

Strategies For Mobilizing Economic Resources to Cover Healthcare Costs for Poor Households in Vinh City, Nghe An Province

Phan Thi Thuy Ha¹ and Trinh Van Tung²

Abstract

Based on qualitative and quantitative data collected from the research project "Differences in Access to Healthcare Services among the Population during the Implementation of Universal Health Insurance Policies" (Case study in Vinh City, Nghe An Province), this paper explores strategies used by poor households to mobilize economic resources to cover their healthcare costs. It also highlights the difficulties these households face in mobilizing economic resources. What strategies have they chosen to meet their expectations, and what are the outcomes of these mobilization efforts? Despite significant efforts, poor households are still considered fragile beneficiaries in the context of implementing universal health insurance policies in Vietnam nowadays.

Keywords: Strategy, Economic Resources, Poor Households, Access, Payment, Healthcare Services.

INTRODUCTION

Healthcare systems play a crucial role in the lives, prosperity, and economic welfare of people worldwide (WHO, 2000). A well-functioning healthcare system ensures that everyone can easily access effective healthcare services at affordable costs to combat diseases (Kumar et al., 2015; Savedoff, 2004). Studies globally identify factors influencing access to healthcare services, including accessibility, affordability, acceptability, characteristics of healthcare facilities, and availability (McLaughlin & Wyszewianski, 2002). Accessibility factors encompass distance, time, and costs associated with accessing healthcare services. Affordability implies the patient's ability to pay fees for healthcare services. Acceptability relates to patient comfort and satisfaction with healthcare services. Characteristics of healthcare facilities describe organizational structures, medical examination procedures, working hours, and waiting times for healthcare services. Availability refers to healthcare providers' capacity in terms of healthcare personnel, physical resources, and technology to meet patients' healthcare needs.

Affordability is a critical issue significantly affecting people's access to healthcare services. Studies show that in high-income groups, payment mechanisms for healthcare services often involve upfront or deferred payments. In contrast, low-income groups (the poor) typically rely on out-of-pocket payments (Savedoff & WHO, 2004; Coelli et al., 2005; Leive & Xu, 2008; Gupta, 2009; Hopkins, 2010). Evidence suggests that out-of-pocket spending on healthcare services in low-income countries can range from 20% to 70% compared to 15% to 20% in high-income countries (Kruk et al., 2009; Joe, 2014). Out-of-pocket healthcare spending places a burden on poor households, forcing them into conditions of deprivation (Preker et al., 2002; Hjortsberg, 2003). The financial burden of healthcare costs and other economic consequences of illness disproportionately affect poor families compared to higher-income households. For example, in Vietnam, despite partial or full exemptions from healthcare costs for the poor, their inpatient treatment costs can still account for 40.5% of total income (Ministry of Health, 2005). Access to and utilization of healthcare services by the poor are more influenced by economic rather than health objectives (Mai Thị Thanh Xuân, 2011). Therefore, focusing on researching affordability and strategies to mobilize economic resources for healthcare treatment in poor households is crucial. This approach aims to propose policy solutions that focus on interventions to increase the ability of poor households in Vietnam to pay for healthcare services.

¹ M.A. Faculty of Tourism and Social Work, University of Social Sciences and Humanities, Vinh University, Vietnam, Email: thuyhaphanle@gmail.com

² Assoc. Prof. Dr. Institute of Leadership and Public Policy, Ho Chi Minh National Academy of Politics, Vietnam, Email: trinhvantung1969@gmail.com

RESEARCH OVERVIEW

Most literature on economic resource mobilization strategies for healthcare primarily originates from studies on poverty and famine in Asia and Africa. Strategies, according to scholars studying famine, "are a set of activities carried out in a specific sequence by a household to cope with exogenous shocks such as drought, crop failure, and livestock deaths leading to a severe decline in food availability" (Davies, 1993, cited in Sumit Kumar, 2017).

Studies on poverty and coping with famine have shown that the risks and impacts of famine cannot be completely minimized; thus, effective means and strategies must be in place to cope with and reduce these risks. According to Barrett (2002), risk sharing within communities, including building support networks, sharing and mutual aid, and establishing formal and informal credit funds, are the best initial solutions to pursue. However, vulnerable households are often less likely to access these initial solutions due to correlated risks, moral risks, imperfect information, and ineffective contracts. Therefore, poor households resort to using secondary coping strategies to minimize the adverse outcomes of these risks. In food security literature, seven common coping mechanisms have been identified: 1) transfer and borrowing, 2) earning and increasing reliance on wild foods, 3) managing non-productive assets, 4) reducing consumption and energy expenditure, 5) selling productive assets, 6) appropriating others' resources through theft or refusing to meet normal social obligations, and 7) migration (Barrett, 2002, cited in Sumit Kumar, 2017). Households facing food insecurity consciously follow these strategies from less harmful and less flexible strategies to more harmful strategies.

