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What it means to say "I Don't have any money to buy health insurance" in rural Vietnam: How anticipatory activities shape health insurance enrollment

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ABSTRACT

Cost is a well-established barrier to health insurance uptake. Although iterations of the phrase "I don't have any money to buy health insurance" are pervasive in research on the determinants of health insurance enrollment, its meaning is not universal. Through ethnographic immersion in Vinh Long Province and 34 semi-structured interviews collected from August 2015-September 2016, I show that being uninsured is not merely about the financial cost of an insurance card. Instead, the use of money in this phrase signals "anticipatory activities," which refer to projects undertaken in the service of a projected future. If participation in insurance is fundamentally about planning for the future, then people weighed the risk management aspect of insurance against other more pressing anticipatory activities. Cash was key as it facilitated one's ability to adjust to rapidly changing circumstances engendered by Vietnam's ongoing marketization and global integration. For informal sector workers in this rural district, the value of health insurance was judged against five primary anticipatory activities where cash had instrumental and cultural dimensions: anticipating care responsibilities following the life course, anticipating changing economic and environmental risks, cultivating relationships as a form of anticipation, anticipating uncertain health vulnerabilities, and anticipating the inequalities of the health care system. By bringing attention to how anticipation is articulated in financial and health-seeking practices, I show how my interlocutors view their decision to remain uninsured as morally worthwhile. This study moves beyond utilitarian frameworks for understanding the uninsured. It also advances the anthropological agenda to study the "social life of health insurance" across the globe.

1. Introduction

Health insurance has become a primary tool for achieving universal health coverage (UHC). With technical and financial support from major development organizations, UHC initiatives have launched across the globe. A major challenge has been the enrollment of informal sector workers, who dominate the labor markets of low- to middle-income countries (Bonfert et al., 2015; Bredenkamp et al., 2015). This study closely analyzes one frequently cited reason for being uninsured: not having money to pay for insurance. Iterations of the phrase "I don't have any money" are pervasive in research on the determinants of health insurance enrollment and are often analyzed as problems of affordability, high pricing, or lacking the ability to pay (Basaza et al., 2008; Dong et al., 2009; Jehu-Appiah et al., 2012; Olowe, 2019). Although the phrase cuts across many country borders, its meaning is not universal.

It is not surprising that a utilitarian phrase would yield utilitarian approaches to the problem of low enrollment (Acharya et al., 2013; Wagstaff et al., 2016). Interventions that use subsidies or promote the financial value of insurance operate on similar premises; they ask what can be done to increase the demand for insurance among informal workers? Will subsidies or incentives encourage people to join? What is their willingness-to-pay for insurance? Questions such as these are limited in scope as they prioritize the concerns of planners over the concerns of everyday people. Increasing enrollment is seen as just a matter of individual behavioral change rather than a critical examination of the context and social circumstances around the decision to not purchase insurance.

What people say is hardly ever the full story. I argue that among informal sector workers in Vietnam, the response of "I don't have any money" is not merely about the financial cost of an insurance card; rather, the reference to money signals what I call "anticipatory activities." Anticipation involves imagining how and when something will

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happen—or might happen. Anticipatory activities are the projects people undertake in the service of a projected future. The purchase of insurance competes with an array of other anticipatory activities for two reasons: first, the value of insurance becomes the clearest when an unfortunate event occurs in the future. Although most organizations promote health insurance as a financial product that alleviates the unpredictability catastrophic illness, it is not until the actual payout that the financial value of insurance becomes known through second or first hand experience. Second, enrolling in insurance requires cash. For Vietnamese informal workers, cash is key for engaging in anticipatory activities. By imagining how an event might play out before it occurs, a person can be ready to perform the appropriate actions in response. Anticipation, in other words, is a fundamental skill for managing foreseeable risks and grabbing hold of foreseeable opportunities in Vietnam's marketizing economy.

By bringing attention to how anticipation is articulated in financial and health practices, I show how informal workers view the decision to remain uninsured as morally worthwhile. If participation in insurance is fundamentally about planning for the future, then people weigh the risk management aspect of insurance against other more pressing anticipatory calculations. For informal sector workers in Vietnam, the value of health insurance was evaluated against five primary anticipatory activities where cash had important instrumental and moral dimensions: anticipating care responsibilities following the life course, anticipating changing economic and environmental risks, anticipating community obligations to achieve moral personhood, anticipating uncertain health vulnerabilities, and anticipating the inequalities of the health care system. Attention to anticipatory activities broadens our understanding of the true cost health insurance and may open up possibilities for institutional level improvements to UHC.

