as presented in the previous manuscript, the government argued that claims by the opposition that the closure would be devastating were 'scare tactics'. Our aim in this paper is to explore not so much the politics of the decision to close STC but the impacts of the decision on people, communities and systems (health and social services). The paper empirically responds to the question of potential impacts of the closure and prioritises the voices of those experiencing its impacts. Drawing on two broad strands of literature, we first explore how austerity affects health and, subsequently, the connections between transportation and health. We then provide evidence through the words of those experiencing it, of health and other impacts encountered two years after the decision. We find that the closure has reduced healthcare access, caused mental health problems and increased isolation. We find as well that families and communities have been caught up in a *web of dispossession* whereby closure impacts move beyond the most visible former users of the STC to other individuals, communities and systems.

6.2 Austerity and Health

Following the 2008 global financial crisis, many countries have pursued austerity as a means to economic recovery (Basu et al., 2017). Austerity has been aptly defined as "drastic but selective

public expenditure cuts" (Schrecker & Bambra, 2015, p. 69). It is an integral component of neoliberalisation, an eclectic concept signifying a number of things from the centrality of markets in determining human relations to the glorification of penal systems (Wacquant, 2012). Austerity typically involves governments cutting services on the grounds of financial unviability. These cuts are made during crises or simply to reduce deficits.

A number of research studies have explored the connections between austerity and health with the majority of these revealing deleterious impacts of budget cuts on population health. Data from the early 1990s in countries of the global south that pursued austerity as part of World Bank mandated Structural Adjustment Programs (SAPs), for example, showed drops in hospital visits by about 45%-50% (Konadu-Agyemang, 2000). A multinational comparison of 21 post-communist countries where austerity was implemented due to International Monetary Fund (IMF) conditionalities between 1992-2002 has also shown that countries that pursued austerity saw higher tuberculosis incidence, prevalence and mortality compared to those that did not (Stuckler et al., 2008). Recent evidence on the health impacts of austerity continue to show negative health outcomes through food insecurity and poor mental health in England, difficulties accessing hepatitis C treatment in France and Cameroon and challenges accessing housing in Canada (Chabrol et al., 2017; Garthwaite et al., 2015; Ruckert & Labonté, 2014).

6.3 Transportation and Health

Transportation has been described as a social determinant of health because of the connections between transportation systems and health outcomes (McCarthy, 2006). While it is beyond the scope of this paper to explore every such connection, some direct and indirect connections between transportation and health are explored below.

Transportation affects health via motor vehicle injury (Godlee, 1992). Globally, 1.5 million deaths and close to 80 million years of healthy life are lost through motorised road transportation; exceeding deaths from HIV, malaria or tuberculosis annually (Bhalla et al., 2014). A 2009 comparison of per capita traffic fatality rates among 16 OECD countries ranked Canada 4th, putting it behind only the USA (1st) , New Zealand (2nd) and Ireland (3rd) (Litman, 2010). The risk of injury and death varies by mode of travel, and public transportation is the safest (Beck et al., 2007; Litman, 2010). Additionally, there is a distinct geography to road accident risks – while crash rates are higher in urban areas, the severity and risk of dying from motor vehicle injuries are higher in lower density and rural areas (Zwerling et al., 2005). This is partly explained by the fact that rural residents may travel more miles than their urban counterparts. In the USA, for instance, rural residents travel 33% more miles than their urban counterparts to access services and account for a higher percentage (49%) of traffic fatalities even though they only represent 19% of the population (Litman, 2017).

Transportation also affects population health through air and noise pollution and, on a macro level, climate change. Increases in particulate matter due to transportation increase the risk of myocardial infarctions by as early as hours post-exposure (Peters et al., 2001). The health costs of air pollution (of which 50% is due to road transportation) in OECD countries in 2010 was about US$1.7 trillion (OECD, 2014). The heat and gases produced by private vehicle use accelerate climate change, with 26% of global carbon emissions related to transportation (Chapman, 2007). Research on carbon dioxide emissions per passenger kilometers shows that single-occupant vehicles are among the highest emitters of carbon dioxide globally compared to public transportation options (Chapman, 2007). Transportation-related increases in carbon

dioxide emissions are also associated with heatwaves, floods and drought-related deaths (World Health Organisation, 2000).

Apart from the direct connections above, transportation systems also affect health through social factors with disproportionate effects on vulnerable populations (Markovich & Lucas, 2011). Key determinants of health such as poverty, social exclusion and access to services depend on transportation systems. The absence of adequate and affordable public transportation increases poverty and inequity by separating people from economic and life opportunities. In urban areas in particular, low-income people often live in neighborhoods with fewer opportunities for employment and a lack of public transportation therefore restricts their ability to search for jobs (Blumenberg & Ong, 2001). Lack of accessible transportation may also increase social exclusion by preventing access to social activities such as visiting friends, shopping and education (Litman, 2003; Lucas, 2004). In these cases, vulnerable population groups already suffering disadvantages in attempting to access services and resources become further marginalised when transportation systems that could facilitate inclusion are absent. Additionally, health-related impacts of transportation decisions disproportionately affect already marginalised populations. For example, environmental exposures due to public transportation such as air and noise pollution and pedestrian casualties disproportionately affect vulnerable populations (Lucas et al., 2016).

Finally, transportation access determines healthcare access. Reviews of studies from countries such as the USA and Australia reveal that people without cars have disproportionately lower rates of healthcare utilisation because of transportation barriers and such impacts are localised to vulnerable populations (Corcoran et al., 2012; Syed et al., 2013).

6.4 A Framework for Understanding STC Closure Impacts

The thematic understandings of the relationships between transportation and health as described above have led to several frameworks to illustrate the etiological pathways from transportation decisions to health outcomes. Drawing on these frameworks and available evidence at the time, the framework below was created prior to data collection. It was adopted to enhance data collection and guide interview questions to help explore impacts of the closure of STC. This framework, although similar to extant frameworks on health impacts of transportation decisions (see James et al., 2014; Khreis et al., 2017b) was innovative in a number of ways.

First, it included austerity and political aspects of the closure of STC. This addition was novel in that most of the research on the relationship between transportation decisions (bus closures, fare increases etc.) and health outcomes do not interrogate why such decisions may occur in the first place but focus more on how they affect health outcomes. Second, our original epistemological framework did not assume that transportation decisions affect all segments of the population equally and therefore paid explicit attention to how combinations of multiple oppressions based on age, gender, disability, race/ethnicity etc. might determine how potential impacts of the closure are experienced and how this translates to mortality and morbidity. The issue of combined oppressions is taken up in detail in the third manuscript (Chapter 7). The original framework proved useful as it allowed for a nuanced understanding of closure impacts on different facets of people's lives. Most of the potential impacts of the closure of STC that were anticipated based on the extant literature, previous frameworks and our adopted framework have been confirmed through interview and focus group data. Figure 6.1 presents the initial epistemological framework that guided data collection and analysis.

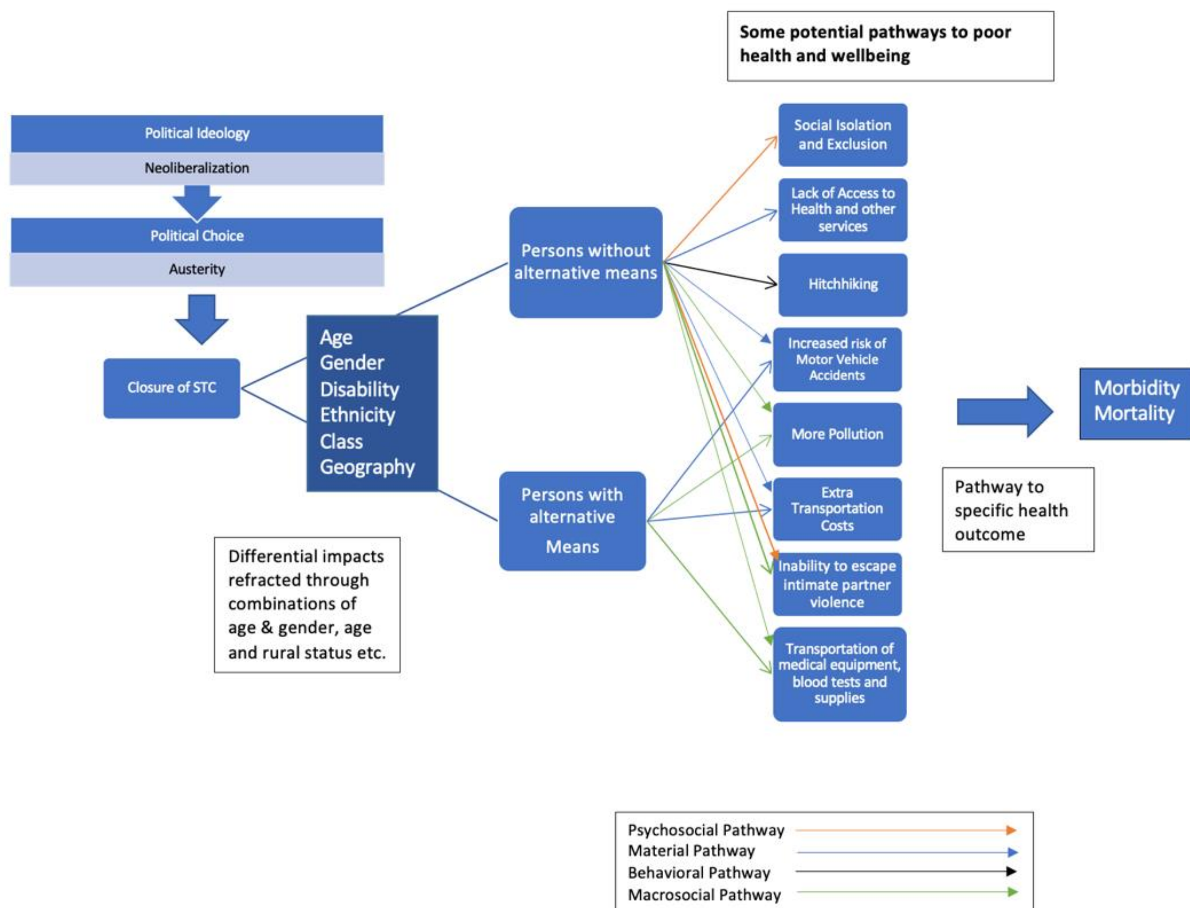

Figure 6.1: Evolving Framework for Investigating STC Closure and Health Impacts.

Source: Authors

Further exploration of the impacts of closure revealed some weaknesses of the initial framework that guided data collection and analysis, leading to a new framework, a *web of dispossession* (Figure 6.2) that enhances and supplements Figure 6.1. It reveals that closure impacts operate across levels from individual former bus riders to systemic disruptions and impacts.

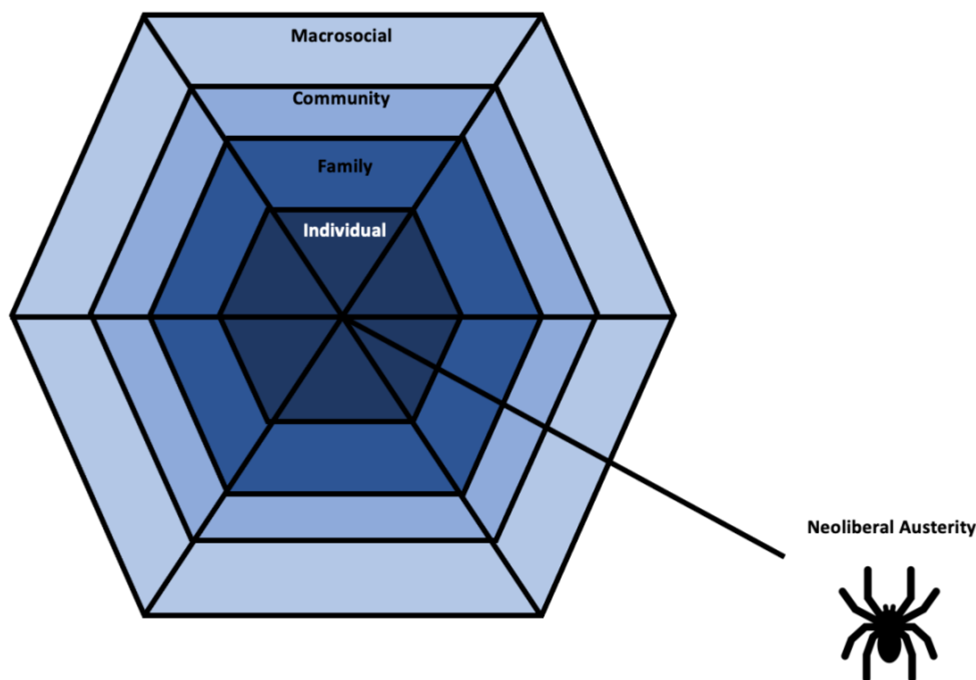

Figure 6.2: The *Web of Dispossession*. Source: Authors

Similar to some of the literature on transportation and health, a major assumption embedded in Figure 6.1 was that the impacts of closure would be individualised, linear, direct and siloed. Further analyses of these impacts however revealed greater complexity requiring one to think beyond aggregations of individual experiences to facilitate understanding of them. Based on this, our new framework, the *web of dispossession* (see Figure 6.2) was created to help locate findings on the impacts of STC closure. The closure of STC which was primarily an austerity decision took away a bus service from former users. The analyses revealed that beyond individual former users, people who did not use the bus regularly such as family and community members are affected in ways that were not captured in our initial framework (Figure 6.1). The section below describes the *web of dispossession* which guided the presentation of findings on closure impacts.

6.4.1 The Web of Dispossession[12]

The concept of 'dispossession' has been used in different contexts in political economy for understanding how capitalism facilitates oppression. Drawing on the Marxian idea of primitive accumulation, Harvey (2004) has proposed the concept of 'accumulation by dispossession' to argue that under neoliberalisation accumulation occurs not only through exploitation of labour but through dispossession. This typically involves governments facilitating the reach of the market through privatisation and welfare state retrenchment. In the Canadian context, for example, 'accummulation by disposession' has unfolded over the last four decades through privatisation and the turn to public private partnerships further broadening the role of the market (Whiteside, 2012). Beyond the "capital-centric" (Gillespie, 2016, p. 67) theoretisation described above, others have theorised the concept of dispossession by paying particular attention to the 'expulsion' of particular segments of society given the expansion of neoliberal capitalism (Sassen, 2014). Those who are dispossessed or to use Sassen's (2010) terminology "expulsed" are a wide range of individuals and communities. The dispossessed are:

> the growing numbers of the abjectly poor, of the displaced in poor countries who are warehoused in formal and informal refugee camps, of the minoritised and persecuted in rich countries who are warehoused in prisons, of workers whose bodies are destroyed on the job and rendered useless at far too young an age, able-bodied surplus populations warehoused in ghettoes and slums. (Sassen, 2010, p. 2)

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[12] Related to the concept of dispossession is that of "commons" denoting shared resources such as land (Antonio, 2013) or public space (Eizenberg, 2012). We use the term "commons" to refer to spheres of life not yet directly under market control in Saskatchewan such as public services.

Using the specifc examples of land grabs in Africa (Sassen, 2014), the prison industrial complex in USA (McNally, 2011; Wacquant, 2009) and the rise in insecurity (Schrecker & Bambra, 2015), many authors have sought to catalogue how the rise in neoliberal economic policies leads to dispossession of particular segments of the population. Although there are elements of possible accumulation and market expansion in our case (some former STC routes have been taken up by the private sector), our interest is in "dispossession" and draws on Sassen's characterisation of the 'expulsed'. Based on the STC's historical public ownership, we explore how the dipossession of former bus riders (via austerity) operates as a 'web' and how this implicates systems and individuals not traditionally discussed in discourses on potential closure impacts.

The *web of dispossession* is a framework for understanding how the impacts of austerity (STC closure) operate, by highlighting impacts that move beyond the individual to disruptions of social life. At the centre of the web are former bus riders. Many have been forced to hitchhike, miss hospital appointments, forego visits with family etc. Given that most former bus riders are connected to others (often family) who do not wish them to bear the full brunt of the absence of a bus, these family members become 'caught in the web' as they try to help the former riders continue to access services. Here, for example, the family member may drive long distances to help the former rider or feel some of the stress, worry and anxiety experienced by them. In some cases, the family member may be unable to provide transportation themselves and some other community member may step in to offer support and bear the driving burden. People trying to offer this kind of help may do so at personal cost.

At the community level as well, the impacts might be felt by people who can no longer access commons that were connected to the bus and such individuals, whether former bus users or not, are caught up in the web as well. Additionally, community level services connected to the bus which might be disrupted or lost due to the closure can lead to the isolation of entire communities. Finally, at the macro level (health system, environment, social services), services that were connected to the bus may be disrupted. For example, hospitals that formerly transported medication and equipment by bus might experience delays and/or higher costs and are thus caught up in the web. Beyond service disruptions at the macro level, health workers are also caught up and a series of individuals not directly connected to the bus begin to experience closure impacts in a manner that might be obscured if all focus were directed at former bus riders (Figure 6.1).

The idea of a web rather than a ripple is to help understand closure impacts which do not necessarily originate with the individual (former user of STC) at the centre to travel outward or the fact that all impacts do not travel to the very distal parts of the web. Taking the example of emotional stress, it begins with the former user, is transferred to family and community members and may even end up with health workers in the macro system but it does not necessarily always travel this way. The health worker (at the macro level) may be stressed not because of stress shifted by a former bus rider but because the entire health system is facing a disruption due to STC closure. Additionally, a person who does not use the bus but whose medication did not arrive at a hospital is caught in the web even though this person is not a former bus rider.

The *web of dispossession* captures the multi-level and complex nature of closure impacts and is meant to supplement Figure 6.1. Its multi-level and concatenated nature are meant

to broaden how one thinks about the closure of STC and its health impacts, moving beyond those affecting individuals, especially those that fall on former bus riders, to those that are so distal that they may be perceived as unrelated to the closure of STC. In terms of nomenclature, beyond its theoretical implications, the word 'dispossession' is used because of the inherent politics of the decision to close the bus company and the contested nature of the government's right to close it. STC was a Crown corporation established under the Crown Corporations Act (O.C 168/46). Crown corporations in Saskatchewan are government agencies or public companies and are held by the government in trust. In this sense Crowns are owned by the citizens of Saskatchewan including the former bus riders.

6.5 Methodology

6.5.1 Qualitative Research Methodology

The research reported in this paper employed a qualitative case study methodology to explore the health impacts of the closure of STC. Case studies involve an in-depth study of single or multiple unit(s) to understand a larger class of (similar) units (Gerring, 2004, 2007). There are several types of case study including exploratory, explanatory, descriptive, multiple, intrinsic and instrumental (Baxter & Jack, 2008). Case studies can be strictly quantitative and motivated by a positivist ontological paradigm (Yin, 2003), qualitative and based on social constructivist ontologies (Stake, 1995), or pragmatic and existing somewhere in the middle of the spectrum (Merriam, 1998). Case studies involve exploring the case in its context. In the present study, the closure of STC is studied in relation to the larger context of austerity in which the decision occurred: an instrumental case study (Stake, 1995). In such case studies, one explores the case (STC closure) not for its own sake (as in an intrinsic case study), but to understand a broader phenomenon – in this case, austerity (Stake, 1995).

6.5.2 Data Collection and Analysis

An essential component of case study methodology is the use of multiple data sources. By drawing on different sources one is able to gain a multifaceted understanding of the case and a nuanced appreciation of it in its context (Yin, 2009). In the present study, one hundred in-depth interviews with former bus users were conducted and four focus group discussions were held with health and social service providers and other stakeholders (see Table 6.1). Although not reported here, the larger study from which this manuscript is drawn has also involved analysis of over 750 newspaper articles, 47 days of Parliamentary Hansards and 2 other focus group discussions. As discussed previously the first study which explored the politics of STC closure relied more heavily on newspaper articles, Hansards and data from the two other focus groups to reveal neoliberal discourses underlying STC closure.

A total of one hundred interviews lasting 30-90 minutes were conducted with research participants from northern, central and southern Saskatchewan. A Research Ethics Board approved research poster was shared on social media (Facebook and Twitter) and at hospitals within the Saskatchewan Health Authority (SHA). Posters were put up in hospitals by the researchers and with help from four Patient Family Advisors (PFAs) recruited from the Saskatchewan Centre for Patient Oriented Research (SCPOR). PFAs collaborate with researchers to help ensure that research is conducted in a way that does not negatively affect patients. The PFAs also helped in refining interview questions and offered advice and support throughout data collection and dissemination.

Semi-structured interviews are one of the main sources of data for qualitative case studies. They provide an opportunity for research participants to share how an issue affects them

in detail, with the opportunity for further probing that might not always be possible when reviewing documents (Merriam, 1998; Yin, 2009). Interviews were conducted with former bus users (some of whom were currently seeking healthcare treatment) to understand their perspectives on the closure, its impacts on them and their families and their thoughts on whether a new bus service would be created in the near future. In every case, participants learned about the research either through social media or a research poster in a hospital and called or emailed the researchers to book an appointment for an in-person interview. Four interviews were conducted by phone in situations where in-person interviews were not possible. At the end of each interview, participants were given a $25 gift card as an honorarium.

The second major source of data was Focus Group Discussions (FGDs). Focus groups are a way of obtaining collective views on an issue and can be used on their own or to supplement another method such as interviews (Gill et al., 2008). They can be an excellent way of clarifying information from other data (Parsons & Greenwood, 2000). Four FGDs (lasting between 40 -120 minutes) were held with professionals from health and social service systems affected by the closure (see Table 6.2). These discussions were held with professionals from northern, rural and urban Saskatchewan and explored health and social service professionals' perspectives on how the closure of STC affects clients and service delivery. Discussants were also asked about the vulnerable population groups who may be suffering a greater burden of the impacts. Similar to interview recruitment, participants contacted the researchers after seeing research posters from hospitals or on social media. All interviews and FGDs were conducted between July 2019 and March 2020.

Data from both sources were transcribed verbatim and imported into NVivo 12 software for thematic analysis. A hybrid of inductive and deductive analysis was performed on the data (Fereday & Muir-Cochrane, 2006). The deductive component involved developing a framework by drawing on the existing literature on possible closure impacts (such as healthcare access barriers, mental health barriers and a number of others). Interview and focus group data were coded to confirm occurrences of such impacts. The inductive component of the analysis involved coding for other possible impacts as well as the development of an integrative framework to show their interrelatedness.

Upon completion of data analysis, a synthesised member checking exercise was conducted with 15 research participants recruited from interviews and FGDs. Drawing on Birt et al. (2016), this involved presenting analysed emerging themes to participants followed by a one-hour discussion in which participants commented and made suggestions on major findings.

6.5.3 Personal Reflexivity

In qualitative research, knowledge producers are not dispassionate, unbiased observers but subjects who themselves are intimately linked to social processes that determine what research questions are legitimate and how one proceeds to answer such questions. Here, researchers are seen as instruments in the process of knowledge generation (Morse, 2012). The acknowledgement of non-neutrality necessitates reflexivity to allow researchers to explore their own positionality as it relates to research.

The researchers are primarily academics with the first author conducting the study as part of doctoral research conducted in solidarity with activists, former STC users and people in Saskatchewan who have been affected by the closure of the STC. The decision to undertake this

study began from an invitation by the doctoral supervisor (one of the authors of this manuscript) to a meeting of academics and community members against austerity in Saskatchewan. The first author spent the next few years participating in meetings of the anti-austerity group and learning about contextual aspects of the decision to close the company. Discussions during sessions helped shape research questions and the methodology used in the conduct of the study.

6.6 Research Ethics

The larger study within which this present manuscript chapter is located, received ethics approval from the University of Saskatchewan Research Ethics Board (BEH 1219). The study also received operational approval from the Saskatchewan Health Authority (SHA) under file number OA-UofS-1219.

6.7 Study Context

Saskatchewan is one of Canada's western provinces with an export-based economy and significant proportions of its GDP coming from oil, mining and public services. In 2017 the economy's growth rate was -1% (Government of Saskatchewan, 2017). Its population is sparsely distributed with 1.1 million people living in a land area of 651,900 km^2. Poverty rates in the province are higher than the national average: 14.8% compared to 14.4% for all persons in poverty in Canada and 24.6% compared to 18.5% for child poverty in Canada (Gingrich et al., 2016).

Saskatchewan was the first province to implement medicare in Canada and has a history of relatively strong healthcare services (Warnock, 2005). Life expectancy in the province is below the Canadian average although the province has seen a rise in the senior population. Healthcare services are generally accessible in the province although data on access patterns

show a slight decline. For example, 84.6% of the population aged 12 years and above reported having regular access to a medical doctor in 2003 compared to 78.8% in 2013 (Statistics Canada, 2014b).

As Figure 6.3 shows, Saskatchewan has a higher percentage of people living in rural areas than the rest of the country. Awareness of the province's relatively high rural population is relevant for understanding STC closure impacts because of underlying healthcare access challenges in rural and northern communities. Rural populations have lower healthcare access and experience a higher burden of chronic diseases (Lavis & Boyko, 2010). Although this study is the first to investigate health and other impacts of the STC closure, earlier research on the health of rural-dwelling seniors suggested challenges with accessing health services, particularly for seniors unable to drive to appointments (Jeffery et al., 2011). Access challenges are especially acute for people seeking specialised care (Karunanayake et al., 2015). There are intra-provincial variations for many social determinants of health (poverty, housing, unemployment and education) with relatively higher numbers of people living in poverty in northern Saskatchewan compared to the rest of the country and the province. In 2010, the median after-tax income for people aged 15 years and above in northern Saskatchewan was 40% lower than the provincial average (Irvine & Quinn, 2016).

One of the most important connections between transportation and health is through motor vehicle injuries. Figure 6.4 compares accident rates in Saskatchewan with the rest of the country over the last decade. Quantitative data are needed over time to explore impacts of STC closure on motor vehicle injuries. Nevertheless, based on data available before the closure, the

rate of accident fatality in the province has been consistently higher than the national average and comparator western provinces Alberta and Manitoba.

