ISCTE Business School
Instituto Universitário de Lisboa

The Impact of Corporate Social Responsibility on Turnover Intention: An Empirical Study of Three Private Hospitals in Ningbo, China

Yu Zhongjian

Thesis submitted as partial requirement for the conferral of the degree of

Doctor of Management

Supervisor:

Prof. Virginia Trigo, Professor Emeritus,

ISCTE -Instituto Universitário de Lisboa, Lisbon, Portugal

Co-supervisor:

Prof. Gu Lihong, Invited Professor,

School of Health Services Management, Southern Medical University, China

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Declaration

I declare that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university and that to the best of my knowledge it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed: 余忠建 Date: 2016.10.20

Name: Yu zhongjian

作者申明

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Abstract

In the process of health system reform in China, the development of private hospitals has drawn wide attention from the government and society. From the central government to local governments at various levels, a package of policies has been introduced to encourage the development of private hospitals. However, efforts over the past 20 years have not achieved significant results. Currently, although an increasing number of private hospitals are appearing, they are typically characterized by small scale, low technology and unsatisfactory economic and social benefits. The high turnover rate of medical professionals is the most important factor hindering the development of private hospitals. A careful analysis of reasons for existing problems reveals that investors and managers in private hospitals excessively pursue the economic benefits while putting little emphasis on the hospital culture construction and hospital social responsibility. As a result, the medical staff lack sense of belonging, accomplishment and safety and the organization lacks cohesion.

The thesis makes an empirical study on three private hospitals in Ningbo and Zhejiang Private Hospital Association and 607 valid questionnaires are retrieved and analyzed. First, the reliability and validity of questionnaires is tested using exploratory factor analysis method, and Cronbach Alpha; second, the model fitness is tested using confirmatory factor analysis method and SEM is used to test the proposed hypotheses; finally, the independent sample T test and ANOV Aare used to analyze the effect of demographic factors such as gender, age and rank on the research variables. The main research results are as follows:

(1) CSR, organizational culture and organizational identification are closely correlated.

(2) Both internal and external corporate social responsibility (INCSR and EXCSR) in the private hospitals surveyed have a positive effect on the organizational culture.

(3) INCSR has a positive effect on organizational identification while EXCSR has a negative effect on organizational identification. This because private hospitals fail to attach great importance to the stakeholder that really matter when performing social responsibility.

(4) The organizational culture (OC) has a positive effect on organizational identification (OI), and OI/OC is negatively correlated with turnover intention

The study focuses on the separate study of CSR, organizational culture and organizational identification and puts forward the functions and effect of performing CSR that

are rarely mentioned by either foreign or Chinese scholars. In a practical sense, it has laid a theoretical foundation for private hospitals on how to construct a good organizational culture and strengthen human resources management.

Key words: Corporate social responsibility, Organizational culture, Organizational identification, Turnover intention

JEL: I11, I18, M12, M14, M51, M54

Resumo

Enquanto parte integrante da reforma do sistema de saúde na China, o desenvolvimento de hospitais privados tem vindo a merecer a atenção do governo e da sociedade. Quer o governo central quer os governos locais a vários níveis têm vindo a introduzir um conjunto de políticas no sentido de encorajar o desenvolvimento deste tipo de hospitais. Contudo e apesar destes esforços já decorrerem nos últimos 20 anos, os resultados não têm sido significativos. O número de hospitais privados tem sido crescente, mas são em geral de pequena dimensão, possuem tecnologia deficiente e produzem resultados económicos e sociais pouco satisfatórios, sendo a rotação de pessoal médico o factor que mais afecta o seu desenvolvimento. Uma análise das razões para este problema revela que investidores e gestores estão mais interessados em benefícios económicos negligenciando a construção de uma cultura organizacional e também a responsabilidade social dos hospitais. Em consequência o pessoal médico não tem sentido de pertença, não se sente realizado, sente-se inseguro e tudo isto contribui para uma falta de coesão na organização.

Esta tese realiza um estudo empírico em três hospitais privados na cidade de Ningbo e na Associação de Hospitais Privados da Província de Zhejiang tendo como base 607 respostas válidas a um questionário desenvolvido para o efeito. O nível de confiança e a validade dos questionários foi testada através de análise factorial exploratória e Cronbach Alpha. A adequação do modelo foi testada através de análise factorial confirmatória e as hipóteses propostas foram testadas através do modelo de equações estruturais. Utilizou-se por fim o teste t e ANOVA para analisar os efeitos das variáveis demográficas tais como género, idade e posto de trabalho nas variáveis do modelo. Os principais resultados foram os seguintes:

(1) A responsabilidade social (RS), a cultura organizacional e a identificação com a organização estão intimamente correlacionadas;

(2) Na amostra analisada, quer a RS interna quer a RS externa (RS-IN; RS-EX) têm um efeito positivo na cultura organizacional;

(3) A RS-IN tem um efeito positivo na identificação com a organização enquanto que esse efeito é negativo no que respeita à RS-EX, isto porque, ao exercerem a sua responsabilidade social, os hospitais privados da amostra não parecem dar grande importância aos stakeholders que de facto importam;

(4) A cultura organizacional tem um efeito positivo sobre a identificação com a organização e ambos os construtos estão negativamente correlacionados com a intenção de deixar a organização.

Este estudo analisa a importância da responsabilidade social na construção da cultura organizacional e no desenvolvimento da identificação com a organização e inclui elementos que raramente são considerados no contexto chinês. Por outro lado contribui com fundamentação teórica para que os hospitais privados na China possam construir uma boa cultura organizacional e assim fortalecerem a gestão dos seus recursos humanos.

Palavras chave: Responsabilidade social; Cultura organizacional; Identificação com a organização; Intenção de rotatividade

JEL: I11, I18, M12, M14, M51, M54

Acknowledgments

How time flies! More than 1000 days and nights have passed before I know it. When my doctoral life is nearing its end, I have never felt relieved like today. Heavy work, southward journey, English learning, management theory, statistical method…there are too much to learn and too many difficulties to overcome. Today, I can say proudly that I have successfully walked through the hard yet happy time.

In retrospect, the warm and harmonious class, the erudite and meticulous professors, as well as the warmhearted and kind classmates are still vivid in my mind. I am truly grateful for the cross-border education program jointly run by ISCTE University Institute of Lisbon and Southern Medical University, which gives me an opportunity for further study.

I am particularly indebted to Professor Virginia, who acknowledged my qualifications in exam interview three years ago and accepted me as one of her students. Although she is fully occupied with her work, she still takes time to guide my thesis writing personally and answer my email quickly. I am immensely grateful for what she has done for me! Just as an old Chinese saying goes, “A teacher for a day is a mentor for a lifetime”, the invaluable friendship between us will be firmly and closely tied across the Pacific.

My most profound gratitude is also to my Chinese tutor Professor Gu Lihong, who has taught me everything she could from the fundamental model concept to the theoretical system through my numerous consultations and communications between us. Her rigorous scholarly attitude and excelsior work style have set a good sample for me.

I also want to offer my sincere thanks to Professor Song Qianliu, who recommended me the doctoral program as well as Professor Yan Yiqun, who introduced me into the medical class, urged me on in a positive and supportive way and congratulated me on each of my stage achievement over the past three years. He is a medical expert with super medical skills and high morals whom I extremely admire. Both of them have set a good example for my work and study.

I am also grateful to the presidents and medical staff in the surveyed hospitals and medical association such as Ningbo Mingzhou Hospital, Ningbo Development Zone Center Hospital, Cixi Xiehe Hospital and Zhejiang Private Hospital Association, who gave me great support and did what they could to offer me large amounts of data and advice through

interviews, discussions and questionnaire survey. Their support convinces me that my research conclusions must be true and reliable and my research results will be valuable.

Doctoral life is an unforgettable journey, during which I maintain the balance between work and study. I apply what I have learned to my work and feed my working experience into my study.

Time flies! After bidding farewell to my doctoral life, I am now already standing at a new starting point. I will apply what I have learned to the management practice of private hospitals in China and do my best to make sure that Chinese people can enjoy the best health care.

Content

List of Tables

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List of Figures

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English Abbreviation

CSR	Corporate Social Responsibility
OC	Organizational Culture
OI	Organizational Identification
TI	Turnover Intention
KMO	Kaiser-Meyer-Olkin
Sig	Significance
CR	Composite Reliability
AVE	Average Variance Extracted
CITC	Corrected Item Total Correlation
Nr	Number
CFI	Comparative Fit index
GFI	Goodness of Fit index
TLI	Tucker-Lewis Index
AGFI	Adjusted Goodness-of-Fit Index
RMSEA	Root Mean Square Error of Approximation
RMR	Root of the Mean Square Residual
x^2	Chi-Square
df	Degree of Freedom

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Chapter 1: Introduction

1.1 Overview

Since the health care system reform was implemented in China 15 years ago, the central government has been encouraging and guiding private capital to sponsor health care undertakings. Efforts have been made to actively promote the healthy development of non-public health care institutions so that they can fairly compete with public hospitals, break their long-term monopoly, contribute to effectively curb the unreasonable increase of medical expenses and take some social responsibility, aiming at resolving China's problem of being difficult and expensive to see a doctor (Zhuang, 2012). However, during the development process, although an increasing number of private hospitals are appearing, they are typically of a small scale, have low technology and show unsatisfactory economic and social benefits. After exploring the root causes of these phenomena, we found that the high turnover of medical professionals is the most important factor hindering the development of private hospitals.

Given the recent development of private units in the healthcare sector in China, we posit that a weak organizational culture, unclearly defined core values, mission and vision as well as low sense of security of medical staff may be at the root of the problem. Based on the research of foreign and Chinese scholars in management science and specifically on organizational culture closely related to human resources management in enterprises, this thesis extensively studies the organizational culture theory, organizational identification theory and turnover intention theory in order to understand to which extent a good organizational culture can improve organizational identification and reduce the turnover intention of medical staff.

Then what should a good organizational culture of private hospitals be like? Like in all other hospitals, private hospitals must take responsibility for healing the wounded and rescuing the dying, which is the unshakable and compulsory responsibility for public health.

Private hospitals should not only be economically self-sufficient, but also abide to this responsibility and be sustainable. They should put more emphasis on life rescuing, in the promotion of people's health and in comforting patients, instead of in the single-minded pursuit of economic benefits. Therefore, the notion of responsibility should be placed on the top priority of private hospitals' management (Liu, Liu & Wu, 2008). Then how can the operators and leaders of private hospitals get a full understanding of which responsibilities they should take and spread the notion of responsibility to each employee? The method is to integrate the responsibility into the hospital culture and internalize social responsibility consciousness into the spirit of the hospital (Wang, 2012). This kind of culture of private hospitals that integrates the notion of responsibility is what we call good organizational culture, which can promote their sound development, play a positive role in humanistic management, enhance organizational cohesion, improve the organizational identification of medical staff and reduce their turnover intention.

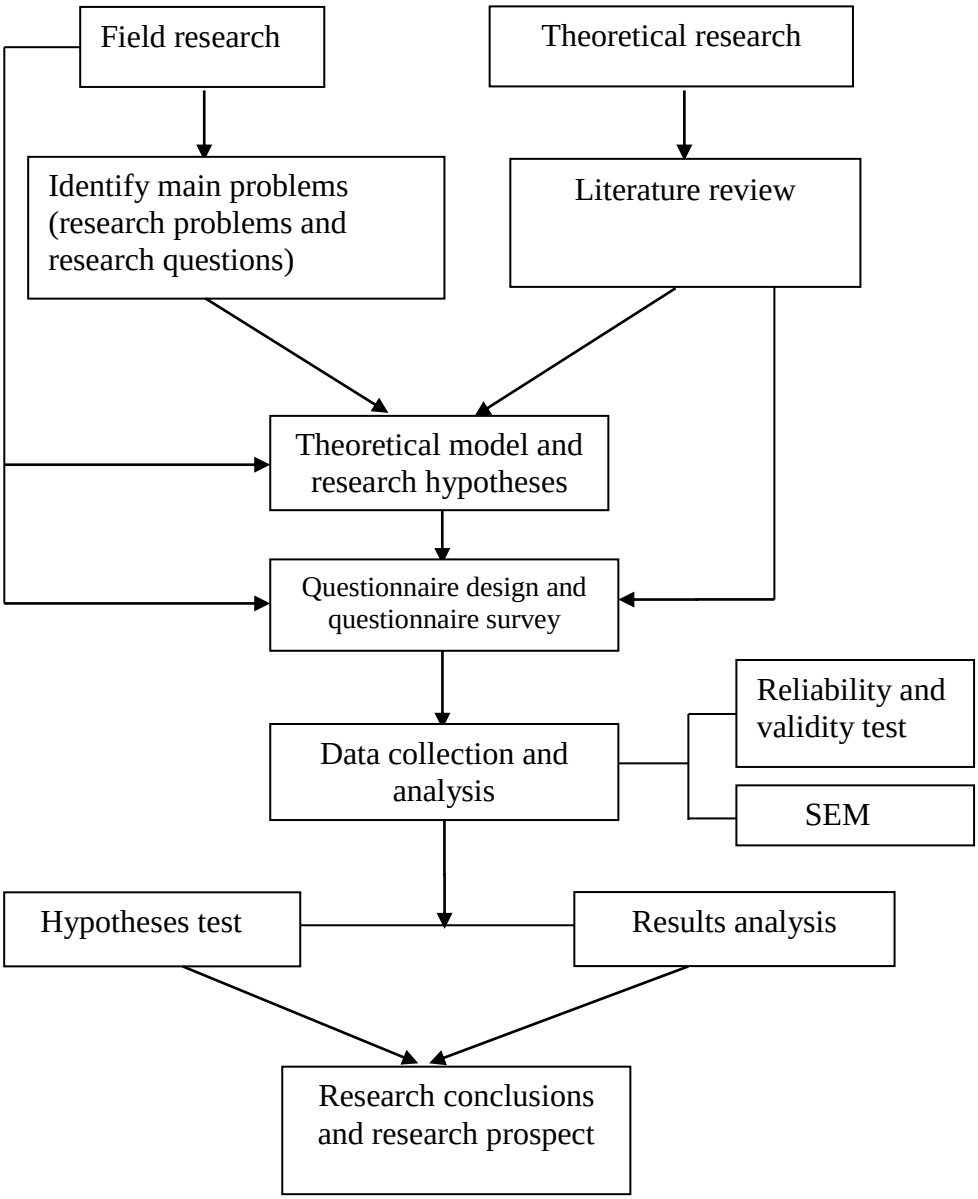
Based on the literature review of foreign and Chinese related theories and combining them with personal interviews and group discussions with medical staff in the surveyed hospitals, this study puts forward, as a basis of argument, the idea that social responsibility can be a means to influence both organizational culture and organizational identification in private hospitals. Further, through empirical research, the study validates the relationship about organization culture, organization identity and turnover intention of private hospitals.

1.2 Research Technique and Route Design

Based on the current high turnover rate of medical staff in private hospitals in China, field research and extensive literature review are made to identify the main problems of the study, namely, how corporate social responsibility (CSR) exercised by private hospitals may affect the turnover intention of medical staff and what effect the organizational culture/organizational identification constructs have on the relationship between CSR and turnover intention. Then a theoretical model is established and research hypotheses are proposed. Subsequently, the questionnaire was designed and the survey conducted among a large sample of medical staff in three privately owned hospitals in the city of Ningbo, China.

Based on the collected data, SEM is used to test the theoretical model and the research hypotheses. Finally, the test results are discussed and analyzed to achieve the final conclusions. The figure below depicts the research design and route followed in this thesis.

Figure 1-1 Research Technique and Route Design



Source: the author

1.3 Thesis Structure

According to the research technical route, the thesis is divided into seven chapters to elaborate the topic using theoretical research and empirical analysis.

Chapter 1: Introduction – Briefly presents the research, including research problems, research technical route and thesis structure.

Chapter 2: Research background and research problems. Presents the current situation of private hospitals in China and the challenges in their development and analyzes the reasons for these problems.

Chapter 3: Literature review- Extensively reviews the relevant foreign and Chinese literature related to the research problems aiming at laying a solid theoretical foundation for the design of the research model and hypotheses.

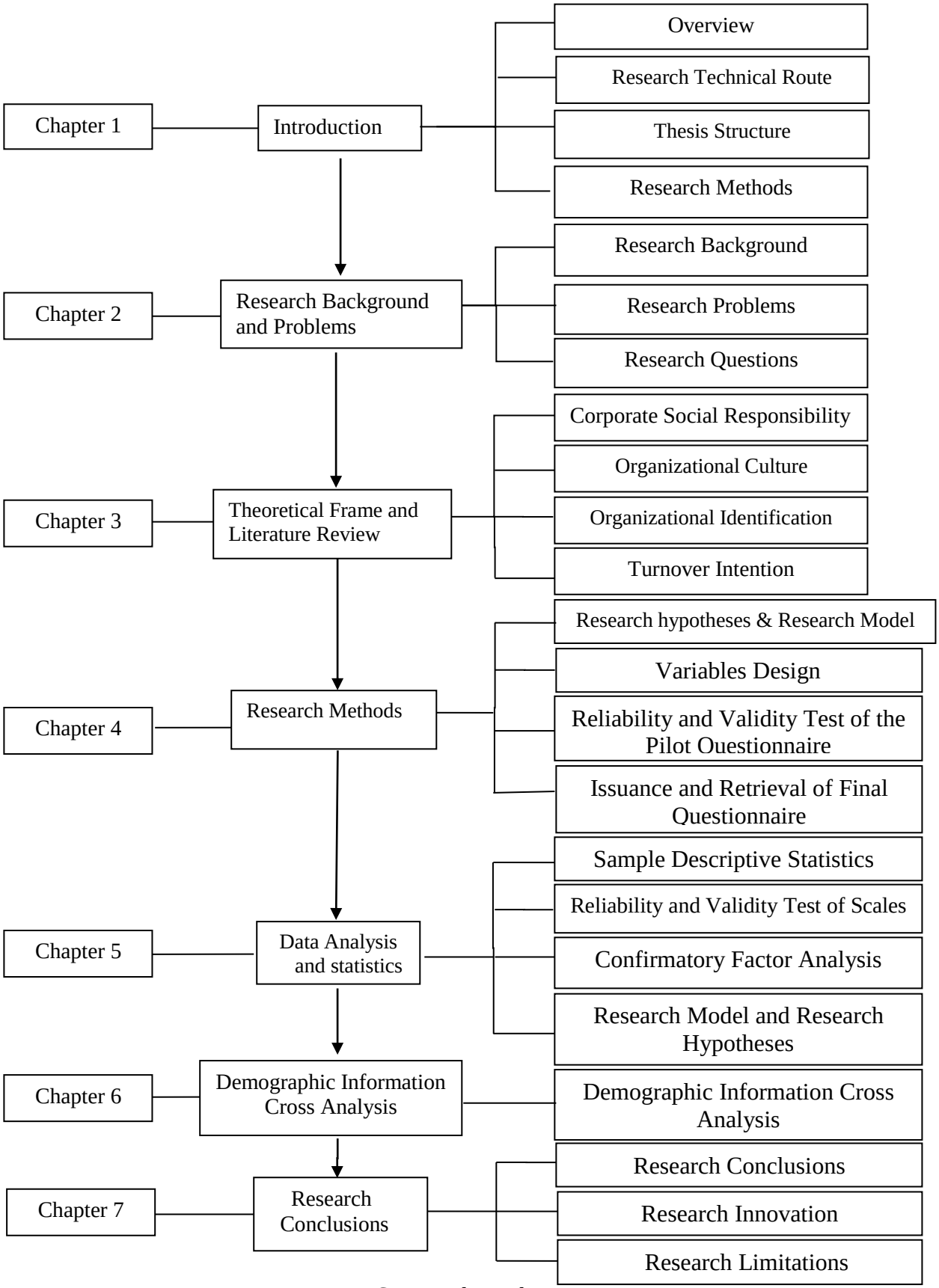
Chapter 4: Research methods-This chapter elaborates on the research process, including variables and questionnaire design, reliability and validity tests of the pilot questionnaire, design of the final questionnaire and data collection.

Chapter 5: Data analysis and statistics – First the chapter makes a descriptive analysis of sample data and research variables; second, it presents the tests on the reliability and validity of the research variables followed by the model fitness. Finally it presents the tests of the research model and hypotheses.

Chapter 6: Demographic information cross-analysis - Demographic information is the most common control variable in management research. In this chapter, the effect of demographic factors such as gender, age, post, professional title and administrative position on the research variables is studied and analysis results are deeply analyzed.

Chapter 7: Research conclusions, limitations and research prospects - This chapter makes a systematic summarization of the research conclusions, and further analyzes the conclusions that are opposite to the research hypotheses based on empirical data. Meanwhile, the theoretical and practical significance are discussed. Finally, the research limitations and research prospects are shown.

Figure 1-2 Thesis Structure



Source: the author

1.4 Research Methods

1.4.1 Literature Method

Literature method, also known as literature review or literature research, is often used to make in-depth study of a particular topic through searching and reviewing relevant literature according to the research purpose or requirement of research project (Lin, 2015). The literature review can help researchers acquire new evidence, find new perspectives, discover new problems, put forward new ideas and form new understandings. Meanwhile, the previous studies can put purposeful light on future ones and help scholars avoid blindness and detours. Especially, the previous authoritative views can effectively support the current study and make it more convincing (Du, 2013).

