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Organisational Misbehaviour and Management Control in China's Public Hospitals: Doctors' Red Packets

Abstract This paper investigates Chinese doctors' informal payment, known as red packets, with reference to the debate on organisational misbehaviour, fiddles and control. It aims to examine the internal and external factors that have contributed to the emergence of red packets in health services and the strategies of hospital management in dealing with informal payment. Data collected from two hospitals show that doctors' misbehaviour is closely related to a number of structural issues embedded in contemporary China's public health services – funding issues, payment systems, corruption and motivation – but more importantly the study demonstrates the rationality of employee fiddles and management responses. Findings indicate that doctors are mainly responsible for this fiddling, unethical and illegal activity because of the financial gains acquired from patient bribery. However, doctor misbehaviour remains under management's latent control as long as hospital income generation and reputation are not severely threatened. The study contributes to the analysis of informal payment in the field of organisational studies and employment relations, with a fresh perspective offered to extend our understanding of red packets in the context of healthcare marketisation reform.

Keywords Chinese doctors, informal pay, misbehaviour, fiddle, control

1 Introduction

Work related misconduct, such as deviance, cheats and sabotage, is not only pervasive but also costly for organisations (Ackroyd and Thompson, 1999; Mars, 1982; Vardi and Wiener, 1996). These activities have been defined as organisational misbehaviour, which refers to 'any intentional action by members of organizations that defies and violates (a) shared organizational norms and expectations, and/or (b) core societal values, mores and standards of proper conduct' (Vardi and Wiener, 1996, p.153). As a prominent feature of work and employment, organisational misbehaviour has been the focal point of study for a long time by industrial sociologists (Collinson, 2000; Burawoy, 1979; Watson, 2003), industrial relations commentators (Blyton and Turnbull, 1998; Edwards and Scullion, 1982) and organisational behaviour writers (Coleman, 1994; Robinson and Bennett, 1995). Studies have ranged from conventional themes such as cheats (Mars, 1982) and misconduct at work (Vardi, 2001), to closer examination of surviving strategies (Noon and Blyton, 2007), humour (Collinson, 2000), resistance (Knights and McCabe, 2000) and management misbehaviour (Ackroyd and Thompson, 1999).

However, such rich literature and emerging scope for research in the West are in sharp contrast with the limited examination of organisational misbehaviour in China.

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The consensus from existing studies is that organisational misbehaviour widely exists at all levels of organisations (Richards, 2008). Hence China's changing workplace regime will not be clearly understood without a proper exploration of a variety of organisational misbehaviour. In the context of social-economic advancement and health service reform in China, the compelling issue of 'informal payment' needs to be closely evaluated with reference to misbehaviour because current studies on this issue mainly focus on the implications for health service quality. This is particularly reflected by the lack of necessary attention to informal payment, so-called 'red packets.' To fill this research gap, a study has been conducted to answer the following questions: what are the main factors contributing to the emergence of red packets? Who are responsible for red packets and what are management strategies in dealing with red packets? Central to these enquires is the conceptualisation of red packets through an organisational misbehaviour framework and the analysis of fiddle and control.

Data collected from two Chinese hospitals allows the query of red packets to be evaluated by considering both individual and organisational factors. The research seeks to contribute to an enhanced understanding of doctors' red packet behaviour in the field of organisational studies and employment relations, with particular reference to fiddle, cheat and management control. This paper attempts to furnish a missing element in the existing literature on red packets by configuring the extent to which doctors' informal pay can be categorised as a fiddle activity as conceptualised by Mars (2008), and by examining the dynamics of management control (Edwards, 1988) in the workplace.

The rest of the paper is structured into six sections. First, it will provide an introduction to red packets in China's hospitals and the current research agenda on informal payment. Second, it will review the existing literature on organisational misbehaviour by looking at various types of misbehaviour and their implications, especially in reference to the debate around fiddle, conflict and control. Third, it will discuss the research methods of the case study, before presenting the major findings in the next section. In the final section, the paper will further analyse the findings and summarise the conclusion and implications of the research by addressing red packets, fiddle and control as reflected by doctors' professional character and management's strategies.

2 Red Packets in China's Hospitals

The term 'red packets' is shorthand for the informal payment given by patients to health workers. It is a wide-spread practice and one of the most frequently discussed topics in contemporary Chinese health services (Yang, 2013). In many ways informal pay has a long history in China, and has been labelled with different terms: red packets (as used in this article), red envelopes and red packages. Its original Chinese term is *hongbao*, and in this context represents patients' gratitude towards doctors and nurses in exchange for better services. In Chinese society, red packets are regarded as gifts and the recipients are expected to benefit the gift-givers in order to sustain and develop social ties between individuals (Zhou and Zhang, 2004). As an important instrument, red packets have a key role in developing personal relations, *guanxi*. For the purpose of establishing and maintaining a *guanxi* relationship, one is likely to use monetary and instrumental red packets to establish reciprocity. This *guanxi* exchange process, characterised by mutual economic gains, is often informal, complicated and

non-transparent, and the outcome of the exchange is not always clear and predictable (Fan, 2007). As Gaal, Belli, McKee and Szoscka (2006) highlight, there is a deep-seated cultural dimension to some informal payments since gift giving is a cross-cultural phenomenon that is an integral part of normal social relations, including in the health sector, used as a means to build trust between patients and health workers.