Despite the challenges described, healthcare delivery in the province is relatively strong and a few healthcare reforms have been implemented in the last three decades. The 1990s saw the closure of very small rural hospitals, moving away from acute care to a greater focus on community care and interest in the social determinants of health (James, 1999). Although some concerns were raised during the closures, research on this reform suggested they did not lead to substantial decreases in healthcare access (Liu et al., 2001). Another recent major reform occurred in 2017 when the province amalgamated its former 12 health regions into one Saskatchewan Health Authority, a move towards greater centralisation and efficiency. It is against this wider context of a relatively strong healthcare system with some access challenges, especially for rural and northern populations, and relative material deprivation in terms of some social determinants of health that the STC closure research was conducted.

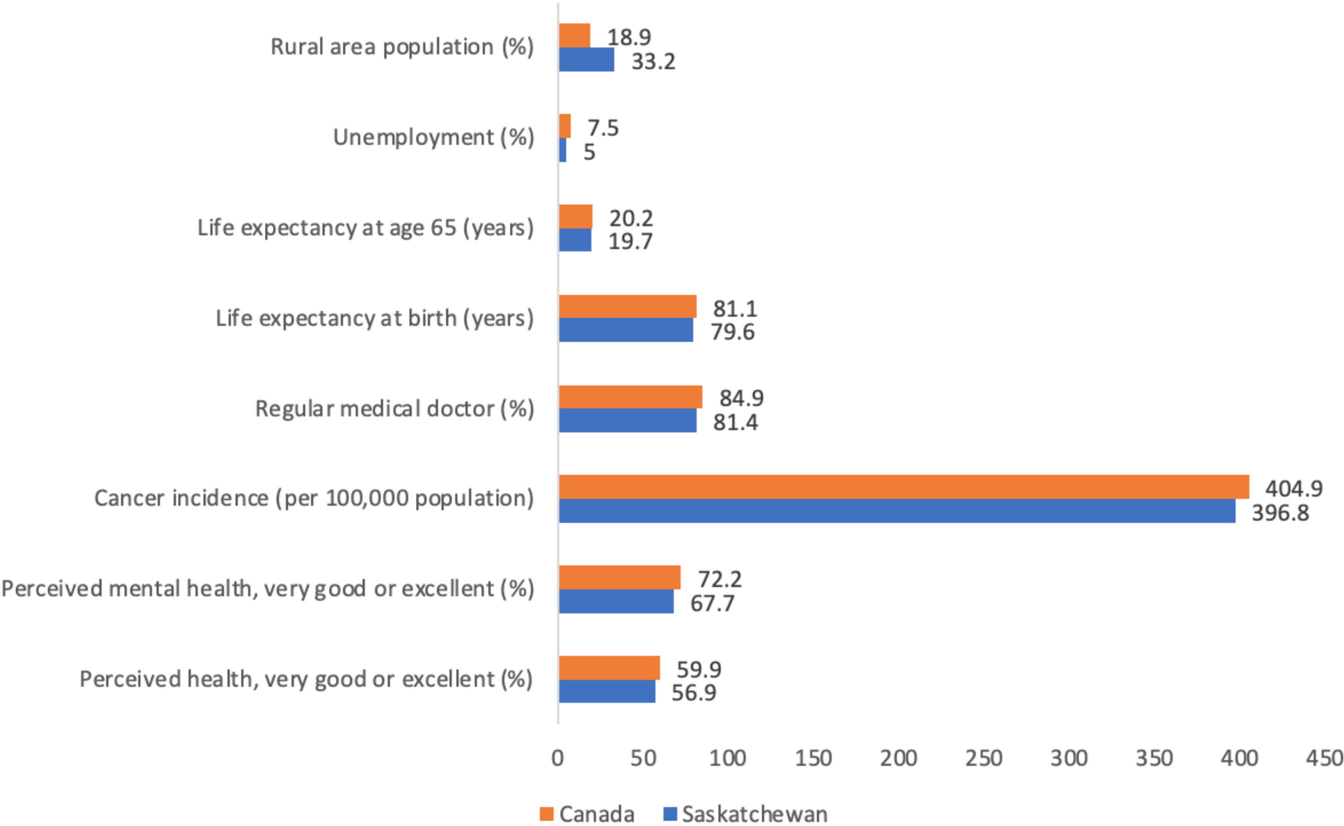

Figure 6.3 Demographic and Health Indicators Saskatchewan versus Canada.

Source:(Authors, based on Statistics Canada, 2014a)

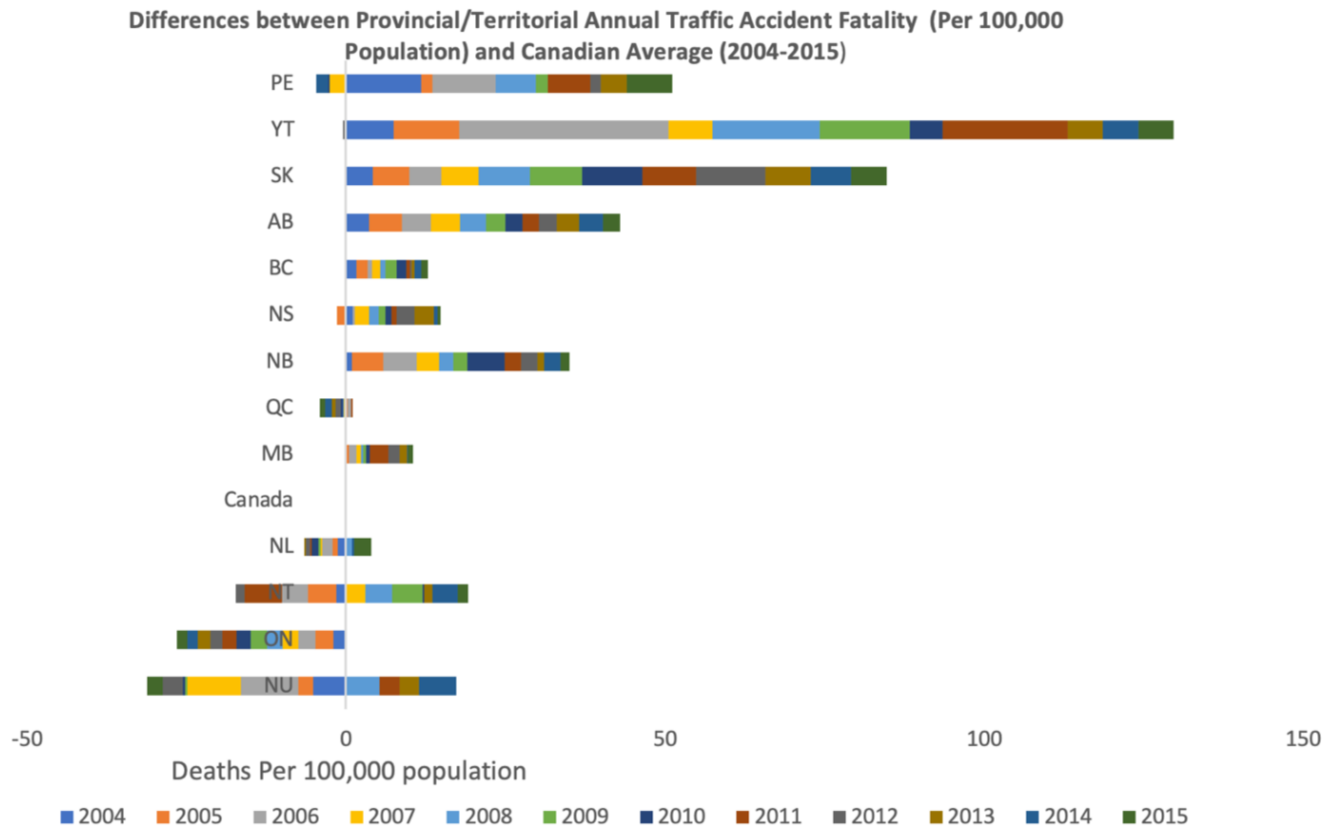

Figure 6.4 Differences[13] **between Provincial* and Territorial Accident Fatality and Canadian Average 2004-2015.** Source: (Authors, based on Transport Canada, 2017)

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[13]Differences for each year are calculated by the authors as the Provincial/Territorial Accident Fatality per 100,000 population minus the Canadian national average. Positive numbers represent extra deaths above the national average. These are crude measures and should be interpreted cautiously.

*PE: Prince Edward Island; YT: Yukon Territories; SK: Saskatchewan; AB: Alberta; BC: British Columbia; NS: Nova Scotia; NB: New Brunswick; QC: Quebec; MB: Manitoba; NL: Newfoundland and Labrador; NT: Northwest Territories ; ON: Ontario; NU: Nunavut

6.8 Research Findings: STC Closure Impacts

In the sections that follow, the main impacts of the closure of STC on individuals, families, communities and systems are presented. We begin by presenting the research participants' demographic characteristics followed by the impacts of the closure shared by participants through interviews and focus group discussions.

Table 6.1 presents descriptive statistics of research participants. The majority of interview participants were aged 50 and above (75%), female (68%), Caucasian (75%) and located in central Saskatchewan (58%). Qualitative methodology does not strive for statistical representativeness however the high number of females and older participants mirrors former STC usage statistics – over 60% of users were female and the majority of users were seniors. The demographic constitution of former bus riders suggests a few things about the politics of the closure of STC and illustrates that some closure impacts were predictable. That so many former bus users were female, older, Indigenous and living with disabilities is important for understanding the politics of health as presented in the previous chapter because these are the very groups often absent in government and the corridors of power where decisions such as STC closure are made. As will be taken up in greater detail in the next chapter (chapter 7), the demographics of former users also suggests/predicts the population groups who could have been expected to bear the worst impacts of STC closure.

Table 6.1: Interview Participant Demographics by Car Ownership

Variable	No car (%) 40 (%)	Owns Car (%) 60 (%)	Total number (%)
Age			
21-29	2 (5.0)	4 (6.7)	6 (6).0
30-39	11 (27.5)	7 (11.7)	18 (18.0)
40-49	8 (20.0)	3 (5.0)	11 (11.0)
50-59	7 (17.5)	10 (16.7)	17 (17.0)
60-69	7 (17.5)	17 (28.3)	24 (24.0)
70-79	4 (10.0)	10 (16.7)	14 (14.0)
80-89	1 (2.5)	8 (13.3)	9 (9.0)
90+	0 (0.0)	1 (1.7)	1 (1.0)
Gender			
Female	28 (70.0)	40 (66.67)	68 (68.0)
Male	11 (27.5)	20 (33.33)	31 (31.0)
Transgender Female	1 (2.5)	0 (0.00)	1 (1.0)
Self-identified ancestry			
African	0 (0.0)	1 (1.7)	1 (1.0)
Caucasian	21 (52.5)	54 (90.0)	75 (75.0)
First Nations	11 (27.5)	3 (5.0)	14 (14.0)
Métis	5 (12.5)	1 (1.7)	6 (6.0)
South American	1 (1.7)	0 (0.0)	1 (1.0)
South Asian	2 (5.0)	1 (1.7)	3 (3.0)
General location			
Northern Saskatchewan	4 (10.0)	12 (20.00)	16 (16.0)
Central Saskatchewan	24 (60.0)	34 (56.67)	58 (58.0)
Southern Saskatchewan	12 (30.0)	14 (23.33)	26 (26.0)
City /Town /Village			
Saskatoon	20 (50.0)	18 (30.00)	38 (38.0)
Regina	9 (22.5)	7 (11.67)	16 (16.0)
Swift Current	2 (5.0)	5 (8.33)	7 (7.0)
Prince Albert	2 (5.0)	5 (8.33)	7 (7.0)
Kamsack	0 (0.0)	6 (10.00)	6 (6.0)
Tisdale	1 (2.5)	2 (3.33)	3 (3.0)
Yorkton	1 (2.5)	1 (1.67)	3 (3.0)
Creighton/Denare Beach	1 (2.5)	3 (5.00)	4 (4.0)
Humboldt	0 (0.0)	2 (3.33)	2 (2.0)
North Battleford	1 (2.5)	1 (1.67)	2 (2.0)
Moose Jaw	1 (2.5)	1 (1.67)	2 (2.0)
Melville	1 (2.5)	1 (1.67)	2 (2.0)
La Ronge	0 (0.0)	2 (3.33)	2 (2.0)
Other	1 (2.5)	5 (8.33)	6 (6.0)
Education completed			
Grade School	18 (45.0)	17 (28.3)	35 (35.0)
Post-secondary training and trades	8 (20.0)	20 (33.3)	28 (28.0)
University	9 (22.5)	14 (23.3)	23 (23.0)
Postgraduate	5 (12.5)	9 (15.0)	14 (14.0)

Source: Authors

Figure 6.5 shows a map of the province and the geographic distribution of the 100 interview participants in the study.

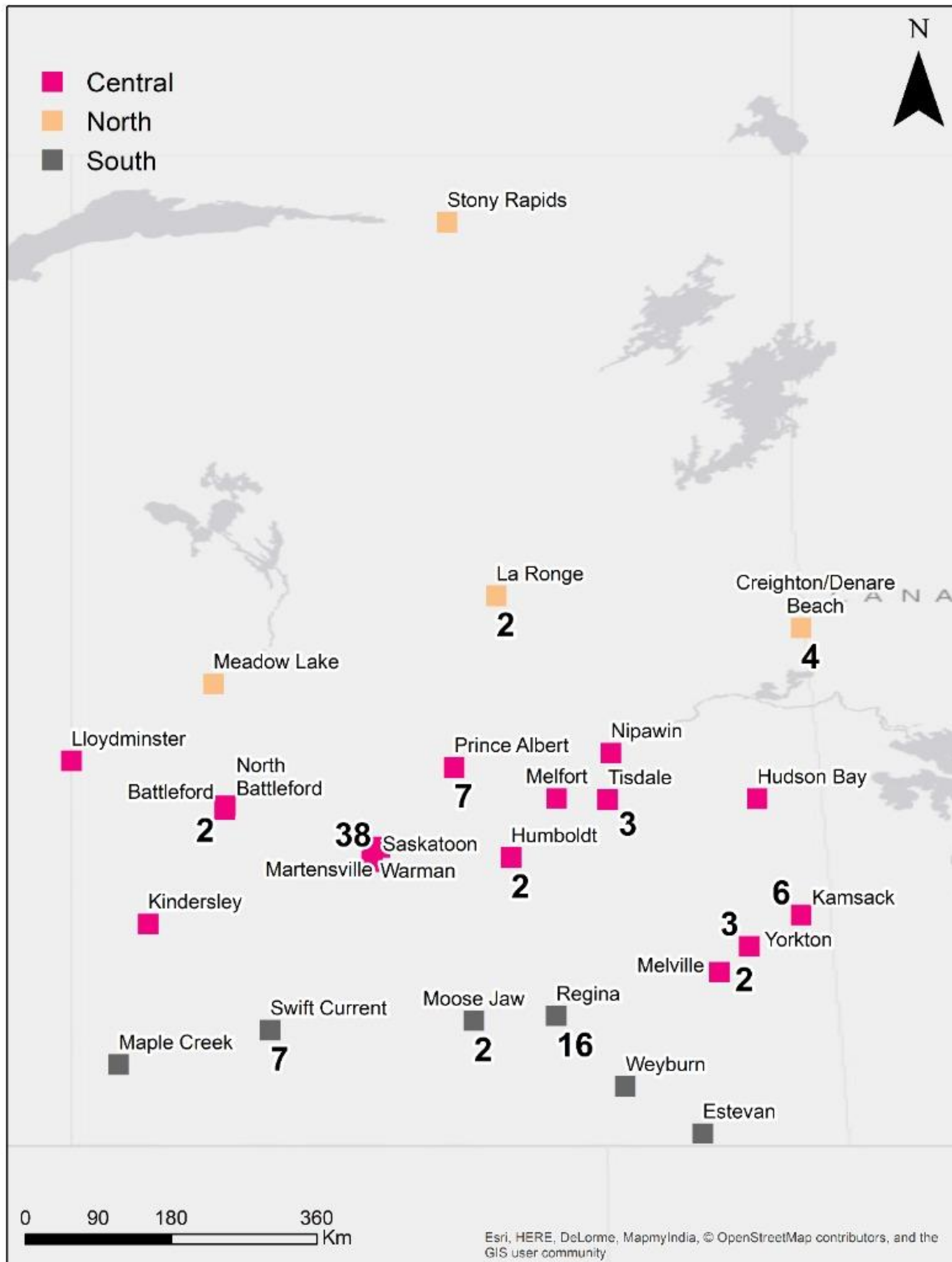

Figure 6.5: Map Showing Cities and Towns in Saskatchewan where Interviews were Conducted. Source: Authors

Table 6.2 shows focus group discussion participants by profession, location and sector. The majority of discussants were in urban settings (63%), worked in the health system (33%) and were managers of programs within the Saskatchewan Health Authority (33%).

Table 6.2: Focus Group Discussion Participants

Characteristic	Number
Profession	
Academic	1
Physician	1
Clerical staff	4
Nurse	2
Other	5
Pharmacist	1
Program Manager	8
Social Worker	2
Location	
Northern	5
Rural	4
Urban	15
Sector	
Community Based Organisation/Program	5
Indigenous Organisation	6
Health System	8
Activist	5
Total	**24**

Source: Authors

6.8.1 Impacts of STC Closure

6.8.1.1 Former Bus Riders (Individual Level Impacts)

The first set of impacts are individualised impacts directly affecting former users of the STC. Participants in individual interviews identified many ways the absence of a bus affected them personally. These impacts thematically fell into categories such as healthcare access barriers, mental health impacts, safety-related impacts and economic/financial impacts of the closure.

6.8.1.1.1 Healthcare Access Barriers

One of the immediate impacts of the closure is impeded access to healthcare services. Under this theme, two recurrent sub-themes emerged, of missed hospital appointments and apparent decisions not to seek treatment due to the absence of a bus. Participants described missing routine health appointments or, in other cases, reported challenges faced in trying to attend recurrent health appointments for treatments such as dialysis, chemotherapy, eye, dental and other appointments.

Missed and Cancelled Hospital Appointments: Many participants described instances when they were unable to travel for medical appointments. These missed and cancelled appointments varied in frequency and in some of the most severe cases participants had been unable to attend for over a year. One participant who had gone to great lengths to attend appointments including making radio station announcements to find rides but with no success noted:

> I had a standing appointment every three months for the Botox shots to relieve the spasticity… I would make the appointment for the next three months. When STC was running, I would pack my bag, put it on the back of my wheelchair. I would order a handicapped bus and they would just wheel me onto the bus, tie me down and when we got here, the wheelchair went into the back of the vehicle and so, I mean, it was, it was very convenient. Now I can't find a reliable ride to get here every three months to get the Botox. The last appointment I had was in November two years ago. (Female, 67, Swift Current)

Other participants described similar situations. Some described how local family physicians put pressure on them to attend specialist medical appointments in larger centres even though they

had no means to do so. One patient who had experienced such pressure shared the following even before anything was asked during her interview:

> I am a 68-year-old lady, I am retired, I have a disability, I have osteoporosis and my doctor sent me to Saskatoon to have some test done for my osteoporosis, but I had to cancel because I had no ways and means of transportation and the STC shut down at the time. My doctor today is still riding me to go for my appointment, but I can't go for it because I have no transportation. (Female, 68, Prince Albert)

Like the participant from Swift Current, others often made efforts to ensure that they attend appointments. Cancellation of appointments was usually the last resort after every attempt to attend medical appointments had failed. As one participant who had done everything to make it to an appointment noted:

> I have a very hard time getting [to] my appointments in Prince Albert. Because I still have to go to the dentist, I've got a fast-growing cataract, I've got to go – there's no eye doctor in Big River and I can't walk to Prince Albert. I have to go to Prince Albert for my eyes. I have to be making calls to see if I can find somebody to take me. I've got my dental appointment on the 13th of next month, I don't even have a ride. I've been asking. People said, "Well, call me closer to the date. Well, could you change it?" – there's a girlfriend of mine – she's going there later on so I called the dental office and I said, "Well, can you change?" She said, "No, we're booked." So, I said, "Okay, just hold on. I'll see what I can get." So, I can tell you right now, September appointment for my dentist – it's going to be cancelled. (Female, 71, Big River)

The issue of missed and cancelled appointments described by patients was corroborated by two participants who worked as medical office assistants in Saskatoon and Prince Albert. These missed appointments were sometimes for CT scans and other medical technologies that are not available in smaller centres. One medical office assistant noted:

> As the medical office assistant, I'm booking patients all the time for things, who aren't from PA [Prince Albert]. They're from PA and area which the ‘area’ is vast, it goes from Rosthern all the way to the top of the province and so I'm phoning patients up in Wollaston Lake and Black Lake and telling them they have to come to PA or even to Saskatoon for a CT scan and they can't. I've had people straight out tell me ‘without the bus, I can't go to my doctor's appointments’. (Female, 37, Prince Albert)

Her Saskatoon counterpart noted the example of a patient who after trying was unable to come for the appointment due to bad weather conditions:

> I remember specifically in the wintertime due to bad road conditions; a patient had to call that morning and say ‘you know what, I can’t get there because my ride doesn’t wanna[sic] drive because the road conditions apparently are not good’. He said, ‘I wish the buses were running’ and had he been able to come by bus, it was a more safer [sic] way of transportation because they [the buses] drive through more inclement weather. So, his test had to be delayed and he had to make arrangements for another ride again. (Female, 52, Saskatoon)

‘Refusal’ to Seek Treatment: Several participants expressed the opinion that if they became chronically ill, they would simply stop trying to attend hospital appointments. This was borne out of a sense of resignation where participants felt it would be needless to keep trying so hard to

attend routine or recurrent medical appointments. One participant described how she would simply stop trying:

> [W]ith no bus and then how do you get around when you're there and how do I get back with no bus, the back and forth for treatment and stuff? I think I would just say, 'give up the ghost. Forget it, I'm not going to go for treatment'. I'm getting old, I'll just die. I'm already thinking that for myself, if something serious happened and I was forced to go, I'm not going to hitchhike. I'm not going to hitchhike 60 below in the winter to go for treatment, I would just say, fuck it, I'm not going, I'll just stay home and not get treatment. And I think a lot of people feel that way. And that is kind of depressing, but it's a reality. You know, you've had so much taken away and what are they going to do? (Female, 64, Creighton)

Another participant from a northern village who had been driving a friend to appointments described similarly how her friend had decided that he no longer wanted to be driven by her for appointments because of the challenges involved. This decision not to seek care anymore was expected to cause blindness in the passenger given the nature of his eye condition. For most people deciding that they would forfeit treatment altogether, it was usually in situations where treatment would be recurrent and there was simply no practical way of consistently attending medical appointments. One participant noted:

> [I]f I was to be diagnosed next week with cancer, I'm not going to be working the phones to get a ride. I'm just going to sit at home and enjoy my life. There'll be no treatments because that is what that Wilson woman [local Member of the Legislative Assembly] told me, 'Oh, if you need to go, call your family. Call your friends.' (Female, 71, Big River)

In most of these cases, participants described scenarios where they would simply not seek care, especially for chronic conditions. In other cases, they explained that they would not go for care if it was for a minor condition. One participant said:

> I just have to do the things I can do here but if I had something wrong with me, I'd have to think twice before 'should I bother doing anything about that little problem if that means going to the city again?' It might affect people's health 'cos [sic] they might think it's too much bother to go in all the time, if there's no easy way. (Female, 82, Humboldt)

In each of the cases described, patients simply may 'choose' not to seek treatment, and this could lead to further complications. The decisions not to seek care could also lead to a misunderstanding that the closure has not had negative health consequences (particularly if the sole metric of missed or cancelled hospital appointments was used to gauge closure impacts).

6.8.1.1.2 Psychosocial and Mental Health

Participants described significant psychosocial health effects of the absence of the STC. The types of mental health issues described generally fell into sub-themes of i) feelings of shame in constantly asking for help, ii) stress in trying to travel and iii) a sense of loneliness in being unable to connect with others.

Shame and Esteem*:* Many participants described how it feels to have to ask for help from others constantly. One participant noted: "Well, it feels demeaning. It feels demeaning cause I've never had to ask; you know, I've been independent." (Female, 77, Kamsack). This feeling of shame and embarrassment was felt even when help was being asked of family members. The main problem in asking was the repeated nature of requests whether for hospital appointments or other travel. A participant with epilepsy noted:

> I can remember begging like a little kid to my daughter, 'please take me with you' and they go, 'but then we have to turn around and come back. We can only take you for a few days. Like if the buses were still running, you could stay longer'…. Do you know what that's like for a grandmother to stand there and cry like a baby in front of her grandchildren? It's embarrassing. (Female, 57, Saskatoon)

These feelings affect self-esteem and sense of self-worth especially when participants reflect on other aspects of their lives in which they have had to ask for help:

> Once again, I'm… feel like I'm a charity. You know I'm a charity case. And that's why [sic] I've kind of felt all my life - so this just adds to it. You know, the feeling that I don't count, that the only way I can get what I need is to ask people and [that] it's only out of the kindness and the goodness of their heart, which is, in my opinion, charitable, right? That's a charity. So, yeah, I feel like a beggar, again, you know, always the beggar and not the chooser. (Female, 64, Swift Current)

Stress*:* Another mental health impact of the closure of the bus on people has been the stress involved in trying to attend appointments or arrange rides. This stress is the price one pays for choosing *not* to 'refuse' to attend treatment. A participant who had just finished treatment for prostate cancer explained:

> [T]here were times I had to postpone, and they made it another date later... But as the time progresses in the future here, I know it's going to be difficult 'cos[sic] anything to do with cancer, now I cannot afford to miss because it is sort of important… I don't know how that yet will work out, but it's definitely a concern, big concern. There's a lot of times you get up in the middle of the night and so worrisome. You start wondering, instead of sleeping

> you can't sleep, and your heart is pounding and you're wondering 'gee how am I going to get here to such and such an appointment?' (Male, 83, Kamsack)

This stress was often also a function of uncertainty created by the absence of a reliable means of transportation especially in scenarios where one has to travel urgently. Here the idea of being stressed out and 'losing sleep' over transportation was a recurrent theme. As one participant unable to drive due to a disability stated:

> I'm not coping well at all, to be honest. I'm still to this point where I can't sleep at night because, like, what if something happens to my mom. My brother calls me up and says, '[X] you need to come home now and you need to do it now.' I'm afraid I'm gonna[sic] have to say, 'I'm sorry, I can't…'cos [sic] I don't drive.' (Female, 31, Regina)

Experiences of stress varied; some people experienced stress even though they could drive. Here, driving *was* the source of stress:

> It can be stressful. And because your motor skills aren't as sharp as it used to be. You know, you always worry about what's around you, you know, if there's a lot of congestion on the highways. It's stressful and riding the bus took that stress away. (Female, 66, Yorkton)

These descriptions of stress are varied and complex. Participants also sometimes described stress using terms such as 'anger' or 'powerlessness'.