1.4.2 Questionnaire Method

The questionnaire method was mostly developed by British Francis Galton, the founder of the Anthropology Test Laboratory (ATL) set up in London in 1882, who randomly sent out a paper questionnaire consisting of a series of questions and other prompts for the purpose of gathering information from respondents. From then on researchers have another research instrument to discover the laws of social phenomena and explore their mysteries (Zheng, 2014). Questionnaire is currently one of the most commonly used methods for social survey. Just as British famous sociologist Earl Babbie put it, around 80 to 90 percent of social survey is conducted through questionnaire (Feng, 1994). Questionnaires have advantages over other types of surveys in that first, the survey data is easy to quantify; second, the survey results are easily statistically processed and analyzed; third, if properly implemented, the questionnaire is the quickest and most effective method for data collection (Han, 2015). In what concerns scales, the Likert Scale is one of the most widely used scales in questionnaire, and consists of an array of statements showing attitudes or views toward certain things. Respondents are required to specify their level of agreement or disagreement on a typical five-level Likert item from “strongly disagree”, ”disagree”, “neither agree nor disagree”, ”agree” to “strongly agree” (Li, 2004) although other gradations may be used.

1.4.3 Interview Method

An interview is a conversation where questions are asked by a researcher and answers are given by a respondent, which usually takes place face- to -face and in person or sometimes by telephone. Typically the interviewer has some way of recording the information that is gleaned from the interviewee, often by writing with a pencil and paper. The interview method has advantages over the questionnaire method in that it can acquire more in-depth information, but its disadvantages such as time-consuming and high costs make it impossible to conduct among a large number of respondents. In practical research, the interview method and questionnaire method are sometimes used in combination (Li, 2004).

1.4.4 Statistical Analysis Method

Statistical analysis refers to collecting, scrutinizing, summarizing and interpreting data sample qualitatively and quantitatively to discover underlying causes, patterns, relationships, and trends (Zhang, 2013). Currently, SPSS is widely used to test the reliability and validity of research variables and AMOS is most often used to construct SEM and test the theoretical model and research hypotheses.

1.5 Chapter Summary

This Chapter briefly presented the origin of this thesis, defined the research object, charted the research technical route and introduced the research methods used.

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Chapter 2: Research Background and Research Problems

2.1 Research Background

2.1.1 Environment Background

Over the past three decades since the reform and opening up, China has made great progress in all sectors in the process of development of a socialist market economy. With the income increasing rapidly, people's demand for healthcare is also on the rise. According to the demographic structure, China's rapidly aging population and rising life expectancy will increase the demand for medical services, thus increasing the stress on an already troubled public health care system. Therefore, without the development of private hospitals sponsored by private capital, the often mentioned problem of "being difficult and expensive to see a doctor" cannot be completely solved by government's efforts alone (Tencent Finance, October 14, 2013). Some researchers now believe that China should vigorously develop private hospitals, break the monopoly, free up the market, encourage competition and standardize management in order to fundamentally solve this problem (Chen & Zheng, 2012). Other scholars argue that the existence and development of private hospitals is helpful to promote orderly competition in the medical market, build a health care system that accommodates to the socialist market economy, and broaden the financing channel for healthcare undertakings in order to meet people's health care needs at different levels (Zhou & Wang, 2004).

2.1.2 Industry Background

Since the pilot property right reform of public hospitals in Jiangsu province from 2000, modern private hospitals are gradually emerging. On March 17, 2009, the *Opinions on Deepening the Health Care System Reform* issued by the State Council proposes to encourage and guide social capital to sponsor health care undertakings. Since then, the number of private hospitals sponsored by private capital has surged but they are typically characterized by a small scale, low technology and low economies of scale (Chen & Wang, 2012).

Table 2-1 Comparison of Data between Chinese Public Hospitals and Private Hospitals in 2012

Item Types of hospitals	Total number	Nr of beds (10 thousands)	Medical staff (10 thousands)	Outpatient visits (10 thousands)	Nr of inpatients (10 thousands)
Public hospital	13519	357.9	355.5	144747.5	7060.0
Grass-roots medical institutions		132.43	205.2	256591.2	2644.4
Private hospital	8864	58.2	50.2	15068.6	782.8
Proportion of private hospitals	65.5%	11.9%	8.9%	3.7%	8%

Sources: Development Report of Private Hospitals & Analysis & Forecast of China's Social Situation, 2014

The above data further shows that after nearly 15 years of development, private hospitals still cannot compete with public hospitals, largely because they are small in scale and occupy just a small share of the medical market. They are just a useful supplement to public hospitals and there is still a long way to go before the vision of "common development, equal competition" takes shape (Wei & Xu, 2011).

There are many reasons why private hospitals are presently in large numbers but are characterized by a small scale and low economies of scale, to name just a few. For instance, public hospitals are public institutions while private hospitals are not. Therefore, the former can enjoy more preferential policies than the latter. Besides, restricted by the industrial policies like the academic status, limitation of research projects and promotion of medical staff, private hospitals are difficult to grow larger and stronger.

2.1.3 Region Background

Located in Zhejiang province, Ningbo city is only 100 km (app. 62.5miles) away from Hangzhou, the host city of G20 in 2016. As one of the most developed regions in China, Ningbo's per capita GDP registered 85,800 yuan (app. 11,400 euro), ranking 20th in China. The city has 5.9 million permanent residents and 4.75 million registered temporary population, excluding some unregistered migrant workers. It can be seen that the ratio of household population to non-household population is close to 11:1. (Shen & Zhu, 2013). By inference,

as the first generation of immigrants is gradually aging, they will have great and diversifying needs for medical services.

Meanwhile, Ningbo is one of five cities specifically listed in the State Economic Plan whose financial policies are under the direct control of China's Central Government and the local government supports the development of private hospitals. The map below shows the location of Ningbo.

Figure 2-1 Map of China (Ningbo)

Source: Fangxiangbiao.edu.com, 2016

This thesis takes the private hospitals in Ningbo city as a study case, focusing on the private general hospitals with more than 200 beds since. It is a typical example of a growing city under the context of China's urbanization policy, with a high number of resident and migrant populations with growing needs of medical care due to the dual effect of high purchasing power and aging.

Table 2-2 Number of Different Types of Hospitals in Ningbo by the end of 2013

Scale / Type	500 beds or above	500-250 beds	50-249 beds	Less than 50 beds
Public hospitals	20	15	24	101
Private non-profit hospital	3	2	4	12
Private for -profit hospital	0	0	12	21

Source: Zhejiang Association of Private Hospitals & Ningbo Municipal Bureau of Health, 2014

Ningbo has five private hospitals with more than 200 beds, all of which are non-profit general hospitals. However, only three out of five are included in this study, because one of them, the largest but youngest, is on the verge of collapse due to poor management, while another has not opened yet. All the other three in question, although in normal operation, encounter difficulties in their development. A preliminary analysis found that all these three hospitals have the problems of instability of human resources and low social credibility. The table below shows the turnover rate of medical staff in A hospital in recent three years.

Table 2-3 Turnover rate of medical staff in A hospital in recent three years

Time / Post	2011	2012	2013
Physician	23.1%	16.4%	24.9%
Nurse	23%	17.2%	25%
Medical Technician	5.7%	8.6%	4.9%

Source: the author

A further analysis shows that the reason for these two problems is because private hospitals, whether for profit or not, and public hospitals are obliged to operate according to the same medical laws and regulations in Zhejiang province. More specifically, the medical charge standard and drug price in private non-profit hospitals must be the same as those in public hospitals. In consideration of the needs of medical insurance payment and market competition, the medical fees in private for-profit hospitals under standardized management are basically the same as those in public hospitals. In addition, the hospital's key position setting, manning quotas and equipment are also required to comply with the standards adopted by public hospitals. While the medical fees are basically the same, private hospitals, unlike public hospitals, do not benefit from financial subsidies. Therefore, their disposable income is lower than that of public hospitals even when its per capita business income is

equal, not to mention the fact that its per capita business income is actually far lower than that in public hospitals. Therefore, it is difficult for employees in private hospitals to earn more than their counterparts in public hospitals.

Given these constraints, how to better develop private hospitals in a time when government encourages their development but national policies and the whole system are unfavorable? This is a subject that deserves to be studied and explored by all industry investors and managers.

In 2012, A hospital in question in Ningbo made a survey among 55 medical staff, including 20 who had already quitted their jobs from two private hospitals and 35 still working in private hospitals in this city. Those surveyed were required to rank 18 factors that could contribute to turnover or dissatisfaction with the hospital in order of impact. The result of the survey among dropouts showed that only eight respondents listed salary or traffic factors among the top six factors, but none put the salary factor into the top three. While the result of survey among working staff showed that 12 respondents put salary and traffic in the top six factors, and only one respondent put the dissatisfaction with salary in the first place. This survey was based on the actual work and most of the factors offered to respondents to rank had contributed to the turnover of medical staff. However, the scientific research methods were not used at that time, therefore the researcher expects to take this opportunity to make a scientific and in-depth research.

A hospital is a knowledge-intensive service organization and the core of its management lies in the human resource management (Wu & Liao, 2008). Each professional constitutes a crucial part of an organization, so a high turnover rate of professionals not only compromises the public recognition but also affects the improvement of team's professional skills and the formation of good organizational culture. With a set of functions like guidance, unification, standardization and motivation, organizational culture plays a vital role in uniting and motivating people in human resources management (Guo, 2013). Building excellent corporate culture can help create first-class corporate environment, shape first-class corporate philosophy and retain first-class talents, promoting an enterprise’s leapfrog development (Xiong, 2009).

Jin & Ning (2008) hold that limited by the collection of longitudinal data, the existing research on turnover focuses more on turnover intention than on turnover behavior. In fact, most scholars believe that turnover intention is a direct antecedent of turnover behavior and that high turnover intention always leads to turnover behavior.

Based on the above conditions, this thesis will study whether the cultural management philosophy can reduce the turnover intention of employees in private hospitals in the current environment.

2.2 Research Problems

The high turnover rate of health professionals and their low social recognition have been common problems faced by most private hospitals. However, the investors and managers of private hospitals always place the blame on the national system instead of taking active measures to improve internal management.

Actually, employees in private hospitals do not have the budgeted posts and high welfare like their counterpart in public hospitals, making them more likely to look for a more appealing job offer. Some leave to work in other private hospitals while others go to public hospitals but still do not secure budgeted posts. Therefore, how to reduce the turnover rate of health professionals in current condition is an issue worthy of being studied.

A considerable number of theoretical research has proved that organizational culture can improve employees' organizational identification and reduce their turnover intention, thus stabilizing the talent team. However, the construction of good organizational culture needs stable employees and takes time. China's modern private hospitals have a very short history, which just started in 2000 when the property right reform of public hospitals was initially introduced. Afterwards, many transformed public hospitals and private-sponsored hospitals have gradually appeared but, due to their short history, high turnover of medical staff and managers' being busy in daily management work, the organization's social responsibility is not clear and the organizational culture is absent. Conversely, the lack of good organizational culture leads to the instability of talent team (Li, 2010; Tian, 2014). Therefore, the purpose of the study is to contribute to minimize this problem. Besides, without good organizational culture, the organizational core values in any organization are also not clear. Further, except for economic indicators, which social responsibilities the private hospitals should fulfill are not clearly defined.

2.3 Research Questions

Why do private hospitals suffer such a loss in their medical staff? What are the major reasons? Is it because of salary, social status, sense of belonging, sense of accomplishment or professional mission?

China's private hospitals are the product of the development of a market economy, then should they be profit-oriented or be committed to fulfilling corporate social responsibilities? What are the core values and connotation of organizational culture of private hospitals? What role can good organizational culture play?

What is the current situation of organizational culture of private hospitals? Is that possible for private hospitals to integrate “the contents of social responsibilities and how they fulfill them” into the construction of their organizational culture through optimizing it, in order to enhance the members’ organizational identification, sense of mission and sense of accomplishment, and strengthen the organizational cohesion, thus reducing the turnover intention of their members and ultimately stabilizing the talent team?

This study aims at answering this set of intertwined questions.

2.4 Chapter Summary

Through analyzing the importance of developing private hospitals, the implications of industrial policies on private hospitals and the status quo of private hospitals, this chapter identifies the research problems and puts forward some preliminary ideas on the approach through which it aims to contribute to a solution. Hopefully, the study may discover the relationship between the CSR-based organizational culture of private hospitals and the turnover intention of medical staff.

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Chapter 3: Literature Review

3.1 Literature Review of CSR Theory

3.1.1 CSR Concept and Definitions

The term "Corporate Social Responsibility" (CSR) originated in America, and the thoughts of corporate social responsibility have been formed in the early 20th century (Yi, 2011).

It was British scholar Oliver Sheldon who, in 1923, first proposed the concept of CSR as he visited enterprises in America. Presently, there is an extensive array of literature on CSR mainly outside China. Sheldon defines corporate social responsibility (CSR) as a concept according to which business operators embrace responsibility to fulfill the needs of employees and their families as well as of the local community and society at large, and holds that the social responsibility of a business also encompasses ethical factors (Sheldon, 1923).

Howard R. Bowen (1953) asserted that corporate social responsibility refers to the obligations of businessmen to pursue specific policies, to make specific decisions, or to follow specific lines of action, which are desirable in terms of the objectives and values of society.

Later, McGuire (1963) proposed his view on CSR from the perspective of economics and law, defining that a business has certain responsibilities to society beyond the economic and legal obligations.

According to K.R. Andrews (1985), CSR is the notion according to which corporations voluntarily curb their desire to seek the highest profits. In more positive sense, CSR means the price the society pays for economic activities and the enterprise's sensitiveness of concentrating its efforts on some objectives. These achievable objectives, though sometimes not economically attractive, are more likely to meet the needs of the society.

In turn Robbins (1991) held that CRS refers to the firm's obligation of pursuing long term goals to the benefit of society beyond the narrow economic and legal requirements of the

firm.

3.1.2 Research of CSR Levels and Dimensions

Different authors described the concept of CSR in terms of levels or dimensions. Carroll (1979), namely, referred to CSR as an obligation that the society expects an enterprise to fulfill. However, according to him, the component of CSR goes beyond the responsibility of an enterprise to be economically profitable: it requires it to obey the law, behave ethically and do public good. Therefore, the social responsibility of a business encompasses the economic, legal, ethical, and philanthropic levels that society demands of organizations at a given point in time. Figure 3-1 below depicts these different levels.

Figure 3-1 Pyramid of Corporate Social Responsibility

Source: Carroll, 1979

G.A., Steninerγu (1980) categorized CSR into two types, including internal and external CSR. Specifically, internal CSR demands that businesses legally and fairly select, train, promote and dismiss employees, and improve staff's productivity and their working environment; external CSR concerns the responsibility of businesses to fuel entrepreneurship of a few groups and train or employ disabled persons.

The *Corporate Responsibility Statement* released by the Business Roundtable in 1981 stated that a business should carry out socially beneficial activities that promote the public interest apart from economic development and financial gains. This idea, known as

stakeholder capitalism, holds that a firm should balance the legal appeals of seven stakeholders, namely, customers, employees, investors, suppliers, communities, society and shareholders (Thomas, 1997). The Business Roundtable (BRT) is a conservative group of chief executive officers of major U.S. corporations formed to promote pro-business public policy.

Wood (1991) defined corporate social responsibility as a collection of social responsibility principles, social responsibility processes and social responsibility results, which constitute as many levels of the concept.

The World Bank defines CSR as a set of policies and practices related to the relationship between business and key stakeholders, values, obedience to the law, as well as respect for people, communities and environment. It is the commitment of businesses to contribute to sustainable economic development by working with employees, their families, the local community and society at large to improve their lives in ways that are good for business and for development (Cao, 2002).

According to You & Wang (1990), CSR refers to the unshakable legal and moral responsibilities of businesses for the sake of their healthy development and that of the society at large, which covers 6 aspects: creation of wealth for the country and ensure the integrity and value increase of national assets; creation of jobs; promotion of the healthy development of the society and improvement of the quality of life; meeting the needs of customers and protecting the interests of customers; improving the living and working conditions of employees; promoting social welfare undertaking.

Other scholars assert that, because of the expectations and requirements that the society has of organizations in different times, societies (countries), and systems are different, the focus and scope of CSR are also different. Therefore, CSR can be divided into two levels: corporate basic responsibility and corporate social responsibility (Bai & Wang, 2000).

Another hierarchical model of CSR presented by Chen & Han (2005) includes three levels, including basic CSR, senior CSR and ultimate CSR. The three dimensions of social responsibilities include shareholders, employees and consumers. Meanwhile, the author argues that the definition of CSR should be comprehensive, but the social responsibility should be fulfilled according to levels. Therefore enterprises need to identify their CSR level

according to actual conditions.

Xu & Yang (2007) believe that the nine dimensions of CSR include economic responsibility, legal responsibility, environmental protection, customer orientation, people first, employment, business ethics, as well as social stability and progress.

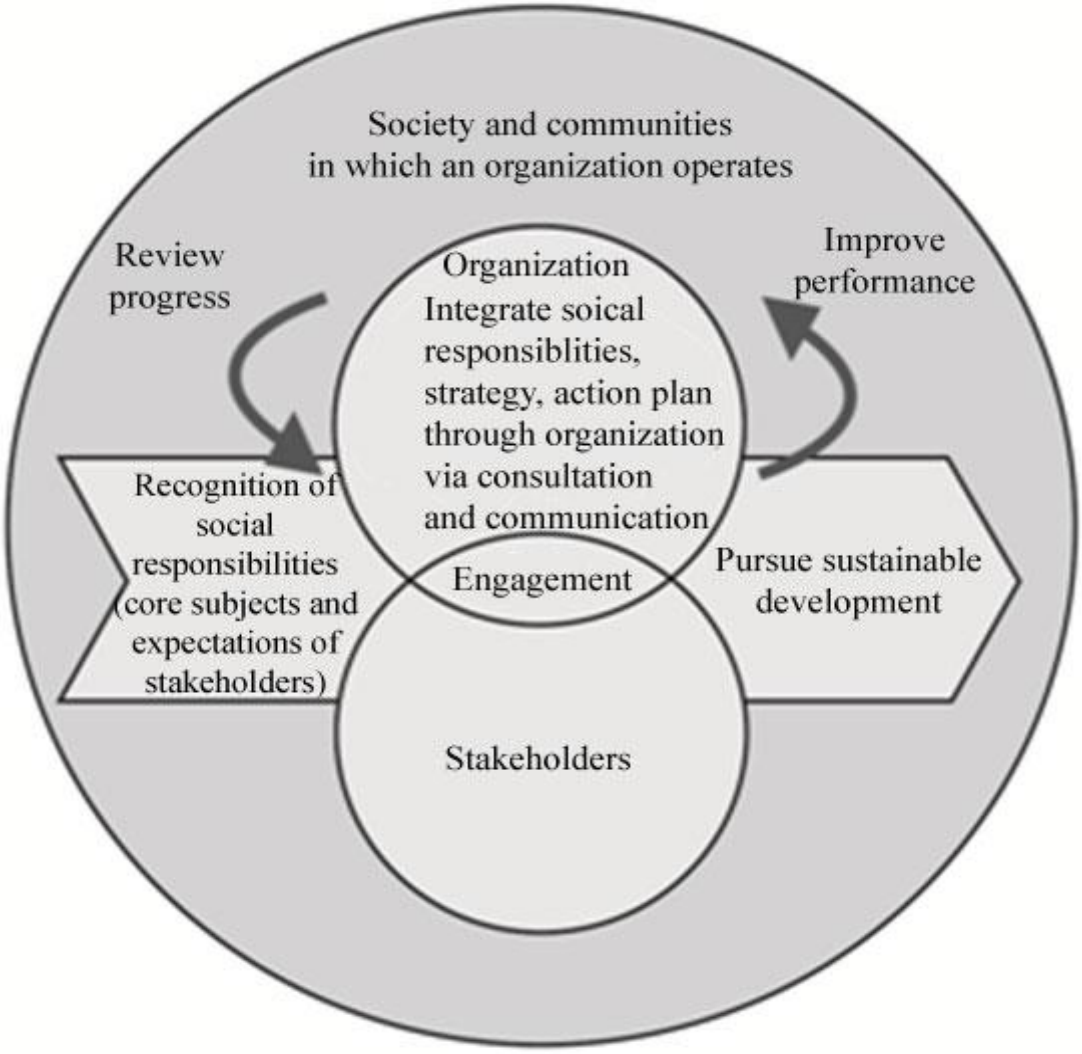
For Tan & Yang (2010), CSR includes eight dimensions, i.e. shareholders, employees, consumers, suppliers, competitors, communities, government and environmental protection.

With the evolution of the CSR concept, the research scope and level of CSR have been further expanded by foreign and Chinese scholars. Although there are considerable differences among them on how to frame the CSR scope and level, they broadly agree that economic responsibility is a priority, legal responsibility is a must, ethical responsibility is a duty and philanthropic responsibility is a voluntary choice (Yi, 2011).

3.1.3 CSR Management Model Research

ISO26000 developed a diagram depicting how CSR is incorporated into an organization. The following is the diagram.