1.1. Anticipation, the Uninsured, and the "Social Life of Health Insurance"

A deeper understanding of how anticipation impacts enrollment contributes to a growing body of anthropological work on the "social life of health insurance" (Ahlin et al., 2016; Dao and Mulligan, 2016; Dao and Nichter, 2016; Prince, 2017). That UHC has become a global phenomenon affords opportunities for anthropologists to apply social science frameworks and methods to health insurance research across cultures. Scholars of insurance acknowledge the future-oriented attribute of insurance (Baker and Simon, 2002; Ewald, 1991). And yet, the role of anticipation in shaping enrollment decisions has only analyzed circumstances where people purchase insurance (Adams et al., 2009; Patel, 2007). Studies, largely examining commercial life insurance, demonstrate how anticipating the financial burden of death for kin and general money management through insurance becomes morally virtuous (Bähre, 2020; Chan, 2012; Golomski, 2015; Maurer, 2005; Zelizer, 1979). One implication of this treatment of anticipation is that it reinforces notions of insurance as moral and rational means for preparing for the future.

Medical anthropologists studying health insurance provide an important corrective to prevailing narratives about being uninsured as a moral failure. They have powerfully illustrated the structural forces—such as exclusionary policy design, poor implementation, or neoliberal restructuring—that curtail one's ability to enroll (Mulligan and Castañeda, 2017; Rylko-Bauer and Farmer, 2002; Sered and Fernandopulle, 2006). Furthermore, bureaucratic hurdles, dizzying choices, race and social class limits access to care even for the insured (Abadia and Oviedo, 2009; Bähre, 2020; Golomski, 2018; González-Agüero et al., 2020; Horton et al., 2014; Mulligan, 2017; Nandi and Schneider, 2020). Beyond structural barriers to access, the uninsured withdraw from insurance based on broader moral and social criteria such as thrift, the desire for more agency in negotiating prices, or ideological justifications for not buying insurance (Brunson, 2017; Fletcher, 2017; Mulligan, 2014; Schwarz, 2019).

I build upon these insights that provide nuanced portrayals of the lives of the uninsured by exploring anticipation as an important dimension for understanding how and why people prioritize their resources in the way that they do. I highlight how planning and activities temporally oriented towards the "near future" (Guyer, 2007) may draw resources away from purchasing insurance. Anticipation is a forward-looking condition characterized by yearning, desire, aspiration, anxiety, or dread (Murphy, 2017). By attaching the word 'activity,' I argue that anticipation is not just epistemic or affective (Adams et al., 2009), it also involves action and decision-making. It is through action and practice that anticipation becomes a moral enterprise (McMullin and Dao, 2014). One would not plan for or prioritize what one does not feel a sense of responsibility toward.

What becomes worthy of anticipation does not appear out of thin air; it is grounded in dynamic moral values that surface when we see how economic activities are being directed. The connection between anticipation, morality, and economic life is inspired by Zaloom's concept of "projective fictions," which are the "moral stories that organize visions of the future to direct economic activities in the present" (Zaloom, 2018). These visions do not need to be fully articulated to govern people's actions. As Adams et al. explains, anticipation is an "ethicized state of being" where imperfect knowledge about what the future holds requires one to attend to and stay informed as a normative affective state. Money in this case is a vehicle for enacting anticipatory calculations as individuals adjust priorities to achieve their visions. The future becomes accessible or imaginable through money as cash allows my interlocutors to adjust to changing circumstances of the growing market economy. What they spend their money on and what actions they take reveal moral underpinnings. Anticipation is expressed in how my interlocutors thought about the worth of health insurance in relation to their own speculation about their future health and economic needs. I will show how anticipation was equally about preventing hazards and acting on expectations for securing good health, and a good future for those around them. These factors draw them away from health insurance enrollment.

1.2. Background: Vietnam and health insurance

Financial decisions about health insurance must be understood amid Vietnam's on-going integration into global markets, where families increasingly bear the risks and rewards of economic volatility. A series of policies beginning in 1986 called *Đổi Mới* ushered the country's transition from central planning to the use of market principles to guide the economy and its health sector (Van Minh et al., 2013; WHO, 2017). As GDP rose, so has wealth inequality as some took advantage of new market opportunities while others could not. Similarly, new opportunities and risks arose in the health sector as decentralization and privatization increased medical stratification and made an array of new health services, products, and technologies available for a financial cost (Lincoln, 2014; Sepehri et al., 2003). It is within this context of rising health care costs that the government implemented health insurance as a way to cushion the financial burden of newly introduced user fees at public health care facilities.

Vietnam follows a social health insurance model managed by the state. Workers pay into the state health insurance fund and the government subsidizes those who cannot work or who are identified as poor. Although the scheme launched in 1992, it was not until 2014 when the state committed to UHC that a concerted effort was put into enrolling the entire population. I was in Vietnam in 2015 when the campaign began. The primary objective was to enroll the last uninsured population: the informal sector.

Policy-wise, the informal sector remains uninsured for two main reasons: first, their wages are not legible to state regulation and cannot be garnished to pay for insurance membership (as is done with formal sector workers). Second, informal workers oftentimes do not qualify as being poor enough to receive government subsidized membership

because their income is difficult to assess using official documentation. Although the law makes insurance mandatory, the government has no direct penalties for not participating, thus creating de-facto voluntary scheme. The informally employed are uninsured by default and must voluntarily purchase health insurance to become covered.