Depression, Loneliness & "Feeling Stuck": Another psychosocial and mental health impact described by many participants was a deep sense of loneliness culminating in depression. For many participants, descriptions and reflection on their current situation (of lacking access to the

bus) caused them to weep. This feeling of loneliness was particularly acute among people feeling completely dislocated and cut off from family. In the case of some Indigenous participants living in urban centres, the absence of the bus caused loneliness and depression and also prevented connection to ancestral land and is in a larger sense a form of colonialism as they are unable to participate in Indigenous ceremonies. One such participant living in Saskatoon but with family in the north explained:

> Oh, it's definitely affecting my mental health. My emotional well-being. I do my best to walk the Red Road and my medicine wheel, the mental, the spiritual, the physical, the emotional, is all affected by this. It really, truly is. So, it's really depressing that I can't see my family. And vice versa…some of them have vehicles but they can't afford to come to the city. (Female, 36, Saskatoon)

This feeling of depression was experienced by participants in urban areas and also by people from smaller communities who were not living with family. One participant who had experienced an extremely depressing winter described the impacts of the closure:

> It isolates me. So, I have no options basically. And I don't like driving here in the winter, so it means I don't go anywhere in the winter. Unless I can find someone to drive me and since I've only lived in this place for 3 years, I don't know many people. I don't know people I can call on to get lifts. And I don't have family here. (Female, 80, Kamsack)

Evocative language was used by many participants to describe the sense of loneliness and isolation and how it feels to be cut off from loved ones. In one of the most severe examples the closure of STC was compared to the Berlin wall:

"I see it as, for me personally, it connects me to my family, you know. It's a huge barrier. You know what I mean. To me, you take away the STC that's like going back to the Berlin Wall days. You know, one family on one side, one family in the other, you can't see each other. It's no different than that. It's no different than putting a wall up between me and my family, taking away the bus." (Male, 36, Saskatoon)

Other participants referenced feeling like "prisoners", that they are "in a fishbowl" and other such symbols that evoke images of confinement and inability to travel at will. Other participants used more evocative symbols: "So, the taking away of the service, to me it feels like somebody cut my legs off. You know, I can't get from place to place." (Female, 64, Swift Current)

6.8.1.1.3 Personal Safety and Danger

At the individual level, many participants expressed safety concerns that had sometimes materialised into a negative outcome while in other cases they were concerns that had not yet manifested in reality.

***Accidents and Winter Driving*:** The local Saskatchewan context and weather have meant that driving oneself especially during the wintertime puts people in great danger. Many participants alluded to incidents in which they had come to physical harm and the psychological distress that is involved when driving during the wintertime. As one participant who was involved in an accident because she was forced to drive recounted:

> [Y]ou become anxious because you don't know what's gonna[sic] happen and you are not in control of what might happen, yeah like we went in the ditch once, and it was lucky that somebody came along and they took him [the passenger/patient] to his appointment. (Female, 72, Denare Beach)

Other participants referenced other accidents such as a rock hitting one participant's windshield when they were driving someone else for an appointment and other unsafe situations caused by the absence of the bus. The dangers of driving in winter were described by several participants who referenced icy roads and the stress of winter driving and the blizzards through which some participants had been forced to drive:

> [Y]ou can drive down to Saskatoon and all the weather's really great and then a blizzard pops up and you have to get home and you have to go and drive in that blizzard and you can't see anything. The snow is coming at you all the time and that's a two-and-a-half-hour drive from Prince Albert all the way back here in, in nowhere. (Female, 60 La Ronge)

Participants often contrasted safety concerns with the remarkable safety of travelling by the bus. One participant who had experienced the ability of the buses to facilitate safe travel particularly in poor weather conditions noted:

> When I first was at [the] centre for treatment in Regina for Hep C [Hepatitis C], it was in March of 2013. We had probably the worst snowstorm going. And I had to cancel the appointment, and then, I mean, remade the appointment. And then again, another massive snowstorm, but I took the STC bus instead. I was able to get to my appointment. I was able to get home okay. (Female, 66, Yorkton)

***Driving While on Medication*:** In other cases, unsafe driving was due not simply to poor weather conditions but because participants (or people they knew) had been forced to drive while on medication.

> I have an uncle that has cancer. He's from Estevan and then he has to come to Regina for treatment and then he used to take [the] bus. Now he has to drive himself and he's, like, old. Like, 75, but I guess he beat cancer yes which is good but yeah... He's a pretty fatigued guy though you know, it's [a] decent drive, it's like an hour and a half. (Male, 32, Regina)

Other participants described not necessarily engaging in unsafe driving but commented on the fact that it would be impossible to drive after medical treatments such as foot surgeries. In one instance, a participant had had 16 surgeries and indicated that driving after such medical procedures would be impossible. In one focus group, a health professional who was familiar with such situations explained what it is like to drive while on some medications:

> I know that people did ride [on the bus] in and out from Prince Albert every day and now that is not an option. When you are at third week of radiation, you might as well be driving to Vancouver doing that every day. If you have to drive it yourself, it is just too difficult. (FGD, IUH1[14])

Hitchhiking & Walking for Days*:* A dangerous example of individual level personal safety effects was the issue of hitchhiking or in some cases walking several days to travel between cities due to the absence of the bus. Some participants explained how the absence of a bus forced them to hitchhike and the different physical and psychological harms they had experienced

[14] The naming of focus groups is as follows: IUH refers to focus groups conducted in urban Saskatchewan, IRH (rural Saskatchewan) and INH (northern Saskatchewan). Where a number is attached it simply means 1st or 2nd focus group conducted in the specific location.

through hitchhiking or walking. One participant who was beaten up by people who picked him up when he hitchhiked recounted:

> Well, I went North and then these three guys picked me, and they beat me up. Because there's no buses, in northern Saskatchewan. They just thought I was just a bum... They punched me in the face a couple of times. That's the reality behind this, there's no buses beyond Prince Albert. For people that live up north it is dangerous. Indian [sic] women have to hitchhike. Indian [sic] men have to, First Nation men have to hitchhike. First Nation women have to hitchhike. (Male, 49, Regina)

Apart from the risk of being beaten up, others who hitchhiked described instances of unwanted sexual advances by people who pick up hitchhikers. One participant who had experienced this type of situation noted:

> I actually ran into this one person that, you know, wanted something out of it but I shut his door and I kept walking… He wanted me to do sexual activity on him… right off the hop. I just shut his door. I said no thank you, I'd rather walk. (Female, 26, Yorkton)

In other instances, participants described situations where people would walk several days to attend a hospital appointment. A participant in a Focus Group noted: “We have had people who have walked significant distances to get to [X] centre. Like, we're talking like spent majority of days walking on highways, either hitchhiking or walking to get here.” (FGD UH2)

In another focus group, references were made to clients who had hitchhiked from very long distances to be able to successfully attend medical appointments. A participant in another focus

group noted:"We had a patient actually up at four in the morning hitchhiking in from Carrot River, Saskatchewan, so he did not miss his appointment". (FGD, UH1)

One participant who had walked from Alberta to Saskatchewan and had also walked and/or hitchhiked in some cases between cities within Saskatchewan to access services said: "When they had the bus… it just made things easier. It put the distance and time lesser. Like with the bus it took, as opposed to, like, three days [of walking], it would take six hours at most". (Male, 40, Saskatoon)

In the situations described above, participants' physical health was put at risk or in danger because of the absence of safe and reliable public transportation in the province.

6.8.1.1.4 Personal Financial Costs

The final set of individual level impacts on former riders were the financial costs they had to bear due to the closure of the bus company. These varied significantly from marginal and substantial increases in travel costs to significant costs such as buying a car.

Higher Travel Costs: Although a few private transportation companies opened up after STC closure, these options are in many cases more expensive. Participants described doubling or tripling transportation costs when using current alternatives. These costs are higher, with no discounts unlike the STC. One former bus rider noted:

> I miss the bus because if I had the bus for the STC, I would be able to see my kid more 'cos [sic] it gets costly for gas, 'cos [sic] it costs like 100 bucks, something like a hundred bucks to go from Canora to Saskatoon and another hundred dollars from Saskatoon to

> Canora. That’s like $200 on transportation and that's a lot of money. (Female, 27, Saskatoon)

Some participants had been forced to buy cars because of STC closure. Four participants specifically stated that they had bought vehicles and the high cost of maintaining such vehicles became a challenge beyond the initial financial investment of buying a vehicle:

> When STC closed, like, I had to buy a car, but that’s not something that I wanted to do or something that I could really afford. And it was quite inconvenient for me because I’d rather just use the bus which was cheaper. (Male, 21, Prince Albert)

***Ancillary Costs**:* Former STC users also reported higher travel costs if they chose to be driven by others or if they had to spend longer periods in one city because of the unreliability of current travel options. Many research participants described increased spending on food, hotels and other costs. Describing how driving on his own to visit his son who lives with his ex-wife ultimately leads to hotel costs a participant noted:

> I'm paying for the car rental and on some occasions, having to go down there and spend the night, because where normally he [participant’s son] would drive down in the evening on the bus, I would drive him down. Now it's, you know, 11 o'clock at night, [do I] go on and turn around and drive back in a risk of hitting a moose or coyote or something on the highway or falling asleep at the wheel or do I want to get a hotel overnight? It's that added cost as well, you know, an extra hundred bucks just to drop off my child. (Male, 46, Saskatoon)

These costs affect the income of individuals already experiencing financial strain, as was the case especially with research participants who were on the Saskatchewan Assured Income and Disability (SAID) program. For such individuals, exorbitant travel costs might cause more psychological stress or take away income badly needed for spending in other areas of their lives. This creates complex (mutually reinforcing) relationships among individual level closure impacts.

6.8.1.2 Family Level Impacts

The second layer of STC closure impacts operates at the level of families. These may be experienced by families that relied on the bus for visiting or those whose members step in to ease the struggles of other family members who were former STC users. These impacts were varied and often more likely to be mental health and stress-related although specific economic impacts of STC closure do exist within this level.

Broken Relationships: One of the main impacts of the closure of STC on families in Saskatchewan has been through broken relationships. Many participants described being unable to visit family members at all because of the loss of the bus. One research participant in Saskatoon noted:

> We don't meet up anymore, like, we're not as close. You want to be in contact with your family no matter what ever happens, you know, if somebody dies… you know what I mean? Like, in situations like that you gotta [sic] keep in contact with your family because you don't know what’s gonna [sic] happen. (Male, 59, Saskatoon)

Participants described the emotional strain of missing out on important family events such as birthdays, funerals, weddings, thanksgivings etc. One of the participants, a grandmother who was unable to ensure that her grandchild visited the grandchild's other side of the family stated:

> For her not to be able to see her other side of the family that she really loves and adores. It's very sad and it affects her. It really does. You know, before, we could jump on the bus whenever we wanted, go down and see him on a weekend or something. Now we just can't. So, her visits will be if it's my appointment, it'll be for whatever the time it is and if it's her appointment or she has to go to hers. And then they [other grandparents] got an hour to spend with her, which isn't a lot of time spent with your child or grandchild. (Female, 61, Yorkton)

These broken relationships caused depression especially for people living far from family who may not have the ability to connect with others for support. Another participant made the connection between broken family relationships and poor mental health as follows:

> [M]y sister's in B.C. [British Columbia] She doesn't have a phone. My uncle in Nipawin doesn't have a phone. My brother who lives on another farm, he has no service out there on his cell phone, so I don't get to talk to him on the phone, ever. I know that I need to start doing a lot more self-care. I have a lot of baths, and I started reading a book on joy last night, by the Dalai Lama and Desmond Tutu, so I'm very enthused about that. So, I'm aware of where this is coming from and what I need to do. However, it's [pause] dragging yourself out of depression is a really, really hard, difficult thing to do. I feel like we've been cut off, isolated, and disconnected even more so by the bus closure. (Female, 36, Saskatoon)

Another more specific scenario of broken family relationships emerged particularly in situations of divorce where a child lives with one parent. The STC which had a program for transporting minors allowed for such children to easily be transported from one city to another. Three participants who were separated from a partner with the child in the custody of the other partner described being part of fractured families, with the absence of the bus aggravating the situation.

Family Economic Costs: In some cases, while a specific family member may bear the cost of driving an older family member, some entire families had to bear more dramatic economic costs including relocation or in some cases renting in two places (in the regular home and in another city where healthcare was being sought). One participant described how the closure has forced some families in rural communities to move: **"**I know I have lots of friends and their families have all moved in from rural areas because there is no bus anymore. You can't live in Melfort, if you can't get to a doctor's appointment in P.A. [Prince Albert]". (Female, 37, Prince Albert)

In situations where families did not completely move to a different community, they had to bear additional costs to be able to transport ill family members to medical appointments. In the case of a Regina family seeking care in Saskatoon for a young adult with cancer (but who could travel on his own for treatment if there was a bus) the mother of the child noted:

> Financially, its draining. If your child is with a critical [condition], even at some point I was discussing with my husband that if the cost of traveling remains the same and if we have to [use] a taxi it's too costly. Last time we had to use the ambulance, the cost was $1,500 so taking an ambulance is way too costly…if you don't take that option and go for the taxi, it's going to be a costly deal and if I have to take my son a couple of days a month it's preferable to have a home here [in Saskatoon] and to stay with him here rather than

traveling around. But at the same time, we have a house [in Regina], we have to pay the mortgage and paying another rent and arrangement, it's costly. (Female, Regina, 40)

Family Driving Burden/ 'Choreographed Trips': At the family level as well, a critical set of impacts is the driving burden where certain members of families are forced to drive others constantly or multiple times for the same trip, leading to stress, fatigue and difficult relationships. A complex phenomenon of 'choreographed trips' has been used as well to support family members. Family members sometimes drive former bus riders halfway so that another family member picks them up for the rest of the trip. A participant whose parents had to travel from the neighbouring province of Alberta to Regina, Saskatchewan to take her to an appointment in Saskatoon recounted:

> I had to go to Saskatoon to a testing unit to be observed there, which we don't have in Regina. And so, for that, I had to have my parents come back from Calgary, because they were away, to drive me over there and they drove me back today. You know, it's really hard on families as a whole because someone will always have to help that person. (Female, 38, Regina)

This phenomenon of doubling trips (i.e., family member driving to former bus user, taking them where they need to go, taking them back and then returning home) was reported many times. In another example, a man living in Saskatoon and without a driver's license described this driving burden on his family:

> Because they have to come and get me which is, like, from Regina it's, like, three hours and, like, three hours back. It's, like, their gas, their time and they're coming to get me. It just takes a while to do whereas taking the bus, I can just get on the bus and just ride the

> bus there and then ride the bus back. Takes a while for a ride because I don't got [sic] no family up in Saskatoon. If I had family in Saskatoon then it'd be a little different, but I don't, so… From Regina and they'd have to come get me and then take me back and back again. It takes some time. (Male, 41, Saskatoon)

The second manifestation of the family driving burden which involves the choreography of trips involves not simply one family member driving multiple times on the highway but arrangements where different family members drive part of the way. In a case involving multiple family members congregating at a central location to meet, a participant noted:

> Well, what we do now, when my sons and my grandchildren want me to go, we make a central destination, and we all go and meet there. So, it could be Fort Qu'appelle, it could be Indian Head, you know. We just all meet there, have an afternoon together and then go our separate ways. But still, it's not the same thing, you know… (Female, 66, Yorkton)

One participant described how meeting her mother in Saskatoon now involved her husband driving from Regina to Davidson where her mother meets them and picks her up to take her to Saskatoon. This choreographed trip is repeated for her to return home to Regina:

> I just make sure that [my husband is] available, and I make sure that I'm available to come up and, like, we try to work it around his schedule as well, 'cos [sic], like, he gets every second Monday off for his earned day off, so… like, if he wasn't off, then he'd bring [me] up, like maybe a Thursday night, meet my mom halfway, and then turn around and go back. And then he would come back up and meet me at Davidson again on the day that I would come home, like on a Sunday… I'd just schedule a time that we'd meet there. (Female, 34, Regina)

6.8.1.3 Community and Social Impacts

The third level of impacts is at the level of communities. Participants described structural isolation particularly of already isolated communities in rural and northern parts of the province. They also described isolation connected with losing access to services and 'key commons' perceived to be shrinking or increasingly out of reach due to STC closure thus reducing people's ability to participate in normal aspects of social life.

Isolated and Disconnected Communities: Several participants described life in rural Saskatchewan and how the absence of STC has created social isolation in communities that are already isolated. A former driver reflecting on such smaller communities and the potential for further isolation noted: "It was literally how they got around, it was how they got things, it's how they went to things. I don't know what they do now. I don't. *Their lives must be smaller*." (Male, 59, Saskatoon- emphasis ours).

This notion of life becoming 'smaller' or entire communities becoming more isolated because of the dynamics of rural life was a recurrent theme. A participant from a small community noted how the absence of STC made her life even smaller:

> I'm not a huge consumer anyways, but just seeing what's out there. Like not having a vehicle, I'm very isolated here. I think that if I was able to catch a bus, I would go out of town more often. I probably wouldn't feel as isolated. You know, come winter, it's very depressing and you feel even more isolated. We don't even have a local bus here from Creighton to Flin Flon. If I want to go anywhere, it's taxicab. So, I wouldn't feel as isolated if there were a bus running. (Female, 64, Creighton)

In these descriptions of isolation, even though individuals were those ultimately experiencing isolation, the effect has been to create isolation on the communal level and the individual experience of isolation was merely an indicator of a larger problem. In one of the focus groups a social worker who had clients from smaller communities noted the changing social fabric:

> [W]hat is culture if not community and then those disconnections between some of the smaller communities like Wadena and Kamsack. Like they're not far away but hey, without any way to get between the two of them, I'm not going to Wadena for their delicious donuts, you know, like it's not happening, and these are the wedges that are being driven in between all of these small, marginalised communities in Saskatchewan that are only getting more isolated and more isolated due to these factors. (FGD, UH1)

Another participant living close to several smaller communities described the significance of public transportation for very small communities scattered throughout the province:

> It's way more than closing down a bus company for economic reasons. It's way more than that. I think you're going to find that out. I don't know if you're looking at the smaller communities, but I'm talking about the tiny communities in Saskatchewan who have no transportation. I'm not talking about medical purposes; I'm talking about just transportation and I'm talking about little communities like two houses and the horse barn you know. Those communities like the tiny, tiny little communities where there is no more bus connection, like, I don't know how many communities were connected by STC, but I think it's over 200. (Male, 70, Prince Albert)

Shrinking Commons: There was also a perceived shrinking of the commons on the community level. Here, basic aspects of the commons that members of society had access to through the bus

system have been removed from reach creating a sense of dispossession. Two key examples used by participants to describe this were access to schools and libraries. In terms of how the STC closure affects access to education, a former student who used the bus to attend school described those he rode the bus with:

> So, most of them were students and it was, I'd say, when I say 'them', I mean about three that I know of, and it was weekly trips. [Students from] La Ronge, Melfort, rural areas. I mean, yeah, I know a couple from La Ronge and mostly from the rural areas. (Male, 21, Prince Albert)

The libraries were the second major point where participants described limitations to their access to the commons. The province's interlibrary loan system which sent and received materials using STC's freight services, was praised by many for its innovativeness. This system has been seriously affected by the closure of STC. Participants in small areas no longer have access to books, DVDs etc. from other libraries. One participant, a former academic, explained:

> I was depending on these two cities when I moved here to learn and the libraries at the universities, I knew I could get a card. I feel like that's closed to me now, also did I mention the libraries? It used to be, say, I like this book and it could be anywhere in Saskatchewan and the books would come to the library. They were all couriered through the Saskatchewan bus service, now many libraries don't even circulate the books out because they can't afford to pay for the transportation. So, my reading is more curtailed now; I have to buy more books if I want to read so I think, educationally it has affected the circulation of books, so to speak. (Female, 78, Moose Jaw)

The closure of STC therefore prevents access and in some cases rights to access services such as those described above. A participant reflecting on this phenomenon noted aptly:

> It was a special thing around education and around access to reading and to materials that the provincial library system handles and was delivering through STC, you had this basically a weekly thing, they could go central library to library without having a car or anything. Maybe you had to ride a little ways or whatever to your little regional library system and say, I've heard about this book, I want to read it, or I want to have it on tape, or I want to do something; bingo!…It is the destruction of key commons in this province and the commons are those equity of services that without, you simply just make it harsher for those - is it 15% is it 20, I don't know- but it makes it very harsh, very miserable, and in fact endangering their lives; shortening them for sure, but mainly endanger. (Male, 72, Prince Albert)

Reduced Participation in Social and Cultural Life: STC closure also limits people's ability to participate in social and cultural life. While an individual's inability to travel is often manifested as a reduced social life, participants described a larger sense of dispossession where people living in small areas were unable to attend concerts, go to the museum or art galleries. These activities which essentially punctuate life in small-town Saskatchewan ultimately have a psychosocial effect on people in smaller areas. In one case a participant living in a small town who had been unable to access art galleries which she always enjoyed described STC's value in ensuring such access in the past:

> I would, say, catch the bus to Regina and maybe grab a coffee and go to Wascana Park or go to Chapters Bookstore or maybe the Mackenzie Art Gallery or, one of those things and

then meet a friend and have a meal perhaps or go to a movie or something like that. We'd enjoy some time together, maybe stay overnight and come back the next day on the bus or maybe even stay two or three days and then come back on the bus; but something like that. I mean it doesn't sound like much until you don't have it. (Female, 55, Moose Jaw)

A grandmother struggling to find more exciting things to do with her granddaughter similarly described small-town life and the important role of the bus in providing access to recreation and cultural life:

> We don't have very many things here to visit. We have the museum and the art gallery and stuff not a lot. If I want to take her [granddaughter] to the Science Centre or the zoo or to anything or even just get out of here. Sometimes you just have to get out of here, you know, to go somewhere else. It's very hard…you can only go to a park so many times before a town[sic] gets tired of it. Children love parks, but they do get bored with them after a while. (Female, 61, Yorkton)

6.8.1.4 Macrosocial Impacts

Environment: At the macro level, STC closure has significant environmental implications. A number of participants described being forced to buy cars; this affects their environmental values and is detrimental to human health on a large scale. On the question of values one participant noted:

> Well, whenever I look at my car or think about my car, I'm not happy about it. Every day I would like to sell my car and, like, not have it anymore, just not worry about it. I would have more peace of mind if I didn't have to have that burden. I mean, most people won't understand because a car is, you know, seen as a necessary part of life and everything, but I

> like to try to live my life, like, differently. And, then when all of a sudden, I'm forced to conform to something that I didn't want to, it's a little bit frustrating, it's quite demoralising… there's no getting around to it. I have to live this way. [Being forced to buy a car] It's like if a vegetarian was forced to eat meat. (Male, 21, Prince Albert)

Another participant describing the vehicles on the road including the vehicles her family members use to pick her up noted:

> Their vehicles are farm vehicles. They're gas guzzlers – whereas [with] the bus you could get many people on the bus. So, where's the environmental saving in them having to come and get me versus me hopping on a bus, that, as I said, was never put in place to make money as a passenger service, ever. (Female, 66, Saskatoon)

Health System: A second major way in which the closure of STC affects people (whether former bus users or not) on a macro level is how it has affected the health system and people working within it or seeking care. Three major themes describe health system impacts: inefficiencies, disruptions of the care process and stress on staff.

***Structural Inefficiency, Delays and Wastage*:** The first major way closure has affected the health system has been through the creation of large-scale inefficiencies and in some cases wastages. Several examples of inefficiencies were referenced by focus group participants such as increasing wait times, long wait lists for patients and overcrowding at cancer lodges where patients wait for treatment. In one focus group, the question of wait times as it relates to blood transfusion processes were described as follows:

> Particularly for blood matching, cross transfusion and things like that, this adds to wait time for patients for their care. So, we have some people waiting for transplant. We have some people waiting for operations where they're waiting on this material or they're waiting to confirm crossmatch. And so, their wait time increases because we're sitting and waiting on some of this. (FGD, IUH1)

A similar example of inefficiency was described by healthcare workers on how the absence of the bus has forced caregivers to live with patients in the city and in some cases use up health resources:

> Most of the time we can accommodate up to 30 people, but what's happened is, now that people don't have the option of their loved one putting them on a bus in Meadow Lake, loved one has to drive them from Meadow Lake. If you're hot on the pedal that's a four hour trip this time of year [winter], that person is going to stay overnight. It's hard for anyone to do an eight-hour round trip in the middle of winter. So now not only are my beds filled with patients, they're filled with companions who are driving people. (FGD, IUH1)

Inefficiencies have also occurred where medication has had to be thrown away or blood being expired because private couriers do not bring blood or medication on a regular schedule as was the case with the STC. As one of the healthcare workers noted:

> Now we're having to rely on private courier services. Medications showing up - it's frozen; we can't use it. Or in the summer it's too hot, we can't use it. We're throwing out thousands of dollars of medication. We never know when medication is showing up and sometimes when we are relying on medications to come, it's really hard to tell someone who has cancer that you can't have your treatment today because your medication hasn't showed up

> on time. Whereas we had an agreement with STC and our bus depot here that when the medication came from Regina and arrived at six o'clock, they just automatically put it in a taxi service to the hospital at 7:30 in the morning. (FGD, IRH)

These inefficiencies lead to significant extra costs sometimes borne by the government through different departments. Since the healthcare budget is about two-thirds of the entire provincial budget and the government had implemented policies like LEAN to increase efficiency (beginning in 2012), the closure of STC in one sector (transportation) to reduce costs has ended up increasing costs in other sectors such as healthcare. In this sense even the government has become a victim of its own decisions. One participant noted:

> I am in direct control of the budget for the patient lodge. It is fully subsidised by the [health organisation], and that's the provincial government. The amount the patients pay does not come close to the cost of operating the lodge. We're staffed 24 hours a day. We provide meals, we provide clean linen and we keep the lights on. We keep the heat up. So, if we go from an 80% occupancy rate, which would be about normal over the course of the year to 100%, the cost to the government are [sic] increased. I now have 20% more people taking showers; that's hot water and using the electricity and I'm feeding 20% more people. (FGD, IUH1)

The idea that closing STC has only served to increase operational costs in other government departments came up many times. Examples included increased costs of medical taxis as more people use them instead of STC and increased costs to Canadian Blood Services which previously used the STC to transport blood to health facilities.

