Health Care Privatization and Migrant Construction Workers in Hanoi, Vietnam

Tranh Khan An

Consortium of Development Studies in Southeast Asia (CDSSEA)

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The Consortium of Development Studies in Southeast Asia has drawn on primary postgraduate research undertaken for theses from the master's programs of Asian Institute of Technology's Master of Science in Gender and Development Studies (MGDS), Chiang Mai University's Master of Arts in Social Science (Development Studies) (MASS); and the Chulalongkorn University Master of Arts in International Development Studies (MAIDS). Scholarships for the students of CDSSEA has been generously provided by the International Development Research Centre (IDRC) of Canada. With a diversity of academic approaches (gender studies, political science, social sciences), the individual works of this collection have in common a focus on the increasing interconnection and regionalization of the five mainland Southeast Asian countries (Myanmar, Thailand, Laos, Cambodia and Vietnam), and examine these exchanges and encounters within the context of the Greater Mekong Sub-region (GMS).

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Tran Khanh An

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Series Foreword

The Regional Center for Social Science and Sustainable Development (RCSD) at Chiang Mai University has extended its publication program to include Master's dissertations from The Consortium of Development Studies in Southeast Asia (CDSSEA). The CDSSEA series covers mainland Southeast Asia: Myanmar, Thailand, Cambodia, Laos and Vietnam, and regionalization, development encounters and exchanges within the Greater Mekong Sub-region (GMS).

The CDSSEA program brings together resources and expertise from three of Thailand's leading institutions offering Master's degrees in development studies: Chiang Mai University's Master of Arts in Social Science (Development Studies) (MASS); Chulalongkorn University's Master of Arts in International Development Studies (MAIDS); and the Asian Institute of Technology's Master of Science in Gender and Development Studies (MGDS). Although the Consortium's program focuses on the relationship between development studies and social sciences, each of the programs has a different emphasis. The Chiang Mai degree focuses on social sciences and anthropological perspectives, with research interests in environmental and resource management, food security and local livelihoods, labour migration and trans-border issues, ethnicity and development, health, tourism, and agrarian transitions. Chulalongkorn's program concentrates on the political dimension of development, including democratization, human rights, conflict resolution, international and civil society development organizations, community development and globalization. The Asian Institute of Technology focuses on the relationships between gender and development—including women's rights, civil society, and gender dimensions of urbanization and industrialization.

The CDSSEA program has a practical dimension, building leadership capacity in mainland Southeast Asia's regional development, bringing together postgraduate students, encouraging debate, and promoting the rethinking of development alternatives in such areas as social equality, justice and participation, environmental and economic sustainability, and community development. In this regard, a major objective is to develop the knowledge and skills of development practitioners and to enhance the quality and effectiveness of policy-making and its implementation in the region.

The publications in this series—selected from the CDSSEA Master's program—are designed to express this diverse range of interests in development studies and regionalization, and to emphasize the relationships between empirical and theoretical research, policy-making and practice.

Victor T. King, Senior Editorial Adviser,
Critical Perspectives on Regional Integration Series

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Abbreviations

CHS	Commune Health Station
CMU	Chiang Mai University
DHO	District Health Office
ILO	International Labour Organization
IMF	International Monetary Fund
ISO	International Organization for Standardization
MOH	Ministry of Health
ODA	Official Development Assistance
PHD	Provincial Health Department
RCSD	Regional Center for Social science and development
TV	Television
UNDP	United Nations Development Programme
US	United States
USD	United States Dollar
VHI	Voluntary Health Insurance
VND	Vietnamese Dong
VSS	Vietnam Social Security
VUAL	Vietnam Union of Arts and Literature
VUSTA	Vietnam Union of Science and Technology Associations
WHO	World Health Organization

Glossary of Terms

bán sức lao động	A phrase means "sell physical strength for money"
Bao Minh	The name of a Vietnamese insurance company
cai	An employer in the construction industry. Often used in the past.
Cảm xuyên hương	The name of a Vietnamese flu medicine
cao đẳng	College
chơi họ	Rotating savings
chúng nó	Them. Normally used by a person who is older or has a higher position than those who were mentioned.
công nhật	Daily wage
đại học	University
Doi Moi	Renovation
đội trưởng	An employer in the construction industry. Often used now.
đủ ăn nhưng chưa có của ăn của để	Have enough money for food but not enough money for accumulation
hộ khẩu	Household registration
khổ	An adjective refers to poor living and working conditions (both physical and mental)
khôn	Smart
lo lắng	Worried
nghèo	Poor
nhanh	Fast
ốm	Sick

rượu trắng	Vodka
sốt	Fever
tay	Hand (fingers, hands, writst, forearm, elbow)
Tet	Lunar new year festival
thoái hóa	Degenerate
thợ nề	Builder
thuốc Nam	Southern medicines
trung cấp	Vocational college
yên tâm	In a good/peaceful mood / no need to be worried

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Readers often skip the acknowledgements page but for me it is the most important part. Without the support of many people, I would have been unable to write this book.

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Tran Khanh An

Chapter 1

Introduction

By way of introduction, this chapter provides general information of the research that will help readers know the background, research purposes and methods of the study.

Research background

After the reunification in 1975, Vietnam followed a centrally planned economy. Only the public sector was recognized while the private one was totally removed. With the absolute dominance of the public sector, the State centrally planned the economy and subsidized all activities. It meant all people were equal and freely enjoyed public services under regulations of the State (Dung, 2010). The strict management failed and led to a long lasting economic crisis. In 1986, the government, in response, launched Doi Moi (Renovation) policy to improve its economy. Vietnam removed various barriers and opened other sectors with an emphasis on the market (Lieberman and Wagstaff, 2009; Witter, 1996).

This economic reform has led to various changes in the health care system. The most vivid difference between the Vietnamese health system before and after *Doi Moi* policy is its privatization. From being totally subsidized by the government, the health system has been gradually privatized. According to Tam, privatization "is defined as the shifting of a function, either wholly or partially, from the public sector to the private sector. It involves greater reliance on private actors and market forces to assume the role of government functions

and responsibilities" (2010, p.64). In terms of typology, there are four kinds of privatization in health care, namely privatization in financing, provision, investment, and management and operation (Maarse, 2006).

In Vietnam, the privatization of the first three aspects (financing, provision and investment) happened more strongly and will be analysed deeper in the second chapter.

Generally, on one hand, the privatization of health care has improved the services, especially at large hospitals in big cities. Citizens, especially the rich, can now access high-quality services and medicines that were rare before. However, on the other hand, the privatization of health care has also led to at least three main problems. Firstly, it has resulted in growing out of pocket payments. Secondly, the privatization has resulted in unequal access. People with high income might access better services but those with lower incomes find it more difficult to access services that are now market-driven. Thirdly, the privatization has also contributed to deteriorating quality of the service in some situations such as the over use of drugs or the boom in unqualified private health clinics.

After the privatization of health care, the Vietnamese government launched social health insurance to ensure health access for vulnerable people. Social health insurance has two schemes, namely mandatory and voluntary ones. In relation to the mandatory scheme, it aims at workers in the formal sector, civil servants, children aged under six, the poor, retired government officers, war veterans, members of Parliament, Communist Party officers, war heroes, etc. Members of this scheme have to pay 1/3 of the contribution rate, equal to 1.5 % of the minimum monthly salary.[1] In relation to the voluntary scheme, it aims at full-time students, family members of the compulsorily insured and the rest, including workers in the informal sector. Voluntary participants have to pay all of the contribution rate (4.5% of the minimum salary) by themselves (Dragon Law Firm, n.d). Detailed information of social and health insurance will be analysed further in chapter 2.

1 Minimum monthly salary is regulated by the State. In 2013, minimum monthly salary varied from 1,900,000 VND (87 USD; 1 USD = 21,800 VND) to 2,400,000 VND depending on geographical areas so the contribution rate of informal workers was around 85,500 to 108,000 VND per month (Hoàng Diên, 2013).

After *Doi Moi* policy, there was a mass flow of migrant workers from rural to urban areas. From 1994 to 1999, there were 1.18 million people, not including short-term and unregistered movements, moving from rural to urban areas (D. N. Anh and Tacoli, 2003). Hanoi, the research site of this study, is an attractive place for rural-to-urban migrants. In the 2000s, the population in Hanoi considerably grew mainly because of the increasing flow of migrants. The Population census in 2009 shows that during 2005-2009, the migration rate[2] for Hanoi was 65.3%, one of the highest in Vietnam (Đ. Q. Hà, 2014). This rural-to-urban migration is the primary trend - it accounts for 79% of the migrants to Hanoi (Chức et al., 2003). Apart from students, workers also account for a large proportion of migrants. According to the statistics of Hanoi Police department, migrant workers in 1996 were 38,387 and increased to 48,000 in 2000 (Chức et al., 2003).

This research focuses on migrants working in the construction industry because of two main reasons. In relation to the first reason, it is recorded that the number of construction workers has increased significantly and accounted for a big part of the labour force. According to Bộ Kế hoạch Đầu tư and Tổng cục Thống kê, construction workers accounted for 6.2% of total employment in Vietnam in 2013 (2014). In Hanoi, this figure was even higher, accounting for 8.3% of total employment (Bộ Kế hoạch Đầu tư and Tổng cục Thống kê, 2014). Besides this, in recent years in Hanoi, the number of construction workers has been increasing. According to Cục thống kê Hà Nội, in 2013, the number of construction workers in state-owned, private and foreign invested enterprises[3] in Hanoi increased remarkably from 2005 to 2013 (2014). In 2005, there were 256,860 people working in the construction industry but in 2013, this number doubled to 536,120.

2 Migration rate is the number of people coming from other places to the receiving community each year. It is calculated by averaging the migration rate with every 1000 people of the receiving community (Tổng cục thống kê, n.d.).

3 In 2011, the National Congress of the Vietnamese Communist Party stated that there were four economic sectors, namely the State, the collective, the foreign-invested and the privately-owned (including the self-employed, household businesses and enterprises) (Vy, n.d.). In the private sector, the difference between a household business and an enterprise is the number of employees. If a business unit has more than 10 employees, this unit has to register with the authority and at that time, is called an enterprise. Meanwhile, if a business unit has less than 10 employees, it is called a household business. The statistics of Cục thống kê Hà Nội (2014) only include the State, the foreign-invested and private sectors. Regarding the private sector, the statistics only cover enterprises and exclude the self-employed and household businesses.

In relation to the second reason, most construction workers work in the informal sector. By way of introduction, it is necessary to define what the informal sector is. There are many ways to approach the informal sector but for the purposes of the research, the paper will adopt the concept of the International Labour Organization (ILO):

> The informal sector is broadly characterised as consisting of units engaged in the production of goods or services with the primary objective of generating employment and incomes to the persons concerned. These units typically operate at a low level of organisation, with little or no division between labour and capital as factors of production and on a small scale. Labour relations - where they exist - are based mostly on casual employment, kinship or personal and social relations rather than contractual arrangements with formal guarantees (ILO 1993 in Cling, et al., 2010, p.44).

There are no official statistics about the issue but Linh and Trang, two key informants, share that in the construction industry there are three types of construction enterprises. The first type are state-owned enterprises[4] that are formal, large scale, and have hundreds of employees - from managers, supervisors to workers. State-owned enterprises often construct large scale sites such as highways, bridges or hydro-power stations. The second type are private formal enterprises that might construct from small to large-scale sites. However, in general, these private enterprises only have managers and supervisors; they do not have any workers because they do not always have work and cannot pay monthly salaries for workers during the times when there is no work. The last type are informal enterprises that are not registered but are often hired for construction. According to Cục thống kê Hà Nội, only 128 enterprises in the construction industry are state-owned (1.3% of the total) while 9,511 are private (98.7%) (2014). More particularly, 66,552 (12.4%) of construction workers work in state-owned enterprises and the remaining 469,568 (87.6%) workers work in private enterprises. The above statistics do not cover informal workers of informal enterprises. However, as private formal enterprises do not have

4 In this research, a state-owned enterprise works as a subcontractor. Two above key informants explain that some managers, on behalf of the State-owned enterprises, might sign a contract with the main contractor to become a subcontractor to get extra income.

workers, they only hire workers from informal enterprises, it might be said that these workers work informally for them. According to the above definition of the ILO, even when working for formal enterprises, these workers are still informal as they do not have a labour contract. Therefore, generally, it can be said that in the construction industry, most of the workers work in the informal sector.

Research problems

According to the above definition, there are two primary characteristics to distinguish the informal and formal sectors, namely the scale of the enterprise and their labour relations. These two characteristics might exacerbate the health of migrant construction workers.

In relation to the first aspect, enterprises in the informal sector are operated at a small scale; so generally, migrant construction workers have less training and protection equipment. Studies show that the lack of training, mostly in small-sized companies, increases occupational accidents (Holte and Kjestveit, 2012; Laukkanen, 1999; Wilkins, 2011). In Vietnam, the construction industry accounts for 28.6% of all accidents and 26.5% of all fatalities reported, the highest numbers recorded for any occupation (Ministry of Labour, 2013). Besides this, migrant construction workers are also more likely to have occupational diseases (Lao động, 2012; Phạm Thanh, 2013). In Vietnam, according to a study of the Hanoi School of Public Health, construction workers often have diseases such as silicosis, hearing loss or musculoskeletal disorders (Diệu Hiền, 2013). Moreover, due to the small scale, informal enterprises cannot provide good accommodations for their workers. Construction workers often have to live at construction sites or low-quality rental houses that sometimes lack basic infrastructure such as clean water (Thuy, 2005). Sixty-one percent of migrants in the informal sector report that they have to live in poor conditions that are harmful for their health (Duong, et al. 2010).

In relation to this second aspect are the labour relations between employers and employees. In the informal sector, migrant construction workers do not have any kind of contract and consequently, they do not have social insurance and social health insurance like workers in the formal sector. If

occupational accidents occur, workers having social insurance[5] will be compensated by Vietnam Social Security, a state-owned enterprise. However, due to the lack of social insurance, migrant construction workers in the informal sector have to seek the compensation from their employers which is not guaranteed. If they are compensated, the amount of compensation is also not fixed, and varies depending on the relationship between them and their employers and the budget of the employers (Ministry of Labour, 2003). Apart from that, workers in the informal sector also do not have fringe benefits such as regular medical tests like those in the formal sector. This makes them even more vulnerable in terms of health prevention.

Under the privatization of health care, groups with low incomes, including migrant construction workers, are those most affected. Albeit even taking into account the above health issues, migrant workers do have limited access to health care services, especially in Hanoi. Duong, Linh, and Thao reveal that only 13% of migrant workers in the informal sector visit clinics/hospitals when they are sick (2011). The toughest barrier for them is the ever-increasing health service fee which is a huge financial burden for those whose salary is the second lowest in the economy, higher only than those in the agriculture sector (Cling, et al., 2010). Just under 78% of migrant workers in the informal sector report that they cannot afford health care expenditures, including the fees for medicines and health treatment (Viện Gia đình và Giới, 2010).

Apart from the difficulty in health care accessibility, migrant workers in the informal sector have two other problems. Firstly, they are not supported by the government. There is no government agency to help and protect those in the receiving community (Duong et al., 2010). As newcomers, migrant workers, therefore, have less information to access quality health services that are affordable (Viện Gia đình và Giới, 2010). Secondly, they are even excluded from voluntary health insurance in the receiving community. Many social policies are based on the household registration system that is unsuitable for the migrant workers because of their mobility. Regarding health security, the management of voluntary health insurance based on the household registration

5 In Vietnam, there are two kinds of social insurance, namely compulsory and voluntary. Compulsory social insurance, designed for formal workers, has five benefits, namely old-age pension, sickness, maternity, work injury and survivor. Meanwhile, voluntary social insurance, mainly designed for workers in the informal sector, only has two benefits, namely old-age pension and survivor (U.S. Social Security Administration, 2010).

system excludes the participation of migrant workers. More particularly, under the regulation of Vietnam Social Security, migrant workers belonging to KT4[6], who have lived in the receiving community from six months to one year, or have unregistered residence status, cannot buy voluntary health insurance in the receiving community. Meanwhile, it is time-consuming and complex to get a permanent residence registration in the receiving community, especially with people who are highly mobile like construction workers.

Apart from the complex registration, people who already have social health insurance also find it difficult to use this social safety net. Under the regulation of Vietnam Social Security, participants have to use social health insurance at a designated hospital/clinic that is, again, unsuitable for the mobility of the migrants. For example, if migrant workers have social health insurance at their hometown, they will have to return there for treatment when getting sick. If they want to use services in the receiving community, they will also need to return to the designated hospital/clinic in their hometown to ask for a reference letter. The referral process is time-consuming and inconvenient. Some migrants have complained that the costs of getting the reference letter are far higher than even the treatment expenditure (Viện Gia đình và Giới, 2010).

Generally, regarding health issues, migrant workers, including construction ones in the informal sector, have two key problems. Firstly, working in the informal sector, their health is exacerbated by poor working and living conditions. Secondly, as migrants, they are also excluded from social policies such as health insurance, thus limiting their access to health services. Besides

6 In Vietnam, citizens are controlled by household registration. Each family is provided a household booklet (ho khau) managed by their local authority. There are five groups, namely KT1, KT2, KT3, KT4 and non-registered residents. Residents with permanent household registration at their place of current residence (or in other words, people living at the same address as where they are registered) belong to KT1. Intra-district migrants who have permanent household registration in the province/city of current residence (or in other words, people living at a different address but in the same province/city that they registered in) belong to KT2. The rest are migrants. Migrants who have lived in the receiving community for more than one year, have a house or are guaranteed by their host belong to KT3. Migrants who have lived in the receiving community from more than six months to one year belong to KT 4. The rest are non-registered residents (Duong, et al. 2010). These migrants are called "non-registered" but in fact, they are also required to inform the local authority of their presence. In theory, all outsiders staying at a new place, even for only one night, must inform the local authority. However, in reality the Vietnamese now rarely care about this system.

this, in the receiving communities, there are no non-governmental organizations or public centres supporting them or helping them to alleviate their health problems. It is, therefore, essential to find out how these workers seek support to improve their health.

Previous studies have shown that migrant workers have to rely on their social relations. According to Antonucci, Ajrouch, and Birditt, the concept of social relations is multi-dimensional and might be approached from structure, type and quality dimensions (2013). Previous studies have shown that migrant workers often rely on social relations such as kinship-based ties, work-related ties, migrant friends or civil society organizations (H. T. Anh, 2011; Duong et al., 2011; Y. Li and Wu, 2010; Minh, 2014). According to Berkman, et al., social networks provide various psychological mechanisms to support individuals improve their health or cope with their health issues (2000). Studying two communities in England, Cattell argues that social networks have positive effects on the health of members of these communities (2001). However, social relations are not able to solve all migrant workers' health issues. Cattell also argues that despite social networks' positive effects, they are not able to tackle all of the impact of poverty issues or the broader, material conditions on health (2001). Cattell argues that social networks are "no substitute for a more equitable distribution of resources nationally" (2001, p.1513). Additionally, Cattell also believes that the pattern of social networks might reflect the way in which class-based health inequalities are created (2001). People from the working class, for example, find it difficult to broaden their networks. Meanwhile, people from the higher classes have wider, looser and more resourceful social networks when necessary. My research, therefore, intends to study to what extent social relations are beneficial for migrant construction workers in the informal sector.

In conclusion, being affected by poor working and living conditions in the informal sector, migrant construction workers have to rely on their social relations to improve their health. However, their social relations are not always able to help them solve their health issues. This research attempts to find out to what extent their social relations are beneficial for them. The results will shed light on the understanding of their vulnerability due to the exclusion of social policies.

Conceptualization of the study

This book aims to focus on the health of migrant construction workers. To fully understand this problem, the research starts from a macro perspective. After *Doi Moi* policy in 1986, there have been significant social changes in Vietnam such as urbanization, industrialization and privatization of health care. The urbanization and industrialization processes have led to the rural-to-urban migration. Meanwhile, the privatization of health care forced the government to introduce social health insurance to protect vulnerable groups. However, the management of social health insurance is based on the household registration system which is in conflict with the mobility of migrant workers.

This research studies construction workers who migrate from rural to urban areas to work in the informal sector. In this sector, their health is often exacerbated by poor working and living conditions. This research attempts to discover migrant construction workers' health issues. In addition to these risks, they are also excluded from various social policies. They are, therefore, restricted from accessing health services in Hanoi. This research will explore what they do to solve their health problems.

Under these conditions, migrant construction workers rely on their social relations. These include: 1) kinship-based ties 2) work-related ties (such as their colleagues or employers) and migrant friends, who also migrate from their hometown to Hanoi and 3) civil society organizations. Regarding civil society organizations, this research will focus on non-governmental organizations, community-based organizations such as faith-based organizations or service-, development-, livelihood-, credit and saving groups. These social relations will cause peer pressure and provide social support for migrant construction workers to help them cope with their health problems. The book also attempts to study what social support and peer pressure their social relations provide for them and how the social support and peer pressure contributes to the solution of their health issues.

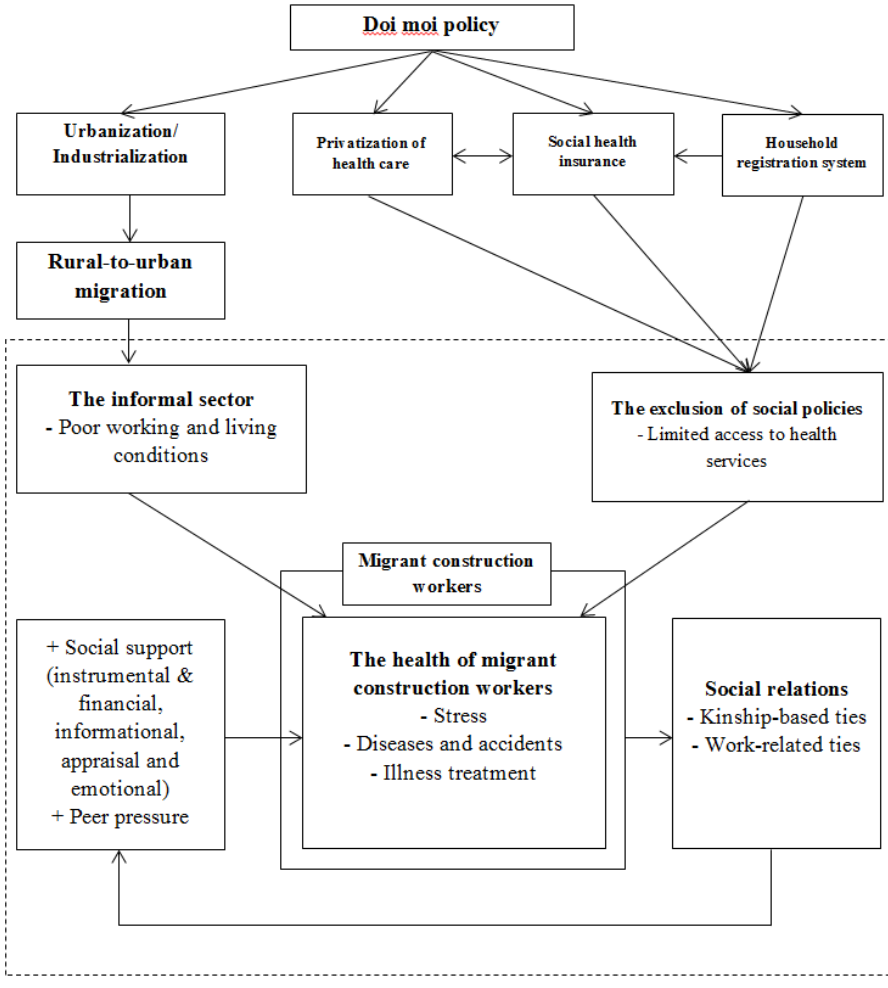

Figure 1.1: The Conceptual Framework *(Image Source: Author)*

Research methodology

Research site

The geographical site of this research is Hanoi where there are a huge number of migrant construction workers and construction sites.

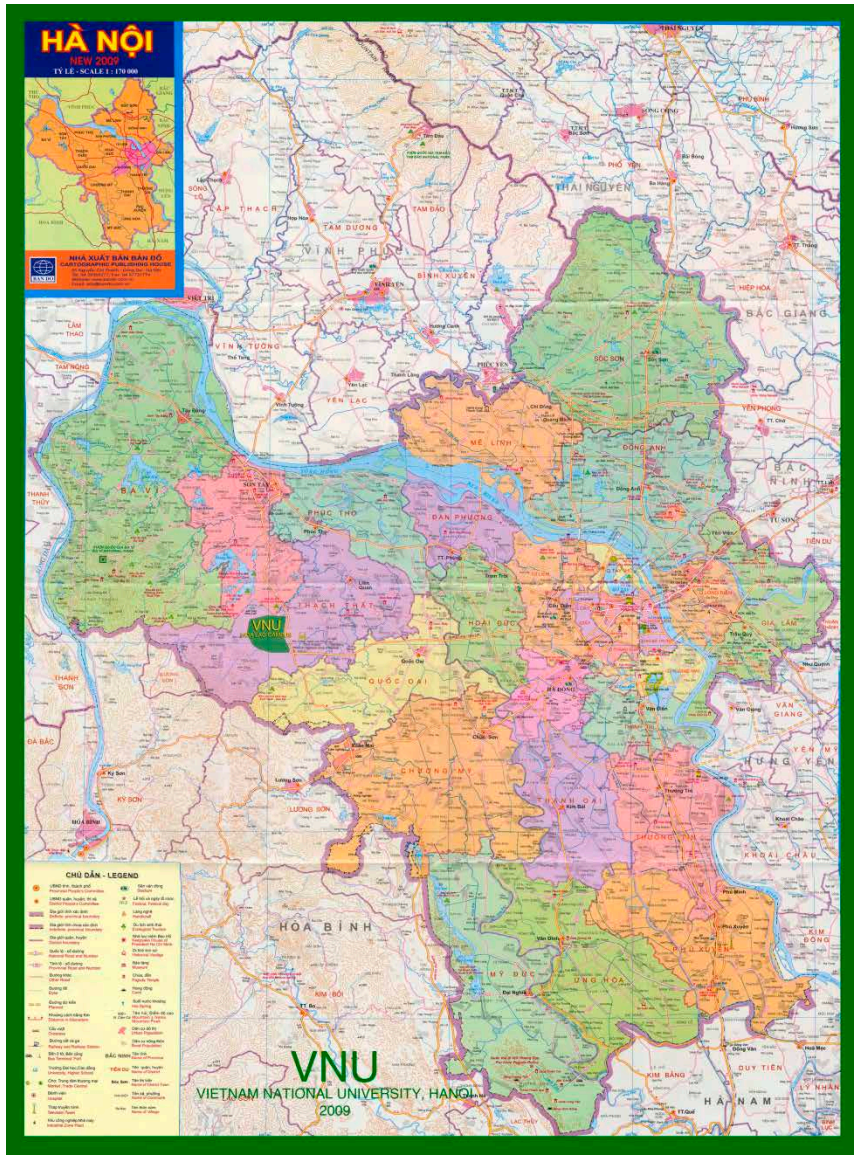

Figure 1.2: Map of Hanoi *(Image Source: Đại học Quốc gia Hà Nội, 2009)*

This research purposely chose two construction sites, one large-scale and one small-scale site. The large-scale site is a factory, managed by a Japanese private formal enterprise and constructed by many workers. Meanwhile, the small-scale site is a private house, managed and constructed by a small informal enterprise. In this research, *scale* refers to the number of workers. When I was in the field, there were more than 60 workers at the large-scale site while at the small-scale site, there were only seven workers. Additionally, the main contractor of the large-scale is a Japanese enterprise so I assumed that their management was professional and met the government regulations about work safety. Meanwhile, the management of the small informal enterprise was less professional and were unable to meet the work safety regulations that might adversely affect the health of their workers.

The large-scale construction site is a 4,000m^2 factory of Tory, a Japanese enterprise in an industrial zone located in a suburb of Hanoi. There are two main contractors, namely Taka and Marko. Both are Japanese, private formal enterprises. Taka is responsible for the electric system. According to the Vietnamese industrial classification system, this work is arranged in the technical, not construction industry, and is not the focus of this study (Bộ Kế hoạch và Đầu tư, 2007). Meanwhile, Marko is responsible for building the factory and is the focus of this study. When I visited the site in January 2015, the factory shell was nearly finished and the contractor was in the process of completing its interior.

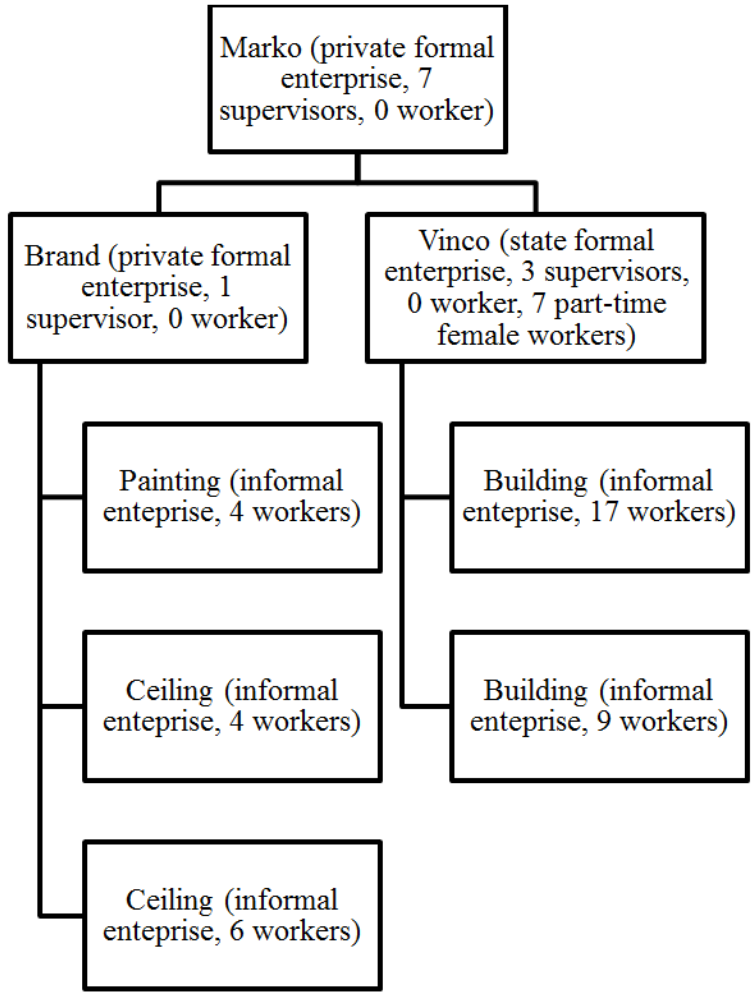

Figure 1.3: The structure of the large-scale site *(Image Source: Author)*

Marko is the main contractor for the project. They have seven supervisors and do not have any workers. Marko is responsible for designing and supervising this project and signs contracts with four Vietnamese formal enterprises as subcontractors for the construction. Vinco, a state enterprise, the biggest subcontractor, is responsible for around 60% of the work, including building the foundations, the raw structure of the factory, roads around the factory and

the sewage treatment facility. Meanwhile, the other three formal enterprises are private. Sun is responsible for the roof, Sana is responsible for the window units and Brand is responsible for the ceiling, painting and steel work. When I visited the site, Sun had finished its work while Sana had not yet started its work; so in this research, I have only emphasized the workers of Vinco and Brand. Generally, Vinco has three supervisors and Brand has only one supervisor and, like Marko, neither Vinco and Brand have any workers.

