Privatization of the Health Care System and Migrant Construction Workers in the Informal Sector in Hanoi, Vietnam

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Abstract

After *Doimoi* (Renovation) policy, the Vietnamese health care system has been strongly privatized, affecting various vulnerable groups including migrant construction workers in the informal sector. An ethnographic approach, including participatory observation, in-depth, and informal interviews, was adopted to understand the health problems of 11 migrant construction workers in two sites, one large scale and one small scale, in Hanoi, Vietnam during December 2014 and February 2015. The research has found that the informal sector exacerbated the health of construction workers. Their health

seeking behavior was to delay treatment of the illness or use drugs without consulting with qualified pharmacists or doctors. The main barrier was financial factors and the lack of formal social protection. Without social insurance and health insurance, construction workers had to rely on their social relations. However, their social relations mainly limited to interpersonal ones, lack a connection with civil society organizations. As the interpersonal networks were also at the low-middle class, they mainly provided emotional, informational, or instrumental, not financial support. The workers, therefore, could not improve their health seeking behavior and might become vulnerable when suffering serious health problems.

Keywords: Privatization, Informal sector, Social Networks, Social support

Introduction

After *Doimoi* policy in 1986, a huge flow of migrant construction workers from rural areas to Hanoi has been recorded (D. N. Anh & Tacoli, 2003). Without qualifications, many of them have to work in the informal sector which is organized at a low level and does not provide labor contracts and fringe benefits for workers (Cling et al., 2010). As construction work is greatly dangerous, construction workers are more likely to have health problems (Diệu Hiền, 2013; Lao động, 2012; Ministry of Labor, 2013; Phạm Thanh, 2013).

However, migrant construction workers find it difficult to access health care services because of three primary reasons. Firstly, the health care system has been strongly privatized, leading to increasing health expenditures (Lieberman & Wagstaff, 2009). Secondly,

construction workers are not provided fringe benefits such as social insurance and health insurance by their employers. Thirdly, construction workers are must join voluntary social and health insurance programmes of the government, by the household registration system (Duong, Linh, & Thao, 2011).

Reviewing literature, this paper has found that in order to tackle their health problems, migrant workers in the informal sector have to rely on their social networks or social relations (H. T. Anh, 2011; Cattell, 2001a; Duong et al., 2011; Li & Wu, 2010; Minh, 2014). This paper[20] aims to explore what kinds of support their social relations provide for them and to what extent their social relations help them in alleviating their health problems. Additionally, the research also aims to explore how their health seeking behaviour is affected by the privatization of the health care system. The results of this research may shed light on their health vulnerability under the privatization of health care and the importance of social relations on alleviating their health problems.

Research methodology

As an interpretive study, the research uses qualitative research methods, including participatory observation, focus group discussions, and in-depth interviews. The main characteristic of these quali-

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[20] The paper is part of the Master of Arts thesis named "Privatization of Health Care System and Migrant Construction Workers in Hanoi", supervised by Assistant Professor Thapin Phatcharanuruk (Chiang Mai University), funded by The Consortium of Development Studies in Southeast Asia. An earlier version of this paper was presented at the International Conference on International Relations and Development 2015 in July 2015.

tative research methods is flexibility that is suitable to examining the lives, reactions, and difficulties of migrant construction workers that are still unclear and complex.

The research studies two construction sites, one large scale and one small scale. The large scale site is a factory located in an industrial zone. The main contractor of this site is a Japanese enterprise which is responsible for the design and management. The construction is implemented by five informal enterprises that are hired as sub-subcontractors. Meanwhile, the small scale site is a private house solely constructed by a small informal enterprise having nine workers.

Working conditions at the large scale site I researched are far better than those found at the small scale one, primarily because of the superior management and subsequent supervision of the work and protective equipment supplied to the workers. However, other worker benefits are fairly similar between the two sites. All workers do not have a labor contract and are not provided fringe benefits such as social insurance and health insurance. Workers are only paid daily wages and are not paid on days off.

