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Dignity in Red Envelopes: Disreputable Exchange and Cultural Reproduction of Inequality in Informal Medical Payment

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Abstract

Disreputable exchanges are morally disapproved and often legally prohibited exchanges that exacerbate and reproduce social inequality but remain ubiquitous. Although previous literature explains the phenomenon by material interests and structural relations, we propose a cultural approach based on three major conceptions of culture: culture in relations, culture in interactions, and culture in inequality. We illustrate this approach by a case study of China's hongbao *(the red envelope) exchange, a typical disreputable exchange through informal medical payment. Drawing on interviews with doctors and patients, we find that participants of the exchange mobilize items from their cultural repertoires, such as professional ethics, face, power, fairness, and affection, to redefine different situations of interactions and project positive self-images to render their problematic exchanges morally acceptable to each other. Moreover, as the participants' responses to our vignettes show, they negatively evaluate the exchanges in general moral terms, such as equality and fairness, but culturally justify their own involvement. This discrepancy between saying and doing tends to legitimize the disreputable exchange amid enduring public outrage and institutional prohibition. These cultural processes contribute to the reproduction of unequal access to scarce health care resources. Findings of this research not only offer insights into understanding disreputable exchanges but also contribute to research on other cases of social problems in which deviant behaviors are morally and culturally justified.*

Keywords

disreputable exchange, health inequality, informal medical payment, interaction order, relational work

Disreputable exchanges refers to the exchanges that are morally disapproved and often legally prohibited, such as political bribery, transactional sex, and so on. They are disreputable because they put prices on nonmarket goods and services and/or happen outside of institutionally sanctioned channels (Schilke and Rossman 2018). They also exacerbate and reproduce social inequality in getting access to scarce resources. Yet they exist

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in various forms in different parts of the world despite the protracted controversies they have caused.

How do people manage to make disreputable exchanges even though they know the moral disapproval and possible legal prohibitions? Why do disreputable exchanges remain ubiquitous and persistent? A recent approach provides a structural explanation: participants of the exchange "obfuscate" its transactional feature by rearranging their relations, such as finding a "broker" and postponing the reciprocal action to make it appear like exchanging "gifts" (Rossman 2014; Schilke and Rossman 2018). Nevertheless, although this structural approach draws on an implicit assumption about the cultural aspect of disreputable exchange, it pays surprisingly little attention to how culture works in its analysis. It does not explicitly address the central feature of disreputable exchange, its disreputability, and how participants make disreputable exchanges morally and socially acceptable. Moreover, it does not explain how the exchanges culturally reproduce social inequality, an outcome that makes it a significant social problem.

In this article, we propose an approach that highlights the cultural aspect of disreputable exchanges by adopting three concepts of culture: culture in relations, culture in interactions, and culture in inequality (Bourdieu 1990; Goffman 1967; Lamont 1992; Zelizer 2012). We specifically focus on how participants render the exchange unproblematic through matching relations with exchanges, how the participants mobilize items in their cultural repertoires to preserve their dignity, how they save each other's face in socially awkward and morally questionable situations, and how these cultural processes sustain the interaction order among the participants but normalize and reproduce social inequality.

We illustrate this cultural approach in an empirical study of the particular disreputable exchange of informal medical payment: the money or favor that patients offer to doctors, in addition to formal payment through the medical institutions, to exchange for better services and priority. Around the world, policymakers, health care administrators, patients, scholars, and public opinion condemn informal medical payment as a symptom of defective health care institutions and medical practitioners' moral degradation. It is believed to create barriers for less privileged patients to access medical resources (Gaal and McKee 2004; Szende and Culyer 2006). Nevertheless, various forms of informal medical payment remain ubiquitous despite governments' toughened restrictions and mounting public outrage (Habibov and Cheung 2017; Yao 2017). How do people manage to make an informal medical payment? Why is it so ubiquitous and enduring?

We answer these questions by conducting an interview-based case study of China's *hongbao* (red envelope), a prevalent informal medical payment offered to doctors to secure better services. In the sections to follow, we first review the literature on disreputable exchange and discuss our cultural approach. Then we examine four typical situations of hongbao exchanges and how health inequality is culturally reproduced in the exchanges. In the conclusion and discussion sections, we discuss the implications of this study for future research.

DISREPUTABLE EXCHANGE: THE STRUCTURAL AND CULTURAL APPROACHES

Despite their intrinsic moral tensions, disreputable exchanges have a history almost as long as that of human societies and remain rife in many parts of today's

world (Rossman 2014). Most people involved in disreputable exchanges know the questionable nature of their actions but are torn between the attractive benefits they generate and the moral disapproval they cause.

A conventional explanation of disreputable exchanges, for example, the social exchange theory, takes a materialist approach: disreputable exchanges are persistent and ubiquitous because the material benefits participants expect to reap from such exchanges outweigh their moral concerns (Blau 1964; Homans 1961). However, material factors and corresponding utilitarian motives are necessary but insufficient conditions; the social, moral, and even legal costs of involvement often override the expected benefits. Contemporary social exchange scholars would suggest a more sophisticated explanation: like other social exchanges, disreputable exchanges repeatedly happen among people who develop affective relationships of trust and solidarity among themselves (Kollock 1994; Lawler 2002; Lawler, Thye, and Yoon 2008). Yet affection and solidarity exist in only some but not all disreputable exchanges. More importantly, the materialist approach neglects how participants take pains to manage the moral tensions and justify their ethically problematic involvement.

A recent approach offers a structural explanation. This structural approach argues that participants of a disreputable exchange rearrange existing relations and develop new relations to obfuscate the morally questionable feature of the exchanges to make them appear less like quid pro quo to external observers (Rossman 2014; Schilke and Rossman 2018). These obfuscation strategies include: bundling (tying multiple seemingly unrelated exchanges together), brokerage (making the exchange through a broker), gift exchange (delaying reciprocity as in the gift relations), and pawning (offering favors that are not for sale to repay earlier debts). Obfuscation strategies can mitigate external observers' moral disapproval by masking the motivations and blurring the causal relationship between the items being exchanged (Rossman 2014; Schilke and Rossman 2018).