Trang, the Vice-Director of Brand, tells me that in the construction industry, private formal enterprises only sign labour contracts with supervisors. For the execution, they often hire known informal enterprises and pay them a flat rate. She shares:

> We (private enterprises) do not always have work so we cannot sign labour contract with workers and pay them monthly salaries. We have to think about profits (She means private formal enterprises do not always have work. They may spend several months looking for work and designing. They cannot pay monthly salaris for many workers during the waiting time). Only big formal state-owned enterprises might sign labour contracts with workers because they have big projects that last for a long time and sometimes, they do not have to care much about profits.

For the execution of the work, Vinco hires two informal enterprises with a total of 26 male workers. Besides this, Vinco also hires seven local female workers for cleaning or carrying small things. However, these workers are not migrants so are excluded from this study. At the beginning of the project, Vinco hired four informal enterprises with around 80 workers. Binh, one supervisor of Vinco, shared with me that the enterprise also has hundreds of construction workers but they work for other projects. Meanwhile, Brand has one supervisor at the site and hires three informal enterprises (one for painting and two for ceiling construction) with a total 14 workers, all of whom are male. However, the supervisor of Brand is not fixed. If the main supervisor is busy, other people will come to replace him. During my stay at the site, there were three supervisors of Brand who worked on the project.

Regarding the small-scale site, Trang informs me that around 10 years ago, there was a large number of small-scale construction sites such as private houses in the central districts of Hanoi. However, now, there are less small-scale construction sites as most of the land has already been used and people tend to buy apartments now instead of building private houses. In central districts of Hanoi, homeowners often hire construction workers to renovate their houses or apartments. Now, there are more private housing sites in the suburbs of Hanoi since the income of the people there is high enough that they can afford to build their own houses. Normally, homeowners hire local workers to build their houses to reduce the expenditure. However, some homeowners hire workers from other provinces because of their better skills or close relationships.

The small-scale site I studied is a two-floor house in a suburb of Hanoi around three kilometres from the large-scale site I studied. The homeowner already had two small houses (one very old and one quite new) and was building the new house next to them. The surface area of this house is 75m2 with a 25m2 courtyard. At the time I visited the site, the raw structure was nearly finished and the workers were building the fence, gate and some decorative parts. It was at the end of the Lunar calendar year in Vietnam so the informal enterprise was attempting to finish its work by 23rd December (by the Lunar calendar) and was planning to come back after the New year holiday to complete the house.

The differences in management and equipment provisions will be analysed in more detail in the third chapter. For now, it can be said briefly that the large-scale site is more professional than the small scale one. The main contractor of the large-scale site sets many safety regulations and has several supervisors on-site to force workers to follow the regulations. Besides this, workers at the large-scale site attended a safety training class before working and/or are provided protective equipment. Meanwhile, at the small-scale site, there are no such safety regulations. Workers work freely and primarily use their experience to avoid accidents.

Moreover, the business structure of informal enterprises should be addressed more clearly. Informal enterprises are generally managed by one employer, called *cai* or *đội trưởng* in Vietnamese. This informal enterprise does not have business registration. The employer seeks out work and, when he gets it, the employer will call his workers. The employer does not sign labour

contracts with his workers. Their relationship is based on trust. The workers are generally his relatives or fellow villagers. When lacking labour, the employer also hires workers from other provinces, normally those he knows well. Additionally, he also may ask other employers to "borrow" workers for a brief time when necessary. Workers normally work for one employer but when the employer does not have work, they might work for other employers.

The size of one informal enterprise is generally small, with less than 10 workers. The employer often works with his employees to guide and supervise them. Because of the small scale, the employer only signs contract(s) with one or two construction site(s) at the same time. Meanwhile, if the size of the informal enterprise is big, the employer will assign some experienced and reliable workers as assistants to help him guide and supervise his workers. At that time, the employer rarely works at the site. He mainly looks for work or is normally at many construction sites at the same time and supervises his workers.

At the large-scale site, there are five informal enterprises. Vinco hires two informal enterprises for building. The first informal enterprise is managed by Huong. Huong has 16 workers: 10 from his hometown in Hung Yen Province (some of whom are his relatives) and six workers from other provinces. These six workers have worked with Huong for years. Huong informs me that then he also had two other contracts, one in his hometown that was managed by his son and one in Hanoi managed by his assistant. Generally, Huong has around 20 workers but when he has many contracts at the same time, he asks other employers to "borrow" more workers. The second informal enterprise is managed by Tuan. Tuan has eight workers all coming from his hometown in Bac Ninh Province. Tuan says that all of his workers are his relatives or are his acquaintances. Before this construction site, these two above mentioned informal enterprises did not know each other.

Meanwhile, Brand has hired three informal enterprises. The first informal enterprise is responsible for painting and is managed by Thong from Vinh Phuc Province. Thong has three workers and all of them are his relatives. The other two informal enterprises are responsible for the ceiling work. One enterprise is managed by Hoang from Hai Duong Province. Hoang has three workers, two of whom are his relatives and the other one being his friend, a man named Vinh from Vinh Phuc Province. Vinh is also an employer but at this time he does not have any work so he is working for Hoang. Another enterprise is

managed by Binh from Nam Dinh Province. Binh has five workers who all come from his hometown. In contrast to the two building enterprises of Vinco, the three ones of Brand have a strong relationship. All the employers have cooperated with Brand for years so they have known each other for a long time. Most of the workers of these three informal enterprises, especially the more experienced ones, also know each other and shared with me that they are very close.

Regarding the small-scale site, the employer is Mr. Huong from Bac Ninh province. Mr. Huong is a friend of Mr. Tuan, the employer at the large-scale site. Mr. Huong is 45 years old and started working in the construction industry when he was studying in secondary school. He established his own informal enterprise around 12 years ago. In the past, Mr. Huong often built houses in Hanoi since the demand and the contract values were higher. However, around 5 years ago, he came back to his hometown where the demand had increased. Besides this, while working in Bac Ninh Province, he and his workers can live near their families. The contract value is a little bit lower than in Hanoi but Mr. Huong does not have to pay for accommodation and food for his workers and that helps him save money. Mr. Huong agreed to build the private house in the suburb of Hanoi because the homeowner is his relative and the place is only around 20 kilometres from his hometown. The informal enterprise of Mr. Huong has seven workers. At the beginning of the project, there were 11 workers but at the end, four people had already left because there was less work and they wanted to go back to their hometowns to prepare for the New Year's holiday or go to Hanoi[7] to earn more money.

It should be mentioned that the informal enterprise at the small-scale site only constructs private houses. The enterprise constructs nearly all parts of the house except the electrical system. Normally, the former customers of the employer refer new ones to him. Sometimes, he uses his social networks to find a job. Meanwhile, informal enterprises at the large-scale site specialize in one area such as painting or ceiling work. They are more flexible; they build at both small-scale and large-scale sites. Normally, employers of these enterprises

7 Before the traditional New Year, most of the migrant workers in Hanoi return to their hometown. Therefore, there is a huge demand for workers at the end of the year such that some people go to Hanoi at the end of Lunar year to earn some money.

cooperate with formal ones. When formal enterprises have work, they will call in the informal enterprises for the execution.

The above information about these two sites provides a glance at the research sites. More detailed information about the working conditions of the large-scale site and the small-scale site will be analysed later in the third chapter. This information will help us understand how working conditions affect the workers' health.

Selection of Case Studies

This section aims to introduce how I chose participants in the field. The sampling process had three main steps. In the first step, I chose two construction sites depending on their scale. Scale is based on the number of workers at each site. Scale is chosen as an indicator as there is a major difference in management between the two sites. As I mentioned in the previous section, at the small-scale site, the management is so loose that workers often work freely and do not follow any safety regulations. Workers are also not provided protective equipment. Meanwhile, at the large-scale site, the level of management is higher. Workers must follow the safety regulations of the main contractor and are supervised by his supervisors. Also, the provision and use of the protective equipment is done strictly. In the second step, I chose workers depending on their job type. In this research, there are three types of construction workers, namely bricklayers, painters and ceiling workers. Each type of worker has their own characteristics. In the third step, I chose participants depending on two indicators: their symptoms/diseases/injuries history and their work experience.

Before interviewing participants, I organized discussion groups with each informal enterprise and asked them about the two above indicators. More particularly, I asked them about their work experience and symptoms/diseases/injuries history. Depending on their information, I chose suitable participants proportionally with the size of their informal enterprises. I chose more workers from the large-scale site, as at that site, there were more workers than at the small-scale one. In total, there were 11 participants and their information will be introduced in more detail in the third chapter.

Data Collection Methods

This section aims to introduce my data collection experiences in the field. In this research, I used three methods, namely participatory observation, discussion groups and interviews.

Before going into the field, I asked for the support of Phu, a key informant who was a supervisor of Brand. Phu is a close friend of Mr. Minh, a supervisor of the main contractor, so with his introduction, I could enter the large-scale site to observe the working activities of the workers. I was also able to talk with them during their break times. Although I was a visitor, I also had to follow all the safety regulations such as wearing a helmet and a high-visibility shirt to join the site. After entering the site, I was permitted to walk around the big factory to observe the activities of different workers from painters to bricklayers. Meanwhile, with the introduction of Mr. Tuan, an employer at the large-scale site and a friend of Mr. Huong, the employer of the small scale site, I was allowed to enter this site and observe their activities. At the beginning, Mr. Huong and his workers were not really open with me since they did not know who I was. We often talked about general things instead of their work since I did not want them to think that I was a journalist attempting to explore their life and write about it for the public. Fortunately, after several days, workers understood my work and they were less cautious with me. They became more open and shared more with me.

Apart from participatory observation, I also conducted four discussion groups. It was simple to conduct discussion groups with workers of Brand and at the small-scale site since I lived with them. For the informal enterprises of Mr. Luong and Mr. Tuan, I needed the introduction of Phu who was very open and good at persuading other people. In the discussion groups, I asked general information of each worker, of the informal enterprises, etc. I also bought some food and tea so the discussion groups, so they were casual. Phu shared that sometimes, in formal meetings, workers did not talk at all but after the meetings, they gathered at beer shops and talked a lot.

The main data collection of this book was the in-depth interviews. Each in-depth interview was conducted around 45-60 minutes after lunch time since workers were often busy. At night time, they had free time but after a hard-working day, they just wanted to relax. I often interviewed them at a tea shop or a coffee shop near the place they had lunch. This place was quiet and private

enough for them to share their opinions. At the beginning, some workers were quite shy and did not want to participate in the interview. They often thought that the interview was something special for special people, not for people holding low positions such as them. However, after I explained my purposes, they agreed to be interviewed. In addition to the in-depth interviews, I also conducted a lot of informal interviews. As I often visited the site and lived with the workers, I had many chances to ask them various questions about their life and their work.

Data Analysis

The process of analysis of this research will follow the conceptual framework which I have already explained to answer my research questions. Firstly, I will describe the poor working and living conditions in the informal sector and analyse how they affect the health of the construction workers. After that, I will analyse their difficulties in accessing health services because of the exclusionary social policies and how they have responded to their health problems in this context. In the next step, I will focus on their social relations: what social relations they had, how they maintained them, how their social relations helped them especially in comparison to social health insurance and what the strengths and drawbacks of their social relations were.

Chapter 2

Seeking Treatment in Vietnam

The main purpose of this chapter is to explore the Vietnamese health care and social protection systems to better understand what supports and prevents migrant workers from accessing health services, especially in the receiving community. In the first two sections, the chapter aims to explore the Vietnamese health care system and its privatization process. Moreover, the chapter also attempts to explore the privatization of the Chinese health care system. China is a socialist country, like Vietnam, so its experiences might provide more useful information for the situation in Vietnam. In the last section, the research attempts to explore the social protection system in Vietnam with a focus on social policies for migrant workers.

According to the Institute of Labour Science and Social Affairs and Deutsche Gesellschaft Fur International Zusammenarbeit, under Vietnam's social protection Strategy 2011-2020, the term "social protection" is defined as:

> A system of policies and programmes implemented by the State and social partners with the aim of ensuring a minimum level of income, universal health insurance and social welfare to enhance the capacity of individuals, households and communities in managing and controlling risks. (2011, p.11)

The Health Care System in Vietnam

As I mentioned in the research background section of the previous chapter, *Doi Moi* policy has strongly affected the health care system. It is, therefore, essential to review the Vietnamese health care system.

The Health Care System Before Doi Moi Policy

In the early 1940s, as a French colony, there were only 47 hospitals and nine maternity homes in the whole country, a total of 4,000 beds, almost all located in urban areas, for a population of around 18 million (Ladinsky and Levine, 1985). After their victory in 1954, the Communist government in the North of Vietnam launched a new health system with six primary regulations that were unremarkably modified in subsequent decades:

1. Vietnamese medicine must serve workers, mothers and children, and the national defence. It must contribute to raise the living standards of the people and provide care for minority groups.
2. Prevention (or prophylaxis) must be the principal task of Vietnamese medicine.
3. Vietnamese medicine must combine prevention with treatment. The patients should be treated as an organic whole.
4. Vietnamese medicine must learn from traditional medicine, studied in the light of modern science.
5. The organization of Vietnamese medicine must be based on the masses. Therefore, it must educate the masses and adopt policies that do not conflict with their spirit and interests.
6. Vietnamese medicine must rely on its own resources, while making the most of aid from friends (Ladinsky and Levine, 1985, p.259).

The health care system, with the Ministry of Health at its highest level, planned and operated health-related issues nationwide. The Ministry also manufactured and distributed pharmaceuticals, trained health workers and coordinated medical research. Below the Ministry were central institutes that provided health professional training, did research, served as tertiary care referral centres and guided inferior organizations, namely provincial, district and commune health care centres. In each province, a provincial health services

department, funded by the central government, was responsible for manufacturing pharmaceuticals, coordinating treatment and prevention activities, training nurses, midwives and assistant doctors and providing referral laboratories. Each province had 1-2 district hospitals of 100-200 beds, funded by the central government. Besides this, these district hospitals also provided referral laboratories, and had a mobile team responsible for water testing, family planning, etc. in villages and hamlets. Additionally, almost all areas in the North and around one-third of the southern provinces had commune health stations providing primary care, simple surgery and trauma care, among others. Below this level, each village's hamlet had a primary nurse, paid by the commune, providing some diagnosis and treatment services, coordinating home care or supervising four to five Red Cross workers (in this context, the term Red Cross did not relate to the International Red Cross). Their main responsibilities were to oversee environmental health controls, provide family planning education, give simple first aid and serve as the access point into the health care system (Ladinsky and Levine, 1985).

The Health Care System After Doi Moi Policy

In terms of administration, now, the health system is divided into four levels, namely central (Ministry of Health [MOH]), provincial (provincial health department [PHDs]), district level (district health offices [DHOs]) and communes (Commune Health Stations [CHSs]). MOH plans and launches policies and programmes for the whole country. MOH manages the departments, institutions, medical colleges and 31 central hospitals and involves itself with the health facilities of other ministries and sectors. PHDs follow these technical directions and guidance and are monitored and inspected by the MOH. However, PHDs work under the control of the Provincial Peoples' Committee in terms of their direction, organizational management, payroll and operations. PHDs manage provincial hospitals, centres for preventive medicine, provincial secondary medical schools and pharmaceuticals enterprises. Under the technical management of PHDs are DHOs. However, DHOs work under the control of the District People's Committee in terms of their direction, organizational management, payroll and operations. DHO is responsible for district health centres and region polyclinics. Meanwhile, commune health stations are designed to provide health care at the grassroots level. They are responsible for the early detection of epidemics, provide care and treatment

for common diseases and supervise voluntary health workers at communes. CHSs work under the control of DHOs and the Commune People's Committee. By the end of 2006, Vietnam had 671 districts and 10,876 communes - 98% of communes had a CHS (Cuong, Kubo, Fujino, Minh, and Matsuda, 2010; Tien, Phuong, Mathauer, and Phuong, 2011).

The Privatization of Health Care

This section attempts to explore the concept of privatization to understand how migrant workers are affected, particularly in Vietnam. Besides this, the section analyses the privatization process in China, a socialist country that has many similarities with Vietnam.

The Concept of Privatization

According to a European observatory on health systems and policies, privatisation "is the transfer of ownership AND government functions from public to private bodies, which may consist of voluntary organisations and for-profit and not-for-profit organisations" (Albreht, 2009, p.448). Meanwhile, according to Tam, privatization "is defined as the shifting of a function, either wholly or partially, from the public sector to the private sector. It involves greater reliance on private actors and market forces to assume the role of government functions and responsibilities" (2010, p.64). In general, privatization might be understood as a shift from the public to the private sector. The private sector is often related to the market and the public sector is often associated with the State. However, in reality, there is no clear boundary between the public and the private sectors. Sickness funds in Belgium and Netherlands, for example, are private not-for-profit agencies but in fact, they are often involved in state activities. Meanwhile, many public hospitals are also flexible, involved in both public and private activities (Maarse, 2006).

Maarse, therefore, suggests that we need to consider a few distinctions to understand the concept of privatization (2006). Firstly, privatization might be driven by policies or by other factors. Policy-driven privatization assumes that the performance of private structures is better than public ones. However, privatization might be triggered by other factors. Technology-driven privatization, for example, is brought on by the development of technological innovation that facilitates a change from inpatient to outpatient care. Meanwhile,

demand-led privatization is a response to the failure of public services. Secondly, there is the distinction between termination and outsourcing. The former refers to the reduction of the State involvement and the increase of the private one. Regarding outsourcing, the State still maintains its role but also hires private agencies for a number of tasks. Privatization by outsourcing, therefore, is less radical than privatization by termination. However, both termination and outsourcing are policy-driven privatization. Thirdly, it refers to the locus of decision-making. Top-down privatization is launched by the central government while a bottom-up one is taken at inferior administrative levels. Finally, it is also essential to distinguish privatization and decentralization. The former is associated with the shift of ownership from the public to the private while the latter is a process happening within the public sector. Public hospitals, for example, might have to become financially autonomous. Decentralization, might be considered a precursor of privatization.

About the origin of privatization of health care, Sen states that after the Second World War, developing countries often followed a universal provision of health care (2003a). However, since the 1970s, the globalization process has strongly affected various economies resulting in the privatization of the public sector, especially health services in developing countries. The transformation has been affected by two primary factors. Firstly, it is a result of financial shortages or the overstretching of public budgets. Due to various problems such as the energy crisis in the 1970s or the high levels of poverty and unemployment rates, many countries had to borrow money from international organizations such as the International Monetary Fund (IMF). This made them restructure the financing of their public provisions to maintain their financial stability. Instead of subsidizing the services sector, the governments had to privatize them so they could off-load these financial burdens from their respective national budgets to the market. Secondly, this privatization can be conceptualized as a new form of seeking capital in the public sector. In the globalization era, the dependency ratios of countries are greatly affected by international investments that distort national income, mainly from personal taxation, demographic changes (increasing life expectancy, growing ageing population) or rising unemployment rates due to the development of technological revolution. These economic and demographic contexts are exacerbated by the economic transformation precipitated by neo-liberal policies that reduce the levels of personal taxation and promote minimalist state intervention.

Financial shortage and capital attraction are the first two factors triggering the privatization of health care systems. Over time, there are more factors leading to the privatization of health care. Albreht argues that there are internal and external reasons resulting in the privatization process (2009). Internal reasons include "dissatisfaction with poorly managed public services, privatization as a part of the general social processes and re-introduction of private practice" (Albreht, 2009, p.448). Meanwhile, external reasons include "patient rights - to choice, to diversity, to quality health care; privatization as an option for competition and 'market-oriented' health care and quality, competition, 'better overall performance' of providers" (Albreht, 2009, p.448). It can be said that in addition to financial considerations, the aims for higher efficiency and better management are other factors leading to the privatization. Maarse also categorized that there are four kinds of privatization in health care, namely privatization in financing, provision, management as well as operation and investment (2006). However, when the privatization is implemented, it might lead to both positive and negative results that will be analysed deeper in the case of China and especially, Vietnam.

The Privatization of Health Care in China

By way of introduction, let us look at the health care system of China. When China was established in 1949, the private sector played a significant role in the health care system. However, in the mid-1950s, the private sector was cut while the public sector became more crucial. At that time, hospitals were strongly subsidized by the government. In 1980, the private sector was partly allowed to return, mainly in the ambulatory sector. Until the mid-1990s, hospitals were gradually privatized on a large scale. However, the influence of the government still remained. In 1999, most of the hospitals (96%) at or above the county level were still public ones (Tam, 2010).

Although the ownership of hospitals is public, their operation is significantly privatized, especially in financing and provision. Firstly, in terms of privatization of financing, before the 1980s, the Chinese government totally subsidized health services. However, since the 1980s, to reduce the financial burden of welfare provisions, the State has had to privatize health financing by cutting health subsidies and regulating what public hospitals can charge their patients. Secondly, in terms of provision, although most hospitals remain state-owned, they are, in fact, operated as commercial enterprises with revenue

generation as the main objective. One tendency in China is the contracting of clinical departments from public hospitals to outside parties even though it is prohibited by law (Tam, 2010).

Tam argues that privatization has resulted in two main consequences (2010). Firstly, privatization has limited the health care accessibility of vulnerable populations who are unable to pay the treatment fees. There is no official data on public hospitals refusing the poor but the author reveals that concern over this issue has alarmingly escalated. Secondly, privatization also erodes service quality. The income of physicians depends on the income they generate for the hospitals; therefore, many physicians prescribe unnecessary and risky medicines and treatments for patients. This results in a deteriorating quality of service. More seriously, "a majority of clinical departments within public hospitals have been leased to individuals who have little experience in running hospital" (Tam, 2010, p.70). This raises a concern that the owners will tend to try all means to extract money from patients regardless of the services' quality or regulations.

It is questioned what factors lead to these above consequences. Tam argues that the privatization process needs an effective regulatory framework to minimize its adverse impacts (2010). Meanwhile, in China, there is a lack of such effective regulatory institutions. There are three factors contributing to this absence of effective regulations. Firstly, revenue generation is set as the main objective so there are fewer regulations to support the market achieving their goals. Secondly, another factor is the bureaucratic politics of the regulators (the health bureaux) have the same bureaucratic ranking as the regulated entities (public hospitals and their directors). Thirdly, regulators also find it difficult to supervise the public hospitals due to their poor finances and even their low qualifications.

The Privatization of Health Care in Vietnam

As I mentioned in the earlier section, in terms of typology, there are four kinds of privatization in health care, namely privatization in financing, provision, management and operation and investment (Maarse, 2006). I will analyse the privatization of health care in Vietnam from the four aspects above.

Financing

Privatization in health care financing refers to the shift of public to private spending or more specifically, a reduction in the State budget and an increase

in the private one. Public spending in health care includes "all government expenditures for health care and all expenditures of agencies, whatever their legal status, implementing compulsory health insurance programmes". Meanwhile, private spending includes "health care expenditures of private health insurers, private enterprises, households, and a few other agents" (Maarse, 2006, p.989).

From 1954 to the mid-1980s, Vietnam followed state-socialist and universal health policies. State-socialism meant that the health system was totally financed by the State and its centrally planned economic institutions. At that time, medicine, materials and labour were all subsidized by the planned economy. Universalism means that the health system ensured preventive and curative health services free of charge as a right of citizenship (London, 2008). According to Ladinsky and Levine, the sole expense patients had to pay was for food during inpatient stays costing approximately 60-90 US cents per day. Wolffers reveals that some people might have had to buy Western medicine on the black market (1985). Before 1986, Vietnam followed a centrally planned and subsidized economy that mainly cooperated with Soviet bloc countries so Western pharmaceuticals were quite rare. Most of them were imported by charity organizations or relatives of Vietnamese people living abroad.

After *Doi Moi* policy, the State has launched various policies to privatize health expenditure to reduce the national budget of the health system. In 1989, the State launched Decision No. 45/HDBT allowing health care providers to collect a part of hospital fees, including charges for hospital beds, medications, tests, X-ray films and other consumables. In 1994, the Vietnamese government launched Decree No. 95/CP regulating partial user fees. According to this decree, most patients, excluding children aged under 6 years old, disabled people, orphans, the elderly, for example, must pay a part of their fees as regulated by the Ministry of Health and Ministry of Finance. 85% of the fee would be directly used for patients and 15% for incentives for staff (Riddle, Son, and Hernandez, 2006).

In the 2000s, the State required the public service providers to become even more financially autonomous. In 2002, the State launched decree 10/2002/ND-CP allowing health care providers to manage their costs and revenues. Hospitals providers could now set the expenditure norms, including wages and allowances of staff that were perhaps the biggest element. In 2006, the State

launched decree 43/2006/ND-CP replacing decree 10. Decree 43 grants hospital directors more power to reduce costs and raise revenues. According to this decree, 25% of the net revenues are for facility upgrading while the remaining 75% are for hospital staff (Lieberman and Wagstaff, 2009).

The privatization of financing has led to remarkable changes in the health expenditure. Before *Doi Moi* policy, most of health expenditures were from the government budget but after the economic reform, financial resources have been diversified with a shift from the State to individual budgets. In 1998, out-of-pocket payments accounted for 80% of the total expenditure on health. In the 2000s, thanks to the improvement of social health insurance, out-of-pocket payment slightly dropped but the number was still the highest (Lieberman and Wagstaff, 2009). In 2007, in the total expenditure of health, the share of out-of-pocket payments was 55.5%, government budgets was 22,7% (3.7% from central government budget and 19% from provincial one), social health insurance was 14.2%, other private spending was 6.3% and Official Development Assistance (ODA) was 1.3% (Tien et al., 2011). According to Cuong et al., in 2006, 70% of out-of-pocket spending was for drugs, 18% for private providers and 12% for public providers (2010).

London argues that public spending is quite low in comparison with other sectors and countries (2008). In 2007, Vietnam's public expenditure on health was quite low in per capita terms, around 6% of the central budget while this number in Cambodia was 18.8%, Thailand was 17.1% and China was 10% (London, 2008). According to Tien, et al., since 2006, most government expenditure on health has been allocated for social health insurance in the form of premium subsidies for children aged under 6 years old, the poor or other vulnerable groups (2011). Direct subsidy for health providers has only been kept at a necessary level to mainly cover essential public health and primary care requirements.

Provision

According to Maarse, privatization in health provision means that the ownership of a health care provider is shifted from a public to a private agency that works either for profit or not-for-profit (2006).

Before 1986, Vietnam followed a centrally planned and subsidized economy that solely recognized the public sector. All hospitals/clinics, therefore,

belonged to the State, were subsidized by the government budget and were operated on a not-for-profit basis. However, in 1986, Vietnam reformed its economy with *Doi Moi* policy. In the new period, public health providers become more autonomous, yet, their ownership still belonged to the State. Due to the reduction of the government subsidy, public health providers have had to become financially autonomous. However, in this situation, the concept of autonomy is broader - not limited to financing. After *Doi Moi* policy, public health providers also had the right to hire temporary workers and could borrow and invest in equipment and infrastructure. In other words, they coulde operate like state-owned enterprises that had their own seal and bank account. Therefore, in theory, these public health providers still belonged to the State but in reality, they also worked for profit like private ones (Wagstaff and Bales, 2012). Maarse argues that the autonomy of health providers is a precursor of privatization in provision (2006).

The autonomy policy has led to different results for different sets of people. In terms of health providers, the policy is beneficial for large hospitals in big cities. With high-quality physicians and modern facilities, these large hospitals, especially in Hanoi and Ho Chi Minh City, might easily attract a large number of patients. They, therefore, might pay their staff better salaries and improve their facilities. Conversely, hospitals and clinics at lower levels such as commune health stations find it more difficult to attract patients due to the limitations of their staff and facilities. To patients, people from the upper classes seemed to enjoy high-quality services that were never provided in the past. However, due to the financial autonomy, hospitals could not provide free services such as they used to. This limited the health care access of many people, especially the poor. Additionally, this autonomy also forced health providers to use more expensive services although they were unnecessary.

There has been an increase in the use of high-tech laboratory tests and pricy medicines. All of these contribute to the growth of out-of-pocket payments that badly affects the access of vulnerable groups (Ministry of Health and The World Bank, 2011).

Management

According to Maasre, privatization in management has also been recorded (2006). The management of many hospitals in Germany, for example,

has shifted to private agencies to improve hospital efficiency. In several countries such as Sweden and Poland, privatization in management is increasingly becoming a phenomenon. However, in Vietnam, the process has not yet happened. Health providers have become more autonomous but their ownership still belongs to the government and they must follow the regulations of the government authority.

Operation and Investment

Meanwhile, Maasre argues that privatization in operations refers to outsourcing done to improve efficiency (2006). In Europe, there have been two kinds of outsourcing, in non-clinical operational activities such as laundry, catering, security, and in diagnostic testing. In Vietnam, the former happens while the latter has not: many physicians use public facilitates for personal purposes.

There has also been a recorded increase in the privatization of investment. Since the 1970s, the services sector, including the health sector, has become a new form of capital accumulation. Private investors have invested more in the health care system, even in foreign countries, to accumulate more capital (Sen, 2003a). Additionally, a growing number of public hospitals also seek private capital for their investment needs because of the long delays inherent in public financial plans (Maarse, 2006).

In the case of Vietnam, before 1986, the State did not recognize the private sector; therefore, there was no private investment. However, after *Doi Moi* policy, the State has recognized a variety of sectors and removed some economic barriers from the market. Thus, it has also witnessed a growing privatization in investment. In 2010, there were 102 private hospitals, mainly located in urban areas (World Health Organization and Ministry of Health, 2012). Private clinics, that were organizationally controlled by People's Committee and technically managed by the Ministry of Health, became more popular. In 2009, there were 30,000 private clinics. On one hand, the ubiquity of private clinics helps people to access health services more conveniently. On the other hand, these private clinics might also provide deteriorating services because the technical management of them is not very successful. In fact, there is, at present, no data on private clinics having technical licenses (Bộ Y tế and Nhóm đối tác y tế, 2009). Due to such loose management, the quality of many

private clinics is not assured, leading to deteriorating services that might be harmful to their patients.

Regarding pharmaceuticals, before 1986, investment was extremely rare. There were two primary sources, self-production and subsidy from Soviet bloc countries. Along with health treatment, pharmaceuticals were freely distributed to all citizens. However, there were not adequate medicines for all people, especially expensive ones. Many patients, therefore, had to seek Western medicines from the black market. There were two main sources of pharmaceuticals at the black market level: from the provisions of international aid organizations and from emigrants sending medicines for their relatives back to Vietnam (Wolffers, 1995). After *Doi Moi* policy, the State has removed economic barriers so foreign pharmaceuticals enterprises might enter the Vietnamese market. Domestic enterprises, both state-owned and private, have also strongly invested in this industry. In terms of distribution, there has been a boom in private pharmacies. In theory, these shops must be managed by qualified druggists but in fact many of them are operated by people who are less knowledgeable in medicines. Additionally, many pharmaceuticals enterprises also give commissions to physicians if they prescribe their medicines, normally expensive ones, for patients (Wolffers, 1995).

Before *Doi Moi* policy, Vietnam considered health care a right of citizenship; from the poor infrastructural provision when it was a French colony, Vietnam broadened its health provider networks, even to communes. Thanks to the absolute subsidy of the State, all people might access health care. At the Alma-Ata conference in 1978, where the concept of primary health care was introduced, Vietnam "was mentioned as an outstanding example of a developing country that had solved its basic health problems" (Wolffers, 1995, p.1326). However, due to the poor economy, the low level of development and limited cooperation between providers and agencies, health services at that time were fairly limited. Most of Vietnamese health providers lacked equipment and medicines, especially expensive ones. Citizens, therefore, found it difficult to access high quality services.

