The current recession is international in scope but affects different places with varying severity. According to the World Bank, poor nations are (and will) bear the brunt of the economic, social, and health fallout from the current recession. As well, it is quite likely that rural regions of developed nations such as Canada, will be disproportionately affected by the current recession relative to urban places. These more severe adverse effects on health will likely arise through direct pathways as health services in rural areas are cut back and indirectly as the often more fragile and less diversified economies in rural regions are harder hit by the economic downturn than economies located in urban places.

By taking an historical perspective on both the timing of the shift in health status between urban and rural places and the impacts of, not just the current recession, but other major recessions that have occurred over the past 30 or so years, we may better understand the likely impact of the current recession on the health of rural residents in developed nations.
approach, in this case focusing on disparities between urban and rural places in British Columbia, Canada’s western-most province, may be useful.

We know that residents in rural and remote communities in Canada (and in many other developed nations) tend to have worse health status and health behaviours compared to their urban counterparts. It is important to understand that this was not always the case. As the industrial revolution unfolded in the late 19th and early 20th centuries mortality rates were generally much higher in cities, which at the time had little sanitary infrastructure and were massively over-crowded and poor, relative to the countryside. However, as cities built their public health infrastructure and sewage systems, as populations living in cities became relatively more prosperous, as urban economies increasingly became the driver of national economies, the health of city dwellers improved relative to country dwellers in most nations [1].

In the United States this transition from unhealthy city to unhealthy countryside appears to have been largely complete by the 1970s. Schneider and Greenb [2] have shown, for example, in 1939/41 all cause mortality for white males aged between 35 to 65 years and living in rural states was 40 percent less than for white males of the same age living in largely urban states. By 1959/61 this mortality gap had narrowed considerably and by 1979/81 it was completely reversed as white males in rural states had all cause mortality rates 32 percent greater than for males in largely urban states. In their study, they noted the same general trends for white females.
Since the 1980s in both Canada and the United States, across most rural regions, mortality and morbidity rates (for most but not all illnesses), self-reported health status and adverse health behaviours such as smoking have tended to be much higher than in cities. (There are some important exceptions. For example, in British Columbia rates for most cancers are lower in rural regions of the province). This fairly consistent rural/urban health disparity is likely the result both of underlying socio-economic inequalities between rural and urban regions in North America as well as worse access to health services in rural communities.

In terms of the latter, it should be noted that rural residents in Canada may be better off than their counterparts in the US as basic medical insurance is available free of charge or (in some provinces) with minimal fees. Given that, in the USA, poor and rural citizens tend to be less well covered by health insurance plans than even their poor urban counterparts, if the current recession worsens (at least to the extent that adverse health outcomes are driven by poor or no access to health services), rural Americans may suffer disproportionately, not only relative to rural Canadians, but also in relation to their poor urban American cousins.

British Columbia is an interesting case study of the urban/rural health divide and also illustrates how several recessions over the last quarter century have impacted the health status of residents especially in rural parts of the province. BC’s rural economy, unlike many rural parts of Canada is not heavily involved in agriculture. Less than 3 percent of the land base is arable and yet the province is rich in mineral wealth, energy resources, forests, fish, and other natural resources. After the Second World War governments tapped these resources by building dams, mills, and infrastructure. The rural population in the province increased through the 1960s and 1970s as
jobs in resource extraction industries were plentiful. Towns expanded and healthcare facilities to service growing young families were provided.

However, in 1981 a major recession caused widespread unemployment leading to major restructuring in forestry, mining, and the energy sector. Thousands of jobs were lost in the forestry sector. This began a wave of depopulation in rural BC, which accelerated during the recession of the early 1990s and has, in the current recession, accelerated even more. The loss of income as mills and mines have closed have led to declines in local tax revenues and ability to fund local infrastructure and in many cases the heart of rural communities has been cut out. As well, as the jobs in these towns disappear dynamic and well educated families tend to leave further eroding the social capital in these communities increasing their economic and social vulnerability [3][4][5][6].

It is no accident that the mortality and morbidity gap, for most, but not all illnesses, observed in BC and other rural regions in developing nations, relative to urban places, has taken place in the context of the steadily eroding rural economy since the late 1970s. During the past 30 years or so, the economic benefits of globalization have been reaped more by cities as with globalization they have increasingly become the engines of economic growth [7]. As rural economies stagnate (the current recession will likely exacerbate the relative economic inequalities between rural and urban places even more), their vitality and health is impacted.

At this point in British Columbia the extent of the urban rural divide in both economic and health terms is stark. For example, considering health disparities, according to the 2005 Canadian
Community Health Survey, approximately 20 percent of residents of northern (mainly rural and remote) regions of BC were obese and approximately 25 percent smoked, compared to, respectively, 8 and 12 percent in BC’s main urban centre, Vancouver [8]. As well, the average age standardized mortality rate between 1997 and 2000 was 6.4 deaths per 1,000 in the largely urban south west corner of the province compared to 8.4 per 1,000 in the Northern Health Authority (largely rural and covering the northern half of the province). In other words, residents of the most rural and remote parts of the province experience all cause mortality rates that are fully one third greater than for urban residents in the province [9].

This health divide is also found when considering other health measures, for example, life expectancy. Residents in the completely urban Greater Vancouver Regional District currently have life expectancies that are among the highest in the world (approximately 82 years) but residents of the Northern Health Authority, on average, have life expectancies which are 4 or 5 years less than this [9] (McGrail et al, 2004). The size of these disparities in all cause mortality and in life expectancy are staggering and not much different to the health disparities observed between highly developed and under-developed nations. The almost one third difference in the mortality experience of residents in these two health authorities is akin to what one might find comparing the current mortality experience between Canada and a much less developed much poorer nation such as Jamaica.

**Conclusion**

Differences in health status and health behaviours among residents of rural compared to urban regions in developed nations have followed pattern strongly related to the rate of
investment and uptake in public health infrastructure as well as the pace of economic
development. While, by and large, cities were more unhealthy in the late 19th and early
20th centuries than the countryside, as the fruits of economic and public health
development were increasingly garnered by urbanites, rural places became less
developed and less healthy.

Globablization has increasingly made cities the engine of national economic
development further marginalizing rural regions to more strictly resource extraction
roles. The lower levels of economic development associated with primary resource
extraction and farming, leave less of the economic pie (in the form of jobs, income, and
infrastructure) available for rural regions and rural populations. As well, these kinds of
industries are more prone to the direct impacts of economic recessions, as they are more
directly dependent on commodity prices which in turn fluctuate with changing market
conditions.

The current economic recession, may be different from previous post-Second World
War recessions. This remains to be seen. However, the impact on rural regions and the
health of residents of these regions will be marked, as in previous recessions. It is to be
hoped that governments in developed nations will direct efforts at economic recovery to
rural regions where the economic and health deficit of its citizens are most pronounced.

References


