

**Submerged discontent and institutions: doctors' pay in Chinese
hospitals**

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ABSTRACT

The paper evaluates doctors' widespread pay-related discontent, and doctors' response through formal and informal action. In a context of authoritarian management and compliant trade unions, Chinese doctors can only have individual, subtle and informal confrontation. Meanwhile the doctors' professional society is expanding its influence, showing a desire to develop doctors' group identity and protect members' interests more effectively. The research findings have wider implications for the conceptualization of skilled workers' professional organizations, which may develop as important new actors in the Chinese industrial relations system.

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INTRODUCTION

This study examines how the conflict between doctors¹ and their employers over pay arises and is accommodated in two Chinese public hospitals in the context of health service marketization. As 'a major source of contention in industrial relations' (Marsden, 1983: 263), pay represents the basis of conflict of interests between workers who want to 'work less' for better pay and employers who want to 'pay less' for more work (Gall and Hebdon, 2009: 591). For employees, conflict may be expressed by individuals alone or through collective action, and in organized or unorganized forms (Batstone, 1979). By analyzing doctors' pay arrangements, I investigate the extent to which doctors in China take individual actions and the prospect for doctors' collective organization.

Hospital doctors are at centre stage of public healthcare systems as they are usually highly skilled practitioners and are vital for delivering the service. This is not only because doctors affect health service outcomes, drive hospitals' performance and command a large share of the budget (Anand *et al.*, 2008), but also due to the fact that doctors' contribution to society cannot be easily replaced. In most Western countries, doctors have been granted certain privileges by society: 'high pay, professional

¹ Doctors in China usually refer to licensed medical practitioners in health services, including surgeons, dentists and some technical professionals. In this study, all doctors are from public hospitals where the majority of Chinese doctors are working.

powers (e.g. prescription control), and self-policing (e.g., control of entry into professional schooling, the so-called gatekeeping control)' (Crum, 1991: 3). In China, however, traditionally doctors' pay was based on an egalitarian principle with narrow differentials between different grades (Bloom *et al.*, 2001), with little influence from trade unions.

Since China started radical transformation from a planned to a socialist market economy three decades ago, there have been substantial organizational reforms in China's public health system. During China's marketization process, the old iron rice bowl employment system has been eroded (Warner, 2004), and the state has placed priority on increasing the public sector's economic efficiency (Taylor *et al.* 2003). Within the public healthcare system, the state has also tried to use market-oriented strategies to ease its financial burden and improve performance. On the other hand, there have been few studies investigating management-labour conflict in China's health services, and much of the literature in this area is mainly interested in government macro health reform policies, with occasional focus on administrative and economic contributions by doctors' bonus systems (for instance Pei *et al.*, 2002 and Liu *et al.*, 2006). Therefore the following question arises: how is doctors' discontent expressed within China's current industrial relations framework?

The paper begins by introducing the nature of pay in the public sector, accompanied with an examination of industrial conflict and its accommodation, with special attention to the issue of informal and unorganized employee behaviour. Then it describes the transformation of managing people and pay in Chinese health services.

After introducing the research methods, it analyzes the evidence which illustrates doctors' pay in case study hospitals, and doctors' formal and informal, or collective and individual, responses. The last two parts discuss the major findings and overall conclusions.

PAY AS A SOURCE OF CONFLICT

As an on-going process of negotiation over the wage-effort bargain, pay has been characterized as the frontier of control which exists in all organizations (Blyton and Turnbull, 2004). In the public sector, for instance, pay usually exhibits a conflictual relationship as employees and their organizations constantly confront employers and the state with 'a perpetual conflict' over the distribution of pay (Allen, 1971: 39). On the other hand, the resolution of pay-related conflict is said to be the outcome of 'a range of institutional, formal and informal rule-making processes' (Grimshaw and Rubery, 2003: 56). For example in recent years, China has started to establish a new tripartite collective contract system to give unions some more roles on pay negotiation, although it is still a management-controlled model within a unitarist industrial relations system (Clarke *et al.*, 2004). Essentially pay is a major source of industrial conflicts, and employees may have various types of response, including formal or organized resistance, and informal or unorganized action.