Some subsequent studies exploring people's access to healthcare services and healthcare found that while high-income groups often use voluntary or mandatory insurance packages from private or state providers to fund healthcare costs (Hopkins, 2010; Gottret & Schieber, 2006), low-income groups pursue various coping strategies to mobilize economic resources for family healthcare (Flores et al., 2008; Asfaw et al., 2010; Kruk et al., 2009; Krishna, 2004; Joe, 2014; Mock et al., 2003; Leive & Xu, 2008). Therefore, these studies also highlight the strategies that households use to pay for medical treatment and healthcare expenditures. One of the most immediate financial responses to illness costs is using available cash and savings, which studies show is feasible only for a small proportion of households (Kabir et al., 2000; Sauerborn et al., 1996; Wilkes et al., 1997). For some families, the focus is often on reducing household expenses (Foster, 1994; Mutyambizi, 2002; Rugalema, 1998). Another common strategy used is selling assets (Kabir et al., 2000; Sauerborn et al., 1996; Wilkes et al., 1997). In many cases, the most common reaction to cope with healthcare costs is borrowing from family and friends (McPake et al., 1993; Nahar & Costello, 1998). The impact of borrowing on household livelihoods can be severe and affected by the nature of the lender and loan terms. Some studies show that households remain in debt for a significant period after illness incurs this debt (Mock et al., 2001; Wilkes et al., 1997). Additionally, to cover indirect costs of illness, reallocating labor within the family, working for free or hired labor, reducing daily household expenses, or withdrawing children from school are also frequently used by households (Sauerborn et al., 1996; Attanayake et al., 2000).

In addition, literature on economic resource mobilization strategies also discusses two factors: Assets and entitlements. These two factors are related to economic resource mobilization strategies of poor households for healthcare (Sen, 1981). Assets include tangible assets such as land, livestock, and other productive assets and human resources—encompassing health, physical labor, education, skills, and other work abilities. Entitlements refer to the ownership rights of assets exchanged or the methods of exchanging these assets.

Chen (1991) mainly formulated a methodology to analyze coping strategies of poor households. Accordingly, households' strategies can be analyzed from four aspects: type, degree, sequence, and success of coping behaviors when ill. Authors Goudge & Goranty (2000), McIntyre & Thiede (2003), and Russell (2004) in their evaluation documents found that researchers focused more on this methodology and amended, focusing on studying economic resource mobilization strategies for healthcare primarily focused on type, sequence, and success degree of coping behaviors. In addition to these three aspects, McIntyre & Thiede (2003) argued that choosing a specific strategy also depends on the type of illness. Therefore, strategies can be analyzed from four aspects: type, sequence, success degree of coping behavior, and nature of illness (Sumit Kumar, 2017).

Thus, faced with economic difficulties due to healthcare costs incurred during medical examinations and healthcare, different economic consequences have left different households with different socio-economic conditions. Similarly, coping strategies with these costs for households are also different. Within the scope of this article, we delve into analyzing economic resource mobilization strategies to pay for healthcare activities and identify the structure of these strategies in poor households in Nghe An, Vietnam. This group is considered vulnerable in society, so how does the economic resource mobilization for healthcare activities take place? What is the structure of these economic resource mobilization strategies? Which strategy is considered the most successful? And do all these strategies adequately meet the healthcare needs of members of poor households or not?

METHOD

This report is drawn from the results of the doctoral dissertation in sociology "Differences in people's access to healthcare services in the process of implementing universal health insurance policies" (Case study in Vinh City, Nghe An province). The study was conducted over 24 months (January 2022 to December 2023) in 06 communes in a total of 25 communes of Vinh City. This is a type I urban area under the provincial government of Nghe An with a total population of 349,206 people, covering an area of 104.96 km² (2022). All voluntary research participants were explained about the study's objectives and methods in accordance with the ethical guidelines in sociology research.

Data were collected using both qualitative and quantitative research methods. Quantitative research method (N = 600, where N (poor households) = 78) to understand diseases, access to healthcare services, financial resources, ability to pay, and satisfaction with services used. The respondents were representative of households; they were the most informed about the household and could provide information on the health status and use of healthcare services by household members. SPSS version 20.0 was used to manage and analyze quantitative data from the study.

Qualitative research data (N poor people = 30, N officials and healthcare workers = 20) included in-depth interviews conducted with residents and healthcare officials and staff to better understand the process of accessing healthcare services as well as the resource mobilization strategies used to pay for this process. With permission from the interviewees, interviews were recorded or written down on-site

RESULTS AND DISCUSSION

The text describes various coping strategies employed by households to deal with healthcare expenses when ill. These strategies are defined as measures used by households to alleviate the financial burden of healthcare expenditures (Daivadanam et al., 2012). Research findings indicate that high-income groups utilize health insurance, savings accounts, and regular income as primary strategies to manage healthcare costs. In contrast, low-income groups, such as poor households, resort to borrowing, selling assets, seeking contributions from friends or relatives, reallocating family labor, and taking loans with high interest rates to cope with healthcare and family health care expenses. Notably, 100% of the poor stated they faced economic difficulties when seeking medical treatment, illustrating that healthcare costs have become a pressing concern for the poor. In the study area, on average, each poor household spends 3.6 million VND per year on medical examinations and treatments (less than the average spending of Vinh city residents, which is generally 4.1 million VND per year per household). However, this expenditure accounts for 8% of the total income of poor households, while the average expenditure for this activity of households in Vinh city is 4.6%.