Figure 3-2 Process of integrating CSR into an organization



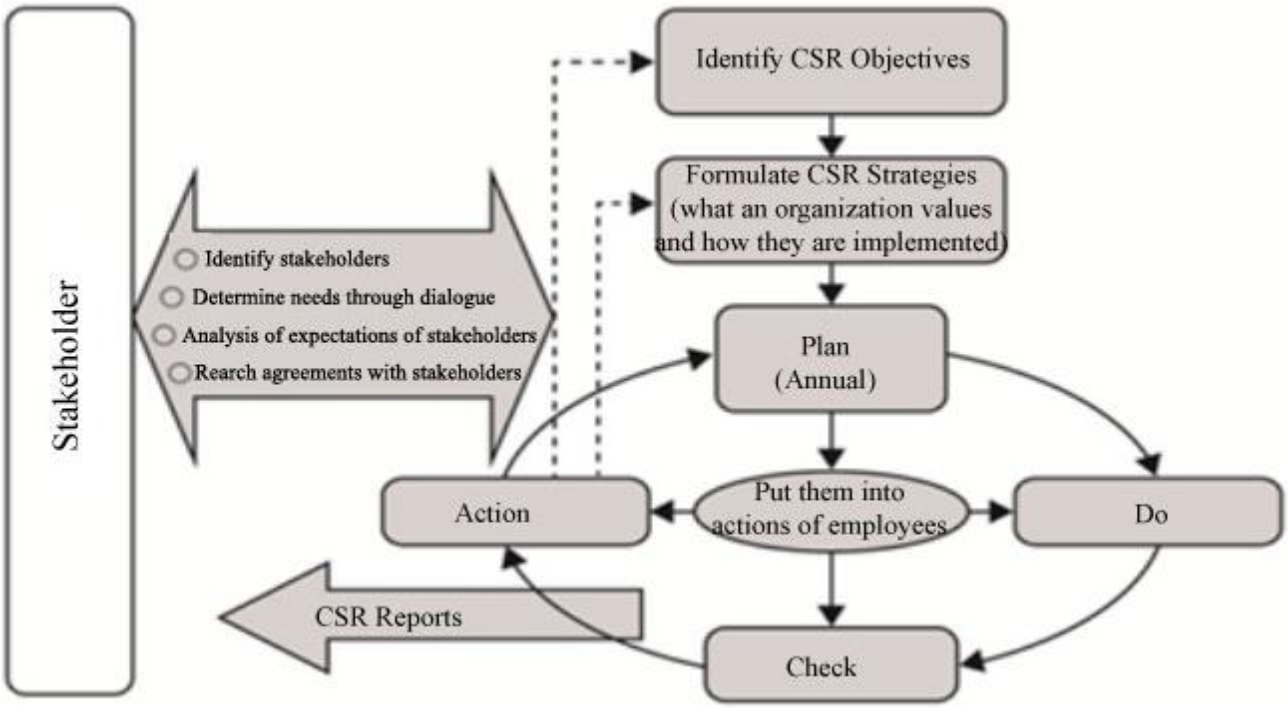
Source: Peng, 2011

As shown in the above picture, there is a big circle comprising 2 smaller circles, with the big circle representing the society and the environment in which an organization operates. The upper smaller circle lists the key contents of internal responsibility management, which includes social responsibility, responsibility strategy, action plans, and engagement with its stakeholders regarding social responsibility. The smaller circle below represents stakeholders involved in the whole process of social responsibility management. The procedure of the CSR management cycle begins with the recognition of social responsibilities, followed by the recognition of core subjects and issues of social responsibility after full communication with stakeholders. Then the organization engages with stakeholders to formulate strategies and action plans to integrate social responsibility throughout an organization for its sustainable

development (Peng, 2011).

A CSR management system developed by The Japan Research Institute (2009) obeys to the following procedures: first, identify the objectives of social responsibility management and its direction; second, formulate CSR strategies to indicate what the organization emphasizes and how they will be implemented; thirdly, integrate the strategies into the daily management of the enterprise through the PDCA cycle; lastly, engage with stakeholders to deliberate over the CSR reports. Stakeholder engagement includes the selecting methods, determining requirements through dialogue, analyzing stakeholders' expectations, as well as reaching agreement with stakeholders.

Figure 3-3 CSR management diagram



Source: The Japan Research Institute, 2009

3.2 CSR-related Theories

Western academic circles have carried out in-depth research on corporate social responsibility, and put forward a large number of related theories and application models. China's CSR theoretical research has mainly focused on business ethics responsibility,

corporate culture theory, social contract theory, stakeholder theory, enterprise control theory, sustainable development theory, economic globalization theory and economics of welfare, among which, business ethics responsibility, corporate culture theory and stakeholder theory which are closely linked to human resource management (Chen, 2011).

According to the research direction, since the stakeholder theory is an integral part of CSR, the relevant literature will now be reviewed followed by a discussion on the relationship between the two theories.

3.2.1 Stakeholder Theory

The term “stakeholder” was first used by Ansoff (1965), who asserted that the objectives of the firm should be derived balancing the conflicting claims of the various “stakeholders” in the firm: managers, workers, shareholders, suppliers, customers.

Freeman (1984) introduced the stakeholder research into the corporate strategy field, putting forward the idea that a stakeholder is any group or individual who can affect or is affected by the achievement of the firm’s objectives. This concept is widely recognized by most scholars across the world. He argued that a firm cannot develop without the participation of stakeholders. A firm should not assign its first priority to shareholders’ interests but give due consideration to the interests of all stakeholders.

Buchholta & Annkargued thatstakeholders refer to an individual or group with one or multiple rights and interests in a firm, who can affect a firm's actions, decisions and policies or be reversely affected by them. The firm and stakeholders are interlinked and interacted (Zhou & Zhang, 2002).

Mitchell, Agle & Wood (1997) identified legitimacy, power and urgency as factors that determine how much attention an enterprise should give to various stakeholders. According to the salience of stakeholders in the eyes of managers, the stakeholders can be subdivided into: (1) definitive stakeholders, including shareholders, employees and customers, who have the most reasonable benefit appeals and the greatest influence on the firm, and expect faster response to their requirements and to whom the firm must pay great attention and meet their requirements and needs to sustain its development; (2) expectant stakeholders, including government, social organizations, social groups and NGOs, that keep close contact with the

firm and have two of the three attributes mentioned above. However, the group with attributes of legitimacy and power needs to win the support of more powerful stakeholders or pin their hope on the good deeds of managers to reach their goal. The measures they often take include forming an alliance, participating in political activities and calling for the conscience of managers. Finally the third group refers to latent stakeholders, that is, those who have only one of the three attributes.

Charkham (1992) classifies stakeholders into two types according to whether they have transactions with a firm. The first type is contractual stakeholders including shareholders, employees, customers, distributors, providers and debtors. The second type is public stakeholders including all consumers, regulators, government departments, media and community.

Clarkson (1999) presented two methods to classify stakeholders. The first method classifies stakeholders into primary stakeholders and secondary stakeholders. The primary stakeholders include shareholders, investors, employees, customers, providers and government; the secondary stakeholders can affect and be affected by a firm but stay out of the firm's affairs. The second method classifies the stakeholders into voluntary stakeholders and non-voluntary stakeholders according to the risks they take in the firm's business activities.

The evolutionary history of stakeholder theory has gone through three main stages:

(1) Stage of influencing firm's survival: from 1965when Ansoff proposed the definition of stakeholders *t*o 1984 when *Strategic Management: A stakeholder Approach* written by Freeman (1984) was published. During this period the studies focused on who are the firm's stakeholders and the basis and rationality of stakeholders' participating in firm's governance (Feng & Zhang, 2009). The representative studies at this stage are as follows: Rhenman (1964) pointed out that stakeholders must depend on firms to achieve their interests and goals while firms need stakeholders to maintain their production; Ahlstedt & Jahnukainen argued in 1971 that as the participants of firms' business activities, stakeholders must depend on firms to achieve their interests or goals while firms need them to maintain development. Although the enterprise survival view proposed by some scholars at this stage deepened their understanding of stakeholders and laid the theoretical foundation for the stakeholders to participate in the

enterprise's governance, the broadly defined concept of stakeholders failed to indicate by what means stakeholders participate in the enterprise's governance and what influence stakeholders can exert on the performance of enterprises (Zhang, 2014).

(2) Stage of implementing strategic management: Freeman's book published in 1984 clearly stated that the strategic management view of stakeholders should focus on the impact of stakeholders on the analysis, plan and implementation of an enterprise strategy, thus defining the concept of stakeholders from the perspective of their impact on the enterprises and acknowledging the importance of the participation of stakeholders in the enterprise strategic management (Feng & Zhang, 2009). This theory applied the stakeholder approach to enterprise strategic management, providing a new idea or reference for other scholars to study strategic management. The representative studies at this stage are as follows: Alkhafaji argued in 1989 that the enterprise strategic decisions should be jointly made with those who have important stakes in the enterprise; Good paste asserted in 1997 that the stakeholders should be strategically treated in the enterprise management. The directors should fulfill not only the fiduciary responsibility for shareholders but also the ethical responsibility. Although the theories at this stage have emphasized the role and status of the stakeholders in enterprise strategic management, they still failed to provide an implementation mechanism for the stakeholders to participate in the business affairs (Zhang, 2014).

(3) Stage of sharing the ownership of the enterprise: the study at this stage focused on how stakeholders share the ownership of enterprise so that they can participate in the enterprise's governance. The theory of sharing the ownership of enterprise emphasized the enterprise's common governance. The representative theories at this stage are as follows: Williamson argued in 1985 that people who invest in the enterprise should be given the proper management positions; Yang & Zhou insisted in 2000 that since all stakeholders, including shareholders, debtors, managers and employees, have done their part in maintaining and increasing the value of corporate assets, then the enterprise should be jointly owned by all of them. They realize their rights through sharing the ownership of the enterprise (Zhang, 2014).

3.2.2 Study on the Relationship between CSR and Stakeholders

Clarkson (1999) pointed out that the concepts of corporate social responsibility and

corporate social performance were generated outside the enterprise. However, their contents were not clearly and concretely defined and did not relate closely to the specific work and therefore sounded like a slogan. As a result, they have not been widely accepted by scholars in business circle. In contrast, the stakeholder theory explicitly points out that an enterprise should hold responsibility for all stakeholders. Under this context, corporate social responsibility and the daily business activities are organically combined together, thus the corporate social responsibility is integrated into the relationship between the enterprise and its stakeholders and into the specific business activities of the enterprise. The practice of applying the stakeholder theory to the corporate social responsibility, especially combining it with the daily management work, is easily accepted by Chinese entrepreneurs.

In his paper *Empirical Study on the Corporate Social Responsibility Undertaken by Private Enterprises*, Yi (2011) argued that the stakeholder theory has overturned the shareholder primacy theory and laid a theoretical foundation for CSR. The stakeholder theory and CSR theory have a lot in common, namely, both study the relationship between enterprise and individuals/groups other than shareholders. The stakeholder theory can be introduced into the study of corporate social responsibility to indicate what social responsibilities enterprises should take, thus providing a theoretical framework for enterprise to define social responsibilities.

Zhang (2014) pointed out that the stakeholder theory and the CSR study should be combined. On the one hand, the stakeholder theory can lay a theoretical foundation for CSR study; on the other hand, CSR study can provide empirical evidences for the stakeholder theory. In fact, the stakeholder theory, which contains abundant thoughts of corporate social responsibility, is a powerful theoretical tool for CSR study.

3.2.3 Study on the Relation between Public Hospital Social Responsibility and Stakeholders

A review of CSR theories shows that foreign scholars have made continuous research on the definitions, contents and influencing factors of hospital social responsibility, but there is still no universally acknowledged definition of what hospital social responsibility should be (Wang, 2012).

Dennis Zimmerman (1991) argued that hospital social responsibilities should include uncompensated charity care, handling of bad debt(debt that is unlikely to be paid）, medical expenses uncovered by medical assistance program, as well as medical costs used to improve health of disadvantaged groups and medical technological talents.

In turn, Buchmueller & Feldstein (1996) held that hospitals should hold social responsibility not only for disadvantaged groups, but for the general public.

The Catholic Health Association in its Guide on Social Responsibility Planning and Reports, pointed out that hospital social responsibility means that hospitals have the responsibility to provide medical services for particular social needs or promote the health of the people in society. Therefore hospitals should be motivated by their responsibility instead of meeting the needs of the market (Zhu & Xu, 2011). The Guide also indicated that hospital social responsibility should cover six aspects, namely, promoting community healthcare, carrying out healthcare education activities and programs, subsidizing healthcare, research projects, money and material donations and community construction (Yang & Xu, 2011).

According to Xu & Zhao (2012), Western scholars generally agree that hospital social responsibility means that hospitals must hold social responsibility for government, shareholders, ecological environment, consumers, employees and sustainable development while pursuing reasonable profits, which covers the following aspects:

(1) in terms of government, the hospital should undertake three kinds of responsibilities, including general responsibilities (operate by law, pay taxes and do business according to government's macro control), special responsibilities (maintain and increase value of corporate assets, create more jobs in community, and maintain social stability) and high-level responsibilities (develop hospital’s advanced culture, ensure the national security);

(2) in terms of shareholders, hospitals should ensure shareholders’ rights in management and dividend revenues. The hospital should strengthen communication with minority shareholders in good faith and boost the confidence of investors in hospitals with real and objective business performance in order to make the hospital an ideal investment destination;

(3) in terms of environment, the hospital should minimize the environmental pollution while maximizing business profits and protect the ecological environment and biodiversity;

(4) in terms of customers, the hospital should provide affordable and quality medical

products and services for them

In recent years, China's scholars and hospital managers have made extensive study on hospital social responsibility. For example, Hu (1994) pointed out that hospital social responsibility means that the hospital should actively fulfill the social responsibilities and obligations of providing medical services for people. In his view, the hospital should hold responsibility for the country, society, patients and employees.

Zhao (2003) asserted that, from the perspective of "hospital-society relationship", the hospital should hold the responsibility for its country, patients and employees; from the perspective of the role of "hospital-society relationship", the hospital should strive to strengthen community diseases prevention, guide the grass-root medical work, provide field emergency treatment and ensure that the hospital meets environmental standard. Finally, from the perspective of essential characteristics of "hospital-society relationship", hospital social responsibilities should include economic responsibility, legal responsibility and moral responsibility.

Xi (2009) discussed the reasonable boundaries of social responsibility of public hospitals from five aspects, for example, politics, economy, law, technology and humanity. First, to serve the people wholeheartedly is the fundamental social responsibility of public hospitals; second, public hospitals should properly handle the relationship between economic benefits and social benefits and put the social benefits in the first place; third, for public hospitals, to operate by law is the basic feature of taking social responsibility; fourth, the limited service capability of public hospitals makes it impossible to provide unlimited medical products and services for people, and therefore it can only ensure basic health care services for everyone; fifth, public hospitals must follow the principles of "Balance the input and efficiency, put the efficiency first" in fulfilling social responsibility.

Qiu (2006) holds that hospital's social responsibility has four levels, i.e. the responsibilities for national development goals; for public health; for community health and for environment.

Liu & Tian (2009) consider that it is of great significance for public hospitals to implement social responsibility strategies. First, it can help to consolidate the brand and improve the hospital's image; second, it will give employees a sense of honor and strengthen

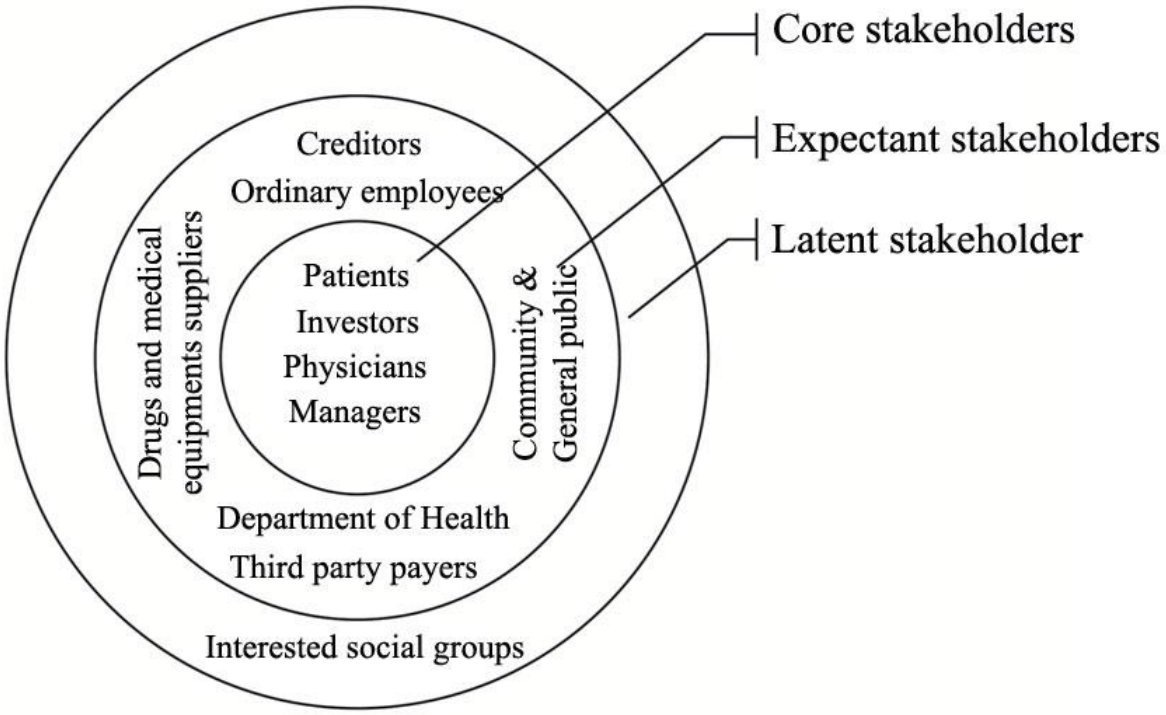
team's cohesion; third, it will increase economic benefits and promote hospital's development; fourth, it may provide new ideas for hospital management and optimize the distribution of health resources.

Jiao, Cao & Wang (2009) indicated that hospital social responsibility can be achieved by (1) putting people first and establishing an all-round, coordinated and sustainable development view - "put people first" includes two meanings, with the first being patient-centered and the second being employees-oriented; (2) fosteringan excellent hospital culture; and (3) increasing the input and strengthening supervision.

Wang (2012) pointed out that increasing employees' sense of honor and enhancing organizational cohesion are essential to hospital social responsibility. The core of hospital social responsibility is to stress the importance of and show respect for people. When a hospital attaches equal importance to economic benefits and social benefits, managers and employees can easily reach consensus, thus making employees psychologically identify with the hospital and laying foundations for the establishment and operation of incentive mechanisms.

In his study of social responsibility of public hospitals, Chinese scholar Li (2013) classified 11 stakeholders of public hospitals into three kinds, namely, core stakeholders, expectant stakeholders and latent stakeholders. As per Figure 3-4 below, the four core stakeholders include patients, investors, physicians and managers; six expectant stakeholders comprise Department of Health Inspection, ordinary employees, creditors, third party payers, medical equipment suppliers, community and general public; one latent stakeholder represents the interested social groups.

Figure 3-4 Stakeholders of public hospitals



Source: Li, 2013

In the same study, Chinese scholar Li (2013) drew a table listing the stakeholders and corresponding social responsibilities of public hospitals as follows:

Table 3-1 Stakeholders and corresponding CSR of public hospitals tabulated by Li

Stakeholders	Economic responsibility	Legal responsibility	Moral responsibility	Philanthropic Responsibility
Investors	Effectively operate and manage hospital, provide medical products and services with advanced technologies and reasonable price	Health prevention and public health work		
Managers	Effective incentive system	Fair employment; reasonable governance structure	Perfect welfare system	
Physicians	Effective incentive system	Decision-maker, fair employment	Construction of ethical committee	
Stakeholders	Economic responsibility	Legal responsibility	Moral responsibility	Philanthropic Responsibility
Patients	Provide medical services with advanced technologies and reasonable price; humanistic care	Patient's right to know	Safeguard patients' interests and rights	Poor patients relief
Department of Health	Timely payment of prescribed fees	Law-abiding; act in accordance with established rules; emergency relief	Practice medical ethics	Support underdeveloped areas
Third party payers	Charge fees honestly and reasonably	Act in accordance with established rules		
Ordinary employees	Reasonable salary; effective incentive	Fair employment	Perfect welfare system	
Creditors	Timely interest payment and repayment	Observe the rules and fulfill the contract		
Supplier	Fulfill the contract; pay in time	Observe the rules and fulfill the contract		
Community, General public		Health promotion; public health	Properly handle medical wastes and protect the environment	Help disadvantaged groups
Interested social groups		Teach students; clinical research	Observe professional norms, increase the information transparency	

Source: Li, 201

In the paper CSR Evaluation System of Public Hospitals, Li & Ren (2012) established a three-level index evaluation system. As per Table 3-2 below, the first-order indicators represent the classification of stakeholders (for example, expectant stakeholders); the second-level indicators represent individuals or organization under each classification (for example, patient, third party payers); the third-level indicators represent the evaluation items of individuals or organizations.