This structural approach successfully provides a novel, cogent explanation through methodologically rigorous studies (Schilke and Rossman 2018). Its success, however, comes at a price. The structural approach is derived from relational economic sociology but loses its core idea: relations are both structural and cultural. Representative figures in relational sociology like Viviana Zelizer argue that social exchanges are culturally defined, undertaken, and reproduced. People distinguish different kinds of exchanges based on their relationship with one another, defining some exchanges as appropriate and others as inappropriate (Zelizer 2012). Such cultural meanings are not secondary to economic actions but are a constitutive part. For example, buying gifts for one's sex partner is considered an appropriate expression of affection, but giving cash will transform the relationship into prostitution (Zelizer 1996).

Scholars that follow the structural approach are aware of the absence of culture in their analysis but justify their analytical choice by dismissing culture as "causally prior motivation" and "rhetorical framing" (Rossman 2014:44, 56) that stops working once structural relations are arranged. This conception of culture is somewhat outdated, in stark contrast to not only relational sociology but also many cultural sociological theories that confirm the role of culture in constantly changing social relations and interactions (Eliasoph and Lichterman 2003; Emirbayer 1997). Its equation of "the sacred" with the nonmarketable and "the profane" with the marketable

has been abandoned by new economic sociologists, who show that economic and noneconomic realms are interconnected and mutually constitutive (Bandelj 2020; Zelizer 2005). Moreover, although the structural approach determinedly departs from the cultural aspect of relation, its basic concepts and implicit assumptions are ironically cultural. For example, its fundamental concepts of the sacred and the profane are an essential pair in the theory of cultural classification (Douglas 1966; Durkheim and Mauss 1963). Obfuscation efforts are also both structural and cultural rather than just only structural: for example, gift exchange, one of the obfuscations in the structural approach, is not just a prolonged exchange with delayed reciprocity but, as numerous studies have shown, a cultural redefinition (Bourdieu 1990; Mauss 1967; Yan 1996). The outcomes of obfuscation are also ironically defined in cultural terms—"disapproval" by the "audiences" of the exchanges (Schilke and Rossman 2018).

Without dismissing the merits of the structural approach, we want to reemphasize the role that culture plays in initiating, maintaining, and reproducing disreputable exchanges. Specifically, *culture* refers to the meaning-making processes embedded in relations and interactions and involved in the reproduction of social inequality.

First, we bring the structural approach back to its origin, the relational sociology of economic actions, by highlighting its cultural core (Chan 2012; Emirbayer 1997; Zelizer 2012). Relational sociology posits that people draw boundaries between different exchanges according to their social relations and make creative efforts to connect the seemingly hostile worlds of economy and intimacy (Zelizer 1996, 2005) and of market and nonmarket domains (Almeling 2007; Healy 2006). Zelizer's "relational work" is particularly important for our inquiry. In relational work, people create viable matches among social relations, types of transactions, media for exchange, and their cultural meanings (Zelizer 2012). This relational-work idea has been applied and developed in studies of disreputable exchanges and related problematic practices. For example, Fridman and Luscombe (2017) find that to avoid being disreputable, donations to public agencies such as the police department require much relational work to "purify" them, including rhetorically denying reciprocity, limiting donation use, screening the giver, and so on. Mears (2015) shows how party promoters of VIP nightclubs in places like New York and Miami use relational work to exploit the labor of "girls" by framing their labor as "leisure" and doing a favor for "friends." But when the elements in relational work do not appropriately align, the women tend to experience the VIP party as work rather than leisure and thus quit the party.

Second, we supplement relational sociology with a compatible approach of "culture in interaction," rooted in pragmatist philosophy and symbolic interactionism in social theory (Blumer 1986; Dewey 1958; Mead 1934). This approach focuses on actors' active efforts to mobilize items in their cultural repertoires (Swidler 1986) to define specific situations and project positive self-images. Their goal is to maintain the "interaction order"—the order in which actors respond to each other to accomplish interactions in ways acceptable for all parties (Eliasoph and Lichterman 2003; Goffman 1983). Cultural meanings, therefore, are fluid and situational and often take the form of interaction norms in particular situations.

The culture-in-interaction approach emphasizes the role of interaction, situations, and actors' agency in creating and maintaining norms and meanings to solve problems. It illuminates a central feature

of disreputable exchanges: even though the exchanges remain questionable by the prevalent moral standards in the larger society, participants in the exchanges can still develop their own norms of interaction by selectively using cultural items to redefine the situation as unproblematic and to maintain positive self-images—dignity, reputation, decency, and so on (Goffman 1959, 1967).

Therefore, this culture-in-interaction approach also suggests a "role-switching" scenario. If one assumes the role of an external observer, one may apply general moral standards to comment on distant cases and easily express righteous anger. But once being involved in a disreputable exchange, one's goal is to achieve a successful exchange—not only a done exchange but also done with everyone's positive self-images intact and external controversies suspended. To do so, one is obliged to redefine the situation as morally acceptable; accept other involved parties' presentation of self-images, saving face for each other; and maintain the interaction order despite the public controversies. Consequently, this norm-following, order-maintaining tendency is likely to perpetuate the problematic practice at the micro level.

Finally, cultural sociologists have shown that social inequality is intrinsically cultural: people from higher social class are deemed more worthy, and in turn, their tastes, traits, style, and behavior become a signal of high class (Bourdieu 1990; Lamont 1992; Reed 2013). In disreputable exchanges, the participants with more power, resources, and social connections tend to have more cultural knowledge about how to handle the delicate exchange through and around the system, that is, "the ability to sense and maneuver emotional currents of interactions; balance the interactional power; and tune in to culturally and situationally appropriate meanings of transactions, social relations, and media of exchange" (Bandelj 2020:264). The more effectively participants justify their transactions and present positive self-images, the more stable and persistent the transactions tend to be. Consequently, inequality is more likely to persist. This is a process of cultural reproduction of inequality.

In sum, the cultural approach enables us to focus on the essential feature of disreputable exchange—its disreputability—and to explain how involved parties take pains to make the exchange less disreputable and more morally acceptable and how such efforts lead to the reproduction of social inequality.

DIGNITY IN RED ENVELOPES: INFORMAL MEDICAL PAYMENT AS DISREPUTABLE EXCHANGE

Informal medical payment occurs outside of formal medical institutions, usually between patients and doctors employed by public hospitals.[1] It often happens behind closed doors and is always off the record. The payment takes the forms of cash, gifts, or favors. Because of its impacts on health equality, it provokes public outrage, institutional sanctions, and legal penalties.