Although informal payment is a worldwide phenomenon in medical services, especially in most post-communist or transitioning economies (Ensor, 2004; Lewis, 2007; Cohen, 2012), the scale and impact of red packets on China's health care are more significant than many people realise (Yang, 2013). In a recent national survey, hospital doctors were regarded as one of the most corrupt occupational groups in China, rated by 74.2% of the respondents (Tam, 2011). This striking fact demonstrates the prevalence of red packets, as the public trust in doctors and hospitals has been deeply eroded by this form of corruption (Lewis, 2007). Year after year, there have been many government campaigns trying to eliminate the phenomena through tough sanctions (Yang, 2013), but red packets seem to be pervasive. As a recent measurement, the Chinese central government has required that from May 2014, all level 2 and above hospitals have to implement a contract system which asks patients and doctors to sign a no-red-packet agreement before hospitalisation (National Health and Family Planning Commission, 2014). However, this might be another fruitless effort which will not be successfully implemented because it appears rather symbolic (Huang, 2014). Nonetheless, the vivid debate about doctors' red packets continuously attracts considerable attention from the general public, media and government authorities.

A few recent investigations focus on doctors' informal pay, although they are mainly concerned with the implications for the quality and equality of the Chinese health care system (e.g. Bloom, Han and Li, 2001; Fan, 2007; Lewis, 2007), and the overall evaluation of doctors' pay and employment relations (Cao, 2014). Elsewhere there is growing interest in analysing doctors' informal pay in Europe, especially eastern Europe and some southern EU countries such as Greece (e.g. Gaal et al., 2006; Liaropoulos, Siskou, Kaitelidou, Theodorou and Katostaras, 2008). In a discussion of doctors' informal pay in developing and transition countries including China, Lewis attributes informal pay to two reasons: one is an outgrowth of the breakdown of poor governance and the absence of accountability in public service delivery, and the other is the lack of proper management and penalties (Lewis, 2007). For Lewis (2007), dysfunctional management in hospitals and negligence may create opportunities for doctors to take such action. Informal pay has also been linked with doctors' formal salaries, because their insufficient wages may push them to supplement their income (Fan, 2007). Yet overall there is a tendency to associate doctors' pay issues with controversial health care reform, since the government's new funding policies have provided numerous opportunities and incentives for hospitals to engage in organisational corruption (Tam, 2011). As hospitals need to generate more income from the market, health workers such as doctors are encouraged to be more active in finding financial gains, some of which have become their own gains (Bloom et al., 2001).

3 Conceptual Reflections on Doctors' Informal Pay

3.1 Red Packets and Organisational Misbehaviour

Theoretically, doctors' red packet activity can be categorised as a type of misbehaviour in the field of organisation studies. Organisational misbehaviour appears to be a universal misconduct phenomenon in the workplace, although it has a variety of forms, intensity, severity and frequency (Vardi and Wiener, 1996). For Ackroyd and Thompson (1999), organisations can produce misbehaviour such as non-compliant or counter-productive behaviours, which are affected by organisations' ways of shaping and directing employee behaviour over time. Another type is employee deviance, voluntary behaviour that violates organisational norms and threatens the well-beings of individuals or organisations (Robinson and Bennet, 1995). But most misconduct activities are subtle misbehaviours or organisational crime, such as sabotage, culture, humour or harassment, and they are hard to identify and measure (Ditto, 1977; van de Broek and Dundon, 2012). Furthermore, although organisational misbehaviour is a lasting feature of organisations, 'misbehaviour continues to develop according to the nature of modern organisations, the people who work within them, and to an extent reflects broader social, political and technological trends' (Richards, 2008, p.654).

Many factors have been identified in relation to organisational misbehaviour, as the motives, frequency and intensity of organisational misbehaviour vary in different circumstances (Vardi, 2001). For Vardi and Wiener (1996), two main types of antecedents are individual factors such as personality and dissatisfaction, and organisational factors such as goals and culture. Organisational culture, including the organisational climate and the ethical climate, is regarded as the major force influencing all kinds of behaviour, characterised by employees' emotional comfort and support and the reward system (Vardi, 2001). But the ethical climate has a more immediate impact on misbehaviour than the organisational climate, and misbehaviour is rooted in 'the organizationally espoused values and precepts' (Vardi, 2001, p.326).

Conventional organisational analysis tends to associate misbehaviour with negative impact, e.g. more or less destructive phenomena (Richards, 2008). For Vardi and Wiener (1996), misconduct is damaging if it simultaneously violates both societal and organisational values through harassing members, sabotaging work and vandalising equipment. When the intention is to hurt others or organisations, misbehaviour will cause damage, even if the damage is subtle or minor (Vardi and Wiener, 1996). This seems to be a reasonable explanation, but it does not reflect the nature of deviant behaviour; for example doctors' informal pay is not intended to cause damage to individual patients or hospitals, although some consequences may be damaging.