Table 3-2 Three-level Index Evaluation System of Stakeholder-based Public Hospital Social Responsibility

First-order dimensions	Second-order dimensions	Third-order dimension
Ⅰ-1 Core stakeholders	Ⅱ-1 Investors of public hospitals	Ⅲ-1 Debt to assets ratio
		Ⅲ-2 Net asset growth rate
		Ⅲ-3 Business expense /business income per one hundred yuan
		Ⅲ-4 Average length of stay and occupancy rate of beds
		Ⅲ-5 Annual outpatient visits, number of surgical operations, and number of admission and discharge
		Ⅲ-6 The ratio of drugs and expensive consumables to total revenue
		Ⅲ-7 Satisfaction of society and patients
		Ⅲ-8 Medical quality and safety system and its implementation
		Ⅲ-9 Performance evaluation and comprehensive objectives management system
	Ⅱ-2 Senior managers	Ⅲ-10 Reasonable hospital governance structure
		Ⅲ-11 Standard bonus-penalty and promotion system
		Ⅲ-12 Clear and reasonable salary
		Ⅲ-13 Steady capital investment
		Ⅲ-14 Reasonable policy and implementation efficiency
	Ⅱ-3Physicians	Ⅲ-15 Reasonable and contribution-matching salary
		Ⅲ-16 Opportunities of getting involved in decision-making
		Ⅲ-17 Safe working environment and working hours
		Ⅲ-18 Perfect social security and welfare system
		Ⅲ-19 Continuing education and encouraging scientific research innovation system
		Ⅲ-20 Reasonable bonus-penalty and promotion system
	Ⅱ-4 Patients and their family members	Ⅲ-21 Reliable medical services
		Ⅲ-22 Complaints and dispute settlement procedures
		Ⅲ-23 Per capital outpatient and hospitalization expenses
		Ⅲ-24 Patients' interests and rights, e.g. protection of rights to know

		Ⅲ-25 Price transparency, eliminate supplier-induced demand
		Ⅲ-26 Expenses reduction and exemption policy for poor patients
Ⅰ-2 Expectant stakeholders	Ⅱ-5 Department of Health Investigation	Ⅲ-27 Comply with laws and regulations; operate by law
		Ⅲ-28 Provides public health services
		Ⅲ-29 Emergency management and medical relief for emergency events
		Ⅲ-30 Support agriculture and train basic level medical staff
		Ⅲ-31 Medical ethics construction and implement performance evaluation system
	Ⅱ-6 Third party payer	Ⅲ-32 Strictly review the medical requirements of insured patients by rules
	Ⅱ-7 Ordinary employees	Ⅲ-33 Reasonable manning quotas and position settings
		Ⅲ-34 Reasonable salary and timely allowance payment
		Ⅲ-35 Perfect social security and welfare system
		Ⅲ-36 Good working environment
		Ⅲ-37 Continuing education and training opportunities
		Ⅲ-38 Standard bonus-penalty and promotion system
		Ⅲ-39 Fair employment
		Ⅲ-40 Put in place assistance system for workers in difficult situation
	Ⅱ-8 Community and environment	Ⅲ-41 carry out health education and disease prevention promotion
		Ⅲ-42 Have environmental protection and energy conservation measures
		Ⅲ-43 Donations for public welfare and provide free medical treatment
	Ⅱ-9 Drugs and medical equipment suppliers	Ⅲ-44 Fulfill contract and pay fees in time
		Ⅲ-45 Fair, open procurement and bidding system
	Ⅱ-10 Creditors	Ⅲ-46 Fulfill contract; repay and pay interests in time
		Ⅲ-47 Information transparency and Good faith cooperation
Latent stakeholders	Ⅱ-11 Interested social groups	Ⅲ-48 Support professional association work and maintain professional image
		Ⅲ-49 Be kind to media and information disclosure
		Ⅲ-50 Mutually beneficial cooperation and fair competition

Source: Li & Ren,

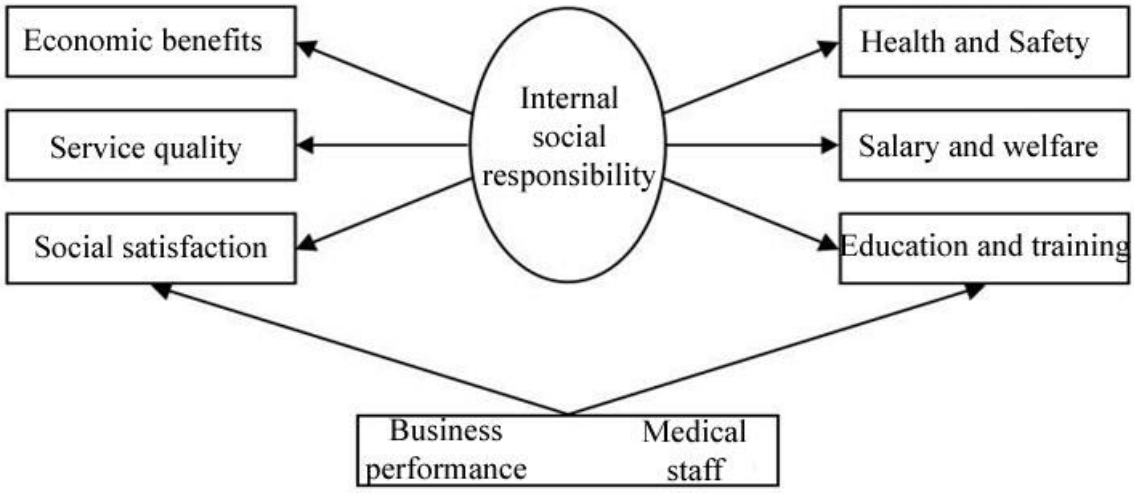
3.2.4 Study on the Relationship between CSR of Private Hospitals and Stakeholders

From the point of view of stakeholders, the enterprise needs to actively safeguard the interests of non-shareholders while maximizing shareholders'profits. Private hospitals have many kinds of stakeholders whose impact islisted as follows: the inverstors and creditors provide the capitals that guarantee the survival and development of private hospitals; medical staff's technical level and service attitude directly determine the medical level and service quality; patients are in good position to evaluate the medical quality and can directly affect the economic benefits of private hospitals; suppliers provide drugs and medical equipments; the government formulates policies and regulations for private hospitals; industry competitors can affect the business environment of private hospitals. In addition, there is mutually beneficial relationship between private hospitals and local community and people (Wang, 2009).

Wang (2012) referred to social responsibility of private hospitals as the economic, legal, ethical and other responsibilities undertaken by private hospitals for stakeholders (for shareholders, medical staff, patients, suppliers, government departments, local society, local community, and local residents) in a given social development period. Specifically, the social responsibility of private hospitals includes internal and external responsibility. Internally, private hospitals should show concern for employees, and promote the development of hospitals. Externally, private hospitals should fulfill the obligations for the country and society including healing sick people, operating by law, standardizing medical service, operating in good faith and protecting the environment.

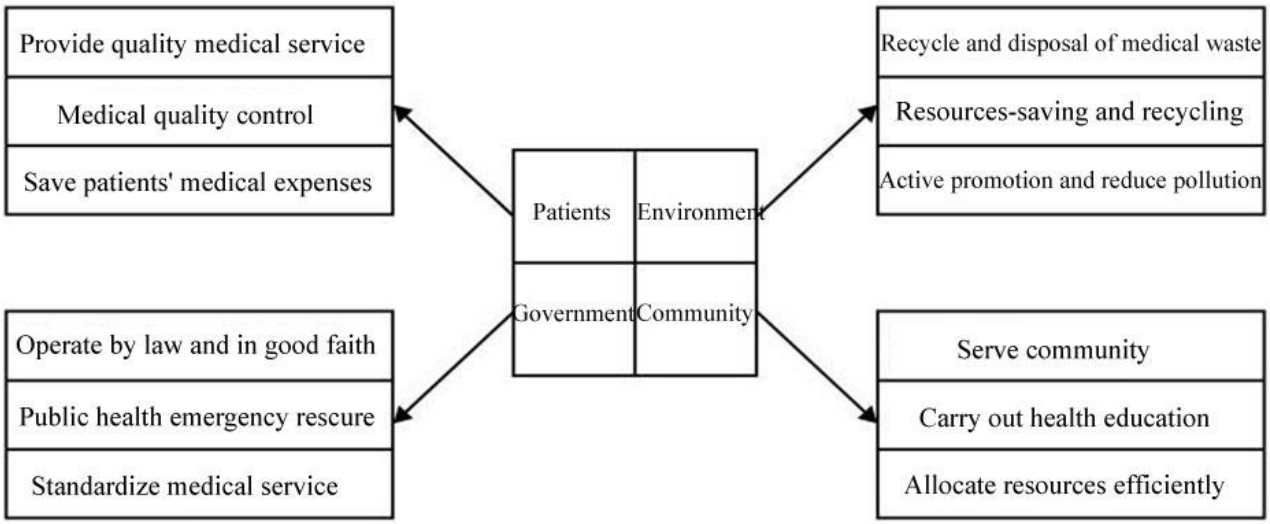
Based on the stakeholder theory, Wang (2012) established two theoretical models for the basic internal social responsibility and external social responsibility of private hospitals as presented in Figure 3-5 and Figure 3-6 below.

Figure 3-5 Internal social responsibility of private hospitals



Source: Wang, 2012

Figure 3-6 External social responsibility of private hospitals



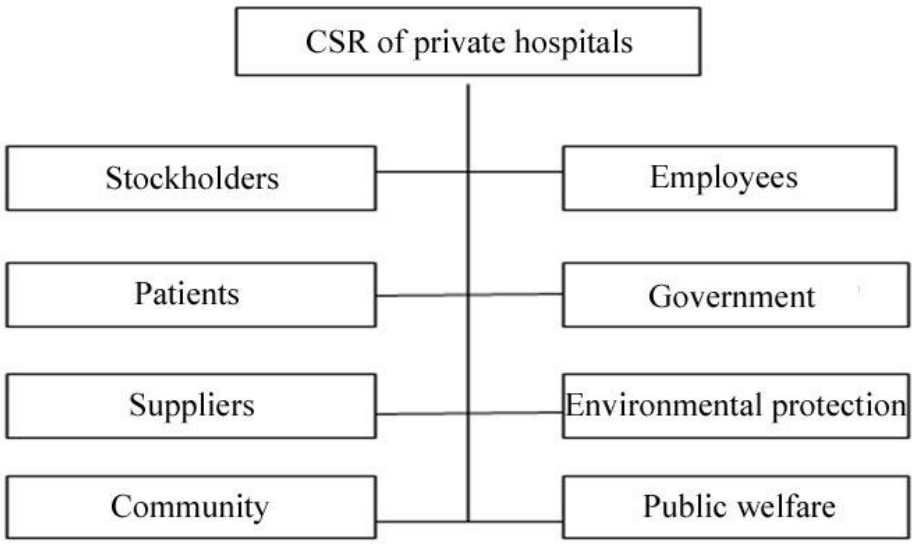
Source: Wang, 2012

Wang &Wang (2013) pointed out that, under market economy, private hospitals often focus more on economic benefits while ignoring social responsibility. Therefore, it is of great significance to promote the harmonious development of private hospitals and society by establishing a social responsibility system, increasing their awareness of social responsibility and giving full play to the social role of private hospitals. These authors classified the social responsibility of private hospitals into three aspects: first, the internal responsibility for employees includes (1) business scope, business philosophy, management style, shareholders'

rights and interests, information transparency, and the communication, exchange and game with patients; (2) training, welfare and working environment of medical staff; (3) strengthening medical ethics construction, standardizing medical service and operating by law; second, the responsibility for patients, includes (1) credit system construction, comprising trust promotion, trust price and trust service; (2) maintaining a good doctor-patient relation; (3) improving medical quality, including competence of medical staff, hospital environment and care for patients; (4) responsibility identification for medical malpractice and medical compensation; third, responsibility for society, including (1) health education and promotion; (2) participation in public welfare activities; (3) prevention and treatment of national major diseases and medical relief in event of emergency accidents; (4) social medical education; and (5) social environment protection.

Chen & Xu (2010) established a social responsibility system of private hospitals based on stakeholders as depicted in Figure 3.7:

Figure 3-7 Social responsibility system of private hospitals



Source: Chen & Xu, 2010

The researchers describe in detail what kind of social responsibility private hospitals should take for each type of stakeholder as follows:

(1) For shareholders who are the investors of private hospitals the main responsibility of private hospitals is to maximize shareholders' profits while taking into consideration economic interests and hospital's fame;

(2) For employees who are the main part of private hospitals and the basis for them to survive and develop, hospitals should first, pay respect toemployees, especially their labor value.

Secondly, they should create a good working environment for them, including material conditions and social environment, and hold responsibility for employees' safety, welfare and education. Thirdly, they should evaluate employees' performance fairly and impartially, establish a fair income distribution system, and protect the legal income of medical staff. Finally they should create wider development space for employees by providing more opportunities for promotion, further study and training;

(3) For patients who are the recipients of medical services, and therefore their trust and support are of central importance to the survival and development of hospitals, they should be committed to treating patients, and private hospitals are no exception. Their basic social responsibility is to provide quality and affordable medical services. Meanwhile, hospitals must respect and protect patients' rights and do not mislead them with false advertising. Medical services have great bearing on patients' health and life, so their rights and interests should be well protected;

(4) For government, private medical organizations as independent legal entities should hold responsibility for the country and society, including lawful operation, good faith management and tax-paying according to regulations. Private hospitals should try their best to provide public medical services and actively respond to public health events under the leadership of local government;

(5) For suppliers the aim is to establish a partnership based on fair trade, fulfillment of contracts and protection of the lawful rights and interests of suppliers. Prices should not be the only criteria of selecting suppliers, their conditions in human rights, safety and health, and environmental protection should also be considered;

(6) For environmental protection, it should be made full use of resources and protect the ecological environment, properly handle medical waste, patients' daily waste and waste water, actively prevent and control infection in hospitals in an effort to build a green hospital;

(7) For the community it is important to actively maintain community health, carry out community health education, provide manpower and technical support for prevention and control of diseases, and actively respond to public health emergencies and join rescue efforts;

(8) For public welfare, best efforts should be made to participate in public welfare and charitable activities; encourage medical staff to give free consultations as volunteers in the community; provide medical assistance for disadvantaged groups, especially for the aged, poor people and people suffering a great loss of property.

3.3 Organizational Culture Theory and Model

3.3.1 Definitions and Classification of Organizational Culture

Organizational culture, also referred to as corporate culture, has been widely studied by numerous Chinese and foreign scholars. Nearly all management scientists and corporate culture scholars had given their definitions but the most influential and widely accepted definition was developed by Schein (1992), who argued that organizational culture represents the collective values, beliefs and norms of organizational members. The essence of organizational culture, at some point, refers to an integrated and harmonious system consisting of values, behaviors, etiquettes and atmosphere. The system is a pattern learned by a group as it solves its problems of external adaptation and internal integration. If this pattern has worked well enough to be considered valid it should be taught to the new members.

Previously, Wallach (1983) had also defined organizational culture as a set of shared values, beliefs and rules that exist among employees within a company and that help guide and coordinate behavior. Lorsch (1986) referred to organizational culture as shared beliefs top managers have about how they should manage themselves and other employees, and how they should conduct business.

Organizational culture has also been variously defined from different perspectives by Chinese scholars. Some argue that organizational culture is the result of an organization's economic activities, whose ideologies and values form observable entities such as behavioral norms that are widely accepted by the group members (Liu, 1999). Corporate culture is established by an organization engaging in economic activities, whose values and behavior norms are shared by all group members.

Other scholars assert that organizational culture refers to the psychological mechanisms, behavioral patterns, behavioral habits and group behaviors of employees that are formed from the shared values of an organization (Qin, 2006).

Although domestic and foreign scholars have viewed organization's culture in different manifestations, they have common ground on the connotation, components and function of organization's culture, for example, most definitions include the concept of values (Chen, 2010).

From the perspective of communication and interaction between group members, Wallach (1983) investigated organizational culture by means of three dimensions:

bureaucratic, supportive and innovative. The bureaucratic dimension is hierarchical, highly formalized and structured, and inflexible and has clear lines of responsibility and authority. Besides, there are written procedures that govern what employees have to do. The supportive dimension concerns openness, harmony, fairness and relationship oriented and is characterized by trust, safety, encouraging a collaborative and highly supportive atmosphere. The innovative dimension is described by the adjectives: 'challenging, risk taking, stimulating, driving, creative and energetic'. Employees are encouraged to try new ways of working without the fear to failure.

Quinn and Cameron determined four basic types of organizational culture: clan culture; adhocracy culture; market culture; and hierarchy culture. Clan culture displays a very friendly and harmonious working place, which is like an extended family where leaders are considered to be mentors or even parents. Hierarchy culture focuses on internal environment maintenance and specifies the need for stability and control. Market culture is achievement and resources oriented with strong desire for heightened market fame. Adhocracy culture attaches great importance to the external environment and encourages high flexibility and individuality inside an organization (Su, 2012).

3.3.2 The Structure and Elements of Organizational Culture

Schein (1985) differentiated the "manifestations" of culture from its "essence" and classified culture into three levels ranging from the very tangible overt manifestations that one can see and feel to the deeply embedded, unconscious, basic assumptions that are defined as the essence of culture. In between these two layers are various espoused values. Culture manifests itself from three levels and the essence of a culture lies in the pattern of basic underlying assumptions. The visible behavior cannot entirely reflect organizational culture.

Based on his previous study, Schein (1992) depicted the levels of corporate culture as a "Water lily Model". The flowers and leaves above the water are the artifacts of culture, including organizational structures, rules and processes; the branches and stems in the middle part represent the espoused beliefs and values including missions, goals and behavioral norms; the root part represent the underlying assumptions including unconscious, taken-for-granted beliefs, perceptions, thoughts and feelings.

Geert Hofstede (1996) argued that although cultures of different nations and in different times have their distinctive features, the structure of corporate culture is basically similar and

includes four levels, i.e. material culture, system management culture, behavior and custom culture, as well as ideological culture.

Chinese scholar Wang (2013) constructed an onion model based on Geert Hoftede's Four-level Cultural Theory, with the core layer representing the values (spiritual culture), the third layer system culture, the second layer behavioral culture and the surface layer the symbol culture.

Accordingto Jin & Ning (2008), organizational culture comprises five elements, namely, business environment, values, heroes, rites and rituals as well as cultural network. Business environment indicates the broad social and market environment in which an enterprise operates, including customers, market, rivals, government and technologies. The business environment is the most important factor in shaping the organizational culture that embodies all strategies needed for business success; values are not only a criterion by which things are judged right or wrong but the basic concepts and beliefs on which a corporate culture is based. They reflect the basic characteristics of an enterprise that distinguish itself from other enterprises through different methods of dealing with internal and external affairs. Heroes are persons, alive or dead, real or imaginary, who personify the values of a culture and possess characteristics that are highly prized in a culture, and thus serve as role models for other people in an organization; rites and rituals reflect the enterprise's dynamic culture and reveal how cohesive an organization is. Specifically, they are widely known, unwritten, visible and programmed routines of day-to-day life in a company, thus indispensable to the perfection and development of the enterprise's values. Culture network is the primary and informal means of communication in an organization and is the effective carrier of the values and hero myths. Storytellers, spies and whisperers form a hidden hierarchy within the enterprise.

3.3.3 Functions of Organizational Culture

Organizational culture has two functions, which provide the behavioral paradigm and ensure the consistency of organization's goals (Wilkins & Ouchi, 1983).

Organization’s culture can solve the external adaptation and internal integration problems, thus guaranteeing the organization’s normal operation and survival. Besides, it can also be a source of competitive advantage (Fiol, 1991).

In sum, the widely accepted, mature and comprehensive theory in relation to the function of organization’s culture argues that corporate culture has the functions of guiding, uniting, motivating, constraining and radiating (Song, 2012).

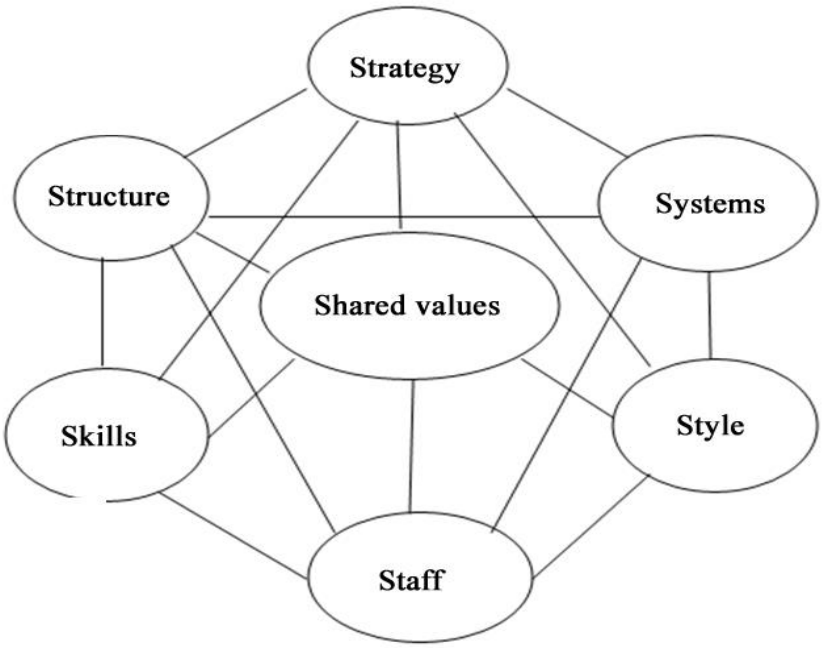
3.3.4 Establishment and Maintenance of Organizational Culture

It is founders who define the fundamental principles of the culture in their organizations. These principles underlie the operation and purpose of an enterprise, namely its business philosophy. Once the culture of an organization established, some measures need to be taken to maintain it, during which three factors play a decisive role, namely, selection, behaviors of senior management and socialization process. Through selection, people with knowledge, skills and abilities are hired while those who may damage or pose threat to the values of the organization are left out, a source of potential conflicts. In turn, the behaviors of top management have important impact on organizational culture as managers establish behavioral norms through their own words and deeds and integrate them into the organizational culture. Socialization is the process through which the organization helps new members adapt to the organizational culture and pass on values and behavior norms to them (Jin & Ning, 2008).

3.3.5Study of the Application of Organizational Cultural Management

According to the 7S model proposed by Peters & Waterman (1982), as depicted in the figure below, it can be seen that the shared values are at the central part, meaning they are the core factor for a firm to have success.