This research focuses on 11 key informants. The sampling process had two steps. The first step was to choose construction sites depending on their scale. In this research, I chose one large scale and one small scale site. The second step was to choose key informants by three indicators, namely job type, work experience, and diseases/injury history. More particular information is as below.

Table 1

Site	Case	Group	Age	Work experience[21]
Large scale site	A1	Painter	25	Experienced
	A2	Painter	27	Fairly Experienced
	A3	Ceiling worker	27	Experienced
	A4	Ceiling worker	21	Fairly New
	A5	Ceiling worker	36	Fairly Experienced
	A6	Assistant bricklayer	40	Normal
	A7	Assistant bricklayer	25	Normal
	A8	Senior bricklayer	37	Experienced
Small scale site	B1	Assistant bricklayer	20	Fairly New
	B2	Senior bricklayer	38	Experienced
	B3	Senior bricklayer	36	Fairly Experienced

Findings

The research has found that the health of workers is exacerbated by their poor working and living conditions. However, workers have limited access to hospitals because of the privatization of health care. To cope with health problems, workers have to rely on their social relations, which are limited and at the low-middle class and thus find it difficult to financially support them.

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[21] The classification of work experience for this research is based on reality. During discussion groups, I asked for the work experience of workers and, based on this information, categorized them into five groups. The work experience of a worker is counted since he worked professionally, i.e. earned a wage. The research ignores their time participants worked in part-time jobs or in the informal sector to support for their families. In conclusion, those who have worked less than one year are New, those who have worked for 1-3 years are Fairly New; those who have worked from 3-5 years are Normal; those who have worked more than 7 years are Experienced.

Poverty and living conditions affect workers' health

By way of introduction, why and how people become construction workers should be mentioned. Many rural people have to migrate to Hanoi to become construction workers mainly because of financial reasons and the low requirements of construction work. Without qualifications, these workers have to work in the informal sector, generally for their relatives or fellow villagers. As these workers are not trained professionally, at the beginning they often do basic work and support senior workers while they gradually learn other skills. When they are skilled enough, they might be promoted and allowed to do more difficult work. At that time, if workers do not want to work for their former employer, they might establish their own informal enterprise or work for other employers who provide them with a higher income.

Besides this, the research has found that the working conditions at the large scale site are far better than at the small scale one. The large scale site is well managed with many safety regulations and supervisors. Additionally, enterprises at the large scale site provide their workers with modern working equipment and full protective equipment. Meanwhile, at the small scale site, there are no safety regulations or protective equipment. Working equipment is not of high quality and is sometimes old and easily broken. However, the research has also shown that not all large scale sites are well-managed and, in those instances, this mismanagement might lead to mass accidents.

Moreover, the research has found that whether working at the large scale or small scale site, informal enterprises, especially for interior work such as ceiling or painting, are often operated on a

small scale, consisting of less than 10 workers. The work of informal enterprises is not stable. Some employers sometimes have to work for other employers. Informal enterprises are, therefore, unable to provide enough working equipment. Regarding benefits, employers only pay wages to their workers and do not pay for days off. Apart from that, the employers do not provide fringe benefits such as regular health examinations or social and health insurance for their workers. When workers get injured, employers might support them by paying for their health expenditures and provide other compensation, depending on their relationship.

Meanwhile, as Hanoi and other urban areas have developed significantly, the living conditions of the workers have also been improved considerably in comparison with the past. Nowadays, workers can easily access various services from food to entertainment. It makes their life more comfortable than before. However, when working in remote areas, the lives of these workers, especially for the bricklayers who have to work from the beginning of the project, is uncomfortable as there are fewer services available. Besides this, the work of construction workers is highly mobile so their living conditions are usually temporary and often lack the amenities that would substantially improve their life, especially regarding hygiene.