3.2 Fiddles and Red Packets

A closer portrait of red packets is exhibited in the study of workplace fiddles and pilferage (Ditton, 1977; Mars, 1982), a significant dimension of misbehaviour analysis for industrial sociologists (Richards, 2008). Fiddles are characterised by workers who recurrently break rules through theft or pilferage and actively re-negotiate them on a continuous basis (Thompson and Ackroyd, 1995). As part of the organisational subculture, fiddling is dependent upon the context and legitimate structure within organisations so fiddles can be delicately balanced between legitimate and non-legitimate activities (Ditton, 1977). On the other hand, the existence of fiddles does not mean these behaviours are immune from being detected. For instance, when fiddles become visible, society will show resentment, envy and occasional social outrage (Mars, 1982). Based on his grid categories, Mars (1982) classifies four different types of fiddles relating to various professions, namely hawks, donkeys,

wolves and vultures that are characterised by different degrees of autonomy, group identity and organisational control.

Hawks are usually more independent professionals who are able to take advantage of their skills by swooping to opportunities and being energetic, adaptable and resourceful (Mars, 1982). Typical jobs include highly skilled professionals such as doctors, managers and academics. For hawks, fiddles and flexibility are common because this is how their work is done. There are a wide range of fiddles for hawks, from direct occupational crime to tax evasion to perks, but the key for hawk professionals is that they have occupational freedom which allows them to fiddle. A typical example, as Mars (1982) notes, is that some successful surgeons keep working in the British National Health Services where formal pay is relatively low, since they can get more informal fringe benefits at work. In contrast, vulture professions are mostly semi-skilled craftsmen with a strong group dimension, as their autonomy for fiddling is less independent and subject to bureaucratic control.

Compared with hawk and vulture jobs, donkey and wolf jobs are taken by less skilled workers whose fiddles differ from what doctors, for example, can do. The typology developed by Mars (1982) is an important categorisation for analysing cheat behaviour, although in reality the examination of workplace fiddles needs to be associated with circumstances. Nevertheless, the complexity of work and employment means that many behaviours and misbehaviours are not always straightforward, and doctors' red packets need to be carefully evaluated with reference to the particular context within which doctors can take advantage of their profession. Particularly when considering cultural elements such as *guanxi*, red packet activity is distinctive from hawk and vulture-type fiddles.

3.3 Red Packets, Fiddle and Management Control

Organisational problem?

To a certain extent red packets are linked with organisational corruption or mismanagement. Research has found that Chinese doctors' reputations are being undermined due to the prevalence of organisational corruption, with a weakened and lower level of patients' trust towards health professionals and hospitals (Tam, 2011). As Cohen (2012) highlights, corruption is an important structural factor that can explain the informal payment phenomenon in many countries' health services. When red packets have become an unspoken rule in health services, patients have to follow because they are frightened of otherwise being disadvantaged (Kong, Du, Zhao, Yang, and Qin, 2011). Kickbacks between pharmaceutical or equipment companies and hospital management or doctors have become an open secret as almost every doctor and manager, if associated with drug or equipment selling, may be given a variety of red-packets (Tam, 2011; Zhou and Zhang, 2004). In the context of the endemic organisational corruption within health services, perhaps it is not surprising that red packets are wide-spread among doctors.

Another organisational reason contributing to informal pay is that doctors' formal pay is too low to reflect their professional contributions. For Lewis (2007), many doctors in developing countries are concerned about low and irregular salary payments accompanied by a lack of government attention and insufficient contributions from patients to formal fees. Lower levels of job satisfaction, partly caused by doctors' feelings about job insecurity, is another motive for accepting informal payments (Stringhini, Thomas, Bidwell, Mtui and Mwisongo, 2009). As a

result, patients may regard low pay as an impetus to contribute to doctors informally, although the informal pay comes with their hope for establishing good relationships and the cultural traditions of gratitude (Lewis, 2007). However, studies have also found that a substantial increase in fees and salaries by itself would not have a serious impact on doctors' behaviour (Liaropoulos et al., 2008). In other words, purely increasing formal pay will not necessarily lead to the reduction of informal payment.

Individuals' problem?

Since health workers are the recipients of red packets, they should be the ones mainly held responsible for their own unethical or illegal behaviour. Cohen (2012) regards individual corruption as a key factor that can explain the phenomenon since red packets are counter to doctors' professional integrity. For Fan (2007), this problem also reflects the failure of modern Chinese health services in maintaining the traditional Confucian ideology that appreciates the proper use of financial and spiritual rewards. On the other hand, accusing doctors and patients cannot effectively help policy makers because both have simply adapted to the rules of the game to survive (Gaal et al., 2008, p.270). As one of the major concerns for China's health services, corruption has seriously damaged the medicine-patient relationship and the efficiency of the service. One solution, as suggested by Fan (2007), is to not only abolish distorting governmental funding policies but also to adopt the traditional Confucian moral approach to re-establish a rightly directed appreciation of the proper financial reward. When corruption is part of daily life in transitional countries, sanctions against individual health workers would not have much impact because policies must focus on the broader context of regulation to reduce the overall level of corruption in society (Ensor, 2004).