Health insurance covers treatment at all state facilities and a small number of private hospitals. Informal workers enroll through the family-based health insurance policy, which means they must enroll along with the other uninsured members listed in the legal household register (*hộ khẩu*). As of 2016, insurance covers the cost of outpatient examinations and up to 100,000VND for medications per visit, after which the patient pays a 20% co-pay. For inpatient care, 80% of the cost is covered, but only for services and products listed in the health benefit package. Many felt this was limiting at times as several internationally-made medications and high-tech procedures were not included. In addition, patients must register at their local commune- or district-level health facility and obtain referrals should they wish to have their treatment covered by insurance at the provincial or central level facilities. At the time of my research, patients were responsible for 100% of treatment costs if they went directly to tertiary level facilities without a letter of approval from the lower-level health facilities.

2. Methods

The article presents selected findings from a larger ethnographic project on the implementation of universal health coverage policies in Vietnam that took place from August 2015 to September 2016. The Vietnamese government was seven months into its UHC campaign to bring down the uninsured rate, which was 20% of the population at the time.

Uninsured people were quick to say they did not have money to buy insurance. Repeated instances of this statement often ended conversations and frustrated me to no end. It was only after living in the community, visiting families at home, at work, and at social gatherings—or what Stacy Lee Pigg refers to as "ethnography as sitting" (Pigg, 2013)—that the nuances behind the phrase "I don't have any money" came to view. Participant observation and in-depth interviewing over time allowed me to discern anticipation, the moralities of money, and categories of concern for this group. I followed the daily demands of their lives, how they prioritized and optimized their monetary and human resources, and what they needed to attend to economically and socially.

With the help of four local research assistants, I conducted 34 interviews (17 insured and 17 uninsured). Non-probability sampling was employed because my research questions focused on people's experiences, thought processes behind, and social contexts of insurance enrollment. Subjects were recruited at hospitals, through social networks, and with the help of government health insurance employees. The majority of interviews took place at the home of the interviewee after they provided permission.

2.1. Data collection, analysis, and ethics approval

The study took place in Vinh Long Province, a primarily rural area in the Mekong Delta located 135 km south west of Ho Chi Minh City. The province covers about 1500 square kilometers, with an estimated population of 1 million people and 80% living in rural areas who are less likely to be insured than their urban counterparts (General Statistics Office Vietnam, 2017). Forty-five percent of people are self-employed farmers, 11% are farm laborers, 22% are self-employed in other sectors, and 22% are non-farm wage laborers (General Statistics Office of Vietnam, 2006). Socioeconomic status was difficult to ascertain as many could not regularly track all their income generating activities. Therefore, in consultation with my local research assistant, we used a combination of land ownership, assets, geographical location, and projected incomes from harvests to estimate socioeconomic status. The cases presented are relatively middle-class in that they owned more land than what their house stood on and did not qualify for free health insurance for the poor.

Fieldnotes and interviews were transcribed and coded using QSR NVivo 12. During analysis, I looked at moments of justification, where participants described the reasons why they did not participate in health insurance among the uninsured. Among the insured, I paid special attention to when interviewees decided not to use insurance to pay for their health care. I also analyzed discussions of their worries and hopes to help contextualize their decisions.

The Institutional Review Board for Research Ethics of Columbia University, and the Southern Institute for Social Sciences in Ho Chi Minh City vetted and approved the study procedures. Informed consent was obtained verbally for recorded interviews, as well as for ethnographic observation and participation. All names presented are pseudonyms.

3. Results: Anticipatory Activities

3.1. "I Don't Have Any Money": Anticipating Care Responsibilities Following the Life Course

Whether or not a person was insured was often less dependent on financial capacity and more on competing demands to meet the short- and near-term needs of the household. The demographic makeup of a household in the village was often multigenerational and multi-life stage. With increasing migration out of the community for work, those who stayed behind took on multiple responsibilities to care for the family farm, elderly parents, and young children. It was typical for working-age adults to practice "domestic triaging" (Han, 2012) by forgoing insurance coverage for themselves in order to oversee the family economy, anticipate the care for aging parents, and pay for school fees.