Figure 3-87S Model

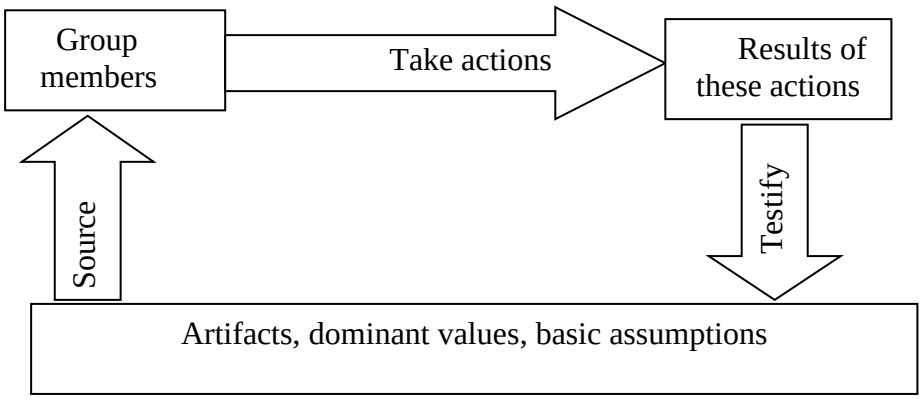


Source: Thomas & Robert, 1982

After a study on values integration, person-organization values fit, organizational identification and individual behaviors, Su (2012) concluded that organization's values are recognized and understood by group members through integration; values integration is positively correlated with organizational identification and Person-Organization Fit (P-O Fit); P-O Fit is positively correlated with organizational identification; organizational identification affects behaviors of group members; values integration and P-O Fit affect individual behaviors through organizational identification, that is, organizational identification acts as a bridge through which organizational culture affects individual behaviors.

Jing & Ning (2008) asserted that the organizational culture plays a coordinating role in culture management inside an enterprise. Besides, they established a culture management behavior model as per Figure 3-8.

Figure 3-9 Culture Management Behavior Model



Source: Jin & Ning, 2008

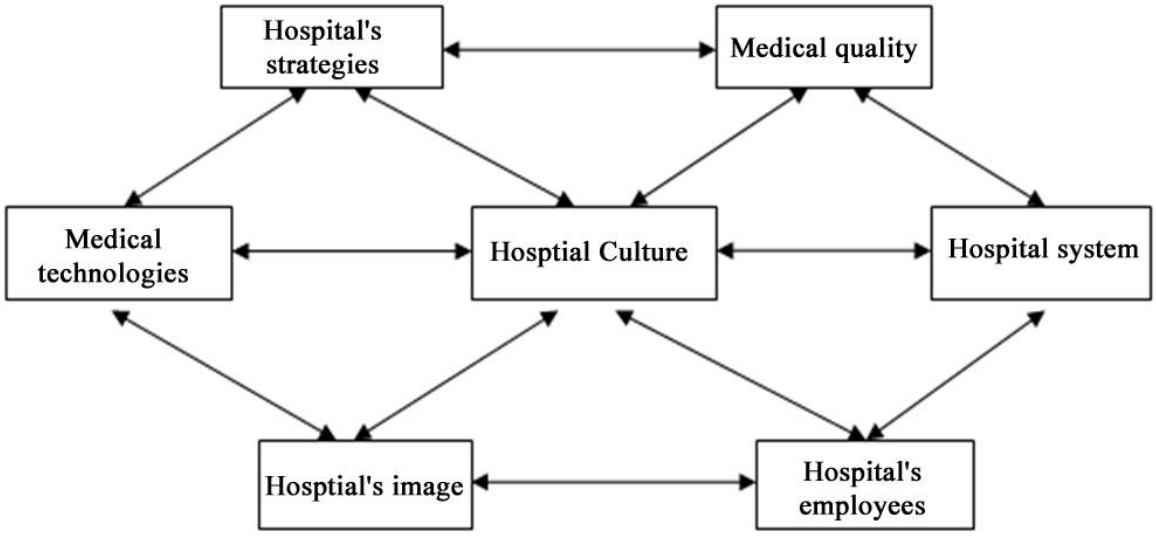
Based on the core values of "Creeds-based, Strive for perfection", Xian Janssen Pharmaceutical Ltd, China's largest pharmaceutical joint venture, has rapidly developed and achieved remarkable success. Credo is the soul of a firm and manifests the high consistency of corporate values and life values of employees. Xian Janssen embraces the credos that "We feel obliged to hold responsibility for our customers, for employees, for society and for shareholders". It always looks ahead with great foresight for bigger market and the whole world. "Strive for perfection" means each employee should make unremitting efforts in innovation and improvement to achieve absolute perfection. "Perfection" is embodied in the company's endless pursuit of perfection in product quality, marketing, corporate management and company's development (Gu, 2002).

3.3.6 Study on Organizational Culture of Public Hospitals

Based on the 7S model, Chinese scholar He, Jin, Ma, Ni & Zheng (2007) made an application to hospital management and integrated it with his new model, "Influencing Factors of Hospital Core Competency Model". The model puts the culture factor at the core with other six factors under its influence. Hospital culture represents the shared values, beliefs and principles spiritually embraced by organizational members, and therefore it is difficult to copy and imperfectly imitable. Hospital culture is the core factor and source power of hospital's core competence, while hospital social responsibility culture reflects the core values of hospitals. Through analyzing the model as depicted below, it can be seen that the other six factors are effective carriers of hospital culture. Only under the guide of hospital social

responsibility culture, can other factors achieve balanced and harmonious development in order to gain core competence.

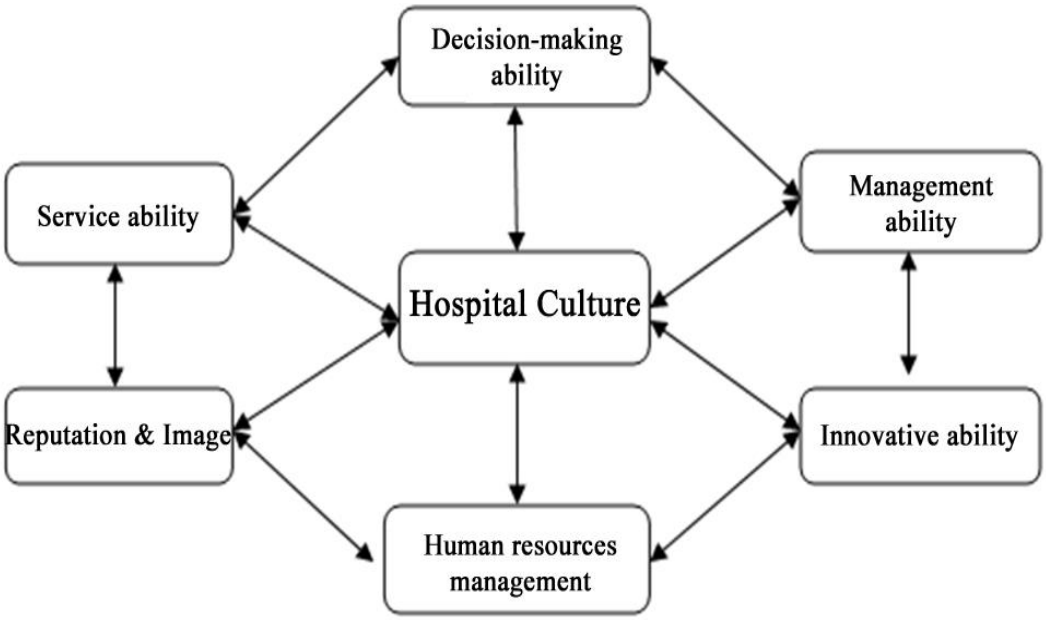
Figure 3-10 Influencing Factors of Hospital Core Competency Model



Source: He, Jin & Ma, 2007

Xia & He (2008) also established a hospital core competence model. Like He, Jin, Ma, Ni & Zheng (2007) they also puts the culture factor at the core with other six factors under its influence. Concerning the implication of hospital culture on human resources management in his model, Xia argues that hospital culture is a human-centered management thinking and method, encompassing the management of talents, technology talents, management team, employee loyalty, employee quality and working attitude. The former's "human-centered" approach and the latter's "taking people as carriers" objectively determines the "hospital culture-human resources path".

Figure 3-11 Influencing Factors of Hospital Core Competency Model



Source: Xia & He, 2008

3.3.7 Research Progress and Status Quo of Organizational Culture in Private Hospitals

Specifically elaborating on the organizational culture of private hospitals, Ju (2014) offered some advice on how to strengthen it: first, foster hospital soul by establishing values that are embraced by all; second, consolidate the foundation by establishing patient-oriented service philosophy; third, strengthen management system by establishing competition and incentive mechanism; lastly, create moral climate by enhancing medical ethics education so that medical staff can be honest in practicing medicine. Her study argued that private hospitals, in order to gain a foothold in the increasingly competitive medical market, improve core competencies and make business more thriving, must give the construction of hospital culture a leading role in hospital development.

The management culture of private hospitals is born out of that of public hospitals. Most managers and experts in private hospitals come from public hospitals and their long experience there has empowered them to grasp a set of mature management philosophies and behavioral norms and to perfectly know the advantages and disadvantages of public hospitals.

Therefore, in order to keep a foothold in the increasingly competitive medical market, private hospitals should borrow the successful management experience from public hospitals and continuously perfect and reform them in practice. Private hospitals, in most cases, are owned by entrepreneurs whose main purpose is to maximize their return on investment. Since management and service philosophies are tremendously affected by organizational culture, private hospitals should learn and mirror the management culture from successful enterprises. (Yu, Chai & Dai, 2015)

Mayo Clinic is the world's first nonprofit health care organization and also one of the largest not-for-profit hospitals. Featuring highly collaborative and actively adaptable systems, Mayo put together expert teams in different medical fields to provide the best care to every patient and thus became a most admired model on which many studies have been undertaken. According to Berry & Seltman in their 2009 book "Management Lessons from Mayo Clinic: Inside One of the World's Most Admired Service Organizations", the annual voluntary turnover rate of Mayo Clinic only stands at 2.5%. The success of Mayo can be attributed to two core values: first, the needs of the patient come first; second, unsurpassed collaboration among staff. The primary values of "the needs of the patient come first", having been baked in the blood and culture of Mayo Clinic, can convincingly explain why the century-old hospital can achieve sustaining success. The values, which cannot be fully reflected by one course, a training session, a strategic goal or a scorecard, permeate all management links such as clinic service systems and procedures, public space, physician's salary and medical treatment methods. The Clinic's strategic planning, implementation strategies and operating tactics and the like are based on the values. The values of "Unsurpassed collaboration among staff" mutually reinforce with the values of "the needs of the patient come first". The collaboration spirit has taken deep root in the minds of staff from their first day of work. The values advocate mutual help and respect. When one employee encounters difficulties, he/she can get the support from the whole team. Mutual respect can increase self-confidence, improve work enthusiasm and enhance the cohesion of the team so that employees are more willing to devote themselves to the work (Berry & Seltman, 2009).

Al Stubblefield, president emeritus of Baptist Health Care (BHC), the largest not-for-

profit medical organization in Northwest, Florida, detailed in his book “The Baptist Health Care Journey to Excellence: Creating a Culture that Wows” (2004) the formation and nurturing of BHC’s culture, which he followed up with several other publications. BHC has been named one of the "100 Best Companies to Work For" by Fortune magazine for three consecutive years. The surveys on satisfaction among global patients show that five hospitals affiliated to Baptist Health Care have earned a spot on the list of top 100 organizations for many years. According to this author, the organization owes its success to five key factors: first, create and maintain a great culture; second, select and retain great employees; third, commit to service excellence; fourth, continuously develop great leaders; fifth, hardwire success through systems of accountability. The leaders started by identifying BHC’s mission (to provide superior service based on Christian values to improve the quality of life for people and communities served), vision (to be the best health system in America) and core values (integrity, vision, innovation, superior service, stewardship and team work) and created a culture that WOWs! (that empowers Workers to become Owners and Winners). Then five pillars of excellence have been established: people, service, quality, finance and growth, among which, people is placed first because none of the other 5 can be successfully achieved without people and, in a hospital, the satisfaction of patients is directly related to the satisfaction of its employees. Only happy, fulfilled employees will provide the highest level of health care to patients. Therefore, BHC tries by every possible means, to hire the best employees, maximize employees’ loyalty, stimulate employees’ enthusiasm, encourage employee-driven culture change and celebrate successes through reward and recognition. By doing these, the employees can maintain high morale and develop a sense of self-worth. In turn, when they become the valuable human resources, they will push the hospital into a new stage (Al Stubblefield, 2015).

China has a large number of private hospitals, but few are excellent. Especially, nearly no newly built private hospitals are reported to have distinctive and excellent culture. One good but rare example is Aikang hospital in Huangshi City, which is a non-profit private hospital with 87 years of history and was converted from a public hospital in 2008. Within the first five years after transformation, the hospital kept giving the building of the culture a high

priority in hospital management. Embracing the values of "Virtue of Great Physician", Aikang hospital believes that people are of great importance to its survival and development, proposing the philosophy of "fulfilled employees create happy customers". "Deliver quality medical services in tertiary hospital at a cost-effective price" has become the behavioral norm and working principle of each employee in this hospital. After five years of practice, the hospital's business has rapidly developed and gained the recognition of the government and has won the trust of patients. Besides, the employees' sense of pride has been greatly heightened (Li, Zhong & Dai, 2011).

3.3.8 Organizational Culture Assessment Instrument and its Dimensions

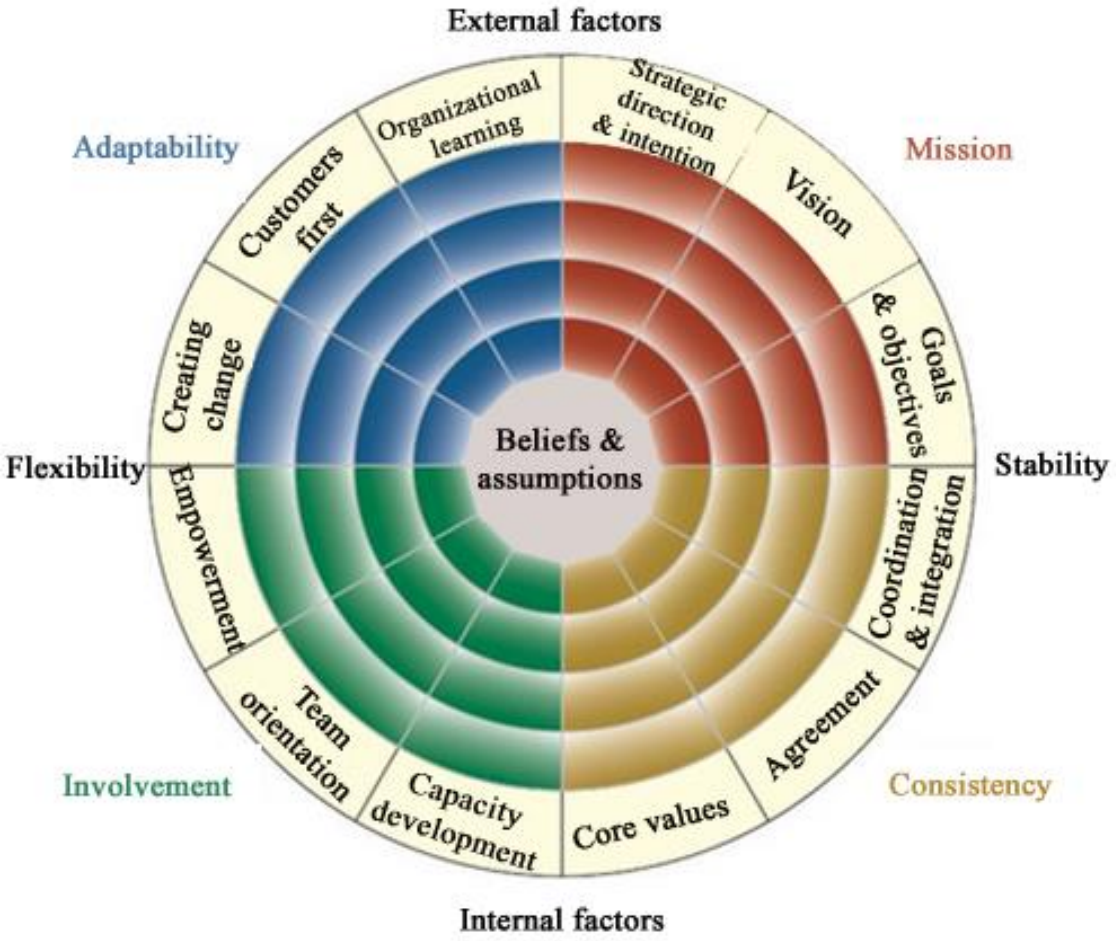
The OCAI (Organizational Culture Assessment Instrument) developed by American Professors Quinn and Cameron in 1998. It has been widely used by China's enterprises to measure organizational culture. Most studies suggest that OCAI has acceptable validity and reliability, and therefore it has been largely recognized by scholars in OC research field and widely applied to the OC research field (Song & Yang, 2009). OCAI has six criteria, including dominant characteristics, organizational leadership, employee management, organizational glue, strategic emphasis and criteria of success. Under each criterion, there are four statements corresponding to four different kinds of culture (clan, adhocracy, hierarchy, market). OCAI is very useful in identifying the type, strength and congruence of OC (Jin & Ning, 2008)

Currently, the widely used OC theoretical model among foreign and Chinese scholars has been developed by Professor Denison in the International Institute for Management Development (IMD) in Lausanne, Switzerland. As per Denison's OC model as shown below, the "beliefs and assumptions" at the center of the circle that shape the thoughts and behaviors of employees need to be measured using four culture traits, including involvement, consistency, adaptability and mission. Involvement relating to employees' working ability, sense of ownership and sense of responsibility, is measured using scales of empowerment, team orientation and capacity development; consistency is measured using scales of core values, agreement, and coordination and integration, to show whether an enterprise has a

powerful and cohesive culture; adaptability is measured using scales of organizational learning, customers first and creating change, to demonstrate whether an enterprise can quickly respond to the external information and transform the information in business environment into the guidelines for corporate behaviors; mission is measured using scales of strategic direction and intention, goals and objectives and vision to show whether an enterprise pays attention to immediate interests or focuses on making systemic strategic action plans (He, Ling & Wang, 2011).

The OCQ scale was developed by Professor Denison in 1995 based on his OC model, which passed 36,542 questionnaire tests in 2000. The scale can be used as an effective tool to qualitatively and quantitatively explore the relationships between organizational culture and enterprise's management and performance (Chen, 2008). Empirical studies using the scale have been conducted in enterprises in North America, South America, Asia and Australia and by 2009 its benchmark database has stored empirical data of 1,076 enterprises. The OCQ questionnaire includes 60 questions with 15 items under each culture trait. Respondents are required to specify their level of agreement or disagreement on a typical five-level Likert item from "strongly disagree" to "strongly agree" (He, Ling & Wang, 2011).

Figure 3-12 Denison OC Model



Source: He, Ling & Wang, 2011

Another measurement tool widely used by researchers is the OCP (Organizational Culture Profile) developed by O'Reilly, Chatman & Caldwell to examine the relationship between person-organization fit and individual availability in 1991. The OCP scale measures the enterprise's values from 7 culture dimensions, including innovation, stability, respect for people, result orientation, detail orientation, aggressiveness and team orientation. OCP is one of commonly used scales in foreign literature for values measurement (Jin & Ning, 2008).

Liu & Jin (2004) used their self-made OC questionnaire to measure hospital culture. The questionnaire selected 31 descriptive questions (statements) related to organizational culture climate and characteristics. The respondents were required to score the 31 questions using the scale of 1 to 5 to express approval degree, with 1-5 representing "extremely disagree", "disagree", "partially agree", "agree" and "extremely agree". Then eight internal structural characteristic factors were extracted with factor analysis (PCA method), including organizational cohesion, hospital management values orientation, system culture, harmonious

state of interpersonal relationship, organizational work style, organizational learning climate, leadership style, innovation.

3.4 Study on the Relationship between CSR and OC

Wang (2014) argued that the relationship between CSR and OC maybe drawn from the following several aspects: first, OC is an intrinsic determinant of CSR; second, CSR can strengthen OC; third, an enterprise can expand its influence to the entire society though social responsibility. Integrating CSR into OC is theoretically and practically important to strengthen, build and perfect enterprise's values and promote the development of China's enterprises, which in particular, provides a new theoretical basis and horizon for China's enterprises to establish a full set of people-oriented management systems.

Gao & Wang (2012) argued that OC is the driving force for enterprises to fully perform corporate social responsibility. Therefore enterprises must establish excellent organizational culture including "people-oriented" values. Conversely, the fulfillment of social responsibility can enrich the organizational culture. CSR and OC can influence and reinforce each other.

3.5 Relationship between Hospital Social Responsibility and Organizational Culture

Li (2010) believes that hospital social responsibility essentially reflects the values of hospital culture and incorporates itself into the system culture and material culture. The fulfillment of social responsibility helps hospitals build good social image while hospital social responsibility has the function of shaping hospital's values, strengthening the functions of hospital culture in cohesion, guidance, motivation, constraint and radiation as well as accelerating the integration of foreign and China's culture.

Yu & Chai (2015) proposed that to "put people first" and fulfill social responsibility should be part of hospital management culture. Hospitals, whether it is government-funded or privately-sponsored, should feel obliged to fulfill the social responsibility of healing the wounded and rescuing the dying.

3.6 Literature Review on Organizational Identification

3.6.1 Definition of Organizational Identification

Tajfel (1982) defined organizational identification as a self-identity when an individual perceives himself as a member of a group. The perception of membership to an organization leads to an alignment of individual and organizational values, as well as an affective attachment to an organization.

Organizational identity was early fined by Albert and Whetten (1985) as the central, distinctive and enduring characteristic of an organization.

In turn, Ashforth & Mael (1989) conceptualized OI as the perception of oneness with and belongingness to the organization while O'Reilly et al. (1989) perceived OI as the individual's self-concept in emotion which derives from attraction by and expectation of an organization, including self-cognition, self-feeling and self-image. The three psychological activities are interrelated and inter-conditioned but integrated in individual's self-concept. They affect the individual's thoughts and behaviors together.