Formal and organized action in resolving industrial conflict is usually through employees' organizations. When workers are collectively organized they will be able to depend on 'formal and infrequently negotiated agreements for the bulk of their

earnings increases' (Hyman, 1989: 25); and bargaining over pay is 'often the line of least resistance for union representatives' (*ibid.*: 26). Once conflict becomes institutionalized each party has to recognize the legitimacy of the other's existence, as institutionalization involves some agreement or acceptance of certain 'rules of the game' as a framework of relationships (Batstone, 1979: 62). This is particularly significant for skilled workers such as doctors in Western countries, as their unions often show a strong bargaining power over pay-effort bargain. As Hyman (1989: 33) emphasizes, skilled workers often possess 'a pride in their trade, a sense of community and commitment to common craft principles, which support powerful resistance to forms of managerial control which challenge their autonomy in the detailed performance of their work'.

Apart from organized actions, employees can always take informal and unorganized actions. Conflicts at work are not just as open struggle or clashes between workers and employers but also involve 'more hidden tensions and frictions' (Gall and Hebdon, 2009: 589). If there is no basic consensus it is not easy for an institutional system to recognize and handle, and other forms of conflict expression will be common (Batstone, 1979). These alternative confrontations are often presented as individualistic, informal and unorganized workers' behaviour, for instance sabotage, pilferage, absence or cheating, and they are said to be usually spontaneous and reactive (Blyton and Turnbull, 2004).

Different patterns of conflict and accommodation may co-exist, reflecting the dynamic development of employment relationship. Even in formally socialist

countries there are still formal industrial conflicts despite the state apparatus' oppression of trade unions' independent status, as organized resistance such as strikes and mass protest break from time to time (Edwards, 1986.: 305). In China, on the one hand, formal and organized confrontation between employees and employers is still less overt. Most employees' responses to conflict are passive, such as labour turnover (Taylor *et al.*, 2003). On the other hand, the level of industrial conflict in China has been rising in recent decades (Taylor 2000). Since the 1990s, there has been a rapid increase in sharp industrial relations conflicts, including strikes and demonstrations (though not allowed by the government), attracting increased attention from the government (Taylor *et al.* 2003). To some extent, increasing employee resistance does put Chinese employers under more pressure to improve the terms and conditions of the work, and public sector management may have to consider market-oriented payment schemes more carefully. Nonetheless, it is still difficult to provide a fair mechanism designed for resolving industrial conflicts under the current unitarist industrial relations system. Although China has official arbitration services and collective consultation mechanisms, much development is needed before conflicts can be accommodated through collective channels successfully (Clarke *et al.* , 2004).

MANAGING HUMAN RESOURCES IN CHINA'S PUBLIC HEALTH SERVICES

By the end of 2007, China's health services employed nearly 6 million staff, including 2 million doctors and 1.5 million nurses (Ministry of Health, 2008). With

such huge number of employees, government authorities face many complexities and difficulties in managing and paying health workers. In particular, the economic transformation has brought in dramatic challenges, including the collapse of traditional co-operative medicine, sharply reduced public health insurance coverage, and weakened patient affordability amid radically increased charges. To ease the pressure from public expenditure and to increase service efficiency, the government has been emphasizing the decentralization of planning and financing functions, introducing profit-making incentives and promoting diversified services (Wong and Chiu, 1997: 76). In doing so the state subsidy would ‘only cover part of the personnel wages and some new facility investments’ (*ibid.*: 81). Consequently the public health expenditure rate has dropped significantly (see table 1 below).

Table 1: Health expenditure in China

	1980	1990	2000	2006
Total health expenditure (100 million Yuan)	14.32	74.74	458.66	984.33
Percentage of health expenditure	100%	100%	100%	100%
Government health expenditure	36.2%	25.1%	15.5%	18.1%
Social health expenditure	42.6%	39.2%	25.5%	32.6%
Personal health expenditure	21.2%	35.7%	59.05	49.3%

Source: Ministry of Health, 2008

Table 1 demonstrates that in 2006 government investment was only 18.1% of the total health spending, while in 1980 the figure was 36.2% (Ministry of Health, 2008). On the other hand, the rate of individual health payment has increased dramatically

from 21.2% in 1980 to 49.3% in 2006 (*ibid.*). It is said that the Chinese government is responsible for most public hospitals' wage bills due to fiscal decentralization, with the exception of basic salaries for a designated number of personnel (Liu, 2004: 536). In 2002 the government could only afford 6% to 7% of total hospital spending, while paying staff wages would cost 26% of the hospital budget (Ministry of Health, 2005). This in practice has forced hospital management to allocate health care resources having greater reliance on market environment, and maintaining qualified service despite the declining government funding (Pei *et al.*, 2000). As a consequence, health workers' payment has been inadequately connected with the effectiveness and quality of the medical service. Study has found that bonuses are widely used by almost all Chinese hospitals, with the revenue-related bonus depending on the income generated by doctors through provision of services and drugs over a revenue target (Liu *et al.*, 2006). The unbalanced pay system has led to a relatively low level of formal pay and heavy use of bonus systems, creating 'a strong motivation on all staff to focus on revenue generation' (Pei *et al.*, 2000: 108).