Household members at different life stages required different anticipatory practices: infants and children were expected to be given care and educated until at least high school, after which as young adults they lived in the family home and contributed their labor and income to the household. As adult children, they were expected to marry and have their own children, and eventually care for their aging parents. The elderly life stage was characterized by the inability to work, physical weakness, and dependency on adult children. While some financial needs could be predicted—like school fees, others could not such as sudden changes to health status, accidents, or even the care preferences of elders. Heads of households needed to hold onto cash reserves as a precautionary measure. Although some of my interlocutors owned land, their wealth did not translate into cash flow. Domestic triaging was necessary as they speculated about which uncertainties to manage. Buying insurance effectively meant handling one uncertainty, only to create more uncertainty in other areas. One such example of domestic triaging was a couple I met named Tuẩn and his wife Như—a lower-middle class household. In total, the household consisted of Tuẩn (age 35), his wife Như (age 36), his son (age 13), his daughter (age 4), his mother Mrs. Khánh (age 68) and his father (age 80). When I spoke with Tuẩn, I learned that all the members in his household excluding himself and Như were enrolled. Although Tuẩn knew he should enroll, he was anticipating the needs of the household following the life course.

Tuẩn and Như were balancing a lot of uncertainty when I met them. Tuẩn's father was bed-ridden, had cognitive decline, and not was communicating. HHis mother had a heart condition she treating once a month. She preferred to go to directly to a central level hospital in Ho Chi Minh City because she was familiar with the doctors and routines there. Her treatment was not covered because she bypassed the lower level health facilities. Tuẩn wanted his mother to receive the care she desired, so he gave her cash for her treatments. He also kept her enrolled in health insurance to buffer potential crises related to his mothers' declining health.

As for their children, cash was required to cover the official and unofficial cost of schooling and health issues. Tuẩn and Như allocated

money to pay school fees and in-kind gifts to teachers—a common practice in Vietnam that influenced how much attention lowly paid teachers gave to their children. Their main concern, however, was their youngest daughter, who was born with cerebral palsy. Determined to improve her cognitive and physical development, Tuấn or Như drove her 30 km to Vinh Long's Provincial hospital three times a week for ongoing exams and physical therapy. Both acknowledged that their daughter's future was unknown, but hoped that the intense therapy could make their daughter whole and give her a chance at having a relatively normal life. They could not seriously consider health insurance for themselves when they did not know their daughter's trajectory of development and any associated costs.

Tuấn and Như's situation demonstrate how families made decisions that relied on long-and short-term planning. Money was used to care for the needs of the family according to the life course of each member in the multi-generation household. Tuấn and Như did not out-right refuse health insurance, as Tuấn purchased it for his mother. But they could not pay for their own insurance cards over properly caring for Tuấn's elderly parents, their son's education, and their disabled daughter.

3.2. *"I Don't Have Any Money": Anticipating Economic and Environmental Risk*

The liberalization and decentralization of the Vietnamese economy has increased risk in both senses of the word: as demand and prices for agricultural goods fluctuate in the global market, people are more exposed to danger. At the same time, volatility generates opportunity where taking risks can reap rewards. Even families with limited resources sought to benefit as they anticipated what uncertainty could bring. They leveraged what they could—such as land or capital from microenterprises—to create the conditions for flourishing. Money invested into risky endeavors could potentially secure their family's future. In these cases, economic aspirations surpassed the value of health insurance.

I became acquainted with Tuấn and Như through Mrs. Khánh, Tuấn's mother. We struck up conversation during a 4-hour ride between Ho Chi Minh City and the rural district in Vinh Long Province. An entrepreneurial family operated the van we rode in. The family capitalized on the demand for a regular source of transportation from the "hard-to-reach" area of my fieldsite to the central level hospitals in Ho Chi Minh City. Mrs. Khánh proudly disclosed to me that the price of pomelos had risen because of international demand. She invited me to her house to show me the pomelo orchards Tuấn grew on the family land.

Upon arriving, my research assistant and I were given a tour of the orchard. They had recently changed 4 hectares (ha) of rice paddies into pomelo orchards after seeing Tuấn's brother and neighbors accumulate large profits from sales. The pomelos were merely shrubs when I saw them. It would take another three years to bear fruit and potential profits.

When I asked how he felt about the new venture, Tuấn was worried about what could happen between now and the three years it would take for his first harvest. The global market price for pomelos could collapse. The anxiety of environmental disaster also loomed over him. A few months before, salt water intrusion into the Mekong rivers damaged over 600,000 ha of agricultural goods in the region. He felt vulnerable about how his new crops would survive as the news warned that salinization could worsen in the Delta. Although state media blamed drought and rising sea levels, most locals pointed to the increasing number of dams built upstream by China, a global competitor and former colonizer of Vietnam. Worries about their future livelihoods were tied to the environment and political issues of Vietnam's global integration.

Tuấn and Như's story demonstrates how families triaged their cash towards activities that could help them prosper over purchasing insurance for themselves. Their decision to prioritize their money to transition from low risk, low profit to high risk, high profit agricultural products reveal their aspirations for a better economic future. Cash on hand also could help them weather risks outside of their control.

3.3. *"I Don't Have Any Money": Cultivating Relationships as an Anticipatory Activity*

When people said they did not have money for insurance, they were often engaging in ongoing community building activities that helped them anticipate the future. These activities—which were community-based rotating credit associations and ritual banquets—required cash. Participation in these activities combined instrumental and sentimental reasons as these relationships were a primary source of economic and social support.