Dutton, Dukerich & Harquail (1994) viewed OI as a process of self-definition and defined it as the cognitive connection between the definition of an organization and the definition a person applies to him or herself. The strength of an employees' identification with the organization is stronger than their identification with any other thing. Besides, the more similar an individual's self-concept is to the organizational identity, the more likely he is to perceive the organization as a social group. When individuals feel their self-concept is consistent with organizational identity, the organizational identification occurs.

Rousseau & Tijoriwala (1998) argued that OI is a concept at the organizational level used to interpret the connotation of "self-identity". The identification takes two forms: situated identification and deep structure identification. Situated identification is a sense of being part of a larger organizational entity. Such kind of identification can occur fairly quickly when cues encourage a perception of shared interests and goals between an employee and the organization. Deep structure identification is a cognitive mode beyond time, role, situations and behaviors, which can align the self-concept at work and self-concepts in a wider sense.

More recently, Dukerich, Golden & Shortell (2002) stressed that organization identification occurs when the organizational member senses his/her self-concept is congruent with the organizational attributes.

3.6.2 Antecedents and Outcome Variables of OI

Table 3-3 below follows work produced by Su (2012) and presents a summary of the main variables considered by different authors in what concerns the antecedents of OI:

Table 3-3 Antecedents of OI

Variable Classification	Variable description	Researcher(s) and papers published time
Individual dependent variables	Number of needs that have been met; the extent to which individuals identify with organizational goals; the frequency of contacts between individual and organization	March & Simon,1958
	Organizational tenure; number of comparable organizations joined; satisfaction with the organization	Mael & Ashforth,1992
	Visibility of individual's affiliation with organization	Charters & Newcomb,1952, Brown,1969
	Individual's perception of organization's identities and attraction; organizational image and attraction	Dutton, Dukerich & Harquail,1994
Organizational dependent variables	Organizational prestige: positive correlation; Inter-organizational competition: negative correlation	March & Simon,1958, Chatman, Bell& Staw,1986
	Organizational distinctiveness: positive effect	Ashforth&Mael,1989 Oakes & Turner,1986
	Communication within organization(communication content and atmosphere): positive correlation	Smidts et al,2001 Bullis&Bach,1991
	Stereotypes of the organization: positive correlation	Hogg & Turner,1985
Environmental dependent variables	Similarity of external organizations	March & Simon,1958, Mael & Ashforth, 1992
	Prominence of external organizations	Winder,1981

Source: Su, 2012

Different authors have also studied the outcome variables of OI, as follows:

Ashforth & Mael (1989) argued that organizational identification is crucially important

because it influences employees' willingness to strive for organizational goals. Later (1995), the same authors asserted that OI can predict the turnover rate in a given period in the future (for example, six months later, ten months later, 12 months later, 18 months later, 21 months later and 24 months later).

Pratt (1998) argued that the more highly an individual identifies with an organization, the more easily he/she is to comply with the organization's regulations.

Similarly, Albert, Ashforth & Dutton(2000) held the more highly individuals identify with an organization, the more easily they are to feel themselves part of the organization and the more likely their behaviors, decisions and activities are for the benefits of the organization's interests.

Wiesenfeld, Raghuram & Garud (2001) found that OI is positively related to willingness to cooperate and strive for the organization's goals, thus decreasing staff turnover.

Riketta (2005) believes that OI is significantly and negatively correlated with intention to leave. The lower the OI is, the higher the turnover intention is.

In confirmation, a survey conducted by Edwards & Peccei (2010) among 736 employees in the British National Health Service showed that OI is negatively correlated with turnover intention.

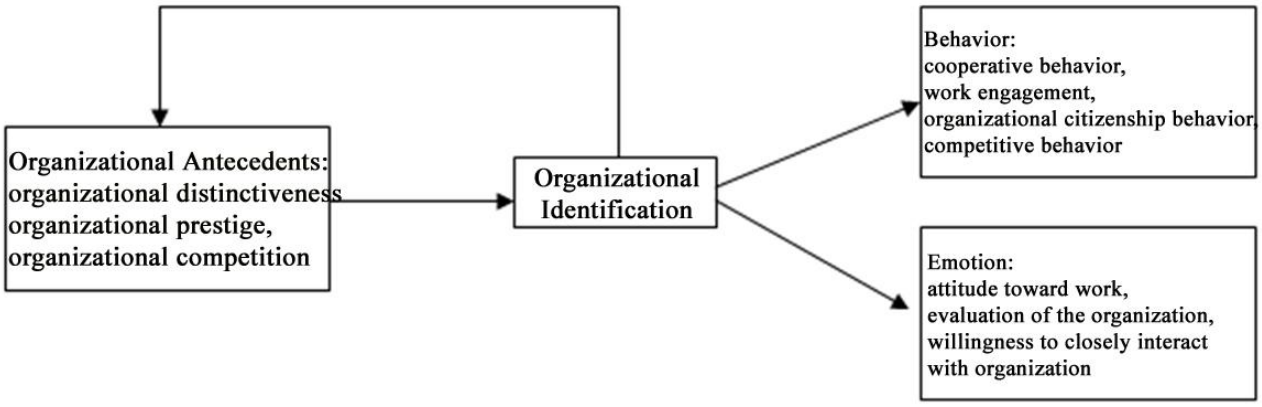
Li, Li & Zhang (2009)'s research among teachers came to the same conclusion that OI has a strong negative correlation with intent to leave. The result is consistent with the research results of foreign scholars.

Wei & Chen (2007) argues that OI reflects the individual's cognition of membership in identity, values and emotional attachment, as well as employee's belongingness and psychological commitment to an organization or culture group.

An internet questionnaire survey and statistical analysis made by Chinese scholar Dai (2009) showed that empowerment is positively correlated with OI but has a strong negative correlation with turnover intention.

Another Chinese scholar, Su (2012) pointed out OI can enhance its antecedents, including organization's prestige, prominence and competitiveness of external organizations, as well as traditional organizational structure factors.

Figure 3-13 Results and Effects of Organizational Identification



Source: Su, 2012

3.6.3 Measurement of Organizational Identification

Cheney (1983) held that OI has three dimension, including membership, loyalty and similarity. His OI scale, including 25 indicators with reliability coefficient up to 0.95, is currently one of the most widely used organizational identification scales.

Mael & Ashforth (1992) developed a single dimension and six-item scale to measure OI. They reported a coefficient alpha of 0.81 in a sample of employed business and psychology students. The scale focuses on the emotional factors of employees to an organization, something like the affective commitment in organizational commitment and is currently most used in scholarly literature.

Dick, Wagner & Stellmacher (2004) argued that OI should be measured from four dimensions: first, sentimentality, representing an individual's belongingness to the organization emotionally; second, organizational recognition; third, evaluation, meaning how an individual evaluates an organization; fourth, organizational behaviors.

According to an empirical analysis of OI survey among employees in state-owned enterprises, Chinese scholar Wang (2004) asserted that there are three kinds of OIs, including survivability, belongingness, and successfulness.

3.6.4 Relationship between OC and OI

Fiol (1991) argued that organizational culture can help organizational members understand the deep meaning of their behaviors.

Ravasi & Schultz (2006) believe that organizational culture is a default and spontaneous behavior based on common rules, which is obtained through comparison of different organizations and conscious self-reflection. This is also the process of organizational identification.

According to a correlation analysis of different dimensions of OC and OI, Sun (2009) found that, excluding a few exceptions, there is a significant and highly significant correlation between the dimensions of OC and OI as follows:

(1) The core values of OC have a significant or very significant correlation with the four dimensions of OI. Specifically, core values of OC are significantly and positively correlated with emotional attachment of OI ($P<0.05$), and very significantly and positively correlate with organizational cognition, positive evaluation and autonomous actions ($P<0.01$).

(2) There is a significant or very significant positive correlation between the agreement dimension of OC and the four dimensions of OI. Specifically, the agreement dimension of OC is significantly correlated with organizational cognition and emotional attachment of OI ($P<0.05$), and very significantly correlated with positive evaluation and autonomous actions ($P<0.01$).

(3) The coordination and integration of OC is significantly correlated with emotional attachment of OI ($P<0.05$), and very significantly correlated with autonomous actions ($P<0.01$), but has no significant correlation with organizational cognition of OI.

(4) The empowerment of OC is significantly and positively correlated with positive evaluation and autonomous actions of OI ($P<0.05$), but has no significant correlation with organizational cognition and emotional attachment of OI.

(5) The team orientation of OC is very significantly and positively correlated with emotional attachment, positive evaluation and autonomous actions of OI ($P<0.01$), but has no significant correlation with organizational cognition of OI.

(6) The capacity development of OC is significantly and positively correlated with positive evaluation of OI ($P<0.05$), and very significantly and positively correlated with autonomous actions of OI ($P<0.01$), but has no significant correlation with emotional attachment and organizational cognition of OI.

(7) The creating change of OC is significantly and positively correlated with positive evaluation and organizational cognition of OI (P<0.05), but has no significant correlation with the other two dimensions of OI.

(8) The customers-first of OC has no significant correlation with all dimensions of OI.

(9) The organizational learning of OC is significantly and positively correlated with positive evaluation of OI (P<0.05), and very significantly and positively correlated with organizational cognition and autonomous actions of OI (P<0.01), but negatively correlated with emotional attachment of OI, yet not significant.

(10) The strategic direction of OC is significantly and positively correlated with positive evaluation and autonomous actions (P<0.05), and very significantly and positively correlated with organizational cognition of OI (P<0.01), but has no significant correlation with emotional attachment.

(11) The goals and objectives of OC is significantly and positively correlated with organizational cognition of OI (P<0.05), and very significantly and positively correlated with autonomous actions (P<0.01), but negatively correlated with emotional attachment of OI, yet not significant.

(12) The vision of OC is significantly and positively correlated with organizational cognition and positive evaluation of OI (P<0.05), but has no significant correlation with emotional attachment and autonomous actions.

3.7 Literature Review on Turnover Intention

3.7.1 Concept of Turnover Intention

Price (1977) categorized turnover into two types: voluntary turnover and involuntary turnover. The voluntary turnover is mainly caused by organizational and personal reasons. Involuntary turnover means that an employer or organization forcibly removes or dismisses an employee from a position. Michaels & Spector (1982) argued that turnover intention is the best indicator of turnover. Mobley (1977) perceived turnover intention as an employee's willful intention to retire from an organization on second thought after a period of work.

Chinese scholar Ouyang (1994) argued that the employees' intention to leave an organization can directly lead to turnover behavior while Miller, Allen & Casey (2000) contends that turnover intention occurs when the employee perceives another opportunity as better than his current position.

3.7.2 Antecedents and Outcome Variables of Turnover Intention

According to Price (2001), in empirical research, turnover behavior is typically replaced by turnover intention because, first, the employee's turnover is influenced by many factors; second, the results of turnover behavior are subject to time change; third, turnover intention is a direct indicator of turnover behavior.

According to the empirical study of Chinese scholars Li & Xu (2009), the person-organization fit (P-O fit) and hire date of new employees can predict their turnover intention.

Maignan, Ferrel & Hult (1999) found that, in order to reduce turnover, an enterprise should establish itself as an organization with humanistic solicitude by doing more for philanthropy, thus attracting attention of stakeholders like employees and shareholders, that is, exercising corporate social responsibility. The long-term adherence to this practice can effectively reduce the turnover rate.

According to Koys (2001), the reactions of stakeholders outside the organization can have effect on the employees' satisfaction and turnover intention.

3.8 Research Hypotheses and Research Model

Based on the previous literature review and considering the current situation of private hospitals, the hypothetical relationships among CSR (Corporate Social Responsibility) of private hospitals, OC (Organizational Culture), OI (Organizational Identification) and TI (Turnover Intention) are put forward.

3.8.1 Hypotheses of the Effect of Private Hospital Social Responsibility on Organizational Culture

According to the literature review, the topics of organizational culture, hospital organizational culture and CSR have already been extensively studied. Meanwhile, the social responsibility of hospitals, especially public hospitals, has also been systematically studied by a few scholars. However the literature focusing on the relationship between hospital social responsibility and organizational culture is still scarce. Therefore, this thesis raises some questions at the very beginning: what does an excellent organizational culture of private hospitals that conforms to China's national condition look like? How to strengthen the cohesion of organizational culture of private hospitals? How to enhance the sense of safety

and belonging of medical staff in private hospitals? What are the core values, mission and vision of an excellent organizational culture of private hospitals? What impact can be exerted on organizational culture by effectively fulfilling the social responsibility of private hospitals? What social responsibilities can influence the organizational culture of private hospitals? What social responsibilities can influence the organizational identification of medical staff in private hospitals? To assist in the answering of these questions, based on the previous literature, the following hypotheses are put forward:

H1- the internal social responsibility of private hospitals has a significant and positive effect on the organizational culture.

H2- the external social responsibility of private hospitals has a significant and positive effect on the organizational culture.

H3- the internal social responsibility of private hospitals has a significant and positive effect on the organizational identification of medical staff.

H4- the external social responsibility of private hospitals has a significant and positive effect on the organizational identification of medical staff.

3.8.2 Hypothetical Relationships among OC of Private Hospitals, OI and TI of Medical Staff

According to Cheng (2012), the organizational culture is significantly and negatively correlated with turnover intention; the organizational culture is significantly and positively correlated with organizational identification; organizational identification is significantly and negatively correlated with turnover intention. Therefore we posit that:

H5- the organizational culture of private hospitals is significantly and negatively correlated with turnover intention.

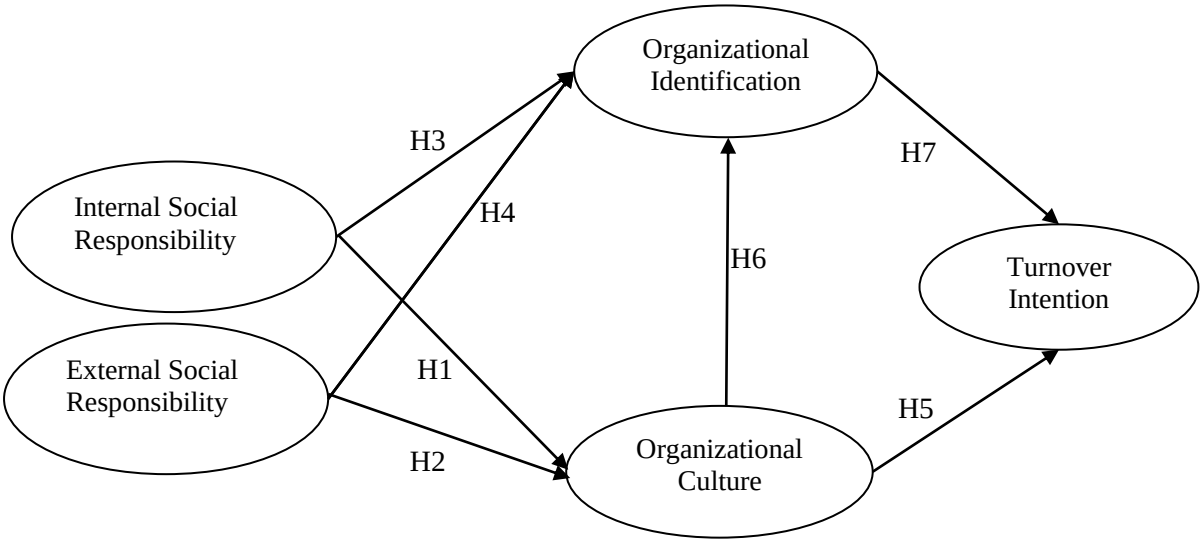
H6- the organizational culture of private hospitals is significantly and positively correlated with organizational identification.

H7- the organizational identification of private hospitals is significantly and negatively correlated with turnover intention.

3.8.3 Model Construction of the Relationship between Social Responsibility of Private Hospitals and Turnover Intention of Medical Staff

According to Han (2005), although the relationship between CSR and turnover intention has been studied by foreign and Chinese scholars in recent years, the mediator variable between CSR and turnover intention has not yet been found. In particular, the literature that focuses on the relationship between CSR and turnover intention in China's context is rarely seen. Therefore, how to apply advanced foreign theories to enterprises in China is a problem worthy of further study. Based on the above hypotheses, the research model is constructed as follows:

Figure 3-14 Research Model



Source: the author

3.9 Chapter Summary

This chapter focuses on the literature review on the theories of CSR, stakeholders, organizational culture, organizational identification, turnover intention and on the interactions among these theories. Meanwhile, the current situations of social responsibility and organizational culture in public and private hospitals in China have been reviewed.

First the chapter reviews CSR theories, including concept, definitions, levels and dimensions. Since Oliver Sheldon proposed the term of social responsibility in 1923, many foreign and domestic scholars have touched upon this topic. China’s scholars basically

focused on the levels and dimensions of social responsibility, represented by Li's (2010) three-level 5-dimension model and Yi's (2011) four-level model. We found that Western scholars have generally studied hospital social responsibility of public and private hospitals as a whole instead of discussing them separately. In turn, China's scholars have mainly based their research on the stakeholder theory and CSR hierarchical theory to analyze what social responsibilities the hospital should take, but few of them have discussed how hospitals should fulfill their social responsibility.

Then it reviews the stakeholder theory and the relationship between stakeholders and CSR. Meanwhile, the current research efforts of hospital social responsibility and stakeholders were reviewed. It is suggested that the stakeholder theory is the most relevant and logical theory to explain CSR. The widely accepted view about their relationship was proposed by Zhang (2014), who asserted that stakeholder theory can provide theoretical support for CSR research and in turn CSR research can offer empirical evidence for stakeholder theory. The CSR evaluation system of public hospitals established by Chinese scholar Li & Ren (2012) and the social responsibility system of private hospitals based on stakeholders constructed by Wang (2012) and Chen (2010) has laid the theoretical foundation for the research of social responsibility in China's hospitals.

The literature review on organizational culture theory covers definitions, classification, structure, elements, functions, establishment and maintenance. It is thought that no matter what kind of culture the organization has, it is expressed from inside to outside, with the spirit of the enterprise, or enterprise values in the central part, which is surrounded by the behaviors based on the rules of the system and under the guidance of philosophies. At the surface are the artifacts that include all the phenomena that one sees, hears and feels. In early studies, the organizational culture was thought to only have a single orientation function, but with in-depth research, it was found that it is multi-dimensional, bestowing other functions such as orientation, constraint, unification, motivation and radiation. The 7S framework proposed by Peters & Waterman (1982) has been widely used as the theoretical basis for most organizational culture management research. Based on this framework, China's scholar He and Xia (2008) established their model depicting hospital core competence influencing factors,

both of which perceive organizational culture as the core factor for an organization to gain its core competence. Ju (2014) offered some advice on how to strengthen the construction of hospital culture in private hospitals: first, foster hospital soul; second, consolidate the foundation; third, strengthen the management system; lastly, create moral climate, which has laid theoretical basis for culture construction of private hospitals. The classical OC scales developed by Western scholars such as OCAI, OCP and OCQ have been widely used by Chinese scholars in academic research to measure OC. Their reliability and validity are highly recognized. China's scholars Liu & Jin (2004) developed a hospital culture evaluation model based on OCAI, which has been regarded as the scale capable of thoroughly assessing hospital culture in China.

This chapter presents an overview of the literature on organizational identification from five aspects including definitions, concepts, antecedents and outcome variables, measurement dimensions as well as relationships between OC and OI. The analysis shows that shared values are the core of OC, while OI is defined as an alignment of individual and organizational values. Therefore, OC and OI are closely linked, with good OC promoting the process of OI and conversely OI helping to spread OC.

Turnover intention is the antecedent of turnover behavior and also an important outcome variable of organizational identification. Foreign and Chinese scholars have reached similar conclusions in terms of the relationship between organizational identification and turnover intention, suggesting that the higher the organizational identification is, the lower the turnover intention is. They are highly correlated with each other.

According to the literature review on various theories, although all theoretical studies are relatively mature, comprehensive studies on management application are still rare, especially the empirical study on what social responsibilities private hospitals should take and how they fulfill social responsibility as well as how to integrate social responsibility into the organizational culture so that excellent organizational culture can improve the hospital's competitiveness.

Based on extensive literature review and combining the current situation of private hospitals in China, the research hypotheses have been proposed and the research model was constructed.