***Disruptions in Planning and the Care Process*:** At the macro level, the STC closure has created an atmosphere of uncertainty within the health system in terms of care delivery. This atmosphere leads to delays in clinical decision making on the one hand and increases in patients showing up with emergencies on the other because of delayed care-seeking. One health worker in a rural setting explained:

> There's emails every single day at work, looking for somebody going to Regina to take a package. I mean, it's every single day, not just our department, but every department are [sic] always looking for rides for packages, or for medications or medical devices, what have you, because we just can't rely on the courier service all the time. And it doesn't run the same. It's not seven days a week like STC was and not on a fixed schedule either, with certain dedicated stops. (FGD, IRH)

The challenges with prompt clinical decision making were also described in similar terms as shown below:

> So, I'd be really interested to know how much of the health budget has been dedicated to private courier services since this all, because… I mean, we can't even send lab work to Regina on a Saturday. It sits in our lab department until Monday morning. How are you supposed to make a clinical decision on somebody's healthcare when you can't get your lab results in five days? Like, it's just absolutely ridiculous. (FGD IRH)

In other cases, the absence of the bus was described as affecting how patients move through the healthcare system, with a number of examples emerging of patients stranded in bigger cities after receiving healthcare services. One northern health worker noted:

> I know a client that's been stranded in Saskatoon, when I worked on [X] First Nation, they've been discharged from the hospital, they don't have access to STC, now they're stuck in the city, they might have arrived the next day. Now the travel coordinator at the band level [Indigenous government] has to try and find a room for this person and get taxi service for them to get from point A to a hotel and back. Maybe the taxi can come the next day, maybe it's not running until the day after. I know there's been situations like that... (FGD, INH)

Staff Stress and Strain: The final issue discussed by participants regarding the health system was stress among health workers. On a health system level, the closure has created stresses on workers in health services as they try to mitigate the negative impacts of the absence of reliable public transportation on clients and patients. One social worker in a focus group described how: "[p]ersonally, for me as an employee doing my work that's a stressor, to try and figure out solutions that may not exist and put that onto my clients". (FGD, IUH1)

The stress faced by health workers and other staff in social services has been exacerbated by the fact that in many cases, organisations in the health system have had to reorganise service delivery with no increased capacity. One health worker noted:

> So, in terms of technologist and support staff, time and effort to develop all of the schedules in terms of how blood was going to get out, how samples were going to get in, had been over and above their already full-time jobs and something that just had to get done. We had no extra money to hire additional staff to support these logistical gymnastics exercise. Canadian Blood Services has logistic staff. They do have supports internally to manage that kind of thing. So, if [information about] the STC closure would've come a

> year in advance at least Canadian Blood Services would have established all those things [and] the government would have seen what the cost impact would have been in terms of logistics and transportation. (IUH, FGD1)

Social Services and Related Organisations: The impacts of closure on social services, community-based organisations and others not technically part of the health system have been similar to the health system impacts. Staff from such organisations are affected by STC closure through stress and increased costs. These organisations have also witnessed a large scale shifting of costs to them which they in turn shift to staff (by demanding more time or increasing stress on staff), clients, or in some cases to other organisations such as the federal government. An example of costs being shifted all the way back to the federal government via Indigenous organisations is described below:

> Another systemic effect is for our people that are covered by First Nations and Inuit Health Non-Insured Health Benefits. So normally our government will look to those First Nation communities to provide transport via their bands, through a medical taxi, so arrange their own transportation. However, sometimes that transportation can be unreliable or is not consistently every day or they don't actually have a means, or they only have one or two drivers and they're out of the community or something like that. When the band medical taxi is not an option, then First Nation and Inuit Health has to pick up that bill for transportation. So, I have seen some circumstances where they have demonstrated that there is no medical taxi option that day or so on, a person has to come in for their treatment or consultation or so on. And so, First Nation and Inuit Health pays for a taxi for that individual from their very northern community or transportation there and back. So, a taxi,

> that's a very costly means of transportation. And when you think that that's not one individual that's, you know, often multiple individuals, so how much is that costing the [Federal] government for that? (FGD, IUH1)

This issue came up multiple times, with most participants in focus groups expressing frustrations about the fact that although the closure of STC was aimed at reducing the province's budget deficit, current alternatives for transporting vulnerable people simply cause workers extra stress, save no money and lead to higher expenditure in social services. While such increased costs may not necessarily affect the provincial government as some are federal government costs, they remain inefficiencies. One participant in another focus group noted:

> So, I heard just the other day, social services is paying people to take a taxi to Regina and back or paying a taxi service to transport those people to a doctor's appointment within Regina. Again, you know, like [X] said, it's not saving any money. It's just transferring it from one budget pot into another. And it's the most vulnerable people [who are the most affected]. (FGD, IRH)

On a macro scale, the closure of STC potentially affects the environment and has created several challenges in the health and social services systems with important impacts and implications for the health of individuals who are not necessarily former bus riders. Figure 6.6 summarises STC closure impacts based on the *web of dispossession*.

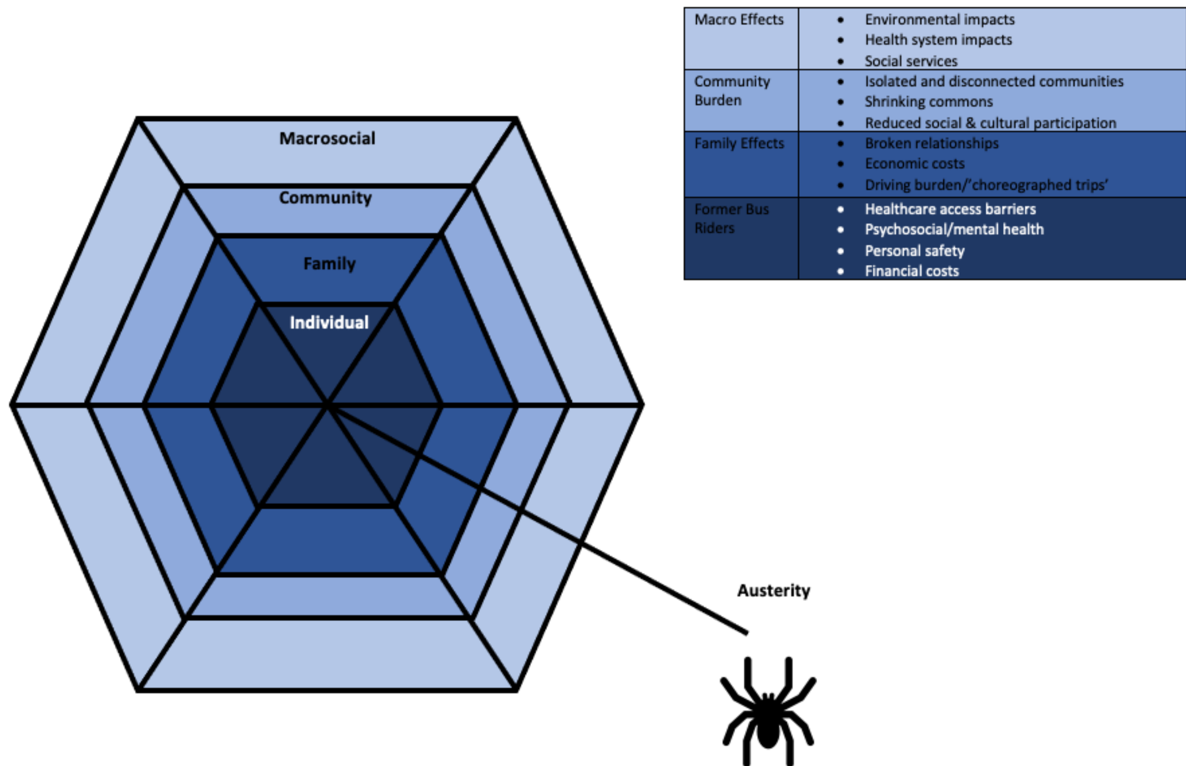

Figure 6.6 The *Web of Dispossession* and Summary of STC Closure Impacts. Source: Authors

6.9 Discussion

This study set out to explore the impacts of austerity on health using a transportation case study (the closure of the STC). The evidence suggests that the closure has created a complex and interrelated set of impacts on multiple levels. Like some of the previous literature on austerity and health, we find that the closure of STC has had many negative impacts on the health of individuals and communities in Saskatchewan (and possibly beyond through environmental impacts). The study contributes to mounting global evidence (Bambra, 2011b; Schrecker & Bambra, 2015; Stuckler & Basu, 2013) on the negative health impacts of austerity. We show that transportation is another important social determinant through which government austerity affects population health.

Although research on the relationship between transportation and health outcomes is well established, our study suggests some methodological changes for better exploring the nexus of transportation and health. First, the evidence shows that although human travel is a critical avenue for understanding the transportation-health nexus, the transportation of medical products can be another important avenue through which transportation affects population health outcomes. Second, the *web of dispossession* can be a useful analytical tool for better understanding the health impacts of cuts to public transportation. It demands that interrogations of the impacts of austerity move beyond individual former users of public services who are often the focus of negative moral judgements and the rhetoric of 'scroungers' (Garthwaite & Bambra, 2017), to a discourse that shows how the whole of society is negatively affected by austerity decisions.

Some literature exists on dispossession as an inherent dynamic of neoliberal capitalism and the role of the state in facilitating market encroachement on the commons (Gillespie, 2016). The expansion of markets and narrowing of commons, partly through 'extra economic force', has occurred in the Canadian context historically through a racialised and gendered colonialism that dispossessed Indigenous populations of land and other resources (Starblanket & Coburn, 2020) and contemporarily through privatisation and or public private partnerhsips that involve greater market dominance (Whiteside, 2012). Without obviating these important findings, we argue the need to think of dispossession as a web, a nuanced way of exploring the effects of austerity because it highlights impacts that are not apparent when such decisions are being considered. Our examinations of the impacts of austerity show not only individual level impacts but also distal impacts such as those on families, communities and systems not directly connected to public services who are caught up in the *web of dispossession*. Indeed, a response to

Krieger (1994) who posed an important social epidemiological question, "Has anyone seen the spider?" becomes, "Yes, the spider is politics (in the present case austerity) and we are all caught up in its web".

Most of our findings on individual level impacts of loss of public transportation concur with existing literature on transportation as a social determinant of health (McCarthy, 2006). The many access challenges described by participants have been reported in previous literature showing that lack of access to public transportation reduces healthcare access (Syed et al,2013). Our findings however highlight several intermediate steps that precede reduced access such as the calculus that ultimately leads people to 'refuse to seek treatment' which may translate into missed hospital appointments. This calculus and the associated psychological stress can easily be missed if the metric of missed appointments is the sole focus for understanding the transportation and healthcare access nexus.

At the individual level as well, we found several safety issues previously recorded in the literature such as increased risk of motor vehicle injuries due to lack of access to public transportation (Beck et al., 2007). We find beyond this several disturbing examples of hitchhiking, walking for days and the possibility of physical attacks while hitchhiking especially among vulnerable people, a phenomenon not widely reported in the transportation and safety literature. Lack of access to safe and reliable public transportation also comes with mental health impacts such as feelings of depression which have been recorded more recently (Litman, 2020; Reinhard et al., 2018). These studies have often been based in urban settings and we demonstrate here rural manifestations of the mental health impacts of lack of access to public transportation on individuals and families.

A series of family-level impacts are also noted. Evidence from our study highlights, for instance, the extant evidence that individuals often feel emotionally impacted when they have to repeatedly ask others to drive them to places (Christie et al., 2017). These feelings of emotional stress do not end with individuals and sometimes affect family members of those who need rides to attend appointments or participate in social activities. Depending on the context, emotional distress may be felt by others in the family who may be forced to bear a heavy driving burden as a result of the lack of access to reliable public transportation. In this sense, austerity and its effects start to move beyond individual public service users to their family members.

At the level of communities, we find closure impacts including increased social isolation and exclusion as well as decreased access to key commons. Church et al. (2000) have shown how isolation operates and advocate for a broad conceptualisation of transportation-related social exclusion to include factors such as economic, geographic and physical isolation which reduce access to services and facilities on a community-wide scale. Transportation-related exclusion commonly affects low-income individuals and other vulnerable populations and serves to peripheralise the most marginalised members of society (Lucas, 2012). This has important implications for health and health equity. The presence of reliable, affordable and accessible public transportation reduces exclusion and promotes health equity by connecting communities to resources necessary for health and wellbeing.

Transportation-related austerity affects health beyond individuals, families and communities through the disruption of systems important for individual and population health. The expansive view of the health impacts of austerity through *the web of dispossession* shows transportation-health connections on a health system level not traditionally explored in the extant

literature. In the case of Saskatchewan, the deep connections between the STC and the health system have led to significant and disruptive impacts of austerity on the entire system. The STC regularly transported vaccines, medical equipment, blood products and other forms of medical freight for the health regions (Saskatchewan Transportation Company, 2010). The loss of the bus has served to create inefficiencies, revealing the illogic of austerity not only because of its human costs (Stuckler & Basu, 2013) but clear financial costs attributable to new inefficiencies. Our findings show that transportation might affect people's health not simply because they cannot get to hospital appointments but also because the entire health system may be disrupted, leading to delays, inefficiencies and disruptions of the care process. This again shows that the impacts of austerity move beyond primary targets of austerity decisions.

Transportation-related austerity might also affect health through climate change. Some of the literature on ecological political economy in Canada has highlighted that "capitalism is inherently ecohostile" by exploring how it depletes the environment through resource extraction (Carter, 2020, p. 107). Our findings highlight other, more complex pathways from neoliberal economic policy to environmental destruction. Although mining and oil extractivism do affect the environment, bus closures do, too, but in more subtle ways that essentially involve forcing people to buy cars. This invented car-centricity benefits oil companies and the owners of capital (Altvater, 2007; Dellheim, 2018) and the associated pollution and environmental destruction disproportionately affect the poor and racialised communities (Kennedy, 2004). The fact that 4% of research participants in the present study reported that they were forced to buy a vehicle is noteworthy. Although the study was not quantitative and cannot extrapolate on the proportion of former STC users in Saskatchewan who have bought private vehicles due to the closure of STC, it is likely that more people have likely been forced to do so. This has significant implications for

human health in Saskatchewan and elsewhere. Recent evidence on the interrelationships among transportation, climate change and population health reveal that approaches to transportation policy that prioritise forms of active transportation including the use of public transportation options and buses can play a dual role of simultaneously reducing greenhouse gas emissions and improving population health (Woodcock et al., 2009).

Through a careful examination of the health and other impacts of the closure of the STC – an austerity decision – we contribute to growing global evidence on 'why austerity kills' (Stuckler & Basu, 2013). This requires attention not only to the politics of austerity but to a new public policy paradigm guided for instance by a Health in All Policies (HiAP) approach so that proposed public policies such as the decision to cut STC go through a rigorous analysis of health implications (World Health Organisation, 2013). Our study shows that austerity's health impacts are often complex and interconnected moving well beyond primary former users of public services such as buses as in the case of STC, to distal impacts that are easily obscured. This necessitates a *web of dispossession* to catalogue and bear witness to austerity's impacts beyond the obvious and anticipated individual impacts to socially disruptive impacts that create inefficiencies and disconnection and serve to normalise and routinise marginalisation.

6.10 Conclusion

The closure of the STC has had many negative impacts on people's health and social and health systems. These impacts operate on multiple levels often starting from the individual where closure impacts are most visible and moving further up to various systems with decreasing visibility. There is a *web of dispossession* such that while the STC bus was seen as taken away

from former bus users, a series of negative unintended consequences has followed with critical implications for health in Saskatchewan and elsewhere**.**

CHAPTER 7: "FOR A PERSON WITH A DISABILITY AND A PERSON WITH DISABILITY WHO IS ALSO POOR…": TRANSPORTATION AND HEALTH EQUITY, AN INTERSECTIONALITY PERSPECTIVE (MANUSCRIPT III)

7.1 Background

May 2017 saw one of the most dramatic changes in transportation policy in the Canadian province of Saskatchewan when the Saskatchewan Transportation Company (STC), a bus service established in 1946, was shut down as part of the March 2017 austerity budget. The closure was aimed at saving $85 million over a five year period (Stansfield, 2017). Beyond the financial explanations, the government used several contextual logics suggesting the non-utility of public transportation such as falling ridership and the exhaustion of all attempts to keep the company viable through public subsidies (Johnson, 2017). Initial concerns raised by citizens about possible negative effects of the closure were met by the former STC minister's unsympathetic recommendation that former users could simply "ask family or friends for a ride" (Johnson, 2017).

Despite these official explanations and rationalisations, many voices of resistance opposed the government's decision and have raised concerns about the possibility of negative consequences of the decision on the wellbeing of people in Saskatchewan. The company served over 250 communities at the time of closure, carried medical products and served over 200,000 passengers per year. Opponents have expressed concern that the closure of the company might have negative impacts on vulnerable former users in particular (Lee & Spilett, 2017; Mattern, 2017).

This manuscript is the third of three manuscripts examining the politics, health impacts and health equity implications of the closure of STC. Drawing on focus group

discussions with stakeholders, media sources and Legislative Assembly Hansards, the first paper revealed that the closure of STC was driven by a neoliberal economic and ideological policy paradigm by exploring the neoliberal austerity discourses that were used to justify the STC closure. The second manuscript catalogued interrelated social and health impacts of the closure of STC on people by means of a *web of dispossession* that highlighted closure effects beyond individual former bus users. This third manuscript moves beyond politics and health impacts to inequities in these impacts on individuals and communities. It focuses on the ways in which people's social and geographical locations combined with underlying social disadvantages structure their vulnerability. It further explores how combinations of existing dimensions of vulnerability may exacerbate the negative impacts of the closure. We begin by exploring the concept of health equity as it relates to transportation access and then provide brief contextual descriptions on axes of marginalisation in Saskatchewan and Canada.

Guided by intersectionality theory, we draw on primary qualitative research data to contribute to the emerging evidence base on the health equity implications of the closure of STC. Drawing on the inter-categorial approach to intersectionality proposed by McCall (2005), we explore equity through three levels of increasing complexity. At the first level, we explore exacerbated vulnerabilities of specific groups focusing on one axis of marginalisation, followed by a second level that combines emerging intersections of two or more axes of marginalisation and a third level that embraces the complexity of intersectionality through lived experience. These demonstrate the inequitable impacts of STC closure on marginalised communities in Saskatchewan.

7.2 Health Equity and Transportation Access

Although the terms are sometimes used interchangeably, health inequalities are not the same as health inequities. Health inequalities refer to differences in health outcomes by social groupings (Bartley, 2016). These differences may exist by age, gender (Hankivsky & Christoffersen, 2008; Springer et al., 2012), sex (Payne, 2006), sexuality (Krieger, 2003), race (Goodman et al., 2017), geographical location (Bambra, 2016) and a vast array of others. Several theories have been proffered to explain health differences ranging from individual biological factors and behaviours (Mackenbach, 2012) to social and structural determinants (Bambra, 2016; Bartley, 2016). These inequalities are considered inequities if they are deemed unjust and unfair (Braveman & Gruskin, 2003). Health equity is therefore a normative conceptualisation of health differences anchored in a human rights approach that prioritises principles of social justice. In an expansive review of definitions of health equity and their limitations, Braveman (2006) suggests the following definition of health inequities:

> [A] particular type of difference in health or in the most important influences on health that could potentially be shaped by policies; it is a difference in which disadvantaged social groups (such as the poor, racial/ethnic minorities, women, or other groups that have persistently experienced social disadvantage or discrimination) systematically experience worse health or greater health risks than more advantaged groups. (p. 180)

This definition highlights several issues including the point that health inequities are not natural and that influences at the policy level may shape or predispose specific population groups to a higher risk of vulnerability to poor health or health disadvantage. Understanding

vulnerability is therefore critical for understanding how and why policy interventions exacerbate health inequities.

A long tradition of literature has interrogated the problem of health inequities and made suggestions on how they can be tackled. Lalonde's Health Field concept identified four major determinants (human biology, social and physical environments, the organisation of healthcare and lifestyles) for explaining health differences (Lalonde, 1974). This approach advocated for targeting 'high risk populations' to reduce health inequities but was later critiqued for its victim-blaming tendencies. Geoffrey Rose contributed to this debate by demonstrating that population-level interventions (rather than Lalonde's 'high-risk' approach) were necessary if population incidence of a health outcome is to be reduced. Rose showed that because the causes of cases of a health outcome are different from the causes of its incidence, interventions that target 'at risk populations' may not necessarily shape the distribution of risk in society, leading to his proposal of population health approaches that target the whole of society (Rose, 1985). While this approach has been influential, more recent critiques have argued that the population health approach can sometimes increase health inequities, requiring as a complement attention to 'vulnerable populations'. A population is defined as vulnerable if it constitutes "a subgroup or subpopulation who, because of shared social characteristics… [or] who, because of their position in the social strata, are commonly exposed to contextual conditions that distinguish them from the rest of the population, [placing them] at higher risk of risks" (Frohlich & Potvin, 2008, p. 218).

Although much of the foregoing discussion specifically refers to interventions that may be aimed at improving health outcomes, any interventions or policies that affect key social

determinants of health (positively or negatively) are also implicated in unfairly and unjustly marginalising vulnerable members of society. In the sections that follow, we bring a vulnerable populations perspective to the transportation and health literature before focusing on Saskatchewan and Canada to describe different extant vulnerabilities articulated through intersectional locations of oppression. Understanding these existing vulnerabilities is critical for conceptualising and demonstrating the health equity implications of the closure of STC.

Evidence on transportation access suggests that those most vulnerable to negative impacts of lack of transportation are low-income persons, the unemployed, welfare beneficiaries, youth/children, women, the elderly, people living with disabilities, outer urban dwellers and ethnic minorities (Dodson et al., 2004). When comparing transportation barriers to healthcare access, for example, Syed and colleagues (2013) have shown that racial minorities (compared to Whites in the USA), rural (compared to urban dwellers) and special population groups such as the elderly and veterans (compared to the general population) face extra barriers to accessing health services.

Additionally, research on motor vehicle injuries shows differences in outcomes for women and ethnic minorities compared to other segments of the population. In the USA, for example, Native Americans have an elevated risk of mortality from motor vehicle injuries due to factors such as rural residence and alcohol-related crashes (Campos-Outcalt et al., 2003). In terms of gender, men are more likely to experience road traffic injuries due to impatience while driving (Al-Balbissi, 2003) however women report greater barriers to accessing transportation due to fear of crime (Loukaitou-Sideris & Fink, 2009).

This evidence from the transportation literature suggests that explorations of the transportation-health nexus are incomplete and potentially miss the mark if not accompanied by an equity analysis, or reinterpretation of such connections through an equity lens. Additionally, as will be shown later, to understand the impact of transportation-related policy decisions, it is necessary to explore intersections of marginalisation that combine to increase the vulnerability of already marginalised population groups, since people often simultaneously embody different identities that shape their vulnerability.

7.3 Health Equity and the Saskatchewan Context

In Saskatchewan, many contextual factors were at play before the closure of STC that placed some segments of the population at greater risk of poor health or health determining factors than others. Some of the most relevant axes of marginalisation are briefly explored.

Saskatchewan is one of the least population-dense provinces in Canada (Statistics Canada, 2011). Because of the sparse distribution of the population, people in rural and northern locations generally have reduced access to services. In terms of healthcare access, for example, an estimated 23% of people in rural Saskatchewan have reported challenges accessing specialist care (Karunanayake et al., 2015). Northern and remote parts of the province have also been historically vulnerable due to lack of access to services including healthcare. Geography is therefore a critical factor in understanding health equity implications of the STC closure.

Canada's colonial history has meant that Indigenous communities are among the most marginalised communities in the country. One of the most brutal aspects of settler colonialism in Canada is the geographic marginalisation of Indigenous populations, historically forced to live on reserves (Daschuk, 2013). Colonialism involved theft of Indigenous land and disruption of

Indigenous social structures (Starblanket & Coburn, 2020). Recent evidence on social policy making in Saskatchewan also reveals that despite rhetoric on reconciliation, governments routinely fail to consult in a meaningful way with Indigenous communities on social policy issues (Beatty, 2011). In contemporary Canadian society, Indigenous peoples often face racism in trying to access services including healthcare (Allan & Smylie, 2015; Goodman et al., 2017). In Saskatchewan, which has one of the highest proportions of Indigenous populations in the country, Indigenous peoples are overrepresented in the distribution of poverty and have lower average family incomes (Gingrich, 2009). They are also more vulnerable to the economic effects of recessions (Lamb, 2015) and can therefore be expected to bear a heavier burden of government austerity policies such as the STC closure.