Vietnamese concepts of *tình nghĩa* or *tình cảm* refers to emotional feeling and intimacy, where care and sympathy characterize a relationship (Leshkowich, 2014; Shohet, 2018; Tran, 2015). Cultivating *tình nghĩa* is an important anticipatory activity because relationships were full of potential. A famous Vietnamese proverb declares "a neighbor nearby is better than a relative far away" (*bà con xa không bằng láng giềng gần*). Relationships could buffer economic precariousness and keep people alert to opportunities. In other words, increasing *tình nghĩa* is an anticipatory activity that solidified relationships as a form of unofficial insurance.

Rotating credit associations—or *hụi*—are community-based unofficial channels for obtaining credit. For informal workers, they are a dominant method for obtaining credit in Vietnam's primarily cash-based economy. Without large amounts of capital or collateral, it is difficult for Vietnamese to access credit from state-owned and commercial banks (Román, 2012). In rotating credit associations, participants in the group make monthly contributions to a common fund and one member is allowed to cash out this fund each month. The association ends when all members have had a chance to cash out on the fund.

Rotating credit associations are polysemous. They are "sociofiscal" relationships that involve financial calculations of gains and losses, but they also help cultivate sociality, mutual assistance, and structured reciprocity (Leshkowich, 2014). Credit associations function as savings, a way to socialize with family and co-workers, a form of friendly gambling, and a source for acquiring capital for business ventures. They are essentially a form of "informal insurance" (Vélez-Ibanez, 1982). Should any crisis arise, members could tap into this pot of money and their social relations, which made having health insurance redundant.

Health insurance was also more limited in its capabilities. My interlocutors preferred the flexibility of their cash in credit associations. Monetary contributions to *hụi* could be accessed within the duration of the association, and could be used for any project—whether it was to pay for new business ventures, sudden medical bills, school fees, or even lending to other relatives. Residents said money used for health insurance on the other hand was stuck (*kẹt*); it was sent to the central government and could only be used for medical care at state hospitals. If people did not use medical services within the year, then that money was considered wasted.

Ritual activities known generally as *đám* (or group) such as weddings, funerals, and death anniversaries were also a means of "investing" in social and kin relations. By engaging in the local moral economy, my interlocutors achieved moral personhood and could rely on these relationships in the future. With Vietnam's increasing marketization, envelopes of money were expected as gifts for the host family. Money was given social meaning when it was embedded in reciprocal gestures at these ritual events. People expressed their social and familial belonging and cultivated *tình nghĩa* by attending and helping with ritual activities, and providing monetary gifts. However, it is important not to romanticize these activities. Even if one did not feel emotionally attached to the family hosting the *đám*, giving money and providing one's labor was an anticipatory activity that helped to maintain networks as sources of support in the future. In cases such as these, going to *đám* and giving gifts may not have been the true desire of the invitee, but attendance by

a representative of one's house was obligatory. Refusal to attend an event without a good reason was subject to moral judgement and strained community relationships. People in the district often had at least four *đám* per month, and sometimes up to seven or twelve depending on how dense their social or kinship ties were. It was important for them to be full participants in these events and bring cash gifts to reaffirm relatedness.

Good relationships were characterized by *tình nghĩa* or *tình cảm* because they could be leveraged in the future. Relationships in Vietnam are instrumental for navigating complex bureaucracies, building businesses, finding jobs, and more (Luong, 2010, 2009; Leshkowich, 2014; Nguyen, 1949; Nguyen, 2015). When people said bureaucracy was difficult they were not referring merely to filling out forms or following policy directions. They spoke about the inflexibility or poor attitudes of staff members who could easily create obstacles. For example, a social connection with an employee at a health facility could overcome bureaucratic inflexibility. As discussed, Vietnam's health care system is organized hierarchically. Many perceived higher level health facilities to have better doctors and medicines. If patients wanted their treatment at central-level hospitals covered, they needed lower-level facilities to approve transfer paperwork. Approvals were unlikely if lower-level health facility employees decided they could handle the procedure. Many expressed concerns that lower-level facilities were incentivized to keep patients because transferring patients meant also transferring revenue. A close social or kin relation could easily provide a signature and stamp of approval for transfers to be covered by insurance.

Social relationships are a defining feature of Vietnamese life, and money is a primary instrument for mediating moral debt, sociality, and intimacy (Truitt, 2013). Anthropologists and sociologists have long demonstrated that love and money are intertwined in intimate and familial economies, despite western beliefs that money destroys intimacy (Bloch and Parry, 1989; Martin, 2014; Maurer, 2006; Zelizer, 1997). Rotating credit associations and ritual exchanges reaffirm trust and mutual support among neighbors, families, or co-workers when successfully operated. People seldom couch their relationships in instrumental terms; instead, they use terms denoting love, good will, and care to describe these relationships.