After *Doi Moi* policy, the State privatized the health sector by various activities. The authority reduced its subsidy for the health sector, required public health providers to become more financially autonomous and allowed the establishment of private health providers and pharmaceuticals enterprises. Additionally, economic and political barriers have been removed to attract

foreign cooperation and investment in various areas, including the health sector. 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 did not have to pay for much, except food expenses. However, after *Doi Moi* policy, they have had to pay much more. In 2007, in the total of health expenditures, the share of out-of-pocket payments was 55.5%, government budgets was 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 et al., 2011). In the mid-1980s, a peasant only had to pay 1% his/her disposable income on health care but after *Doi Moi* policy, this person must 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 became a financial burden for the poor (Witter, 1996). According to Cuong et al., in 2006, 70% of out-of-pocket spending was for drugs, 18% for private providers and 12% for public providers (2010). The major percentage on drugs might be conceived of as the result of the privatization in investment. Drugstores have become more ubiquitous, while pharmaceuticals 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, 2003a; 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, over the next 10 years, except in 1993, the numbers of visits has sharply dropped to around 1.5 times per year (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 pharmaceuticals enterprises on physicians, medicines are sometimes over-used. Furthermore, 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 and Wagstaff, 2009). In fact, many pharmacies are managed by low-educated people who prescribe all kinds of medicine for patients without any guidance from doctors. Mass media has also shown many cases wherein patients died at low quality and unregistered 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).

Factors Leading to Privatization's Problems

It should be questioned what factors have led to these abovementioned problems. The first factor resulting in the exclusion of the poor is the lack of diversity. Due to various economic issues, the governments quickly reformed the health sector by changing their economic policies. This approach neglected the diversity of society where there are various groups with different income levels. Sen suggests that it is essential to address socio-economic, demographic and epidemiological realities prior to the economic reform of the health sector (2003b).

The second factor regarding unequal access is that the market is supported more than patients. In terms of disease control, for example, medical care that is considered a preventive tool and other such medical interventions, must cover the public's needs. However, current reforms of the health sector ignore this lesson and mainly focus on expensive programmes that are unsuitable for the majority of people (Qadeer, 2003). Qadeer argues that the current reforms provide more benefits for the drug manufacturing multinational corporations (MNCs) than the patients (2003). The reforms process often ignores the socio-economic roots of diseases, neglects the importance of health care and mainly focuses on medicine trade that is beneficial for MNCs.

The final factor is the lack of effective regulatory institutions that also exacerbates both unequal access and deteriorating services quality. Analysing the case of China, Tam argues that regulatory institutions consist of health regulation and regulators (2010). In China, many local governments neglect to create tighter regulations to help private hospitals earn more profit. Besides this, regulators are also poorly financed and unqualified to supervise the increasing number of private health providers. Tam argues that the privatization process, which is profit-oriented, needs an effective regulatory framework to minimize its adverse impacts (2010).

In the case of Vietnam, the government has already launched some regulations for the health sector but they seem to be less effective, especially in terms of supervision. Lieberman and Wagstaff argue that the Vietnamese government, like governments in other developing countries, has not been active in terms that insure the quality of services and regulate and supervise the private sector (2009).

There has been a boom in private clinics but the number of supervisors is greatly limited. In Hanoi, there are only eight supervisors for 2,308 private clinics and 2,827 drug stores (H. Hà, 2013). Additionally, the poor management of drug prices and use is the most acute issue now. Wolffers argues that many Vietnamese physicians' knowledge of drugs is limited due to a long-time lack of training in drug regimens (1995). Witter reveals that Vietnam lacks regulation of the market for drugs (1996). More particularly, drugs' prices are not regulated; therefore, providers might easily exploit patients (Lieberman and Wagstaff, 2009).

Social Protection System in Vietnam

According to Institute of Labour Science and Social Affairs and Deutsche Gesellschaft Fur International Zusammenarbeit, the Vietnamese social protection system has four elements, namely Active labour, Market programs/policies; Insurance; Social assistance and Others (2011). The Active labour, Market programs/policies element includes vocational training, retraining, credit, labour mobility support, job introduction and temporary/public work. The Insurance element includes compulsory and voluntary schemes. Compulsory schemes include social insurance, health insurance and unemployment insurance while voluntary schemes lack the last one. The Social

assistant element includes regular assistance, a social safety net, social services, emergency assistance and poverty reduction programs. Meanwhile, the Others element includes child protection, crop insurance, micro-insurance, community-based funds and others. For the purposes of this book, I will review the Insurance element with a focus on the voluntary scheme.

The Insurance Element

By way of introduction, it should be emphasized that the Insurance element here is managed by Vietnam Social Security (VSS), a state-owned enterprise, and not insurance services of private enterprises. The Insurance element has compulsory and voluntary schemes. The compulsory scheme that is mainly for employees in the formal sector has social insurance, health insurance and unemployment insurance. Meanwhile, the voluntary scheme that is mainly for employees in the informal sector only has social insurance and health insurance. Besides this, the contribution and benefits of compulsory and voluntary social insurance and health insurance are also different. For the purposes of this book, I will focus on social insurance and health insurance.

According to the Institute of Labour Science and Social Affairs and Deutsche Gesellschaft Fur International Zusammenarbeit, in Vietnam, social insurance "refers to a guarantee of income replacement or compensation when employees' earning capacities are lost or reduced due to sickness, occupational accidents, occupational disease, maternity leave, unemployment, old age or death" (2011, p.14). Social insurance has two schemes, namely compulsory and voluntary ones. Compulsory social insurance is for employees who have labour contracts from three months and above. In this research, it refers to employees in the formal sector. Meanwhile, voluntary social insurance is for Vietnamese citizens who are from 15 until 60 (men) or until 55 (women), who are unable to join mandatory social insurance (Bảo hiểm xã hội TP. Hồ Chí Minh, n.d.). Formal employees have to contribute 8% of their monthly salary and their employers have to contribute 14% (Bảo hiểm xã hội tỉnh Bình Dương, n.d.-a). Meanwhile, informal employees have to pay the entire contribution rate that they might choose. The lowest contribution rate is 22% of the minimum monthly salary and the highest one is 22% of the 20 times of the minimum monthly salary (Bảo hiểm xã hội tỉnh Bình Dương, n.d.-b). The compulsory social insurance has five benefits including sickness, employment injury and occupational disease, maternity leave, pension and survivors' benefits.

Meanwhile, the voluntary social insurance has only two benefits, namely for pension and survivors. It can easily be found that informal employees must contribute more than formal ones but their benefits are fewer.

	Mandatory social insurance	**Voluntary social insurance**
Participants	Employees who have labour contracts from three months and above.	Vietnamese citizens, from 15 to 60 (men) or to 55 (women), are not able to join mandatory social insurance
Contribution rate	8% of their monthly salary	22% of the minimum monthly salary
Benefits	Sickness1, employment injury and occupational disease, maternity leave, pension and survivors' ones	pension and survivors' ones

Table 2.1: A comparison of mandatory and voluntary social insurance
(Source: Author)

Regarding health insurance, it should be said that its development is the focus of this study. After the introduction of user fees in 1989, the Vietnamese government launched health insurance to ensure health access for vulnerable people. After more than 20 years, the Vietnamese health insurance is managed by VSS, a state-owned enterprise, under the financial and technical management of the Ministry of Finance and the Ministry of Health respectively. It has two schemes, namely mandatory and voluntary ones. The compulsory scheme is aimed at two primary groups. The first group is for employees in the formal sector and civil servants. Their family members are not covered. This group pays 4.5% of the minimum monthly salary among which employers have to pay two-thirds while employees have to pay one-third of the contribution rate. The second group, that is non-contributory, includes children aged under six, the poor, retired government officers, war veterans, members of Parliament, Communist Party officers, war heroes and so on. The voluntary scheme aims at various targeted groups. The first group is full-time students, the second group is family members of the compulsorily insured and the rest, who do not belong to any of the above categories, might be peasants or employees in the informal sector.

These groups are also allowed to join voluntary social health insurance. Voluntary participants have to pay the entire fee (4.5% of the minimum monthly salary) by themselves (Dragon Law firm, n.d). However, Lieberman and Wagstaff state that the benefit package of health insurance, both compulsory and voluntary, is nearly the same for everyone, covers most outpatient and inpatient care received at government facilities; exclusions include interventions covered by vertical programs such as HIV/AIDS prevention and treatment programs, drugs not on the Ministry of Health list, treatments not yet approved by Ministry of Health, various "luxury" interventions such as cosmetic surgery, dental care, treatment of self-inflicted injuries, and treatment for drug addiction (2009, p.65).

Detailed information of the benefits of health insurance can be found in Decree No. 62/2009/ND-CP dated July 27, 2009 of the Government detailing and guiding a number of articles of the law on health insurance (Dragon Law firm, n.d).

	Mandatory health insurance	**Voluntary health insurance**
Participants	+ Employees in the formal sector and civil servants (1.5% of their monthly salary) +Non-contributory, includes children aged under six, the poor, retired government officers, etc. (0%)	+ Full-time students + Family members of the compulsorily insured + The rest, who do not belong to any above categories, might be peasants or employees in the informal sector
Contribution rate	0%-1.5% of their monthly salary	4.5% of the minimum monthly salary

	Mandatory health insurance	Voluntary health insurance
Benefits	Most outpatient and inpatient care received at government facilities; exclusions include interventions covered by vertical programs such as HIV/AIDS prevention and treatment programs, drugs not on the Ministry of Health list, treatments not yet approved by Ministry of Health, various "luxury" interventions such as cosmetic surgery, dental care, treatment of self-inflicted injuries, and treatment for drug addiction (Lieberman and Wagstaff, 2009, p.65)	

Table 2.2: A comparison of mandatory and voluntary health insurance
(Source: Author)

Although the coverage of social insurance has increased, it has still not covered around 30% of the population. Paulette et al., estimate that in 2008, only 11.1% of about 23 million workers in the informal sector and the inactive had social health insurance (2011). Apart from the quality of social health insurance and the perception of informal workers, there are two policy-related issues preventing workers, especially migrant ones, in the informal sector from accessing health insurance. Firstly, the State does not financially support this group. Workers in the informal sector pays the entired contribution rate by themselves and that has proven to be too high due for their unstable income.

Secondly, the regulation of social health insurance registration[8] based on household registration has also been a barrier for migrant workers who are highly mobile.

Social Policies for Migrants

Duong et al. argue that migration is beneficial in several areas (2011). Firstly, it is a good source of poverty alleviation and development for the sending communities. Secondly, it provides a labour force for various sectors. However, findings show that migrants are a vulnerable group due to many factors, including the lack of adequate policies and institutional programmes for their social protection. Duong et al. argue that social protection in Vietnam was provided widely for decades but the current legal structure does not cover spontaneous migrants (2010). Institutionally, there is no government agency that is responsible for matters relating to this group. The primary institutional barrier to social protection for spontaneous migrants is *ho khau* (household registration). The authors also reveal that many residence-based social policies prevent migrants from accessing key social, economic and political entitlements. This makes migrants face two kinds of risks, namely covariant (employment, housing, health care, education of children) and idiosyncratic ones (deteriorating health, poor working and living conditions, low and unstable income, little or no welfare at the workplace and social exclusion among the receiving community).

8 Migrant workers in the informal sector have two options to buy voluntary health insurance (VHI). Firstly, and the most popular, informal workers can buy VHI at the place where they have permanent household registration to use the services of a hospital/clinic that has a contract with VSS in this area. When they get sick, they must go to the registered hospital/clinic (or primary care provider) to receive the full benefits. If they go to another hospital, even in the same province, they are only accepted in limited cases such as in an emergency and are only paid a part of their benefits. This is one of the reasons why migrants are not interested in health insurance as they must return to their hometown to use the services provided. Besides this, services of commune hospitals/clinics are often poor so people tend to go to big ones in cities. Secondly, migrants can also buy VHI and use the services of a hospital/clinic in the receiving community if they belong to the KT3 group. However, it is not easy to register at the receiving community since the regulations in Vietnam are so complex that they will take them a lot of time. Even if they can register in the receiving community, it would not be convenient for many migrant workers since so many of them are seasonal migrants.

Category	Status	Rights	Obstacles/Legal restrictions
KT1	Residents (including both non-migrant and migrants) with permanent household registration at place of residence • Purchase and sell land and housing and have land/house ownership certificates • Access to public facilities and social services at current place of residence • Access to formal financial loans • Access to employment		Access to public social services including education and health care only within their district of residence
KT2	Intra-district migrants who have permanent household registration in the province/city of current residence.	• Purchase and sell land and housing and have land/house ownership certificates • Access to public facilities and social services at current place of residence • Access to employment	• Access to public social services including education and health care only within the district where they are registered. • Lack of access to financial loans/ formal financial services.
KT3	Migrants who do not have permanent registration at the place of current residence but have temporary registration for 6-12 months with the possibility of extension.	• Access to public facilities and social services	• Lack of access to legal housing • KT3 children can go to public schools only when they are not used to full capacity (by KT1 and KT2 children). If the schools are overcrowded, KT3 have to go to private schools where they have to pay higher school fees. • Lack of access to financial loans/ formal financial services.

Category	Status	Rights	Obstacles/Legal restrictions
KT4	Migrants who do not have permanent registration at the place of current residence but have temporary registration for 1-6 months.	• Do not have the right to purchase land and access to public social services and financial loans	
Non-registered residents	Those who do not belong to any of the above category.	• Do not have the right to purchase land and access to public social services and financial loans	

Table 2.3: Social policies for different household registration statuses
(Duong et al., 2011)

After the privatization of health care, health access for people greatly depends on their income. When thwarted from accessing public health providers, two-thirds of Vietnamese people have to rely on self-medication and this number is even higher within lower income groups (Witter, 1996). The salaries of workers in the informal sector are the second lowest, only higher than those employed in agriculture; therefore, they are more likely to choose self-medication (Cling et al., 2010). According to Duong et al. (2011), when being ill, 7% of unregistered migrants do nothing; 81% of them do self-treatment and only 12% of them go to clinic/hospitals. Self-medication is the most popular choice of Vietnamese citizens, especially migrant workers in the informal sector, because of its convenience, low expenditure and the ubiquity of drugstores. However, the way people use medicine without prescription from doctors is considered to be harmful, especially in the long term (Wolffers, 1995).

Vietnamese migrant workers are also not strongly supported by the government in other ways. Firstly, there is no institution or government authority to support migrant workers in the receiving community (Duong and Liem, 2011). Viện Gia đình và Giới argue that this is a serious problem since many immigrant workers lack information about local health care providers. Secondly, Duong and Liem reveal that the household registration system is the key barrier preventing migrant workers from many public programmes in the

receiving community (2011). Most particularly, temporary migrants cannot access public social services, formal financial loans, poverty reduction programmes, school fee reductions or exemptions, free medical care booklets or the right to purchase land. Duong and Liem reveal that the household registration system "is complex, multi-layered, bureaucratic and politicized" (2011, p.158). Migrant workers, therefore, find it difficult to become permanent residents in the receiving community.

Regarding health issues, the household registration system constrains migrant workers from two main aspects. Firstly, local communities often have medical programmes for children of permanent residents (Duong and Liem, 2011). Children of temporary migrant workers cannot access these programmes. Secondly, the management of social health insurance, a safety net for vulnerable people, is based on the household registration system. Therefore, even if migrant workers have social health insurance, they will find it difficult to use it in the receiving community (Viện Gia đình và Giới, 2010). Studies in China, which also uses the household registration system, argue that it is a disadvantage of rural-urban dualism. The dualism approach neglects the mobility of migrant workers, divides all citizens into two separated groups. Social policies based on the household registration system, therefore, are not suitable for migrant workers who are highly mobile.

Concluding remarks

In conclusion, after *Doi Moi* policy, the Vietnamese health care system has been changed significantly. The most considerable change is its privatization in financing, provision and investment. The privatization of health care has improved the services, especially at large hospitals in big cities. Vietnamese citizens, especially those with high incomes, can access high-quality services and medicines that were rare before. However, the privatization of health care has also resulted in various problems among which increasing unequal access is the most serious. After privatization, health services have been less subsidized by the government, shifting the expenditure onto individuals. For those who have a limited income, health expenditures have become a huge financial burden.

To tackle this problem, the Vietnamese government introduced several social protection programmes, including Insurance elements. However, this research has found that these programmes 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 programmes. It can be said that in the context of rising market-driven health services, migrant workers, including construction ones in the informal sector, are greatly vulnerable as they are excluded from the social welfare system.

Chapter 3

The Life of Migrant Construction Workers in the Informal Sector

General Information of Participants

Using the qualitative approach, this research focused on the life of eleven participants who are migrant construction workers in Hanoi. Thong is an employer of an informal enterprise but in fact he also works like the other workers so he was interviewed as a worker. All workers come from the North of Vietnam. Their hometowns are 20-100 kilometres from the centre of Hanoi. Workers live with their families in their hometowns and only go to Hanoi when they have work. Since they are paid wages on an hourly basis, workers often try to work as much as possible. The length of time they stay in Hanoi depends on the duration of their construction sites, from several weeks to several months. When working in Hanoi, workers only go back to their hometowns when there is a special event such as a wedding party for one of their relatives.

Besides this, their family background should be mentioned. Regarding marital status, among the 11 workers, five people (Thong, Phuc, Thien, Yen and Bac) are single while the rest are married. Among the six people who are married, three people continue to live with their parents. Including the five unmarried individuals, eight people, in total, live with their parents. Meanwhile, three married workers (Duong, Hung and Thu) live separately from their

parents. However, the houses of these three people are near their parents[9]and they often communicate and support each other with housework and their relationships remain very close. As I mentioned previously, their families live in their hometowns in the countryside. Workers do not bring their families to Hanoi with them because their income is not high or stable enough to afford the expensive living costs in the capital. Workers, therefore, have to keep in touch with their families by various ways that will be analysed later in Chapter 5.

It is also necessary to mention their economic background as it greatly affects the financial support workers receive when having health problems. Generally, based on government standards, their families are not poor households[10] but some of them are also far from comfortable. Parents of Thong and Bac are relatively poorer, so they had to work instead of furthering their study. Bac's parents are farmers and his younger brother is a high school student. Meanwhile, Thong's parents used to be farmers but now have started working as assistant bricklayers in their hometown for the last 1-2 years. Thong has an older sister who has already gotten married. As the only son, Thong is the main breadwinner of his family. He does not have to support his parents much but needs to save money for such significant events as the building of a new house. The families of Duong and Hung are also poor. The wives of Duong and Hung are both farmers with limited income. Duong and Hung are the main breadwinners, earning money to raise their children; each has two kids. Duong shares that, without his wages, his family "will be hungry". The situation of Hung is more difficult as his parents are even poorer so sometimes he must support them as well. Hung has an older brother who migrates to the South of Vietnam and rarely comes back to his hometown.

Meanwhile, the economic status of families of Phuc, Thien, Ha, Yen and Thu are normal. Phuc's father is a construction employer, his mother is a farmer and his younger sister is an accountant in his hometown. Tien's parents are farmers with normal income while his uncle (the younger brother of his mother) is his employer. His uncle is financially strong and is very close to his family. Phu's wife is a farmer, mainly raising pigs so their income is quite good. They

9 In Vietnam, after getting married, the first son often lives with his parents to take care of them. Meanwhile, other sons will build new houses, often next to the house of his parents and stay there.

10 In Vietnam, the government divides households into several groups based on their monthly income.

do not have to economically struggle with everyday activities but are still not relatively comfortable. They share that "*đủ ăn nhưng chưa có của ăn của để*" (their income is enough for food consumption but not enough for savings). The responsibility of Ha and Phu is higher as they have already gotten married and need to raise their families.

Among 11 participants, only the families of Vinh and Ninh are economically stable. In his hometown, Vinh's parents are traders who cook cow legs and sell to food shops while his wife is a clothes trader. Their businesses are reasonably good. Moreover, Vinh shares that his parents gave him a lot of land in his hometown so now he feels comfortable and does not have to worry about land issues. Meanwhile, Ninh is living with his parents. His father is a veteran and his mother is a former primary teacher. Now his parents stay at home to help him raise pigs and chickens that bring a good income. Nevertheless, his wife is a primary school teacher with a stable income.

Most of these workers come from the same province and have close relationships with their employers. Only two workers come from different provinces than their employers. As far as I have observed, employers tend to recruit their relatives and fellow villagers since they know each other and this leads to easier management. However, when necessary, employers also recruit employees, especially those who are skilful and experienced, from other provinces. This practice will be analysed deeper in the following sections.

All key informants are below 40 years old. Six people are from 20-30 years old and the rest are from 30-40 years old. At two sites, I also observed that most of the workers were fairly young and only a few workers looked old, around 40 years old. This situation is unsurprising as construction work is strenuous. It is, therefore, more suitable for young people. However, there seems to be no correlation between age and work experience. Some workers are young (25-27 years old) but have worked in the industry for around seven years while some older people have less work experience. Moreover, workers are not well-educated. Most of the workers have only graduated from high school and that is quite normal in the North of Vietnam. Two workers had only graduated from secondary school and one person is even illiterate. Two workers studied at vocational training schools but could not graduate. Only one worker graduated from vocational training but his major was in engineering, not construction or architecture. None of them joined any formal construction school before working in the industry.

It is also essential to explore what workers did before joining the construction industry. Young workers who were born at the end of 1980s or the beginning of 1990s often started working in the construction industry right after their studies. After graduating high school, most of these young workers started working. Two workers studied at vocational training schools but they did not like it so they left school to work. Meanwhile, older workers who were born in the 1970s often did various jobs before working in construction. This may be because around 20 years ago Vietnam was still a poor country and construction work was not popular.

Name	**Job**	**Age**	**Work experience (years)**	**Hometown**	**Education**	**Relationship with employer**
Thong	Painter	25	>7	Vinh Phuc	Secondary school	Himself
Phuc	Painter	27	5-7	Vinh Phuc	Un-graduated college	Relative
Vinh	Ceiling worker	27	>7	Vinh Phuc	High school	Colleague
Thien	Ceiling worker	21	1-3	Hai Duong	High school	Relative
Duong	Ceiling worker	36	5-7	Nam Dinh	Vocational training	Fellow villager
Hung	Bricklayer	40	3-5	Hung Yen	Illiterate	Fellow villager
Yen	Bricklayer	25	3-5	Hung Yen	Un-graduated college	Relative
Ha	Bricklayer	37	>7	Ha Nam	High school	Colleague
Bac	Assistant bricklayer	20	1-3	Bac Ninh	High school	Relative
Ninh	Senior bricklayer	38	>7	Bac Ninh	High school	Relative
Thu	Senior bricklayer	36	5-7	Bac Ninh	Unknown (but very low)	Relative

Table 3.1: General information of participants
(Source: Author)

The distance from these workers' hometown to Hanoi is illustrated more clearly in the below picture. As I mentioned above, all participants come from the North of Vietnam, around 20-100 kilometres from Hanoi. Among participants, the hometown of Thong and Phuc is next to Hanoi, just around 20 kilometres from the centre of the capital. The large-scale site they worked is around 30-40 kilometres far from their hometown. It is one reason why these workers return to their hometown more than others. When I was in the field, I observed that workers of Thong often came back to their hometown for events such as a wedding party. They might come back for one day or even a half-day to join the party and return to the site later in the afternoon. Meanwhile, the hometown of Mr. Duong is the furthest, around 100 kilometres far from Hanoi. He does not come back to his hometown on a regular basis because of the distance. Mr. Duong shares that it often takes him two days for a home visit affecting his wages so he rarely returns to his hometown unless it is necessary.

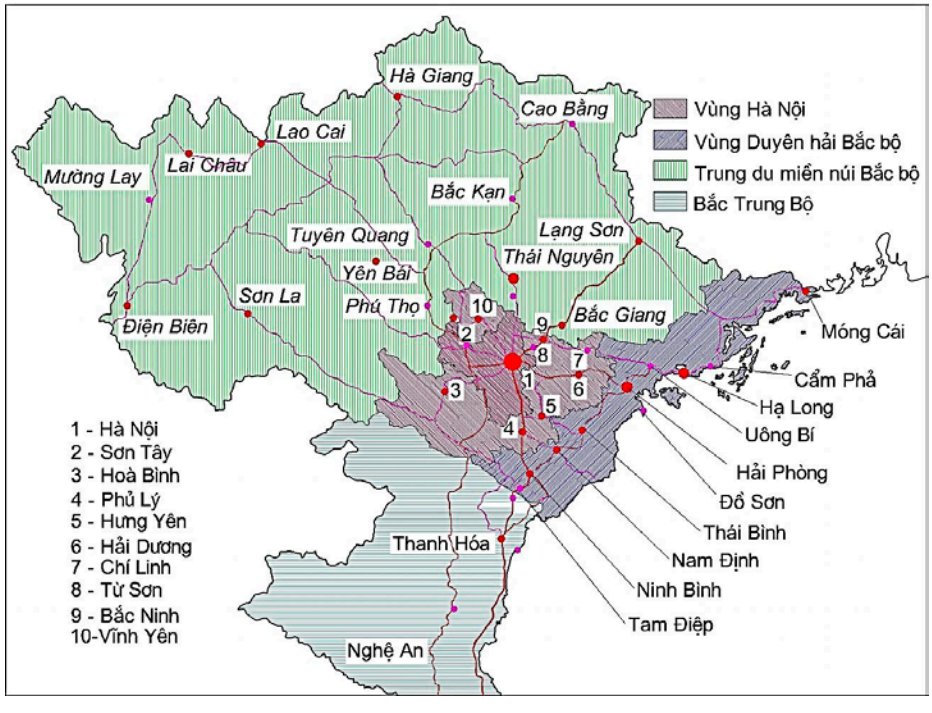

Figure 3.1: The map of the North of Vietnam
(Source: Wikipedia, 2017)

Why Become a Construction Worker?

Among the 11 participants, four people became construction workers because they were not interested in further study. It should be mentioned that in Vietnam, after graduating high school, students have two choices. Firstly - the option that is most popular - they attempt to further their study. In Vietnam, education plays an important role and a good qualification can help people get a job in the formal sector. People can study at a vocational college (*trung cấp*) in two years, a college (*cao đẳng*) in three years or a university (đại học) in four years. Secondly, those who are not interested in study will find a job. Four of the above workers belong to the second case.

All of them were born at the end of 1980s or the beginning of 1990s. Two workers joined the construction industry right after their high school graduation. Vinh shares, "After graduating high school, I asked my uncle (a construction employer in Hanoi) to work for him. I was not good at study so I worked." Two other workers attempted to further their study at vocational colleges but, in the middle, they left schools. After that, they joined the construction industry. Yen shares:

> At that time, (after coming back from Hanoi where he studied at a college) I was idle[11] (*lông bông*), and often went out with my friends. My parents worried (about me) so asked me to work. My family had a kinship-based relationship with Mr. Huong (the employer) so my parents asked him to permit me to work (for him).

Additionally, people joined the industry because of financial reasons. Two workers come from poor families and construction work is suitable for them. In particular Thong and Bac are two young construction workers whose families were so poor that they could not continue their study and thus joined the construction industry. Thong shares that he had to leave school and started working at the age of 16:

> At that time, my family was so poor. My mother's health was not good so I wanted to support my family. Frankly, my study was still very good. I was at the top of my class. One of my

11 He used the word lông bông which is an adjective meaning "no purpose".

> villagers worked as a painter in Hanoi. I asked him to introduce me (to his employer).

The training at informal enterprises is free. In the context of an increasingly privatized education system, the free training is a remarkable benefit. Besides this, although they are inexperienced, workers still get wages, are surely provided free accommodation, meals and maybe, transportation, depending on the particular employer. It is a significant benefit that not all other jobs can provide for them. Thong shares:

> At the beginning, I was only paid 10,000 Vietnam Dong (VND) per day. However, at that time, 10,000 VND was also high12. I did not have to pay for anything. I was provided meals and accommodation. Therefore, I could save some money. After that, I could establish my own group (informal enterprise) thanks to this saving money.

Besides this, some key informants joined the industry because of its better income compared to their previous jobs. Studying rural-to-urban migrants in Hanoi, Mori says that now rural people "are not hungry for rice but hungry for money" (2008, p.3). In this research, two participants also shared that nowadays, if relying on agricultural work, except when raising animals, they cannot afford daily activities. Ha shares:

> At that time, there was a construction group in my hometown. I asked to join. The wage was not high but better than doing agriculture... After 2-3 years, I also moved to Hanoi, also did construction work. At that time, my hometown was so poor that there was little (construction) work.

Meanwhile, Duong joined the construction industry because its income was better than his previous job:

> In the past, I did mechanical work, also freely (he refers to the informal sector), not for the government (enterprises). The income was not good, unstable. When Mr. Binh (the employer)

12 Nowadays, workers are often paid around 200,000 VND per day. However, the inflation rate in Vietnam is high so at that time, 10,000 VND was still high.

> asked me to work for him, I agreed. At that time, the group of Mr. Binh was quite good, had a lot of work.

Apart from that, some people became construction workers as it was less stressful than their previous jobs. As construction workers, they only "sell" their strength as they often say. They normally work eight hours per day, can relax at night-times and get wages at the end of each project. They do not have to invest their own money or worry about profits as a self-employed person does. Besides this, as employees, their responsibilities are simple. At sites, they only do the work that their employers assign. After work, they can go back home and relax and do not have to worry about anything. They are provided food and accommodation and, sometimes, even transportation. Meanwhile, street vendors in Hanoi often feel stressed because of various pressures. Before working as a bricklayer, Hung was a street vendor selling fruits. He shares:

> Generally, selling goods is headachy. (I) have to take care of everything, from choosing fruits to escaping policemen[13]. It is headachy…Working as a bricklayer is (financially) safer. Selling fruits sometimes can earn a lot of money but sometimes, lose a lot.

Finally, I have found that one factor attracting people to join the industry is its basic requirement. Construction work is diverse and at beginning steps, it requires more strength than skills. Workers often say that they must *bán sức lao động* (sell their strength). Newbies may do trivial work such as preparing and carrying building materials to support senior workers and gradually learn skills later. Therefore, nearly all people can do construction work.

In conclusion, it may be said that in general, construction workers have low education and are not professionally trained to work in the construction industry. Besides this, some of them have financial problems so they should join the industry. Regarding the nature of the work, at the beginning, it does not require many skills so it is suitable for low-educated people. Additionally, construction work is not financially risky as workers do not have to invest their own money. In recent years, the wages of construction workers, especially in

13 In Hanoi, the authorities do not allow people to trade in the streets. Sometimes, policemen go around and catch street vendors. Street vendors, therefore, should run if they see policemen.

Hanoi, have increased significantly so it has been recorded that many people have left their previous jobs to join the construction industry.

How to Get a Job in the Construction Industry?

To begin with, it should be said how one becomes a construction worker in the formal sector. Mr. Linh, a key informant, shares that to become a construction worker, in any position of a state-owned enterprise, a person needs to have at least one certificate from a vocational school and above. After that, this person asks someone from his social network (normally, relatives but maybe, neighbours or friends) who works at the State-owned enterprise to introduce him to the director. The introduction of his acquaintance is very important and without it, the person may not get the job. If the position of his acquaintance is high, he will be more likely to get the job. Sometimes, the person bribes leaders of the enterprise to get the job. The situation is unsurprising as, according to the survey on Public Administration Performance Index, 50% of participants answered that a bribe was required to get a job in the public sector (Lao động, 2015). Apart from that, the enterprise might announce its job opportunities for construction workers through the mass media and people might apply for a job that way. However, this situation is quite rare.

Meanwhile, in the informal sector, job opportunities are not announced in the formal way. Workers use their social networks to find opportunities but they do not need to bribe to get a job. However, there should be a distinction made between two different cases in getting a job in the informal sector. The first case is when workers are new to the sector and do not have any skills and experiences. The second case is when workers are more skilful and have more work-related ties.