Historically the political character of China's pay policy was enhanced by the ideological significance of supporting a low salary and high welfare system (Verma and Yan, 1995). Under the iron-rice bowl principle, pay differentials between health workers with different grades were quite small, as egalitarianism was deployed in the public sector to ease conflict and maintain social stability (Cooke, 2004). After the economic reform, the commercialization of Chinese health services encourages hospital management to pay doctors according to their economic contributions, which

has widened the pay gaps between doctors in different departments and hospitals. There has been an increasing level of dissatisfaction among Chinese doctors due to unequal opportunities for pay between rural and urban, developed and under-developed, regions (Lim *et al.*, 2004). Therefore marketization has intensified the conflict over doctors' pay, although the traditional iron-rice bowl system has not been completely replaced.

In recent decades, the significant liberalization of the economy has created the opportunity for Chinese organizations to adopt Western types of HRM (Rowley *et al.*, 2004). However the implementation of Western HR policies in China seems to be more 'difficult in practice than in theory' (Cooke, 2005: 19), and personnel reform in the public sector faces a number of challenges. For instance, the payment of public sector employees is still characterized by a relatively heavy proportion of bonuses in the total pay package and the residual egalitarian culture (Cooke, 2004). Moreover, pay arrangements in China are still largely determined by management discretion, because the ACFTU (All China Federation of Trade Unions, the only officially recognized union organization in China), the so-called 'transmission belt'², has not been legitimized to provide an effective channel through which 'members can articulate their aspirations and express their grievances' (Clarke *et al.*, 2004: 251).

RESEARCH METHODS

² *Transmission belt* is used to signify the way in which Chinese trade unions act as a transmission belt between the Party-state and workers, transmitting policies to workers and reflecting workers' opinion through 'democratic management' (White, 1996: 437).

This research attempts to answer the following question: How has marketization influenced the way that Chinese doctors express their discontent over pay? It deploys a case study approach and uses interviews and documents as major evidence. Two government hospitals were selected, one of which is in an urban area of Beijing and another is in a rural part of Guangdong province in the Southern part of China. The selection of these two hospitals is based on the following criteria: location, scale and access. Case study hospital A is a municipal city general hospital in Beijing, with a larger number of staff, better facilities and higher pay. Case study hospital B is a county general hospital in Guangdong, with a relatively lower level of pay and smaller number of doctors mainly serving the rural population. Given the development gap between capital Beijing and a remote county in Southern China, the two different cases allow a reasonable coverage of urban and rural possibilities on doctors' pay.

During the fieldwork, 39 semi-structured interviews were conducted, including 24 doctors, 5 managers and 3 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 government, health economists, and an official from the ACFTU and doctors' professional bodies. Relevant documents were collected from the case study hospitals, government health authorities and trade unions. It has been argued that the reliability of official documents from Chinese government is 'always problematic' for political reasons (Shen, 2006: 349). Similarly the responses from interviewed officials and managers

need to be carefully interpreted as the official language might have prejudiced opinions. In addition, accurate interpretation is a key issue as all interviews were conducted in Chinese and the scripts need to be translated into English. The participants' privacy and confidentiality has been respected.

DOCTORS' PAY IN THE CASE STUDY HOSPITALS

Although the two hospitals are different in size and scale, evidence shows that the pay arrangements are generally the same. Doctors are paid a fixed reward according to their positions and years of service and a flexible reward which is mainly performance-related bonus (see Table 2 below). Like most Chinese medical institutions where bonuses are tied to revenues and profits for each department and doctor (Hsiao, 2008: 995), the two hospitals have prioritized economic targets. Some autonomy in personnel practices and financial responsibilities have been given to them so that they can have more freedom in managing employees. It is the hospital director who has the discretion to determine the internal pay distribution method, which will be normally accepted by the Party committee in which the hospital leaders are secretaries. Department directors have some authority to distribute some bonuses internally.