Informal medical payment widely exists in post-Communist countries, Africa, and East Asia, where the health care systems have undergone a dramatic transition from a centralized one to a market-oriented but sometimes disintegrated system (Chereches et al. 2013; Habibov and Cheung 2017; Yao 2017). A representative case of informal medical payment is China's red envelope (hongbao) exchange. In many of those exchanges, cash payments are enclosed in a red envelope, reflecting a Chinese

[1]Self-employed doctors, such as those who own their clinics, or doctors working at private hospitals usually do not have this issue (Chan and Yao 2018).

custom to wrap and give gift money. But the payment could also be made in other forms, such as gifts, favors, scarce resources, and opportunities that cannot be obtained through normal ways. In this article, we use the colloquial phrase *hongbao* as a shorthand for these forms.

The hongbao exchanges emerged when China underwent economic reform in the late 1970s and early 1980s. Although most medical institutions remain public, the government's budgets for the medical system have significantly decreased, accounting only for about 7 percent of public hospitals' total revenue (Ministry of Health 2013). Meanwhile, most medical service fees remain low. Therefore, 90 percent of a public hospital's revenue comes from commissions from pharmaceutical companies and high medical examination fees (Yao 2017). This revenue structure directly impacts the salaries of doctors, most of whom are hired by public hospitals. According to a survey, 75 percent of doctors have base salaries under 3,300 yuan (about $500) per month in 2016, only a little above the average monthly income (2,800 yuan) of Chinese city residents.[2] Eighty-two percent of them were unsatisfied with their incomes.[3] To supplement doctors' low base salaries, hospitals pay bonuses to doctors according to the number of services they provide, such as operations and lab tests. Doctors also receive commissions from the medicines they prescribe, which account for 30 percent to 70 percent of the regular price of medicines (Yao 2017). Some doctors are still unsatisfied with their compensations and venture out of the legitimate track to make additional income through legally gray-zone practices, such as treating patients outside their hospitals and receiving hongbao from patients.

The hongbao exchanges have provoked public controversy and have been condemned as a pathology of morality in contemporary China. To respond to the mounting grievances, in 2008, the Chinese Communist Party launched an "Anti-Corruption Campaign," aiming to monitor the use of public funds of government officials and to severely punish acts of embezzlement and corruption. The hongbao exchange was one of the target malpractices. In 2014, the National Health and Family Planning Commission introduced a regulation that requires both doctors and patients to sign an agreement not to receive or give hongbao.[4]

Yet despite the deepened oversight, the hongbao exchange has become part of Chinese people's tacit knowledge, a taken-for-granted option for patients to seek better medical services. In our sample of patients or patients' family members, 11 out of 23 said they had given hongbao to doctors, and all of them admitted the importance of offering hongbao, especially when a major procedure is necessary. This corroborates Chan and Yao's (2018) finding: 51.2 percent of their respondents (N = 572) reported offering surgeons hongbao. Doctors, especially surgeons, also regard hongbao as part of their professional life. Every one of the 32 doctors we interviewed reported that patients attempted to give them hongbao. Six of them admitted accepting hongbao, and the rest gave ambiguous answers.

Previous studies explain the emergence and prevalence of informal medical payment by citing institutional deficiencies, such as the lack of a national health insurance system, low government investment

[2]Data are from the National Bureau of Statistics of China: http://www.stats.gov.cn/tjsj/sjjd/201701/t20170120_1456174.html (retrieved April 16, 2021).

[3]For a detailed report (in Chinese), visit https://www.51test.net/show/7532460.html (retrieved April 16, 2021).

[4]The agreement (in Chinese) is available at http://www.gov.cn/gzdt/2014-02/20/content_2616571.htm (retrieved April 16, 2021).

in public health care, and unreasonable pricing of medical services (Fu and Chan 2016). At the micro level, this institutional explanation is converted into a classical social exchange theory. Because doctors' medical services are underpriced, patients harbor doubts about the quality of the services provided by such poorly paid, inadequately motivated doctors. Thus, they are willing to pay extra money to secure better services even though doctors may not ask for it (Gaal and McKee 2004). The underpaid doctors are reluctant to exit the system not only because of their long training period, which increases the opportunity costs, but also because the system provides them with benefits that cannot be gained from private sectors (Guo and Wang 2015). When doctors are not likely to exit (leave the organization) or express voice (offer open complaints), both doctors and patients turn to another option—*inxit* (staying in the system but using informal methods to reap benefits)—to meet their demands, which leads to informal payment (Gaal and McKee 2004). Studies also show the detrimental consequences of informal payment. It increases patients' financial burden and creates barriers for underprivileged patients to access medical services. It exacerbates the already rampant inequality in health care systems in many contexts (Chereches et al. 2013). This sensible explanation, however, is incomplete. It tells little about how involved parties, especially doctors, make efforts to reconcile the benefits of the hongbao exchange with its immoral nature, which could bring about possible risks to their career, reputation, and even personal safety (Chan and Yao 2018).

The structural approach could offer some interesting accounts: for example, doctors and patients practice obfuscation, such as finding a broker and giving gifts. Yet the structural approach does not capture the purpose of the obfuscations: the concerted effort to make the exchange morally and culturally acceptable to all involved parties and to maintain their dignity despite the moral tensions. Hongbao is not an empty symbol but a cultural statement that this exchange is not an outright economic transaction, let alone bribery. With neither the desire nor the ability to change the institutions and public opinions, patients and doctors endeavor to sustain their exchanges with selected and adjusted cultural vocabularies. All these processes fall outside of the scope of the structural approach and must be addressed by a cultural approach that focuses on the delicacy in individuals' maneuvering of cultural meanings to define and manage situations, interactions, and relations.

METHODS AND DATA

Our study aims to explain the ubiquity and persistence of hongbao exchanges by addressing three interrelated questions. First, how do involved parties endeavor to make the problematic exchange technically successful and ethically acceptable? Second, how is the exchange normalized in relations and interactions? Third, how do such cultural processes reproduce inequality and perpetuate the controversial practice? To answer these questions, between 2015 and 2018, the first author collected data from in-depth interviews with 32 doctors in public hospitals, 15 patients, and 8 patients' family members.[5] We chose Shanghai and Nanjing as our main sites to examine whether hongbao practices vary in these two cities with different institutional environments. Nevertheless, we did not find significant differences. We chose midcareer and senior doctors, 30 of whom have over 10 years of experience, because their

[5]We focus on public hospitals because they are backed by the government and are three times larger in number than private hospitals in China (Ministry of Health 2017).

higher prestige makes them targets for informal payment. Among the patients, 14 were older than 50 and had chronic diseases such as type 2 diabetes. Patients' family members were also interviewed because often they, instead of patients, are the ones who enact the hongbao exchanges. The first author used a snowball sampling method through her networks to recruit participants. She first identified two key informants, including a hospital president in Nanjing and a chief physician in Shanghai, and then asked them to connect her to other participants. She also tried to diversify the sample in terms of gender, age, and socioeconomic status. See Table 1 for the basic information of the participants.