In relation to the first case, workers asked for the introduction of their relatives or fellow villagers who worked in the construction industry. Seven out of eleven workers interviewed were introduced to the construction industry by their relatives (at the time of this study, six of the seven workers continued to work with their relatives). Meanwhile, the rest (four of the eleven) were introduced to the industry by their fellow villagers. In this case, if workers have a close relationship with their employers, they might be easily accepted. These workers did not experience any difficulties when applying for their jobs. However, if workers are unfamiliar with the employers, they may have to beg

for work. Thong shares, "I was very young so it was quite difficult to get his (the employer's) acceptance. I nearly bended (on one) knee to ask for his acceptance".

In relation to the second case, when being skilled, workers might work for other employers if they pay higher wages or their former employer does not have work. After several years, workers, especially those who work at large-scale sites, are often known by many colleagues from other informal enterprises. When lacking a job, they will contact these colleagues at other informal enterprises to get a temporary job. Thien often works for his uncle but when his employer doesn't have work, he may work for someone else. In this case, he has to arrange his time more carefully. He shares:

> When there is no work, my uncle allows me to work for other people. I know some people from other groups (informal enterprises). When necessary, I call them to ask whether there is any work. If yes, I will go and work. If no, I will come back to my hometown...

Thien shares that if he is being paid well while working with the new employer, workers may continue with this employer, "Other workers sometimes work for (other employers) for a long time". However, as a nephew of the employer, Thien cannot work for other employers for an extended period. He shares, "(When working for other employers), I often work briefly. I am a nephew so I have to come back when he has work."

Apart from that, Thuy shares that workers may go to a construction site and directly ask the employer for job opportunities (2005). This situation might have been more popular in the past, since around 10 years ago, there was a large number of private construction sites in Hanoi. According to Thuy, at that time, the scale of informal enterprises that constructed private houses was quite big (2005). At that time, an informal enterprise might comprise 30-35 workers, while in this research, the informal enterprise now constructing a private house only has around 10 workers. Nowadays, there are fewer private construction sites in Hanoi because of land scarcity[14]. Meanwhile, large-scale sites are tightly

14 Hanoi is a small city with very high land prices. Nowadays, most of the land in the city is already used so there is less land for constructing private houses. Nowadays, people tend to build apartments that are cheaper and more convenient.

closed with high metal fences; strangers are not allowed to enter. Therefore, the direct approach is increasingly rare.

Apart from actively finding a job, workers may be recruited by employers. During their first few days, informal enterprises often lack workers. Employers, therefore, have to ask their relatives or friends, even those who are unskilled, to work for them and train them from the beginning. In this research, two cases left their own jobs to become construction workers following the invitation of their employers. Duong used to be a mechanic but after his friend, Mr. Binh, invited him to work, Duong left his old job. Meanwhile, Thu was a street vendor in Hanoi and also left his job after the invitation of Mr. Huong, his relative. At the beginning, they did not have any skills so their employers had to train them gradually.

Besides this, sometimes, informal enterprises might lack workers because they often construct several sites at the same time. To hasten the rate of progress, employers may recruit workers of other informal enterprises, normally skilled ones, in a short period. While I was in the field, I also heard about a ceiling employer who called his colleagues to "borrow" some workers. In another case, Thuy reveals that when lacking work, some employers even ask other employers to recruit their employees for a short time (2005). By doing so, these employers help their workers always have work.

How to Become a Construction Worker?

This section aims to explore how a person becomes a construction worker after being accepted for work in the industry. As I mentioned earlier, most of the workers did not have any knowledge and skills before joining the industry. Only a few workers had experience in construction work, such as a part time job while they were studying in high school. Therefore, workers generally started as unskilled assistant workers. Their responsibility was to support senior workers by carrying building materials, clearing working garbage or cooking. After several months or longer, depending on the smartness of workers, they might accumulate enough knowledge and skills to become experienced assistant workers. At that time, assistant workers might do more difficult tasks such as mixing mortar (bricklayers) or cutting planks (ceiling workers) without the guidance of senior employees. Similarly, after accumulating enough knowledge and skills, assistant workers can become senior ones.

Assistant workers learn all of the knowledge from their senior employees. Thinh, the supervisor of the main contractor, helps support senior workers teach their assistants what they need to learn. Some senior workers are open and willing to share their knowledge and experiences with their assistants. However, other senior workers are quite uncommunicative. During these times, the assistant must be active and ask other senior workers. Apart from painting work, which does not require many skills, this learning process takes time. It takes an assistant bricklayer 1-2 years to become a senior (Thuy, 2005). Apart from time, this learning process also requires intelligence. If the assistant is smart, he may quickly become a senior. Meanwhile, if the assistant is not smart enough, he will never become a senior worker. Mr. Huong, the employer of the small-scale site, shares that senior workers may share general knowledge and experiences but reality is always diverse and workers need to be smart. Moreover, Thuy shares that if the assistant has a strong relationship with the senior worker or the employer, he may learn more knowledge (2005). At that time, his learning process will be quicker.

Working Situation

The purpose of this section is to explore working conditions, the hierarchy and promotion at sites, as well as the benefits for workers.

Insecure Working Conditions

This section attempts to provide information about regulations, equipment and the management of two sites. Generally, working conditions at the large-scale site are far better than at the small-scale one. At the large-scale site, there are more regulations on safety while at the small-scale site, there are no regulations. Additionally, the large-scale site is better equipped with modern equipment; all workers there are also provided protective equipment. Meanwhile, the small-scale site uses less equipment and some of the equipment does not work well. Workers at the small-scale site are also not provided protective equipment. Regarding management, the large-scale site is better managed; as a consequence, the working environment is neater and cleaner. Besides this, there are more supervisors from the main contractor and subcontractors who supervise the quality of equipment and the activities of

the workers so as to ensure their safety. Workers at the small-scale site have to take care of themselves.

It should be mentioned that Marko, the main contractor of the large-scale site, is a Japanese enterprise. Ha, a supervisor of Brand, tells me that in general, Japanese construction enterprises often have a good working culture. He has worked with many foreign enterprises and Japanese ones are the strictest with a long list of working/safety regulations. At this site, Marko also has many working regulations that will be introduced below. Meanwhile, the contractor at the small-scale site is an informal enterprise that is established and organized by only one employer and does not follow any regulations.

Regarding regulations at the large-scale site, every worker has to join a safety training[15] course before the project. During the project, every worker has to go to the construction site at 7 AM (or 7.30 AM in Winter) to do morning exercises for 15 minutes. People who come late will be fined 10,000 VND and those who do not join the training will be fined 50,000 VND. After the exercises, supervisors of each enterprise assign tasks for workers. They start working at 7.15 AM (or 7.45 A.M) and stop working at 11 AM (or 11.30 AM in Winter). In the afternoon, workers work from 1 PM to 5 PM (1.30 to 5.30 PM). Theoretically, if workers want to work more than eight hours, they have to ask for the permission of Marko. However, Ha tells me that to ensure the rate of progress, supervisors of Marko allow workers to work more than eight hours. However, all workers always have to ensure their safety at work.

Before entering the site, all people have to wear protective equipment (helmet, safety shoes, etc.). Painters or steel workers, who work in high positions, have to wear lifelines. Welders have to wear safety goggles and masks. All protective equipment is provided by formal enterprises that hire workers. Besides this, men are not allowed to carry more than 40 kilograms and the limit of women is 30 kilograms. These are only some of the more than 40 regulations of Marko.

Additionally, before the project, all workers must have at least one type of health insurance. All subcontractors of the project bought health insurance

15 In this training class, Marko, the main contractor, informs all workers about its working regulations and give trainees a certificate. Workers must have this certificate before joining the project. However, in reality, Ha informs me that if necessary, he might get the certificate for his workers who did not join the training class.

from Bao Minh, a Vietnamese insurance company. Trang, the manager of Brand, shares with me that enterprises often choose Bao Minh because of its cheap price. Brand chose the second lowest scheme (56,000VND per year) for its construction workers. With this scheme, workers are reimbursed their health expenditure but the reimbursement does not exceed 50,000 VND per day and 20 million VND in total.

In contrast to the large-scale site, there are no regulations at the small-scale site. Every day, the employer assigns work for each employee. Workers can basically do anything they want. There is no uniform or protective equipment. Workers wear casual clothes instead of protective ones. This is the general situation at all small-scale sites. Workers at the large-scale site shared that when working at small-scale sites, they were never provided protective equipment. This lack of protective equipment is one reason leading to the occupational accidents that will be analysed further in the next chapter.

Regarding working equipment at the large-scale site, Marko, the main contractor, requires all subcontractors to provide enough equipment for their workers. Minh, one supervisor of Marko, informs me that generally, equipment is sufficient and of a high-quality. However, at the end of the project, I observed that some of the workers of Brand lacked equipment and had to borrow from other enterprises. The reason was that when the site work was almost completed, the amount of work was so small that the enterprise did not want to transport equipment to the site. Besides this, some workers of Sana, the enterprise responsible for windows and glasses, also used scaffolds without sticks that make it safer. Minh, the supervisor of Marko, knew this situation but ignored the mistake to hasten the rate of progress. Moreover, all workers are provided protective equipment by the formal enterprises that hire them. Marko supervises this activity and asks all people, even visitors, to wear high-visibility clothing and helmets before entering the site.

Meanwhile, the provision of working equipment at the small-scale site is also worse than at the large-scale one. The employer informs me that now, he buys more machines such as concrete mixer machines or pulleys to improve their work and reduce the toughness of the work. However, in comparison with equipment at formal enterprises, the ones at the small-scale site are worse. For example, at the large-scale site, formal enterprises provide the informal ones with scaffolds with metal planks that are carefully checked before use. When

scaffolds are used at inconvenient areas, they will use strong sticks to ensure their safety. Meanwhile, workers at the small-scale site have to use scaffolds with wooden planks. Workers at the large-scale site are provided protective equipment such as reflected-light shirts, special shoes, helmets, lifelines, etc. while workers at the small-scale site aren't provided anything. They even have to buy gloves to avoid hand chapping in winter.

Regarding the management, at the large-scale site, there are many supervisors. Marko, the main contractor, has seven supervisors and each enterprise also has one to three supervisors. Apart from supervising technical requirements, supervisors, especially those of Marko, also supervise the activities of workers to ensure their safety. One supervisor of Marko shares that they have to ensure their safety to avoid accidents. If accidents occur, their brand will be badly affected and the site work might be postponed, affecting their rate of progress. Supervisors of Marko often go around the site to check whether workers wear helmets, use lifelines when working at high positions and so on. If not, they will ask workers to follow the regulations. If it is the second time, they will take photos as evidence and fine these workers. Besides this, all scaffolds must be checked before use by supervisors of Marko. However, at the end of the project to hasten the rate of progress, sometimes, some supervisors of Marko ignore this step.

I observed that the working conditions at the large-scale site were fairly clean. Materials and garbage was well organized into special areas so that dangerous things such as nails or sharp stones were not disorderly. Besides this, there was one female worker often sweeping the floor. All of these actions reduce the risk of treading on dangerous things such as nails or sharp stones. Dust is unavoidable at construction sites but at this site, workers often sprinkle water around to reduce the amount of dust. Additionally, many workers also wear surgical masks to protect themselves. It should be said that wearing surgical masks is not mandatory. I observed that all female workers and supervisors wore surgical masks while only half of the male workers did. Some male workers said that wearing a surgical mask is inconvenient and makes it difficult for them to breathe. Meanwhile, some people told me that they lost their surgical masks and were too lazy to buy new ones. One problem on the site was its toilets. The site had four mobile toilets. However, I checked them out and found that only one toilet was open and it was already broken and could not be used. Workers tell me that they often go to the field near the site or return to their houses for

relieving. Besides this, according to the International Labour Organization, each construction site needs two separated bathrooms for men and women but this site did not have any bathroom facilities for workers (2008).

Meanwhile, there was no supervisor at the small-scale site. The employer had to be responsible for the safety at this site. For example, the employer had to check the scaffolding before his workers used it. Besides this, senior workers also advised younger ones to be more careful in some dangerous situations. However, in reality, as the employer also had his own work, he could not pay attention to the safety of his workers. Workers have to take care of themselves. Besides this, the management of the small-scale site is also less professional than the large-scale one. At the large-scale site, working materials and garbage are arranged in a more orderly manner into separated areas. Meanwhile, at the small-scale site, working materials and garbage are arranged in a disorderly manner. Additionally, no one cleans the site so there is more dust.

Regarding time, under the Vietnamese law, workers work eight hours per day and have two days off at the weekend. However, the workers I researched worked seven days per week. They have to work continuously since they are not paid for their days off. Apart from working in the daytime, many workers often work at night during some periods. Ha, the supervisor of Brand, informs me that theoretically, subcontractors have to report the issue with the main contractor but practically speaking, Marko ignores it. Marko understands that subcontractors lack workers so they have to work more than eight hours to ensure the rate of progress that is so important to the large-scale site. It should be known that workers also prefer to work more than eight hours, especially at night. Firstly, the income for working at night is double of that during the daytime. Secondly, workers do not always have work. Therefore, when getting work, they want to work more than eight hours to increase their income to make up for lost time.

Besides this, the working time of workers is sometimes not fixed. I mentioned above that workers often work from 7-11 AM and 1-5 PM. However, sometimes, when cars are transporting building materials to the site, they have to work nonstop and have lunch or dinner 2-3 hours later than usual. They have to do this because formal construction enterprises often rent transportation for a short time to save money. Workers, therefore, have to work harder to carry all materials out of the cars in time. Some workers inform me that it is one of

the reasons for making their stomachs ache. Meanwhile, at the small-scale site, workers work eight hours per day (7-11 AM and 1-5 PM), 7 days per week. Sometimes, when they have parties at noon and return to work later (for example 2-3 PM), they will stop their work later, at 6-7 PM. They almost never work at night because they are already tired and it is unnecessary. At both sites, workers are not forced to work seven days per week but if they do not work, they will not get paid. All of them, therefore, work continuously and only leave the site when they are busy doing something else.

The Hierarchy and Work Routine at Construction Sites

By way of introduction, it is necessary to introduce the hierarchy at construction sites and the working routine. At the large-scale site, after the morning exercises, all supervisors and workers gather. The supervisor of each formal enterprise informs the supervisors of the main contractor what they will do that day. After that, each formal enterprise divides separately. They often gather in a circle. Supervisors assign work to the employer of each informal enterprise and warn them about workers who made mistakes on the previous day. Finally, all of them shout, "Start a new working day efficiently! Safety first!" After that, each informal enterprise gathers separately and the employer will assign work for each worker. All of this happens in around 15 minutes.

During the working time, supervisors of the main contractor will go around the site to check the quality as well as supervise activities of workers in order to ensure the safety regulations are adhered to. If there is any technical problems, they will directly ask workers to solve it. If the workers cannot do it or have a bad attitude, they will call the supervisors of the formal enterprise and the employer to report the case. Generally, supervisors of the main contractor only know employers of informal enterprises and rarely remember individual workers. It may be said that employers have a better position. When the main contractor or formal enterprises organize parties[16], they invite supervisors and employers of informal enterprises, not all workers.

At Brand, supervisors are closer to workers and often chat with them. However, regarding the work, they also mainly talk to employers. Ben, one

16 Parties are strongly popular at construction sites, especially at the large-scale site. At this site, the main contractor and subcontractor in turn organize parties for supervisors and employers to tighten their relationships.

supervisor of Brand, shares that since the amount of work is large, he cannot talk to each worker. He, therefore, often talks to employers who will talk to their workers later.

When Brand organizes parties, they often invite employers but not all workers. Apart from the fact that there are so many workers that Brand cannot afford to invite all of them, there is a gap between workers and supervisors and formal enterprises. Even a very young supervisor of Brand, who had just graduated with a Bachelor degree little more than a year ago, sometimes used disrespectful words towards the workers who were far more experienced than him. For instance, once he told me that he assigned work for *chúng nó*[17] and asked to me to go out for breakfast.

At the large-scale site, in each informal enterprise, the employer assigns work that is suitable to the skills and experiences of each worker. Regarding bricklayers, the responsibility of assistants is to support senior workers. In particular, they often filter sand, mix mortar and carry building materials (mortar or bricks) for senior workers. Senior bricklayers are responsible for the execution. Among them, there are different positions. For difficult work such as building underground sewer systems, more skilful bricklayers will construct it. Meanwhile, ceiling work requires skills and accuracy. Senior ceiling workers are responsible for the measurement, building the structure and execution. Assistant workers often cut the building materials and carry them for the senior ones. Regarding painters, there is not a serious difference as painting work is fairly simple and does not require many skills. The difference is quality. Senior workers work more efficiently with higher quality. If the quality of the work of inexperienced workers is not good enough, senior workers will have to repair it to meet the requirement of the main contractor.

At the small-scale site, the working time is more flexible. In the morning, workers often start working at 7 AM until 11.30 AM and in the afternoon, from 1.30 PM to 5 PM. However, sometimes, when having a party at noon, they start working at 2 PM or later. Regarding the hierarchy: it is simpler. As there is no supervisor, the employer has the highest position. Every day, he assigns work for each worker. In Vietnamese, these workers are often called bricklayers but

17 In Vietnamese, it is a term for a person that carries a disrespectful nuance. Normally, only older people use this word about younger ones.

in reality, they do nearly all steps, from constructing the raw structure to completion. It means they are all bricklayers, painters and ceiling workers.

There are two types of workers, assistants and seniors. Being similar to the large-scale site, assistant workers often take care of the preparation work such as filtering sand, mixing mortar or carrying bricks. There are two types of assistants - unskilled and skilled. Unskilled assistant workers often have to filter sand or carry bricks while the skilled ones mix mortar. Some assistant workers even have the ability to build something. They need to learn these skills to become senior workers in the future. Besides this, the employer also wants them to know some skills as sometimes, he does not need a lot of assistant workers. For instance, at this site, the homeowner and sometimes his relatives also support the preparation. Therefore, some assistant workers might be required to do other work. They can do simple work such as constructing a fence that does not require much skills and accuracy.

Meanwhile, senior workers are responsible for execution, particularly the difficult parts. Senior workers have the right to ask assistants to support them. There are two types of senior workers. A normal senior worker is responsible for constructing the raw structure and plastering. Meanwhile, a more skilful worker does the finish work. Among senior workers, two people, the employer and one worker named Ninh, take care of the decoration. At the small-scale site, decoration may be the most difficult. Only workers who are skilful and have a sense of art can do this work. Thuy shares that a skilful worker is always paid a higher wage and might work for several employers (2005). The reason is that employers do not want to pay too much for them for simple work (during the phase of building raw structure) while the skilful workers also do not want to get the lower wage. The solution is that the skilful worker only works during the finish phase of decoration.

In conclusion, whatever types of construction workers there are, they are divided into two groups, namely assistant and senior. The main responsibility of assistant workers is to support senior workers who are responsible for the execution. In general, senior workers have higher positions than assistants, have the right to ask their assistants to support them and also have higher wages. However, sometimes, a good assistant worker who is experienced and works efficiently may have a higher wage than a new senior worker (Thuy, 2005). Among senior workers, there are also different levels, which are shown

by their work. For instance, a less skilled senior worker mainly constructs simple parts while a more skilful one constructs more difficult parts. Especially, the very skilful workers with an artistic sense might be responsible for the decoration. At the small-scale site, as there is no supervisor, the employer and also the most skilful worker is responsible for the technical factors of the house construction. Similarly, assistant workers have different levels. A new assistant bricklayer mainly carries building materials or cooks while a better assistant is responsible for mixing mortar or sometimes, building simple parts. Meanwhile, a new ceiling worker is mainly responsible for the transportation of materials while a better one may cut building materials for senior ones.

Promotion

As there are different levels among workers, it should be explored how they can get higher positions and what their benefits are. Regarding their promotion, there are three factors, namely experience, skill and intelligence.

As construction workers in the informal sector are not trained at any formal schools, their experience plays an important role. With a diverse experience, a worker may know how to work more efficiently and have better quality outputs. Besides this, an experienced worker also knows how to avoid occupational accidents. A young, inexperienced worker named Nam got hurt when he accidentally stepped on a nearly broken, old plank. The employer said that if he had been experienced, he would have realized the problem and avoided stepping on the nearly broken spot.

However, experience is only one factor. Although working in the industry for years, some workers cannot get promoted because they cannot accumulate enough skills. Thuy shares that some workers work as assistants for 20 years (2005). Among senior workers, a more skilful worker will have a higher position, is assigned more difficult work and is certainly paid better.

The last factor is intelligence (*khôn*, *nhanh*). The way employers use this word is not really clear but in general, it has two key meanings. Firstly, intelligence means the ability to manage work at sites. An experienced and skilful worker may work efficiently but cannot manage other workers. To become an employer or the assistant of an employer, a worker needs such smartness. Thong, the employer of the painting group, shares that his workers, even the experienced ones, are inactive and only do what they are assigned

and, without him, they could not work efficiently. It is why Thong sometimes has to go back and forth between two sites. Secondly, the employer at the small-scale site defines intelligence as the ability to learn fast.

Besides this, it should be mentioned how an assistant worker can become a senior one. In general, assistant workers often try to accumulate knowledge and skill to become senior workers. As workers did not study at formal school, they have to learn from real life experiences, mainly from their seniors. At the beginning, assistant workers have to observe the activities of the seniors. After that, they may ask senior workers to teach them some skills. Thuy shares that a senior worker is responsible for guiding one assistant (2005). Moreover, if the assistant has a strong relationship with senior workers or employers, the process will happen faster. Mr. Huong, the employer of the small-scale site, shares that promotion also depends on the smartness of the worker. Some assistant workers have worked for years and have not accumulated enough skills to be promoted but those who are smart enough might become a senior after only one year.

Generally, senior workers are paid better than assistant ones. However, Thuy shares that sometimes, an experienced assistant worker might make more money than a bad senior worker (2005). However, this situation is quite rare. In this research, no assistant worker had a higher wage than a senior one.

Benefits

A construction worker who works in the formal sector gets all the benefits regulated by the government. Apart from his monthly salary, the worker has fringe benefits such as social health insurance, health insurance, holidays or regular health examinations. Meanwhile, construction workers in the informal sector have fewer benefits. Generally, workers mainly have wages and free food and accommodation. If workers get sick, they will not get wages. When the site is postponed or it is rainy so that workers cannot work, they will not get wages. On that day, workers are still provided free food. At the large-scale site, workers are also provided a private health insurance, but from formal enterprises, not their employers. Workers share that the health insurance is mainly to cope with the regulation of the main contractor and is not beneficial for them. At the small scale, workers are not provided this fringe benefit. However, when there

are accidents, the employers at both sites will partly support the worker affected; this will be further analysed later.

Regarding wages, it is fairly diverse and not fixed. At the large-scale site, two informal enterprises of Vinco pay 250,000-300,000 VND per day for skilled workers and 180,000-220,000 VND per day for less skilled workers. For local female workers, Vinco pays them 140,000 VND per day. Meanwhile, three informal enterprises of Brand pay 200,000 VND per day for less skilled workers and around 250,000-300,000 VND per day for skilled workers. All of the above wages are for eight hours in the daytime and the wage is double that for any nighttime work. Tuan, the employer of Vinco, and Thong, the employer of Brand, share that when they have contracts at large-scale sites or in the centre of Hanoi, they might pay higher wages. However, at construction sites in rural areas, the wage is lower.

In comparison with the large-scale site, workers at the small-scale one get lower wages. At this site, the employer has to pay for food and a transportation fee so their wages are a little bit lower. An assistant worker might get 180,000 VND per day, a senior worker gets 200,000 VND per day while the most skilful worker gets 220,000 VND per day. Normally, they can earn around 10-15% higher than the above wages. Thuy also shares that the contract value of the small-scale sites are generally lower than large-scale ones (2005). Wages at small-scale sites are, therefore, lower than at large-scale ones. Workers at the small-scale site accept this situation as they normally work in their hometown. They, therefore, may live near their families and may do other work such as raising pigs or chickens that can supplement their income.

Generally, senior workers have higher wages than assistant ones. However, Thuy shares that in some special cases, a good assistant worker might have a higher wage than a bad senior worker (2005). Mr. Ha shares that wages are paid depending on abilities. Generally, an assistant bricklayer gets 200,000 VND per day for new ones, they are paid lower, may be around 180,000 VND. Meanwhile, Ha is paid higher (300,000 VND per day). Ha is paid higher as he is an experienced worker and he is able to assist his employer in arranging work for other workers and supervising them. In other words, Ha is the supervisor while the employer is absent.

Regarding the payment, Thuy shared that around 10 years ago, wages would be paid at the end of the Lunar new year (2005). It was a strategy used

by the employer to keep workers working for him. At that time, there was a huge demand for workers so employers had to devise different ways to keep them. However, now, this situation rarely happens. Generally, wages are paid at the end of the project. Even, one employer named Thong shared that some young employees, who need money day-to-day, will receive a daily wage. When workers need money, the employer will give them some money based on their need and their relationship. If the relationship between Thong and the employee is close, he might lend him a large amount of money.

When being asked, "In what case, does an employer flee and not pay wages to his employees?" employers share that this situation is very rare. Employers have to maintain their reputation so they almost never do anything like this. However, sometimes employers cannot pay their workers because of several reasons. Firstly, if the formal enterprise does not pay money to the employer, some employers will have to delay paying the wages of their employees. If the wages are not too big, the employers will pay it by themselves to keep his reputation with his employees. If the wages are too big, some employers will ask for the understanding of their workers. Mr. Son shares that he was once not paid when his employer spent a huge amount of money on gambling and was in debt so he could not pay him. Generally, if workers are not paid, they will have to accept the situation. They only have one solution: to stop working with the employer and spread bad information about him.

Additionally, Thuy shares that some employers delay paying wages for workers who are not his fellow villagers to keep these workers working with him (2005). However, in this research, this situation did not happen. Since employers and workers have a strong relationship, employers do not do like to do this. As I mentioned before, when necessary, some employers even pay wages for workers in advance. For the cases of Vinh and Ha, they are fellow villagers or relatives of employers but have worked for a long time so they are also treated like close workers. Sometimes, workers also cooperate with employers they do not know well. In these cases, they are more careful, often asking for wages more frequently so they do not accumulate over too long a time.

Apart from wages, all employers of Vinco and Brand pay accommodation and food for their employees. Thong shares that when he has only one project and lives with workers, everything is simple. He and his workers eat together

and he pays for the food expense. If he has two projects, he will have to divide his employees into two groups. In this case, Thong will pay higher wages (260,000-280,000 VND per day, depending on the location of the site) and will not have to take care of their food. For the accommodation, if the homeowner does not allow workers to live at the site, Thong will rent a room (2,000,000 VND per month) for every four people.

At the small-scale site, the employer also provides free accommodation and food for his employees. They stay at one old house of the homeowner, borrow cooking equipment from the homeowner and cook by themselves. For construction sites in his hometown, the employer generally does not provide food and accommodation. At noon or after work, workers return to their homes. For some construction sites in his hometown that are quite far from their villages, the employer does provide free lunch.

Thuy shares that around 10 years ago, in Hanoi, there was more work while the number of workers, especially senior ones, was limited (2005). Employers, therefore, had to provide various benefits to keep their more experienced workers. Apart from wages, employers had to give senior workers some money or even sexual services. However, in recent years, the real estate market in Vietnam has decreased because of the economic crisis. The construction industry is, therefore, also badly affected. Employers do not always have work and some of them even have to work for other employers, like in the case of Mr. Vinh. Sometimes, employers may lack senior workers but in general, they do not need too many workers. They, therefore, do not need to provide benefits to keep their senior workers. Only a few experienced workers like Mr. Ha are paid higher or given some money on special occasions. One employer named Thong buys motorbikes and pays for petrol for all of his employees. However, this situation is not really common.

In conclusion, although all participants are informal workers, they have different working conditions. Regarding benefits, all of them are fairly similar: They do not have labour contracts, are only paid wages and are not paid for their days off. The wages of the large-scale site are higher although not significantly so. However, the working conditions of the large-scale site are far better than the small-scale one. The large-scale site is well managed and fully equipped so the health of workers is less affected. Meanwhile, at the small-scale site, the management, as well as all working and protective equipment, are of

poor quality so their health problems are more likely to be exacerbated. It shows that if the quality of the sites were increased, the health of the workers might be better. While it is difficult to generalize about all workers, improving the quality of sites might be a useful solution. However, it should be mentioned that in this book, I chose a site managed by a Japanese enterprise. Large-scale sites managed by other private enterprises might be worse and in those cases, the situation of workers might be more vulnerable.

Living Situation

The life of construction workers does not remain limited to their work. It is essential to explore their life. In this section, I will introduce how workers live in the informal sector.

Mobility and the Temporary Living Conditions

At the large-scale site, I mainly lived with workers of Brand during the time I visited so I will focus on this group. Brand rents a three-floor, newly built house near the construction site for its supervisors and workers. Thong, one employer, tells me that if the project is far from the centre of Hanoi, the enterprise will pay for the accommodation. If the project is in Hanoi, the employer will have to rent houses for their workers. Thong often rents a room (which costs 2 million VND per month) near the site for every four workers. Close to the site in the suburb, it is a large, newly built house[18]. The first floor is a kitchen and a dining room where the workers have their dinner. Workers live on the second floor. On each floor, there are two 10 m^2 rooms and one 25 m^2 room. Three workers live in one small room and nine people stay in the bigger room. Workers might live on the third floor but workers want to sleep together in the big room because they can talk with each other at night. There are three clean bathrooms with clean water; the one in the first floor even has hot water.

Similar to other guesthouses in Vietnam, this guesthouse is unfurnished. There is no bed so workers arrange planks to sleep on. Each person has one

18 The house is newly built and is not well furnished. The homeowner built the house for his children sometime in the near future. Now, he and his family still live in their old house next to the new house.

thin blanket, only few have thick ones. There is no wardrobe so workers hang strings and hang their clothes on the strings. Most of the workers rarely wash their clothes because of the cold weather, because of their busy routines or the nature of their work. "My work is very dirty so I rarely wash my clothes. Today I wash them and tomorrow, they will be dirty again. When I go out with my friends, I will wear clean clothes but at work, I always wear the trousers. I have used them for years and rarely wash them", Phuc, a painter of Brand, says. It is perhaps one of the leading reasons for skin diseases among construction workers, especially when they often use the clothes and shoes of other people.

Meanwhile, Vinco financially supports its two informal enterprises instead of hiring houses for them. One informal enterprise with 17 workers of the employer Huong and one supervisor named Binh of Vinco, live in a three-floor, newly built house like Brand. One informal enterprise with nine workers of the employer Tuan, stay in two 15m^2 newly built rooms. As the construction site is located inside a new industrial zone, there are many newly built houses for rent. The above accommodations are also unfurnished but in comparison with the living standard in Vietnam, it is acceptable. In one focus group discussion, workers of two of the abovementioned informal enterprises informed me that at their site, their living conditions were far better than usual.

In the construction industry, most of the supervisors and workers I interviewed agreed that bricklayers (*thợ nề*) are the most miserable, often having to live in dreadful conditions. In Hanoi, the employer rents guesthouses for their workers but as the bricklayers have a lot of equipment, some workers, normally the younger ones, have to put up tents near the sites in order to house everything. Their living spaces are small, wet, smelly and filthy. For bathing, they have to use water from a deep well that is often unclean and for cooking, they ask for clean water from their neighbours. When the neighbours are not willing to help them or are not at home, they will have to use the unclean water from the deep well. However, they tell me that, despite the poor living conditions, it is still more convenient to work in Hanoi. There are many markets to buy food and many entertaining places to visit outside of work. Sometimes, they have to work in remote areas that are isolated and do not have any services.