Misbehaviour, fiddle and management control

As mentioned earlier, the concept of organisational misbehaviour provides a strong case for categorising red packets as one of workplace fiddle or cheating activities. For Ackroyd and Thompson (1999), organisational misbehaviour can be very prevalent and varied in content and recurrent in normal working situations. The fiddle perspective, as suggested by Mars (1982), maintains that doctors are one of the professionals who are able to take advantage of their position to gain economically through their positions. Again, doctors can be categorised into both 'hawk' and 'vulture' professions whose fiddle activities are part of their daily work (Mars, 2008), since doctors have professional freedom and independence that can help them cheat and are not easily caught by management. For management, the strategy for dealing with fiddles may be direct or indirect, but management endeavours to retain final control over productivity and quality. Often management will tolerate workers' fiddle activities to a certain extent (Thompson and Ackroyd, 1995) because such fiddle activities can help to secure employees' co-operation. As Blyton and Turnbull (1998) indicate, management may show a kind of persistence of a pragmatic and opportunistic approach to elicit employees' compliance rather than active cooperation. For many hospital managers, the attempts to control hawk fiddles are likely to fail (Mars, 1982), because these organisations must rely on professionals who persistently have freedom. But ultimately, employment relations strategies are based on management's basic objective that is aimed to 'secure and maintain a predictable, productive and cost-effective labour force' (Blyton and Turnbull, 1998, p.335). More

importantly, fiddles sometimes can help to achieve organisational targets. Therefore, ‘many “unofficial” practices can, by interpreting formal expectations, contribute to managerial goals’ (Edwards, 1988, p.189). Even if some fiddles are known to management, perpetrators like doctors may be tolerated when their official jobs are done, and control mechanisms must co-exist with misbehaviours.

4 Research Methods

To broaden the understanding of red packets, case studies were carried out in two Chinese public hospitals and interviews were conducted with doctors, managers and trade union officials. Case studies are said to be ‘suitable to provide further understanding for complex social phenomena and the power relations between management and workers’ (Kitay and Callus, 1998, p.101). Two hospitals were selected, one in Beijing and another in Guangdong province in south China. Case study hospital B is a municipal city general hospital in Beijing, with a large number of staff, good and modern facilities and relatively good pay. Case study hospital G is a county general hospital in Guangdong, with a relatively lower level of pay and a smaller number of doctors mainly serving a rural population. There are geographic and demographic differences between the two case hospitals; however, the study tries to distinguish common issues over doctors’ informal pay and its implications for misbehavior and employment relations.

An economically advanced place such as Beijing can generate more resources, including financial and human resources, for its local hospitals. On the contrary a county hospital such as case study hospital G has less financial investment and less advanced equipment, as well as a smaller scale of organisation. Table 1 compares the two case study hospitals regarding their location, types and general background. Because of the disparities in local economies and the existence of a ‘strong urban bias’ in allocating Chinese health resources (Anand, Fan, Zhang, Zhang, Ke, Dong and Chen, 2008, p.1776), the two case study hospitals differ in several aspects. First, most doctors in case study hospital G come from a provincial medical school or local universities, whereas in case study hospital B most doctors come from better medical schools in Beijing. Second, as income levels in Beijing are higher than in the county where the case study hospital G is located, most doctors in hospital B earn more. Third, medical facilities and equipment are much better in Beijing, and the buildings of case study hospital B are newer and more advanced.

Table 1 The Two Case Study Hospitals

	Case study hospital B	Case study hospital G
Location	Beijing	Guangdong Province
Type	City General Hospital	County General hospital
Grade	Second Division Class A	Second Division Class A
Scale	1,012 staff, 424 doctors (male 160, female 264)	820 staff, 305 doctors (male 184, female 121)
Ward	900 beds	400 beds
Local population	3,000,000	600,000

(Source: Fieldwork materials from the case study hospitals)

During the fieldwork, 39 semi-structured interviews were conducted, 24 with

doctors, 5 with managers and 3 with full-time union officials in the case hospitals. In addition, two officials from doctors' professional bodies were also interviewed. Other interviewees include health officials in the central and local governments, health economists, and an official from the All-China Federation of Trade Unions (ACFTU). Interview responses were used as the main evidence to reflect perceptions of the practitioners and managers regarding informal payment, together with an examination of the data from documentation. Most documents come from the case study hospitals, government health authorities, trade unions and government bodies.

Except for commonly deployed ethical considerations such as anonymity and confidentiality, the researcher took into consideration culturally related research challenges, especially during the data collection process. Interviews with managers and some doctors had to be carefully handled because conversation languages may be sensitive about pay-related topics. Many research respondents have low levels of experience in taking part in academic research so their answers should be interpreted with special care (Stening and Zhang, 2007). One tactic in this research is to cross-check different sources of data and compare between documents, interviews and literature to avoid the potential problem of subjectivity.