Furthermore, alongside directly measurable healthcare costs, indirectly incurred healthcare expenses are often less quantified and challenging to measure due to methodological difficulties. Nevertheless, some studies on healthcare expenditure assert that these expenses include both direct and indirect costs. They emphasize that indirect costs can represent half of the burden of disease costs (Russell, 2024). Therefore, most poor people are very concerned about the costs of medical examinations and healthcare. To cope with these expenses, a range of economic resource mobilization strategies has been used by poor households.

When asked about economic resource mobilization strategies for medical examinations, poor households in Vinh city mainly use the following strategies: (Chart 1)

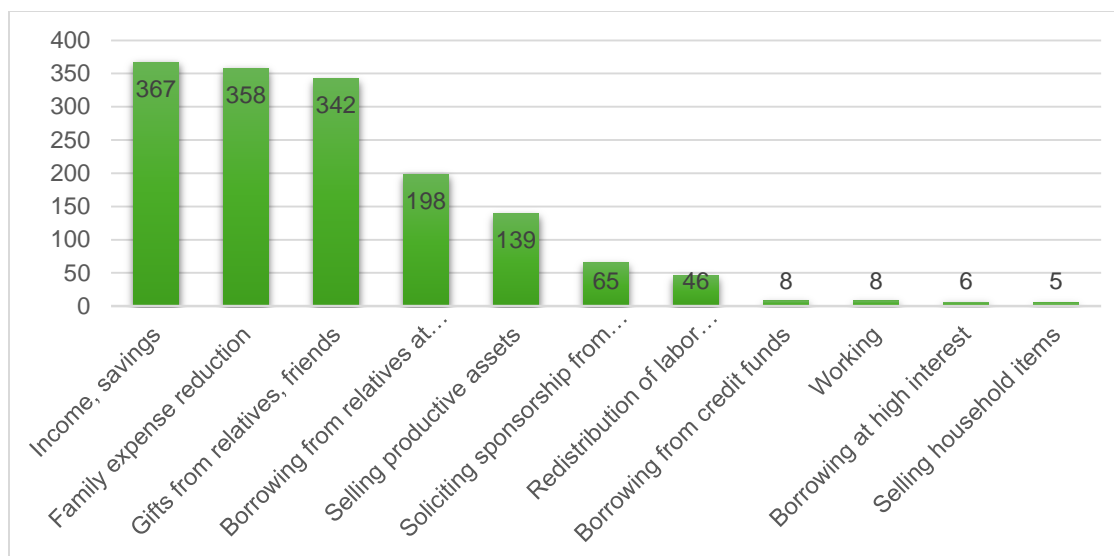


Chart 1. Strategies for mobilizing economic resources for healthcare activities of poor households in Vinh City

Income, Savings

Income and savings are considered the most immediate response to cope with healthcare costs. 94.3% of health incidents in poor households use this strategy. However, poor households with average income per capita (below 0.7 million in rural areas, below 0.9 million in urban areas) and limited savings (average: 1.2 million/year/poor household) have relatively poor capacity to cover their healthcare expenses. Therefore, although this strategy is the most frequently used and immediate, its effectiveness is not high. This strategy only optimizes results for mild illnesses, outpatient care, or low-cost healthcare. It is ineffective for severe illnesses. Nonetheless, these results also demonstrate the self-reliant spirit of poor households in Vinh City. When economic resources are needed, the poor primarily rely on their own internal resources (income and savings). Only when income and savings are insufficient to cover healthcare costs do they turn to other economic resource mobilization strategies. Additionally, these results reflect the characteristics of the people of Nghe An, Central Vietnam, who are resilient, frugal, and thrifty, even in poverty, allocating a very small amount for emergencies.

Reducing Family Expenditures

Reducing family expenditures is the second most chosen strategy after using income and savings. Up to 92% of households reduce expenditures when a family member falls ill. *"Since my husband had to be hospitalized, I dare not buy food for the family. For over a week, the children have been eating rice with fish sauce or sesame and vegetables from the garden. I feel sorry for them, but in this situation, we have to endure. My children understand, they don't ask for anything"* (Female, 36 years old, Hung Chinh commune). Due to their frugality and endurance, this strategy seems to be consistently used alongside the prevalence of illness within the family. However, due to the fragile economic conditions, the effectiveness of this strategy is not high and cannot become the main strategy in mobilizing economic resources for healthcare activities. Moreover, reducing family expenditures when someone is ill can exacerbate their already fragile health conditions. Nevertheless, for poor households in Vinh City, Nghe An, this strategy has directly supported them economically immediately after the need for healthcare and health care expenses.