Each interview lasted approximately 1.5 hours. Interview questions for doctors covered four topics: what their typical days in a hospital were like, how they managed the relationships with different kinds of patients, whether and how they received hongbao from those patients, what they did in return, and their attitudes toward and justifications for hongbao. Drawing on the interviews with doctors, the first author prepared a set of vignettes describing four hypothetical scenarios and showed them to patients to solicit their responses.[6] After showing each vignette, she asked questions like "How would you evaluate the act of *giving hongbao*?"; "How would you evaluate the act of *receiving hongbao*?"; and "*Who* is more morally questionable, the doctor or the patient?" She also asked the patients to recall in detail their own hongbao exchanges with doctors, if any. These vignette interviews are to test whether the subjects talk about hongbao differently when they comment on the phenomenon in general and when they are the participants of the exchange and how any discrepancy between the two has implications for inequality. The interview transcripts were analyzed in MAXQDA with open coding first and then with a focused coding that related different codes with one another to constitute explanations.

[6]See online Appendix.

Table 1. Basic Information of the Participants

Demographic information	Doctors	Patients (or patients' family members)
Gender		
Female	10	14
Male	22	9
Age		
20–29	2	6
30–39	5	3
≥40	25	14
Ranking / SES[a]		
Resident / low	2	11
Junior / middle	8	6
Senior / high	22	6
Region		
Shanghai	12	14
Nanjing	20	9
Total	32	23

Note: SES = socioeconomic status.
[a]For doctors, ranking is more relevant than SES in this study. Therefore, we provide ranking information of doctors and SES information of patients. Rankings and SES are self-identified by the participants.

FOUR SITUATIONS OF DISREPUTABLE EXCHANGE

We identify four typical situations of hongbao exchange—immoral transaction, face and power, fair recognition, and affective obligation—according to the involved parties' cultural understanding and definitions and their corresponding actions (see Table 2 for a summary).

Immoral Transaction: "Business Transaction in One Hammer Blow"

In the immoral-transaction situation, patients define the situation in an

Table 2. Four Situations of Informal Medical Payment

Features	Immoral transaction	Face and power	Fair recognition	Affective obligation
Structures of exchange	Attempted quid pro quo	A mix of brokerage, bundling, and gift exchange	Quid pro quo	Pawning
Patients' preexisting ties to doctors	Very limited ties to doctors	Weak ties to doctors but strong ties to brokers	Weak ties to doctors	Strong ties to doctors
Power relations	Doctors more powerful than patients	Patients more powerful than doctors and equally powerful as brokers	Approximately equal	Approximately equal
Definition of relations	Doctors and patients	Friends; superior and subordinate	Teammates	Loved ones
Chance of rejection	High	Low	Low	Low
Reproduction of inequality	Patients with lower socioeconomic status rejected and excluded	The internal inequality within the hospital reproduced	Inequality based on the ability to pay to show respect	Inequality based on strong ties that exclude others

imbalanced moral narrative: doctors on the profane side and themselves on the sacred side. They believe that people who give hongbao should not take the blame because they, compared to doctors, are disadvantaged and intimidated: "Those greedy doctors want more money, so we'd better give them to save our lives" (Interviews 37, 44). But doctors' acceptance of hongbao is unethical: "We can give hongbao, but they shouldn't take it, otherwise they are immoral" (Interview 48). The patients who define the situation in this way usually have lower socioeconomic statuses and thus focus on the cost of services. For example, one interviewee who had type 2 diabetes and gallstones said:

> *I'm also clever*. They [doctors] want to make money, but I don't let them. I won't take the ultrasound, and I only ask for a pain-killing injection. . . . I know which medicine is both cheap and effective, but they would say that this medicine has strong side effects, and I'd better take the [expensive] medicine they prescribed. They are *so corrupt*! (Interview 44, italics added)

Another patient, who suffered from late-stage thyroid cancer, made a stronger moral accusation: doctors and hospitals, especially those who treat serious diseases, are "the black hands sticking out of coffins" (Interview 37), meaning they profit from patients' suffering and death.

This generalized distrust in doctors' professional ethics and the health care system justifies a perception of the hongbao exchange as a mere transaction. This is characterized by a Chinese saying, "business transaction in one hammer blow" (*yi chuizi maimai*), meaning "by repaying immediately and ending the

relationship so soon, one not only gives up a chance to cultivate a long-term *guanxi*, but the relationship is also demeaned into an overt instrumentality of 'buying and selling' (*mai mai*)" (Yang 1994:144). This definition of the situation is enabled by two conditions. First, very few patients have connections with the doctors before the exchange and tend to view the exchange as a one-time transaction rather than an extension of preexisting connections. Second, most of them lack knowledge about the routine practices and norms of interactions in the medical system. Both conditions have to do with their lower socioeconomic status.

Consequently, when this definition of the situation is enacted in their actions, the patients often appear to have no intention to save face for doctors (Goffman 1967). They rarely give much thought to the right time and place to deliver hongbao. For example, they hand the money right before the surgery, when other people are present, perfectly putting the doctor in a scandalous quid pro quo position. When doctors explain to the patient's family members the risks of the operation and ask them to sign the consent form, many interpret this normal practice as the doctors' signal to solicit hongbao by presenting them with terrifying ramifications. Then they think they get the message, quickly show a red envelope, and often make the doctors feel awkward (Interview 1). Patients are often unsure of the "right" amount, and they cannot afford more or do not want to give more. Therefore, their offered gift is commonly below average, for instance, less than 2,000 yuan ($300) for a major procedure.