5 Red Packets in the Case Study Hospitals

Evidence shows that many doctors received red packets in both case study hospitals, although the full picture was not entirely clear because of the sensitivity of the topic. This part will present findings from the case studies by examining the scale of the red packets in the two hospitals, the major reasons for doctors receiving red packets and the response of hospital management.

5.1 The Scale of Informal Payment

Doctors' formal pay

In both hospitals, doctors' informal pay is in addition to the formal payment system that includes fixed wages and flexible bonuses. Apparently as in most Chinese medical institutions where bonuses are associated with institutional revenue (Hsiao, 2008), the two hospitals have made economic targets their main priority. It should also be noted that doctors' pay is closely related to the development of the local economy, which influences residents' income and ability to afford healthcare. Higher levels of economic development in Beijing provides more resources for hospital B to generate income, whereas hospital G's revenue is constrained by the county economy. As a result, health care affordability in these two regions influences both doctors' formal pay (revenue-oriented bonuses), and informal pay (red packets).

Table 2 Comparing Doctors' Formal and Informal Pay in the Two Hospitals

	Case Hospital B	Case Hospital G
Formal payment		
Pay structure	Standard wage + bonus	Standard wage + bonus
-Standard wage	Fixed	Fixed
-Allowance	Fixed	Fixed
-Bonus	Flexible	Flexible
Bonus determinant	Hospital management	Hospital management
	-Director and Party	-Party Branch Committee

	Committee Standing Member Meeting -Department directors	Standing Member Meeting -Department directors
Informal payments	Red packets Drug company kickbacks (unconfirmed)	Red packets Drug company kickbacks (unconfirmed)
Employee voice	Nearly none on pay	Workers' Congress discussion (limited and symbolic)

(Source: Fieldwork materials from the case study hospitals)

Table 2 shows the scale of doctors' formal and informal pay in the two hospitals. Strictly speaking, informal payment also includes drug company kickbacks, but in this paper the focus is on red packets exchanged between patients and doctors. For doctors' formal pay, it appeared that management discretion is the main pay determination method, and this might partly explain the low level of doctors' satisfaction regarding their formal pay. Compared with management's confident view regarding pay strategy and personnel management, doctors' responses showed contrasting attitudes as generally they were not happy. They were also not satisfied with the bonus distribution methods and hospital personnel management in general. By contrast, it was the point of view of the hospital management that the formal payment systems could positively motivate doctors and nurses. The vice director of hospital G suggested that compared with the traditional 'iron rice bowl' system, the new method was intended to 'break the egalitarianism'. A strategy, combining individual and collective performance-related pay, had been adopted by both case study hospitals. By linking doctors' economic performance with their bonuses, it was clear that both hospitals aimed to boost service quality, doctors' commitment and hospital income; however, the actual effect did not always match these goals.

Doctors' informal pay

In both case study hospitals, red packets seem to be a wide-spread phenomenon as many doctors admitted that they knew of the existence of red packets somewhere in the hospitals. As a consultant said, 'I think this (red packet issue) is very common, especially in those key departments like surgical and cardiology clinics where patients and their families are more anxious about the quality of the treatment' (Interview, Hospital B, Traditional Chinese Medicine). But doctors seemed to be very cautious about discussing who got red packets, let alone their own practices. So most doctors and managers did not want to point fingers or name names, but only claimed that there were a few such incidents in general. Nevertheless, most doctors thought that receiving red package was unacceptable, although none of them was willing to disclose how much he or she could usually get. In addition, not every doctor had 'equal' opportunity to be given informal pay by patients. For instance, one diabetes doctor from hospital G complained that he was unhappy to be in his position, because the bonus was less and there was no chance to be given anything by patients. He assumed that the surgeons were better-paid through red packages.

Most doctors interviewed agreed that receiving red packets was incorrect although they did not deny the existence of the phenomenon. It was believed that as a matter of common sense, receiving patients' money was not only morally wrong, but also against medical professional ethics. An obstetrics consultant in case study hospital B said that the red packet was common in a few other departments where patients often

provided money to doctors. She said:

...as a doctor, accepting red packets is absolutely wrong after patients have paid service fees. The extra and unnecessary money means our service is not purely for the public interest but for the private pocket as well. If we all receive red packets, what is the purpose of being a professional doctor? But I think the red packet phenomenon will decline when the regulations and monitoring mechanisms are more comprehensive (Interview, Gynaecology Obstetrics, Consultant).

On the other hand, not every doctor had the same opportunity to be given extra money by patients privately as people tended to give red packets when they needed services that were in high demand. For instance, one doctor from the Technical Department said that her colleagues did not have red packets from patients or commissions from drug sellers; therefore their income was low although the department had very expensive equipment (Interview, Hospital B, Radiology, Consultant).

5.2 Why Do Doctors Accept Red Packets?

It is not entirely clear as to why doctors accept red packets, because not all doctors would openly discuss this sensitive issue; however, existing evidence from the study does show the main reasons for red packets include doctors' low level of satisfaction about their formal pay, their heavy workload, the extent to which patients give red packets and management's half-hearted control over red packets.