Gifts from Relatives, Friends

Accounting for 87.8% of usage when the poor fall ill, gifts from relatives and friends become a very meaningful economic resource mobilization strategy for poor households when seeking medical treatment. With the social characteristics of a country where 60% of the population currently lives in rural areas and the cultural foundation from agriculture and rural areas, the values of family, lineage, and village are always

cherished and reinforced through many generations. Community solidarity, family bonds, and responsibilities among family members are always emphasized (Dao Duy Anh, 2006). This is an important value foundation of Vietnamese people, having a significant impact on sharing and mutual support through the activity of gifting (economically) to the sick.

Clearly, the use of resources from contributions by relatives and friends brings about a significant economic outcome to cover medical treatment expenses in the early stages for poor households. The gifts studied are objects that relatives, friends, and neighbors use to give to the sick with the hope that they will recover quickly. These can be: food, drinks, nutrition... with material value beneficial to the health of the sick or giving cash. This can be said to be a cultural aspect or an exchange mechanism in reciprocal relationships between individuals, a spiritual mechanism of “give and take” that attracts respect from both givers and receivers (Mauss, 2002). In Vietnam in general and Vinh city in particular, this viewpoint is expressed right in folk songs and proverbs “Bau oi thuong lay bi cung. Tuy rang khac giong nhung chung mot gian” (Nguyen Trung Dung, 2020). “*When I heard that my grandfather would have to be transferred to a hospital outside Hanoi for treatment, that night, almost the entire block came to visit him. People here are very dear; when they heard that he had to be taken to Hanoi (to a higher-level hospital), the Elderly Association, Veterans Association of the ward began to fundraise, supporting the family with some money. Many people at the head of the block, we have never visited before but also came to share, encourage the family...*” (Male, 25 years old, Hung Binh ward). The act of giving and receiving gifts when sick as if there was some social contract meaning if one does not give gifts to relatives or acquaintances when they are sick then they would feel very uncomfortable: “*Nowadays, with the development of social networks, information about my grandfather’s illness was spread very quickly to those who knew him. Many times I was asked by people to provide bank account numbers so they could send gifts to him. And many of my grandfather’s friends if they were too busy to visit him directly then they also sent their children or acquaintances to deliver gifts to my grandfather.*” (Male, 25 years old, Hung Binh ward).

Gifts from relatives and friends when sick are a cultural trait, a mechanism in people’s behavior. This activity is not entirely carried out according to the principle of “giving” - “returning” symmetrically or seeing it as a “debt” that people must repay (Mauss, 2002) but mostly the spirit of “giving” stems from solidarity in social relationships, emotional relationships between individuals. Relatives and friends of poor households give gifts without expecting to receive equal value for their gift in subsequent interactions. They consider it as support and sharing with difficult circumstances in the community.

Thus, gifts from relatives and friends become a meaningful economic resource mobilization strategy for poor households at the beginning stage of medical treatment. In the context of family poverty and difficulties due to illness, this becomes a considerable economic source supporting poor households. Moreover, this strategy takes place at the beginning of medical treatment hence preparing an initial resource for poor households to cope with illness while also adding spiritual strength, encouragement, and faith for them.

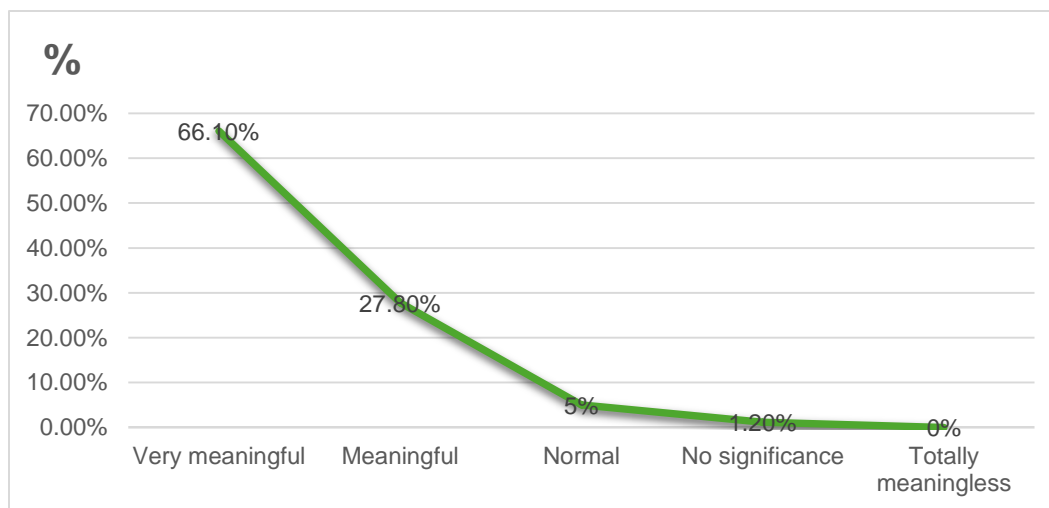


Chart 2. Poor people's assessment of the strategy of mobilizing economic resources through borrowing from relatives at low or no interest rates for medical treatment activities.