Table2: Internal payment distribution methods in two case hospitals

	Case Hospital A	Case Hospital B
Pay structure	Standard wage plus bonus	Standard wage plus bonus
Standard wage	Fixed. Paid according to a national scale.	Fixed. Paid according to a national scale.
Allowance	Fixed with professional grade index	Fixed with professional grade index
Bonus	Flexible, linking to department income target and individuals' professional grade index	Flexible, linking to department income target and individuals' professional grade index
Bonus determinant	Hospital management Director and Party Committee standing member meeting Department directors	Hospital management Party Branch Committee Standing Member Meeting Department directors
Employee voice	No collective voice but doctors can talk to department leaders	Workers' Congress discussion (limited and symbolic). Communications with department directors

Source: Fieldwork material

The determinants of doctors' payments are illustrated in Table 3, showing how different elements contribute to total income, and how hospitals heavily rely on economic performance to motivate doctors. In these two hospitals, doctors' total income comes from four main sources: standard wage, hospital allowance (including trade union benefit³), departmental bonus, and informal pay – red packets⁴ (see Table 3 below). In addition to formal income paid by hospitals, extra payment is given to some doctors by patients. Over the years, doctors and nurses in key positions have had

³ As Chinese unions have welfare functions, sometimes trade unions distribute 'union benefit' (cash or domestic items), expressing unions' care of members. In fact these beneficiary allowances are also from the hospital budget.

⁴ It is a tradition that Chinese people give others gift money packed in a red envelope or packet to express good will. Red packets also refer to the money used for commission or bribery.

this unofficial income given by patients in order to ‘jump the queue or gain special services’ (Bloom *et al.*, 2001: 29). Red packets are exchanged as an expression of mutual obligation, and commonly exist in many other monopoly public service providers.

Table 3: Pay structure and determination for hospital doctors

Factors	Distributor	Impact factor	Nature
Standard wage	Hospital	National income policy	Fixed
Hospital allowance	Hospital	Hospital revenue, local comparability and policy	Slightly flexible
Union benefit (also from hospital)	ACFTU hospital branch	Hospital budget	Small amount
Departmental bonus	Hospital and department	Hospital and Departmental revenue; professional position and individual (economic) contribution	Similar internal distribution methods; various levels
Informal income: red packets	Patients	Doctor’s skills and discipline, and hospital reputation	Variable and secret Not everyone receives these

Source: Fieldwork material

Hospital management seems to be satisfied with doctors’ pay arrangements, by claiming that the current pay distribution methods have successfully motivated doctors. The Director of case study hospital A says that compared with the traditional ‘iron rice bowl’ system, the new method can ‘break the egalitarianism’ and ‘encourage staff to make more contribution’. In an official document, case study hospital B says that ‘through personnel reform, especially the new payment system, our hospital appears to have a better teamwork spirit and coordination between the management

and staff, which have helped to improve the efficiency and quality of our service’ (Case Study Hospital B, 2005).

By contrast, most doctors interviewed are not satisfied with their payment. Some doctors say their income is less than that of many other professionals in the public sector, such as the civil servants and university teachers. In general doctors in hospital A (in Beijing) have a higher level of pay than their counterparts in hospital B, showing a disparity between urban and rural areas. Within each hospital, pay levels vary between departments as their revenue differs. As Table 2 and Table 3 show, doctors’ fixed wages in both hospitals are paid according to a national scale, while departmental bonuses differ according to departmental and individual economic contributions to the hospital. It is understood that doctors’ fixed wages are kept as a generally stable amount of the salary in each month, which contributes to about 30 to 50 per cent of total formal pay. Overall the ‘flexible’ part of the payment attracts more doctors’ attention, as they expect a higher level of bonus and a wider pay gap which could reflect the contribution of those in higher professional grades. Not surprisingly doctors in Orthopaedics and Surgical Departments have more bonuses since expensive operation fees can make a big contribution to departmental income. By contrast, in low-income departments such as Traditional Chinese Medicine (TCM) and the laboratory, doctors have fewer bonuses and therefore they have many complaints about the pay system. One Paediatrician in Hospital A describes his ‘unfairly’ low pay:

‘Our department’s monthly bonus is the lowest in the hospital, because our patients come here with minor illnesses and our prescription is usually

cheaper than some other departments. We are paid less since our service income is relatively low, which is unfair as our professional contribution is the same as that of others.’