Ms. Yu, a university professor, once played the role of a broker and introduced her working-class relative to her best friend, who was a doctor. The doctor did many things for Yu's relative and made the dangerous surgery successful. Yu suggested giving some hongbao or gifts to the doctor, but in the end, her relative only gave 500 yuan ($75), an amount that could easily offend a doctor because it functions as if attaching a low price tag on her expertise. "That's extremely embarrassing," said Yu. "I'd rather he gave nothing! That way, I could still save my *guanxi* with my friend by giving her expensive gifts later" (Interview 49).

Doctors unanimously express low opinions about this business transaction in one hammer blow. Note that doctors feel offended by the patients' inappropriate methods of giving hongbao instead of the action of giving itself. They label the distrustful patients as "people with whom we cannot communicate." They identify potential troublemakers and take preemptive actions, such as keeping their medical records perfect and complete (Interview 3). Sometimes, when a patient constantly refuses tests and vocally expresses suspicions, doctors may retaliate by prescribing inexpensive but frequent tests, such as several blood tests every day, which may accumulate into higher costs. A brain surgeon says: "They [patients] think they are clever, but they are actually not. They pay much more" (Interview 5).

Without mutual trust and joint efforts, which are prerequisites for a successful negotiated exchange (Molm 2006), the doctor-patient relationship often deteriorates quickly and even degenerates into a vicious cycle: the more the patients guard against doctors' "theft" of their money, the more money they will lose; doctors' questionable reactions to the patients' distrust substantiate a self-fulfilling prophecy of avaricious and manipulative health relations.

Face and Power: "Give Your Boss Face"

The face-and-power situation typically involves a triad exchange among a powerful patient, a powerful broker, and a less

powerful doctor. The patient can be a person with higher socioeconomic status and/or political power, such as a high-ranking government official or a corporate executive, who has a strong tie with the broker. The broker is usually a hospital administrator, a health care official, or, in one of our cases, a famous host of a TV show who interviews doctors (Interview 49). The broker initiates the exchange, cuts the deal, and also gets returns from the patient. Note that if the patient only has weak ties with the broker and the broker is less powerful, the situation changes to fair recognition (the third scenario). The doctor usually has less administrative power and a lower rank than the other two participants. This scenario expands the usual scope in previous studies from focusing only on patient-doctor relations to the power differentiation within the medical system.

In this situation, cash is often devalued. The actual hongbao—cash in a red envelope—does not even appear. Instead, the patient offers the doctor exclusive resources that cannot be easily obtained through cash exchanges, ranging from small goodies like a free vacation provided by the patient's company and deep discounts on the company's products, to a big favor like a job offer for the doctor's relative and helping the doctor's child get into a top high school.

This situation is the best case to illustrate some of Schilke and Rossman's (2018) obfuscation strategies: brokerage (cutting a deal through a powerful broker), bundling (tying the exchange with other exchanges), and gifts (offering favors or resources). It also partially confirms the affective theory of social exchange: as their successful exchanges tend to repeat, the broker, the patient, and the doctor develop positive emotions and a commitment to future exchanges (Lawler 2002).

Nevertheless, the exchanges would not have been effective if power relations are not defined in cultural terms, such as friendship, *renqing* (personalized obligations), or *mianzi* (face; Interviews 5, 16, 30, 31, 32), which is a fact both the structural obfuscation and affective theory overlook. For example, Mr. Li, age 26, the son of a high-ranking official, was once diagnosed with tuberculosis, which would negatively impact his career due to the state's discriminatory restrictions on tuberculosis patients' eligibility for government jobs. His father worked through his connections, reached out to the president of the hospital for infectious disease, who now became their long-time friend, and offered the president's nephew a job. A deal was quickly made. Several specialists in the hospital gave Li expert consultation and promised not to write this diagnosis into his medical record (Interview 42). With these cultural justifications, the brokers, especially those who are hospital administrators, can find a way to bypass the governmental regulations about hongbao because there is no actual hongbao money involved, and they are "just friends" rather than patients and doctors (Interview 5).

The rhetorical burden, however, is placed on the less powerful doctors. They have experienced the awful situation of being forced into a disreputable exchange, even if the exchange brings some benefits to them. They have to follow their superiors' instructions to offer the patient exclusive services. To maintain their dignity, they must justify this unequal exchange by using other items in their cultural repertoires. They usually say they follow the *social norm* in their *danwei* (a work unit to which workers are bound for life) and feel obliged to give face to their superiors (Goffman 1967), which is a typical justification of power or privilege (Bourdieu 1990; Lamont 1992). As an internist put it:

> You must do a favor for your boss when he or she asks you to. You have to do your best to "serve" your boss. That's for sure. You just have no choice. . . . After all, we can't live in a vacuum. We have to maintain our social connections. That's a social norm we have to conform to. (Interview 2)

Fair Recognition: "Giving Hongbao Is to Show Your Respect"

In the situation of fair recognition, patients and doctors have only indirect, weak ties and relatively equal power relations. It involves limited obfuscation work such as brokerage, but in many cases, there is no brokerage or other structural obfuscations. Weak ties are crucial in this situation. The relatively less sentimental attachment of weak ties makes it possible for doctors to accept hongbao in its monetary form (Chan 2012; Uzzi 1999). A cardiothoracic surgeon articulates this tacit rule:

> There's no need for those we have a very good relationship with to give us hongbao. Doctors take most hongbao from those who are introduced by our relatives, ordinary friends, classmates, or colleagues—people outside the inner circle but within the outer circle of relationships. We rarely take hongbao from total strangers. (Interview 3)

A hongbao in this situation is interpreted as a fair monetary recognition of the doctors' work and expertise, which, both the patients and doctors agree, is undervalued in the current medical system. In other words, the participants do not obfuscate the economic feature of the transaction but use the principle of fairness to redefine the transaction. Thus, hongbao is no longer an epitome of corruption and bribe; rather, it is an extrainstitutional but fair reward to correct the erroneous institutional pay scales. "Hongbao is a good thing since it recognizes doctors' value and expresses respect towards doctors," said a plastic surgeon (Interview 18). A cardiothoracic surgeon said even more candidly:

> If patients want an expert to do the surgery for them, they should give hongbao, shouldn't they? If your disease is complicated and the expert is still willing to help you, then giving hongbao to him or her is like showing your respect. The expert will take more care of you if you give hongbao; that's human nature. (Interview 31)

Patients also accept this underlying logic of fairness and expect better services:

> It would be better if doctors can put a price on hongbao. The salaries of doctors are too low, so we should make their salaries fall within a reasonable range by giving them hongbao. It's not problematic to me. After all, doctors earn the money with their expertise. (Interview 42)