The research has found that the nature of construction work is strenuous and harmful to the workers' health. Additionally, the poor working and living conditions also exacerbate their health, even though there is more working equipment available now and workers use more protective equipment such as life lines or facial masks than previously to reduce the dangers inherent in construction work. However, workers still have to use a lot of strength and

face various kinds of dust and harmful chemicals present on their job sites. Several participants in this research, who have worked in the construction industry for years, had to visit hospitals/clinics and found that they have lung problems or have seen their bodies become weaker over time.

Moreover, construction sites are dangerous because of the potential for various accidents. There is a correlation between the management level of a job site and its accident rates. In this research, several workers reported having suffered serious injuries in the past and all of them happened at small scale sites. The primary reason for these accidents was inferior management and supervision of the work and lack of protective equipment supplied to the workers at small scale sites. However, not all large scale sites are well managed and, in this case, the consequences of an accident might be more serious. At the end of March 2015, there was a serious scaffold collapse at a huge industrial zone in Ha Tinh province, Vietnam that caused 13 worker fatalities and dozens of worker injuries (Vietnamplus, 2015).

Table 2: Health problems and illness treatment of participants

Name	Health problems	Illness treatment
A1	Cough up blood	Visit a private clinic
A3	+ Stomach ache + Crushed by a stick + Fall from the third floor	+ Visit a state-owned hospital in his hometown + Delivered to Tu Son hospital + Delivered to Viet Duc hospital, hospitalized for a dozen days.
A4	+ Kidney stone + Aches in his arms and backs	+ Visit E hospital + Using medicines
A6	Lumbar nerve pain	Visit Medical University hospital
A7	+ Bricks fell on his head + Scaffolds fell on his body	+ Delivered to a state-owned hospital in his hometown + Rehabilitation at home
A8	Arthritic arms and wrists	Visit a private clinic near 103 hospital
B1	+ Fall from one-floor scaffold + Fall from a ladder	+ Rehabilitation at home + Delivered to a state-owned hospital in his hometown
B2	Back degeneration	Visit 108 hospital
B3	Pneumoconiosis	Visit108 hospital

The privatization of the health care system limits workers' accessibility to health services

1. The privatization of the Vietnamese health care system

By way of introduction, it should be noted that after *Doimoi* policy, the Vietnamese health care system has been changed significantly. The most considerable change is its privatization of financing, provision, and investment. Regarding the privatization of financing, before *Doimoi* policy, all hospitals were public and totally subsidized by the government. However, after *Doimoi* policy, the

government has reduced the subsidy for public hospitals, forcing them to become financially autonomous. This change has shifted the financial burden from the government budget to individuals (Lieberman & Wagstaff, 2009). Regarding the privatization of provision, public hospitals' ownership still belongs to the state but the way they operate is similar to private hospitals. Now, public hospitals have their own seal and bank account. Additionally, they have the right to hire temporary workers and are allowed to borrow and invest in equipment and infrastructure. Most importantly, they might charge their patients as they have to become financially autonomous (Wagstaff & Bales, 2012). Regarding the privatization of investment, before *Doimoi* policy, the government did not recognize the private sector; therefore, there was no private investment. However, after *Doimoi* policy, the government has recognized a variety of sectors and removed some economic barriers from the market. Thus, a remarkable growth of private hospitals, clinics, and especially drugstores has been recorded (Bộ Y tế & Nhóm đối tác y tế, 2009).

On one hand, the privatization of health care has improved the services, especially at large hospitals in big cities. Citizens, especially the rich, might access high quality services and medicines that were rare before. However, on the other hand, the privatization of health care has also led to the various problems mentioned below.