Borrowing from Relatives at Low or No Interest Rates

As the expenses for healthcare activities rise and savings dwindle, poor households implement borrowing strategies. These borrowing strategies include loans from relatives, friends, credit funds, or high-interest loans. Among these, loans from relatives and friends at low or no interest rates are prioritized by poor households in the initial stages of their borrowing strategy. This is considered a safe and effective strategy, widely used, and yielding high economic resource mobilization. Particularly for severe illnesses, this strategy demonstrates the highest effectiveness (see Table 1). Among the 30 poor individuals deeply interviewed, 21 admitted to feeling ashamed ("face lost") when frequently borrowing cash and food from acquaintances, relatives, and friends. Without money for medical visits, they borrow; lacking funds for groceries and healthcare products, they also borrow. It's as simple as "going to the local grocery store for a few eggs, or asking neighbors for a tomato, so we can make an egg soup for the family. We manage today, and tomorrow will be the same. We know we're out of money, but we must eat. People feel sorry for us, but I keep buying food on credit, making them upset, and reluctant to sell. So, I face the embarrassment of complaining about hunger, and they take pity on me and again agree to help." (Female, 47 years old, Vinh Tan Ward).

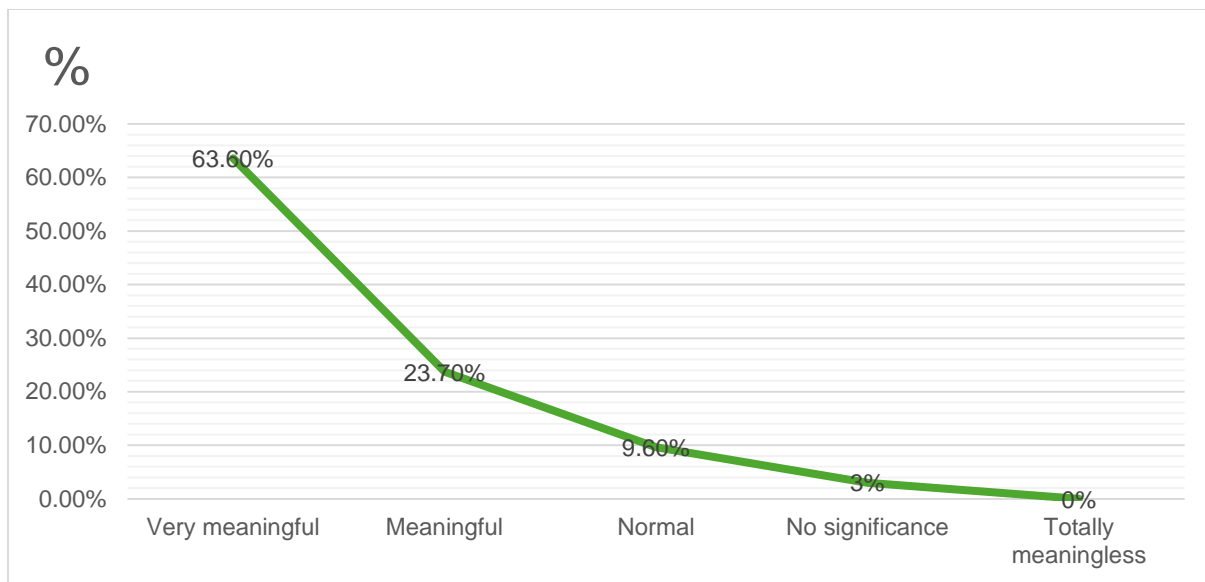


Chart 3. Evaluation of the strategy to mobilize economic resources through borrowing from relatives at low or no interest rates for healthcare activities.