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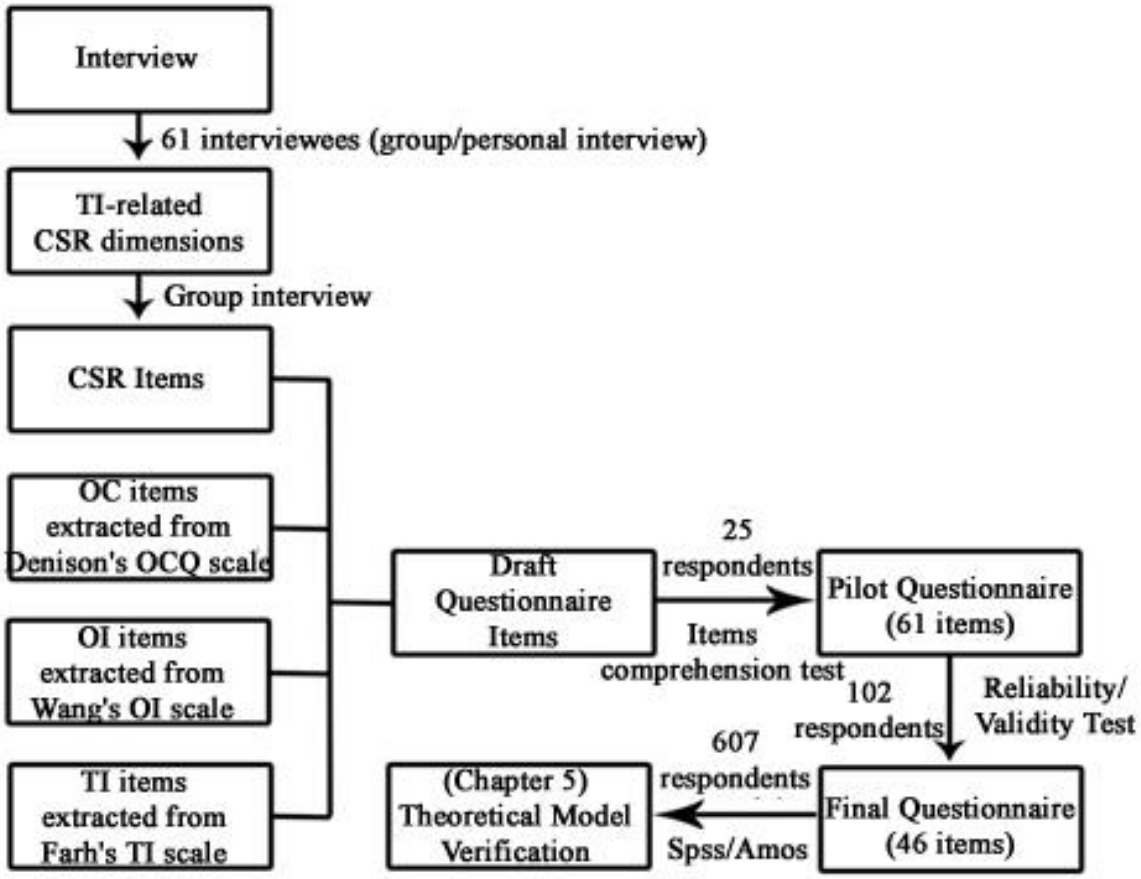
Chapter 4: Research Methods

4.1 Introduction

Based on a review of a large number of foreign and Chinese literatures, the hypothesized relationships among social responsibility of private hospitals and organizational culture, organizational identification and turnover intention have been put forward. The research variables have been designed based on the theoretical framework and research hypotheses. According to the theoretical model and research hypotheses, the interview outline and questionnaire items weredevelopedand the pilot questionnaires have been sent out to selected respondents as scheduled. The amount of collected data was fully analyzed and studied using statistical methods to achieve satisfying conclusions and results.

Figure 4-1Questionnaire Design, Data Collection and Statistical Process



Source: the author

4.2 Variables Design

The literature review method was used for variables design. The theories related to the research topic were reviewed including (1) CSR theory and stakeholder theory (CSR's definitions, level and dimensions; definition of stakeholders of public and private hospitals); (2) organizational culture theory (OC's definitions, structure and elements, functions, measurement and its application in management); (3) organizational identification theory (definition, antecedents and outcome variables to OI, measurement); (4) turnover intention (definition, antecedents and outcome variables). In addition, the logical relationship and correlation between these theories are discussed and discovered.

The study method was used to identify which social responsibilities private hospitals should take and which social responsibilities can influence organizational culture and organizational identification, ultimately affecting staff turnover intention. There were 61 persons who were interviewed, including (1) government officials from provincial or municipal Health Bureau, Department of Health Inspection, Social Security Bureau and Civil Affairs Bureau, who are the objects of external social responsibility of private hospitals and expectant stakeholders and have direct authority over private hospitals; (2) members in associations like Medical Responsibilities Investigation Committee and Medical Association, who are the objects of external social responsibility of private hospitals and the latent stakeholder according to the Chinese scholar Li's stakeholder classification. Meanwhile, they have a good knowledge of the medical quality, academic level and physician-patient relationship of the three private hospitals surveyed; (4) middle and senior managers as well as a small number of ordinary medical staff in the targeted private hospitals, who are the objects of internal responsibility of the private hospitals surveyed and core stakeholders (Table 4-1).

Through the interview method, the questionnaire items related to the turnover intention of medical staff in private hospitals were identified. These items were extracted from CSR-related scales with high reliability and validity including Denison's OCQ scale (1995), Wang's OI scale (2004) and Farh's TI scale (1998). Finally, a five-level Likert scale questionnaire was designed and sent to medical staff in different positions in the three private hospitals surveyed.

4.2.1 Variables Design of Social responsibility of Private Hospitals

The social responsibility of private hospitals, which acts as the independent variable of the study, refers to which social responsibilities the private hospitals should take in order to influence the turnover intention of medical staff through organizational identification and organizational culture. Through extensive review of foreign and Chinese literature, there is still no scale specifically designed for social responsibility of private hospitals. However, because the surveyed hospitals are all not-for-profit private hospitals whose size, organizational structure, staffing structure, service procedures and medical fees are basically the same as those of public hospitals, we draw the variables design fromChinese professor Li's *Three-level Index Evaluation System of Public Hospital Social Responsibility* (Li & Ren, 2012) and Chinese scholar Wang's private hospital internal and external social responsibility model (Wang, 2012).

The interview and questionnaire methods were used forthe variables design. The interview method, rather than questionnaire method, was used first because (1) Currently the knowledge of CSR is still unknown to most people in China, especially medical practitioners, so the questionnaire survey might not achieve satisfying effects; (2) interview method can show more respect for respondents who are senior managers with solid experience in management of private hospitals, officials in health departments and members in medical association; (3) through interview, the researcher can further discuss the specific topic with respondents face to face. Based on the interviews with industry regulators, senior managers and medical staff with rich working experience both in public and private hospitals, the items that can evaluate the turnover intention of medical staff in private hospitals were drawn from Li's Three-level Index Evaluation System. Then the questionnaire method was used in the second step. The questionnaire with draft items was sent out to a few medical staff in surveyed private hospitals to test whether the items were easy to comprehend. According to the suggestions of the respondents, the text description of some items was revised and a single dimension questionnaire was generated, which was sent to a small number of medical staff in private hospitals surveyed to test the reliability and validity.

4.2.1.1 Interview Outline

Given that the knowledge of corporate social responsibility is still unknown to most people in China, most of the personnel working closely with private hospitals or medical staff in private hospitals lack a systematic understanding of the CSR knowledge. Therefore the first

step of the interview was to understand the extent to which the 61interviewees (Table 4-1) know the CSR. Then each interviewee was sketchily or concretely told about the knowledge of hospital social responsibility according to his/her actual condition. In the second step of the interview, each interviewee was given a paper carrying professor Li's Three-level Index Evaluation System of public hospital social responsibility, which contains three first-order dimensions, 11 second-level dimensions and 50 evaluation items. They were required to do two things: first, evaluate item by item whether the social responsibilities that private hospitals currently fulfill are consistent with the 50 evaluation items; second, select the items that could affect the turnover intention of medical staff by just answering "yes" or "no", but are as on should be given for each choice. (Appendix Ⅰ: Interview Outline).

4.2.1.2 Interviewees and Interview Method

All interviews in this study took place face-to-face, among which, the group interviews were made with medical staff in three targeted private hospitals and individual interviews were made with other interviewees. The group interviews were conducted in three private hospitals surveyed because they can help the young or primary-level medical staff with little knowledge of CSR understand and know more about the concept. The number of medical staff in group interview each time was not more than nine and a total of 61 persons were interviewed.

Table 4-1 Information of Interviewees

Health Department/Institution	Profession/Post	Working Years			
		Nr	5-10	10-20	20-30
Health and Family Planning Commission.	Medicine	10	2	6	2
	Finance	3		2	1
Bureau of Civil Affairs	Public Management	5	2	2	1
Medical Dispute Mediation Commission	Staff	2	1	1	
Medical Association	Medicine/Chairman	2			2
Private Hospital Association	Medicine/Management Science	12	2	5	5
Surveyed Hospitals	Medical Staff	27	7	12	8

Source: the author

4.2.1.3 Interview Data

The nearly 6-month-long interviews have achieved satisfying results thanks to the enthusiastic and earnest interviewees who put forward various factors that may contribute to the turnover of medical staff and generally agree that private hospitals should systematically fulfill theirsocial responsibility. According to interview records and discussion topics, most interviewees agree on the following several points: first, that professor Li's social responsibility of public hospitals is comprehensively described and fully based on the study of public hospitals, so its classification of social responsibility is different from that of social responsibility of private hospitals. Therefore, it is advised to extract the social responsibilities that private hospitals should fulfill from the third-level dimension of Professor Li's Three-level Index Evaluation System of Public Hospital Social Responsibility then classify them into internal and external social responsibility based on Wang's private hospital internal and external social responsibility model. Second, most medical staff knows little about hospital's social responsibility for suppliers, environment and medical insurance and meanwhile these responsibilities can barely affect the turnover intention; therefore it is recommended to delete these evaluation items under some second-level dimensions. Third, according to Professor Li, the hospital should take different social responsibilities for senior managers, physicians and ordinary employees, but considering that all employees in private hospitals, excluding post-retirement and part-time employees, have the same identity, the hospital should take the same social responsibility for these three kinds of employees. Same identity means that all medical staff in private hospitals is employed on a contract basis. By contrast, medical staff in public hospitals has different identities. For example some of them enjoy budgeted posts while others are employed on a contract basis. This is the biggest difference between public hospitals and private ones in terms of human resources management in China.

According to the interviewees' opinions, privatehospitals should take social responsibility on medical staff's turnout for four stakeholders, namely investors, medical staff, patients and industry regulators in order to reduce turnover rate, as described in the table below:

Table 4-2 Private Hospital Social Responsibilities that could Turnover Intention

First-order Dimension	Second- order Dimension	Third- order Dimension
Internal social responsibility	Investors	Ⅲ-1 Net asset growth rate
		Ⅲ-2Satisfaction of society and patients
		Ⅲ-3 Medical quality and safety system and its implementation
	Employees	Ⅲ-4 Reasonable hospital governance structure
		Ⅲ-5 Standard bonus-penalty and promotion system
		Ⅲ-6 Reasonable and contribution-matching salary
		Ⅲ-7 Opportunities of getting involved in decision-making
		Ⅲ-8 Safe working environment and working hours
		Ⅲ-9 Perfect social security and welfare system
		Ⅲ-10Reasonable manning quotas and position settings
		Ⅲ-11 Put in place assistance system for workers in difficult situation
		Ⅲ-12 Continuing education and encouraging scientific research innovation system
External social responsibility	Patients and their family members	Ⅲ-13 Reliable medical services
		Ⅲ-14 Complaints and dispute settlement procedures
		Ⅲ-15 Per capital outpatient and hospitalization expenses
		Ⅲ-16 Patients' interests and rights, e.g. protection of rights to know
		Ⅲ-17 Price transparency, eliminate supplier-induced demand
		Ⅲ-18Expenses reduction and exemption policy for poor patients
	Department of Health Investigation	Ⅲ-19 Comply with laws and regulations; operate by law
		Ⅲ-20 Emergency management and medical relief for emergency events
		Ⅲ-21 Provide medical services for rural patients and train grass-root medical staff

Source: the author

The content in Table 4-2 was discussed in group interviews with medical staff from three surveyed hospitals respectively with nine respondents in each hospital. The main aim of these

group interviews were to make 21 evaluation items easy to understand by respondents. For instance, most respondents might not be quite familiar with the financial term “Net asset growth rate”. Therefore, the expression of the item was replaced by “reasonable economic benefits and moderate development speed”.

Table 4-3 Items displayingPrivate Hospital Social Responsibility

Dimension	Code	Items
Internal Social Responsibility	P1	My hospital enjoys sound economic benefits and maintains good development speed.
	P2	My hospital complies with laws and regulations and operates by law and has never been punished by Health Department.
	P3	My hospital enjoys good social reputation and public trust.
	P4	My hospital has reasonable and contribution-matching salary system
Internal Social Responsibility	P5	My hospital has perfect bonus-penalty system (except regular performance bonus evaluation system) and promotion system. They are well implemented.
	P6	My hospital pays all kinds of social insurances for all employees.
	P7	My hospital has reasonable post setting and manning quotas and legal working time.
	P8	Employees in my hospital enjoy a comfortable and safe working environment.
	P9	My hospital is well structured with a high level of work autonomy.
	P10	My hospital gives full support to employees for further education and training and provides help in all aspects for medical research and academic innovation.
	P11	All employees in my hospital have opportunities to take part in the decision-making of issues concerning hospital management and development.
External Social responsibility	P12	My hospital uses medicine rationally and treats patients in a proper method, and the average medical expenses are not more than those of other local hospitals at the same level.
	P13	My hospital fully guarantees the patients' right to know, e.g. inform the patient about the true condition of his illness and the use of drugs and consumables, keep service price transparent.
	P14	My hospital has transparent, fair complaints and dispute settlement procedures.
	P15	My hospital enjoys high level of patient satisfaction due to its convenient and quality medical services.
	P16	My hospital attaches great importance to the life demands of patients and their family members in hospital.
	P17	My hospital has favorable policies for poor and special patients.
	P18	My hospital places great importance to medical ethics and moral education and has perfect education program and evaluation system.
	P19	My hospital proactively undertakes public health work such as prevention and control of infectious diseases and epidemic diseases.
	P20	My hospital actively participates in medical research and education.
	P 21	My hospital actively helps train grass-root medical workers.

Source: the author

4.2.2 Organizational Culture Variable Design

Currently, organizational culture scales have been maturely developed by foreign and China's scholars, such as the widely used OCAI developed by American professors Quinn & Cameron (1998), OCP by O'Reilly, Chatman, and Caldwell (1991) and OCQ by American professor Denison (1995). The OCQ scale is often used to measure the characteristics of organizational culture, which has four first-order dimensions, namely, Direction, Consistency, Participation and Adaptation. Based on the OCQ scale, Zhou & Chang developed the *Public Hospital Organizational Culture Assessment Scale*, a relatively comprehensive scale used to study the organizational culture of China's hospitals, which includes four first-order dimensions (Direction, Consistency, Participation and Adaptation), 13 sub-dimensions and 80 items. Based on this scale, the study develops a new OC scale with 20 items by selecting five items from each first-order dimension of Zhou & Chang's scale, as depicted below:

Table 4-4 Items of Organizational Culture Scale

Dimension	Code	Items
Participation	P22	My hospital gives as much work autonomy to its employees and the employees are willing to take responsibility.
	P23	Most employees in my hospital have sense of ownership and are enthusiastic about their work.
	P24	My hospital has strong team spirit and often solves problems through concerted efforts.
	P25	My hospital encourages employees to cooperate in order to achieve common goal.
	P26	My hospital gives full support to employees' education and training to satisfy their needs for further study and development.
Consistency	P27	My hospital has clear values and employees have strong sense of identification.
	P28	My hospital's leaders are competent enough to help employees reach broad consensus and reconcile different views in key issues
	P29	The division and difference between departments or medical teams in my hospital do not constitute an obstacle for them to closely cooperate.
	P30	The management departments and medical departments in my hospital cooperate closely
	P31	My hospital’s employees have clear and same attitude about right and wrong behaviors.
Adaptation	P32	My hospital is not afraid of risks of reform and has the courage to reform management measures.
	P34	The needs and advices of patients promote the reform in my hospital and directly affect the decisions of senior managers.
	P35	My hospital pays close attention to the new trends of academic development and encourages medical staff to update their knowledge and actively innovate.
	P36	My hospital is good at competing with its rival and actively adapt to the change of business environment.
Direction	P37	My hospital has clear mission, which provides guideline for our work.
	P38	My hospital has clear strategic objectives and all employees are working hard to make them real.
	P39	My hospital has clear vision, which keeps employees in high spirits and self-motivated.
	P40	My hospital has clear stage objectives to achieve and we closely follow the progress.
	P41	My hospital’s objectives are ambitious and practical.

Source: the author

4.2.3 Organizational Identification Variable Design

Currently, the most used OI scale in scholarly literature was developed by Mael & Ashforth (1992) and includes only one dimension and 6 items. The scale focuses on the emotional factors of employees vis-à-vis the organization, something like the affective commitment in organizational commitment. Dick, Wagner & Stellmacher (2004) argue OI should be measured from four dimensions, namely, sentimentality, organizational recognition, organizational evaluation and organizational behaviors. China selecting Wang (2004) asserts that OI should have three dimensions, including survivability, belongingness and successfulness, with 26 items under the three dimensions. Based on Wang's OI scale, the study develops a new scale by selecting 5 items from each dimension of Wang's OI scale.

Table 4-5 Items of Organizational Identification Scale

Dimensions	Code	Items
successfulness	P42	I always tell others that I am working for a good hospital.
	P43	Our values are highly consistent with that of my hospital.
	P44	I am very concerned about the future of my hospital.
	P45	My work can bring my knowledge and skills to full play.
	P46	I'd like to work in this hospital as long as possible.
belongingness	P47	I regard the hospital as a big family where I and my colleagues live together
	P48	As a member of the hospital, I am perfectly willing to do whatever is assigned to me.
	P49	I can feel I have much in common with my colleagues
	P50	My individual interest and that of the hospital are easily coordinated.
	P51	My individual objectives and those of the hospital objectives are easily coordinated.
survivability	P52	I am still willing to work in this hospital, although I don't earn much.
	P53	The current position in this hospital is the most suitable to me.
	P54	As the hospital's staff, I do not need to worry about my future.
	P55	I can feel the hospital's care for me.
	P56	I am willing to work in any hospital that can offer me satisfying salary.

Source: the author

4.2.4 Variable Design of the Construct Turnover Intention

Currently the most widely used Turnover Intention Scale in China was developed by Farh (1998) and includes 4 items. The text description of items is considered very sensitive and therefore should be carefully phrased in order to dispel the concerns of respondents still in service in a given organization. So the original negative sentences have been purposefully changed to positive sentences. Besides, considering the openness of social recruitment information and diverse means of communication, the new scale was generated based on Farh's scale with modifications.

Table 4-6 Items of Turnover Intention Scale

Dimension	Code	Items
Turnover Intention	P57	I have never intended to quit my present job.
	P58	I'm sure I won't quit my job to work in other hospitals within 2 years.
	P59	If I continue to work in this hospital, the career prospects will be very good.
	P60	I never notice other recruitment information.
	P61	I have developed a long-term career plan in this hospital.

Source: the author

After the four draft scales have been created, a 7 level Likert scale questionnaire consisting of 61 items was sent out to 25 medical staff in surveyed hospitals for a pilottest in order to evaluate the reading comprehension of the questionnaire contents. The 25 respondents were required to specify their level of agreement or disagreement on the 7 level Likert scale for 61 statements, with "1" representing *"extremely disagree"*, "2"*strongly disagree*, "3"*partially disagree*, "4"*neither agree nor disagree*, "5"*partially agree*, "6"*strongly agree*, and"7"*extremely agree*.

The 25 respondents offered the following advice:

First, OI reflects how a member of an organization perceives that organization and the propensity to identify with that organization. If the statements are plainly phrased, the respondents might be reluctant to express their real thoughts. Therefore, the word expressions of the 15 statements of OI were dramatically changed. Take for example P42 which stated:"I

always tell others that I am working for a good hospital": it is actually difficult to get a honest and real answer from respondents because some of them may tell others that they work in a good hospital out of self-respect and face keeping while inwardly they think the opposite. As a result of this comment, the phrase P42 was replaced by "I think my hospital is good". The pilot questionnaire also revealed that respondents may be sensitive to the use of the first person of the singular in most statements and therefore may be reluctant to express their real thoughts. Although using "We" or "Most people" in place of "I" may not reflect the respondents' real thoughts it may reduce the untruthful answers in sensitive statements. Therefore the "I" in statements P43-51 was replaced by "We" or "Most people".

Second, according to the pilot respondentes, the statements P57 and P61 inthe Turnover Intention Scale convey the same meaning, so P61 should be deleted. Meanwhile, most of the 25 pilot respondents think the item "actively ask their former colleagues about the new hospitals where they currently work" can also reflect whether a staff has an intention to leave. Therefore, the P61 was changed to "actively get information from their former colleagues about the hospitals where they currently work".

Third, all the25 pilot respondents agree that under the influence of Chinese traditional culture, most staff with the intention to leave may not select "1" - *Extremely Disagree* and some staff mayeven give ingratiating answers by selecting "7"- *Extremely Agree* in some sensitive statements. These practices will seriously undermine the truthfulness of the survey results and therefore they advice that levels"1" -*Extremely Disagree* and "7"- *Extremely Agree* should be deleted.

In this part, a 7 level Likert scale questionnaire consisting of 61 items was sent out to 25 medical staff in surveyed hospitals for a pilot test in order to evaluate the reading comprehension of the questionnaire contents. After the questionnaire survey and group discussion with the 25 medical staff, the text description of some items was revised and the 7-level Likert scale questionnaire was changed to a 5-level Likert pilot questionnaire with 61 items.

4.2.5 Selection of Respondents

The survey forth is study was conducted among all medical graduates who are receiving clinical standardized training, clinicians, nurses, medical technicians and management personnel with professional qualifications in targeted private hospitals. The gender, age, education degree, post, position and title of respondents may affect their perceptions about the

survey content. For the convenience of SPSS analysis, these variables were coded as M1-gender, M2-age, M3-education degree, M4-position, M5-title, M6-post.)

4.3 Reliability and Validity Test of the Pilot Scales

4.3.1 Sample Description

The five-level Likert pilot questionnaire was randomly sent out to 120 medical staff in different departments in surveyed A hospital. Finally, 105 questionnaires were retrieved, of which102 were valid (response rate:86%).