At the small-scale site, to save money and because there is no guesthouse near the site, the informal enterprise stays at the old house of the homeowner. This old house was built by the parents of the homeowner (Mr. Chung) many

years ago and is now used for storage. As a storage space, the house has almost nothing except a small light and one plug. Workers unroll mats on the floor, substitute thin blankets for a mattress and use thick blankets to cover themselves. Some of their equipment is borrowed from the homeowner and the employer has purchased some. As the staff of the informal enterprise of Mr. Huong often work in their own hometown, they do not have much living equipment. Workers share a small bathroom with the homeowner. It is a little bit old and inconvenient, especially in comparison with a new, modern house. However, in comparison with the lifestyle in the countryside, it is normal.

Lifestyle

As I lived with the construction workers of Brand at the large-scale site during the time of this research, I will mainly describe their routine lives. A normal day started at around 5.30-6 AM. Workers of the informal enterprise of Mr. Binh had breakfast at home while most of them ate out at a favourite food shop near their guesthouse. After that, they went to the construction site that is around one kilometre from the food shop. At noon, workers have lunch at this same food shop and return to their guesthouse to sleep for around one hour. At 1.15 PM, they return to the construction site and start working from 1.30 PM until 5.30 PM. After work, workers once again go out for dinner at the same favourite food shop. Sometimes, they play football together or play billiards at a nearby house. Meanwhile, workers of Mr. Binh come back to the guesthouse to cook. The youngest worker, a nephew of Mr. Binh, usually has to cook while the other workers take a bath or wash their clothes.

Among the three informal enterprises, the one of Mr. Binh's is more traditional and professional. They bring cooking devices, rice and a television (TV) to cook and relax with at home. Except for the nephew of Mr. Binh, he and his other workers are mature, from 35-40 years old. Their lifestyle is also more professional. I observed that after a few days, they often washed their clothes while workers of the other informal enterprises, especially the younger ones, rarely washed their clothes. All the workers of Mr. Binh's enterprise wore the uniforms of Brand that they hang out carefully on the first floor. The supervisors of Brand give them some money and eat with them. Once, this group organized a party and invited Mr. Minh, the supervisor of the main contractor. The way these workers talk is also more polite. They are calm and rarely use swearwords like other workers. Generally, supervisors have sympathy

for this informal enterprise. At the beginning, Ben, the supervisor of Brand, suggested to me that I interview this group and ignore the younger workers who were very naughty.

After dinner, workers of Mr. Binh stay at home to watch TV while some young workers may go out to drink coffee, sing karaoke or play games. Around 9.30-10 PM, most of the workers go to bed because they will have to go to work early the following day and, at the time of my field research, it was very cold. Workers of each informal enterprise often sleep in the same room. However, as the group of Mr. Binh has six people, two or three workers sleep in other rooms. Although coming from different informal enterprises, they all know each other and are very open. Before sleeping, they often joke together.

At the small-scale site, workers often get up around 6 AM. They have breakfast at home - normally instant noodles. After that, they drink tea, smoke and watch TV and start working at around 7 AM. One thing I realized that while working, workers of the small-scale site often chatted together while those at the large-scale site rarely did. Perhaps, it is because the working area of the small-scale site is smaller and most of workers often work together. Meanwhile, at the large-scale site, workers often work individually. Around 11.30 AM, they have lunch and then sleep for around one hour before coming back to work at 1.30 PM. After finishing work at 5.30 PM, they take a bath, wash clothes and have dinner around 6.30 or 7 PM.

In Vietnam, older people normally have higher positions and have to do less housework. At the large-scale site, workers come from various places and not all of them are relatives so they are generally equal. However, at the small-scale site, all the workers come from very close villages and have close relationships so there is a hierarchy. At the small-scale site, there are three young workers, around 20 years old. Two of them often wash clothes for everyone else and one of the workers helps an older one to cook. Workers said that these youngsters do not know how to cook so the older people had to do it. After meals, the young workers have to clean the dishes in turn.

After dinner, workers often gather at the house of the homeowner to watch TV, drink tea and smoke. As the house of the homeowner is not big enough for all workers, some of them often stay at home. Some workers have smartphones so they often surf the Internet or play games. Moreover, some workers know how to massage, so sometimes, they often do massage together. I observed that older workers can do massage better and they try to teach the

younger ones. Sometimes, they do not ask younger workers to massage them as their skills are not good and they might hurt them. This is a voluntary activity, not a must designed to divide people into a hierarchy. One worker shares that he learnt massage skills while working in the centre of Hanoi years ago. Mr. Ninh shares that during that time, there were less entertainment activities so they learnt the skill to kill time and reduce pain.

Cooking

At the large-scale sites, among the three informal enterprises of Brand, the one of Binh's from Nam Dinh Province often cooks at home. Binh shares that he and his employees have done this for years. In the morning, they often eat instant noodles and cook at night. At noon, they eat out because they do not have time to cook. Mr. Binh often cooks since he can cook better, while his nephew, the youngest one, often supports him by cleaning vegetables or cooking rice. Sometimes, when Mr. Binh goes out, another worker who is a good cook will cook. After dinner, the youngest worker and Mr. Duong will clean the dishes.

Meanwhile, three other enterprises always eat out. In the morning, they often eat noodles or Vietnamese bread that cost from 5,000 to 15,000 VND. For lunch and dinner, all of them eat at a favourite food shop and pay 25,000 VND for each person. Each meal has four dishes, three dishes of meat and one dish of vegetable. Soup and rice are free. The quality of these meals is fairly good, even compared with families in urban areas. Mr. Vinh shares that meals are now better than they used to be. He jokes, "Workers nowadays are *khổ* but not *nghèo*"[19]. I also visited several food shops near the industrial zone and found that, generally, the meals of the workers at factories were worse. There were lots of rice and vegetables (both cheap in Vietnam) but little meat (which is more expensive).

At the small-scale site, in the morning, workers eat instant noodles or bread with condensed milk. At noon and night, they cook by themselves to reduce the expenditure. In the morning, they ask the homeowner to buy some fresh materials for them. Generally, their meal has two dishes of meat, one vegetable and one bowl of soup. When the homeowner celebrates an event, he

19 Vietnamese people often use the phrase "nghèo khổ" (nghèo means poor and khổ refers to poor living and working conditions (both physical and mental)) to describe construction workers.

may invite workers to join it or give them some delicious food. Besides this, workers sometimes go back to their hometown and when they return to the site, they often bring some delicious food. After meals, young workers have to clean dishes in turn.

Concluding remarks

In conclusion, this chapter aims to explore some characteristics of migrant construction workers as well as their work and their life in the informal sector.

The research has found that construction workers are often fairly young as construction work is strenuous, requiring a lot of physical strength. Participants became construction workers because of its basic requirements, higher income and less pressure. It is fairly easy to become a construction worker: Participants often ask their relatives or fellow villagers who are the employers for work. No participants are trained professionally at formal construction schools so in the beginning, they often did simple work and gradually learned other skills. When they became good enough, they were promoted to do more difficult work and at that time, their wages became higher. At construction sites, senior workers, especially skilful ones, are often more respected and are strongly supported by their employers. However, there is a big gap between workers and more well-educated people such as managers or supervisors. In Vietnam, well-educated people are often more respected and have higher positions.

Regarding benefits, workers are paid wages (*công nhật* - it means they receive wages for the days they work and do not receive wages for days-off). To earn more money, workers, therefore, work continuously seven days per week. They do not have labour contracts and are not provided fringe benefits such as social and health insurance. At the large-scale site, workers are provided a private health insurance plan. However, its benefits are very poor and workers share that the formal enterprises that hire them buy it only because it is a requirement of the main contractor. If workers get injured, they will be financially supported by their employers. However, it is an unwritten law that their employers might refuse to provide support if they lack money.

Regarding the life of construction workers, they are provided free food and accommodation by their employers. In this research, the living conditions of the workers were fairly good as their sites are near urban areas where there are various activities, including food and entertainment. However, some workers share that when they have to work in remote areas, their living conditions are terrible. The research has found that at sites and guesthouses, workers are very friendly to each other, even the newly arrived ones, so that they rarely feel lonely even while living far from their families.

In general, the research has found that nowadays, the benefits and living conditions of workers are better than before. However, they are still insecure, as they are not covered by formal social protection mechanisms such as social and health insurance or being protected by a trade union.

Chapter 4

Health Problems of Migrant Construction Workers

This chapter aims to explore how living and working conditions in the informal sector affect migrant construction workers' health. Moreover, the chapter attempts to find out when facing health problems, what do migrant workers do in the context of limited access to health services. More broadly, the purpose of this chapter is to examine their health problems and difficulties in accessing health services in Hanoi.

Previous Studies on Health Problems of Construction Workers

Dahlgren and Whitehead suggest a model of social determinants of health (2006). The key idea of this model is that multiple layers from a micro to a macro level affect people's health. In particular, individuals are at the centre and are surrounded by four layers. The first layer is individual lifestyle factors; the second one is social and community networks; the third one is living and working conditions while the final one is general socioeconomic, cultural and environmental conditions. This research focuses on the third layer to understand how working and living conditions affect migrant workers' health. In this section, I attempt to review related studies on this topic.

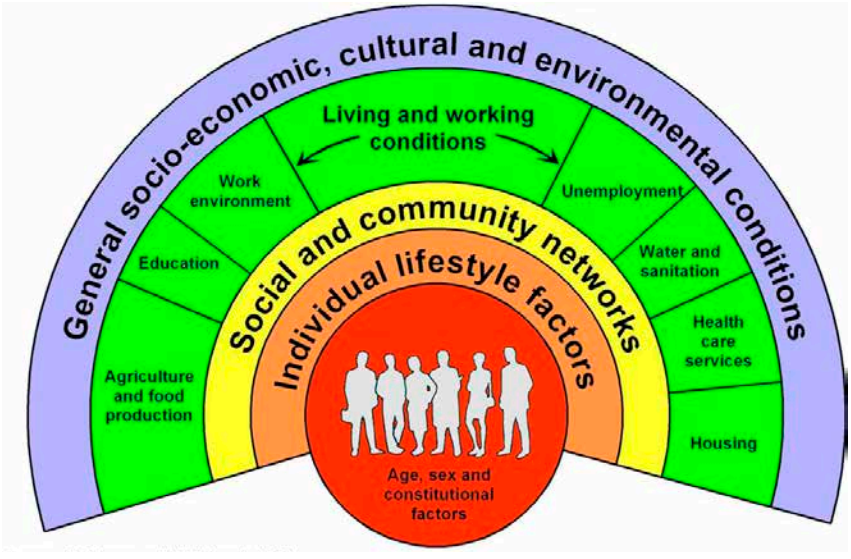

Figure 3: Social determinants of health
(Source: Dahlgren and White cited in Hiaconnect, 2012)

Impact of Working Conditions in the Informal Sector on Construction Workers' Health

The ILO estimates that globally, every year, there are 60,000 fatal accidents in the construction industry with about 64% in the Asia and Pacific region, 17% in the Americas, 10% in Africa and 9% in Europe (Dias, 2009). According to the ILO, fatal accidents in the construction industry in developing countries such as China and Indonesia account for 17-18% of the total number of fatal accidents in these two countries (Pearson, 2009). This situation is repeated in developed countries. In Sweden, in the construction industry, the risks of occupational accidents and of occupational diseases are 200% and 50% higher respectively than in other industries (Laukkanen, 1999). In America, in 1996, construction workers accounted for 5% of the total labour force but claimed 20% of all occupational fatalities and 9% of all disabling occupational injuries (Abdelhamid and Everett, 2000). Similarly, the construction sector in Japan occupies 10% of the workforce but accounts for 42% of work-related deaths (Weeks, 2011).

According to the ILO, the term occupational diseases is defined as, "each member should, under prescribed conditions, regard diseases known to arise

out of the exposure to substances and dangerous conditions in processes, trades or occupations as occupational diseases" (2010, p.7). The ILO also shows that this definition has two key elements, "the causal relationship between exposure in a specific working environment or work activity and a specific disease" and "the fact that the disease occurs among a group of exposed persons with a frequency above the average morbidity of the rest of the population" (2010, p.7). According to Grandjean, construction workers often have occupational diseases such as hearing loss, disorders due to vibration, musculoskeletal diseases, dermatological diseases, intoxications, pneumoconiosis, other respiratory diseases or cancer (1983).

It should be discussed what factors lead to these dangers in the construction industry. There are two main approaches, namely the nature of the construction industry and human-related ones. Regarding the nature of the construction industry, Grandjean reveals that construction sites are dangerous and have at least two main health hazards (1983). The first hazard is physical including excessive levels of noise, heavy burdens or uncomfortable positions; vibration dangers; solar radiation or severe weather conditions. The second hazard relates to working materials. In the construction industry, workers often have to deal with hazardous materials such as cement, toxic substances or fibrogenic dusts.

Regarding the human-related approach, based on the results of R.Y.M Li and Poon, the information can be divided into three key groups, namely employee-related, employer-related and legislative ones (2013). Regarding employee-related factors, workers are more likely to have occupational diseases and accidents because of unsafe attitudes and behaviour. Regarding employer-related factors, the poor investment in proper equipment and construction methods, the lack of safety training provisions, the demand for employees to shoulder heavy workloads and/or the method of payment to their workers all lead to increased risks for the worker. Besides this, legislation and legal enforcement (or more appropriately, the lack of it) also exacerbate the risks of construction workers. However, these factors cannot be separated as they are mutually related.

It should be emphasized that working conditions in the informal construction sector are extremely bad (Spooner and Hopley, n.d.). Enterprises in the informal sector are often operated on a small scale as subcontractor or sub-subcontractors. This results in three main problems. Firstly, informal

enterprises often provide less protective equipment (Guo, 2012; Spooner and Hopley, n.d.). Secondly, they also cannot provide enough safety training for their workers. In the case of Hanoi, Thuy reveals that there is no training at all for workers (2005). Unskilled workers learn from more experienced ones. Thirdly, workers in the informal sector often have to work for 10-12 hours per day, six days per week (Spooner and Hopley, n.d.). In Hanoi, Thuy reveals that construction workers have to work for around 12 hours per day without weekends off (2005). Sometimes, construction workers even have to work at night to ensure the schedule is finished on time. According to R.Y.M. Li and Poon, all of these above factors lead to occupational diseases and accidents (2013).

Besides this, regarding labour relations, construction workers, both outside and within Vietnam, generally do not have any kind of labour contracts (Cling et al., 2010; Spooner and Hopley, n.d.). They, therefore, do not have social protection, including social insurance and social health insurance. Without social health insurance, informal workers find it more difficult to access health services under the privatization of health care. Additionally, they also do not have other non-wage benefits such as days-off or regular medical tests. Spooner and Hopley show that construction workers often have only one day off per week while, in Hanoi, Thuy reveals that sometimes they do not even have that (n.d.; 2005). According to R.Y.M Li and Poon, this hectic schedule is one factor leading to higher occupational diseases and accidents (2013). Meanwhile, without regular medical testing, migrant workers often simply do not know about their health issues so that they cannot tackle them before they get serious.

Impact of Living Conditions in the Informal Sector on Construction Workers' Health

Apart from working conditions, poor living conditions in the informal sector also strongly affect workers' health. To begin with, it should be emphasized that the living conditions of construction workers are terrible worldwide. In Malaysia, around 82% of immigrant workers have to live at construction sites where the living conditions are very poor and they lack basic infrastructure such as clean water or sanitation. This situation also happens in China and India where migrant workers have to live at construction sites which are overcrowded, full of mosquitoes, rats and/or dust (Spooner and Hopley, n.d.).

In Hanoi, migrant construction workers also have to face poor living conditions in the informal sector. Thuy reveals that migrant construction workers also have to live at incomplete construction sites (2005). If migrant workers are not allowed to live there, their employers will provide rented houses for them. However, one migrant worker complained that the provided rented house was even worse than living at the incomplete construction site. It lacked basic infrastructure and was so filthy that the worker said he could not sleep inside it and preferred to sleep outside (Thuy, 2005).

These poor living conditions lead to various health issues. Studying the living conditions of construction workers in India, Jayakrishnan, Thomas, Rao, and George argue that they often have diseases such as tuberculosis, malaria, jaundice or typhoid more than the general population (2013). Alluding to these poor working conditions, it might be said that working in the informal sector does exacerbate migrant workers' poor health. Since there have been no previous studies done in Vietnam or, more specifically, in Hanoi about this issue, this research aims to identify the patterns of diseases and accidents occurring to migrant construction workers in the informal sector. Additionally, previous studies have shown that such work in the construction industry and its related migration also make many migrant workers stressed (Huy, Dunne, Debattista, and An, 2010; Leung, Chan, and Yuen, 2010). This research intends to study how this situation happens in the case of migrant construction workers in Hanoi.

Health Problems of Migrant Construction Workers

In the previous section, I reviewed related studies on the impact of the construction industry on workers' health. In this section, I aim to present findings of my research. I will present workers' health problems as well as analyse what factors led to their problems.

Worried, Homesick and Annoyed

By way of introduction, it should be mentioned that living as a migrant in Hanoi is not easy. With a low income, migrants are only able to afford low quality living conditions that lack basic infrastructure (Liem and White, 2007). Moreover, living far from their families is a handicap, especially when they are in difficult situations. This problem may be made worse because, in this bustling

city, migrants are often seen as outsiders. They sometimes face discrimination from local people who think migrants make the city worse (Duong et al., 2011). Additionally, their work is not always favourable. Hung, who used to be a street vendor selling fruits in Hanoi, shared that he always had to worry about profit. Sometimes, he might earn sufficient money but, on other days, he might lose a lot of money and this made him tired. Some street vendors are even threatened by local competitors (Viện Gia đình và Giới, 2010). All of these factors may make migrant workers stressed.

Regarding construction workers, Thuy shares that around 10 years ago, the living conditions of construction workers were bad (2005). They often lived at sites that lacked basic infrastructure. If the homeowners did not allow them to live at the respective construction sites, their employers would rent guesthouses for them. However, workers shared that these guesthouses were so damp, filthy and smelly that they could not sleep. Some workers even had to go outside and sleep by sewage pipes. The living conditions for such workers was harmful to their health.

In this research, as I described in the previous chapter, workers lived in solid houses that were not harmful to their health. However, the living conditions of workers were not always comfortable. When working in remote areas, the workers often have to set up bamboo tents near the site. Since the site is likely far from the community, there usually are almost no services available. Every day, workers have to travel to the nearest community to buy food. This is inconvenient at best, especially in the rainy season. Thinh, the supervisor of the main contractor, shares:

> Your brothers (interior workers of Brand whom I lived with) are very lucky to stay at this solid house. However, not all sites are as convenient as this one. I built a hydro factory. You know that hydro factory is located in the forest. No house is around it. Workers had to set up tents. I also had to live in a tent. However, I am a supervisor so my tent is better, used metal materials. Workers have to use bamboo. Living at that site, there is nothing outside, no toilet. When it rains, the smell is terrible. Even when I went to the gate, the smell was terrible. If I went inside, I would die.

Besides this, migrant construction workers sometimes have problems with the local people. Workers share that local people, especially in Hanoi, often do not have a positive attitude towards them. Thien shares:

> In Hanoi, local people do not like us. We do not harm them but there are a lot of bad stories about construction workers so they are afraid of us. (They) do not discriminate but they are not close to us.

Thong also agrees with Thien. He adds that workers who have strange hairstyles and wear informal clothing are the most hated. However, the work of construction workers is quite independent and is generally done in an area separated from most of the local community so they rarely communicate with local people. They, therefore, do not often have problems with local people. Nevertheless, Thien shares that sometimes he might be worried (*lo lắng*). Once he and his colleagues were threatened at a construction site:

> Working in Hai Phong (province) is also dangerous. On the first day we were there, some gangsters entered the site, asked for some protection money, asked us to hold our heads up when going outside. At the beginning, it was worrisome but we mainly worked at the site and rarely went out so it was not so serious. If I went there for business, it might be dangerous.

Another mental problem workers face is homesickness. In Vietnam, family sentiment is important so workers sometimes feel homesick when separated from their families. However, as breadwinners, they have to migrate to Hanoi and overlook this problem. Duong shares:

> Certainly, I sometimes feel homesick….If I stay at home, my family will be hungry. In the past, I did not have work for several months and my wife was very worried. My children study, I have to take care of them. Now, everything needs money. Agricultural work is not enough. Going to work is certainly tiring and I am sometimes homesick but I have to accept it. Working to earn money, I have to accept. Everyone wants to stay at home with family but I have to ignore it.

Before becoming a construction worker, Phuc was a street vendor and even went to the South of Vietnam but never felt homesick. However, when he and his wife had a child, he felt homesick when working in Hanoi. To tackle this problem, he often arranged time to visit his hometown:

> At that time, I did not have a mobile phone and my family also did not have a telephone so it was difficult to contact them. After several weeks, I tried to arrange time to come back and visit them… When I was free, I often came back to my hometown. I had an 81 (a motorbike brand name) so it was easier.

Now, thanks to technological developments, mobile phone use is ubiquitous in Vietnam so workers can easily contact their families. This helps them reduce their loneliness at construction sites as well as helps them control activities in their hometown. Hoang, the employer of an informal ceiling enterprise, shares that his children are adolescent and have various emotional issues. He, therefore, often calls his children to supervise them from a distance.

Moreover, workers are sometimes annoyed by work-related problems. When comparing the two sites, workers at the large-scale site are more annoyed than those at the small scale one. It should be mentioned that at the large-scale site, there are more regulations that workers have to follow. If workers break the rules, they will be warned and fined by supervisors of the main contractors. The regulations are beneficial for the safety of workers but some of them sometimes feel uncomfortable with the regulations. Thong shares that his work is mobile and he often has to change positions so, sometimes, he doesn't use the lifeline on the scaffolds. He knows that this is wrong but he dislikes the way one supervisor criticizes him, as if he was a newbie. He, therefore, sometimes argues with the supervisor and feels annoyed.

Fever, Weariness and Aches

During the time I was in the field, three workers had fevers. Two workers were exhausted and could not go to work while one was also tired but still could go to work. All of them were painters of the informal enterprise of Thong. From my observation, there were several reasons why these workers had fevers. Firstly, they had to work under harsh conditions. At that time, the weather was very cold (around 10 Celsius degree with a strong wind). Albeit the cold weather,

workers did not wear warm clothes as it was inconvenient for their work. Workers shared that when they worked, they felt very hot and did not have a problem with the cold weather. However, when they stopped working to relax, have lunch or came back to the site, they would get cold. They could have brought extra warm clothes with them but, since there were no lockers at the construction site, they did not bring warm clothes. Secondly, these workers were careless. After work, they felt hot and took a bath with cold water. The guesthouse where they lived had a water heater. However, there was only one water heater and there were many workers so they used cold water. This likely made them even colder. Thirdly, these workers lived in a small, enclosed space so diseases could be easily transmitted. In actuality, the three workers who got sick all stayed in the same room.

Moreover, weariness (*mỏi*) was also prevalent. Construction work is strenuous so nearly all the workers are weary after work. Workers often share that their work is manual and demands a lot of physical effort. Besides this, they have to work continuously for eight hours with a short break so at the end of the day, they often feel weary. More seriously, some workers sometimes have aches when continuously working hard. Hung, an assistant bricklayer at the large-scale site, shares that sometimes he has to work 10-12 hour days. During such times, he is in a lot of pain and said:

> Normally, I feel a little bit weary. I just relax at night and the next day it will be normal. But when I have to work at night-time, like I told you, it was very tiring. In the next day, sometimes, I cannot work. My body, especially my shoulder, flanks and lower back, has sharp (muscle) pain.

Lung Problems and Other Illnesses That Cause Weakness in Workers

As I mentioned in previous chapters, construction work is strenuous. Construction workers are, therefore, more likely to have work-related diseases and symptoms. This section aims to explore what diseases and symptoms construction workers get while working at construction sites. These health problems might be caused by their strenuous work or poor living conditions. Besides these problems, this section focuses on serious diseases and symptoms that sometimes afflict workers and may even prevent them from working. It is different from the mild symptoms that make them tired for only a short time.

The research finds that, generally, construction workers mainly have lung problems. Additionally, some experienced workers become more fragile after years of working in the industry. Among these groups, bricklayers are more likely to have work-related diseases than the other groups as the nature of their work is more strenuous and their working conditions are more harmful. Moreover, experienced workers, especially older ones, are more likely to have work-related diseases than less experienced ones. It must be understood that occupational diseases often gradually affect the health of workers over time so those working in the industry longer are more likely to have these diseases.

More particularly, regarding lung problems, Thong, a painter, shares that he once coughed up blood because of a harmful working environment:

> Once, I coughed up blood, I had to stop my work, and I visited a clinic and my health became… (thinking). Even now, my lung is not good enough. I have a problem with my lung. Normally, I can work normally. But when I do hard work or play football or run, I sometimes feel breathless…. Perhaps, my work is so harmful. You saw that I had to heavily scrape (*chà*) the surface of the wall or ceiling. There was always a lot of dust. Scraping the wall had less (dust) but scraping the ceiling, all the dust directly came down on my face. Unavoidable. I used a facial mask and it was less harmful but it still could not solve the problem. And paint is harmful. I cannot see (the harmfulness of paint) but I know paint is harmful.

Meanwhile, Thu, a bricklayer, shares:

> I found it difficult to breathe, often spat saliva. When it was too painful, I visited the Tu Son hospital (a district-level, state-owned hospital in his hometown) and was diagnosed to have lung cancer. I did worry. My family worried. So I visited 108 hospital (a state-owned hospital in Hanoi) to check again..... (The doctor said) I had a kind of pneumoconioses20. The

20 The worker shares that he has "a kind of lung dust (bụi phổi) problems". In Vietnamese, we often combine two simple words to make a new word. In the dictionary, bụi phổi means pneumoconiosis.

> working environment was too harmful, a lot of dust, cement dust.

Although not having serious lung problems like in the two above cases, some older workers share that their breath is worse after years of working in the industry. Ha, a bricklayer, shares, "Carrying a dozen 50kg cement packs was normal. Now, I breathe fast and hard (meaning he easily becomes tired) when carrying a few packs." I observed that at construction sites, both large and small-scale ones, it was always dusty. There was a lot of dust from soil, sand, stone or cement. When there was a big wind, the sites seemed to be covered in dust. At the large-scale site, some local workers sometimes cleaned the floor but it only reduced the amount of dust and could not totally solve the problem. For painters and ceiling workers, the situation was even worse. Before painting, painters had to scrape the surface of the wall or ceiling and this creates a lot of dust. Similarly, ceiling workers had to drill into the wall or ceiling, also creating a lot of dust. Now, workers often wear facial masks but they shared that, five years ago, they never used them. Even now, some workers do not use surgical masks because they lose them or feel uncomfortable when wearing the masks for a long time.

Moreover, older bricklayers are more likely to become more fragile. Hung, an assistant bricklayer, shares that he often has to filter sand, mix mortar or carry building materials such as packs of cement or bricks for senior bricklayers. His work is diverse but in general, is strenuous and requires a lot of physical effort. Now, assistant bricklayers can use wheelbarrows to carry heavy things but Hung shares that "cement packs do not fly to wheelbarrows". It means that he still has to use a lot of energy. Besides this, when lifting some particularly heavy and big things, he cannot use a wheelbarrow. Over the years, this strenuous work has badly affected his health and has resulted in lumbar nerve pain:

> At that time, the (muscle) pain was smouldering for the whole day. I did not feel comfortable. When I worked hard, it really hurt. I nearly could not work. I had to visit a hospital…. The doctor told me that I had lumbar nerve pain…. (The doctor told me it was because) I worked so hard.

Ninh, an experienced bricklayer, shares that now he does not have to carry heavy things but, in the past, he was also an assistant bricklayer and had to do all the hard work. Additionally, his work now is less strenuous than that of assistant bricklayers but it is still physically tiring. He often has to bend down or sometimes sit for hours in an uncomfortable position. It affects his back. He states:

> I still can work but my body is not as strong as it used to be. In the past, I could carry a dozen cement packs but now, it is quite difficult. Now, when I have to bend down to pick something up that is heavy, I feel a lot of pain…. The doctor told me that I worked so hard, I had symptoms of back degeneration[21]… Doing this work, it is very strenuous. Everything has degenerated.

Similarly, Ha, an experienced bricklayer, shares that he does not have to carry heavy things but it is still strenuous. His working position is very inconvenient and harmful to his health; he has to stand or sit with a heavy dish of plaster and perform the same action over and over again for hours. Besides this, he also used to carry heavy building materials for years. All of this has made his shoulder and wrist become arthritic:

> I cannot remember exactly the symptoms.... At that time, my *tay* (in Vietnamese, *tay* may refer to shoulder or arm or wrist or hand or all of them) was weaker. I felt a dull and lasting pain, sometimes it was very painful. I did not know what the disease was…. The doctor told me that my shoulder and wrist had become arthritic….Now, it sometimes still hurts. In the morning, I cannot work as hard with my tay as I used to. I have to do a warm-up.

In this research, I did not discover any painters or ceiling workers that had had degeneration problems. However, the pattern of their work is also strenuous and it might also lead to such problems in the future. For example, painters often have to raise their *tay* high, more than 90 degrees and scrape the wall or ceiling for hours. Meanwhile, ceiling workers often have to work in high

21 The key informant uses the word "degeneration" (thoái hóa). However, normally, degeneration refers to a natural process in which the body gradually gets worse.

positions and narrowly enclosed spaces for a long time. This is very uncomfortable for their bodies. They have to work in positions that are higher than their *tay*. All of these conditions can make their *tay* arthritic in the future (Kiệm, 2014).

Poor living conditions in the informal sector also lead to several serious diseases. Thien got a kidney stone because of contaminated water. He shares that in Hanoi or other urban areas, he might buy bottled water but in rural areas, it is too difficult so he has to use unclean water:

> Here (Hanoi), we can buy bottled water but in Quang Binh Province (a poor province in the middle of Vietnam where he worked), in remote areas, there is nothing. We have to use unknown water sources. Sometimes, I saw a lot of of dregs in the bottom of a cup of water but I still had to drink it.

Meanwhile, Vinh, a ceiling worker, got a stomach-ache because his meal times were not fixed. Sometimes, he had to work continuously and had lunch very late. In addition, he also often has to work hard immediately after eating.

> Sometimes we have to work for long hours. You know last time we had to carry building materials from the morning to the afternoon and had lunch at 3 PM. Our time is not fixed. Sometimes, especially at the end of the year, we have to finish the building soon so we have to work harder and do not have time to relax after lunch. We know it is not good but we have to ensure the rote of progress.

Work-related Injuries

The purpose of this section is to explore the injuries of construction workers that were caused by accidents at the sites. Under the law, an occupational accident is defined as "an accident that causes injury to any organs, functions of the body or make the worker dead, happens during the process of working, closely connects to the implementation of work, of labour tasks" (Quốc hội Việt Nam, 2012 translated into english by the author). During the time I visited the sites, there were no serious accidents. Among my key informants, three of the construction workers had had serious accidents previously and all of them

happened at small-scale sites. There were two primary reasons leading to their accidents: low-quality working equipment and the lack of protective equipment.

In particular, Nam, an assistant bricklayer, shares that he fell from a great height twice.

> Once I climbed up a scaffold. One plank broke. I felt surprised and fell down. Fortunately, it was just a one-floor scaffold... My accident was not so serious. I was just black and blue, some parts were cut but not so serious.... Another accident was also caused by climbing up. I climbed up a ladder. A step suddenly broke and made me fall to the ground… My *tay* was broken.