Yet this fairness has its social boundaries. The patients in this fair-recognition situation are typically from upper-middle-class or upper-class families, who have sufficient money to show their respect, adequate knowledge about the medical profession, and sophisticated social skills to handle such delicate situations. Both patients and doctors silently follow and sometimes improvise some tacit norms of interactions and communications. The norms include the appropriate amount wrapped in the envelope, ways of delivery, and its distribution among relevant actors. Determining the right amount is crucial. Because hongbao is perceived as a fair reward for the doctor's service, the amount of money should fairly correspond to the doctor's expertise, skills, rank, and popularity and represent

his or her market value. Patients must know the market prices: for example, 5,000 yuan ($765) to 10,000 yuan ($1,530) for a well-known chief surgeon or physician with over 20 years of work experience. If major surgery is involved, the patient must give a large hongbao to the surgeon's whole team, including anesthetists, nurses, assistants, and certainly the surgeon. Another, perhaps more important, function of this type of "team hongbao" is to prevent someone in the team from airing grievances to outsiders. Delivering the hongbao also requires cultural knowledge and concerted actions. Time and space have to be carefully chosen to avoid awkwardness, build mutual trust, and protect the doctor's privacy. All these strategies are patients' relational work to show that they are trustworthy teammates to the doctors.

Unlike in the immoral-transaction situation, money here does not have a profane meaning; it does not contaminate patients' relationships with the doctors. Rather, money becomes a symbol of respect toward the value of doctors (Simmel 2011). Once redefined, money also has real-world impacts on outcomes. The patient can choose an experienced senior surgeon, and the patient's surgery will be scheduled first in the morning when the doctors are most alert. Some doctors even said bluntly that they would not let the patient die on the operating table if they took hongbao from the patient. The surgeon will also be more solicitous regarding the patient's recovery and long-term care, as a senior nephrologist claimed:

> The difference is that the doctor will tell that patient his or her private cell phone number, and the patient can call the doctor whenever an emergency occurs. It will be more convenient for the patient since many medical services are continuous: the patient will come back to the hospital for a check-up after surgery. Another benefit is that the doctor will arrange the wards for the patient in advance. (Interview 30)

Most importantly, doctors who accept hongbao will be more willing to make optimal but troublesome moves. Ms. Fang, whose grandmother had a benign tumor near her uterus, got in touch with a specialist through her friends and gave a total of 16,000 yuan ($2,440), a proper amount, to the surgeon's team. During the surgery, the surgeon changed the common practice of removing the whole uterus and spent five more hours removing the tumor bit by bit. Fang later attributed the "success" of the surgery to the hongbao that they had given: "If we didn't give hongbao, I don't think doctors would bother to keep my grandma's uterus. They could have taken measures that are less risky and less troublesome to them" (Interview 50). These benefits of giving hongbao are also well documented in empirical research (Chan and Yao 2018; Yang 2013).

Affective Obligation: "It's Wrong for Us to Queue Like Ordinary Patients for a Bed!"

In this situation, the doctor and the patient already have established strong ties, such as close friends, lovers, or family members, before they engage in a hongbao exchange. Or, sometimes, the broker has strong ties with both patients and doctors. The underlying logic of the exchange is long-term reciprocity and sentiment, expressed in Chinese terms like *renqing* (human sentiments or personalized obligations; Chan 2012). The structural approach would regard this exchange as a case of "pawning": individuals provide services or resources that are not for sale to repay earlier debts

(Schilke and Rossman 2018). Yet this explanation neglects how the involved parties deal with the tension between different systems of ethics—in this case, codes of professional ethics and the ethics based on familial and intimate relationships—to justify their actions (Fu and Chan 2016).

The participants usually make cultural justifications with affective discourses about family obligation, friendship, and intimacy, a culturally significant and even dominant discourse in Chinese society (Chan 2012; Fei 1992; Hwang 1987). Hongbao in its literal sense—cash in red envelopes—rarely appears in this situation or even becomes a taboo. Returning the favor is certainly expected but must be in other forms of scarce resources in the next exchange, when the roles are reversed; for example, the doctor might need some resources (e.g., their child's enrollment in a prestigious school) from the patient. The return is also expected to happen in the distant future because an immediate payoff would imply one's reluctance to maintain the long-term relationship (Bourdieu 1990; Mauss 1967; Yan 1996).

Doctors and patients use a particular logic to justify their choice of sentimental favoritism over professional ethics. The doctors usually regard giving favorable treatment to their families and friends as an unstated benefit of being a doctor and a moral obligation to their families: "It's *impersonal and wrong* if we queue like ordinary patients for in-patient beds" (Interview 2); "we *must* have our advantages in these things" (Interview 22); "I think that's the reason why many people hope that one of their family members becomes a doctor" (Interview 13). Ms. Yun, age 55, a retired middle-ranking government official, had recently been diagnosed with breast cancer. Yun's cousin, who happened to be a gynecologist, asked the most well-known expert in the field at his hospital to see Yun. She described her experience with some pride:

> Because we are close relatives, they only prescribed the most effective and least expensive medicines. They got no commission from prescribing them, and I only pay the lowest price. I didn't need to wait several hours to see the doctor and skipped a lot of unnecessary examinations. . . . While other doctors talked vaguely about my situation, he [her cousin] candidly told me that conservative treatment would be better for me, especially considering my age. (Interview 45)

THE CULTURAL REPRODUCTION OF INEQUALITY

Public debates over informal medical payment revolve around its consequences. It exacerbates the reproduction of health inequality, which exists in normal medical institutions (Marmot 2005; Shim 2010; Song and Lin 2009), by bypassing the rules and regulations. Our research confirms this reproduction thesis. Three of the four exchange situations have high "success" rates. This corroborates Chan and Yao's (2018:745) finding that 80 percent of offered hongbao are accepted. Among our four situations, the only one that is likely to fail is the immoral transaction, in which the underprivileged patients are repeatedly rejected and gradually excluded from the exchange. It should be noted that rejecting one's hongbao does not always mean providing low-quality medical services. Doctors also make claims about their professional integrity:

> As doctors, we will *never* treat patients badly on purpose because patients don't give us hongbao, like, you break your left leg, but the doctor performs surgery on your right leg, just because you don't give a hongbao to the doctor. (Interview 30)

This claim, however, should be put in perspective. The purpose of hongbao is to secure *better* services and acquire priority. In a health care system in which quality medical care remains scarce, a doctor sees over 100 patients each day and spends only three minutes on average on each patient, obtaining "better" services and priority in queue means other patients' long waits or loss of opportunities for quality care. Even those doctors who make the equal treatment claim admit that once they receive hongbao, they feel obliged to provide better services (Yang 2013).