There are a few doctors who seem to be happy with the bonus system because they work in higher-income departments. But even in these ‘better’ departments, some doctors are not very satisfied with pay levels either, and also have other concerns. One Senior Consultant from Cardiovascular in Hospital A is concerned about his income, although his Department is believed to have higher bonuses due to expensive operation charges. He complains about the workloads and pressure:

‘The income insufficiently reflects reward because doctors’ contribution is not simply the numbers of operations, but also a valuable work for a complicated human body. We work very hard while we have to face the challenge from some patients’ families who might misunderstand our work’.

When doctors are facing unequal opportunities, their individual responses to market-oriented bonus system vary considerably. These marked differences clearly fragment doctors’ collectives and are likely to obstruct the development of collective responses.

DOCTORS’ RESPONSE IN CASE STUDY HOSPITALS

Evidently marketization has led to wide-spread discontent in both hospitals, as Chinese doctors are not happy with the unequal bonus distribution methods, the heavy workload and lack of recognition for their professional contribution. However doctors’ dissatisfaction can not be easily conveyed through formal, collective actions, e.g. trade unions. The doctors’ union, the ACFTU, is unable to represent its members, despite recent government initiatives encouraging the ACFTU to take on a more representative role in order to diffuse widespread social unrest. It has been proved that essentially the ACFTU is unable to respond to the demands of the situation.

The absence of ACFTU in organizing collective resistance

Both case hospitals have ACFTU branches as trade union organizations and full-time officials, but hospital unions are more like a management department in responsible for entertainment and welfare issues – a typical ‘Soviet’ type of union. There is hardly any employee involvement and little communication between management and doctors regarding their pay. As a surgical doctor in hospital B says, ‘unions’ regular Workers Congress meetings only have symbolic meaning because big issues will be finally decided by our hospital leaders’. When there are grievances about pay, doctors do not ask unions for help, simply because the ACFTU is unable to provide such assistance. The ACFTU has acted ‘sometimes half-heartedly, inconsistently and not particularly effectively’ (Chan, 2000: 274). One doctor from hospital A says:

‘I feel that the bonus distribution is unfair as it cannot rightly reflect my professional contribution as a senior consultant. But I would never speak to the union, because those people only do what hospital leaders tell them to do. They do not actually represent us.’

The doctor here is clearly expressing discontent. However he does not expect his grievances to be resolved collectively, as he understands the hospital union does not have any real power to take collective action. For instance in hospital B, employee voice can be heard through delegations of Workers’ Congress meeting (see Table 2, page 12); however this channel is not always meaningful because it is up to management whether doctors’ advices can be adopted (see Table 2, page 12).

The emergence of a doctors' professional organization

On the other hand, interesting evidence is found that doctors' professional body, the Chinese Medical Doctors Association (CMDA), is expanding its influence. Established in 2002, the CMDA is aimed 'to provide professional guidance on doctors' service, self-discipline, coordination and supervision; to provide the evaluation of doctors' professional qualifications' (CMDA, 2007). The CMDA also has a self-regulatory role to look at doctors' ethical issues. As a CMDA official interviewed says, 'we are doctors' own professional society which is devoted to protect doctors' interests and to safeguard doctors' career development and profession identity'.

Another important function for the CMDA is to help doctors to advance their skill base and status, as well as to protect themselves, through education and training programmes. In general, educating members is 'an important step in fostering the collectivist outlook that is often a critical precursor to unionization' (Fiorito, 2002: 630). Training is a potentially powerful vehicle to transform unions into more inclusive organizations with the ability to conceptualize a broader set of collective interests (Kirton and Healey, 2004). According to the CMDA official interviewed, the CMDA has called for educating doctors on how to avoid unnecessary medical disputes and protect their legal rights. In addition the official also says that the CMDA has asked the public 'to give doctors more understanding about their unfair treatment, because prejudiced social opinion will worsen the ordinary medical environment'.