Low level of formal pay

Psychologically, red packets are related to lower levels of formal pay, as some doctors suggested that their hospitals did not pay them enough so they had to find ways to improve their overall income. As a junior doctor hinted, 'Most doctors do not earn enough from their salaries but they could afford to buy cars and properties because they had second channels of earnings from their services' (Interview, Hospital B, Internal Medicine). Evidence indicates that doctors in both case study hospitals were not satisfied with their pay, and in general they wanted better pay. Furthermore, in both hospitals the payment (especially the 'flexible part') was unilaterally decided by hospital management, while doctors and unions had very limited opportunities to take part in the decision making process. To some extent the extra-legal behavior is attributed to the low income of Chinese doctors, and it is the marketisation of hospitals, not the doctors themselves, to blame (Xinhua News, 2008). One consultant from case study hospital B suggested that the most important thing about bonuses was 'whether your department is prioritised in the hospital director's reform plan' (Interview, Hospital G, Radiology, Consultant). He said: 'Because the priority of the hospital is economic output and patients' charges, there will be more support from the hospital leader to the department – including more bonuses – if the department can generate more income.'

Most doctors interviewed were unhappy with their pay. A female consultant complained that the bonus level was so inadequate that 'The income does not give us enough compensation for what we have contributed, which is unfair' (Interview, Hospital B, Gynaecology Obstetrics, Consultant). It appears that doctors' expectation

of what they should be paid are often compared with other better-paid occupations in the public sector, The major comparisons they make are with higher education, higher-level hospitals, and civil service and research institutes. Overall doctors in case study hospital B thought their monthly income should be from 5,000 to 8,000 Yuan, and the case study hospital G doctors wished they could earn as much as 4,000 to 5,000 Yuan. A few doctors even hoped they could have earnings as high as 10,000 Yuan a month. A senior consultant from the Gastroenterology Department in case study hospital A believed that doctors like him should be paid 10,000 Yuan or more, in order to reflect their social contributions. He said: ‘The society is not isolated so we should refer to and compare with each other. But we should not compare with doctors in foreign countries, who have more free choices than we have’ (Interview 13, Hospital B, Gastroenterology, Senior Consultant).

To some extent, informal income has more or less compensated doctors’ ‘insufficient’ formal income provided by hospitals. As Lim et al. (2004) have noted, in China, ‘poorly paid public sector doctors are resorting to other means of compensation such as accepting gifts for favors, or over-prescribing and over-treating for profit.’ Arguably, Chinese doctors’ informal income ‘closes the gap between the limited payment required under law and a payment more commensurate with the quality and attention the patient and the family seek to secure’ (Chen, 2006). Regardless of the issues of morality and professional ethics, informal payment does give doctors a pay rise to some extent, albeit in a controversial way.

Heavy workload and low morale

It seems that accepting extra payment is associated with heavy workloads because the formal payment system does not sufficiently compensate their professional contributions. Almost all the respondent doctors said their workload was heavy and they had too much pressure. In addition, concerns were raised with regard to the pressure and the risk of medical services, as often patients’ expectations were too high. When the pressure was combined with a stressful environment and patients’ mistrust, things could become worse. A senior consultant in the Cardiovascular Department admitted that the pressure was mainly from the risk involved in surgical operations: ‘The patient’s family cannot understand our doctors, and they always think our service should be perfect and mistake-free. If there is an accident they normally consider it to be our fault and then they want us to give them huge compensation. We are quite nervous because the patients’ families now have more ways to appeal or accuse us’ (Interview, Hospital G).

With the growing pressure from workload and lower levels of morale, some doctors wanted higher pay to correspond to these problems. As a doctor stated, ‘I don’t normally have red packets but I understand why some of my colleagues do this – because they work in very busy environments and their reward has been too little’ (Interview, Hospital B, Gastroenterology, Senior Consultant). Ironically, patients are not happy with doctors either. A recent national survey shows a deteriorating relationship between Chinese hospitals and the public due to relative shortages of medical resources and rising medical costs, as many doctors complained of a heavy workload, while patients accused doctors of being impatient, money-oriented and unethical (China Daily, 2008).

Passivity of being given red packets

Another explanation is that many patients just wanted to give extra payment to doctors and nurses voluntarily in exchange for better service. Some doctors admitted that they had experienced receiving red packets, but they identified themselves as passive acceptors rather than demanders. As one consultant in case study hospital G declared, he had got ‘something’ from a patient, but he thought that was realistic since the patient was a millionaire who insisted on offering a treat. He claimed: ‘I never take poor people’s money. Sometimes I even pay fees for those farmers who cannot afford our service. But you know I don’t mind if a rich friend wants to thank me by treating me with a decent dinner or a good gift. It is natural to receive your friends’ presents’ (Interview, Hospital G, Radiology, Consultant). As another consultant stated, the general public had a widely accepted view that giving red packets was a norm, without which patients would not feel comfortable (Interview, Hospital G, Paediatrician). In the two hospitals, it seemed that the Chinese culture had a significant impact on the formulation of red packets because it was seen as a way of establishing *guanxi* between the patient and hospital. To some extent, many red packets are not always necessary for current treatments but patients might be looking to the future and want to establish a long-term relationship with their doctor. The *guanxi* relationship is moderated or balanced by mutual obligations of reciprocity. In an organisational context, instrumental *guanxi* practices may offer opportunities since gains and favours are exchanged for personal purposes (Millington, Eberhardt, and Wilkinson, 2005); but apparently the nature of *guanxi*-based red packets in these hospitals is seen as corrupt and unethical.