Another important axis of marginalisation in Saskatchewan relates to age. According to extant research on the wellbeing of seniors, especially those living in rural Saskatchewan, many people lack access to healthcare services and face challenges with accessing social supports as they grow older. Prior to the STC closure, Jeffery et al. (2011) noted that seniors in rural Saskatchewan faced a range of challenges including lack of access to transportation. About 75% of former STC users were low-income seniors and this demonstrates that the bus was especially important for them (Legislative Assembly of Saskatchewan, 2017). Although little research exists on vulnerabilities of young people in Saskatchewan, research on poverty shows that child poverty (for those under 18) is higher than the national average, and is the third highest in the country at 26.2%, placing it only behind Manitoba (27.9%) and Nunavut (31.2%) (Hunter & Sanchez, 2020). This means that young people are also vulnerable and may have difficulties accessing services especially in the absence of reliable transportation.

Disability increases vulnerability in Saskatchewan and elsewhere. The prevalence of disabilities among those aged fifteen years or older in 2012 was higher in Saskatchewan (15%) than the national average (13.7%) (Statistics Canada, 2017a). In Saskatchewan, programs such as the Saskatchewan Assured Income and Disability (SAID) program exist to provide some financial support for people with disabilities. That notwithstanding, people with disabilities and those on such programs are particularly precarious and often the targets of government austerity. Recent reports indicate that people with disabilities may have to use extreme measures (for example, divorcing a partner) to continue to meet eligibility requirements for accessing program funds (Bridges, 2019; Fraser, 2016). In the case of STC, the bus service accommodated the needs of people with disabilities (Saskatchewan Transportation Company, 2010) and this combined with the other factors described suggests that disability is an important axis of vulnerability when there are cuts to public services.

Gender is an essential category for understanding oppression and how societies reproduce themselves (Bakker, 1989). In health research, gender is an important axis of marginalisation for many social determinants of health (Krieger, 2003). In Saskatchewan, women are another segment who face several vulnerabilities including the risk of intimate partner violence. A recent survey of 437 women in Saskatchewan found that 45.3% of women had experienced some form of intimate partner violence (Giesbrecht, 2020). Women are also more likely to live in poverty, earn lower wages than men, and routinely provide labour for which they are not compensated (Fox & Moyser, 2018; Fraser, 2017). These factors, combined with the fact that majority of former STC users were women (Saskatchewan Transportation Company, 2017) are important for understanding why women may become more vulnerable due to the closure of STC.

The final relevant axis of marginalisation worth exploring in the Saskatchewan context relates to low income and poverty. As indicated above regarding child poverty, Saskatchewan also has higher rates of family poverty which predisposes families and their members to disadvantages including challenges in accessing services. Table 7.1 summarises the axes of vulnerability that are important for understanding the health equity implications of the closure of STC.

Table 7.1: Summary of Vulnerable Population Groups in Saskatchewan

Axes of vulnerability	Saskatchewan Context and Existing Vulnerabilities
Geography	Given the low population density and existing access barriers, people in rural and northern communities often do not have equal access to services compared to those in bigger centres. Northern communities are often remote, lack services and have higher proportions of Indigenous peoples who are already socially disadvantaged.
Ethnicity	Indigenous populations in Canada have historically been subjected to forms of marginalisation and face challenges accessing services. They may face mistreatment for being Indigenous and experience higher rates of poverty, unemployment and health access barriers.
Ability	People with disabilities are vulnerable for many reasons. They may have limited incomes because they cannot work and may need more support to participate fully in society. They are also vulnerable because they cannot use all means of transportation (the options must be accessible). Additionally, they often need social and economic support to live dignified lives. Saskatchewan has a high proportion of people living with disabilities compared to elsewhere in Canada.

Gender	Women face many forms of social and economic marginalisation. In particular, Saskatchewan has high levels of intimate partner violence which makes access to transportation essential for economic and social participation as well as the ability to flee dangerous situations.
Age	Age is an important source of vulnerability. In Saskatchewan, many seniors, especially those living in rural and northern locations, lack access to services and social support. Children and young adults are also more vulnerable because of the high child poverty rates and legal restrictions to driving.
Socioeconomic class	Low income and poverty are associated with forms of travel-related vulnerability. People with low incomes rely on public transportation options to access services and may not be able to afford other modes of travel such as the use of a personal car.

Source: Authors

Informed by the notion of 'vulnerable populations' from the literature on health equity and transportation access, we now draw on intersectionality theory to understand the complexities of intersecting marginalisation based on social and geographical locations.

7.4 Intersectionality Theory

Kimberlé Crenshaw, an African-American legal scholar and feminist researcher, coined the term 'intersectionality' because of the inadequacy of race or gender alone in describing experiences of discrimination faced by African-American women (Denis, 2008; McCall, 2005). This theoretical perspective, which is often employed by feminists and anti-racist researchers (Nash, 2008), has contributed to robust analyses in a number of fields including sociology and health research (Denis, 2008; Springer et al., 2012).

Intersectionality explores how the intersection of marginalised social locations may interact to exacerbate existing social disadvantage. This approach to understanding social and health inequities posits that because people belong to different social groups (based on gender, class, ability etc.) and belonging to each socially disadvantaged group can negatively affect one's life chances, those who simultaneously belong to different axes of disadvantage may be doubly (triply, or even more) oppressed in a fashion that is syndemic, or greater than the sum of the parts (Crenshaw et al., 1995; Veenstra, 2011). These intersections of social disadvantage often exist within the context of structural issues like poverty, disease, war or other ongoing traumas (Singer et al., 2017; Wyatt et al., 2013). All of these underlying issues demand that explorations of health inequities move beyond individual identities and additive approaches to embrace the complex reality of people's lives to understand how inequities are created and reinforced.

Intersectionality analysis provides a nuanced and critical approach to the exploration of social disadvantages and existing marginalisation related to health by highlighting critical intersections (Gkiouleka et al., 2018). Through this perspective, exploring how a policy affects health equity moves from simply comparing effects on men and women, for example, to reflecting on how Indigenous women and/or men, rural women living with disabilities, etc. experience inequitable policy impacts. An intersectionality analysis is marked not simply by summing up identity categories but 'centring the margins', paying attention to the nuances of social disadvantage and exploring the lived experiences of those facing marginalisation (Rodriguez, 2018).

7.5 Methodology

The analysis reported here is part of a larger qualitative study employing case study methodology (Creswell, 2013). Case study methodology is one of the five main methodologies (others are phenomenology, narrative inquiry, grounded theory and ethnography) used in the conduct of qualitative research (Creswell, 2013). Several key features have come to typify the case study approach such as defining the case, intensively studying it, drawing on multiple data sources and considering the context of the case (Flyvbjerg, 2011; Sandelowski, 2011; Yin, 1994).

The closure of STC is the case under exploration and is studied in relation to the broader social and political context of budget cuts and government austerity. This is referred to as an instrumental case study where the case (STC closure) is studied not for its own sake but is used as an instantiation for understanding something bigger (in this case, government austerity and its health consequences) (Stake, 2000). The analysis involved document reviews (of 47 days of Parliamentary Hansards and over 750 newspaper articles), one hundred in-depth interviews with former STC users (including former bus riders, people who used the bus to post personal and professional packages and former drivers) and six focus group discussions with stakeholders. The analysis reported here draws on interview and focus group data only. The study received research ethics approval from the University of Saskatchewan Research Ethics Board (BEH 1219) as well as the Saskatchewan Health Authority (file number OA-UofS-1219).

7.5.1 Qualitative Interviews

This manuscript draws on one hundred in-depth interviews conducted with former STC users between July 2019 and March 2020. A semi-structured interview guide containing questions on how the closure of STC had affected former users was administered to participants across

villages, towns and cities in rural, northern and urban Saskatchewan. Interviews lasted between 30 and 90 minutes and included questions on participant demographics, purposes for which participants used the bus, major ways participants felt the absence of public transportation affects them and invitations to reflect on what the bus meant to them as well as stories that illustrate how lack of transportation affects participants and people they know. At the end of each interview, participants were given a $25 gift card as an honorarium. The research interviews allowed for an in-depth understanding of the lived experiences of people affected by the closure and their perspectives on how the absence of the bus marginalises them (Merriam, 1998).

7.5.2 Focus Group Discussions

Six focus group discussions (FGDs), each lasting between thirty minutes and two hours were conducted. Focus groups (participants ranged from two to seven in each group and totaled 24) were organised with stakeholders to understand the effects of the closure of STC on service delivery and clients seeking services. The first four discussions involved stakeholders from the health sector (social workers, nurses, doctors, pharmacists) and social services (program managers, benefits navigators etc.) to understand how the closure of STC affects service delivery and to reflect on clients who have been impacted most severely by the loss of the bus. Participants were selected to reflect the three main divisions of health delivery in the province (urban, rural and northern Saskatchewan). Two other focus groups were conducted with activists and representatives from Indigenous and non-profit organisations working on issues that affect women and people with disabilities. These FGDs explored the politics of the closure to understand which population groups would potentially be impacted most negatively by the loss of the bus. These participants were selected based on the Saskatchewan context and an *a priori*

understanding that, because they serve vulnerable populations (as discussed earlier), they would be able to contribute to understandings of the equity dimensions of the closure.

7.5.3 Data Analysis

Interviews and focus groups were transcribed and imported into NVivo 12 software for analysis; data analysis was a hybrid of deductive and inductive analysis (Fereday & Muir-Cochrane, 2006). The deductive component focused on identifying and coding from the data, connections between transportation and health, based on published academic literature of how transportation is a social determinant of health (McCarthy, 2006). The inductive component involved identifying impacts of the closure that are not widely reported in the literature as well as drawing on intersectionality theory to reveal how the closure of the bus might inequitably affect some population groups (McCall, 2005). Identifying inequities was based on participants' own descriptions, as well as comparisons of described patterns of closure impacts among population groups with specific attention to social and geographical locations. Drawing on intersectionality theory, a first set of inequitable impacts was examined by exploring how social and geographical locations based on one axis of marginalisation exacerbate vulnerability to the impacts of closure. A second set of impacts was explored by examining compounded effects of the closure based on intersecting axes of marginalisation. Finally, a third set was explored by focusing on the lived experiences of participants who were seen as typical cases.

Several efforts were made to ensure the rigour of the analysis. First, a form of data source triangulation was used to increase rigour (Stake, 1995). This involved the use of multiple data sources (documents, interviews, FGD etc.) to allow for diverse perspectives to emerge and for an opportunity to corroborate, elaborate and verify some of the claims made by participants.

This was done with an emphasis on crystallisation, where the interest was not necessarily for the findings to converge at some specific 'truth' but to allow for the combination of data sources and multiple voices to make room for further interpretation of how the STC closure affects former users in different ways (Tracy, 2010).

Second, a member checking exercise was conducted as a means of increasing the trustworthiness of the findings. Member checking can be conducted at various levels from returning transcripts to research participants to the presentation of research findings to them and other stakeholders for comment. Drawing on Birt et al. (2016), 15 research participants recruited from interviews and focus groups participated in the member checking exercise. Major themes emerging from the study were presented to the participants followed by a one-hour discussion in which participants commented on emerging themes, made suggestions and reflected on research findings. Additionally, a research 'town hall' was organised to share the findings of the research with the wider Saskatchewan community and included both research participants and other former users of STC. Seventy-five (75) participants attended the town hall. In this session, an opportunity was given for comments on the findings and for people to describe if and how they resonated with their experiences.

Table 7.2 summarises research participant demographic characteristics. The majority of interview participants were aged 50-79 (55%), female (68%), Caucasian (75%) and located in central Saskatchewan (58%). The higher number of women and older participants reflects the general demography of former STC users. A total of 27% of participants identified themselves as living with disabilities. These included mobility-related disabilities (amputation, paralysis etc.), visual disabilities (blindness), learning disabilities (slow learner, Fetal Alcohol Spectrum

Disorder) and others such as epilepsy, Schizophrenia, etc. Focus group participants worked in various sectors and were mostly female (83%) and from urban settings (63%).

Table 7.2: Research Interview and Focus Group Participants by Various Characteristics

Interview participants – former STC riders/users			**Focus group participants – Stakeholder organisations/Professionals**	
variable	**number**		**variable**	**number**
Age			**Profession**	
21-49	35		Academic	1
50-79	55		Physician	1
80 and above	10		Non-Manager	4
			Nurse	2
			Other	5
			Pharmacist	1
			Program Manager	8
			Social Worker	2
Gender			***Gender***	
Female[15]	69		Female	20
Male	31		Male	4
Self-Identified Ancestry			**Sector**	
African	1		Community Based Organisation	5
Caucasian	75		Indigenous Organisation	6
Indigenous[16]	20		Health System	8
South American	1		Activist	5
South Asian	3			
Location			**Location**	
Northern	16		Northern	5
Central	58		Rural	4
Southern	26		Urban	15
Disability				
Mobility	6			
Visual	2			
Learning	9			
Other[17]	10			
Total	**100**		**Total**	**24**

Source: Authors

[15] This includes one participant who self-identified as a transgender female
[16] Indigenous participants include self-identified First Nations and Métis participants. There are three main groups of Indigenous peoples in Canada: First Nations, Métis and Inuit
[17] Participants identified other disabilities such as epilepsy, post-traumatic stress disorder, schizophrenia and a host of others.

7.6 Findings

Concepts such as intersectionality are complex, nuanced and intuitively closer to reality than many ways of thinking about inequity, disadvantage and marginalisation. Operationalising intersectionality can, however, be difficult with the constant risk of oversimplification (Rodriguez, 2018). McCall (2005) suggests three approaches to operationalising intersectionality: anti-categorical (not focusing on social categories), inter-categorical (comparing categories) or intra-categorical (examining differences within the same social category). We use an inter-categorical approach reflecting on differences in closure impacts across axes of social marginalisation. In the sections that follow, at the risk of some oversimplification, we use three levels of complexity to highlight the equity implications of closure. The first level explores the impacts based on one relevant axis of marginalisation (i.e., effects on members of specific social groups rendered more vulnerable). Level two builds on level one and adds some complexity by highlighting effects that emerge when two or more axes of marginalisation intersect. Level three presents the complexity of lived experience through six vignettes - not focused on specific social locations- that help to paint a picture of the varied nature of closure impacts.

7.6.1 Equity Complexity Level 1: STC Closure and Exacerbated Vulnerabilities

The first level at which STC closure has equity implications is that the absence of the bus exacerbates the vulnerability of some members of society who are already vulnerable. We use the examples of i) lack of a driver's license (connected to age, disability, immigration status or low-income status), ii) reduced access to services and alienation (connected to geography or Indigeneity), iii) financial burdens (connected to age or poverty), iv) loss of freedom and

autonomy (connected to disability) and v) safety (connected to gender or geography) to highlight exacerbated vulnerabilities due to STC closure.

7.6.1.1 Age, Disability, Low-income status, Immigration and Driver's license/Driving

Evidence from interviews revealed that many people have become more vulnerable due to the STC closure because they do not possess or cannot obtain or maintain a driver's license. Age, disability status, income and immigration status are the relevant axes of exacerbated vulnerability. Regarding age, younger participants described how legal restrictions (people are able to obtain a driver's license at a specific age) prevented them from obtaining a license while older participants described how increasing morbidity and disability with age affects one's capacity to maintain and keep a license. Having a license is a necessary but insufficient condition for driving as this also depends on vehicle access and/or ownership. According to one of the youngest participants:

> Well, of course I couldn't rent a car. I was too young. I'm only just now old enough at 21 to rent a vehicle, so that was off the table. I could have borrowed a friend's vehicle, but I wasn't really close enough to anyone in [city] in those first years to even ask someone to do that. I think, honestly, it maybe would have come down to actually flying between the two cities because I would not feel safe enough just, you know, posting on Kijiji [website] and looking for a car share or something like that. (Female, 21, Southern Saskatchewan)

Other young participants noted financial strains associated with maintaining vehicles and or keeping a driver's license. For older participants, some of whom had managed to maintain a license, mobility issues, vision challenges and general loss of competence to drive are important

for understanding how age is implicated in exacerbated vulnerability. One of the oldest participants noted:

> I can drive to the hospitals I know where they are in [city], but I won't drive around in the city much anymore because I don't feel capable. There's too much traffic and I don't know the city as well. I know certain parts of it. As I said, I can go to the hospitals, I know where they are, and they are easily accessible, but I don't drive around in the city at all. (Female, 91, Central Saskatchewan)

Many rural seniors expressed discomfort at the thought of driving to bigger centres such as Saskatoon, the largest urban centre in Saskatchewan, and in this sense had a different lived experience of impacts related to age than people in other age categories. People with disabilities related to mobility, visual impairment or epilepsy also described how disability-related legal restrictions prevent them from obtaining a driver's license. Here too, the loss of STC exacerbates vulnerability. When one participant living alone in Saskatoon but who had family in rural Saskatchewan was asked if she owned a vehicle, she responded:

> No, and I can't drive. I have epilepsy, I don't have a license. I had it revoked because of my seizures, I had way too many seizures and now they're under control. They're under control but the last one I think was on the fourth or the third [of the month] - …I rarely can get to see my daughter or my grandsons or anybody anymore and I don't have anybody in the city that I can see, like family. (Female, 58, Central Saskatchewan)

Immigration status was another important axis of exacerbated vulnerability. Some newcomers may have challenges obtaining a driver's license. In some cases, newcomers may have had a license in their home country but may fail the Canadian driving exam multiple times, leading to

financial stress. Their inability to obtain a Canadian license also increases vulnerability even if they have access to a vehicle since they cannot drive. One newcomer who had access to a vehicle through her husband but who could not drive her chronically ill son for hospital appointments noted:

> I didn't pass my driving test. I took the test twice; I couldn't pass it so that's where I am…I wish if I could pass my test this time. It's not that I haven't been driving, I've been driving back home, but the town that I had been driving was very small we didn't have the traffic lights, it was just driving with safety by looking at the other cars and it's very different here you don't have to look at the other cars, you have to look at the signals, so it's a completely different mode of driving. (Female, 40, Southern Saskatchewan)

7.6.1.2 Indigeneity and Geography (Alienation and Reduced Access to Services)

Participants from rural, northern and Indigenous communities expressed a sense of alienation caused by the closure. They also described the profound injustice of the government's decision to close STC especially for communities where people already feel cut off or may have limited access to services. Expressing this sense of alienation and abandonment by the government, one health worker from rural Saskatchewan noted:

> I just think it's another example of trying to move all of our services into the bigger cities and like [another participant] said, isolate us even more so that we do disappear off the map. That's kinda [sic] how it feels. It's really tough, to have older adults and young

families living in rural Saskatchewan if they can't get to the cities for basic healthcare needs, *it's not fair*. (FGD, IRH[18])

In the Saskatchewan context, geography is sometimes tied to Indigeneity, as the northernmost parts of the province which are also more remote have higher proportions of Indigenous populations. In one FGD, when health workers were asked which communities and population groups have become more vulnerable due to STC closure, a social worker familiar with barriers to accessing mental health services explained:

> [I]t would be Indigenous groups specifically tied to Northern communities where they don't want to get counseled by their next-door neighbor or their mom's friend or whatever. So, they're coming down to [city]… I was listening to a psychiatrist talk a couple of weeks ago and she does a lot of work up North and it's like, it's just one extra thing that takes away from some of the services that are being provided to the Indigenous communities, the remote Indigenous communities and reserves up North. (FGD IUH1)

Other participants connected the closure to systemic disadvantages faced particularly by Indigenous communities who have suffered historical disadvantages. One Indigenous participant living in a bigger centre but who had family up north described how the closure of the company specifically marginalises Indigenous and northern communities:

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[18] The naming of focus groups is as follows: IUH refers to focus groups conducted in urban Saskatchewan, IRH (rural Saskatchewan) and INH (northern Saskatchewan). Where a number is attached it simply means 1st or 2nd focus group conducted in the specific location.

> I've heard the people in the North, they can't travel down here for education, justice, health, business. Here's my biggest point: this is going against Truth and Reconciliation.[19] This is going against all the Calls to Action. I highlighted some. We're supposed to be building bridges, not burning them. I feel it's a violation of human rights and it goes against UNDRIP as well, United Nations Declaration on the Rights of Indigenous Peoples. (Female, 36, Central Saskatchewan)

The sentiment that the closure of STC particularly marginalises Indigenous peoples and communities and is, in essence, a form of racism was referenced by people from most FGDs and many interview participants.

7.6.1.3 Low-income, Age and Financial Burdens of STC Closure

The STC closure has also exacerbated the vulnerability of some former users because of financial burdens. The key axes of marginalisation here are low-income status and/or age which lead to a deeply unjust burden. For younger people, being young or in school and generally having lower levels of income means that current alternatives for travelling after STC closure such as buying a vehicle can be a huge financial stress. Younger participants reflected on how the financial burden of maintaining a vehicle can be especially daunting on a limited income:

> Another way would be that extra financial strain of having to maintain my car and being on a student budget; often I take summer classes so that's why I don't have an actual job at the moment. It's just a lot of money and, for example, yesterday I had to go to the dentist but

[19] Canada set up a Truth and Reconciliation Commission to look into historical injustices in the treatment of Indigenous peoples; it made 94 calls to action. See the official website at trc.ca.

> also, I had a mechanical problem on my car and then my laptop broke, so that's just a lot of money, and if I was just with the STC, and I used the public transit, that would be a lot less financial strain…. I mean, it's not a big difference for somebody who does have a career… But when you're a student and you gotta [sic] pay tuition it's a lot of money… (Male, 21, Northern Saskatchewan)

Although this sentiment was not unique to young people and some participants in their 40s explained a financial burden as well, the allusion to a 'career' shows why age is a relevant axis of vulnerability. Older participants who were retired and on a fixed income also described financial stress. One retired senior noted:

> I have noticed so far [in the provincial election campaign] … nothing has been mentioned about transportation for the seniors and also we have old age security like OAS and our pension cheques we don't get raised and yet when our rent goes up then you gotta [sic] pay it and where's the extra money coming from? And you are that much short, and you are also short of money for medication, for food, whichever, no raise in that either, no raise in the pension cheques or nothing. Since I've been on pension, I have maybe gotten a $5 raise from the time I was a pensioner till now, a $5 raise and that's not much and it seems they don't care for the seniors, that's how I feel. The cost of living is going up and we can't get nothing and it's hard, it's hard living on that and especially when you are diabetic 'cos[sic] you gotta [sic] take insulin and insulin is pretty expensive so when do you give up? Makes you wonder… (Female, 68, Northern Saskatchewan)

Another participant described how her elderly mother's low-income status means that current travel options such as booking a van are not real options. When asked what travel options exist for her mother living in rural Saskatchewan she responded:

> Generally, my mother… can book a van, but again, the cost to her, because she's low-income, would be a lot of money to her at 83 years old. So, there is that alternative for her, but it is out of her income. She doesn't have the ability to pay that. (Female, 59, Central Saskatchewan)

Age and/or a fixed/low-income status both served to exacerbate the vulnerability of participants who were already marginalised. In either case, such participants faced financial and psychosocial stress in trying to maintain vehicles or travel to appointments; activities that appear normal and routine to many people.

7.6.1.4 Disability and Transportation as 'freedom' & autonomy

One of the key insights that emerged from research interviews was the idea of transportation as 'freedom'. While many participants alluded to it, a group who almost always referred to it were people living with various forms of disabilities. When asked what the bus meant to participants, people with disabilities primarily described access to public transportation as a form of freedom, thus the loss of the bus means a loss of freedom and autonomy. One participant with a mobility disability responded with the following when asked what the bus meant:

> Freedom. I can tell you that right off the top is freedom; being able to go and do what I want, when I want with some notice from me to STC to book accessible bus. It's freedom and right now I don't have that freedom because there's no bus and that's where the word imprisonment comes in, I feel imprisoned in my own community, in my own city. When I

would like to get out and go and visit family or go to meetings in [city] that I have, that I should be attending but can't attend in person. I don't want to be over Skype, I want to be at the meeting in person and right now I don't have that freedom. (Female, 51, Southern Saskatchewan)

The injustice of the closure is evident from the fact that people living with disabilities usually struggle with losing independence and having to ask for help. The STC and its disability-friendly policies allowed some level of autonomy which is now eroded. Another research participant who had experienced a stroke and had no other way of visiting family described how the bus ultimately means freedom when one has a disability:

> I have always been a very independent person. It's hard for me to [pause] even still 17 years into being the way I am now [having a stroke]. It's still hard to ask for help. So STC was a way for me to still have my independence, and that independence has been taken away from me and my world has just gone from this - being huge to being minuscule… It just gives you the freedom to go when you want to go. Now, I don't have that freedom to just pick up and go. Whereas I could pick any day of the week that I wanted to go, and now I can't. So, I've lost that sense of freedom, of being able to come and go and that's sort of the same as the independence thing. I mean, it takes your world from being huge to being small and when you don't have anything it's very important; because you lose your world. (Female, 67, Southern Saskatchewan)

7.6.1.5 Geography, Gender and Safety

Many participants alluded to safety issues connected with the loss of STC but this was most salient across two axes of marginalisation (being a woman and/or living in northern or rural

Saskatchewan). In FGDs, it emerged that on a systemic level, women fleeing domestic violence used the STC as a means of escape and so the absence of the bus exacerbates women's vulnerability to violence. As one participant working with a women's shelter noted:

> [S]o for us at work, we quite often have women that travel distances just to try to put some distance between their abuser and themselves or their family members and the bus was an easy and affordable way for them to do that. And now that it's gone, we're finding that women are relying on friends and family and other facets of getting places. I've actually heard of women, getting into a vehicle with a stranger to try to get to where they need to be. So, it's putting them at risk. Just because they're not in a safe place. So, it's a concern for us and we're finding that women aren't able to put miles in between abusers and themselves. (FGD, IRH)

In another focus group, participants noted the important role the bus played in protecting already vulnerable women. A priest in charge of a program that offers supports to vulnerable members of society including women fleeing violence noted:

> Oftentimes women would either call or show up and say, 'Hey, my partner has said they're going to kill me or my kids by morning. How can you help?' And when STC was up and running, it was fairly easy to find at least some place for that woman and her kids to be overnight, with the aim of buying a family bus pass for the next day, being in communication with a shelter probably in [cities in another province], and to get her out of harm's way. Now I have women that are making the same calls. The domestic violence situation hasn't changed, but our ability to respond to it is next to nothing. We have to be able to work through the local shelters, which are at their capacity, and are still within

> unfortunately, arm's and harm's reach for those who are seeking to perpetrate violence. (FGD, Activists)

Women also described instances of sexual harassment when trying to use alternative means of travel such as cabs, which are in some cases the only other way to travel between cities. One participant described an incident of a sexual assault:

> Some of the drivers, they give you that vibe. I don't like the cab drivers, some of them… because my youngest daughter took a cab one early morning, and that cab driver was feeling her up and it scared her and that's where I get that fear from. What if they try [pause] you never know. (Female, 56, Central Saskatchewan)

Participants in rural and northern communities also described safety issues in terms of winter driving dangers, stretches of road without cell phone coverage and the dangers of accidents due to animals on the road. These factors increase vulnerability of such participants and place them in danger. Summarising what it is like to drive on one's own for long distances and the risks associated, one participant noted:

> [D]usk and dawn is the worst thing, but I remember almost when I was in [city in another province] with somebody else was driving, we almost hit a couple of moose in the middle of the night. I said slow down because there was [sic] animals. Looking for the animal eyes and stuff in the sides [of the road] all the time that you're going down there at night and scanning for animals all the way up and down, so you don't bash into something big and kill yourself and stressing out.... In [city] you can drive down to [city] and the weather's really great and then a blizzard pops up and you have to get home and you have to go and drive in that blizzard and you can't see anything… There's [sic] even places where there's

> no cell service on the way up here… if I ended up in the ditch or something, I'd have to wait for somebody. I couldn't call for help. It's just, it's really stressful to do that. (Female, 60, Northern Saskatchewan)

Many participants living in small and remote communities expressed similar concerns about the safety issues associated with driving long distances on one's own under dangerous weather conditions in situations of risk where it might be extremely difficult to find help if something went wrong.