Many doctors in the two hospitals are members of the CMDA and another professional body, the Chinese Medical Association (CMA). Doctors in Beijing have more opportunities in taking part in CMDA events, since CMDA is less active in rural hospitals. Both societies are professional organizations and have no influence on hospital management at the moment, although the CMDA seems to be focusing on recruiting doctors and to be a closed society with highly skilled practitioners only. Membership expansion provides the CMDA with more collective power, because to achieve greater outcomes, unions need greater resources such as financial capital and human or physical capital (Fiorito *et al.*, 2002). As a new society specifically for Chinese doctors, the CMDA differs from the ACFTU because members of CMDA come from a group of medical practitioners, whose common identity is characterized by high level of education and skills. Cregan *et al.* (2009) suggest that people wish to belong to a group that they perceive to be distinct from other groups in order to raise their self-esteem, as well as the regard of society and government. Doctors choose to join in the CMDA because membership can bring more training or academic exchange opportunities provided by the organization. These educational activities, such as a journal publication, training courses and conferences, can help build doctors' professional identity and therefore provide important basis for employees' resistance. As Kirton and Healey (2004) indicate, in employees' professional organizations, the development of confidence through presentations and debate is part of the process of shared learning that enhances individuals' potential contribution to collective organizations and actions. On the other hand, currently the CMDA has

nothing to do with doctors' pay determination in the workplace. As a consultant from hospital A says:

'Becoming a CMDA member can help build my networks and improve skills by attending professional training. But I don't think the CMDA could represent us to increase our income because at the moment only hospital leaders can decide our pay'.

Professional network helps build important social capital that the CMDA provides for doctors to develop their group identity, which is the basis of employees' collective organization. Even though the purposes of most conferences and trainings are academic or medical technique-oriented, members may take these opportunities to discuss doctors' common issues such as professional ethics and the protection of rights. This platform provides doctors with a lot of opportunities to develop their social capital. As Cregan *et al.* (2009) note, the social identification with fellow members in the group is associated with individual workers' collective behaviour, therefore the CMDA's activities contain chances for doctors to build up social capital for organizing collectively. Gradually this informal collective organization may reinforce doctors' common value with increased profile, influence and power in defending doctors' own interests. As Hyman (1989: 34) argues, the occupational solidarity of privileged white-collar groups, reinforced by their dominant position, is able to protect 'even incompetent individuals from the type of controls to which ordinary employees would be subject'. Nevertheless, the use of social capital to achieve improvements in workers' situation through collective action depends on their own values and aspirations (Taylor, 2000). There are possibilities that new institutions may emerge, or alternatively, employees may take informal collective action.

Doctors' informal response

Because it is impossible for doctors to have genuine collective resistance, doctors' discontent about their pay is more often expressed and handled through subtle and individual channels, including limited communication, turnover and informal payment. The first kind of individual response is that doctors can air their grievances to colleagues, and sometimes to lower ranking managers whose authority is limited. At a certain level doctors are allowed to make individual complaints through department managers, or Workers Congress meetings. As Taylor *et al.* (2003: 213) note, to some extent Chinese workers can 'air grievances' by using the more common complaint route of going through management. These complaints might be ignored by senior management in the end, but doctors do feel a bit comforted as they think at least somebody from management has listened to them. For instance, many doctors interviewed believe that they have many 'common languages' with the head of department, so doctors would like to exchange views with line managers rather than with hospital leaders.

The extent to which doctors can convey their dissatisfaction is constrained by management's bureaucratic control. Evidence shows that hospital senior management lacks adequate contact with frontline employees, and personnel managers have little shop floor communication with doctors as well. As a Traditional Chinese Medicine consultant in hospital A points out, 'Hospital leaders seldom come to speak to us in person or enquire about individual situations. We can usually see them speaking on the stage during hospital staff meetings'. Most doctors' grievances are made through

department managers although their voices are usually ignored by hospital leaders. An ophthalmology consultant in case study hospital B says: ‘Although personnel cadres have little contact with us doctors, we sometimes can suggest that the (department) leader asks the hospital director to increase our bonus. Normally the leader is willing to pass our messages to senior management because he also has a similar interest’. In contrast, there are more channels that hospital senior management uses to make downwards communications, such as staff meetings or internal newsletters which can brief employees on policies from time to time.

The second form of individual response is employee turnover, an alternative action for doctors to express their discontent. Leaving the job is one of the most direct ways of reacting to the dissatisfaction within the work situation (Rose 2001). Some doctors claim that they wish to leave the hospital, however quitting current posts means that doctors will not be able to air their grievances. Turnover will undermine doctors’ collective resistance, although it can bring concessions from management to reduce it. More grievances are found in hospital B than hospital A, as the county hospital has less incentive to retain doctors than its city rivals. To a large extent this is due to the unequal distribution of health resources between different geographic regions in China (Anand *et al.*, 2008). When the situation is combined with the stressful environment and patients’ mistrust, things could become worse. Young doctors particularly feel strongly that their payment is too low and therefore they are under pressure to leave. A doctor from the Medical Department who has only worked three years complains:

‘I work so hard on extra hours and many night shifts, but one night shift’s allowance can only buy me a breakfast (laughing). My income of course is the lowest in the hospital. Why am I so young? ... I also face huge pressure from the busy work and low pay. I am too busy to think about my future, although I admit that I have been considering going back to university to do a postgraduate degree programme.’