Firstly, it has resulted in growing out-of-pocket payments. Before this policy, patients had to pay for nearly nothing except food expenses. However, after *Doimoi* policy, they have had to pay much more. In 2007, of the total health expenditures, the share of out-of-pocket payments was 55.5%, government budgets were 22,7% (3.7%

from the central government budget and 19% from provincial ones), social health insurance was 14.2%, other private spending was 6.3%, and ODA was 1.3% (Tien, Phuong, Mathauer, & Phuong, 2011). In the mid-1980s, a peasant only had to pay 1% of his/her disposable income on health care but after *Doimoi* policy, this person has to pay 8% of his non-food consumption income for a visit to a commune health centre, 26% for a hospital outpatient visit, and 45% for a hospital inpatient visit. These increasing expenditures have become a financial burden on the poor (Witter, 1996). According to Cuong, Kubo, Fujino, Minh, and Matsuda (2010), in 2006, 70% of out-of-pocket spending was for medicine, 18% for private providers, and 12% for public providers. The major percentage of medicine might be seen as a consequence of the privatization in investment. Drugstores have become more ubiquitous while pharmaceutical enterprises have put more pressure on physicians to prescribe expensive medicines (Wolffers, 1995).

Secondly, the privatization has resulted in unequal access. People with high incomes might access better services while those with lower incomes have found it more difficult to access services that are more market driven. International studies show that privatization, especially in developing countries, often leads to inequity in health care access for vulnerable people who are unable to pay (Qadeer, 2003; Sen, 2003; Sexton, 2003; Tam, 2010). This situation has also happened in Vietnam. One example is that before 1989, when the user fee was introduced for the first time, annual individual contacts with commune health stations were quite high, fluctuating from 2.2 to 3 times per year. However, in about the next 10 years, the number of visits has sharply dropped to around 1.5 times per year, except in 1993 (London, 2008).

Thirdly, the privatization has also contributed to deteriorating quality in some situations. Due to the ubiquity of drugstores, the lack of drug trading supervision, the perception of self-medication or the pressure of pharmaceutical enterprises on physicians, medicines are sometimes over used. Non-essential drugs such as antibiotics or gentamicin injections are often used even though it may be harmful in the future (Witter, 1996; Wolffers, 1995). This situation is also exacerbated by the boom in private providers such as pharmacies or clinics that are not registered with the authority (Lieberman & Wagstaff, 2009). In reality, many pharmacies are managed by low-educated people who dare to prescribe all kinds of medicine for patients without any guidance from doctors. Mass media has also shown many cases wherein patients died at unregistered, poor quality private clinics. This situation also happens in China and this raises a concern that the owners will tend to try all means to extract money from patients regardless of the quality of services provided or pertinent state regulations (Tam, 2010)

To tackle this problem, the Vietnamese government introduced several social protection programmes, including insurance elements. However, this research has found that these programs excluded migrant workers in the informal sector. The management based on the household registration system prevents migrant workers in the informal sector from accessing public health services in the receiving community as well as insurance programs. It can be said that in the context of rising market-driven health services, migrant workers, including construction workers in the informal sector, are greatly vulnerable as they are excluded from the social welfare system.

2. Health seeking behaviour of migrant construction workers

In comparison with formal workers, the benefits of informal workers are worse. Workers in the formal sector have regular health examinations arranged by their enterprises at least once a year. Additionally, big public enterprises even have at least one doctor to take care of workers' health at every site and provide free first aid medicine. In addition, workers in the formal sector are provided health insurance that helps them access health services when they get sick. Moreover, they are also provided social insurance that ensures they continue to receive their salary during any time they spend in the hospital due to occupational diseases or accidents. Generally, when they are sick formal workers can access health services from the grassroots level all the way up to the more professional health providers such as a hospital. Being strongly supported by their enterprises and insurance, workers often feel secure enough to have their health checked regularly because they do not have to worry much about the cost.

Meanwhile, the benefits of informal workers are far more limited. Firstly, workers are not provided regular health examinations by their enterprises. They, therefore, do not know about or treat their health problems in advance before they become serious. Secondly, there are no qualified doctors at private sites, both large and small scale, so workers have to consult with their colleagues who only have some experience and lack medical knowledge. Finally, informal workers do not have two important fringe benefits, namely social insurance and health insurance. It means that when they get sick, they have to pay nearly all of their health expenditures by themselves. Besides this, they are also not paid wages on their days off. All of

these factors force them to forgo treatment and follow risky behaviour when seeking health solutions. In the beginning, when their health problems are minor, they often neglect them or use medicines suggested by their colleagues or pharmacists at nearby drugstores. Only when the problems become severe do they visit a clinic/hospital. However, even when they do visit the hospital, these workers do not have follow-up examinations since they think that they are unnecessary. More accurately, from my analysis, workers also neglect these follow-up examinations due to their cost.