More seriously, Vinh, a ceiling worker, shares that he once fell from the third floor. At that time, he was renovating the office of Brand, a formal enterprise:

> (While I was working), the scaffold was not good. It was old. When I stepped on one plank, it broke, I lost my balance and fell.... Fortunately, when I fell, my bottom touched the floor first. If it had been my head, I would already be dead. My whole body was unbearable but luckily, my bone was not broken. My bottom was cut quite deeply and had to be sewed.

In both cases, Bac and Vinh had accidents because their working equipment was old and they did not use protective equipment. Although at that time, Vinh was working for Brand and at the office of Brand, the formal enterprise did not ask him to use a lifeline. Vinh shares, "We never use lifelines at small projects. Only at large projects. Main contractors ask us to use protective equipment." This implies that workers and/or even their employers do not appreciate the importance of protective equipment.

I observed that working equipment at the small-scale site is often quite old. Some working equipment, when broken, was simply fixed with some strings. Besides this, at the small-scale site, workers are not provided with protective equipment. Meanwhile, at the large-scale site, protective equipment is provided. Additionally, supervisors of the main contractor often check the working equipment so the subcontractors often provide higher quality. At the

small-scale site, there is no supervisor checking the working equipment so workers have to be responsible for themselves.

However, it cannot be said that large-scale sites are safer than small scale ones. If accidents happen at large-scale sites, they tend to be more serious. Minh, one supervisor of the main contractor, shares that at large-scale sites the working equipment is better but, if the assembly is not good, it might lead to accidents. He cites as an example that at a large-scale site, if an excavator driver makes a mistake, he may damage many surrounding people. In reality, at the end of March, 2015, there was a serious scaffold collapse at a huge industrial zone in Ha Tinh province, Vietnam, that left 13 workers dead and dozens of workers injured (Vietnamplus, 2015). Thong opined that the situation might have been even worse than the statistics provided by the Ministry of Labour, Invalids and Social Affairs. Once, he worked at a large-scale site and observed a worker who was killed because of a falling lift. However, the managers of the site kept this information silent.

At construction sites, minor accidents such as having heavy things dropped on workers' hands or legs, stepping on sharp objects or slipping and falling are the most prevalent. When I visited the sites, at the large-scale site, one painter fell from a one-floor scaffold and was bruised. Additionally, while carrying a scaffold, one ceiling worker dropped a bar that was used to stabilize scaffolds (workers often call it a stick) and was crushed by it.

Workers share that minor accidents are prevalent because of two main reasons. Firstly, they have to work strenuously so they sometimes feel tired and this causes accidents. Secondly, some workers are fairly subjective and often carry many things at the same time, which, unintentionally, causes them to drop them. Meanwhile, stepping on sharp objects or slipping and falling often happens while constructing private houses. The floor is rarely cleaned so sharp things are often present and the area is often small which makes workers more likely to have accidents.

For these minor accidents, workers often rest before continuing to work. If the accident is fairly minor, workers may relax for a short time and keep working. The accidents that occurred to the two above-mentioned workers were not so minor so they were allowed to take a rest for the remainder of the working day. Workers share that if they are bleeding, they will use hydrogen peroxide to clean the wound before it is bandaged. At the large-scale site, the

main contractor has a small medicine box for minor diseases and accidents. Meanwhile, at the small-scale site, there is no medicine box. If accidents occur, they will have to go to a nearby drugstore and buy hydrogen peroxide and cotton for the injured.

Apart from poor working equipment and the lack of protective equipment, another factor that leads to occupational accidents is the lack of safety training. According to the ILO, many construction activities such as demolition, transporting and arranging building materials or constructing special sites are highly risky (1998). Therefore, there are many regulations in these particular areas of construction work to help workers avoid occupational diseases and accidents. For example, transporting and arranging building materials, especially heavy ones, might affect workers' back or cause harm to their legs. Workers, therefore, need training on how to carry heavy things correctly.

However, my key informants did not have such knowledge. Thien, a ceiling worker, shared that only supervisors who graduated from a formal school may know this kind of safety knowledge. As I mentioned before, construction workers in the informal sector do not graduate from any formal schooling. They mainly accumulate knowledge and skills on the job. Regarding occupational accidents, when comparing these two groups of workers, those at the large-scale site are a little better off than those at the small scale one. Before the project, workers at the large-scale site joined a safety training class taught by the main contractor. At other large-scale sites, they had also joined similar safety training classes conducted by the main contractors. Meanwhile, workers at the small-scale site were not trained about workplace safety so they could only use their own experiences to work more safely. However, workers shared that the training classes provided by the main contractors mainly just focused on the pertinent regulations for the site and did not cover all the related health risks that they may face. Minh, the supervisor of the main contractor, shares that sometimes he gives workers some advice on safety but, in general, he cannot advise them all the time as he is too busy with his own work.

Illness treatment

The purpose of this section is to explore how workers cope with their health problems, from minor to serious ones.

When three of the above-mentioned workers started exhibiting symptoms of a fever (such as feeling tired or coughing), they stopped taking baths with cold water. When they had fevers and felt exhausted, two workers had to stay at home. As it was cold, they covered themselves in a blanket and slept in their room. On that day, their colleagues of the same informal enterprise bought food and some medicines for them. Their colleagues visited a nearby drugstore, told the pharmacist that their friends had fever and bought some medicine. The workers preferred Panadol, a medicine that has Paracetamol, as it was often advertised on the television. All of the expenditures were paid by the employer, Thong. However, on their day-off, the workers were not paid and it was one reason why they only stayed at home for one day. They returned to work the next day even though they were still unwell.

For other participants, when asked "What do you do when getting sick[22] *(ốm)*?" they mentioned various solutions, depending on the level of their symptoms. When they get their very first symptoms such as being tired or sneezing, workers often ignore them, do not stay at home to relax or eat nutritious foods to increase their strength. When getting more serious symptoms such as a headache, five workers used balm. Thien, a ceiling worker, shared that he often brings a balm in the winter. Meanwhile, Ha often brings some first aid medicines such as balm or cotton wool with him as he sometimes has to work in remote areas.

When getting fever *(sốt)*, most of the workers take some kind of medicine. No one shares whether they use a thermometer or not. They know they have a fever when they begin to feel very tired. Some workers have a preferred medicine such as Panadol or *Cảm xuyên hương* (a Vietnamese brand). They or their colleagues will visit a nearby drugstore to buy that medicine. However, if the drugstore does not have the medicine, they will buy the pharmaceutical the drug seller suggests. Workers only stop working and stay at home to relax when they have become completely exhausted or like Vinh says, "cannot wake up". In this case, their colleagues will support them by buying food and medicines for them. The expenses are normally paid by their employers. Ha shares that sometimes his colleagues cook rice porridge for him. Workers only stay at home for one day and will come back to work in the next day although they

22 In Vietnam, sickness often refers to influenza (*cảm cúm*) and cold (*cảm lạnh*). People often talk about their symptoms such as tiredness, sneezing or fever more than the diseases.

are still tired. Workers do not want to stop working because of two reasons. Firstly, workers only get daily wages so if they stopping working, they "will be hungry" as Duong states. Secondly, Phuc shares, "(his painting informal enterprise) only has a few workers. If workers stay at home when getting sick, who will work?"

Meanwhile, regarding weariness, the most popular solution is to drink local wine at dinner to reduce muscle pain and to sleep better. They often buy vodka (*rượu trắng*) at nearby convenient shops, food shops or sometimes, bring a 20-litre bottle made from their hometown. In his hometown, Ninh, the worker at the small-scale site, often drinks wine steeped with some herbs. In Vietnam, this herbal wine is fairly popular and often used by the elderly to reduce muscle pain. However, at this site, Ninh often drinks vodka, as he cannot bring a lot of herbal wine with him. Another solution to reduce weariness is massage. At the small-scale site, at night, workers sometimes do massage to one another. Some experienced workers know some basic skills and share them with younger ones. Besides this, one worker whose name is Ninh uses a cream to reduce the pain. It is a gift from his relatives who are studying in Singapore and had a child there. However, the worker shares that it is not really useful.

When having aches, Hung's solution is to rub Salonpas cream (a kind of painkiller) to reduce the pain. Thien also experiences pain when he has to work hard continuously for hours. Being similar to Hung, he uses Salonpas, which is popular and often advertised in Vietnam to immediately reduce the pain:

> Normally, I feel a little bit weary but when a container transports goods, I have to unpack and carry them. It is very tiring. The amount of goods is huge. We have to unpack and carry them quickly to free the container. On that day, I feel very weary. When coming back home, I nearly cannot sit normally. It hurts a lot.... When it is too painful, I rub Salonpas on the pain. It can reduce the (muscle) pain.

For more serious accidents that make workers unable to continue working, there are two different cases. If accidents are serious but workers do not need to be hospitalized, they may stay at home for rehabilitation. Their employer will pay for the health expenditure (medicine, bandage, etc.) and give

them some financial support, as during those days when the workers cannot work, they cannot get wages. Thu, a bricklayer, shares:

> Once I slipped and fell... My body was black and blue. My wrist resisted the floor, badly affecting my tendon.... The accident was not serious. I was not hospitalized.... My colleagues had to buy ice to cover it and used some oil to reduce the pain. (They) bought some painkiller medicine and bandages to cover it.

If accidents are more severe, initially, the employer or colleagues will take the patient to the nearest hospital. After that, the employer will contact the family of the worker and call them to the working site to support the patient. Vinh, a ceiling worker who fell from the third floor, shares:

> They took me to Viet Duc hospital (it is near the office of Brand) to check whether I was dead or not. I was scanned in the head and bone..... My bottom was cut quite deeply and had to be sewed. I stayed there for 2-3 days and then, moved to the 198 hospital. It was near my guesthouse and was more convenient for my uncle and colleagues to take care of me.

The employer has to pay all of the health expenditures. If the worker has to be hospitalized for a long time, the employer will still have to support him. The employer must take care of his worker to maintain his prestige. Apart from the health expenditures, the employer might pay for his food and give the patient some money during his days off. It should be considered as financial support since workers do not get any wages during those days. The level of financial support is not fixed; it depends on the severity of the accident and the relationship between the employer and the worker. Workers share that some employers refuse to support their workers because they have just started their business or are in such debt that they do not have enough money.

Generally, when exhibiting symptoms of occupational diseases, workers often neglect them. They think that the nature of their work is strenuous so pain is unavoidable. When the symptoms become more serious but do not prevent them from working, workers have two choices. Firstly, they might visit drugstores to buy medicines and consult with the drugsellers. They believe in

the consultation of pharmacists and the efficiency of pharmaceuticals. This situation is unsurprising as in Vietnam, more than 80% of people go directly to drugstores when getting sick (Chalker, Chuc, Falkenberg, and Tomson, 2002). Workers use pharmaceuticals suggested by pharmacists without consultation from doctors or before searching for information from other qualified sources. It should be mentioned that not all pharmacists in Vietnam are qualified. Licensed pharmacists are rare and are not often present at drugstores. In reality, unqualified people work behind the counter (Chalker et al., 2002).

Additionally, they might ask to share the drugs of their colleagues, especially those who have already experienced similar symptoms. They think that their colleagues are like them so this information should be more useful. Besides this, their colleagues are close to them so they might easily share their experiences. They do not look for information from books, magazines or the Internet or from consultation with doctors. It should also be mentioned that many workers lack the means to find such information. At construction sites, there are no doctors present for consultation. Linh, a focal person, shares that big, state-owned enterprises always have at least one doctor present to examine the health of workers or to give them advice when necessary.

Workers only visit a clinic/hospital when their health problems become severe and they cannot work. They have diverse ways of finding a health provider, which will be analyzed in more depth in the next chapter. It is essential to mention that most of these workers visit health providers in Hanoi. Only three workers visited provincial hospitals even though they were cheaper and more convenient. When working in Quang Binh Province, one worker had a health problem but he delayed visiting a hospital until he returned to Hanoi. Some workers shared that if they had health problems, they would only visit renowned hospitals in Hanoi and ignore the ones in their hometowns. In general, workers do not have a positive attitude towards provincial hospitals, a fact that is unsurprising since other people also have this same attitude.

Visiting a health provider is the last choice of the workers for several reasons. Firstly, they have a negative attitude towards hospitals. Secondly, their work is a barrier. Construction work needs teamwork. The absence of a single member, particularly a senior one, might affect the rate of progress. Finally, finance is perhaps the biggest constraint. Workers are very afraid of visiting

hospitals since the health expenditure is high in comparison to their income. It should be mentioned that workers have to pay all the treatment fees by themselves. If their illness is serious, their employer might give them some money but it is insignificant to the overall cost. If the worker has a strong relationship with the employer, he may be supported more. One young worker had a health problem and was totally subsidized by his employer who was also his uncle, for example.

One other thing that should be mentioned is the follow-up examination of workers. Generally, after the first visit, even when they are sometimes still experiencing pain, most of the workers do not revisit the clinics/hospitals for treatment. There are two primary reasons for this. Firstly, some workers assume that because they are aging and their work is strenuous, occupational diseases are unavoidable and cannot be totally solved. Secondly, it is a financial issue. Workers have to pay for all treatment and transportation fees by themselves so they neglect to revisit health providers. Besides this, if workers do not work, they will not get paid so they choose to continue working and not return to the health providers.

Regarding hospitals, workers often have a negative attitude. Many of them think that the doctors in their hometown are not good enough and are only able to treat minor diseases. When they have serious health problems, they will visit hospitals in Hanoi. However, they think that hospitals in Hanoi are over crowded. Additionally, the health expenditure is expensive in comparison with their income. For workers, hospitals are their last choice. Workers only go to hospitals when their health problems become serious.

One thing that should be mentioned is that workers rarely use traditional medicine. Among the cases I have researched, only one worker named Ninh used traditional medicine for a short time. As he had a problem with his *tay*, his mother bought some traditional medicine at a nearby shop for him. However, he did not continue using it since it required a long time to prepare and he considered that inconvenient for his construction work.

One useful solution to prevent occupational diseases is to have a regular health examination. This may help workers find out the cause of the symptoms they may be experiencing before the disease becomes serious. Formal workers are often provided this benefit but workers in the informal sector are never provided this benefit. None of my key informants had ever had regular health examinations of their own accord. Some workers shared that they are strong

so regular health examinations were unnecessary. They only visited health providers when they were sick. Meanwhile, some of them knew regular health examinations could be beneficial but they still never had them.

Name	Health problems	Illness treatment
Thong	• Cough up blood	• Visit a private clinic
Vinh	• Stomach ache • Being 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.
Thien	• Kidney stone • Aches in his arms and backs	• Visit E hospital • Use drug
Hung	• Lumbar nerve pain	• Visit Medical University hospital
Yen	• Bricks fell on his head • Scaffolds fell on his body	• Delivered to a state-owned hospital in his hometown • Rehabilitation at home
Ha	• Arthritic arms and wrists	• Visit a private clinic near 103 hospital
Bac	• Fall from one floor scaffold • Fall from ladder	• Rehabilitation at home • Delivered to a state-owned hospital in his hometown
Ninh	• Back degeneration	• Visit 108 hospital
Thu	• Pneumoconioses	• Visit 108 hospital

Table 4.1: Summary of workers' health problems and illness treatment
(Source: Author)

Factors Affecting Workers' Illness Treatment

The above section already introduced some of the illness treatment regimens of migrant workers. Workers do not have regular health examinations. When they have a health problem, workers often consult with their colleagues or pharmacists to buy some medicines. They only visit a health provider when their health problems become severe. This section attempts to explain their health seeking behaviour from various aspects.

First and foremost, economics is the most significant factor affecting the health seeking behaviour of workers in the informal sector. By way of introduction, the Vietnamese health care system should be reviewed. After *Doi*

Moi policy, the health care services in Vietnam were, for the most part, privatized. Now, health providers, even public ones, have to be financially autonomous so they often have to charge their patients as much as possible. Apart from this formal health expenditure, it is said that patients often have to bribe doctors to have better treatment. In total, patients have to pay a considerable amount of money for health services.

To migrant construction workers whose income is low and unstable, this rising health expenditure is a real obstacle for both regular health examinations as well as illness treatment. Ha knows he needs to check his health but the expenditure prevents him from accessing the service. He shares, "Sometimes, I also want to check my health status. Once I took my mother to Bach Mai hospital. I intended to check my health but finally, I did not as I regretted spending money." When a worker has a serious health problem, it becomes a burden for him. Thu shares that he had to spend the equivalent of several months' salary to treat his lung problem.

In addition to the rising health expenditure, workers in the informal sector cannot access social insurance and health insurance because of various reasons. To begin with, their employers only provide them paltry benefits. Most particularly, in the informal sector, construction workers are not provided regular health examinations or social and health insurance like those in the formal sector. When they get injured, their employers might financially support them but in general, workers have to pay all health expenditures by themselves. Informal enterprises are generally operated on a small scale and do not always have work. They, therefore, find it difficult to provide fringe benefits like the formal enterprises. Thong shares that he is an employer but in fact, he has only a few workers (at this site, only three) and not always work. Sometimes, he also has to work as an employee for other employers. He, therefore, cannot provide fringe benefits for his employees. They sometimes work for him but also sometimes work for other employers.

At the large-scale site, all workers are provided a private health insurance plan named 24 insurance by *Bao Minh*. However, the benefits of this health insurance plan are very limited. In particular, the reimbursement for health expenditures does not exceed 50,000 VND (2.2 United States Dollars [USD]) per day and 20 million VND (889 USD) in total. None of the workers have used this private health insurance. Some workers share that their formal enterprises bought this health insurance because it is a requirement of the main

contractor. The Research Centre for Female Labour and Gender et al. reports that more than 10 years ago an employer in the informal sector also had to buy this private health insurance plan and could afford to because of its very low price (2003). It can be said that this health insurance plan makes workers feel safer (*yên tâm*) but, in reality, it is not really helpful. Workers cannot rely on it very much, especially in serious situations.

Moreover, as I reviewed in Chapter 2, the Vietnamese government has introduced voluntary social and health insurance for workers in the informal sector. However, none of the participants in this research have bought these insurance plans. Firstly, all of them have a negative attitude towards social health insurance. Thong shares, "Once I took my mother to check (her) health by health insurance. The applications (for health examination by health insurance) were full. We had to wait for a long time". Hung, an assistant bricklayer, also has similar ideas and shares health insurance is suitable only for the elderly who have a lot of free time. These results are similar to those found in the study of Viện Gia đình và Giới (2010). In that research, migrant workers in the informal sector also had negative attitudes towards health insurance. Secondly, this research has also found that many regulations of voluntary social and health insurance are inconvenient for migrant workers. In Chapter 2, I showed that migrant workers have to pay all of the contribution rates and that they are quite high. In the formal sector, employees only have to pay one third of their contribution rate and their employers subsidize the rest. Similarly, in China, those who join voluntary health insurance plans have to pay only one third of the contribution rate. The rest is subsidized by the central and local authorities (Barber and Yao, 2010). Apart from that, the management of the Vietnamese social and health insurance programs is based on the household management system (*hộ khẩu*), which is totally inconvenient for migrant construction workers who are highly mobile.

Apart from the lack of insurance, it should also be mentioned that migrant workers in the informal sector only get paid for the days that they work and are not paid for their days off. It means that, if they visit a health provider, they will not only have to pay for the health expenditure, food and/or transportation required but will also lose their wages for taking the day off. In the case of workers in the formal sector, this scenario is more convenient. They get a monthly salary. When they have a day-off, their salary still remains the same. Additionally, some experienced and skilful workers like Thong or Ha have to

be at the sites to guide others. Because of this responsibility, they often delay a visit to a health provider. To avoid losing wages or affecting the rate of progress, workers might visit a hospital after work but, at that time, the hospital - except the Emergency department - is also closed. In general, even apart from the rising health expenditures' issue, the opening hours of hospitals, especially public ones, are not convenient for workers.

According to Viện Gia đình và Giới, in addition to the financial barriers, many migrant workers in the informal sector in Hanoi also lack information about qualified health providers whom they might afford (2010). They, therefore, have to delay their illness treatment or wait and take treatment when they return to their hometowns. The health seeking behaviour of participants in this research is also affected by this lack of information. As I analysed in the earlier section of this chapter, when they first start exhibiting symptoms, the workers often ask for advice from their colleagues, especially from the experienced ones or from those who have had similar symptoms. When they need to visit a health provider, they seek advice from their colleagues. Workers often believe that they share similar socio-economic conditions with their colleagues so they think their advice is more suitable for them. However, workers have to rely on their work-related ties because they lack information from other sources.

Mr. Linh, a key informant, shares that state-owned enterprises always have at least one doctor on-site to examine the workers' health or consult with them when necessary. This research has found that there was no doctor at either the small-scale or large-scale site. At the large-scale site, there is only a small first aid box in the office of the main contractor. The main contractor is a private enterprise and has to be financially autonomous so they have to cut all "unnecessary" expenses, even if it is not good for their workers. Additionally, workers also do not have any connection with aid organizations. As I mentioned in the second chapter, Duong, et al. reviewed that there is no aid organization supporting migrant workers in the informal sector in Hanoi (2011). In the next chapter, I will also show that workers do not know about any of the non-governmental organizations presently operating in Hanoi. Again, even if they did have information about these NGOs, none of them at present support migrant construction workers in Hanoi. In conclusion, it can be said that workers lack information when they get sick so they have to rely on their closest colleagues.

The health seeking behaviour of workers is affected not only by their socio-economic conditions but also by other factors. Workers do not study at construction schools and do not have many opportunities to access health knowledge from qualified sources such as doctors. However, they have their own ways to gain health knowledge and this shapes their health seeking behaviour.

In particular, the health knowledge of workers is strongly affected by their work-related ties. Firstly, workers live and work together so they often learn from each other. For example, the use of Salonpas, a cream that helps alleviate pain, is very popular among them. If one worker uses it and feels better, other workers will follow. Secondly, when getting sick, workers often share with their colleagues. They discuss what measures they should take like resting, drinking medicine or visiting a clinic/hospital. In this case, the network of workers plays an important role. When he gets sick, Thien often consults with Mr. Hoang, his employer, who is also his uncle. Mr. Hoang is around 40 years old, mature and often advises and even financially supports Thien when he has to visit big hospitals in Hanoi. Meanwhile, Thong is an employer and often hires very young employees. He is independent so, when he gets sick, he rarely consults with other people. He goes directly to a clinic that he spotted on the way to work from his guesthouse.

Additionally, workers are also affected by advertisements in the mass media. When getting fever, some workers often use Panadol since it is advertised on television. It can be said that this is their one and only strategy to attain health knowledge as they lack opportunities to acquire such knowledge from qualified doctors or medical books or magazines. As I mentioned in the previous section, at construction sites managed by private enterprises, there is no qualified doctor. There are also no health books for workers. At the beginning of a large-scale project, workers were required to join a training class but this class only provided information about the site regulations and did not mention how to avoid or treat health problems. In general, workers lack the means to access health knowledge so they have to take advantage of other sources even though they may not be professional.

Besides this, the workers' health seeking behaviour is also shaped by their attitudes and beliefs about drugs and hospitals. In general, workers have a positive attitude towards drugs and a negative attitude towards hospitals.

There are four main reasons for this. The first factor is its convenience. Drugstores are very popular in Vietnam, even in rural areas, so they are far more convenient for the workers. I observed that there were several drugstores near the two construction sites. Just around a few hundred metres from the house and the site, there were several other drugstores. Meanwhile, health providers, especially the big hospitals, are fairly rare. When Vinh had an accident, his colleagues had to take him to Tu Son District Hospital, which was around 10 kilometres from the site. It is, therefore, much more convenient for workers to visit a drugstore and consult with the pharmacist, rather than visiting a clinic/hospital. The second factor is its price. Pharmaceutical prices are affordable, suitable for the income of workers. The third factor is the hospitality of pharmacists. Pharmacists are often friendly, listen attentively to their customers and freely consult with them. It is different to the attitude of doctors at hospitals. Ha explains; "Going to hospitals takes a lot of time. It is always crowded. I have to queue up for a long time and when I meet the doctor, the doctor only spends a few minutes with me, asks cursorily." The final factor is its efficiency. Wolffers argues that many Vietnamese people prefer drugs (1995). Before *Doi Moi* policy, Vietnamese hospitals often lacked necessary pharmaceuticals such that their patients' treatments were ineffective. At that time, many people, especially in the South, often used Western drugs bought in the black market and found these drugs to be more effective. For many Vietnamese, "drugs from abroad have become symbols of progress, bio-medical possibilities, the free market and a better and more efficient health care system" (Wolffers, 1995:1329).

Concluding remarks

This chapter aimed to explore how the informal sector affects migrant construction workers' health. It can be concluded that poor working conditions directly affect workers' health while limited benefits prevent them from accessing health services when necessary.

First of all, from the above analysis, it can be concluded that construction work is harmful and badly affects the health of workers, especially those who have worked for a long time in the industry. Nowadays, there is more working equipment available on job sites; the workers do not need to work as hard as they did before. However, this equipment only partially reduces the

strenuousness of construction work. It still requires a lot of physical effort and the fact that several of the experienced workers get fragile over time is an exemplar of this. Moreover, construction sites are often dirty with various kinds of dusts and toxic chemicals abound. This negatively impacts the workers' lungs. Now, more and more workers use a facial mask on the job to reduce the effects of dust and air-borne chemicals but many workers still neglect this item of protective equipment. The health consequences may not come immediately but do accumulate over time such that the workers often may not realize the harm that they are subjected to.

Nevertheless, it can be said that construction sites are dangerous places with many potential accidents inherent to them. Inconvenient working positions, from underground to great heights, plus being surrounded by various big machines and equipment puts workers in potential danger. The probability of an accident occurring at a small-scale sites often seems to be higher than at large-scale ones. The lack of professional management, qualified working equipment and the non-use of protective equipment are key factors leading to this problem. Being operated on such a small scale, informal enterprises are not able to provide qualified working and protective equipment for their workers. Additionally, the management is loose. There are no safety regulations and no one supervises the workers, allowing them to work freely and often dangerously. It should be mentioned that the government does not supervise the activities of informal enterprises. They only check these enterprises when accidents occur and are reported to them.

Apart from that, the limited benefits afforded those in the informal sector are also a constraint for workers to access health services. In comparison with formal workers, the benefits of informal ones are far 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 getting 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 (*yên tâm*) 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, either large or small-scale ones, 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 use drugs suggested by their colleagues or pharmacists at nearby drugstores, neglecting other solutions. Only when the problems become severe do they visit a clinic/hospital. However, even when they do visit the hospital, these workers do not attend 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.

Chapter 5

Social Relations of Migrant Construction Workers

As I mentioned in the Introduction chapter, previous studies show that being excluded from formal social protection programmes forces migrant workers to rely on their social relations, including kinship-based, work-related ties and non-governmental organizations and community-based organizations. This chapter attempts to explore what social relations workers have, the way they broaden their social relations, maintain them and finally, how their social relations help workers to cope with their health problems.

Related Studies on the Support of Social Relations

This section aims to review related studies on the support of social relations. Being excluded from social policies, it should be questioned how migrant workers cope with their health issues. To answer this question, it is necessary to understand the concept of risk management strategies. According to Holzmann and Jorgensen, individuals, households and communities are vulnerable because of various risks; therefore, they need risk management strategies to prevent, mitigate and cope with these risks (2000). Risk management strategies have different actors ranging from various levels. At the micro level, they are individuals and households and at higher levels, they are communities, non-governmental organizations, market institutions, the government and international institutions.

Additionally, Holzmann and Jorgensen also suggest the level of formality of arrangements that is used under each risk management strategy (2000). The first level is informal arrangements such as marriage, savings in real assets or mutual community support. The second level is market-based arrangements such as financial assets or insurance contracts. The final level is publicly mandated or provided arrangements such as social insurance, transfers and public works. Based on the suggestions of Holzmann and Jorgensen, the actors of risk management strategies might be categorized into two main groups (2000). The first group includes government and market institutions because their arrangements with individuals such as contracts (market institutions) or law (public social protection) are formal. The second group, called social relations, includes individuals/households, communities and civil society organizations because their arrangement with individuals are voluntary, based on trust or philanthropy. As migrant workers are excluded from the first group, they have to rely on the second group.

For the purpose of this research, I will focus only on the health support of social relations. According to Berkman, Glass, Brissette, and Seeman, to understand the impact of social networks on health, one needs to study the whole framework (2000). 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 psychosocial mechanisms, 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 physiological pathways.

This research aims to adopt the above framework. It can be seen that at the macro level, factors such as social change, unequal social policies or the labour market structure contribute to migrant construction workers vulnerability in terms of health care. More specifically, the health of migrant construction workers is affected by stress, poor working conditions (the lack of adequate protective equipment provision, safety training provisions, regular medical test provisions and heavy workloads), poor living conditions (the lack of clean water and sanitation), limited information about health providers and limited budgets. This section aims to analyse what and how social relations

provide the psychosocial mechanisms necessary for migrant workers to tackle their health problems.

According to Berkman, et al., psychological mechanisms include five components and each component consists of sub-components (2000, p.847). Most particularly, social support includes instrumental and financial, informational, appraisal and emotional support. Social influence includes constraining/enabling influences on health behaviours, norms toward help-seeking/adherence, peer pressure and social comparison processes. Social engagement includes physical/cognitive exercise, reinforcement of meaningful social roles, bonding/interpersonal attachment, handling effects and grooming effects. Person-to-person contact includes close personal contact and intimate contact. Meanwhile, the access to resources and material goods includes jobs/economic opportunity, access to health care, and housing, human capital and referrals/institutional contacts.

Moreover, it is essential to review particular studies on the impact of interpersonal relations such as kinship-based, work-related ties or migrant friends on the health of migrant workers. Most particularly, regarding stress, these social relations often provide social support for migrant workers to tackle their mental issues. Families in their hometown often provide emotional support for migrant workers to help them reduce their loneliness in the cities (Huy et al., 2010; Y. Li and Wu, 2010). In Vietnam, migrant workers often contact their families via mobile phone because of its convenience and low cost (Duong and Liem, 2011). Additionally, migrant workers also receive social support from their fellow villagers at the workplace. Thuy reveals that construction workers coming from the same village tend to consider the group a family and mutually support each other (2005). Meanwhile, Huy et al. show that colleagues might create peer pressure to force all members to work harder (2010). At such a time, the group will have more work; more income and the feeling amongst its members will be better.

However, in some cases, when helping migrant workers' to reduce stress, interpersonal social relations might badly affect their health. To cope with stress, many migrant workers adopt risky behaviours such as smoking, drinking alcohol or having sex with sex workers. These people may even use peer pressure to persuade their colleagues to undertake similar risky behaviours (Huy, Dunne, and Debattista, 2013). Thuy argues that this situation might happen when there

is a loose relationship, where migrant workers do not have strong relationships (2005). He argues that if construction workers come from the same village, they will supervise each other (Thuy, 2005). Members, therefore, do not dare to behave in such a way, as they are afraid that this information will be known in their hometown. On the other hand, if construction workers come from different places, they will not supervise each other. At that time, members might engage in risky behaviour such as engaging sex workers. Thuy even reveals that one employer provided his skilled workers with free sex from sex workers, as a way to satisfy these key employees (2005).

When getting sick, migrant workers face two main problems, namely limited information about health providers in the city and limited budgets. Regarding information, Y. Li and Wu show that in China, fellow villagers provide migrant workers information about health providers that are suitable for them (2010). Regarding financial budgets, in China, Y. Li and Wu reveal that in serious cases, migrant workers tend to seek financial support from their kinship-based ties (2010). In Vietnam, Minh also emphasizes that kinship-based ties are the strongest ones (2014). Moreover, in Vietnam, migrant workers also seek financial support from their employers. The amount of support depends on the financial ability of the employer and/or the relationship between the employer and employees (The Research Centre for Female Labour and Gender et al., 2003; Thuy, 2005).