The major reason for doctors thinking about leaving is pay; however it is not easy to leave because competition is quite high for posts in better hospitals where the pay and working conditions are much better. It is also hard for doctors to find a better job outside the health service. Nevertheless hospital management has realized the potential problem of staff turnover. As the personnel assistant in case study hospital A notes, there is pressure coming from those ‘talented personnel’ who have been trying to leave the hospital because of all kinds of reasons including payment’.

The third type of individual resolution is informal payment, as some doctors take patients’ money secretly for exchange of providing quicker or better service. For instance, surgical and obstetrics doctors used to have more chances of being given red packets, since the risk of operations and helping pregnant women have made people believe that some extra money could lead to better treatment. As Table 3 (page 14) , indicates the amount of red packages are connected with doctors’ skills and discipline, and the hospital’s reputation. Moreover, not every doctor can be given red packets because ‘opportunities’ vary between different departments or between doctors with different professional grades. For instance surgery doctors have more chances being giving red packets than traditional Chinese medicine doctors. When patients are going to have surgical operations, they will be more likely to bribe doctors because the operations are more expensive and risky than herb prescriptions given by traditional

Chinese medicine doctors. Because red packets are often secret and hard to estimate, doctors' real income is not clear. Furthermore, red packets are an individual solution to a collective problem. This action may undermine the attempt at collective response, for instance the potential of developing a powerful organization for doctors themselves.

When doctors are asked about this sensitive topic, most of them acknowledge the existence of informal pay 'somewhere' in hospitals, although none of them is willing to disclose how much he or she can usually get. In addition, not every doctor has the opportunity to be given informal pay by patients. For instance, one diabetes doctor from hospital B complains that he is unhappy to be in his current position, because the bonus is less and there is no chance to be given anything from patients. He also assumes that the surgical doctors are particularly well-paid through red packets. Interestingly some doctors admit that they have experiences of receiving 'gifts', but they indicate themselves as passive acceptors rather than demanders. As one radiology consultant in the same hospital declares, he has got 'something' from a patient, but he thinks that is realistic since the patient is a millionaire.

In public, hospital management seems to be firmly opposing red packets. The director of hospital A claims: 'As a public hospital, we never allow doctors to accept patients' money privately. We will give serious discipline to any doctors who receive red packets.' However the existence of informal payments, as admitted by many doctors interviewed, indicates the ineffectiveness of management's effort to eliminate this behaviour. Although red packets are expressively prohibited by the government,

actually offenders are not disciplined seriously by hospital management. As a consultant in hospital B says: 'As long as red packets are not exposed by public media or nobody makes complaints about the issue, our leaders' main concern is still about raising hospital's income. Of course there are national and local publicity activities to call for eliminating this behaviour, but it is difficult to be completely implemented.' Clearly, the existence of red packets and managements' public rejection of them as a way of working can be used by management as a latent tool for undermining the organization of doctors. In short, doctors receiving them can always be 'discovered' to be doing so if they need to be disciplined.

DISCUSSION AND CONCLUSION

Findings of this study illustrate that Chinese doctors are paid unevenly and most of them have been de-motivated by the market-oriented bonus distribution mechanism. As Table 1 (page 7) illustrates, reduced government responsibility for funding health services means that hospitals are forced to pursue a market-oriented pay strategy. Linking doctors' pay with economic performance has made payment unequal, and out of line with their professional contribution. There is wide-spread dissatisfaction; however Chinese doctors cannot generate collective resistance like their counterparts in Western countries. The ACFTU is not a union with enough independent power, although doctors' discontent may be expressed through other channels. As Clarke (2005) remarks, due to the political weakness of trade unions, Chinese workers' interests cannot be easily defended by collective organizations. Chinese doctors, far

from achieving a degree of autonomy, are even more subordinated to hospital management than before as marketization has provided workplace managers with more authority.