As workers have limited access to a clinic or a hospital, they often use medicines that are not prescribed by a qualified doctor when having health problems. They prefer using medicines for four primary reasons, namely convenience, hospitality, price, and efficiency. Firstly, drug stores are more popular than clinics or hospitals. Secondly, pharmacists are more willing to consult with workers than doctors who are always busy with hundreds of patients every day. Thirdly, medicine prices are cheaper and more affordable for construction workers than the health costs at a clinic/hospital. Finally, many people also believe that medicines are more efficient than treatment at a clinic/hospital. This belief has been shaped by poor treatment experiences in the past, primarily before *Doimoi* policy.

More broadly, workers' health seeking behaviour is shaped by two main factors, namely the privatization of the health care system and their poor working benefits. In relation to the first factor, as I mentioned before, the health care system has been privatized in regards to financing, provision, and investment, leading to various changes. Before Doimoi policy, the government totally subsidized hospitals so they might provide free services for all patients. However,

after *Doimoi* policy, the government has reduced the subsidy for state-owned hospitals and forced them to become financially autonomous. On one hand, the privatization has helped several hospitals, especially the big ones in the largest cities, because now they have more chances to improve their facilities and treatment quality. Richer patients are more likely to enjoy positive results from the privatization. However, on the other hand, the privatization has shifted the financial burden from the public budget to individuals. From being subsidized by the state, state-owned hospitals now have to charge fees for care like the private hospitals. This is a burden for low income people like migrant construction workers whose income is unstable. In other words, the privatization has limited their chances to access health services. To cope with their health problems, workers have to buy medicines from drugstores that have become considerably popular after the privatization in investment in the national health care system. It should be emphasized that the management of the drug market is not really effective. The fact that many drugstores are operated by unqualified pharmacists is one example. The over-use of medicines without prescription by qualified doctors might be, therefore, harmful to the workers' health, especially in the long term. Moreover, medicines cannot solve all health problems, especially the more serious ones. To reduce the negative impact of the privatization of health care, the government has introduced health insurance. However, migrant construction workers are excluded from this safety net. Working in the informal sector, workers are not provided fringe benefits such as social and health insurance. Besides this, the management of health insurance is based on the household registration system and is unsuitable for migrant workers due to the

high levels of mobility required. Apart from that, the high contribution rate is also a barrier to the participation of these workers.

In short, after *Doimoi* policy, the Vietnamese health care system has been privatized. The quality of health services has been improved and high-income people might benefit from this result. However, the privatization has led to increasing health expenditures on individuals which are a burden on low income people like migrant workers. They, therefore, find it difficult to access health services, especially since they are also excluded from the social protection system.

3. Social relations as a safety net for workers

Being excluded from formal social protection, workers have to rely on their own social relations. The research has found that social relations of workers are fairly limited. Their two primary social relations are family and work-related ties. The latter is dynamic as workers often attempt to broaden their relations at construction sites, especially on the large scale sites. At the beginning, workers make friends with their new colleagues to reduce their loneliness at such sites. If they have opportunities to work together again, they might tighten their relationships. Some workers, even though they come from different provinces, have become close friends. However, workers find it difficult to broaden their relations with people in a higher socio-economic class such as their managers or supervisors. Besides this, they also do not have any relationship with organizations such as non-governmental or community based organizations. It can be said that workers mainly have inter-personal relationships and lack connections with organizations.