Apart from financial support, interpersonal social relations also provide other social support for migrant workers who are getting sick. Hong et al. reveal that families of migrant workers might give them advice about health seeking behaviours such as self-medication or using traditional medicines (2006). Additionally, these relations might also provide instrumental support that relates to physical activities or labour support (Berkman et al., 2000). Y. Li and Wu argue that for migrant workers, the instrumental support is very important (2010). Living far from their closest ties and being excluded in the city, many migrant workers have to cope with their illness alone which is very dangerous for their health, especially in emergency cases.

However, interpersonal social relations are not always beneficial for migrant workers when they get sick. Firstly, their relations are not always available to support them. Migrant workers, therefore, have to delay their treatment which may be harmful to their health in the long term (Y. Li and

Wu, 2010). Thuy even reveals that if the relationship between employers and employees is loose, the employer will deny or use various ways to delay his financial support (2005). Secondly and more seriously, Hong et al. show that in China, the employer even denies their employees the right to go to the hospital in order to ensure progress at work (2006).

Regarding poor working and living conditions in the informal sector, there is limited literature on how interpersonal relations support migrant workers. Cattell argues that these interpersonal networks are not able to tackle all of the impacts of such poverty issues or the broader, material conditions on health (2001). This author also believes that social relations mainly include people from the same class so the support of these relations cannot tackle all class-based health inequalities. The social relations of working class people are often limited and are less resourceful than those available to the upper classes so they are not always able to help them when necessary.

This research agrees with Cattell, in that the social networks of migrant workers are not always able to help them cope with their health issues (2001). Firstly, social relations of migrant workers, especially in the receiving community, are limited. They are often face discrimination from their neighbours in cities and are also excluded from social policies. Secondly, their social networks are often in the same class with them so these relations cannot tackle all class-based health inequalities.

Social Relations of Workers and Their Roles

The purpose of this section is to identify what social relations workers already have, the way they broaden their social relations, as well as how they maintain their social relations. This section also attempts to analyse the characteristics of the social relations that will shed light on their social support.

Kinship-based Ties and Their Role

Bich argues that family plays an important role in the life of the Vietnamese (1999 in Dalton, et al. n.d.). This research has also found that the impact of kinship-based ties on workers is significant. In the beginning, it was their relative who introduced them to the construction industry and trained them to become construction workers. When they have health problems, the

workers will receive greater support if they have a kinship-based relationship with their employers. Additionally, when they encounter serious health problems, workers will have to rely on their families. The role of their kinship-based ties will be analysed deeper below.

As migrant workers often live away from their families, it is essential to explore how they keep in touch with their family in their hometowns. According to Berkman, et al., frequency of contact is one important characteristic of social networks (2000). Mobile phones are the most popular choice. All key informants in this research have mobile phones so they may easily contact their families or vice versa. Young workers call home several times per week while older workers, especially those with small children, contact their families more regularly, sometimes on a daily basis. It is one way to know what is happening in their hometown as well as a way to solve the loneliness they face in the receiving community. In the past, when telephones and mobile phones were rare and expensive, workers rarely contacted their families. Thong shares that every two weeks, he went to a post office and called his family. At that time, as his family did not have a telephone, he had to call a neighbour.

Another solution is to keep in touch with their families via home visits. In comparison with street vendors, construction workers visit their hometowns less. Mori shares that female petty traders often come back to their hometown every 20-30 days (2008). The purposes of their visits are "not only for particular occasions such as for transplanting and harvesting the rice, rituals, ceremonial events or, family events, but also they visit their home either for no more than several days or over a few weeks, whenever they wish" (Mori, 2008, p.87). Female petty traders visit their families regularly because of two main reasons. Firstly, in Vietnamese culture, one of the women's roles is to take care of their families. Secondly, they are self-employed so they can stop working whenever they want.

Meanwhile, construction workers do not visit their families on a regular basis like petty traders. All workers share that they often come back to their hometown when finishing their work or for special events such as rituals, ceremonial events or family events. All workers come from the north of Vietnam, 50 to 150 kilometres away from Hanoi so distance is not a big handicap. However, they do not go back frequently to their hometowns for several main reasons. The first reason is financial. When they leave the working place, they do not

get wages. Besides this, they will have to pay for the transportation fees, gifts for their loved ones and/or food. The second reason is that they work in teams so their absence, especially senior workers, might affect the rate of progress. On average, the duration of construction projects fluctuates from one to several months, depending on the scale of the site. However, as there are many special events, workers do come back to their hometowns quite often anyway. In general, workers return to their hometowns at least every three months. Some young workers even come back more frequently as they have many meetings in their hometowns.

Sending remittances is another solution. As workers often get paid their wages at the end of the project, they do not send remittances to their families as regularly as petty traders. As I mentioned in the third chapter, workers prefer to get wages at the end of the project because of two main reasons. Firstly, since their accommodation and food are subsidized by their employers, they do not have to pay much money for daily activities. Secondly, by receiving wages at the end of the project, they accrue a large amount of money that is better for their savings. Workers who are married, send most of their wages to their wives who will be responsible for saving money as well as all the activities and provisions required in their hometowns. Meanwhile, young workers often keep their wages for themselves and, sometimes, give some money to their parents on special occasions such as the New Year holiday.

Generally speaking, although workers leave their hometowns, they still have consistent contact with their families via calling and visiting. Around 10 years ago, it was fairly difficult for workers to contact their families via telephones or mobile phones but now, it is much more convenient because of developments in technology. The popularity and affordability of mobile phones reduces geographical distances between workers and their families. Besides this, in comparison with immigrants, participants of this research have more advantages since they are rural-to-urban in-country migrants. They often work in Hanoi or in other Northern provinces that are not too far from their hometowns. This relative closeness to their hometowns helps the workers return on a more regular basis. These frequent returns nurture their relationships and keep them close.

Moreover, it should be mentioned that workers are close with their families because they have very strong interactions. Firstly, as I mentioned

above, workers have regular frequency of contact with their family members. Secondly, their migration itself is beneficial for their families so they understand and accept the situation. All the married workers I interviewed for this research are the main breadwinners of their families. They migrate so they can support their families. Mr. Duong says that without his wages from construction work, his family would struggle financially. It can be said that these workers' migration heightens their importance. Their families need to remain connected with them. However, the interaction is not only one-way. Their families use the remittances to raise children or pay for events in their hometowns. In other words, their family members, especially their wives, help them by taking care of all family matters in their absence.

Apart from their immediate family, it is quite surprising that workers rarely maintain relationships with their other relatives. Workers mainly only meet such relatives at special events when they return to their hometowns. Several workers shared that they have numerous relatives and nowadays, people are often so busy that it is inconvenient for them to visit everyone. At sites, workers who are over 30 years old rarely call their relatives except when necessary. Meanwhile, several young workers, who are around 20 years old, often contact their closest relatives on a regular basis. They often send SMS or chat on over-the-top applications such as Viber or Zalo or interact with their friends on social networking sites such as Facebook or Zing Me.

Generally, the main family type for these workers has changed from an extended one to a nuclear one. It has reduced the importance of kinship-based ties that used to be a pillar for family members. Participants in this book often share that while they still may enjoy events together with their kinship, they cannot rely on their relatives as much as in the past. However, the research has found that while working together, migrant workers who have a kinship-based relationship become closer. For example, Bac did not have a close relationship previously with his extended family relatives because of a generational gap. However, after working together with them, he has tightened the relationships and now might ask their support if necessary.

Regarding social support, these workers' families and their other relatives help to alleviate their health problems. When workers get minor health problems such as a cold, their family or relatives find it difficult to emotionally and instrumentally support them because of the distance barrier. In these cases,

their families mainly share with them via mobile phones. However, when workers incur serious injuries and are forced to return to their hometowns, their families will take care of them. In another case, when workers have to be hospitalized for a long time in Hanoi, their families might go to Hanoi to take care of them there. Vinh shares:

> One day after I fell, they called my family to visit and take care of me. ...My mother stayed at the hospital with me, took care of me there while my relatives (who are also his employer) often brought food for me. My mother was not familiar with Hanoi so she just stayed there to support me.

If workers have relatives living in Hanoi, their relatives might support them. When Vinh got injured and was hospitalized for twelve days, his relatives (family members of his uncle, who is also his employer) sometimes came to support his mother. Ha has a relative in Hanoi so I asked him whether he would ask for the support of his relative if he had a serious health problem and had to be hospitalized in Hanoi. Ha shares, "At that time, I might ask my uncle to stay at his house. Staying at hospital is expensive and inconvenient, three or four people share a bed. Coming back to (my) hometown is also inconvenient (for follow up examinations in Hanoi or in case of sudden problems)".

Regarding informational support, workers share that their families worry about their health but are usually unable to help them. Firstly, their family members are not knowledgeable about medical issues. Secondly, they live in the hometown so they do not know much about qualified health providers in Hanoi. Among participants of this research, only the mother of Ha had bought some traditional medicine at a nearby traditional drugstore for him to help alleviate his health problem. Ha shares, "My mother bought some traditional medicine (*thuốc Nam*) at a nearby (traditional) drugstore. (She) heard that the drugstore was good so she bought (the medicine)".

The most important support of these kinship-based ties is financial. As I mentioned before, their employers only financially support workers when they have accidents on the job. It means that they have to pay for all other health expenditures by themselves. Among participants, only Thien was financially supported by his employer when he required a health examination for his kidney stone at E hospital (a state-owned hospital in Hanoi). However, his

employer is also his uncle so, in this case, it can be considered support from a kinship-based tie.

Apart from Thien, other workers have to pay health expenditures by themselves. Sometimes, workers do not have money and they have to rely on their families. Hung shared that when he visited a hospital for a health examination, he was penniless so he had to borrow money from his older brother. His parents were poor so he had to rely on his sibling who was also not economically well off. Meanwhile, other workers such as Ha, Ninh or Thu have to rely on their nuclear family. These three abovementioned workers are the breadwinners of their families so relying on family means relying on themselves. They have to raise their children so they are reluctant to pay much money for health examinations. It is a reason why these workers only visit a health provider when their health problems became serious and do not take follow up examinations.

Nevertheless, when getting a serious disease, workers receive some financial support from their relatives but the amount of money can be insignificant and should be considered as a gift. On the other hand, when they do get sick and have to come back to their hometown, their relatives will often visit them like in the case of Yen, Bac or Thu. Thu shared that, generally, when he had a serious health problem, he had to rely on himself or his direct family and could not expect much financial support from his other relatives or colleagues. The reason is that now people are independent and their relatives or colleagues are also not economically stable. Thu shares, "(My) relatives are also poor. They came (to my house) to inquire about my health and gave me an insignificant amount of money."

Work-related Ties

I will introduce the work-related ties the workers had before joining the construction industry. Generally, the size of an informal construction enterprise is small. Members of this enterprise are normally relatives or fellow villagers of the employer. As I mentioned in the third chapter, most of these workers also work for their relatives or fellow villagers. It means that workers already had a relationship with their colleagues before working together. For example, at the small-scale site, all workers came from neighbouring villages and some of them were relatives. Most of them knew each other quite well before working

together. Ninh is a brother-in-law of his employer and has worked with the informal enterprise since its beginning. Chu is a distant relative of the employer but they are of the same generation and live in neighbouring villages so their relationship is fairly close. Meanwhile, Bac is also a distant relative of the employer but he is from a different generation than his colleagues. Bac, therefore, did not have a close relationship with many of his older colleagues.

At the large-scale site, the situation is fairly similar. In the same informal enterprise, most of the workers came from the same province and knew each other before working together. For instance, Phuc is a relative of his employer, while Duong is a friend, a fellow villager of his employer. However, it should be mentioned that workers from different informal enterprises did not know each other before joining the industry. For example, painters like Thong or Phuc do not know bricklayers working for Vinco. However, after years of cooperating within a formal enterprise, some workers such as Thong and Vinh have become close friends.

To understand the way migrant workers broaden their relations, the nature of their work should be examined. Every job has its own characteristics and unique location so the strategy for relationship broadening is different. For instance, studying migrant female petty traders, Mori shares that these workers rely on their village-based ties to trade in Hanoi (2008). In particular, before going to Hanoi, newcomers asked for social and market related information from their fellow villagers who had already worked in Hanoi. These queries sought information such as the names of homeowners with guesthouses or for knowledge about the relevant wholesale markets. When working in Hanoi, petty traders, who are usually unable to pay for a fixed trading space, cooperate with those who come from the same village and sell goods together at the same place. They normally congregate in crowded areas such as around a school or a hospital. By doing so, they "legitimize their presence on the streets through trading with their neighbours in Hanoi" and "gain acceptance from them (neighbouring urban people)" (Mori, 2008, p.154).

In comparison with the work of migrant petty traders, the work of construction workers is less mobile. Their work is often situated within one construction site for months at a time. Construction workers, therefore, mainly broaden their social relations at their sites, not on the streets like migrant petty traders. The working place of construction workers is quite closed. At the

small-scale site, the neighbours of the homeowner may come to see the house but, at the large-scale site, outsiders are not allowed to enter the premises without the guarantee of workers and the permission of their supervisors. Workers, therefore, mainly broaden relations with work-related ties, as they do not have many opportunities to meet new friends from other areas. They may make friends with some local people such as the owners of guesthouses, teashops or food shops but these relationships are quite loose.

As construction workers mainly work at sites, those at the large-scale site have more opportunities to broaden their social relations than those at the small-scale site. The reason is that the large-scale site has more supervisors and workers who come from various enterprises. Moreover, at different large-scale sites, workers may have opportunities to cooperate with new colleagues. At the large-scale site, most of the workers I interviewed shared that they have worked in many, if not most, of the provinces in the north of Vietnam. The more they travelled, the more opportunities they had to broaden their social relations. Meanwhile, workers at the small-scale site had limited chances for expanding social relationships. Generally, the workforce of the informal enterprise is fairly stable and only changes a little bit over time. Thus, workers have mainly cooperated with almost all the same colleagues for years.

Most particularly, before migrating to Hanoi, workers at the large-scale site did not know those of different enterprises but, because of working and living together, they have become friends. Workers of Brand enterprise, coming from three different informal enterprises, live in the same house. When staying at home, they often talk or joke together. Some workers, normally the younger ones, often go out to play e-games or billiards together. On special cases, such as national holidays, someone wins the lottery or brings a speciality food from his hometown; they often cook and have dinner together. On national holidays, the employers will pay the fee but, in other cases, it comes from the contributions of the individuals. Generally, workers are very open and friendly with each other so they gradually become closer.

Vinh is an exemplar. He comes from Vinh Phuc Province but, at this site, he works for Mr. Hoang who is from Hai Duong province. Before joining the industry, he did not know any workers of Thong's or Hoang's informal enterprises. However, now, he is very close to them. I observed that he was

close to all those in the groups of Thong and Hoang. They slept in the same room and often had lunch and dinner together. Vinh says:

> I have known them for years since I worked for my uncle. When there is any project, Brand often calls these groups (he means the informal enterprises of Thong, Hoang or Binh). So we often meet each other, (become) closer. Now, when Thong or Hoang have some special events, they often invite me to join...At work, we also help each other. At this site, I work for Mr. Hoang. Or sometimes, if Thong knows about some work, he introduces me and vice versa.

At the construction site, workers also often make friends with colleagues and supervisors from other enterprises. At break time, they often gather at the smoking place to smoke, drink water and chat. As there is almost no entertainment activity at the construction site, chatting is a way to make friends and to entertain oneself. Additionally, chatting also helps workers broaden their relations that will be beneficial in terms of future job-finding strategies. At the end of the project, Duong, one ceiling worker of Brand, even worked for the window-glass enterprise as his enterprise had nearly completed its work and he was no longer needed. Thong, an employer, shares:

> In the past, I hired some workers from different places (provinces)....I knew them when working together. At this site, there is only one painting group but at bigger sites, there are several groups. Or sometimes, I also asked my friends (colleagues) to introduce workers for me.

Ha who comes from a different province than his employer may be another example. He shares, "At the beginning, I worked for another employer. Once I worked together with the group of Mr. Huong so I knew them. We were compatible so I changed to work for him".

Moreover, some of the younger supervisors and workers from all the different enterprises, including the main contractor, subcontractors and informal enterprises, often play football together once a week. They set up a fund, rent a football field near the construction site for several hours and play football together on Saturday afternoons after their work. After matches, they

might go to a teashop or a small restaurant, depending on the funds. Phu, one supervisor of Brand, says that this activity entertains participants and tightens their relationships. Thanks to these football matches, Phu knows more people from the other enterprises. Agreeing with Phu, Thong, the employer of a painting enterprise, admits that in addition to the love of football, he joins this activity because he wants to broaden his relations. As an employer, he always has to seek work and a good relationship with supervisors and other employers will help him get more work.

Regarding the maintenance of these relationships, after completing a construction job, workers often return to their hometowns and do not stay in contact with their new colleagues or supervisors whom they had recently met at the site. This result is similar to that found by Thuy (2005). Thuy shares that at large-scale sites, construction workers often make friends with colleagues of other informal enterprises (2005). However, they do not keep in touch with these friends as their work is highly mobile and they do not have chances to meet these friends again. Besides this, Thuy states that after marriage, some workers devote themselves to their family and no longer make real friendships (2005).

However, the research has found that if workers have a chance to work together again, they might develop their bond further and become close friends. Although coming from different informal enterprises and from different provinces, workers who have cooperated with Brand for years have a close relationship. Each year, many of them work and live together for several months. After several years, this relationship is strengthened and has made the workers become closer. Several workers like Thong or Vinh consider each other as brothers and are willing to help each other whenever necessary. Sometimes, they invite each other to visit their families on special events such as wedding parties or funeral ceremonies.

When making friends with supervisors or the managers of formal enterprises, workers usually meet them at the construction sites. A few workers interact with them on Facebook. Generally, as I mentioned in the third chapter, the relationship between workers and supervisors and managers of formal enterprises is fairly loose as there is a gap between them. Employers of informal enterprises often maintain closer relationships with supervisors and managers than the workers do. These employers cultivate these relationships because

they need the work these managers and supervisors can provide. Thong, the employer of the informal painting enterprise, sometimes visits the office of Brand and joins in with activities sponsored by the formal enterprise but his workers almost never have such opportunities to participate in these activities.

At the small-scale site, workers do not have many chances to broaden their relationships. However, because of the small scale, their relationships are often closer. I observed that while working, as I mentioned earlier, workers often chat with each other since the working area is small. The discussion may happen between two or more of the workers. After work, workers have two choices. Some workers go back to the house of the homeowner, watch TV and chat. Some workers will stay at their house, chat, play games, surf the web, play cards or do massage on each other. At this site, I observed that the workers were very close. There was hardly any gap between the workers, even among the younger and older ones. They talked to each other quite openly. At the time I visited the site, it was near the Lunar New Year (*Tet* in Vietnamese) holiday so workers often talked about this topic. They shared that they would celebrate *Tet* together[23]. These activities further tighten the relationships between the workers. Bac who previously did not have a close relationship with his other colleagues shares, "In the past, I only knew these uncles a little bit. However, after working together, it has become closer. Now, when there is any special event, I am also invited."

Apart from this, workers also make friends with other people. At the small-scale site, there were three electricians who were hired by the homeowner. Construction workers sometimes talked with them but they did not develop the same kind of close relationships as they did with others since they performed very different work. Since the workers lived with the homeowner and the homeowner is a relative of the employer, their relationship was quite close. As I mentioned in the third chapter, in the morning, workers often ask the homeowner to buy food for them. At night, some workers go to his house to drink tea, watch TV and chat. Moreover, the homeowner sometimes celebrates parties or gives the workers some food. However, experienced workers share that normally, homeowners are not very close with the workers, especially in cities. In the past, when working in the centre of Hanoi, workers had to set up

23 In the rural areas of Vietnam, before the Tet holiday, people who are neighbours or relatives, often pool their money together to buy a pig and cook various dishes.

a tent near the site and did not live with the homeowners at all. The homeowners visited the site, mainly to supervise the quality and the rate of progress. In other words, their relationship was mainly work-related.

Similarly, workers at the small-scale site sometimes made friends with the neighbours of the construction site but their relationship was not close. At this site, they lived with the homeowner and often asked for his support so rarely did they network with his neighbours. They sometimes talked with the neighbours who often visited the house but they did not develop this relationship. When working in the centre of Hanoi, they lived at construction sites and often lacked clean water, electricity and/or some equipment. Workers, therefore, sometimes had to network with their neighbours. However, in general, the relationship with neighbours was unpleasant. Duong et al. shared that in some communities, the perception of migrant workers is negative (2011). Thuy also reveals that some construction workers do not make friends with local people because of their perceived lower social positions (2005). Meanwhile, some workers interviewed in this research shared that when working in Hanoi, local people were not sociable with them. They often looked unclean and since the mass media often presented bad stories about construction workers, local people were often afraid of them.

Regarding social support, according to Berkman et al., social networks might influence people's health via various pathways including peer pressure (2000). The research has found that peer pressure has both positive and negative impact on workers' health.

In particular, I observed that in some parties, at both sites, workers often pressured their colleagues to drink more. Although workers at the small-scale site would have to work in the afternoon, they still drank a lot of wine at noon. Workers shared that it was at a party hosted by the homeowner and they felt they could not refuse. Meanwhile, at the large-scale site, the workers employed by Brand did not drink alcohol at noon. Even when eating dinner after work, they might drink some wine but they stopped before getting drunk. Workers shared that since they would have to work later in the same day or early the next morning, they did not want to drink heavily at any time. Firstly, they had to protect themselves. Secondly, there was a regulation prohibiting them from working after drinking alcohol. If the supervisors of the main contractor discovered them smelling like alcohol, they would be fined. It can be said that

the regulations at the large-scale site created pressure that prevented the workers from getting drunk.

However, at the large-scale site, workers often smoke a lot. At break time, many workers gather and smoke. It may be said that since smoking is not prohibited and many workers do smoke, it has become the norm. Workers, therefore, feel free to smoke. This peer pressure makes some workers, who do not smoke frequently, also smoke. Thien shares that he is not a heavy smoker but when he is invited, he accepts a cigarette. Meanwhile, at the small-scale site, some of the older workers who have tried to stop smoking often pressure the others to stop smoking, too. Chu has a health problem so he does not smoke and shares, "Now, when I see people smoke, I ask them to go far from me." Other workers still smoke but this peer pressure makes them smoke less as the working place is small and they cannot always go far away in order to smoke.

Besides this, the research has found that when workers have health problems, work-related ties often provide emotional, informational and instrumental support. The first and also the most popular support is an emotional one. Living far from their family, workers, especially those living together, are very close to each other. When a worker has a health problem, be it a simple fever or a more serious disease or injury, his colleagues often inquire about his health. When the three workers of Brand got a fever and had to stay at home, their colleagues went to their room and inquired after their health. In another case, when Vinh, who fell from the third floor, had to be hospitalized, many of his colleagues, even those who were not working with him at that time, visited him.

Besides this, work-related ties also provide information for the workers. When they get sick, whether it is something minor or more serious, workers often ask for advice from their colleagues, especially from those who have already had similar problems. When exhibiting minor symptoms, workers often asked their more senior colleagues what they would recommend to solve their problem. Thien, a young worker, shares:

> Initially, when I had (muscle) pain, I did not know how to solve it. Then my colleagues advise me to rub Salonpas... (When I had kidney stone), at the beginning, I also did not know what to do. I shared with my colleagues. They asked me about my symptoms and advised me to visit a hospital.

When they get more serious symptoms and diseases, workers often ask their colleagues about qualified health providers. After years of working in Hanoi, some of the workers know about some qualified health providers but they still ask their colleagues for advice since they believe that their friends know better which places are the most suitable. Hung shares:

> Initially, I intended to go to Bach Mai hospital. I worked in Hanoi for 10 years and I know it is famous. Medical University Hospital is quite new but Mr. Thu (one of his colleagues) told me that it was less crowded and doctors were excellent so I went there.

Similarly, Ha also visited a clinic near 103 Hospital (a state-owned hospital in Hanoi) at the suggestion of one of his colleagues who had previously gotten some treatment there. The advice came from someone he had worked with a long time ago. However, he still keeps in touch with his old friend via mobile phone:

> I called one of my old colleagues who worked with me a long time ago. I still remembered that he had gotten the same symptoms before and I called him. He came from the same village as me… In the past, it was difficult to keep in touch with other people….Now, all people have mobile phones and it is easier. I can call them whenever I want.

Workers prefer sharing with their colleagues as they are in the same socio-economic class and thus they feel free to discuss. Hung shares, "We are all casual workers and are in the same situation so it is easy to talk with others. We are not well-educated, knowledgeable like you, but we are open, very open (with each other)".

Additionally, workers also get instrumental support from their colleagues. Instrumental support in this context refers to "help, aid or assistance with tangible needs such as getting groceries, getting to appointments, phoning, cooking, cleaning or paying bills" (Berkman, et al., 2000, p.848). In this book, instrumental support is assistance in daily activities and transportation.

During or after an accident, the colleagues are the first people to respond and take the patient to the nearest hospital. Vinh shares that right after he fell

from the third floor, his colleagues took him to Viet Duc Hospital (a state-owned hospital in Hanoi) that was near his working site. After that, his colleagues also took him to 198 Hospital (a state-owned hospital in Hanoi) that was near the house of his employer. Meanwhile, Thien shares that once one of his colleagues took him to the hospital for a health examination since he did not have any transport.

Additionally, when having a fever or suffering from an accident, patients find it difficult to take care of themselves so they need the support of their colleagues. Generally, work-related ties often help patients to buy food/ medicines or access some first aid treatment. In particular, I observed that when two painting workers had fevers, their colleagues bought them food and medicines. Duong, a ceiling worker, also shares:

> At that time (when I get fever), I needed the support of my brothers (colleagues). It is good that we have worked for years, (so we are) close as a family.... Food expense is paid by Mr. Binh (the employer). If Mr. Binh buys medicine, the medicine expense will be paid by him. If other brothers buy medicine, I will pay. It is just a little.

Besides this, colleagues also support workers in everyday activities such as washing clothes. Apart from that, Chu shares that when he had a minor injury, his colleagues did some first aid treatment on him. He states, "(When I fell), my brothers bought some ice to cover (my injury). Perhaps they also bought some painkiller". Chu also shares that at that time, his colleagues helped him do everyday activities such as cooking or washing clothes.

Moreover, when they had more serious injuries, their employers also financially support workers. Vinh shares that when he fell from the third floor, he was totally supported by his employer including food, transportation and health expenditures. Apart from that, his employer also gave him around one million VND since he did not get any wages during his time in the hospital. It should be mentioned that his employer is also his uncle so the support that he received might be better than the norm. Nevertheless, Thong, an employer, states that, in the construction industry, it is an unwritten law for employers to support their workers who have accidents no matter whether these patients are relatives or not or whether they come from the same hometown. He shares:

> If my workers get accidents, I will support them as much as possible. Certainly if they are my relatives, I will support them more. However, if they come from different places (provinces), I will still support them. They work for me (so) I have to be responsible.

When being asked "In what cases do employers not support workers and what will you do in this case", workers share that, generally, if employers want to maintain their reputation in the construction industry, they will have to pay. However, in several cases, employers might run away or pay only part of the expenditure. Firstly, it is likely because the employer is in debt, usually because he has not been paid by a formal enterprise himself or due to having lost money gambling. Secondly, it is generally the new employers, those who have not had a chance to accumulate enough capital to pay for their workers no matter what. Thirdly, employers may pay only part of the health expenditures when many of their workers get accidents at the same time. When not being paid by their employers, workers have to rely on themselves and then spread bad gossip against their bosses.

When suffering from serious health problems, their colleagues or their bosses at formal enterprises might give them some money. However, this money is usually an insignificant amount. For example, Vinh was given some money from Brand, the formal enterprise that had hired his informal one, and from his colleagues. Vinh received around one million VND from Brand but it was an exception. When he had his accident, Vinh was working at the office of Brand and had a close relationship with his employer. Brand, therefore, gave him more money than usual.

Civil Society Organizations

Apart from the inter-personal relationships, civil society organizations are also a useful risk coping strategy. The research has found that, albeit the popularity of civil society organizations in Vietnam, the participation in these organizations by migrant construction workers has been limited. They have, therefore, not been supported by the civil society organizations.

By way of introduction, the concept of civil society organizations should be discussed as well as their situation in Vietnam. Civil society is a social sphere,

including various organizations that are voluntary, non-profit and separated from the State, the market and family (World Health Organization, n.d.). However, Norlund argues that the concept of civil society in Vietnam is fairly different (2007a). As a one-party country, the authority attempts to partly control civil society or, in other words, they are not totally separated from the State. According to Norlund, Vietnamese civil society includes four primary types of organizations, namely mass organizations, professional associations, Vietnamese non-government organizations and community-based organizations (2007a). Although there are at least 550 international non-governmental organizations in Vietnam that play an important role in society, they are excluded in the study of Norlund as "they are regarded as funding organizations rather than implementing organizations" (Norlund, 2007a, p.77). However, as these international non-governmental organizations have a strong impact in Vietnam, they will still be grouped with the other civil society organizations in this book.

In this paragraph, I will introduce more detail about the four abovementioned groups categorized by Norlund (2007a). The first group includes mass organizations such as Women's Union, Farmers' Association, Youth Organization or Workers' Union. These are state-sponsored and controlled by Fatherland Front and are the largest such organizations with 12, eight and five million members respectively. Mass organizations are a special characteristic of Vietnamese civil society. Mass organizations, that have been set up since 1931, along with the establishment of the Vietnamese Communist Party, are state-sponsored. In general, civil society is a counterbalance to the authority while mass organizations are a mediator between citizens and the government to achieve goals set by the State (Norlund, 2007b). The second group is professional associations and umbrella organizations such as the Red Cross, the Vietnam Union of Science and Technology (VUSTA) or the Vietnam Union of Arts and Literature (VUAL), controlled by Fatherland Front as well. There are 320 national professional associations and about 2,000 local ones. In regards to their membership, the Red Cross has five million members while VUSTA has around one million. In relation to Vietnamese non-governmental organizations, in 2000, there were 320 organizations working for various purposes such as charity, research, consultancy, education or health. The last group includes community-based organizations consisting of faith-based

organizations, neighbourhood groups, family clans or service-, development-, livelihood-, credit and saving groups.

The research focuses on community-based organizations and non-government organizations. In the countryside, community-based organizations are popular. Each village had at least one community-based organization providing assistance in cases such as sickness or financial need. Regarding health care, saving groups, which are a component of community-based organizations, are considered helpful in providing finance when necessary (Priwitzer, 2012). Meanwhile, non-government organizations are more ubiquitous in cities and in recent years, "have established several important insurance and saving schemes" (Priwitzer, 2012, p.155).

In Vietnam, civil society organizations work in different fields with at least six missions (Hannah, 2003). However, for the purpose of this study, I will focus on analysing how they support migrant workers to cope with health issues. Regarding the structure, according to the World Values Survey 1999-2002, 74% of Vietnamese participants (1,000 interviewees) are members of at least one organization. 14.8% of interviewees participate in health groups, meanwhile these figures in China and Singapore are only 2.7% and 3.6% respectively (Norlund, 2007a). The survey neglects to mention the impact of these health groups on their participants.

Based on the framework of Hannah, H.T. Anh argues that, in Vietnam, civil society organizations play four key roles in promoting health equity, namely implementing state policies, policy advocacy, lobby and supervision (2003; 2011). Among the four above-mentioned roles of civil society organizations, the first mission, state policies implementation, is the one directly involving citizens. Most importantly, the author reveals that civil society organizations often do supplement work for the government or do what the State neglects. Their most common work is to provide health education in order to change the behaviour of specific target groups. Besides this, civil society organizations also provide counselling and psychological support, information about health services, health services, health insurance or free medical fees and meals for various vulnerable groups, including migrant workers.