7.6.2 Equity Complexity Level 2: STC Closure and Compounded Effects

This second level of equity complexity emerges when two or more axes of marginalisation intersect. We present three examples of combinations of marginalisation that recurred throughout the research and were often associated with very negative experiences of closure effects.

7.6.2.1 Middle-aged Women and Time Poverty

The STC closure uniquely affects middle-aged women. Throughout the research, a gendered pattern emerged where middle-aged women (typically 40-64) have had to bear the brunt of taking time off work and other activities to drive a parent (usually their mother) to hospital appointments. The fact that women often take on a caring role for both parents and children likely explains why the extra burden of driving falls on women. This ultimately robs women of time for themselves and to participate in social, economic and cultural activities. As one participant taking care of her mother noted:

> It takes an hour and a half to get out there and hour and a half to get back. So, I have no time for myself… I could get somebody to put her [participant's mother] on the bus at [town] and I meet her at the bus station *and I have a life, but now I have no life outside of looking after my mother* because we have no way of transporting her and she's at the stage where she probably really should be in the city or in a home, but she does not want to leave her house. It's an old parish house from the church, the cemetery there is where my dad is buried. He's been dead for 25 years; she goes out there and visits his grave periodically and she likes being close to him. That's home for her and she does not want to leave her home (Female, 66, Central Saskatchewan. Emphasis added)

This particular participant also noted in her interview that "I'm not spending more than maybe three or four days a month at my own home because I'm at her place". This particular type of story where one spends a lot of time caring for a parent was referenced by several women irrespective of their level of educational attainment, geographical location or ethnic background. The two critical ingredients for this type of experience appeared to be womanhood and middle age.

7.6.2.2 Low-income Indigenous Women and Hitchhiking

Another unique combination that was connected with negative closure impacts such as hitchhiking (although not exclusively) was being female and being Indigenous. Throughout the research, the participants who referenced having hitchhiked were often Indigenous females mostly living in poverty. Such participants referenced having recently hitchhiked or planned to hitchhike due to limited transportation options. In the case of Indigenous women, the issue of

Missing and Murdered Indigenous Women and Girls (MMIWG) was often referenced. One participant noted:

> [F]or me, missing a couple family events and one funeral, I'm severely depressed. This whole week, I was supposed to go somewhere last weekend and I couldn't make it. I couldn't hitchhike. I was going to, last Friday I was going to hitchhike, but two girls were found outside of [city], in the ditch, murdered. I can't – I can't hitchhike anymore. It's too dangerous. (Female, 36, Central Saskatchewan)

Another younger participant who had hitchhiked a couple of weeks before the interview did so because she was "a person with, like, low-income and no help so I usually just hitchhike. I don't have any other way to get around". In her interview, she described some negative experiences while hitchhiking:

> P: I actually ran into this one person that, you know, wanted something out of it but I shut his door and I kept walking.
>
> I: What do you mean, what happened? Can you tell me more?
>
> P: He wanted me to do sexual activity on him.
>
> I: So, you raised your thumb for the car…
>
> P: Yeah, and he stopped and asked me, you want this for that, and I said, nope, keep driving and I kept walking. (Interviewer (I) and Participant (P), Female, 26, Central Saskatchewan)

Examples such as this highlight both hitchhiking and sexual attacks. Sexual attacks associated with hitchhiking or travel by taxi were described by several Indigenous women and, in one instance, a Caucasian woman living with a disability.

7.6.2.3 Low-income People with Disabilities: "Feeling Trapped" and "Like a Charity"

Many research participants who had disabilities were also low-income and thus more likely to feel "trapped" or "like a prisoner" if they could not travel. The intersection of disability and low-income status was noted by one participant who said:

> A lot of my friends that are disabled, that are in chairs, are low-income so they can't pay the $75 an hour plus mileage on top of that for paratransit to get from [city]. I know taxis are out of this world [expensive] for taking you places. (Female, 51, Southern Saskatchewan)

This combination of low-income status with disability limits travel options for individuals due to cost and inability to drive and explains the common expression of "*feeling like prisoners*". A participant actively involved in the disability community noted:

> I have a friend that has cerebral palsy and another individual has spinal bifida. They can't drive so they're trapped. Like they, one of my friends would say, 'I'm a prisoner in my own community. I can't go anywhere. I'm a prisoner.' And that's how I feel sometimes, too. I'm a prisoner. (Female, 34, Southern Saskatchewan)

Another participant living with a visual impairment noted that the only alternative to feeling like a prisoner would be to feel "like a charity" by asking for help, which many people living with disabilities strive to avoid:

> For a person with a disability and a person with a disability who's also poor, I don't like feeling like a charity because there's so many other ways that I also might need help with stuff. And so, here's just one more way that makes me feel like a second-class citizen or

charity case… Feeling that I don't count, too. Like I said before, the government just doesn't figure that I...I don't take it personally, but for people like myself, we just don't count. (Female, 64, Southern Saskatchewan)

7.6.3 Equity Complexity Level 3: STC Closure and Lived Experience

Given that nobody ever *just* experiences life as a woman, Indigenous person, or living with a disability but their experiences and identities are a product of the complex interactions of social and geographical locations that are historically situated and context-specific, we present the following six pseudonymised cases or vignettes to represent how the closure of STC inequitably impacts real people within their intersecting locations of marginalisation. By drawing on the stories of Martin, Louise, Jennifer, Amira, Charlie and Evelyn, and Jessica, we show how the loss of STC makes life much more difficult for people in Saskatchewan.

Table 7.3: The different faces of STC closure impacts; 6 vignettes

Vignette 1: The story of Martin
I had tried to schedule an interview with Martin, a 49-year-old off-reserve Indigenous man living in Saskatchewan's capital, Regina several times without success because he did not have a mobile phone or fixed address.. Although he is originally from The Pas Manitoba, he has been living in Saskatchewan for the past 18 years. Martin moved off-reserve to find a job but has not been very successful in finding one. He knows many others who moved off-reserve to find jobs without success. Visiting family beyond Prince Albert is impossible because no buses go further north than Prince Albert. Martin has schizophrenia and has hitchhiked several times to go home. According to him "It's hard hitchhiking. I get blisters on my feet and back problems when you're hitchhiking on cement. You're walking on the highway for a long period of time". Martin has had many negative experiences while hitchhiking. One time while hitchhiking he was picked up by three men, called a bum and beaten up. His experiences are not unique, and he is acutely aware of the ongoing issue of Murdered and Missing Indigenous Women and Girls (MMIWG). One time Martin's girlfriend Britney got picked up while hitchhiking from a northern reserve to Prince Albert. The driver asked Britney for sexual favours, which she refused and so the driver "just kicked her out of the car in Prince Albert. Told her to leave, get out of here". The closure of STC, according to Martin, affects him in many ways and makes him feel emotionally distressed. He relies on a United Church for some supports, hitchhikes because he has no other travel options and is regularly depressed and anxious. He tries to get mental health support as regularly as possible, but he misses being able to go home and visit his family in safety. Living in Regina is not easy- especially since the only relative around is a cousin - but Martin does his best to get by.

Vignette 2: The story of Louise

Louise is a 60-year-old Indigenous woman from Qu'Appelle, Saskatchewan. She is a mother and a grandmother who has worked in Indigenous social work. She suffers from paralysis. At the beginning of our interview, she asked me if I knew what it was like to be paralysed. Such a simple question but it had never crossed my mind. She asked me to try moving my ear – that was her simple demonstration of what paralysis is like. Louise needs to attend regular treatments in larger centres for other health conditions and faces several challenges in accessing healthcare services. Because she uses a wheelchair, travelling without STC means she has to rely on a van she owns and this comes at great cost to maintain. Given the unpredictability of weather, there are many situations where she would greatly prefer an STC bus. Louise recounted one example where she was stuck in a blizzard on her way to seek healthcare services: *"I had a catheter. Then by standing on the side of the road because of the blizzard, the motor filled up with snow and wouldn't stay running because it had so much snow in it. This was not a predicted blizzard, that's the thing that you deal with. It could be nice on this side of the valley, but the other side of the valley, when you're driving, it could be horrible. That's exactly what happened. I had to wait and get rescued. Now, who needs that when they're sick? It was so cold in that car that there was [sic] ice crystals forming in my urine bag."* As an older Indigenous woman living with a disability, Louise is marginalised on several fronts and is aware of this. Louise advised that if I ever wrote about her story, I should make it clear "t*hat being a female Indigenous person, having no reliable, safe transportation, puts my life at risk. That's the truth. I mean, so many of our people, our women are already at risk. You may know in your communities; Black women are most likely at risk in poor environments…*"

Vignette 3: The story of Jennifer

Jennifer is a 66-year-old woman. She is a retired civil servant who worked with the federal government in Ottawa and is now living in Saskatchewan. As an environmentally conscious person, she has never owned a private vehicle and has now been forced to buy a car due to the STC closure. Like many middle-aged women, Jennifer has to take care of her elderly mother who lives on a farm near a small town. Her mother who is in her 80's is perfectly capable for doing many things independently but cannot drive long distances on the highway. She does not want to move out of the small town because her husband is buried there and living there allows her to feel connected to her late husband and the life they had. Although Jennifer has other siblings, she has been obliged to take on the role of taking care of her mother, driving her to hospital appointments and making sure she is doing well in other aspects of her life. This caring role comes at a significant financial and time cost to Jennifer yet when there was a bus, she would just have someone put her mother on the bus and accompany her to the hospital when the bus arrived in Saskatoon. Jennifer is struggling mentally and is unable to take care of herself. She knows that taking care of her mother is the right thing to do and wants to continue doing so but there is not enough time to take care of her mother and herself. She is forced to choose between care for self and care for her mother and she chooses the latter:

"I used to go out dancing, I've gained 30 pounds almost in the last three years because I'm not doing the things I need to do, my blood pressure's gone up, so it's been a huge health cost for me, the stress levels and now I'm on medication for blood pressure. I mean, luckily that's the only medication I have, but my blood pressure was good I had [sic] physically active, I had great circles of friends, everything. And now looking after somebody as a caregiver is a big responsibility. But without STC, I'm having to spend all this time running back and forth, I can't make commitments to participate. In Ottawa, I was the president of our community association in a very diverse community, over 50% of our community was recent immigrant population and it was a fabulous community."

Vignette 4: The story of Amira and her family

Amira is a 40-year-old South Asian woman who recently immigrated to Saskatchewan. She has graduate level education and used to drive prior to immigrating to Canada. In Saskatchewan, her attempts to obtain a driver's license have been futile - she failed after multiple tries. Her son is sick with cancer and so her husband drives her and their chronically ill child to seek care in Regina. Amira's husband works in a fast-food restaurant and was recently promoted to manager which is the only reason he has been able to take more time off to drive the family to the hospital. Amira feels anxious and guilty about her husband taking time off work and knows that very soon this will not be an option, as he is nearing the maximum number of paid days off. The loss of the STC has had a dramatic effect on Amira's family. According to her, taking rides from others would be nice, but culturally, she would not feel comfortable accepting rides especially from a man who is not her husband. Although Amira is a graduate student, that aspect of her life is on the back burner - she has not worked on her thesis in a while - because family comes first. In the past, she would travel on the bus with her son to the hospital and her husband would remain at work. Sometimes she even read on the bus and got a bit of school work done during those journeys. In some cases, when her son was feeling very well, she would put him on the bus on his own knowing that he would arrive safely, especially given that the bus had a program for transporting minors. None of this is possible any more; her husband must regularly take time off work to drive her and her son to the hospital. This is hard for everyone but that is the only way for her son to obtain the care he needs.

Vignette 5: The story of Charlie and Evelyn

83-year-old Charlie and his wife, 76-year-old Evelyn live on a farm in rural Saskatchewan. Their parents moved to Canada from Eastern Europe but they both grew up in Saskatchewan. Charlie and Evelyn were hoping for a quiet and peaceful retirement but Charlie was recently diagnosed with prostate cancer. He has had to complete his chemotherapy treatments in a hospital in Regina since the nearest health centre only provides basic primary care. The chemo treatments, 38 in one year, always involved arranging to have someone drive them to the hospital since Evelyn finds it difficult to drive and take care of Charlie at the same time. The couple have sons and daughters, but they no longer live in Saskatchewan as they have grown up, married and started families of their own elsewhere in Canada (Alberta, British Columbia). This means that beyond the issue of cancer and treatments, the couple have no way of seeing their grandchildren to find the emotional support they need during such a difficult time. According to Charlie it is not just the cancer that troubles him but the huge stress when arranging rides. Thinking about the future and all the stress in sorting out treatments worries Charlie often and according to him:

"There's a lot of times you get up in the middle of the night and so worrisome. You start wondering, instead of sleeping you can't sleep, and your heart is pounding and you're wondering 'gee how am I going to get here to such and such an appointment?'"

The stress is not only borne by Charlie. Evelyn, a retired nurse, feels helpless and is constantly worried about her husband. She has accompanied him to every appointment and made it a point to take care of him as much as she can, but 38 appointments in a year is a lot for anyone.

Vignette 6: The story of Jessica

Jessica is a 38-year-old Caucasian female with a graduate degree. She has a small business of her own and has been fairly independent her whole life. She is very cheerful and friendly. Unlike many people whose disabilities are visible, Jessica's isn't. She was involved in an accident a few years ago and now has epilepsy. After her diagnosis she had to give up her driver's license for her own safety and that of others. This change, although difficult, was bearable because she knew there was the STC which took her all over the province to visit tourist sites, visit with friends in other towns and attend festivals in the summer. Jessica has experienced discrimination in many spheres of her life, particularly in the job market, due to her disability. In many cases, she would apply for a job for which she is qualified and when she reveals that she does not have a valid driver's license her chances become zero. Because of the absence of a province-wide bus, it is more difficult to obtain employment outside Regina where she currently lives. Jessica misses how she used to be able to visit tourist attractions independently and dislikes constantly having to ask family to drive her to places. The STC made life so easy. People like Jessica who are not necessarily low-income or dealing with visible disabilities such as blindness, paralysis or mobility challenges also need the bus. In trying to schedule an interview with Jessica we had to cancel several times. The reason we had had so much trouble scheduling Jessica's interview was:

"because, yeah, I had relapsed. I had had some medication questions that we had to go through. So, I had to go to Saskatoon to a testing unit to be observed there, which we don't have in Regina. And so, for that, I had to have my parents come back from Calgary, because they were away, to drive me over there and they drove me back today."

Whenever Jessica needs to seek any kind of treatment outside Regina, she is forced to rely on others and be reminded of her disability.

7.7 Discussion

The idea that transportation is a social policy issue connected to equity and social inclusion is receiving attention globally and in Canada (Litman, 2003). Many have argued the need to accelerate efforts to increase accessibility to transportation because inadequate access disproportionately affects marginalised people (Lucas & Jones, 2012). Transportation can be a means for increasing social participation and building social capital, particularly for marginalised groups (Currie & Stanley, 2008). The use of an intersectionality perspective highlights the different axes of transportation-related marginalisation and how their intersections heighten vulnerability in a syndemic manner (McCall, 2005; Rodriguez, 2018).

One of the fundamental issues that emerges when thinking about transportation and equity is the question of access to vehicles and driver's licenses. Research on social inclusion and driver's licenses has consistently shown that in places with poor public transportation options people who do not have a driver's license are at risk of exclusion. There are different reasons why people may not have a driver's license including disability, age, immigration status, the cost associated with obtaining a license or a combination of these factors (Litman, 2003; Priya & Uteng, 2009). People in these categories or their intersections are therefore automatically excluded and their discrimination routinised when public policy choices create a climate (as in the case of STC closure) where obtaining and maintaining a license becomes a prerequisite for leading a "normal", dignified life.

Extant literature on transportation as a mechanism for promoting social participation has shown that socially disadvantaged groups such as people with disabilities, younger children, seniors or combinations of these social locations face significant challenges in trying to

participate in social activities (shopping, visiting, education) due to difficulties accessing transportation (Lucas, 2004). The evidence from the present research concurs but also demonstrates that access to public transportation can mean diverse things to people in adverse social circumstances. For many low-income people living with disabilities, transportation is far more than a means for accessing specific services and feeling included. It is, on a metaphysical level, a form of ‘freedom’. The negative psychosocial health impacts of lacking this ‘freedom’, or what Whitehead et al. (2016) refer to as ‘control over destiny’, is well documented in the academic literature and is connected with poor mental health outcomes which fall heavily on the vulnerable. Thus, the loss of STC has health equity implications as it robs vulnerable members of society - particularly those with disabilities and those who belong to other vulnerable social locations - of independence, control and dignity.

Some of the transportation literature has focused on the gendered impacts of transportation policy decisions and the many disadvantages women suffer due to how transportation systems are organised. Such literature has revealed that transportation and how it is organised can lead to reductions in labour market participation for women (Dobbs, 2007) or heighten their vulnerability through safety-related issues as women are often targets of crime and violence (Ortoleva & Brenman, 2004). Like other forms of uniquely gendered austerity that disproportionately affect women given their reliance on public services or patterns of employment (Brodie, 2014), the closure of STC has had gendered effects, and many young women have reported instances of sexual harassment while using some of the current alternatives to the STC bus service.

In the Canadian context in particular, the connections between transportation and Indigenous women's wellbeing are of special significance. Canada's historical (mis)treatment of Indigenous peoples has intersected with existing gender-related inequalities and transportation challenges to worsen the negative gendered impacts of STC closure because of the connection to Missing and Murdered Indigenous Women and Girls (MMIWG). Throughout the country, many Indigenous women and girls are missing or victims of violence and their vulnerability is sometimes predicated on a lack of access to safe travel options. Indeed, the report on Canada's national inquiry into MMIWG identified the availability of safe and reliable transportation as important for ensuring Indigenous women's safety especially in cases where women are fleeing violence (Government of Canada, 2019). The loss of STC and the increased vulnerability of Indigenous women reveals parallels with colonial histories of "patriarchal, racialised, legal" violence particularly against women whose wellbeing (physical and spiritual) has been under attack by the settler colonial state from its inception (Starblanket & Coburn, 2020, p. 92).

In Western Canada in particular, the gendered nature of transportation access and the importance of transportation for Indigenous women and girls is most evident when one considers the tragedy of the Highway of Tears. This refers to a series of murders and disappearances of about 40 women, mostly Indigenous, that occurred on Highway 16 in northern British Columbia between 1969 and 2011 due, among other things, to lack of access to transportation (Carleton, 2015). These existing social issues highlight differential impacts of STC closure on women and Indigenous women, and demonstrate a heightened vulnerability to impacts that might go unnoticed if not interrogated with an equity lens. Other gendered issues emerging from this research include the issue of time poverty reported elsewhere (Church et al., 2000; Ortoleva & Brenman, 2004). Many women reported no longer having time to participate in social, economic

and cultural activities as they are forced to step in to drive family members and this robs them of time to do any number of things including taking care of their own wellbeing. The gender-related issues above highlight the important health equity implications of STC closure on women, particularly middle-aged women (through time poverty) and young Indigenous women (through lack of safety).

The ongoing disadvantages faced by seniors, newcomers and people living in isolated rural communities in trying to access services in larger centres confirm the special importance of access to transportation for such groups. These disadvantages underscore the necessity to interrogate transportation policies not only from a health perspective but also from a health equity angle. The evidence on how STC operated reveals that the bus company contributed to reducing these gaps by providing access for vulnerable and marginalised groups. At the time of the closure of STC, an increasing proportion of service users were seniors (defined as 60 years and above) with 75% of these being low-income seniors. These former bus riders used the service for medical appointments and to access other services in larger centres in Saskatchewan (Saskatchewan Transportation Company, 2010, 2017). The bus service was an important vehicle (literally and figuratively) for promoting equity and social participation for all, because it paid attention to "passengers with varying mobility" (Saskatchewan Transportation Company, 2017, p. 11). It had wheelchair accessible buses, programs that allowed people seeking medical treatment to sign up for discounted medical passes, allowed service dogs on board and regularly offered discounts to seniors and frequent riders (Saskatchewan Transportation Company, 2017). STC's operational model was therefore sensitive to some of the intersectional vulnerabilities described earlier and the demise of the company represents a major affront to health equity in the province.

The STC was consistently rated highly by riders and its importance in the province is summarised by this 2000 annual report: "In our province, there are thousands of reasons for needing the service [of STC]. The one constant is that STC will be there to provide you with safe, reliable, affordable, courteous service" (Saskatchewan Transportation Company, 2000). This attention to safety and equity explains why the closure has a differential impact on marginalised population groups since they more heavily relied on the bus. Many current alternatives to STC are not wheelchair accessible, do not serve many communities and are prohibitively expensive and there is an ongoing gap in access for the most vulnerable people in Saskatchewan. The STC closure has equity implications that are easily obscured if insufficient attention is paid to existing social and structural inequities as well as to the nuanced intersectional locations within which vulnerabilities emerge and become visible.

7.8 Conclusion

The negative impacts of STC closure are inequitable depending on where people stand in the social hierarchy. For the most part, people with disabilities, seniors, young people, newcomers, Indigenous people, low-income persons, people in rural and northern locations and people in urban centres without cars whose family live elsewhere, as well as people in various intersections of these categories have suffered the most negative consequences. Given that nobody is ever just a woman, a senior or a person living with a disability, certain combinations of marginalisation interact to produce unique ways in which the closure is experienced. There is an urgent need to rethink the decision to close the STC and to reflect on the underlying assumptions of the decision. Such reflection reveals the unjust nature of the decision and the ways in which closure exacerbates vulnerability for different people, and why the loss of such a company contributes to health inequities.

CHAPTER 8: DISCUSSION AND CONCLUSION

8.1 Introduction

This project set out to explore political, health and health equity dimensions of the decision to close the Saskatchewan Transportation Company (STC) in the context of the global rise in neoliberal austerity. This exploration was guided by four interrelated research questions, the first three culminating in a manuscript each, to show a complex set of contextual factors that facilitated the closure of the company and to bear witness to the emergent and ongoing impacts of the closure of the company, particularly on the most vulnerable. Specifically, the project sought to answer the questions:

1. What was the political rationale underlying the closure of STC?
2. What are the health impacts of the closure of STC on former bus riders and systems in Saskatchewan?
3. How do any impacts of the closure on health differ for people based on social and geographical locations?
4. What theoretical pathways are suggested between austerity, health and health equity as illustrated by the closure of STC?

8.2 Taking the Politics of Health Seriously

The first manuscript explored the political context of the closure of STC by performing a socio-political autopsy of its demise. Through a discourse analysis, it revealed the power dynamics that underpinned the closure and the discourses used by the government to justify the decision. It showed the profound lack of an evidence base in guiding the decision to close the STC or any considerations for closure impacts on population health and revealed how a set of neoliberal and minimisation discourses were employed by the governing Saskatchewan Party to justify the

closure. It also revealed many dynamics of neoliberalisation including the use of the law to justify neoliberal public policies, a phenomenon that has been noted by other authors (McBride, 2016).

On the other hand, the first manuscript (Chapter 5) also revealed the power of resistance and the important role of activists and others in advocating to protect the STC on human rights and climate change-related grounds. Such discourses rejected the financial logic that motivated the proponents of the closure. Conducting the research raised a number of methodological and practical questions about political economy of health research and some of the possibilities that exist for pursuing the question of how politics is implicated in health. Based on recent critiques demanding more innovation and caution when connecting neoliberalisation to health issues (Bell & Green, 2016), I offer the following methodological reflections based on the conducting the STC research.

First, on the question of methodology, the evidence from the research suggests that more could be gained in our understanding of the politics of health through methodological plurality and a willingness to explore the politics of health through data sources that are not routinely used. The use of Parliamentary Hansards and media sources allowed me to gain perspectives that may not be present in explorations of the connections among politics, austerity and health that rely solely on interviews and focus group data. If politics is to be truly seen as influencing health, then the Parliamentary Hansards should be a staple for those interested in the politics of health, as they reveal, for example, the thinking of politicians in ways that may not be found in policy documents which are often polished by bureaucrats prior to publication. Indeed, in situations such as STC closure, there was no clear and specific policy ‘document’ and so the

Hansards provided a rich data source. Access to information requests can also be a useful way to access rich data to understand the (il)logic that guides political choices to pursue austerity.