According to Berkman, Glass, Brissette, and Seeman (2000), to understand the impact of social networks on health, the whole framework needs to be studied. There are four levels in this system. At the macro level, there are social structural conditions including culture, socioeconomic factors, politics, and social change. These conditions will affect social networks that are at the mezzo level. Social networks will provide opportunities for the psychosocial mechanism, including social support, social influence, social engagement, person-to-person contact, and access to resources and material goods, at the micro level. These mechanisms will affect health, behavioural, psychological, and physiologic pathways. Thi research focuses on social support that includes financial, instrumental, informational, and emotional support.

The research has found that when they have health problems, workers often rely on their work-related ties since they often live together. Their colleagues often inquire about their health, give advice about illness treatment, and take care of them when they are ill. In other words, their work-related ties provide them with emotional, instrumental, and informational support. Workers prefer sharing with their colleagues as they are in the same socio-economic class and thus they feel free to discuss these matters. However, their colleagues cannot provide them with financial support because they too are poor. Their employers only financially support them when they get serious injuries on the job. This financial support is only limited to their health expenditures and does not include their wages.

When they have a serious health problem that requires a visit to a clinic or hospital, workers have to rely on their families. However, most of the workers are the breadwinners for their families

so they do not want to spend much money on health services. It is one reason why workers often neglect to visit a health provider. Besides this, surprisingly, the support of other kinship-based ties is not important. Among 11 participants, only one worker is financially supported by his uncle who is also his employer. Meanwhile, when getting a serious disease, other workers only receive some financial support from their relatives but the amount of money can be insignificant and should be considered as a gift. The reason might be that now people are independent and their relatives or colleagues are also not economically stable. One worker said, "(My) relatives are also poor. They came (to my house) to inquire about my health and gave me an insignificant amount of money" (A1, 25 years old, painter, experienced).

Generally, in some aspects, social relations are beneficial for workers but, in more serious cases, they cannot fully support workers. In other words, workers' social relations are a safety net but they cannot replace the formal social protection system.

Discussion

The main finding of this research is that workers have limited access to health services because of their limited social relations. This section attempts to discuss the above finding from a theoretical perspective. By way of introduction, related studies on the impact of social relations on health should be reviewed. Previous studies have shown that people's health is affected by their social relations (Cattell, 2001; DiMaggio & Garip, 2012; Smith & Christakis, 2008). In their review of this literature, DiMaggio and Garip (2012) argue

that socioeconomic status has a positive correlation with most behaviours, resources, and practices that are beneficial for people's life chances. More particular, DiMaggio and Garip (2012, p. 7) quote a finding of Freese & Lutfey (2011) which argues, "Network effects may contribute to the greater capacity of high-income people to exploit advances in medical science, causing such advances to widen rather than reduce inequality in health outcomes". Studying two working class communities in England, Cattell (2001) also argues that even in the light of several positive effects, social relations cannot tackle all impact of poverty on health. More broadly, the author states that social relations are often of the same class and are not able to tackle all health inequalities that are class based.

In this research, I have found a similar result. Although social relations of migrant construction workers are beneficial in some situations, they cannot solve all their health problems. To begin with, it should be emphasized again that the social relations of construction workers are mainly interpersonal relations such as kinship-based or work-related ties. They lack relationships with organizations, especially formal ones such as non-governmental organizations or trade unions. Moreover, interpersonal relationships of workers are often of the same class. Some workers attempt to broaden their social relations but they are mainly limited to their colleagues. Workers find it difficult to develop relationships with their supervisors or managers who are in a higher socio-economic class. For example, workers of Brand are fairly close to the supervisor named Phu since they work and live together. However, when projects are completed, most of the workers do not maintain this relationship. Only employers of informal enterprises develop and maintain social relations with supervisors and

managers of the formal enterprises so they can get more work. In parties organized by Brand, only the employers of informal enterprises are invited while workers are not invited. Because of this gap, workers find it difficult to develop relationships with higher class people.