5.3 Doctors’ Cheats and Fiddles

Whatever the reasons were, doctors in these two hospitals fiddled their official duties and responsibilities when they accepted red packets. It is obvious that this cheating behaviour was against professional standards and legal regulations, because doctors gained personal income at the expense of patients’ private money and their hospital’s reputation. Informal pay exhibits a conflict of interest between the physician’s commitment to quality patient care and their own financial self-interest (Leiderbach, 2001). Moreover, red packets show the ability of Chinese doctors to fiddle, which comes from their professional control over patients because their status and special skills are regarded by many as a monopoly power (Mars, 1982). Doctors dared to cheat partly due to the fact that they likely understand management’s loose control strategies, since there is a low risk for under-the-table red packet transactions that are hardly detected by other parties (Kong et al., 2011).

Many doctors confirmed the existence of red packets in some part of the hospital. On the other hand, many doctors did not think red packets were very damaging. Due to the peculiarity of the issue, it is extremely difficult to determine the precise numbers of red packets, which actually have contributed to the overall income of some doctors. For obvious reasons, doctors were reluctant to disclose the accurate amount of money they or their colleagues had received, and it was also hard to know how many doctors had accepted red packets. When looking at the responses from the doctors interviewed, it is interesting to see that most doctors admitted to the existence of red packets in some departments, though few would be so frank as to identify themselves. Nevertheless, widespread red packets do illustrate the reality of corruption in Chinese health services. This phenomenon stands in sharp contrast to the government’s call for Chinese doctors to keep morale high when they are ‘overworked and underpaid’ (Pei et al., 2000), and the assumption that the motivation

for doctors is associated with their ethical requirements (Liu and Mills, 2005). The problem also signifies the government's failure to motivate doctors by using moral encouragement through ideological and political education (Pei et al., 2000).

5.4 Management Reactions

Although doctor responses confirmed the existence of red packets in both hospitals, management seemed to be confident that red packet activity was rare and under strict control. Management also expressed serious opposition to the behavior. Both hospitals had set up 'professional ethics committees' and management took a public stance against this behaviour. During the fieldwork, the researcher found in case study hospital G, there were some wall posters with the words 'We do not accept red packets.' The vice director of case study hospital G believed that to some extent, his hospital had eliminated this controversial activity. He insisted: 'We are absolutely opposed to red packets. As a public hospital, we never allow doctors to accept patients' money or presents. We will discipline any doctor who dares to receive red packets. The central and local government have developed effective systems to prevent this behaviour. If offending doctors were caught we would terminate their chance to upgrade their professional posts. We think the red packet is a very bad thing that damages our reputation' (Interview, Hospital G). In a document from this hospital, it is claimed that in 2004, there were 36 doctors in total who 'refused patients' red packets in various ways' (Case study Hospital B, 2005, p.3). Management views appear to be totally different from doctors' reflection on red packets, and this might be explained in two ways – either no red packets exist or management was either ignorant or tolerant of the situation.

One has to acknowledge that red packets have had 'a negative impact on the efficiency of service delivery' in China (Pei et al., 2000, p.107). Similarly in many eastern European countries, unofficial and informal payment has been found to provide a 'significant but possibly distorting contribution to health care financing' (Ensor, 2004, p.237). In Russia there has been 'thank you money' for hospital doctors inherited from the Soviet era, as the unofficial pay for service system is still common (Barr and Field, 1996). Interestingly in this study, hospital management did not take this issue too seriously although publicly they condemned this behavior and prohibited doctors from accepting red packets. An explanation is that hospitals have to publicly prohibit red packets, probably due to the pressures from the health authorities and the public.

In the case study hospitals, department managers acknowledged the existence of red packets, and some managers also hinted that receiving patients' gifts might show that doctors' achievements are recognised by the public. As one manager said: 'Our surgery department has a good reputation for attracting many patients, so our doctors are very popular' (Interview, Surgery Department, Hospital B). Elsewhere a study has found that in general, 'first-line supervisors do not just tolerate fiddles as constraints that they are forced to accept but also take them for granted as ways of getting work done' (Edwards, 1988, p.192). For management, the benefit from these kinds of informal patterns of behavior is that 'supervisors find fiddles useful because they give workers some interest in the job and thus make the task of supervision easier' (ibid.). As long as management control and organisational reputation is not threatened, managers may continue to tolerate such activity. This is because managers may 'tolerate a certain amount of fiddling...or some relatively minor sabotage, if it helps them to secure control over the workplace' (Williams and Adam-Smith, 2007, p.285).