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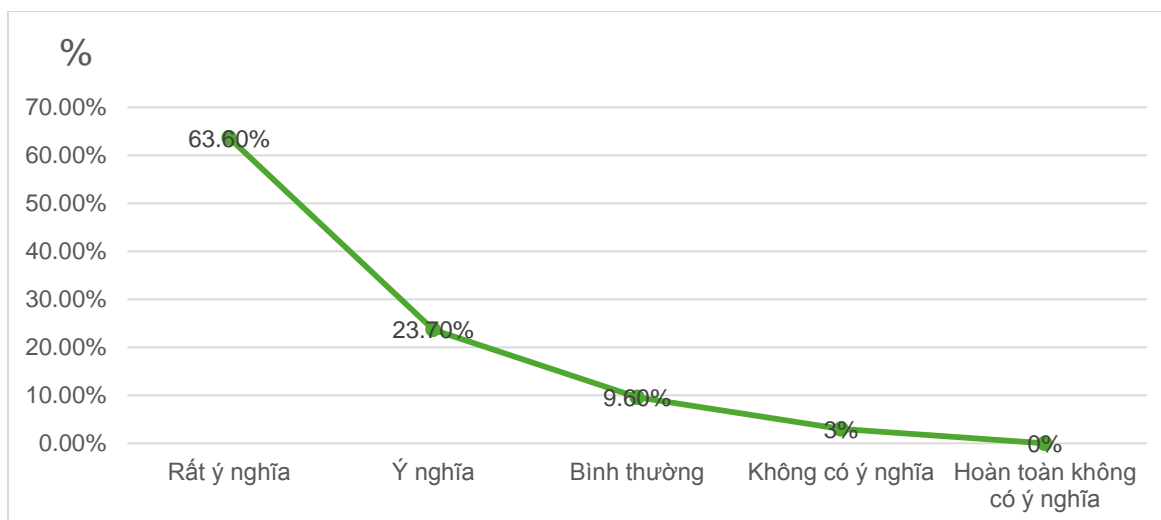


Chart 3. Evaluation of the strategy to mobilize economic resources through borrowing from relatives at low or no interest rates for healthcare activities.

For poor households, loans from relatives and friends at low or no interest rates are considered debts that impact their livelihoods and create difficulties. Although this strategy is less burdensome than high-interest loans, using borrowing as a coping strategy is seen as causing deterioration in family livelihoods and worsening relationships with relatives and friends when debts are not repaid on time. According to survey data, the majority (88.4%) of loans taken by poor households up to the present time remain unpaid. Due to this characteristic, poor individuals find it very challenging to access loans. They lack collateral or sufficient credibility to secure loans, thus this strategy appears to fail when poor households attempt it during times of minor illnesses. Surprisingly, this strategy shows a high success rate for both moderate and severe illnesses (see Table 1). Therefore, this strategy is considered the most meaningful and successful among borrowing strategies. "My husband underwent artificial disc replacement surgery. Just the cost of the disc was over 50 million, plus the surgery cost 25 million. We opted for open surgery with health insurance. Additional costs for non-insurance medication totaled over 10 million. It amounted to over 85 million. I had to rely on my younger sister. She has helped my family a lot, sending us a few million almost every month to help feed the grandchildren. My husband and I also borrowed 50 million from her initially for shrimp farming investment, which failed and we haven't repaid. Her family is not wealthy either, but they can still borrow. I asked her for another 50 million. Then I begged friends, neighbors, each one for a little money to cover my husband's surgery." (Female, 45 years old, Dong Vinh ward). "Luckily, my friends are compassionate. I haven't paid back old debts, but I go back to borrow again. They hesitate, but probably out of pity, they lend to me again." (Female, 43 years old, Nghi Duc commune). The spirit of mutual assistance and reciprocity once again forms the basis for the successful implementation of this strategy by poor households.

Table 1. Frequency of Using Economic Resource Mobilization Strategy "Borrowing from Relatives at Low or No Interest Rate" for Healthcare Activities of the Population, Classified by Disease Severity and Type of Disease

NO	Disease categories	Mild illness		Moderate illness		Severe illness		Total	
		Frequency	%	Frequency	%	Frequency	%	Frequency	%
1	Respiratory	0	0	0	0.0	3	1.5	3	1.5
2	Ophthalmology Dermatology	0	0	7	3.5	1	0.5	8	4.0
3	Dentistry	0	0	0	0.0	0	0.0	0	0.0
4	ENT	0	0	14	7.1	8	4.0	22	11.1
5	SKSS	0	0	15	7.6	2	1.0	17	8.6
6	Psychiatry	0	0	1	0.5	3	1.5	4	2.0

7	Acute diseases	0	0	8	4.0	25	12.6	33	16.7
8	Chronic diseases	0	0	47	23.7	36	182	83	41.9
9	Injuries, accidents	0	0	13	6.6	9	4.5	22	11.1
10	Andrology	0	0	0	0.0	5	2.5	5	2.5
11	Other	0	0	1	0.5	0	0.0	1	0.5
	Total	0	0	106	53.5	92	46.5	198	100.0

Selling Production Assets, Selling household Items

Selling assets is also a common strategy to cope with healthcare expenses. This strategy is often pursued concurrently with borrowing from relatives and friends. Immediately following strategies involving income sources, savings, and household expenditure reduction, poor households resort to selling assets. Types of assets that poor households may sell include production assets (land, motorcycles, livestock or poultry, grains, food, etc.) or household items (TVs, refrigerators, wooden furniture, etc., and other valuable assets).