Regarding social support, since most of the social relations of workers are interpersonal, the support provided is mainly voluntary or some kind of informal arrangement, according to Holzmann and Jorgensen (2000). Construction workers do not have insurance contracts and are not supported by the government so they lack formal arrangements. In this study, workers often have close relationships with their employers so, when getting injured, they are usually well supported. Like in the case of A4 (21 years old, ceiling worker, fairly new), who was working for his uncle when he got injured on the job; he was fully supported by his employer, including having all of his health expenditures, food, and transportation costs provided. However, if the injured person does not have a close relationship with his employer, the compensation will be worse. In this research, workers also shared that such compensation is an unwritten law. If the employer runs away, workers often have no evidence to support a claim for compensation. But the threat of the worker spreading bad information about such employers is usually sufficient because the employer's reputation is more important for future work. Generally, since the social support of social relations is voluntary, workers are more vulnerable, especially when they are injured.

Additionally, since social relations of workers are limited and often of the same class, support is also limited. Their social relations mainly provide emotional, informational, and instrumental

support but find it difficult to provide financial support. It should be mentioned that informational support is not always effective. It comes mainly from the experiences of the more senior workers or from those who have had similar symptoms, not from more professional sources. Workers lack chances to communicate with qualified doctors. It is a management problem of the main contractor. A key informant shares that at large scale sites of state-owned enterprises, there is always, at least, one doctor who is responsible for the health of workers. However, in this research, there were no doctors available at these sites.

Regarding financial support, when getting injured, workers might rely on their employers but, as I analysed before, this source is not mandatory. Workers are vulnerable if their employers refuse to compensate them. Meanwhile, regarding other illnesses, workers have to rely on their families. Nowadays, workers find it more difficult to rely on their kinship-based ties who are also likely to be poor, as in the experience of one worker (A1, 25 years old, painter, experienced). It should be emphasized that most of these workers are breadwinners for their family so relying on family means relying on themselves.

In conclusion, the research has found that construction workers are more likely to have health problems. They, however, have limited access to health services because of the exclusion of social policies as well as the privatization of the health care system. The research, therefore, has three key recommendations.

Firstly, regarding worker safety, enterprises need to follow the work safety guidelines of the government and ensure the quality of their working equipment. Besides this, enterprises should only hire workers who have the required skills and they should provide

safety training classes for them. Nowadays, many workers join the construction industry without any formal training. This leads to various health problems. Additionally, the government needs to heighten their role. The government needs to improve the management of both large and small scale construction sites. Currently, the management, including those managers involved with work safety, depend solely on the self-awareness of each enterprise. The government only examines the management when accidents occur.

Secondly, there needs to be more policies and programmes supporting construction workers' health. Nowadays, workers are not provided social and health insurance by their employers and also find it difficult to access voluntary ones. It is difficult for informal enterprises, especially very small-scale ones, to provide fringe benefits for workers so the government needs to become more responsible. In particular, the government's existing voluntary social and health insurance programs for migrant workers in the informal sector need to be upgraded. These two insurance programs still have various limitations in their contribution rates and benefits. These limitations should be improved to provide workers more opportunities to access these safety nets.

Besides this, there needs to be more supporting centres or programmes by the government or from non-governmental organizations to support migrant workers in the receiving community. Nowadays, there are many non-governmental organizations specializing in health issues in Hanoi. However, their programs have not covered migrant construction workers, a vulnerable group. These organizations should organize more activities for these workers from prevention to treatment.

Finally, regarding the privatization of the health care system, the government needs new policies to increase the accessibility of health services for these workers. Workers find it difficult to access the health care services that are market-driven. Social policies or health insurance provisions for migrant workers might help them reduce their health expenditures, thus improving health accessibility. Additionally, the research has found that construction workers prefer using medicines, normally without prescriptions from qualified doctors. This over-use of medicines, especially without the guidance of qualified doctors and pharmacists, might be harmful to workers in the long term. As far as I'm concerned, the pharmaceutical market is not well organized so the government needs to tighten its management. Additionally, programmes informing the public about the drawbacks of medicine overuse should be implemented.

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