Most uninsured respondents saw health insurance as a consumption item that was only valuable when medical treatment was needed in the foreseeable future. For example, one strategy was to enroll in anticipation of pregnancy and drop coverage after childbirth. It was better—and most of the time obligatory—to use their money to "invest" in their nearby relationships that could help them anticipate an uncertain future. The purchase of insurance was weighed against participation in these financial and emotional exchanges as anticipatory activities. Nearly all of my participants earmarked part of their earnings to participate in family, neighborhood, or work-related rotating credit associations and ritual feasts. Given the state's thin social safety net, bureaucratic obstacles, and barriers to accessing formal economic institutions, it was not surprising that relationships were also instrumental at times. They preferred to put their funds into these economic activities because it helped them to save, gave them access to credit when needed, and increased relational life. These relationships helped my interlocutors to anticipate the unpredictability of rural life. Attention to sociofiscal relationships demonstrate how historical and cultural conceptions of exchange are important to consider when understanding why people do not enroll in health insurance.

3.4. *"I Don't Have Any Money": Anticipating Health Vulnerabilities*

As Vietnam's economy became restructured along market principles, families were made more precarious as the cost of medical services went up. In this case, cash—rather than insurance—helped patients and their families gain recognition from overburdened medical staff. When dealing with a grave illness, cash helped alleviate the anxieties of the patient and family because it was a method for quickly establishing intimacy with doctors. As rural residents, they felt disadvantaged when entering into a hospital where they did not know anyone. Money was oftentimes the only way they felt they could guarantee some quality of care.

Residents judged their illnesses by the level of uncertainty and anticipated accordingly. Symptoms denoting common illnesses such as colds, coughs, or aches had little uncertainty and were generally taken care of by a trip to the pharmacy or natural home remedies that were paid for out-of-pocket. Treatments that required surgery were the most uncertain and family members used everything available to them to alleviate uncertainty in their efforts to obtain the best care possible for their kin. Often, this meant the family would prepare to pay out-of-pocket directly to the hospital or make use of the hospital's private service wards (*khu dịch vụ*), which did not accept insurance.

While waiting in the outpatient waiting area of a provincial hospital, a man named Quân (age 43) overheard me conversing with patients about health insurance. He chimed in, explaining that he was at the hospital today for his monthly check-up to refill his diabetes medication. He was a middle-class grade school teacher who also owned rambutan orchards. Quân had insurance through his employment because he was a state employee. Although he would not be considered to be part of the informal sector, his story is instructive as it demonstrates people's views about the different advantages of insurance and cash.

Quân decided whether or not to use insurance depending on the type of medical experience he anticipated. Before arriving at Vinh Long Provincial Hospital, he went to a private doctor's office for lab work, which did not accept insurance. He then shared his results with a friend, who was a doctor, for a second opinion. Next, he gathered all the paperwork and results in advance so that all he needed was the slip to pick up his diabetes medicine when he arrived at the provincial hospital. He thus avoided outpatient treatment at the provincial hospital. For Quân, overloaded public hospitals made it impossible for staff to conduct quality outpatient checkups. It was incumbent on patients and their families, then, to be pro-active to mitigate uncertainty. He told me, "Health comes first, so it's our responsibility to take care of it (*vì sức khoẻ là trên hết, cho nên mình tự lo cho mình thôi*)." Despite his poor view of the public services, he was fine with using insurance to cover his medications at government facilities. He was willing to endure the long wait to save money on medications he had to take regularly as well as indefinitely.

Anticipatory calculation also reflected how he managed the health of his family. His household consisted of himself, his two sons (grade school age), his mother (age 66), and his father (age 69). In 2013, he dealt with three health crises: his father was diagnosed with prostate cancer, his mother with breast cancer, and his son had appendicitis. All three required surgery, but Quân did not treat all surgeries equally. He explained, "My parents' surgeries were life and death, so we paid our own money out of our pockets. For my son, taking out an appendix is very common so we used health insurance. We have to be aware of what is dangerous, and that's when we use money (*Mình phải nhận thức biết cái nào nguy hiểm mới dùng tiền*)."

As he also explained, direct payments in cash changed the relationship between the doctor and patient. Quân continued, "If you put out your own money, you will not lose time. Paying for surgery out-of-pocket will get you seen more quickly. If we already know what the problem is, then we want to start surgery quickly so our health doesn't deteriorate while we are waiting. When you pay with your own money you will be seen as a blood relative, the doctor will care for you more, and your health will be safer" (*bác sĩ sẻ cơi như con ruột, nên se quan tam hơn, và sức khoẻ se an toàn hơn*).

Money was a quick way to gain intimacy with doctors, which increased caretakers' feelings of security that their family member would be well taken care of. To pay for these consecutive surgeries, he used all the money he had saved and he borrowed about 70–80 million VND (~3111.11–3555.56 USD) from relatives, promising to pay them back after the rambutan harvest. All the family members survived and

were healthy now.