Based on the above information, it can be said that, at least in theory, civil society organizations provide various forms of social support that vary from informational to instrumental aid to vulnerable groups, including migrant

workers. This social support might help migrant workers tackle poor working and living conditions in the informal sector as well as access better services in the city. However, H.T. Anh mainly lists activities of civil society organizations (2011). The author neglects to analyse the kinds and amount of social support, especially for migrant workers. This research, therefore, attempts to find out what kind of social support migrant workers actually receive from civil society organizations and what do they expect from these organizations. The results will provide information for civil society organizations and enable them to improve their activities.

It is essential to mention faith-based organizations. According to Norlund, in Vietnam, there are six main religious organizations including Buddhists (7-9 million followers), Catholics (6-8 million) and Protestants (0.6 million), Hoa Hao (1.5 million), Cao Dai (1.1 million) and Muslims (0.09 million) (2007a). Research on the health related activities of these religious organizations is limited. Regarding Buddhists, Minh reveals that pagodas often provide spiritual care and protection for people, both Buddhists and non-Buddhists (2014). People have to pay for these services in the form of charity and Minh argues that it is a commodification process that polarizes the society (2014). In terms of Catholics and Protestants, he goes on to reveal that they often provide basic health services for all people (Minh, 2014). Most of the services are free, except food and medicine costs.

Theoretically, Vietnamese citizens, including migrant workers, are members of many civil society organizations. These organizations are able to help them solve most of the health issues mentioned above. However, the research has found that all interviewed workers have a limited relationship with civil society organizations. They do not have relationships with any non-governmental organizations and some people do not even know this term. Also, they rarely join community-based or faith-based organizations. Their high mobility and the lack of non-governmental organizations for migrant construction workers are the key factors leading to this situation.

Furthermore, the role of non-governmental organizations in workers' lives is insignificant. Ha shares, "I have only heard (the term). Once they supported some poor families in my village to build water tanks." During the time of my data collection, I contacted the Centre for Consultation of Investment in Health Promotion. Their director had studied the role of non-governmental

organizations in Vietnam in promoting health equity, the findings that I reviewed above. I was informed that, at that time, there were no non-governmental organizations in Vietnam dealing with migrant construction workers' health. It can be said that, albeit the popularity and diversity of non-governmental organizations in Vietnam, there is still a lack of such organizations supporting construction workers.

Additionally, workers rarely join community-based organizations. The sole community-based organization some workers used to join is a rotating savings organisation (*chơi họ*). Workers joined it with a few friends for only a short time to buy something singular so its role was insignificant and not ongoing. Now, they have stopped participating since their work is highly mobile and it is inconvenient for them to contribute. Moreover, workers I interviewed are not members of any faith-based organizations. They sometimes visit temples to pray for health and success when travelling with families or friends but they are not Buddhists or part of any faith-based organizations.

Concluding Remarks

In conclusion, this chapter attempts to explore what social relations construction workers have, how they broaden and maintain their social relations as well as the social support found within their social relations.

The research has found that construction workers mainly have interpersonal relations among which their family and work-related ties are the most important. They lack relationships with organizations such as non-governmental or community-based ones. Workers at the large-scale site have more opportunities to broaden their relations than those on the small-scale one because, at the large scale site, there are more workers coming from different enterprises.

However, regarding relationship maintenance, workers rarely keep in touch with the new friends they meet at these sites. They only maintain relationships with colleagues with whom they have worked together for many years. Moreover, when at sites, workers rarely keep in touch with their relatives in their hometowns. One's nuclear family is the network workers often contact the most. They often contact their families via mobile phone or sometimes, by sending remittances or visiting home.

The research has also found that the social relations of workers are normally often of the same class. They might make friends and keep in touch with their colleagues. However, they find it difficult to broaden social relations with people of a higher socio-economic class such as their managers or supervisors. As I analysed in the third chapter, in the hierarchy of construction sites, there is a big gap between workers and better educated people such as managers and supervisors.

Regarding social support, at sites, workers often seek the help of their work-related ties. Their colleagues often provide emotional, instrumental and informational support for them. However, their colleagues are also from the same economic class so they find it difficult to provide financial support. Their employers only financially support them if/when they get injured. When getting serious symptoms or diseases, workers have to ask for the financial support of their family or relatives. However, for some workers, this support is limited as their family is also poor and they often are the sole breadwinners for their families.

In general, the social relations of construction workers are limited, both in quantity and quality. Their social support is, therefore, also fairly limited, especially in terms of finance.

Chapter 6

Conclusion

In the last five chapters, this thesis has introduced the background of the study, the Vietnamese health care and welfare systems as well as analysing workers' health problems, illness treatment and the social support of their social relations. This chapter aims to sum up its main findings, put them into a theoretical discussion as well as suggest several implications for policy makers, civil society organizations and for further research.

Major Findings of the Study

The research aims to explore three primary points, namely the living and working conditions of migrant construction workers: their health problems and illness treatment and finally, their social relations.

Poverty and Living Conditions Affect Workers' Health

Many rural people have to migrate to Hanoi to become construction workers mainly because of financial reasons and low barriers of entry to construction work. Without a degree, these workers are forced 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 skilful enough, they might be promoted and allowed to do more difficult work.

At that time, if workers do not want to work for their current/former employer, they might establish their own informal enterprise or work for other employers who may provide them with a higher income.

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

Moreover, the research has found that whether working at the large-scale or small-scale sites, informal enterprises, are often operated on a small scale consisting of less than 10 employees. The work of informal enterprises is not stable. Some employers occasionally have to work for other employers. Informal enterprises are, therefore, unable to provide enough working equipment.

Regarding benefits for employees, 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 employees. 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 improved. Nowadays, workers can easily access various services from food to entertainment. These developments make their life more comfortable. However, when working in remote areas, the life 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 focus of this book is the health of workers. 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, it still only reduces the dangers inherent in construction work. Workers still have to use a lot of strength and have to 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, 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. They were injured due to poor working equipment or the lack of protective equipment. Additionally, the lack of safety regulations and supervisors also led to these accidents. However, as I mentioned before, not all large-scale sites are well managed and, in this case, the consequences of an accident might be more serious. In general, it can be concluded that the poor level of management on a job site is directly proportional to the accident rate.

The Privatization of the Health Care System Limits Workers' Accessibility to Health Services

Although construction workers are more likely to have health problems, they have limited access to health care services. Because they are not provided regular health examinations, informal workers often do not know their health problems in advance. When they do experience a health problem, workers will often neglect them until the symptoms become serious. Then, they might go to a nearby drugstore to consult with the pharmacist or, as is usually the case, they might ask their colleagues for advice, especially the more experienced ones who have had similar ailments. Workers think that their colleagues who have had similar health problems, work in the same conditions and are in the same financial situation tend to be able to provide the most suitable advice. Going to a clinic or a hospital is usually the last choice for workers and they only do this when their health problems become so severe that they are unable to work.

Lack of money is the main barrier preventing workers from visiting a health provider. They have to pay for nearly all the health expenditures and transportation fees by themselves. In the context of an increasingly market-driven health care system such as we see in Vietnam today, this expense is a burden for them. In addition to these expenses, workers also lose their daily wages since they do not get wages on their days off. Visiting a health provider is, therefore, a double burden that takes their money and prevents them from making more. Moreover, workers are also not covered by social and health insurance programs since their employers do not provide these fringe benefits for them and the voluntary social and health insurance programs that are available to them have many limitations that are unsuitable for the workers. As I mentioned before, informal enterprises are operated on a small scale and are unstable so they cannot provide fringe benefits.

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, drug prices are cheaper and more affordable for construction workers than the health costs at a clinic/hospital. Finally, many people also believe that drugs are more efficient than treatment at a clinic/hospital. This belief has been shaped from poor treatment experiences in the past, primarily before *Doi Moi* 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 in Chapter 2, the health care system has been privatized in regards to financing, provision and investment, leading to various changes. Before *Doi Moi* policy, the government totally subsidized hospitals so they might provide free services for all patients. However, after *Doi Moi* 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 ones. This is a burden for low-income earners, like migrant construction workers, whose income is unstable. In other words, privatization has limited their chances to access health services. To cope with their health problems, workers have to buy drugs 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 unqualified pharmacists operate many drugstores is one exemplar. The over-use of drugs without prescription by qualified doctors might be, therefore, harmful to the workers' health, especially in the long term. Moreover, drugs 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 of them. Apart from that, the high contribution rate is also a barrier for the participation of these workers.

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

Social Relations as a Safety Net of Workers

Being excluded from formal social protection, workers have to rely on their own social relationships and networks. The research has found that social relations of construction 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 these 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 organizations or community-based ones. It can be said that workers mainly have inter-personal relationships and lack connections with organizations.

The research has found that when they have minor 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 each other when they are ill. In other words, their work-related ties provide them with emotional, instrumental and informational support. 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 usually limited to their health expenditures and does not include their wages. When they have serious health problems that require a visit to a clinic or hospital, workers have to rely on their families. However, many 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.

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.

Theoretical Discussions of the Findings

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.

Previous studies have shown that people's health is affected by their social relations (Cattell, 2001; DiMaggio and Garip, 2012; Smith and Christakis, 2008). In their review of this literature, DiMaggio and Garip argue that socioeconomic

status has a positive correlation with most behaviours, resources and practices that are beneficial for people's life chances (2012). More particular, DiMaggio and Garip quote a finding of Freese and Lutfey 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" (2012, p.7; 2011). Studying two working-class communities in England, Cattell also argues that albeit several positive effects, social relations cannot tackle all impacts of poverty on health (2001). 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.

Within this book, I have found a similar result. Although social relations of migrant construction workers are beneficial in some situations, they cannot solve all of 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 their supervisor, 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 and that is to get more work. In parties organized by Brand, only the employers of informal enterprises are invited. As I mentioned in Chapter Three, there is a hierarchy at sites and workers are at the bottom, lower than the supervisors and managers. 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, any support provided is mainly voluntary or a 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 Vinh, 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 likely not be as good as Vinh's. In this research, workers also shared that such compensation is an unwritten law. If the employer runs away from his informal obligation, workers often have no evidence to support a claim for compensation. However, the threat of the worker spreading negative information about such employers is usually sufficient because the employer's reputation is important for future work. Generally, since the support of social relations is voluntary, workers are more vulnerable, especially when they are injured.

Additionally, since the social relations of workers are limited and they themselves are often of the same class, their support is also limited. Therefore 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 or qualified sources. Workers lack chances to communicate with qualified doctors. It is a management problem of the main contractor. Linh, 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 either of the 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 family. Nowadays, workers find it more difficult to rely on their kinship-based ties that are also likely to be poor, as was the experience of Thong. It should be emphasized that most of these workers are breadwinners for their family so relying on family means relying on themselves.

Implications

In conclusion, the research has found that construction workers are more likely to have health problems then workers in other sectors. 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 construction sites, both large and small-scale ones. 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 or health insurance by their employers and, in addition, 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 implemented 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 programmes have not covered migrant construction workers, as proven through this research, a particularly 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 health care services that are market-driven. Social policies or health insurance provisions for migrant workers might help them reduce their health expenditures thereby improving health accessibility. Additionally, the research has found that construction workers prefer using drugs, normally without prescription from qualified doctors. This over-use of drugs, especially without the guidance of qualified doctors and pharmacists, might be harmful to workers in the long term. The drug market is not well organized so the government needs to tighten its management. Additionally, programmes informing the public about the drawbacks of drug overuse should be implemented.

Bibliography

Abdelhamid, T., and Everett, J. (2000). Identifying root causes of construction accidents. *Journal of construction engineering and management, 126*(1), 52-60.

Albreht, T. (2009). Privatization processes in health care in Europe - a move in the right direction, a 'trendy' option, or a step back? *European Journal of Public Health, 19*(5), 448-451.

Anh, D. N., and C. Tacoli. (2003). *Migration in Vietnam: A review of information on current trends and pattern and their policy implications*. Paper presented at the Regional conference on migration, development and pro-poor policy choices in Asia, Bangladesh.

Anh, H. T. (2011). Promoting health equity in Vietnam: the role of civil society. In PAHE (Ed.), *Health equity in Vietnam: A civil society perspective* (pp. 90-106). Hanoi: Labour Publishing House.

Antonucci, T., K. Ajrouch and K. Birditt. (2013). The Convoy model: explaining social relations from a multidisciplinary perspective. *The Gerontologist, 54*(1), 82-92.

Bảo hiểm xã hội tỉnh Bình Dương. (n.d.-a). Bảo hiểm xã hội bắt buộc [Compulsory social insurance] Retrieved 14th July, 2015, from http://www.bhxhbinhduong.gov.vn/bh-xa-hoi-tu-nguyen

Bảo hiểm xã hội tỉnh Bình Dương. (n.d.-b). Bảo hiểm xã hội tự nguyện [Voluntary social insurance], from http://www.bhxhbinhduong.gov.vn/bh-xa-hoi-tu-nguyen

Bảo hiểm xã hội TP. Hồ Chí Minh. (n.d.). Đối tượng đóng, mức đóng, phương thức đóng [Participants, contribution rate, payment method] Retrieved 23rd September, 2015, from http://bhxhtphcm.gov.vn/bao-hiem-xa-hoi/bao-hiem-xa-hoi-tu-nguyen/29/doi-tuong--muc-dong--phuong-thuc-dong/

Barber, S., and L. Yao. (2010). Health insurance systems in China: A briefing note (Background paper no. 37). WHO.

Berkman, L., T. Glass, I. Brissette and T. Seeman. (2000). From social integration to health: Durkheim in the new millennium. *Social science and medicine* (51), 843-857.

Bộ Kế hoạch Đầu tư, and Tổng cục Thống kê. (2014). *Báo cáo điều tra lao động việc làm năm 2013 (Report of employment in 2013)*. Hà Nội: NXB Thống kê.

Bộ Y tế, and Nhóm đối tác y tế. (2009). Báo cáo chung tổng quan ngành y tế năm 2009: Nhân lực y tế ở Việt Nam [Report on the health system in 2009: Health workforce in Vietnam].

Cattell, V. (2001). Poor people, poor places, and poor health: the mediating role of social networks and social capital. *Social science and medicine, 52*, 1501-1516.

Chalker, J., N.T.K. Chuc, T. Falkenberg and G. Tomson. (2002). Private pharmacies in Hanoi, Vietnam: a randomized trial of 2 year multi-component intervention on knowledge and stated practice regarding ARI, STD and antibiotic/steroid request. *Tropical medicine and International Health, 7*(9), 803-810.

Chức, H. V., Đ. T. M. Tuyết, N. T. Kiểm, T. T. Lâm, T. B. Lan, H.T. Cường and V. T. Bính. (2003). Một số giải pháp nhằm tăng cường quản lý di dân tự do đến Hà Nội: Đề tài nghiên cứu khoa học cấp bộ [Some solutions to improve the management of migrants to Hanoi: Ministry-level project]. Hanoi: Bộ Nội vụ

Cling, J.-P., Nguyễn Thị Thu Huyền, Nguyễn Hữu Chí, Phan Thị Ngọc Trâm, Razafindrakoto, M., and Roubaud, F. (2010). *The informal sector in Vietnam: A focus on Hanoi and Ho Chi Minh City*. Hanoi: The Gioi Editions.

Cục thống kê Hà Nội. (2014). Niêm giám thống kê Hà Nội 2013 [Hanoi statistical yearbook 2013]. Hà Nội: Cục thống kê Hà Nội.

Cuong, L. D., T. Kubo, Y. Fujino, P. T. Minh and S. Matsuda. (2010). Health care system in Vietnam: current situation and challenges. *Asia Pacific journal of disease management, 4*(2), 23-30.

Dahlgren, G., and M. Whitehead. (2006). Levelling up (part 2): a discussion paper on European strategies for tackling social inequities in health Retrieved 27 November, 2014, from http://www.who.int/social_determinants/resources/leveling_up_part2.pdf

Đại học Quốc Gia Hà Nội. (2009). Bản đồ thành phố Hà Nội [The map of Hanoi] Retrieved 25th September, 2015, from https://www.vnu.edu.vn/home/?C2084/N7520/Ban-do-thanh-pho-Ha-Noi,-duong-pho-khu-trung-tam,-cac-tuyen-xe-buyt-va-ban-do-du-lich.htm

Dalton, R., P. M. Hac, P. T. Nghi and N.-N. T. Ong. (n.d.). Social relations and social capital in Vietnam: the 2001 World values survey Retrieved 3th October, 2015, from http://www.democracy.uci.edu/files/docs/vietnam/vietnam02.pdf

Dias, L. (2009). Inspecting occupational safety and health in the construction industry. Turin: ILO.

Diệu Hiền. (2013). Hội thảo về bệnh nghề nghiệp trong ngành hóa chất và xây dựng [Conference on occupational diseases in the chemical and construciton industries] Retrieved 14 November, 2014, from http://baolamdong.vn/xahoi/201312/hoi-thao-ve-benh-nghe-nghiep-trong-nganh-hoa-chat-va-xay-dung-2292956/

DiMaggio, P., and F. Garip. (2012). Network effects and social inequality. *Annual Review of Sociology* (38), 93-118.

Dragon Law firm. (n.d). Decree No. 62/2009/ND-CP dated July 27, 2009 of the Government detailing and guiding a number of articles of the law on health insurance Retrieved October 15th, 2014, from http://congtyluatdragon.com/en/decree/prsdi78/ildn316.htm

Dung, T. T. L. (2010). The subregional economic integration and the economic transition: the case study of the greate Mekong subregion (GMS) and the economic transition in Vietnam. Master of Arts, Thammasat University, Bangkok.

Duong, L. B., and N. T. Liem. (2011). *From countryside to cities: Socioeconomic impacts of migration in Vietnam*. Hanoi: Workers' Publishing House.

Duong, L. B., T. G. Linh and N. T. P. Thao. (2011). *Social protection for rural-urban migrants in Vietnam: current situation, challenges and opportunities*. Hanoi: Institute of Development studies, Centre for Social protection.

Grandjean, P. (1983). *Occupational health aspects of construction work*. Denmark: The World Health Organization.

Guo, W. (2012). A preliminary exploration on transformative social work model in China: a case study on social work with migrant construction workers. *China Journal of Social work, 5*(1), 51-66.

Hà, H. (2013). Bất an y tế tư nhân Retrieved October 5th, 2014, from http://thuonghieuvacongluan.com/xa-hoi/doi-song/15880-bat-an-y-te-tu-nhan.html

Hà, Đ. Q. (2014). Di dân tự do nông thôn - đô thị với trật tự xã hội ở Hà Nội [Rural-to-urban migrants with the social management in Hanoi]. Tiến sỹ (Doctor of Philosophy), Học viện Chính trị Quốc gia Hồ Chí Minh, Hà Nội.

Hannah, J. (2003). Local non-government organizations in Vietnam: Development, civil society and state-society relations. Doctor of Philoshophy, Washington University, Washington.

HiaConnect. (2012). General socio-economic, cultural and environmental conditions. Retrieved 1st March, from http://hiaconnect.edu.au/wp-content/uploads/2012/09/Dahlgren-and-Whitehead.jpg

Hoàng Diên. (2013). Tăng mức lương tối thiểu vùng từ 1/1/2014 [Increase provincial minimum salary from 1/1/2014]. *VGP News* Retrieved 14 October, 2014, from http://baodientu.chinhphu.vn/Chi-dao-quyet-dinh-cua-Chinh-phu-Thu-tuong-Chinh-phu/Tang-muc-luong-toi-thieu-vung-tu-112014/186182.vgp

Holte, K., and K. Kjestveit. (2012). Young workers in the construction industry and initial OSH-training when entering work life Retrieved November 15th, 2014

Holzmann, R., and S. Jorgensen. (2000). Social risk management: a new conceptual framework for social protection and beyond (working paper). The World Bank.

Hong, Y., X. Li, B. Stanton, D. Lin, X. Fang, M. Rong, and J. Wang. (2006). Too Costly To Be Ill: Health Care Access and Health Seeking Behaviors among Rural-to-urban Migrants in China. *World Health Population, 8*(2), 22-34.

Huy, N. V., M. Dunne, and J. Debattista. (2013). Modeling predictors of risky drug use behavior among male street laborers in urban Vietnam. *BMC Public Health*(13), 453-464.

Huy, N. V., M. Dunne, J. Debattista and D. T. M. An. (2010). Stress and coping among migrant labourers in urban Vietnam: an adaption cycle and health vulnerabilities. *International Journal of Migration, Health and Social care, 6*(2), 15-30.

Institute of Labour Science and Social Affairs, and Deutsche Gesellschaft Fur International Zusammenarbeit. (2011). *Viet Nam Social protection glossary*. Hanoi: ILSSA/GIZ.

International Labour Organization. (2008). An toàn vệ sinh lao động trong thi công xây dựng [Safety and sanitation in the construction industry]. Hà Nội: NXB Lao động xã hội.

International Labour Organization. (2010). List of occupational diseases (revised 2010). Identification and recognition of occupational diseases: Criteria for incorporating diseases in the ILO list of occupational diseases. Geneva: ILO.

Jayakrishnan, T., B. Thomas, B. Rao and B. George. (2013). Occupational health problems of construction workers in India. *International Journal of Medicine and Public Health, 3*(4), 225-229.

Kiệm, H. H. (2014). Viêm quanh khớp vai thể thông thường [Normal arm arthritic] Retrieved 9th April, 2015, from http://hahoangkiem.com/benh-xuong-khop/viem-quanh-khop-vai-the-thong-thuong-295.html

Ladinsky, J., and R. Levine. (1985). The organization of health services in Vietnam. *Journal of public health policy, 6*(2), 255-268.

Lao động. (2012). Công nhân xây dựng chủ yếu mắc bệnh phổi silic [Construction workers mainly have sillicios] Retrieved 4th October 2014, from http://laodong.com.vn/cong-doan/cong-nhan-xay-dung-chu-yeu-mac-benh-phoi-silic-90426.bld

Lao động. (2015). 50% người dân cho rằng xin việc trong cơ quan nhà nước cần có "lót tay" Retrieved 22nd April, 2015, from http://laodong.com.vn/xa-hoi/50-nguoi-dan-cho-rang-xin-viec-trong-co-quan-nha-nuoc-can-co-lot-tay-315889.bld

Laukkanen, T. (1999). Construction work and education: occupational health and safety reviewed *Construction management and economics*(17), 53-62.

Leung, M.-y., Y.-S. Chan and K.-W. Yuen. (2010). Impacts of stressors and stress on the injury incidents of construction workers in Hong Kong. *Journal of construction engineering and management, 136*(10), 1093-1103.

Li, R. Y. M. and S. W. Poon. (2013). *Construction safety*. Heidelberg: Springer.

Li, Y., and S. Wu. (2010). Social networks and health among rural-urban migrants in China: a channel or a constraint? *Health promotion international, 25*(3), 371-380.

Lieberman, S. and A. Wagstaff. (2009). *Health financing and delivery in Vietnam: Looking forward*. Washington: The World Bank.

Liem, N. T. and M. White. (2007). Health status of temporary migrant in urban areas in Vietnam. *Journal Compilation*(4), 101-136.

London, J. (2008). Reasserting the State in Vietnam health care and the logics of market-Leninism. *Policy and Society, 27*, 115-128.

Maarse, H. (2006). The privatization of health care in Europe: An eight-country analysis. *Journal of health politics, policy and law, 31*(5), 981-1014.

Minh, N. T. N. (2014). Migrant households and care institutions in the Red river delta of Vietnam: Moral authority and commodification of entitlements (Working paper). Max Planck Institute. Halle/Salle.

Ministry of Health, and The World Bank. (2011). Lessons for hospital autonomy implementation in Vietnam from international experience: Issues identified from international studies and a public hospital survey in Vietnam.

Ministry of Labour, I. a. S. A. (2013). Thông báo tình hình tai nạn lao động năm 2013 (2013 occupational accidents report).

Norlund, I. (2007a). Civil society in Vietnam: Social organizations and approaches to new concepts. *ASIEN*(105), 68-90.

Norlund, I. (2007b). Filling the gap: the emerging civil society in Vietnam. Hanoi: VIDS, UNDP, SNV.

Paulette, C., Tran Mai Oanh, Tran Ngo Thi Minh Tam, and Vu Hoang Dat. (2011). Health insurance in Vietnam towards universal coverage: The case of the workers of the informal sector (Policy research study). Hanoi: UNDP Vietnam.

Pearson, K. (2009). The causes and incidence of occupational accidents and ill-health across the globe Retrieved 20 November, 2014, from https://www.britsafe.org/sites/default/files/editor/The_Causes_and_Incidence_of_Occupational_Accidents_and_Ill-Health_Across_the_Globe.sflb.pdf

Phạm Thanh. (2013). Bệnh nghề nghiệp nhiều gấp 10 lần so với báo cáo [Occupational disease are 10 times higher than reports] Retrieved 14 November, 2014, from

http://dantri.com.vn/suc-khoe/benh-nghe-nghiep-nhieu-gap-10-lan-so-voi-bao-cao-724368.htm

Priwitzer, K. (2012). The Vietnamese health care system in change: A policy network analysis of a Southeast Asian welfare regime. Singapore: Institute of Southeast Asian Studies.

Qadeer, I. (2003). Ethics and medical care in a globalizing world: Some reflections. In K. Sen (Ed.), *Restructuring health services: Changing contexts and comparative perspectives*. New York: Zen Books.

Quyết định số 337/QĐ-BKH về việc ban hành Quy định nội dung Hệ thống ngành kinh tế của Việt Nam [Decision no. 337/QD-BKH about regulations of industrial classification system of Vietnam] (2007).

Riddle, D., N. H. Son, and C. Hernandez. (2006). Impacts of basic public services liberalization on the poor and marginalized people: the case of health, education and electricity in Vietnam Retrieved 27th September, 2014, from http://europeandcis.undp.org/uploads/public/File/2_Impact_on_Poor_Report_72.pdf

Schutt, R. (2011). Investigating the Social World: The Process and Practice of Research (7th Edition). Singapore: SAGE Publications.

Sen, K. (2003a). Introduction: Restructuring health services – Public subsidy of private provision. In K. Sen (Ed.), *Restructuring health services: Changing contexts and comparative perspectives*. New York: Zen Books.

Sen, K. (2003b). Restructuring health services and policies of privatization – An overview of experience. In K. Sen (Ed.), *Restructuring health services: Changing contexts and comparative perspectives*. New York: Zen Books.

Sexton, S. (2003). Trading healthcare away: the WTO's General Agreement on Trade in Services. In K. Sen (Ed.), *Restructuring health services: Changing contexts and comparative perspectives*. New York: Zen Books.

Smith, K., and N. Christakis. (2008). Social Networks and Health. *Annual Review of Sociology*(34), 405–429.

Spooner, D. and A. Hopley. (n.d.). Construction Workers Retrieved 20 November, 2014, from http://wiego.org/informal-economy/occupational-groups/construction-workers

Tam, W. (2010). Privatizing health care in China: Problems and reforms. *Journal of Contemporary Asia, 40*(1), 63-81.

The Research Centre for Female Labour and Gender, Institute of Labour Science and Social Affairs, Ministry of Labour, I. a. S. A., and Howell, F. (2003). *Equality, labour and social protection for women and men in the formal and informal economy in Vietnam*. Hanoi: Labour and Social Affairs Publishing House.

Thuy, B. T. T. (2005). Social life and sexual behaviour of construction workers in Hanoi. Master of Arts, Amsterdam, Amsterdam.

Tien, T. V., H. T. Phuong, I. Mathauer and N. T. K. Phuong. (2011). *A health financing review of Vietnam with a focus on social health insurance*. WHO. Hanoi.

Tổng cục thống kê. (n.d.). Tỷ suất nhập cư, xuất cư, tỷ suất di cư thuần [Migration, departure rate; raw migration rate] Retrieved 25th September, 2015, from https://gso.gov.vn/danhmuc/HTCT_tinh.aspx?ma_nhom=T021202

U.S. Social Security Administration. (2010). Social security programs throughout the world: Asia and the Pacific (Vietnam) Retrieved 23 October, 2014, from http://www.ssa.gov/policy/docs/progdesc/ssptw/2010-2011/asia/vietnam.html

Viện Gia đình và Giới. (2010). Sự thích ứng của người di cư tự do từ nông thôn vào các thành phố và các vùng phụ cận - nghiên cứu trường hợp Hà Nội (Đề tài cấp Bộ) [The adaption of migrants from the rural to urban - A case study in Hanoi (Ministry-level study)]. Hà Nội: Viện Hàn lâm Khoa học Xã hội Việt Nam.

Vietnamplus. (2015). Công bố nguyên nhân vụ sập giàn giáo tại công trường Formosa [Annoucing reasons leading to the scaffold collapse at Formosa construction site] Retrieved 12th April, 2015, from http://www.vietnamplus.vn/cong-bo-nguyen-nhan-vu-sap-gian-giao-tai-cong-truong-formosa/314407.vnp

Vy, L. V. (n.d.). Nhận thức của Đảng cộng sản Việt Nam về thành phần kinh tế từ đại hội đại biểu toàn quốc lần thứ III đến đại hội lần thứ IX [The consciousness of the Vietnamese Communist party on economic sectors from the National Congress III to IX] Retrieved 22nd December, 2014, from http://truongchinhtrina.gov.vn/ArticleDetail.aspx?_Article_ID=327

Wagstaff, A. and S. Bales. (2012). The impacts of public hospital autonomization: Evidence from a quasi-natural experiment: The World Bank.

Weeks, J. (2011). Health and Safety Hazards in the Construction Industry Retrieved 20 November, 2014, from http://www.ilo.org/oshenc/part-xvi/construction/health-prevention-and-management/item/518-health-and-safety-hazards-in-the-construction-industry

Wilkins, J. (2011). Construction workers' perceptions of health and safety programmes. *Construction management and economics*(29), 1017-1026.

Witter, S. (1996). Doi Moi and health: the effect of economic reforms on the health system in Vietnam. *International journal of health planning and management, 11*, 159-172.

Wolffers, I. (1995). The role of pharmaceuticals in the privatization process in Vietnam's health care system. *Social science of medicine, 41*(9), 1325-1332.

World Health Organization. (n.d.). Civil society Retrieved 11 November, 2013, from http://www.who.int/trade/glossary/story006/en/

World Health Organization, and Ministry of Health. (2012). Health service delivery profile: Vietnam Retrieved September 27th, 2014, from http://www.wpro.who.int/health_services/service_delivery_profile_vietnam.pdf

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Health Care Privatization and Migrant Construction Workers in Hanoi, Vietnam

Tranh Khan An

Since the introduction of the *Doi moi* policy, Vietnam has changed significantly. Vietnam has moved from poverty to its current status as a middle income country. From lacking food, Vietnam has become the top rice exporter of the world. In big cities, skyscrapers are mushrooming from where once only old, cramped buildings stood. However, behind the flashy picture, not all people have enjoyed the achievements of *Doi moi*. The gap between the rich and the poor has increased remarkably and the latter are sometimes left behind.

This book focuses on the hidden parts of Vietnam's health care system. Before Doi moi all Vietnamese citizens equally enjoyed health services. However, economic reform has gradually privatized the health care system. Citizens, even the poor, have to spend more and more out-of-pocket expenditures for health services that are often above their incomes.

Focusing on migrant construction workers, whose work is harsh and dangerous, this book reveals how the poor cope with health problems and their vulnerability as a group under a privatized health care system. This study provides vivid information on the life, work, health problems and treatment of construction workers. Social health policies, especially for migrant workers, are also analysed to provide a comprehensive picture of the work, the life and health problems of migrant workers in the construction trades.

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