Among these, selling grains, food, livestock, poultry, or household items is the most common. This strategy typically begins with selling non-profitable assets such as household items. The second phase includes selling significant production assets, such as cattle or other large livestock. Selling production assets can lead to long-term financial losses because these assets are often sold at a lower price than their optimal value, thereby reducing future income for the household. The third phase occurs when the economic situation of the household becomes severely deprived, funds are depleted, and then poor households typically sell large production assets such as agricultural land, manufacturing workshops, motorcycles, etc. Selling such crucial production assets when savings are exhausted and assets depleted can cause significant harm and have a profound impact on future economic stability.

Despite the fact that assets of poor households are not abundant and do not hold high value, this strategy remains effective for mobilizing economic resources to cover their healthcare expenses. However, very few poor households have the opportunity to use this strategy due to their impoverished conditions and the reality that they no longer have valuable assets to sell.

Appealing for Sponsorship from Organizations, Communities, and Society

Appealing for sponsorship from organizations, communities, and society for healthcare activities of poor households is understood as assistance and support provided by these entities to individuals who are ill or in pain but lack the resources to access healthcare services to maintain health, through material support enabling these recipients to independently manage their lives, overcome difficulties, and potentially reintegrate into society.

It can be said that in recent times, community support activities have been extremely active and robust. In the research area, 65 out of 1542 instances of mobilizing resources using this strategy were recorded (accounting for 4.2%). This strategy not only provides economic resources but also offers hope and opportunities for improving the lives of poor households. Common forms of appeal include direct sponsorship from socio-political organizations such as women's unions, farmers' associations, elderly associations, and office trade unions, or financially strong organizations and businesses in the area. Regular support program developments like patient support programs and periodic assistance programs are also called for, along with online appeals through websites, social media, and online fundraising platforms. Among the 65 cases of illness or pain where this strategy was employed, 55 cases (84.6%) affirmed the strategy's significant importance, while 10 cases (15.4%) acknowledged its meaningful impact. *"My son has congenital heart disease. Without the support of these benevolent individuals, my son wouldn't have survived until now."* (Female, 36 years old, Hung Binh Ward).

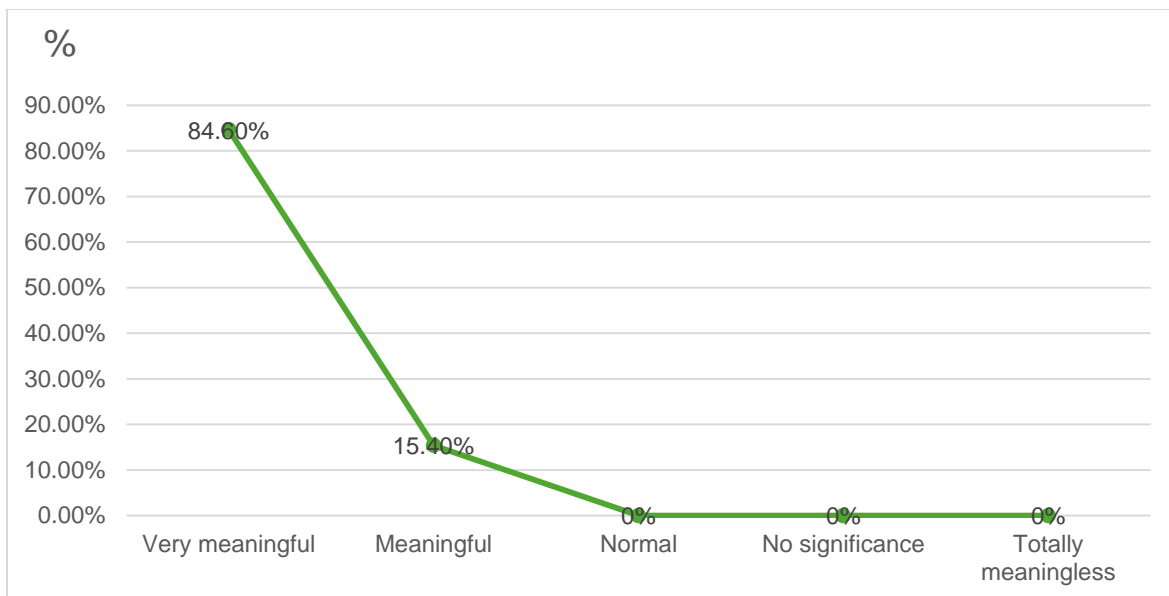


Chart 4. Poor people's assessment of the strategy to mobilize economic resources through fundraising from organizations, communities, and society for healthcare activities.