When I asked about why he had to pay with his own cash in these situations, he explained it as a mentality (*tâm lý*) of Vietnamese people to believe cash and intimacy brought security in highly unpredictable situations. However, he did acknowledge the injustices associated with this type of monetary practice. People without the economic or social resources could not mitigate uncertainty in this manner. He explained, "the people who buy voluntary insurance or the ones who purchase through family-based enrollment often do this [choose when or when not to use health insurance to pay for care], but people who are poor do it less. For them, they must take life as it comes (*để tới đâu hay tới đó*)." With money, caretakers and patients no longer felt like passive recipients of fate. Payment using their own cash made patients and their families feel like they could overcome fate by compelling doctors to treat them like kin. Although it was not economically rational, it was reasonable given the uncertain circumstances of illness and the limitations of the Vietnamese health system.

Households and communities provided the social and economic resources for people to manage the precariousness of economic and health care restructuring in post-reform Vietnam. Money was an important mediator of relationships and facilitator of anticipatory activities. These activities were attuned to present circumstances and the near future as people planned to meet specific obligations to the ones around them. For these reasons, the use of their cash to purchase health insurance was not part of their economic or care repertoire.

3.5. *"I Don't Have Any Money": Anticipating Inequalities in the Health Care System*

The stratified design of the Vietnamese health system makes having cash advantageous. Many residents lamented the fact that cash determines what they could expect from the health system, which was often based on one's ability to pay. The decentralization and privatization of the health care sector embedded inequality into the design of the system. Many expressed how convenience and quality care were concentrated at central-level facilities. This deterred people from purchasing health insurance because it provided two alternatives that were at times better than using health insurance: first, the availability and convenience of private doctor's clinics. Second, the option of first-class service wards (*dịch vụ*) located in the public hospitals. Both of these avenues were private—generating income for the doctors and generating revenue for the government hospitals in the wake of decreasing state subsidies. More importantly, insurance did not cover both avenues of medical care.

Since *Đổi Mới*, physicians could open their own private clinics outside of hospital hours to alleviate crowded state-run hospitals. Most are strategically located near the state hospitals. Using health insurance required people to use the public system. For outpatient care, this was highly inconvenient as it forced patients to wait in line for care and lose the rest of their productive workday. People often anticipated waits of 3–4 h per visit. Many planned to arrive in the morning—some as early as 4:00AM—to guarantee that their appointment would not spill over into the next day. Private doctors' clinics allowed them to bypass this inconvenience as they were often seen in an hour or less and the clinics were open at various hours of the day and evening. Such circumstances demonstrate why informal workers decline from participating in insurance.

First class amenity wards are located inside public hospitals. Patients can bypass the lines, choose their preferred doctor, and be seen on the weekends and afterhours when paying out-of-pocket for this level of service. For workers in the informal economy, these conveniences outweighed the money they would save using health insurance for outpatient care. They could instead use this time to tend to their fields, wait for a potential call for work, engage in community-oriented activities, or rest from a hard day of work.

4. Discussion

This paper provides an in-depth analysis of what it means when people say "I don't have any money" as a reason to not buy health insurance in Vietnam. Through a descriptive and ethnographic approach to decision-making, I show how anticipation shapes monetary practices which, in turn, shapes enrollment behavior. Among my interlocutors, five anticipatory activities outweighed the value of health insurance: care responsibilities for family members following the life course, changing economic and environmental risks, cultivating intimacy within the community, managing health vulnerabilities and the inequalities of the health care system. Just as insurance is oriented towards the future, so are these moral projects which ultimately take precedence over buying insurance. Attention to anticipation challenges researchers to rethink the multidimensionality of cash, polysemic notions of cost, and the structural and institutional conditions that shape people's orientation towards the future.

The decision to forgo health insurance occurs against the backdrop of Vietnam's ongoing marketization. As individuals and families increasingly shoulder more economic and health care responsibilities, cash becomes key for optimizing all manner of resources—be they economic or social—as they anticipate care for themselves, their families, and their community. Money appears as the top reason to withdraw from health insurance participation not just because of its quantities, but because of its qualities (Truitt, 2013). It has exchange value: whereas insurance can only pay for health care following certain rules, cash is more flexible and allows informal sector workers to engage in other moral projects that constitute anticipatory activities. Cash also has cultural value: it helps them cultivate numerous relationships which can potentially be leveraged in the future. Together, these qualities of cash allowed them to adjust to changing circumstances ahead. When the utilitarian phrase "I don't have any money" is taken at face value, the moral projects that underlie anticipatory activities are easily obscured.