Apart from methodological questions, aspects of the decision to close STC reveal ongoing gaps in ensuring a Health in All Policies (HiAP) approach. Although the Helsinki Statement on HiAP was released almost a decade ago to foreground the need for health considerations in the implementation of public policy (World Health Organisation, 2013), evidence from this research shows that austerity decisions that clearly have health implications are taken by governments with little to no consideration of those impacts. In countries like Canada, there are calls for a pan-Canadian HiAP framework to encourage provincial governments to explicitly evaluate health impacts of public policies (Tonelli et al., 2020). Such calls are important and could potentially prevent future political choices of austerity similar to the STC closure.

That notwithstanding, there is a politics of evidence and governments sometimes selectively (if at all) make use of evidence when implementing austerity budgets. In this sense, what is important beyond calls for a pan-Canadian HiAP approach would be the re-politicisation of health and explicit and appropriate use of social determinants of health language by activists, academics and practitioners to hold governments accountable. Austerity is always an ideological choice (McBride & Whiteside, 2011) and those wishing to protect the people's health will have to move beyond theoretical abstractions to activism if they want to be able to defend public services that influence health and are the targets of budget cuts.

8.3 Closing the Evidence Gap

The second research question set out to answer one that Saskatchewan government ought to have asked and answered prior to closing STC: the question of health and other impacts of the closure. As shown in Chapter 5, several discourses were used to justify the decision to close the STC, and one major issue highlighted by activists and opponents of the decision has been the evidence gap. At the time of writing, no official analysis has been presented by the government to show evidence on the potential impacts of the decision to close STC. This project has contributed to closing the evidence gap and reveals existing and ongoing impacts of the closure.

The evidence from manuscripts 2 (Chapter 6) and 3 (Chapter 7) bear witness to several negative health impacts of the closure of the company and the ongoing nature of these impacts. I still receive email from former users of the bus describing these impacts. On September 11, 2020, I and others from the Activist group ‘Stop the Cuts’, shared the findings of the research with the wider Saskatchewan community. A total of 75 people attended the research town hall even though the event was held online and was being conducted three years after the closure. Such a high level of interest shows that the loss of the bus continues to affect many former users and riders. As shown in Chapter 7, the closure has created isolation and forced many people to miss medical appointments or avoid seeking healthcare. These impacts do not end with individual former users but affect members of their families who have to bear a heavy driving burden or financial costs. Communities and systems are also caught up in a web of negative closure effects.

The *web of dispossession* I propose in the second manuscript allows for analysis of the impacts to move beyond individual former bus users to a whole-of-society analysis. The web

reveals various communities and systems that are impacted by the loss of STC and helps to push discussions on austerity and its effects beyond the regular users of public services who are sometimes represented as a drain on the public purse. The web could be useful in further analysis of other forms of austerity. As highlighted by other researchers, austerity-related analysis could move beyond the discourse of "scroungers" or "welfare queens" (Garthwaite & Bambra 2017; Cronin, 2012), where people who depend on public services or receive social welfare are shamed, and begin to analyse how societies are dramatically changed and systems disrupted when governments decide to cut support and public services.

Advocates, activists and academics can draw on the varied data sources referenced earlier to reframe how austerity affects us all. This could encourage policymakers to think of budget cuts beyond low-income and minority groups to the ways in which all of us, including governments themselves, are caught up in the *web of dispossession*. In the case of the STC, the evidence of waste in the healthcare system which will be paid for by this or other governments shows the importance of approaching analysis of austerity from a society-wide approach. Such analyses could illuminate its connections to communities and broader impacts to reframe discussions by highlighting that society as a whole is worse off because of political choices to pursue austerity.

The evidence debates regarding STC closure continue, and the actual impacts of the closure remain contested. For example, in July 2020, a political columnist for the *Regina Leader-Post* and *Saskatoon Star Phoenix* newspapers wrote "STC was shuttered…simply because it wasn't making a profit or — regardless of what the NDP insists — actually providing a viable public service for its cost" (Mandryk, 2020). The impacts continue to be minimised and,

consistent with discourses by its proponents, economic rationalisation continues to be used to justify the closure.

Throughout this research, I and others have tried our best to set the record straight and have countered such claims using evidence from this research. We shared an advocacy brief with the media (Appendix 6) and have used various media (a video, a podcast, letters to the editor, interviews with the media, etc.) to show that the closure of STC has had negative impacts on people in Saskatchewan. I have no doubt that this debate is not over and that, given the ideological nature of the closure as shown in Chapter 5, the evidence from this research will continue to be used for advocacy purposes. There is also good reason to broaden the evidence base through other forms of research as presented in the directions for future research section of this discussion.

8.4 Whither Equity?

The third manuscript responded to the third research question and sought to move beyond the impacts explored in the second manuscript and to tease out some of the major ways in which they differ for people based on their social and geographical locations. The evidence indicates that, not only have the impacts of the closure been negative for former bus users, their family members and communities and systems, but the closure has served to further marginalise specific segments of the population.

Former STC users with disabilities, seniors, young people, newcomers, Indigenous people, women, low-income people, people in rural and northern locations and intersections of these locations have suffered the worst effects of the closure. Combinations of these axes of margination have exposed specific segments of the population to indignities and suffering. For

low-income people with disabilities, for example, the concept of transportation as ‘freedom’ reveals the ableist nature of the decision to shut down STC. Its closure has robbed people with disabilities of basic human dignity and serves as a constant reminder that they are unwelcome in or are not full members of society. Many participants’ references to feeling like a “prisoner” even though they had committed no crime is a clear indication of the seriousness of the decision and its implications for human dignity.

Human rights issues raised in Chapter 5 suggest that the decision is a potential large-scale violation of the rights of people with disabilities. Many members of the disability community have recounted harrowing accounts of the loss of human dignity due to closure. Perhaps one of the most striking examples is the story of a former user in a wheelchair who was stranded in a blizzard and who described crystals forming in her urine bag as she desperately waited for a ride (Chapter 7, p. 214) . These and many other stories reveal the ableist nature of the decision to close STC and the disregard for human rights and human dignity for many people living with disabilities in Saskatchewan. This calls for an urgent revisiting of the decision and concerted efforts to work towards a more inclusive society where people with disabilities can live with dignity.

The application of an intersectionality lens in interpreting the closure also reveals the sexist nature of the decision and the ways in which women are forced to bear some of the harshest impacts of austerity. Revealed through the example of time poverty for middle-aged women, it is clear that claims, as shown in Chapter 5, that other organisations, neighbors and communities would step in to help fill any gaps created by the loss of STC are inaccurate. Austerity is always gendered and sexist (Brodie & Bakker, 2008). Austerity is sexist, first

because it can often function as an attack on working class women and second, because women are those "filling in for society" when cuts to services occur (Cronin, 2012, p. 32). Social expectations that women would provide care work are tied to the global capitalist system of economic exploitation and oppression of women, people of colour and other minorities (Bhattacharya, 2017). In many cases, the very concept of 'time poverty' referenced in this research is itself symptomatic of the larger issue of social reproduction where women provide unpaid care work for various reasons (including austerity), so much so that they have little time to take care of their own wellbeing (Fraser, 2017). Reports of sexual attacks on women and the inability to escape domestic violence all point to inherent sexism in the closure, as many women are placed in increased danger and their vulnerability exacerbated.

The closure was described as a racist and colonial decision by many research participants from interviews and focus group discussions because of how the decision marginalises minorities, particularly Indigenous communities in Saskatchewan. One of the by-products of Canada's colonial history is the reserve system where many Indigenous communities were confined to reserves often located far away from major centres (Daschuk, 2013).

In the context of the STC closure, any decision that limits access to transportation in the province will disproportionately affect Indigenous communities because, in Saskatchewan as in many parts of Canada, geography is tied to Indigeneity. In reflecting on the closure of STC, therefore, it is useful to pay particular attention to how Indigenous communities are forced to face many negative consequences because of the geographic location and distribution of such communities. Some of these disadvantages are not unique to Indigenous people and also affect people in rural and northern communities. However, in the case of some urban-dwelling off-

reserve Indigenous populations, difficulties in accessing rides to reserves to participate in ceremonies uniquely affect Indigenous communities. As well, the issue of missing and murdered Indigenous women and girls (MMIWG) connected to hitchhiking as a result of lack of access to transportation reveal a disproportionate Indigenous impact. These kinds of disproportionate and inequitable impacts reveal the racism underlying the decision to close the company. The idea of STC closure as a form of racism signifies a departure from reconciliation; bridges are being burned rather than built by the government. Evidence from other parts of the world such as Australia reveal similar examples of transportation policy choices that place Indigenous communities at a disadvantage (Currie & Sendbergs, 2007).

Finally, the ageism and classism of the closure of the bus was revealed in Chapter 7. The examples of low-income seniors or young people who are unable to travel highlights this. Seniors suffer isolation and heavy financial burdens and are forced to miss hospital appointments because they can no longer drive or are no longer able to maintain a driver's license. These issues are tied to their age and class and reveal an ageism and classism inherent in the closure. The same are evident for low-income younger research participants who are financially insecure and may have been forced to buy vehicles and maintain them whether or not they prefer this, as shown in Chapter 7. These aspects of the closure show that austerity is always "Janus-faced", that it affects the poor more than the rich (Fanelli & Hurl, 2011). The evidence from this dissertation supports this conceptualisation, not only because of the differences in impacts on the rich and the poor but also because of different impacts on the axis of age. As shown through the *web of dispossession*, however, there is a sense in which the whole of society is implicated in closure impacts.

8.5 From Politics to Embodied Health Inequities

The idea of the social and political causation of ill health is an old one that is increasingly popular particularly after the publication of the World Health Organisation's commissioned report on the social determinants of health (Marmot et al., 2008). While this idea is becoming less debatable, efforts to demonstrate how politics causes poor health are plagued with problems including epidemiologically pedantic approaches that render 'causation' perversely difficult to prove (Schrecker, 2013).

This project has sought to travel the long and complex road of showing how politics affects health using the STC case study. Although research from different parts of the world has shown that austerity negatively affects health, the evidence from this project shows the types of discourses that are summoned to justify austerity and the kinds of resistance that are available through the work of advocates and activists. By pursuing the effects of the austerity decision to shut down STC, I have shown not only that austerity affects health negatively, but also that it is truly expensive, for the vulnerable and for all members of society. Multiple intersections of marginalisation exacerbate vulnerability to the health and health equity impacts of austerity.

As I have learnt through my own lived experience, however, it is easier than one expects to become a victim of austerity. The irony that I as a PhD student needed a bus to travel around Saskatchewan to investigate the health effects of the closure of STC has taught me that in the neoliberal war against public services anyone can become a victim. This necessitates not only a vigorous analysis of the health effects of austerity but a "pragmatic solidarity" (Farmer, 2003, p. 121) with those already bearing the harshest brunt of austerity. There is "a moral imperative for a critical perspective" (McGibbon, 2012), because politics affect health and bad politics kill.

One only needs to patiently connect the dots to see the ways in which bad political choices become inscribed in the bodies (Krieger, 2005) of many men and women who are made expendable by the new global austerity regime.

8.6 Recommendations

The following recommendations are made based on the findings of the research, suggestions from research participants during interviews and focus group discussions and conversations with activists and community members during the research town hall.

8.6.1 Recommendations for Future Research

- Since no evidence was ever presented to show the potential impacts of the closure of STC, a complete large-scale audit is needed in the health and social service systems to understand the economic cost of the closure for operations in those systems.
- Future research could explore the impacts of STC closure on stress levels among health and social service workers, as suggested from the findings in Chapter 6.
- A full environmental analysis is needed to understand the impacts of STC closure on an environmental level either through analysis of changes in vehicle emission levels after the closure or, failing that, a quantification of the proportion of the population currently using motor vehicles after (or due to) the closure. The evidence in the second manuscript (Chapter 6) suggests that there has been an increase in the number of people using personal vehicles.
- A quantitative analysis of the incidence and prevalence of hitchhiking and of motor vehicle crashes and injuries is needed to compare rates before the closure of STC to rates after the closure. The evidence from Chapters 6 and 7 shows that there has been a rise in

hitchhiking especially among low-income Indigenous peoples. Some participants also referenced being in accidents and this requires further interrogation.

8.6.2 Recommended Policy Changes

- A new bus service should be created to promote social participation and afford vulnerable populations the ability to travel. It should be wheelchair friendly and accessible to people with varied abilities.
- Advocacy on STC closure needs to continue and activists and advocates who have spoken up about the closure need to keep advocating for it and keeping the issue alive in the public consciousness. Their voices remain important.
- Saskatchewan needs to consider the implementation of a Health in All Policies (HiAP) framework by creating a taskforce or other body to subject major public policy and austerity decisions to HiAP and equity analyses. This could prevent future health-relevant public policy decisions from further marginalising vulnerable populations.
- Given that STC ridership fluctuated over time, any future version of a publicly owned bus company could consider mandating the use of the bus by all public servants travelling on official business. This could increase ridership and encourage use.
- In the context of climate change, any future bus service created to replace STC could consider a rewards system for people who choose the bus over their own cars. This could serve as an incentive to use public transportation as it is a more environment-friendly option.
- Until a new bus service is created, the government should consider collaborating with hospitals and the Saskatchewan Health Authority to assist vulnerable people needing rides to attend hospital appointments.

8.5 Conclusion

The closure of STC in 2017 as part of an austerity budget has caused more harm than good. The decision was ideological and not supported by evidence but by a neoliberal public policy paradigm. The decision has negatively influenced the health and wellbeing of individuals and communities through systemic disruptions and reduced access to services. Although the whole of society is forced to bear negative consequences of the decision, specific segments of the population such as people with disabilities, seniors, women, low-income people, young people, newcomers, Indigenous people and people in rural and northern locations have borne the most negative effects of the decision. It is, therefore, necessary to rethink the closure of STC because of the negative effects revealed through this project and because the findings of this research, like other research on austerity, demonstrate that austerity is bad for health.

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APPENDIX 1 – RESEARCH POSTERS

Department of *Community Health and Epidemiology*
University of Saskatchewan

PARTICIPANTS NEEDED FOR RESEARCH on *the health impacts of closure of the Saskatchewan Transportation Company (STC)*

We are looking for volunteers to take part in a study on the topic: **Public transportation and health: The contexts and impacts of closure of the Saskatchewan Transportation Company (STC)**

As a participant in this study, you would be asked to: *participate in an interview on how the closure of STC has affected you or people you know.*

Your participation would involve *1* session,
each of which is approximately *30-60* minutes.

In appreciation for your time, you will receive
a $25 grocery gift card.

For more information about this study, or to volunteer for this study, please contact:

Dr. Lori Hanson or *Jacob Alhassan, PhD Candidate*
Department of Community Health and Epidemiology
at
Email: *jaa178@mail.usask.ca*, *loh817@mail.usask.ca*

306-229-3618*, 306-966-7936*

This study has been reviewed by, and received approval through, the Research Ethics Office, University of Saskatchewan.

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Department of *Community Health and Epidemiology*
University of Saskatchewan

PARTICIPANTS NEEDED FOR RESEARCH on *the health impacts of closure of the Saskatchewan Transportation Company (STC)*

We are looking for volunteers to take part in a study on the topic: **Public transportation and health: The contexts and impacts of closure of the Saskatchewan Transportation Company (STC)**

As a participant in this study, you would be asked to: *participate in a focus group discussion on how the closure of STC has affected you or people you know.*

Your participation would involve *1* session, which will take approximately *60-90* minutes.

For more information about this study, or to volunteer for this study, please contact:
Dr. Lori Hanson or *Jacob Alhassan, PhD Candidate*
Department of Community Health and Epidemiology
at
Email: *jaa178@mail.usask.ca*, *loh817@mail.usask.ca*

306-229-3618, *306-966-7936*

This study has been reviewed by, and received approval through, the Research Ethics Office, University of Saskatchewan.

APPENDIX 2 – ETHICS APPROVAL

Behavioural Research Ethics Board (Beh-REB) 08-Jul-2019

Certificate of Approval

Application ID: 1219

Principal Investigator: Laurel Hanson

Department: Department of Community Health and Epidemiology

Locations Where Research Activities are Conducted: Saskatchewan, Canada

Student(s): Jacob Alhassan

Funder(s):

Sponsor:

Title: Public Transportation and Health: The Contexts and Impacts of Closure of The Transportation Company (STC)

Approved On: 08/07/2019

Expiry Date: 07/07/2020

Approval Of: Behavioural Research Ethics Application

Consent forms (interviews and focus groups)

Recruitment poster

Recruitment email

Interview and focus group questions

Transcript release form

Acknowledgment Of:

Review Type: Delegated Review

CERTIFICATION

The University of Saskatchewan Behavioural Research Ethics Board (Beh-REB) is constituted and operates in accordance with the current version of the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS 2 2014). The University of Saskatchewan Behavioural Research Ethics Board has reviewed the above-named project. The proposal was found to be acceptable on ethical grounds. The principal investigator has the responsibility for any other administrative or regulatory approvals that may pertain to this project, and for ensuring that the authorized project is carried out according to the conditions outlined in the original protocol submitted for ethics review. This Certificate of Approval is valid for the above time period provided there is no change in experimental protocol or consent process or documents.

Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.

ONGOING REVIEW REQUIREMENTS

In order to receive annual renewal, a status report must be submitted to the REB Chair for Board consideration within one month prior to the current expiry date each year the project remains open, and upon project completion. Please refer to the following website for further instructions: https://vpresearch.usask.ca/researchers/forms.php.

Digitally Approved by Patricia Simonson, Vice Chair
Behavioural Research Ethics Board
University of Saskatchewan

1 / 1

August 26, 2019

Dr. Lori Hanson
Department of Community Health and Epidemiology
Health Sciences Building

Study Title: Public Transportation and Health: The Contexts and Impacts of Closure of the Saskatchewan Transportation Company (STC)
File Number: OA-UofS-1219

Authorization Granted By:

- Karen Earnshaw, Vice President, Integrated Rural Health
- Sharon Garratt, Vice President, Integrated Urban Health
- Andrew McLetchie, Vice President, Integrated Northern Health

RE: LETTER OF AUTHORIZATION TO CONDUCT RESEARCH

Dear Dr. Hanson,

This letter is to notify you that the above-listed research study has been reviewed and meets all criteria for Operational Approval within the Saskatchewan Health Authority (SHA).

Please note that Operational Approval is conditional upon continued review and approval by the Research Ethics Board (SHA, U of R or U of S). Should Research Ethics approval lapse or be revoked, Operational Approval will also be suspended. In addition, Operational Approval is issued based upon the details provided in the Operational Approval to Conduct Research Application Form. Should the resource utilization deviate from what was requested in the initial application, Operational Approval may be revoked and an amendment must be submitted for review. Any publications or presentations that result from this research should include a statement acknowledging the assistance of the Saskatchewan Health Authority.

This letter serves as your official authorization to conduct research; **study activities may now commence**.

If you have any questions, please contact the Research Approval Coordinator, Shawna Weeks, at 306-655-1442 or shawna.weeks@saskhealthauthority.ca.

Sincerely,

Dr. Elan Paluck
Director of Research
Saskatchewan Health Authority

APPENDIX 3 – REQUEST FOR REPRODUCTIONS

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				(2) 1950-51			11
				(3) 1951-52			9
				(4) 1952-53			11
				(5) 1953-54			13
				(6) 1954-55			16
				(7) 1955-56			14
				(8) 1956-57			15
				(9) 1957-58			15
				(10) 1958-59			18
				(11) 1959-60			17
3.	R33.1	VI 284 (3 of 5)	T.C. Douglas Papers	STC Bus Lines 1951-1954 - Correspondence / News Release (March 26, 1954)			5
4.	R33.1	VI 284 (4 of 5)	"	STC Bus Lines 1954-1957 - Memorandums Apr 5 1957, Aug 12 1954			9
5.	R33.1	IV 162	TC Douglas Papers	Memo - "Relations between the GM + Board"			13

Special Instructions:

Total: ca. 176 pp.

APPENDIX 4 – INTERVIEW QUESTIONS

1. Please tell me a little bit about yourself- you age, gender, location/residence, car ownership, education, occupation, ethnicity, treatment being sought at the hospital (specific condition you are receiving treatment for)
2. What are your thoughts about the closure of STC?
3. Are you aware of any existing alternatives?
4. How have you been affected by the closure (directly/indirectly)?
5. What specific costs have you had to incur due to the closure?
6. Can you share any specific story (personal or of someone you know) about how the closure is affecting people?
7. What did the STC mean to you? What does losing it mean to you?
8. How has the closure of STC affected your social life?
9. How have you and others been coping with the closure?
10. What are your thoughts about the future regarding public transportation in Saskatchewan?
11. Why have you chosen to take part in this research?
12. Is there anything you would have expected me to ask that I ended up not touching on?

APPENDIX 5 – FGD WITH HEALTH AND SOCIAL SERVICE WORKERS

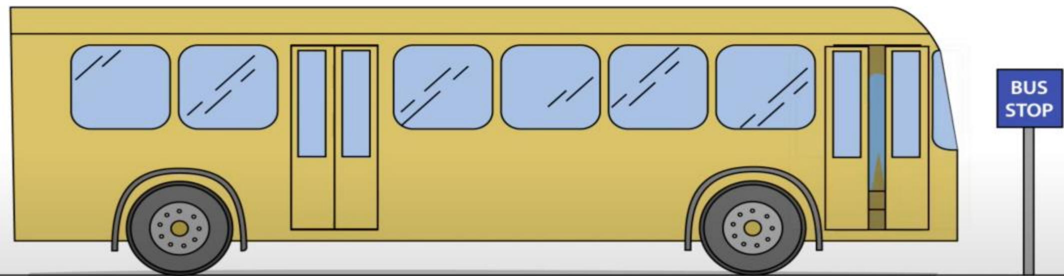
1. Please provide us with a brief introduction- your name, title, role and some context on the work you do
2. What are your thoughts about the closure of STC?
3. Two years after the closure what are some of the negative impacts of the closure on your work?
4. Describe any new costs created by the closure of STC
5. What stories have patients told you about the impacts of the closure on them?
6. What are your biggest concerns about the closure as health service providers?
7. What population groups have been affected the most by the closure?
8. What does the closure mean for rural/northern/urban health?
9. What has been the response of the Health Authority/Public Health or your organisation to the closure?
10. Any other comments you wish to add (pertinent issues which did not come up)

APPENDIX 6 – FGD WITH ACTIVISTS AND INDIGENOUS ORGANISATIONS

1. Please provide us with a brief introduction- your name, title, role and some context on the work you do
2. What are your thoughts about the closure of STC?
3. Two years after the closure what are some of the negative impacts of the closure on your work?
4. What explanations did the government offer for the closure and what are your thoughts on these explanations?
5. Describe any new costs created by the closure of STC on your work
6. What population groups have been affected the most by the closure?
7. Are there any stories people have shared with you about how the closure is affecting them which you might want to share?
8. Are there any specific population groups suffering the greatest disadvantages from the closure? Please elaborate.
9. How have people been coping after the closure?
10. What does the closure mean for the Indigenous rights? For disability rights? Women's rights?
11. What has been the response of your organisation to the closure?
12. Any other closing comments, remarks?

APPENDIX 7 – ADVOCACY BRIEF

ADVOCACY BRIEF:



Austerity, Transportation and Health Equity: Emerging impacts of the closure of STC

Jacob A.K. Alhassan
Lori Hanson

ACCORDING TO THE GOVERNMENT, STC WAS CLOSED:

- To allow the private sector to take up former STC routes
- Because of a general decline in intercity transit usage throughout Canada
- To save $85m within a five-year period
- Because of a 77% decline in provincial bus ridership over the last 35 years

ACCORDING TO RESIDENTS, THE STC CLOSURE HAS:

- Increased barriers to healthcare especially in rural Saskatchewan
- Increased stress, depression and other mental health challenges for people in isolated communities
- Increased risk of accidents and personal safety issues among the vulnerable
- Increased travel costs, especially for low income residents
- Created an emotional toll and strain in maintaining family relationships
- Isolated entire communities and made access to various services in big centres more difficult
- Increased inefficiencies in the healthcare system and disrupted care processes
- Increased stress for healthcare and other workers
- Forced people to purchase vehicles which creates environmental concerns

THE WAY FORWARD - SASKATCHEWAN NEEDS:

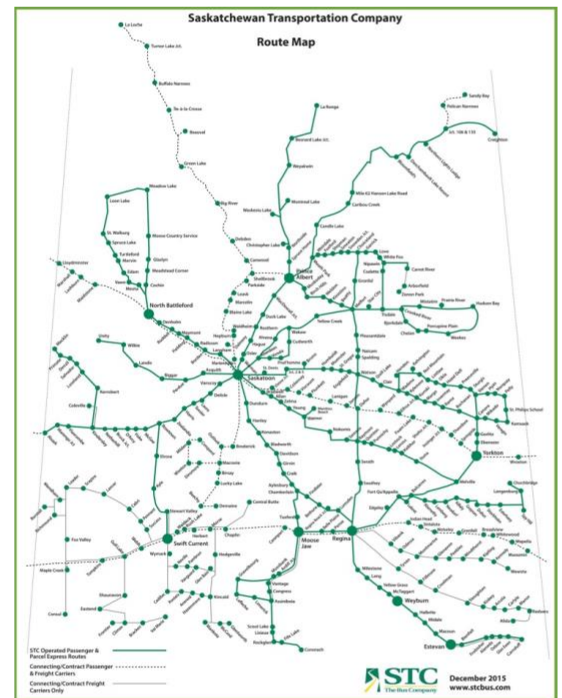
- An audit of the healthcare system to understand the real costs and wastages caused by the STC closure
- A province-wide bus system operated not for profit but to increase access to services for residents and reduce carbon emissions
- Activists and advocates to continue to mobilize and play a role in amplifying closure effects
- To hold politicians accountable for the stress, suffering and harms caused by the loss of STC

Background:

On 31st May 2017, after 70 years of service, the final bus of the government-owned Saskatchewan Transportation Company (STC) took its last trip from Regina. At the time of its closure the company served 253 communities and transported about 200,000 Saskatchewan residents yearly. STC was abruptly shut down as part of the March 2017 budget that saw cuts to several other public institutions and services including libraries, post-secondary institutions among others - although some of these cuts were later reversed after significant public outcry.