On the other hand, under-organized Chinese doctors do have responses. Their discontent on pay has been accommodated through individual actions such as limited communication on grievances, turnover and informal payment. In the case hospitals there is limited employee voice within departments or through Workers' Congress meetings (see Table 3, page 14). Doctors do share their grievances with colleagues or talk to managers about their complaints, although this 'employee voice' channel is less meaningful. Some doctors have a turnover intention as an individual response to the conflict, despite the difficulties of using such an 'exit mechanism' in reality. Doctors also act like traditional employees who find individual ways to survive at work and supplement their income, in their case particularly through informal practice – red packets. As Chen (2007: 77) notes, there seem to be two options for contemporary Chinese workers – they become defenseless in the face of employers' power, or they 'have to fight for their rights as individuals'. While these subtle and unofficial behaviours have eased tension at workplace, management shows some extent of tolerance as long as doctors can make good contributions to the hospital. As Edwards (1988: 192) suggests, managers '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'. Nevertheless, doctors' individual solutions may undermine the attempt to develop formal, collective resistance, and employee turnover may weaken doctors'

chance to exercise voice.

When collective solutions are denied, informal action may be the ‘only option available and as such the most rational thing to do’ (Blyton and Turnbull 2004: 258). In particular the red packets, as well as other forms of informal activities, are alternative solution for Chinese doctors to the conflict at work when collective solution is unavailable. Nonetheless, informal payment does give doctors some pay increase, albeit in a controversial and illegal way. This is not unusual in countries where there are corruptive practices in the public sector. In Russia, for example, there has been ‘thank you money’ for hospital doctors inherited from the Soviet era, as unofficial pay for service system is still common (Barr and Field, 1996). Similarly in many Eastern European countries, unofficial and informal payment has been found which provides ‘significant but possibly distorting contribution to health care financing’ (Ensor, 2004: 237). In addition, red packets have escalated pay disparities between doctors, as this study has found that there are ‘unequal opportunities’ for this kind of behaviour between different doctors. In this way, doctors’ individual and informal responses undermine the development of their collective organization.

Despite the absence of independent trade unionism, there still have protections for workers rights in China (Shen 2006). The renewal of the Trade Union Law in 2001 and the establishment of the new Labour Contract Labour in 2008 have provided Chinese unions with more active duties in protecting employees. As Zhao and Nichols (1996: 19) indicate, the economic reform has at the same time sharpened Chinese workers’ consciousness since ‘the advance of the market encourages workers to fight

for their pay, not just to wait as they did under the planned economy'. The increasing number of labour dispute in recent years brought by Chinese workers to arbitration commissions and courts reflects the growth of workers' rights consciousness (Chen, 2007). During a period of transformation, Chinese workers' reactions to their discontent have become more diversified, like a number of different individual resolutions shown in this case study. Moreover, the marketization of doctors' pay has intensified their conflicts with management, while the existing unorganized resolutions seem to be inadequate and there is a need for collective activity to accommodate these conflicts. .

Against this context, Chinese workers may try to 'use their social capital as a basis to transform a common interest into collective action' (Taylor *et al.*, 2003: 342). To effectively defend their own interests, professional workers like Chinese doctors may need a good professional organization like the BMA in the UK, rather than a classical union like ACFTU that does not function properly. The expansion of a doctors' professional organization, the CMDA, provides a new platform for Chinese doctors to develop their social capital and collective identity. As Chan (2000: 275) remarks, public sector workers in China are 'better organized and educated and more aware of their rights' and there are preconditions for collective bargaining. Once the CMDA can use its strength to increase the level of control in doctors' training, education and the supply of the profession, it will have better position to mobilize members and to safeguard their interests. Where members see their organization as effective in improving work and employment conditions, collective action is more likely taken by

members (Buttigieg *et al.*, 2008). Yet the prospect of change is likely to be subject to the extent to which the Communist regime will permit employees' collective representation within current political framework.

This research, an observation on conflict and resolution over doctors' pay, provides a contribution to documenting employee resistance in contemporary Chinese health services. While most existing literature on management-labour conflicts in China focuses on enterprise workers and the role of ACFTU – a residual collective organization (For example Taylor, 2000; Clarke, 2005), this study offers an insight into medical practitioners' informal response and the emergence of a new collective organization – doctors' professional society the CMDA. The research findings have wider implications for understanding alternative channels for employees' discontent in China, and there is a scope for further study of the role of skilled workers' professional organizations. These societies may develop as an important new actor in the Chinese industrial relations system in the near future.

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