The strategy of fundraising from organizations, communities, and society is quite common in Vietnamese society, which values the culture of "helping each other" and "mutual compassion." In the difficult circumstances of poor households, especially when they are burdened with medical expenses that they cannot afford, this strategy can be implemented and realized. The scale of support may vary, but it is based on the spirit of "collaborative contribution," and all processes of soliciting support are transparent, public, and respect the law. This strategy also demonstrates advantages in terms of "timeliness" in mobilizing economic resources and "meeting the needs" of the people. "A year ago, my daughter was in her first year at Vinh University when she was diagnosed with kidney failure and needed emergency kidney transplant surgery, which was critical to her life. Our family is poor; my husband and I work as laborers in Gia Lai, and our grandchildren live with us. When I heard about her illness, our house fell silent. I rushed back, trying every way to save my child. We sold all our savings and valuable assets, and even borrowed more. But the surgery costs were very high, up to 500 million VND. Fortunately, my kidney was a match for her, so we didn't need to buy a kidney. The surgical costs were too high for a poor family like ours. No matter how hard we tried, it wasn't enough. I felt helpless, only hoping for a miracle. Fortunately, there were teachers and friends at Vinh University who organized support, and some journalists also reported on my daughter's situation. Luckily, the fundraising process gathered almost enough money for the surgery. I really don't know what else to say; it was truly a timely miracle that saved my daughter's life." However, this method of resource mobilization also raises issues regarding the self-initiative of the activities. The bottleneck in receiving, processing, and distributing aid has led to overlapping situations, with some areas having surpluses while others lack transparency in receiving aid, which has significantly affected community trust in this support channel. Along with that, unintentional policy barriers have prevented these activities from achieving the expected results. Therefore, improving institutional regulations for assistance activities is indeed necessary, especially in the context where the State encourages the socialization of emergency relief activities (Nguyen Thanh Thuy, 2021).

Reallocating Labor Within the Household

Reallocating labor within the household is a common measure chosen by families during illness, especially in cases of chronic illness. Out of 46 instances of illness in poor households, accounting for 11.8%, this strategy has been used to redistribute tasks among family members. In four cases, external labor was hired to assume responsibilities for sick family members.

According to the study, there were 17 cases, corresponding to nearly one-third of poor households with someone who quit their job to care for the sick. Whether these individuals previously held formal or informal jobs, they contributed to the family's production or reproduction work.

In the deep interview results, five households had children who skipped school (either less or more) to care for sick or injured individuals or to compensate for lost labor.

Borrowing From Credit Funds

Borrowing from credit funds is considered a safe and effective economic resource mobilization strategy for poor households when needed. Typically, this strategy is used when a household member has a chronic, severe illness, or an accident. However, the reality shows that this strategy has not been fully utilized by poor households because they are currently using loans from credit funds for other purposes unrelated to health care. Moreover, 24 out of 30 deep interview cases reported that they found it very difficult to implement this strategy if previous loans had not been repaid or if they did not have the resources to ensure these loans. Therefore, borrowing from credit funds is considered effective, but its utilization rate is limited among poor households.

High-Interest Loans

High-interest loans are usually the last resort for poor households when all other strategies fail to meet health care needs. High-interest loans are a risky strategy. Due to the fragile economic situation of poor households, repaying loans with high interest rates is almost inevitable. Five out of six cases using the high-interest loan strategy to care for health have not yet repaid the loan; among them, two out of five cases have lost collateral. This strategy can be concluded that borrowing only increases the difficulties for poor households and becomes worse when the repayment period of these short-term loans is approaching.

Other Strategies

Although there are economic resource mobilization strategies for poor households to serve health care, in addition to some strategies, some specific households sometimes do not allow their children to go to school, move families from expensive rental apartments to cheaper ones, or seek funding from organizations, community, society, or selling labor... These strategies certainly do not increase the financial burden on households but make economic management more complex.

CONCLUSION

This study has identified the economic resource mobilization strategies that poor households use to fund their medical examinations and treatments, including: Using income, savings; reducing family expenses; gifts from relatives, friends; Borrowing from relatives with low interest rates; Borrowing from credit funds; Selling productive assets; Reallocating labor within the family; Selling household items; Seeking funding from organizations, communities, and society; High-interest loans; and Selling labor. Despite making every effort to apply the possible capabilities to implement economic resource mobilization strategies, the results have not yet achieved effective results, with signs being: using many strategies simultaneously to mobilize, most strategies are borrowing funds, even high-interest loans, and some households after implementing economic resource mobilization strategies, but still cannot go for medical examinations because the economic resources mobilized are not enough. This raises issues that require more specific and effective social security policies for this poor group. Support policies need to focus on enhancing access to health services through health insurance for the poor not only to ensure broader access to health care services but also to ensure they fully use health care services when needed, such as expanding the scope of benefits enjoyed in health insurance, including transportation costs in emergency cases or hospital transfers, expanding the scope of benefits of advanced technical services and high-cost, expensive cancer treatment drugs, etc. At the same time, the relationship between poverty and health is a mutually reinforcing dialectical relationship. Weak health conditions can be a catalyst for the poverty cycle, and in turn, poverty can create and sustain poor health conditions. Therefore, economic development policies for poor households aimed at a stable, sustainable economy are the best way to manage individual and household health risks.

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