Our research also shows that the reproduction of inequality is a *cultural reproduction* process. The economically and socially deprived people are also *culturally deprived*—lacking adequate inside knowledge or cultural capital about how to interact with doctors (Shim 2010) and offer money appropriately. Doctors often "prescreen" patients according to their evaluation of the patients' socioeconomic status in the initial contact before they make decisions on accepting hongbao or not. They tend to engage in hongbao exchanges with patients whose socioeconomic status and cultural capital are equal to or above theirs.

Moreover, the involved parties' effort to maintain the interaction order leads to the reproduction of inequality outside of their immediate situation. The stabler the interaction order, the more likely such questionable practices will repeat and persist and the more unequal the fallout of such exchanges on wider society will be. A culturally exclusive circle for priority in getting access to medical resources forms among the well-connected, relatively affluent, and socially savvy networks, including patients, doctors, and brokers.

In the immoral-transaction situation, this cultural reproduction of inequality is enacted in a tacit process of cultural exclusion. Doctors can identify those patients who have both low socioeconomic statuses *and* little knowledge about the appropriate interactions because those patients interpret the hongbao as outright bribery and act on this interpretation with no effort to save the doctor's face. To prevent the patients' cringeworthy and even potentially dangerous moves, doctors switch the informal rules of hongbao to the official rules of professionalism to reject their hongbao. Even if such patients' hongbao are accepted in some cases, the interaction order is uncomfortable, ephemeral to both sides because they do not share the same understanding of the situation. The Chinese saying "business transaction in one hammer blow" says it all: everybody knows it is a business transaction, but "one hammer blow" or other actions that peel off the cultural camouflage over business are unacceptable.

In the face-and-power situation, inequality is reproduced through a complex game that combines power with tacit knowledge about the delicacy of the situation. The powerful patients have not only power and money but are also well versed in *guanxiology*: no cash transaction is involved; rather, other scarce resources are exchanged to form an affective relationship after repeated, successful exchanges. The lower-ranked doctors perceive their involvement in the problematic exchange as a social norm (face) and an obligation to please the powerful brokers (usually their superiors), a process that reproduces the inequality within the medical institutions.

In the fair-recognition situation, the patients usually have enough economic and cultural capital to impress the doctors with their decent socioeconomic status and adequate knowledge and skills so that they can be accepted as reliable teammates to complete this ethically dubious exchange. For example, Ms.

Zhou, a researcher at a university in Shanghai, quickly gathered her family members to form a task force to deliver hongbao when her aunt needed surgery to treat late-stage lymphoma. Her uncle found a connection in the hospital and sent the doctor some gifts, including tea, wines, and cigarettes. Being an alumna of an elite university, Zhou made good use of her high cultural capital and her decent job to play the role of charmer: having small talks with the doctor and quickly convincing the doctor that "this person is good, so is her family." Mutual trust was established, and the doctor gave Zhou his private phone number. Unsurprisingly, her aunt's surgery was a success: the doctor even decided on the spot to remove her aunt's gall bladder filled with gallstones, which was not included in the previous operating plan. The doctor later explained that if the gall bladder had not been removed at that time, her aunt's health condition would not allow a second surgery (Interview 47).

In the affective-obligation situation, inequality is reproduced through reinforcing existing strong ties and exclusive privileges, which are justified in the cultural terms of affection and moral obligation in familial relationships and friendship. Doctors help their families and friends cut in line to make an early appointment, get in-patient beds when other patients have to sleep in the hallway for a month, and ask their colleagues who treat their friends and families to skip unnecessary exams and prescribe cheap medicines. This situation also corroborates previous studies that Chinese people tend to treat those within their inner circle of guanxi (sentiment-driven instrumental ties) with trust, affection, and asymmetric obligation but interact with those in the outer circle with rational calculation (Bian 2018; Chan 2012; Fei 1992; Hwang 1987). The cultural terms of family and friendship are so powerful that even those who only have weak ties with doctors use these terms loosely to imitate this strong-tie situation (*friend* for a mere acquaintance and *relative* for one's uncle's stepdaughter's boyfriend). Those who know clearly that they befriend doctors for instrumental reasons still act and talk as if they were real friends (as in the face-and-power situation).

The vignette interview part of our research yields further findings that reveal another aspect of the cultural reproduction of inequality. We found that when the patients were asked to read and evaluate the vignettes of the four typical situations presented earlier, most of them condemned the harmful effects of the hongbao exchange, but not in the way expected in prior studies (Schilke and Rossman 2018). Most patients regard exchanges in the face-and-power vignette as most immoral and those in affective obligation as somewhat morally problematic, although these two situations contain many obfuscations (brokerage, bundling, pawning, and gift exchange), which according to Schilke and Rossman (2018), should have received more approval. In contrast, the two situations closest to quid pro quos (immoral transaction and fair recognition) are evaluated by our interviewees as morally neutral.

The reason is that most patients, when they are observers, judge the exchanges by the utilitarian principles of fairness and equality. They care little about individuals' moral characters but much about the consequences of the exchanges for others. Upon reading the vignette describing a typical face-and-power situation, 9 out of 23 patients immediately recognized the exchange as "*corruption*, since the [highly ranked] doctor uses his or her *public power* to force other doctors to help with his or her private things"

(Interview 48); "the [highly ranked] doctor is both an owner and a distributor of [social and medical] resources, and the ways he or she mobilizes these resources are unfair" (Interview 46); "it feels like if people can be connected to that doctor, they would get whatever they want . . . it is very problematic if they abuse their power like this" (Interview 45). When the interviewees read the affective-obligation vignette, they think the exchange violates the norms of fairness and the clear rules of priority (Interview 43). An interviewee made a somewhat philosophical remark: "Repaying someone is not immoral, but the outcome of this unfair resource distribution is" (Interview 46).

