Health Status, Urbanization and Migration in Vietnam:
Preliminary Findings from the 1997-98 Living Standard Survey

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Executive summary
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I. Introduction

Compared to other countries at its level of development, Vietnam has achieved many successes in health care derived from a social service system based on equity. Concrete evidence of such achievements can be seen through a very low level of infant mortality since the 1970s, as well as a high life expectancy at birth – two of the most popular indicators of health achievement. The successful health improvements in Vietnam were made possible by devoting large resources to the health sector.

This remarkable achievement, however, is presently being challenged by the introduction of a political and economic reform, known as "*Doi Moi*", in 1986. In general, a free market economy boosts economic growth while transforming social structures in ways that widen socioeconomic differences between groups.

The reforms have led to an important shift in economic policy from central planning to a market-oriented economy. On one hand, the reforms have created new job opportunities and higher income, resulting in higher living standards. People have better nutrition and better quantity and improved access to medicine and health care facilities. Such improvements, however, come at a considerable cost: higher inequality and the emergence of new patterns of inequality that are the results of market mechanism. Though better health services and medicines are available, larger inequality in access to health care has occurred since the reforms. This inequality is due to the privatization of health services. After the introduction of the economic reforms, many public goods, which were provided on a free-of-charge basis, have been either partially or completely privatized and provided on a pay-for-service basis. The poor and the disadvantaged groups are therefore less able to meet their health needs.

A noticeable consequence of the political and economic reform is the rapid growth of migration flow to urban areas. Some of the main reasons for increased migration are rural people are no longer tied to lands, the countryside is open to national market exchanges, and the household registration system no longer limits acquisition of essential goods and residence in the cities. The greater concentration of resources and investment in urban centers create greater job opportunities. In addition, better services in urban areas further contribute to the appeal of urban over rural areas, and hence, the growth of the migration flow to urban areas. Data from the 1999 census shows that of the 4.5 millions registered migrants aged five and over who migrated in the five year period before the census, 53 percent or 2.3 millions people were urbanward migrants, and among those, a little bit more than half were rural-to-urban migrants.

Given the backdrop of increasing inequality in health, economic and social services, urban migrants in Vietnam might have to face double burdens. First, most migrants are poor and

have a lower-SES compared to urban natives. Therefore, they are in the same boat as the urban poor or urban lower-SES groups. Moreover, a large proportion of them are "invisible" since it is not strictly required to have residence registration and many of them have never done this at their urban destinations. As a result, they are left out of social policies and social plans that are based mostly on the downward biased vital statistics that are collected from registration books.

Concerns about urbanward migrants were not voiced in the past, but they are getting more attention recently. Municipal governments are facing questions of the 'floating' population: who are they; how does the government manage them; how do they affect local services (education, health, housing, sanitation, etc.); to what extent do they contribute economically to the city; how do they affect crime rate in the city, and so on. Although these questions are being asked, there is much uncertainty about how to cope with the 2.3 million migrants and an undetermined number of unregistered migrants. Obviously, better estimates and understanding of urbanward migrants and revisions of migration and social policies, including health policies, are expected.

II. Objectives

Since the economic reform has introduced a degree of uncertainty into what was previously known about the health status of migrants, the current study looks specifically at differentials in health status between different groups of urban migrants and non-migrants at both the origin and the destination places. More specifically, this study is an attempt to answer two major related questions: whether health status varies across migrants of different types and non-migrants and, if so, in what ways.

The study also examines differentials in health determinants among different groups under examination. The argument is that different groups of migrants have different socioeconomic backgrounds and thus experience urban life differently. Hence, their health is affected in different ways. Besides common determinants, some of the factors that are strong health determinants to one group might have no effect on the others. Consequently, it may be advisable for health policy to be made more flexible, and for health policy makers to assign higher or different priorities to the more vulnerable groups.

Finally, this study aims to discuss and provide implications for health policies and the ongoing health reform program.

III. Data and methods

The data for this analysis came from the "Vietnam Living Standard Survey (VLSS), 1997-98". The survey was conducted by the Ministry of Planning and Investment and it was funded by UNDP and Swedish International Development Authority (SIDA). A total of 5,999 households with 23,033 individuals from 194 communes/wards were successfully interviewed. The sample was designed to make sure that 80% of the household was living in rural areas and 20% in urban areas. Corrective weighting was done to ensure that the sample can be extrapolated to the national level.

Migration and health are two among fourteen sections in the household questionnaire. This study focuses on illness status as an indicator of health status, and duration of illness as an indicator of severity of illness. One is considered ill if s/he got ill of any kind during the four weeks prior to the survey. The section on migration is applied to respondents aged ten and older,

and it includes questions on place (i.e. province) of birth, previous place of residence, and current place of residence, type of those places (city, town, rural areas). Migrants are defined as those whose current place of residence is different from their place of birth.

The current study utilizes descriptive (i.e. frequency tables), bivariate (i.e. cross-tabulation, t-test, χ2-test), and multivariate techniques. Logistic regression is used to analyze health determinants when health status (i.e. the outcome variable) is dichotomized, i.e. illness versus no symptom of illness. When health status is a continuous variable, i.e. duration of ill-leave, OLS regression is used.

IV. Results and Conclusion

It is found that migrants, in general, have worse health than non-migrants, and that rural-to-urban migrants have worst health. It is shown that rural-to-urban migrants have the highest rate of having at least one illness during the four week period prior to the survey (54 percent), with the next highest rate among the rural-to-rural migrants (52 percent). In contrast, urban non-migrants have the lowest rate (32 percent) of having illness, followed by rural non-migrants (39 percent). It is to be noted that temporary migrants are not included in the 1997-98 VLSS and that selectivity, i.e. rural-to-urban migrants are younger and healthier than the population who stays at the rural places of origin, is most likely to happen. The fact that more rural-to-urban migrants get ill than rural non-migrants suggests that rural-to-urban migrants' health deteriorates faster than that of the rural non-migrants.

The urban penalty is evidenced: those who live in major cities are having the highest likelihood of getting ill regardless of the concentration of medical facilities in these settings. Towns are found as the healthiest place to live following by the rural areas: while half of those living in cities reported ill, only 41 percents of those living in rural areas and 32 percent of those living in towns reported ill during the past four weeks.

Both the disadvantageous situation of urban migrants and the urban penalty hold after controlling for other socioeconomic and public health factors.

Results from this study also suggest that public health and environmental factors play an important role in improving health for urban residents. Having access to clean water and using less polluted fuel for cooking, i.e. electricity and gas versus charcoal and wood, decrease the likelihood of getting ill and shorten the duration of suffering from illnesses. Large households seem to have more advantages as those who live in larger households are less likely to get ill.