If cost is a common barrier to insurance uptake, then re-signifying "not having money" through anticipation invites us to think more expansively about costs as multifaceted. The decision to buy and use health insurance may lower the financial costs of medical treatment, but it also raises other costs. There are social costs for improperly caring for children and elders, or disengaging from community affirming activities. Even with limited cash on hand, relationships characterized by intimacy could provide emotional and financial support when needed in the present and future. There are health and well-being costs. With increasing medical stratification, it is common to question whether they are receiving the best care. Cash rather than insurance diminishes feelings of vulnerability especially since access to perceived higher quality treatment depends on ability to pay. Lastly and not surprisingly, there are time costs. Time is a finite resource. Most expected to lose several hours when seeking insurance-covered medical treatment and this could be untenable for informal workers who had few labor protections or access to social security. The benefits of insurance did not outweigh the anticipated array of economic and social costs. To be uninsured was economically and morally sound.

Readers should not mistake the ability to act upon alternatives to insurance as a sign of unfettered agency. As discussed throughout, my interlocutors evaluated their decision to remain uninsured amid the country's rapid integration into the global capitalist economy. Their anticipatory activities occurred in relation to their expectations of economic and environmental volatility with little official institutional supports. The complexity with which they evaluated what to do, what health route to take, and how to optimize their resources took great labor and intellectual effort. Many acknowledged the importance of health insurance as a resource, but it was not practical for them to enroll while bearing all the risk when crops failed, or when family members became ill. It was also not practical as they aspired for a better life and directed their present economic activities towards those visions. Without dependable help from the state, their vigilance and orientation

towards the future was rooted in the knowledge that their networks may be their only safety net and source of social capital. A focus on anticipation alerts us to this complex internal processing, and it captures their interactions with systems and institutions that structure their visions and options.

In this way, my findings are in accordance with other anthropologists studying insurance who promote structural approaches to well-being (Mulligan and Castañeda, 2017). Rather than focusing on how to get informal sector workers to purchase health insurance at the microlevel, researchers can investigate anticipatory activities as a way to access what uninsured people were most concerned about. Structural changes that focus on increasing overall capabilities can help increase enrollment (Sen, 2011). For example, Shigute et al. found that providing other social protections and membership in safety net programs contributed to higher uptake of insurance enrollment in Ethiopia (Shigute et al., 2017). This information can help policymakers decide how to allocate resources to curb other risks as part of efforts to achieve universal health *care* over mere universal health *coverage* (Abadía-Barrero and Bugbee, 2019).

5. Conclusion

Over 100 countries have pledged to reform their health financing systems under Universal Health Coverage (Mayhew, 2016). Although findings from this research are particular to Vietnam, its approach can inform any context where researchers may hear the phrase "I don't have any money" as justification for not buying health insurance. The fact that people do not enroll in health insurance because it is not high on their list of priorities compared to other expenses is not a new. What is new, and what a focus on anticipatory activities allows us to see is what they prioritize and how they prioritize. It also widens our breadth of knowledge about what those "expenses" or costs may entail. Following other anthropologists, I have shown how their preference towards anticipatory activities that cultivate relationships, diminish uncertainty when health care seeking, or contribute to improving economic futures makes informal sector workers in Vietnam "responsibly uninsured" (Fletcher, 2017). Anthropologists studying a variety of insurance products have long shown how decisions to purchase insurance are layered with moral reasoning. Here, I show how moral reasoning—as revealed through anticipatory activities—can also lead one to *not* participate in insurance.

An ethnographic approach shows that the uninsured are not passive agents to policy implementation, but sophisticated in their anticipatory calculations. Informal workers are beneficiaries of health insurance, but they also must be recognized as sources of revenue for health insurance programs. They are critical stakeholders in UHC who are intricately involved in and affected by the campaign. In asking people to buy health insurance, policymakers are also asking them to incorporate insurance into their anticipatory repertoires of financial planning. For informal and precarious workers, this requires them to prioritize buying insurance over other activities which optimize their resources under conditions of high risk. "Not having money" actually signifies the capacity of cash to provide some purchase on the future. The universal recognition of money has the power to obscure the diverse meanings, moralities, and economic structures behind it (Guyer, 2004; Zelizer, 1997). The phrase "I don't have any money" or its iterations should invite researchers to consider the underlying implications of these statements in other country and cultural contexts. Research on UHC must be attentive to the factors that demotivate people from participating in the health insurance programs they are purported to benefit from.

Many are increasingly finding that traditional economic theories of demand and pure financial factors do not explain enrollment patterns in the Global South (Dror et al., 2016; Mladovsky, 2014; Mladovsky et al., 2014). The concept of anticipation and anticipatory activities may offer a more fruitful avenue for analysis because it deviates from the habitual utilitarian frameworks frequently used to study the determinants of health insurance enrollment. In broadening how we think about the uninsured, anticipation helps us see more clearly what is going on. With better clarity, better solutions can follow suit.

Author contribution

Amy Dao: Conceptualization, Methodology, Software, Validation, Formal analysis, Investigation, Resources, Data curation, Writing (Original-Review-Editing), Visualization, Supervision, Project administration, Funding acquisition.

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