Yet when the patients switched their roles from observers to participants, the same morally righteous people did not hesitate to normalize their actions. When asked whether they had used their connections to do things like the four situations, 10 out of 23 answered yes. Note that even those who do not give an unambiguous yes have already talked in detail about how they actively involved themselves in hongbao exchanges. To give another example, a male patient with cerebral aneurysms condemned the preferential treatment of veterans, but he himself worked through his connections to get a VIP ward. He normalized what he had done as using *renqing* and felt no guilt about it (Interview 54).

We argue that this ironic discrepancy between saying and doing can further explain the paradox that hongbao exchanges remain ubiquitous despite public controversies. This also testifies to our theoretical focus on culture: the norms of interaction vary across different situations and may be different from the prevalent moral principles used in public discourse (Eliasoph and Lichterman 2003; Goffman 1967). When people need disreputable exchanges, they might pick up another item from their "cultural toolkit" (Swidler 1986) to justify their choice and form a different set of norms for interactions than the one they use when they are asked to comment on such exchanges as a general social phenomenon.

DISCUSSION AND CONCLUSION

Our study of the hongbao exchange, a typical informal medical payment, examines how individuals manage to make disreputable exchanges and why such exchanges remain ubiquitous and persistent despite intense moral disapproval from the public. We argue that the participants of informal medical payment, including patients, doctors, and brokers, mobilize various items in their cultural repertoires to redefine meanings of their relations, project a positive self-image, and maintain the interaction order among them. In various situations (immoral transaction, face and power, fair recognition, and affective obligation), the participants make these efforts to render their exchanges unproblematic and morally acceptable to each other. These efforts, however, contribute to a cultural reproduction of inequality in getting access to scarce health care resources. Underprivileged patients lack not only economic and social resources but also adequate cultural knowledge about when, where, and how to offer a payment, and they are excluded from the interaction order formed and maintained by those participants with more socioeconomic resources and cultural knowledge. Moreover, the participants negatively evaluate the exchanges in general moral terms such as equality and fairness but culturally justify their own involvement. This discrepancy between saying and doing tends to legitimize the disreputable exchange and partly explains its ubiquity despite public controversies.

This study advances our knowledge about disreputable exchanges by proposing a cultural approach that combines

three major conceptions of culture: culture in relations (Zelizer 2012), culture in interactions (Eliasoph and Lichterman 2003; Goffman 1967), and culture in inequality (Bourdieu 1990; Lamont 1992). Our cultural approach complements but differs from the structural approach by Schilke and Rossman (2018). The structural approach shuns the core of relational sociology that relations in exchanges are simultaneously structural *and* cultural. It also neglects an important aspect that the participants—in addition to external observers—must interpret a disreputable exchange as morally and culturally acceptable. These problems lead to inadequate explanations. When the participants are observers of disreputable exchanges described in our vignettes, they feel more morally offended by those situations with more obfuscations, a result opposite to the structural approach. When they are involved parties, their focus is not obfuscation but to justify and normalize their exchanges and reduce the moral tensions. Moreover, the structural approach does not address how inequality is *culturally* reproduced.

Beyond disreputable exchanges, our findings can also shed light on deviant behavior in general and, thus, can potentially contribute to criminology and social psychology. Prior studies have shown how norm violators justify their deviant behavior with "techniques of neutralization," including shifting the responsibility, minimizing the harm, blaming the victim or the condemner, changing the reference group, choosing to conform to another set of norms, and so on (Horne and Mollborn 2020; Mollborn 2017; Sykes and Matza 1957). Our study corroborates these findings, especially some techniques like changing the reference group and selectively following norms. But we theoretically emphasize the role of situations, interaction norms, and individuals' uses of particular cultural tools. When individuals violate universal norms defined in formal institutions, such as laws and regulations, they actively pick cultural tools, usually particular norms, to justify their actions and make them socially acceptable. As our vignette interviews show, when individuals are observers of deviant behaviors, their internalized universal values are at work, and they tend to feel outraged about corruption and other violations of the values (Horne and Mollborn 2020). Yet such internalized universalistic values may be compromised by particularistic norms that are mobilized to justify their problematic behavior (see Vaisey 2009). Our study thus contributes to criminology and social psychology by showing how this discrepancy between universalism and particularism contributes to the ubiquity of some forms of deviance.

Some may object to our findings by resorting to more materialist accounts: those with resources and power can afford informal medical payment; it is ubiquitous because gains from disreputable changes override moral concerns; the reproduction of inequality operates along the fault lines of class. These explanations indicate necessary but not sufficient conditions; our purpose is not to dismiss but complement them with another necessary but not sufficient condition: the cultural dimension of the exchanges. Without an examination of this cultural dimension, we are unable to answer the question of how inequality is produced and reproduced and leave many processes in the uncracked black box of interaction. Moreover, neither relation nor power can make a disreputable exchange "reputable." Without the participants' cultural redefinition and justifications to ease moral tensions, such exchanges would not have stubbornly resisted public condemnations and legal prohibitions and existed in so many forms in so many parts of the world for such a long time. If all the

cultural redefinitions and justifications specified in this article do not matter, then everyone in these hongbao exchanges would have been openly and happily giving and taking hongbao without contrition. At the conceptual level, as many theories and studies have documented, power and inequality are intrinsically cultural (Bourdieu 1990; Lamont 1992; Reed 2013). The powerful participants have more cultural tools at their disposal and can come up with more elaborate cultural justifications. The reproduction of inequality, thus, is also cultural.

This study has several limitations, which indicate some starting points for future research. First, although our "small-N" interview study has its strength in an in-depth analysis of nuances, a more rigorous study should use "big-N" methods, such as surveys or text analysis, to test our findings and generalize them to other situations. Some concepts (e.g., capital and health inequality), which are descriptive in our article, can be operationalized into more precise measures for quantitative studies. Second, our focus on China's hongbao phenomenon plays out subtleties in a particular cultural context but has its methodological and theoretical costs. Because Shanghai and Nanjing are among the largest cities in China, our findings may not apply to the hongbao phenomenon in smaller cities or rural regions. Additionally, a central debate in the literature on China's guanxi-based relational culture is whether stronger institutions and a more marketized economy would lead to less significant guanxi-related phenomena (Bian 2018). Our study suggests that more institutional restrictions and discipline do not curtail such phenomena partly due to the guanxi culture rooted in the exchanges. But whether relational cultures in other contexts contribute to the ubiquity in the same ways remains an open question for future research.

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SUPPLEMENTAL MATERIAL

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