At the time of the company's closure, the STC was an integral part of life in Saskatchewan and played a pivotal role in transporting many essential equipment and supplies used by the various health regions, small businesses and farmers in the province. For example, the bus transported vaccines, blood products and medical equipment (Saskatchewan Transportation company, 2010).

Figure 1: Former STC Routes

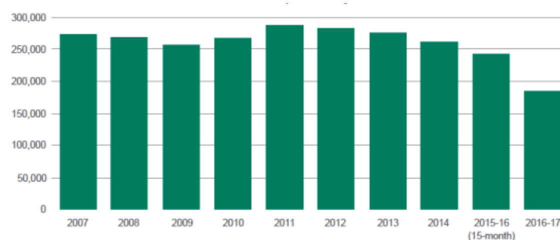


(Source: Saskatchewan Transportation Company, 2017)

Understanding STC Closure Impacts

The government offered a number of reasons to justify the March 2017 austerity budget in general and the need to shut down the STC in particular. These included: i) to reduce the province's budget deficit ii) the decline of intercity bus travel in Canada iii) a 77% decline in bus ridership in Saskatchewan over the last 35 years iv) that the private sector would pick up former STC routes v) that all efforts to limit the provincial subsidy had been exhausted (Johnson, 2017).

Figure 2: STC Ridership History 2007-2017



(Source: Saskatchewan Transportation Company, 2017)

Citizens, activists and advocates have raised concerns on the potential impacts of closing a company that formed such an integral part of life in Saskatchewan. The government was also critiqued for failing to create a clear mitigation plan to address the effects of closing the STC. Indeed, the STC closure may be interpreted not as a unique Saskatchewan issue but as part of a global rise in austerity (budget cuts) driven by a neoliberal ideology that aims to reduce public provision of various services (Alhassan and Hanson, 2019).

A Study of the Cuts:

We conducted a qualitative research study between July 2019 and March 2020 to gain an in-depth understanding of the closure of STC. The research aimed to 1) understand the political rationale for closing STC; 2) explore the impacts of the closure of STC on people, communities and various systems; 3) reveal how any impacts of closing STC might differ for different people in the province (for example rural compared to urban residents, seniors compared to young people etc.); and 4) create a framework that connects budget cuts and health.

The research involved interviewing 100 Saskatchewan residents from over 15 cities, towns and villages across northern, central and southern Saskatchewan. Six (6) focus group discussions were held with 24 health sector workers (program managers, doctors, nurses), social service workers (benefit navigators, social workers) activists (women's organizations, disability rights activists, activists against STC closure etc.) and Indigenous stakeholders to understand the system level effects of STC closure beyond individual stories obtained from the 100 interviews. Other data sources used in the research but not reported here have included 47 days of parliamentary Hansard on the closure, 751 newspaper articles and archival sources.

What We Found:

The research revealed that the closure of STC has had a set of interrelated effects on various individuals and communities. Some of these effects are described below:

Healthcare access barriers

Research participants reported missing and or cancelling hospital appointments or deciding not to seek healthcare after several failed attempts to find rides to attend hospital appointments. One participant who had lost all hope in seeking care said:

"if I was to be diagnosed next week with cancer, I'm not going to be working the phones to get a ride. I'm just going to sit at home… There'll be no treatments" (71-year-old woman from Big River Saskatchewan)

Mental health effects

Research participants reported mental health challenges caused or worsened by the closure of the bus. These issues ranged from shame in having to constantly ask for help, stress in trying to arrange rides and feelings of loneliness and isolation as a result of inability to connect with family members or loved ones. One research participant who was unable to visit family in the north due to the closure described the mental health effects:

Understanding STC Closure Impacts

"[i]t's definitely affecting my mental health. My emotional well-being. I do my best to walk the Red Road and my medicine wheel, the mental, the spiritual, the physical, the emotional, is all affected by this. It really, truly is. So, it's really depressing that I can't see my family". (36-year-old woman living in Saskatoon)

Personal safety

Participants described safety-related impacts both in terms of physical safety while travelling, but also safety, especially for women fleeing domestic violence. Other participants described sliding into ditches while travelling due to icy roads, hitchhiking to attend medical appointments in larger centers or walking several days to travel between cities. Interview respondents also described challenges in driving while on medication and how this puts them and other road users at risk. In one of the focus groups, a program manager described the risk people in smaller communities face while seeking treatment for addictions services:

> "*We have had people who have walked significant distances to get to [our treatment] center. Like we're talking like spent majority of days walking on highways, either hitchhiking or walking to get here."* (Health worker in Focus Group Discussion)

Broken family relationships

A number of research participants, especially divorced parents who used the bus to transport minors described challenges visiting their children while others described being unable to participate in family gatherings such as birthdays, thanksgivings, funerals and other occasions due to the closure.

Family driving burden

Family members described many challenges in trying to ensure that their parents, siblings or children (especially those who cannot drive due to disability or age) continue to access needed services. Family members are forced to take time off work and to drive several hours to help out those unable to drive. One participant noted:

"I have had to take time off work at the hospital to drive 300 km to [get my mother] and bring her back the same day so she can attend a physician appointment in Saskatoon" (52-year old woman living in Saskatoon)

Isolated and marginalized communities

The closure of STC has served to isolate, disconnect and marginalize many small communities. According to participants, these are communities that already feel marginalized and forgotten. One of the healthcare workers commented on this saying:

"I just think it's another example of trying to move all of our services into the bigger cities [and] isolate us even more so that we do disappear off the map. But that's kinda how it feels. It's really tough to have older adults and young families living in rural Saskatchewan. If they can't get to the cities for basic healthcare needs, it's not fair." (Healthcare worker in Focus Group Discussion)

Environmental effects

Research participants expressed concerns on the environmental effects of the decision to close STC. In total, 4% of research participants indicated that they had purchased a vehicle because of the STC closure. Being forced to buy a vehicle according to one participant is a serious ethical issue:

"[w]henever I look at my car or think about my car, I'm not happy about it… It's like if a vegetarian was forced to eat meat." (21- year old man living in Prince Albert)

Health system effects

Research participants especially those in the health sector, described how the absence of the STC is affecting health service delivery. The absence of the bus has created several inefficiencies and wastages, causes stress to health and social service workers as they try to deliver services as best they can and in some cases disrupts the care process making clinical decision making more complicated. As one healthcare worker from a rural area noted:

"Medications showing up - it's frozen; we can't use it. Or in the summer it's too hot, we can't use it. We're throwing out thousands of dollars of medication." (Healthcare worker in Focus Group Discussion)

Understanding STC Closure Impacts

Apart from throwing away medication because they arrive at odd times through private couriers, in some cases wait times are increased for patients who have to come with care givers. These care givers end up using health resources leading to further wastage. Care processes are also disrupted because of the absence of the bus because:

"There's emails every single day at work, looking for somebody going to Regina to take a package. I mean it's every single day, not just our department, but every department …I mean we can't even send a lab work to Regina on a Saturday. It sits in our lab department until Monday morning. How are you supposed to make a clinical decision on somebody's health care when you can't get your lab results in five days?" (Healthcare worker in Focus Group Discussion)

Healthcare workers described the stress involved in trying to keep services running without adequate transportation services. In most cases the government pays for these inefficiencies by paying more for delivery, health workers pay by being stressed and patients pay by receiving sub-par services.

Discussion:

Three issues are important for understanding STC closure: 1. Impacts go beyond former users 2. Closure impacts vary for different people. 3. The work of activists and advocates matter.

STC closure effects beyond former users

A fundamental insight from this research is the idea of a '**web of dispossession**'. The closure of the STC does not only affect the individual former users but affects for example family members who bear a heavy driving burden to ensure former users continue to access services. The closure also affects entire communities whose libraries used the bus or small towns that are now completely isolated. Beyond individuals, families and communities, the closure affects the health system through inefficiencies and disrupted care processes and perhaps through the environment and climate change as more people are forced to buy vehicles leading to more emissions. This means that people who may perceive themselves as unaffected by the closure may find themselves caught up in the 'web' of closure effects as they interact with various systems.

Health equity effects of the closure

The closure of STC does not affect everyone equally. The closure assumes that everyone has (access to) a vehicle, can drive or has relatives who are able and willing to drive and therefore excludes many people with disabilities, seniors, low income residents and other vulnerable people who for various reasons are not able to travel due to the closure.

Activism and advocacy matter

Activists and advocates have played a crucial role in highlighting closure effects. These efforts give voice to the most marginalized who suffer closure effects quietly. Activists, academics, health and other professionals need to continue to speak out on closure effects to promote accountability, improve access for the marginalized and help reduce the negative effects of the closure especially among the most marginalized members of society.

Recommendations:

The closure of STC has had many negative effects on people in Saskatchewan. The evidence is clear - current private alternatives have not been successful in ensuring access to various services especially for people living in rural and remote parts of the province. This necessitates the creation of a bus system that is accessible, affordable and safe – focused not on profit but improving access especially to the most vulnerable. These are the pillars that marked STC, and they need to be reignited. Several inefficiencies in the health system are attributable to the closure and this calls for a large-scale audit to increase understanding of the social and financial costs of the closure.

The closure of the STC has caused systemic inefficiencies, needless hardships and barred the most vulnerable from participating in basic aspects of social life such as visiting family. These negative effects reveal the connections between austerity (budget cuts) and health, and call for more mobilizing, advocacy and activism against budget cuts especially by those interested in promoting population health and equity.

Authors

Jacob A.K. Alhassan is a PhD candidate in the department of Community Health and Epidemiology. Dr. Lori Hanson is an associate professor in the department of Community Health and Epidemiology and director of the Division of Social Accountability, College of Medicine, University of Saskatchewan.

Acknowledgements

The authors acknowledge the contribution of members of Stop the Cuts in conceptualizing and implementing the research study. The authors also acknowledge the contributions of Drs Sylvia Abonyi (PhD), Charles Smith (PhD), Cory Neudorf (MD) and Rachel Engler-Stringer (PhD) who have acted as a thesis advisory committee.

Other resources on STC and Transportation in Saskatchewan

Video: https://www.youtube.com/watch?v=4msWMzmMFOo

Podcast: https://soundcloud.com/user-335804690/sets/transportation-and-health

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Alhassan, J. A. K., & Hanson, L. (2019). 'It feels like I've lost my independence…Now I just feel like I'm a prisoner trapped in my own city'- Politicizing the transportation-health nexus: Evidence from the Canadian province of Saskatchewan.*Journal of Transport and Health, 14* (supplement). 100635. Retrieved from: https://www.sciencedirect.com/science/article/pii/S2214140519304360

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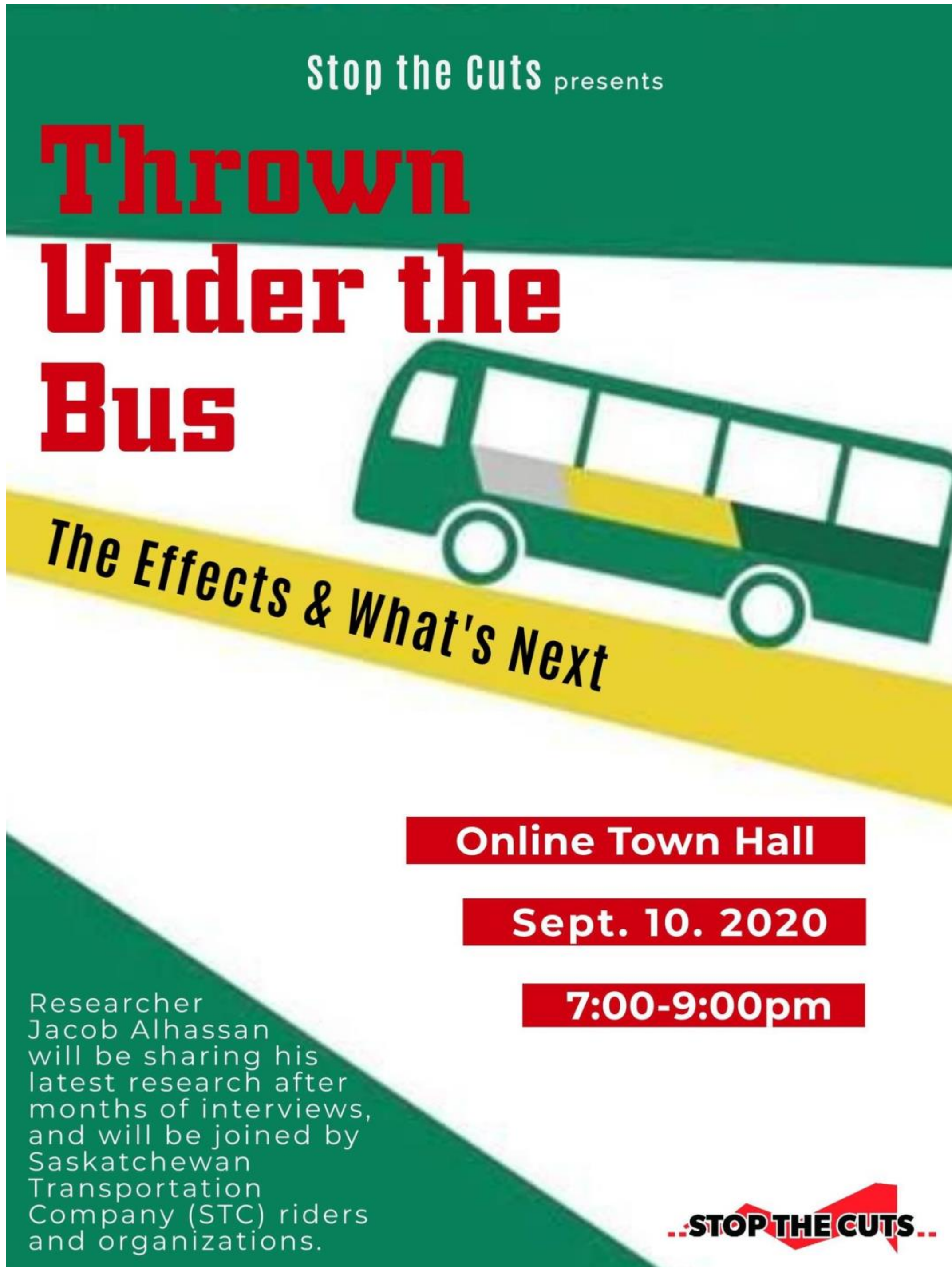
APPENDIX 8 – ONLINE TOWN HALL POSTER



APPENDIX 9 – INTERVIEW CONSENT FORM

You are invited to participate in a research study entitled:

Public transportation and health: The contexts and impacts of closure of the Saskatchewan Transportation Company (STC)

Researcher
Jacob Alhassan, PhD Candidate
Department of Community Health and Epidemiology
University of Saskatchewan
Saskatoon, SK S7N 5E5
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306-229-3618

Supervisor
Lori Hanson, PhD
Associate Professor, Department of Community Health and Epidemiology
Director, Division of Social Accountability
College of Medicine
University of Saskatchewan
lori.hanson@usask.ca
306-966-7936

Purpose(s) and Objective(s) of the Research:

- In May 2017, the Saskatchewan Transportation Company (STC) was shut down as part of a provincial government budget aimed at reducing the province's budget deficit. There are several connections between public transportation and health outcomes. The connections between absence of public transportation and health can range from increases in road traffic accidents, challenges with social isolation and inability to access services including attending medical appointments. This research aims to do four things. 1. To identify and reveal the political rationale underlying the closure of STC 2. To identify and elucidate the health impacts of the closure of STC 3.To examine how the health impacts, differ based on social (differences based on gender, ethnicity, race, disability status) and geographical location (rural or urban status) 4. To advance a theoretical pathway for understanding the effects of austerity on health and health equity (using a transportation case study)

Procedures:

- You are invited to partake in an in-person or telephone interview. Interviews will last approximately 30-60 minutes. You may choose the location for the interview. Alternatively, a meeting room at the University of Saskatchewan will be used. Interviews will be audio recorded. The audio recording will be transcribed and analyzed as part of the research project. Interview questions will focus on the impacts of the closure of the Saskatchewan Transportation Company on you or people you know or work with.

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- The Social Science Research Lab (SSRL) may be contracted to transcribe the data from this interview in which case they will be made to sign a confidentiality agreement before accessing data.
- Please feel free to ask any questions regarding the procedures and goals of the study.

Funded by:

- The researcher is funded as a Trainee of the Saskatchewan Center for Patient Oriented under the College of Medicine Graduate (COMGrad) Award

Potential Risks:

- Talking about the STC could be upsetting for some people. In any case of emotional distress, the researcher will refer participants to their GP.

Potential Benefits:

- The goal of the research is to chronicle some of the impacts of the closure of STC and to understand the rationale for the decision to close STC. Your participation will help to develop the knowledge base on the relationship between austerity (public sector cuts) and health using a transportation case study.

Compensation:

- Interviewees will receive a $25 grocery gift card. The full 25$ grocery gift card will still be received even if you later chose to withdraw from the study.

Confidentiality:

- Should you consent to participate, you will be given an opportunity to indicate how your data may be used. You will be given the option of having your statements remain confidential, if you so wish. If you would like your interview to be confidential, we will ensure that we do not disclose identifiable information about you in the reporting or dissemination of the research findings.
- You can indicate on this sheet, below in the Consent section, whether you wish to have your participation and statements be confidential or for you to be named as a participant and have your direct and identifiable quotations included in our research. If you give permission to have your identifiable quotes included in our research, we will give you the opportunity to review any statements of yours we wish to use in our research prior to publishing it and you will have the option to edit or remove your statements at that time.
- Your right to withdraw data from the study or to revise transcripts will apply until 1st September 2019. If you request to revise transcripts they will be made available to you via email and should be returned in two weeks.
- Interviews will be audio recorded, and transcribed. You may request audio devices to be turned off at any point during your interview without giving a reason. To protect confidentiality, audio files and transcripts will be stored on password-protected computers accessible only to the researchers. Files will be backed up on an external hard drive that will be stored in a locked filing cabinet at the University of Saskatchewan. Research data will be stored separately from consent forms. The data will be stored for a minimum of five years before it will be destroyed.

Right to Withdraw:

Your participation in this project is voluntary and you can answer only those questions that you are comfortable with. Should you wish to do so, you may withdraw from the research project for any reason,

at any time without explanation or penalty of any kind. You can contact Jacob Alhassan at jaa178@mail.usask.ca or 306-229-3618 if you wish to withdraw. Should you wish to withdraw, your data will not be used as part of the research. Your right to withdraw data from the study will apply until September 2019. After this date, it is possible that some form of research dissemination will have already occurred, or that data will have been de-identified and pooled, and it may no longer be possible to withdraw your data.

Follow up:
To obtain results from the study, please contact at jaa178@mail.usask.ca or 306-229-3618

Questions or Concerns:

- Contact the researchers using the information at the top of page 1;
- The University of Saskatchewan Research Ethics Board has approved this research project on ethical grounds. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent:

- For interviews conducted by phone, the contents of the consent form will be explained to participants and consent will be audio recorded.

If you wish to have your data remain confidential, you will not be named as a participant any data you provide us will not be used in ways that could identify you. Please indicate how we may use your data by checking one of the following boxes:

☐ I am willing to be named as a participant. The researchers can refer to my statements and quote me in their research. I understand that I will have the opportunity to review any statements of mine you plan to use in your research prior to dissemination, and edit or remove my statements at that time.

☐ I wish to have my interview be confidential. You may refer to my statements or quote me in your research, only if my identity is protected. I understand that if you plan to use any statements in your research dissemination that could potentially be linked to me, I will be asked for my permission before you to do so.

Your signature below indicates that you have read and understand the description provided;
I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

______________________ ______________________ __________
Name of Participant *Signature* *Date*

______________________ ______________________
Researcher's Signature *Date*

A copy of this consent will be left with you, and the researcher will take a copy.

APPENDIX 10 – FGD CONSENT FORM

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HEALTH AND EPIDEMIOLOGY

You are invited to participate in a research study entitled:

Public transportation and health: The contexts and impacts of closure of the Saskatchewan Transportation Company (STC)

Researcher
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Director, Division of Social Accountability
College of Medicine
University of Saskatchewan
lori.hanson@usask.ca
306-966-7936

Purpose(s) and Objective(s) of the Research:

- In May 2017, the Saskatchewan Transportation Company (STC) was shut down as part of a provincial government budget aimed at reducing the province's budget deficit. There are several connections between public transportation and health outcomes. The connections between absence of public transportation and health can range from increases in road traffic accidents, challenges with social isolation and inability to access services including attending medical appointments. This research aims to do four things. 1. To identify and reveal the political rationale underlying the closure of STC 2. To identify and elucidate the health impacts of the closure of STC 3.To examine how the health impacts, differ based on social (differences based on gender, ethnicity, race, disability status) and geographical location (rural or urban status) 4. To advance a theoretical pathway for understanding the effects of austerity on health and health equity (using a transportation case study)

Procedures:

- You are invited to partake in a Focus Group Discussion (FGD). FGDs will last approximately 60-90 minutes. The location will be agreed by consensus of all participants and will take place in either Saskatoon, Regina or Prince Albert. FGDs will be audio recorded. The audio recording will be transcribed and analyzed as part of the research project. FGD questions will focus on the impacts of the closure of the Saskatchewan Transportation Company on you or people you know or work with.
- The Social Science Research Lab (SSRL) may be contracted to transcribe the data from this focus group in which case they will be made to sign a confidentiality agreement before accessing data
- Please feel free to ask any questions regarding the procedures and goals of the study.

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Funded by:

- The researcher is funded as a Trainee of the Saskatchewan Center for Patient Oriented under the College of Medicine Graduate (COMGrad) Award

Potential Risks:

- Talking about the STC could be upsetting for some people. In any case of emotional distress, the researcher will refer participants to their GP.

Potential Benefits:

- The goal of the research is to chronicle some of the impacts of the closure of STC and to understand the rationale for the decision to close STC. Your participation will help to develop the knowledge base on the relationship between austerity (public sector cuts) and health using a transportation case study.

Confidentiality:

- Should you consent to participate, you will be given an opportunity to indicate how your data may be used. You will be given the option of having your statements remain confidential (to certain limits given that this is a group activity), if you so wish.
- Your right to revise focus group transcripts will apply until 1 January 2020. If you request to revise transcripts they will be made available to you via email and should be returned in two weeks.
- You can indicate on this sheet, below in the Consent section, whether you wish to have your participation and statements be confidential or for you to be named as a participant and have your direct and identifiable quotations included in our research. If you give permission to have your identifiable quotes included in our research, we will give you the opportunity to review any statements of yours we wish to use in our research prior to publishing it and you will have the option to edit or remove your statements at that time.
- FGD will be audio recorded, and transcribed. To protect confidentiality, audio files and transcripts will be stored on password-protected computers accessible only to the researchers. Files will be backed up on an external hard drive that will be stored in a locked filing cabinet at the University of Saskatchewan. Research data will be stored separately from consent forms**.** The data will be stored for a minimum of five years before it will be destroyed.
- The researcher will undertake to safeguard the confidentiality of the discussion, but cannot guarantee that other members of the group will do so. Please respect the confidentiality of the other members of the group by not disclosing the contents of this discussion outside the group, and be aware that others may not respect your confidentiality.
- In focus group discussions some participants may easily be identifiable since they would be selected on the basis of their roles. For example, participants in leadership positions may easily be identified by their statements.

Right to Withdraw:

- Your participation is voluntary and you can participate in only those discussions that you are comfortable with. You may withdraw from the research project for any reason, without explanation or penalty of any sort. Should you wish to withdraw, you may leave the focus group meeting at any time; however, data that have already been collected cannot be withdrawn as it forms part of the context for information provided by other participants. You can contact Jacob Alhassan or Dr Lori Hanson if you have any concerns

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Follow up:
To obtain results from the study, please contact at jaa178@mail.usask.ca or 306-229-3618

Questions or Concerns:

- Contact the researchers using the information at the top of page 1;
- The University of Saskatchewan Research Ethics Board has approved this research project on ethical grounds. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office ethics.office@usask.ca (306) 966-2975. Out of town participants may call toll free (888) 966-2975.

Consent:
If you wish to have your data remain confidential, you will not be named as a participant any data you provide us will not be used in ways that could identify you. Please indicate how we may use your data by checking one of the following boxes:

☐ I am willing to be named as a participant. The researchers can refer to my statements and quote me in their research. I understand that I will have the opportunity to review any statements of mine you plan to use in your research prior to dissemination, and edit or remove my statements at that time.

☐ I wish to have my responses confidential. You may refer to my statements or quote me in your research, only if my identity is protected. I understand that if you plan to use any statements in your research dissemination that could potentially be linked to me, I will be asked for my permission before you to do so.

Your signature below indicates that you have read and understand the description provided;
I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project. A copy of this Consent Form has been given to me for my records.

____________________ ____________________ ____________

Name of Participant *Signature* *Date*

____________________ ________________

Researcher's Signature *Date*

A copy of this consent will be left with you, and the researcher will take a copy.

APPENDIX 11 - MEDIA COVERAGE OF RESEARCH PROJECT

- Alhassan, J. A. K., & Hanson, L. (2020). *Austerity , Transportation and Health Equity : Emerging impacts of the closure of STC*. Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/thestandcentre/pages/314/attachments/original/1599056621/STC-Advocacy-Brief-August-26.pdf?1599056621

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APPENDIX 12 - HANSARDS AND NEWSPAPERS CITED IN MANUSCRIPT 1

Hansards cited

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Forbes, K. (2017, October 30). "Orders of the day." Regina. Legislative Assembly of Saskatchewan. *Edited Hansard 59*(3A). 28th Legislature, 2nd session. Retrieved from the Legislative Assembly of Saskatchewan website: http://docs.legassembly.sk.ca/legdocs/Legislative%20Assembly/Hansard/28L2S/171030Debates.pdf

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