6 Discussion and Conclusion

This paper has attempted to fill in a key research gap on conceptualising red packets in China by offering a fresh perspective and coverage on this important issue. The study extends our understanding of Chinese doctors' red packet activity by reconfiguring the organisational misbehaviour approach and linking informal payment with workplace fiddles and management control. Accepting patients' monetary gifts is one of the misbehaviours as doctors overcharge on services for personal profit, echoing part of the typology of workplace deviance (Robinson and Bennett, 1995). To some extent, the organisational misbehaviour thesis is prevailing for the analysis of red packets, which are also related to organisations' ethical climates (Vardi, 2001) such as Chinese hospitals' corrupt environment. Nevertheless, it is evident that red packets, just like other organisational misbehaviours, have had costly and negative consequences for both hospitals and patients.

This study reveals that red packets are the results of low levels of formal pay, hospitals' mismanagement, social attitudes such as *guanxi* and doctors' own cheating behaviour. Findings demonstrate the scale and impact of red packets in the two case study hospitals. Most doctors feel underpaid and de-motivated due to the marketisation of services, which lead to their rent-seeking behavior such as red packets. This black market of red packets in Chinese hospitals shows that management finds it difficult to 'officially and openly reward those doctors who can provide somewhat better quality care to patient' (Chen, 2006, p.10). Evidently red packets are unable to contribute to hospital service efficiency, because only individual doctors receive financial gains from informal pay. As Ensor (2004) notes, since informal payments relate to the abuse of market power and rent extraction, there is no positive effect on health service efficiency and patients have to face increased administrative bottlenecks for choosing alternative services.

There are a few similar features of red packets in the two hospitals, especially in management's covert tolerance compared with hospital public statements against such activity. Doctors in both hospitals had similar complaints about low formal pay and heavy workloads that are used as excuses for red packets. However, there are some aspects that are different between these two hospitals. First, the Beijing hospital seemed to be more active in its campaign to eliminate red packets, whereas the Guangdong hospital appeared to be less passionate in dealing with the problem, though its management did have 'official' objections to red packets. Secondly, doctors in Beijing were more reluctant to talk about red packets than their Guangdong counterparts, partly due to more restrictive regulations imposed by the management in Beijing.

For Chinese doctors, opportunities to take bribes come from their own intention to earn more, especially when organisational and social environments give space for these transactions to occur. This study also reveals a number of structural issues embedded in contemporary China's public health services – the funding dilemma, payment systems, corruption and motivation – but more importantly it demonstrates the rationality of employee fiddles and management responses. Doctors are mainly responsible for fiddling around red packets because their financial gains exceed the legal and ethical boundaries. In this regard, Chinese doctors have some of the common characters exhibited within both the 'hawk' and 'vulture' groups (Mars, 2008), as they are able to capitalise on their professional status and individual control

of the service while they are not easily detected by colleagues or managers. Even with tough sanctions, red packets still exist amongst some doctors in Beijing hospitals, because fiddling is part of the elasticity of these professions (Mars, 1982).

In contrast, although hospital managers have recognised the problem of red packets, much of the red packet activity is tolerated because it does not threaten hospitals' reputations unless their activities are exposed to the public. As Blyton and Turnbull (1998) highlight, management is primarily concerned with ensuring the productivity and cost-effectiveness of their workforce through control and compliance, hoping employees will respond with active cooperation and commitment. The study also shows the dynamics of conflict and control at the point of production between health professionals and management. Managerial control tactics, meanwhile, can vary considerably because red packet behavior shows different formalities from time to time, 'and managerial toleration may disappear when conditions change' (Edwards, 1988, p.194).

This is a portrait of a kind of misbehaviour as Chinese doctors deliberately fiddle in order to adapt, cope, interpret and challenge hospitals' rules through red packet activity. On the one hand, red packets have helped hospital management to ease the tension that arises from the problematic formal payment system. On the other hand, the essence of the workplace employment relationship remains as demonstrated through conflict and co-operation in Chinese hospitals through red packet fiddles and management reactions. But overall Mars' (1982) examination of workplace cheats appears to be an appropriate framework to conceptualise red packets, since the fiddle factor exists in workplaces where economic returns are directly relatable to individual efforts or skill. Red packets are also a culture phenomenon influenced by *guanxi*. What is more, doctors' fiddle activities arise partly due to workplace discontent towards formal pay, and the complicated and sometimes covert workplace fiddles are featured through employees' illicit cheats and management's latent control (Edwards, 1988). If doctors' official jobs are done, hospitals may be more likely to tolerate red packets in a way that would not threaten both managerial authority and organisational interests. In other words, doctors' misbehaviours are under management's latent control as long as hospitals' income generation and reputation are not seriously threatened.

Admittedly, the study is limited by the sensitivity of the topic, making it extremely difficult for respondents to talk freely about their experiences of red packets, because most doctors and managers were self-conscious about associating their colleagues and themselves with this matter. Analysing red packets would benefit from further study, with more data and in-depth evaluation of the circumstances embedded in China's culture context and health service reform. Eventually, a developmental approach is helpful to evaluate red packets because misbehaviour 'continues to develop as an organisational phenomenon due to a range of contemporary internal and external forces' (Richards, 2008, p.654).

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