4.3.2 Exploratory Factor Analysis

The KMO value (ranging from 0 to 1) is used to measure how coherently a set of variables are (Cheng, 2012). When KMO>0.9, factor analysis is perfectly preferred; when 0.8<KMO<0.9, factor analysis is very preferred; when 0.7<KMO<0.8, factor analysis is preferred; when 0.6<KMO<0.7, factor analysis is not preferred. According to Table 4-7 below, the results of the KMO values of exploratory factor analysis of all variables are higher than 0.8, therefore the factor analysis is very preferred.

Table 4-7 Cumulative Proportion of Variance Explained

Scale	Factor	Cumulative Proportion of Variance Explained	KMO	Significance
Internal social responsibility	1	56.946	0.839	P<0.05
External social responsibility	1	55.927	0.816	P<0.05
Organizational culture	4	72.543	0.890	P<0.05
Organizational identification	1	55.795	0.800	P<0.05
Turnover intention	1	68.826	0.800	P<0.05

Source: the author

4.3.3 Factor Analysis

Factor analysis is a statistical method used to extract common factors from a set of variables and explore latent factors among many observed variables. Categorizing variables with the same nature into a factor can not only reduce the number of variables, but test the hypothesized relationships among them. The principal component analysis (PCA) is used to extract factors from a set of variables of scales: first, factors are rotated using varimax method; second, a maximum of iterations for convergence was set as 25, and finally those factors with eigenvalue higher than 0.5 were extracted.

During this process, several problems have occurred: First, P7 under the internal social responsibility couldnotbe categorized into any factor. Second, P22 and P35 under organizational culture caused the occurrence of cross-factor phenomenon and P31 and P32 could not be categorized into any factor; P26, P29 and P36 were displaced, with P26 being displaced from Participation to Consistency, P29 from Consistency to Adaptation and P36 from Adaptation to Direction. Third, P43 and P46 under organizational identification caused the occurrence of cross-factor phenomenon; P52 and P56 could be categorized into a new factor; P44, P45, P47, P48 and P53 could not be categorized into any factor. Fourth, P61 under turnover intention could also not be categorized into any factor.

In an attempt to solve this, medical staff in targeted A hospital, including 5 head nurses, 5 physicians, 5 medical technicians and 2 managers, were organized together to discuss these problems. The meeting lastedfor nearly 5 hours. After analysis of causes, the following advices were given:

(1) For P7 stating that “my hospital has reasonable post setting and manning quotas and legal working time”, the first half of the statement and the second half may sometimes contradict each other in the hospital’s context. Therefore respondents would feel confused in answering it. Actually, the hospital’s job responsibilities are set according to industry rules; when medical staff get involved in an emergency treatment beyond legal working hours, there are generally no compensatory leaves for them, which is a common phenomenon in this industry. Meanwhile, China’s labor law is also silent in this point. Therefore, you cannot say that the post setting is unreasonable or thatover time work is illegal. Given this ambiguity, respondents may give an answer at will or even select none. Therefore, P7 should be deleted;

(2) P22 and P35 caused the occurrence of cross factor phenomenon because they have similar meaning with P9 and P10. It was therefore recommended that P22 and P35 be deleted;

(3) P30 and P31 cannot be categorized into any factor and therefore they should be delete;

(4) The displacement of P36 from Adaption to Direction wasthought to be reasonable, since achieving success in changing business environment is the common goal of members of an organization. Therefore, P36 should be retained;

(5) P43 has a similar meaning with P27, thus it should be deleted;

(6) P49 states "I can feel I have much in common with my colleagues", but in an organization with a high turnover rate, this statement may mean that one does notidentify that organization and therefore P49 should be deleted;

(7) P52 was thought to have asimilar meaning with P56, therefore P56 should be deleted.

After P43, P46, P49 and P56 under OI were deleted, the remaining items under OI could not be categorized into a factor, considering that there is no needto study the second-level dimensions of OI, 1 or 2 items with similar factor component coefficients were selected from each original second-level dimensions and they were put directly under first-order of OI. Meanwhile, the P44, P45, P47, P48 and P53 should be deleted. Finally, since P61 is originally not among the items of Farh's scale, it was also decided to delete it. After modifications, the factor analysis results of variables are shown as below

Table 4-8 Factor Analysis of Private Hospital Internal Social Responsibility

	Factor
P1	0.740
P2	0.611
P3	0.610
P4	0.736
P5	0.600
P6	0.573
P8	0.635
P9	0.776
P10	0.693
P11	0.661

Source: the author

Table 4-9 Factor Analysis of Private Hospital External Social Responsibility

	Factor
P12	0.530
P13	0.630
P14	0.561
P15	0.758
P16	0.800
P17	0.650
P18	0.612
P19	0.590
P20	0.716
P21	0.677

Source: the author

Table 4-10 Factor Analysis of Organizational Culture

	Factor
P23	0.657
P24	0.880
P25	0.847
P26	0.783
P27	0.671
P28	0.654
P30	0.765
P29	0.625
P33	0.841
P34	0.718
P36	0.736
P37	0.784
P38	0.888
P39	0.776
P40	0.758
P41	0.746

Source: the author

The factor analysis result of OC shows that the factor classification of the original scale was slightly changed from P23, P24, P25 under Participation, P26, P27, P28, P30 under Consistency, P29, P33, P34 under Adaptation, and P36, P37, P38, P39, P40, P41 under Direction.

Table 4-11 Factor Analysis of Organizational Identification

	Factor
P42	0.675
P50	0.810
P51	0.742
P52	0.729
P54	0.713
P55	0.675

Source: the author

Table 4-12 Factor Analysis of Turnover Intention

	Factor
P57	0.881
P58	0.826
P59	0.777
P60	0.831

Source: the author

According to the data in the above tables, all 46 retained items have been categorized into different factors and it was found that they fully meet the requirement of validity assessment.

4.3.4 Analysis of Internal Consistency Reliability

The internal consistency reliability of scales was tested using SPSS.19.0 with Cronbach of scales categorized into different factors to test the stability and consistency of variable factors. The higher the Cronbach α value is, the higher the consistency of measured variables in a group is and the higher the reliability is. When Cronbach α value of a scale is greater than 0.7, the scale can be used for further study. Otherwise, the reliability of the scale does not meet the requirements.

According to the factor analysis results, the internal consistency reliability of five variables in question based on the 102 pilot questionnaires was tested, and the results are listed as below:

Table 4-13 Reliability Analysis of In CSR of Private Hospitals

Item	CITC	Alpha if Item Delete	Cronbach α
P1	0.647	0.839	0.860
P2	0.515	0.851	
P3	0.508	0.851	
P4	0.646	0.840	
P5	0.497	0.852	
P6	0.476	0.853	
P8	0.537	0.849	
P9	0.693	0.835	
P10	0.595	0.844	
P11	0.55	0.847	

Source: the author

Table 4-14 Reliability Analysis of ExCSR of Private Hospitals

Item	CITC	Alpha if Item Delete	Cronbach α
P12	0.427	0.847	0.851
P13	0.518	0.84	
P14	0.446	0.845	
P15	0.657	0.827	
P16	0.706	0.823	
P17	0.545	0.837	
P18	0.517	0.840	
P19	0.493	0.842	
P20	0.629	0.829	
P21	0.582	0.833	

Source: the author

Table 4-15 Reliability Analysis of Organizational Culture of Private Hospitals

Item	CITC	Alpha if Item Delete	Cronbach α
P23	0.636	0.828	0.831
P24	0.728	0.728	
P25	0.721	0.745	
P26	0.680	0.820	0.853
P27	0.791	0.776	
P28	0.720	0.803	
P30	0.601	0.851	
P29	0.543	0.686	0.742
P33	0.601	0.618	
P34	0.661	0.667	
P36	0.698	0.914	0.910
P37	0.758	0.906	
P38	0.863	0.891	
P39	0.798	0.900	
P40	0.780	0.902	
P41	0.730	0.910	

Source: the author

Table 4-16 Reliability Analysis of Organizational Identification of Private Hospitals

Item	CITC	Alpha if Item Delete	Cronbach α
P42	0.542	0.829	0.841
P50	0.686	0.801	
P51	0.684	0.802	
P52	0.583	0.822	
P54	0.602	0.818	
P55	0.613	0.816	

Source: the author

Table 4-17 Reliability Analysis of Turnover Intention of Private Hospitals

Item	CITC	Alpha if Item Delete	Cronbach α
P57	0.766	0.771	0.848
P58	0.681	0.810	
P59	0.618	0.836	
P60	0.692	0.805	

Source: the author

According to the analysis results in theabove tables, the Cronbach α of external social responsibility, internal social responsibility, organizational identification and turnover intention of the private hospitals surveyed is 0.86, 0.851, 0.841 and 0.848 respectively. The Cronbach α of Participation, Consistency, Adaptation and Direction under OC is 0.831, 0.853, 0.742 and 0.91 respectively. The Cronbach α and Corrected Item Total Correlation (CITC) of all variables meet the requirements of validity test. These new scales can be used for further study.

4.3.5 Item Code of Final Scales

According to the test results of the validity and reliability of the pilot scales, the factors of organizational culture are slightly different from the original scale, but considering the high recognition of the original scale and the relative smaller size of the questionnaire, the structure of factor classification will not be changed in the final scale, whose item codes are listed below:

Table 4-18 Item Code of Scales

Pilot Code	**P1**	**P2**	**P3**	**P4**	**P5**	**P6**	**P8**	**P9**	**P10**
Final Code	P1	P2	P3	P4	P5	P6	P7	P8	P9
Pilot Code	P11	P12	P13	P14	P15	P16	P17	P18	P19
Final Code	P10	P11	P12	P13	P14	P15	P16	P17	P18
Pilot Code	P20	P21	P23	P24	P25	P26	P27	P28	P29
Final Code	P19	P20	P21	P22	P23	P24	P25	P26	P27
Pilot Code	P30	P33	P34	P36	P37	P38	P39	P40	P41
Final Code	P28	P29	P30	P31	P32	P33	P34	P35	P36
Pilot Code	P42	P50	P51	P52	P54	P55	P57	P58	P59
Final Code	P37	P38	P39	P40	P41	P42	P43	P44	P45
Pilot Code	P60								
Final Code	P46								

Source: the author

In this part, according to the statistical analysis of 102 valid questionnaires, the reliability and validity of the pilot questionnaire was tested and the final questionnaire with 46 items was generated.

4.3.6 Issuance and Retrieval of Final Questionnaire

The electronic questionnaire was generated on the Sojump platform and sent out via Wechat to head nurses' WeChat group in the three surveyed hospitals. Then the questionnaire was forwarded to the Wechat groups of different departments whose medical staff filled themout and submited them via Wechat. One request was that the questionnaire must be completed and submitted within 36 hours since it was sent out from Sojump. Wechat, developed by *TENCENT* (China), is a social platform widely used in China, on which the users can chat or transfer files. Sojump is a Wechat-based software used to sent out and retrieve electronic questionnaires. The electronic questionnaire can be issued to a large number of targeted respondents and be retrieved quickly. In additiontothe three surveyed hospitals, the questionnaire wasalso sent out via Wechat to members of Zhejiang Private Hospital Association, who are all middle or senior managers of private hospitals in Zhejiang province. After 36 hours, 598 electronic questionnaires were retrieved, with 52 considered invalid. However, only 85 are from physicians, accounting for just 15% of valid questionnaires, which is disproportionate to the number of physicians in the three private hospitals surveyed. Therefore, a futher round of130 paper questionnaires have been sent out to the three surveyed hospitals with 104 being retrieved and three invalid. The reason why only 85 electronic questionnaires from physicians were retrieved is perhaps because when the physicians are providing outpatient services or in surgical operation, they are forbidden to use mobile phone. Meanwhile, it is difficult for physicians who are fully occupied with their work to take out five minutes to finish the electronic questionnaire in the Wechat platform.

4.4 Chapter Summary

This chapter describes the research methods used in the study. Based on the research hypotheses and research model, combined with the theories from the literature review, the questionnaire scale was designed with the assistance of the interview method, group discussion and pilot questionnaire method. The results of the pilot questionnaire conducted among a small sample of 25 medical staff were examined and the reliability and validity was tested among 102 medical staff in one of the hospitals surveyed. After the reliability and validity was tested, the reserved items were re-encoded to assure that the final scale is accurate and reasonable.

Chapter 5: Statistics and Data Results

5.1 Overview

In this chapter, the statistical analysis of the results of the collected 607 valid questionnaires is conducted in three steps. First, the demographic information of respondents is analyzed to examine whether the collected data is in accordance with or close to the actual staffing structure of the surveyed hospitals. Second, the reliability and validity of the retrieved questionnaires are tested using SPSS19.0. Finally, structure equation modeling (SEM) is established using AMOS2.0 to test the research hypotheses.

5.2 Sample Descriptive Analysis

The questionnaire survey was mainly conducted among the medical staff in three not-for-profit private hospitals in Ningbo city. As mentioned in the former chapter, the electronic questionnaire was sent out via Wechat to head nurses' WeChat group in the three surveyed hospitals with 598 being recovered, of which 52 were considered invalid. However, among the valid questionnaires, only 85 were from physicians, accounting for just 15%, which is disproportionate to the number of physicians in the target hospitals. Therefore, another 130 paper questionnaires were sent out to the three surveyed hospitals with 104 being retrieved and three invalid. Meanwhile, the questionnaires were also sent out via Wechat to members of Zhejiang Private Hospital Association with 56 being retrieved, most of which were completed

by medical staff in other private hospitals in Zhejiang province. After eliminating invalid questionnaires, a total of 607 valid questionnaires were considered for statistical analysis. The response rate of the recovered questionnaires is about 80%.

There are 453 questionnaires from female respondents, who account for a large proportion of the total, up to 74.6%. According to the Hospital Grade Evaluation Criteria in Zhejiang Province, the proportion of health workers to beds in secondary hospitals should be 1.1:1, and the ratio of nursing staff to beds should be 0.55:1. Given that the nursing staff is basically women and the female staff accounts for a considerable proportion of medical technicians and physicians, the number of questionnaires returned by female respondents is proportionate to the staffing structure in the surveyed hospitals, which is acceptable.

In terms of age, the respondents under 36 account for 69% of those surveyed. Among the medical staff with rich experience and long working years in private hospitals, most have been reemployed after retiring from public hospitals or are physicians with multi-site medical practice, who are actually not formal employees of the surveyed hospitals. The data is found to be consistent with the personnel structure of the targeted hospitals.

In terms of the education degree, there is nearly 20 medical staff with PhD degree in the three surveyed hospitals and they were included in the questionnaire survey. However the survey results show that only one questionnaire is from the medical staff with doctoral degree, which makes it impossible to analyze the data of “education degree” using SPSS software in demographic information cross analysis. Therefore, the data analysis of “education degree” category is abandoned.

In terms of the position of respondents, it is in good agreement with the current situation of surveyed hospitals and meets the requirement of Health Departments.

In terms of the profession title of respondents, the ungraded and primary staff accounts for 11% and more than 50% of the total respondents respectively, which are extremely inconsistent with the actual personnel structure in the hospitals surveyed. But given that the number of quitting primary and intermediate medical staff account for more than 50% of the total dropouts at the same period and new employed staff with same technical title did not get involved in the survey, the proportion of ungraded and primary staff in the recovered questionnaires meets the research requirement. The actual number of medical staff who has quitted their jobs comes from the statistical data of the three hospitals surveyed.

In terms of the administrative post of respondents, the persons in lower level positions account for 80.7%, which is consistent with the personnel structure of the surveyed hospitals the basic information of respondents is listed as below:

Table 5-1 Sample Descriptive Statistics

	Information of Respondents	**Nr**	**Percentage**
Gender	Male	154	25.4%
	Female	453	74.6%
Age	Under 25	127	20.9%
	26-35	297	48.9%
	36-45	120	19.8%
	Above 46	63	10.4%
Highest degree	Junior college and below	204	33.6%
	Bachelor	376	62.0%
	Master	26	4.3%
	Doctor	1	0.01%
Work post	Physician	164	27.0%
	Nurse	344	56.7%
	Medical Technician	63	10.4%
	Managerial Personnel	36	5.9%
Professional title	Ungraded	70	11.5%
	Primary title	318	52.4%
	Intermediate title	125	20.6%
	Vice senior title	81	13.3%
	Senior title	13	2.1%
Administrative post	lower-level post	490	80.7%
	Head of department	112	18.5%
	Hospital leader	5	0.8%

Source: the author

The items under turnover intention are positively phrased so the higher the total scores are, the weaker the turnover intention is. For instance, P43 states “I have never intended to quit my present job”; when most respondents score “5-strongly agree”, it means the turnover intention in this hospital is at a low level,while for items under OI /OC, the higher the scores are, the higher/better the OI/OC is. Therefore, when the scores are input into SPSS, the score sequence is adjusted from 1, 2,3,4,5 to 5,4,3,2,1, so as thatall items of the scale are positively correlated with score.

5.3 Reliability and Validity Analysis of Scales

The reliability and validity of internal social responsibility scale, external social responsibility scale, organizational culture scale, organization identification scale and turnover intention scale were tested using SPSS and AMOS to ensure the data meet the requirement of empirical study.

5.3.1 Exploratory Factor Analysis

The exploratory factor analysis method is used to determine underlying constructs for a set of measured variables in the research model to ensure that the variables are mutually different and exclusive. KMO value and Bartlett test were used to measure how coherently a set of variables are (Cheng, 2012). When KMO>0.9, factor analysis is perfectly preferred; when 0.8<KMO<0.9, factor analysis is very preferred; when 0.7<KMO<0.8, factor analysis is preferred; when 0.6<KMO<0.7, factor analysis is not preferred. Bartlett's test is to test whether P value is smaller than given sig. According to Table 5.2, the KMO values of all variables are higher than 0.8, and p value is smaller than given 0.05, therefore the factor analysis is very preferred for this study.

Table5-2 Cumulative Proportion of Variance Explained of Scales

Scale	Factor	Cumulative proportion of variance explained	KMO	(Significance) P value
Internal social responsibility	1	59.164	0.942	0.00
External social responsibility	1	56.190	0.932	0.00
Organizational Culture	4	79.201	0.962	0.00
Organizational Identification	1	66.469	0.802	0.00
Turnover Intention	1	62.063	0.827	0.00

Source: the author

5.3.2Factor Analysis

Factor analysis is a statistical method used to extract common factors from a set of variables and explore latent factors among many observed variables. Categorizing variables with the same nature into a factor can not only reduce the number of variables but also test the hypothesized relationships among variables. The principal component analysis (PCA) is used to extract factors from a set of variables of scales: first, factors are rotated using varimax method; second, a maximum of iterations for convergence was set as 25, and finally those factors with eigenvalue higher than 0.5 were extracted. See tables below for details:

Table 5-3 Factor Analysis of Internal CSR of Private Hospitals

	Factor
P1	0.750
P2	0.770
P3	0.753
P4	0.770
P5	0.774
P6	0.788
P7	0.758
P8	0.790
P9	0.733
P10	0.802

Source: the author

Table 5-4 Factor Analysis of External CSR of Private Hospitals

	Factor
P11	0.668
P12	0.703
P13	0.725
P14	0.813
P15	0.797
P16	0.736
P17	0.725
P18	0.689
P19	0.751
P20	0.749

Source: the author

Table 5-5 Factor Analysis of OI of Private Hospitals

	Factor
P21	0.687
P22	0.830
P23	0.796
P24	0.714
P25	0.650
P26	0.601
P28	0.771
P27	0.549
P29	0.802
P30	0.548
P31	0.743
P32	0.749
P33	0.800
P34	0.758
P35	0.774
P36	0.761

Source: the author

Table 5-6 Factor Analysis of OI of Private Hospitals

	Factor
P37	0.872
P38	0.774
P39	0.804
P40	0.869
P41	0.819
P42	0.746

Source: the author

Table 5-7 Factor Analysis of TI of Private Hospitals

	Factor
P43	0.874
P44	0.865
P45	0.819
P46	0.836

Source: the author

According to the factor analysis results above, the factor values of all items under Internal CSR are higher than 0.7; the minimum factor value of items under External CSR is 0.668; the factor values of items under the 4 second-level dimensions of OC is higher than 0.5; the factor values of 6 items under OI are higher than 0.7; the factor values of items under TI are higher than 0.8. According to table 5-2, the KMO values of all variables are higher than 0.8, showing that the validity of the scales meets the research requirement.

5.3.3 Internal Consistency Reliability

SPSS.19.0 software is used to test the internal consistency reliability with Cronbach α Coefficient as the measurement standard. The higher the Cronbach α is, the higher the consistency of measured variables in a group is, and the higher the reliability is. When Cronbach α of a scale is higher than 0.7, the scale has good reliability. Otherwise, the reliability of the scale does not meet the requirement. According to Jiang (2011), CITC values of all items should be greater than 0.35, otherwise the item is thought to be poorly correlated with other items.

Table 5-8 Reliability Analysis of Internal CSR of Private Hospitals

Item	CITC	Alpha if Item Deleted	Cronbach α
P1	0.686	0.916	0.923
P2	0.708	0.915	
P3	0.689	0.916	
P4	0.708	0.915	
P5	0.713	0.915	
P6	0.728	0.914	
P7	0.693	0.916	
P8	0.731	0.914	
P9	0.666	0.917	
P10	0.746	0.913	

Source: the author

Table 5-9 Reliability Analysis of External CSR of Private Hospitals

Item	CITC	Alpha if Item Deleted	Cronbach α
P11	0.621	0.908	0.913
P12	0.648	0.906	
P13	0.678	0.905	
P14	0.725	0.902	
P15	0.708	0.903	
P16	0.670	0.905	
P17	0.722	0.902	
P18	0.647	0.906	
P19	0.699	0.903	
P20	0.691	0.904	

Source: the author

Table 5-10 Reliability Analysis of OC of Private Hospitals

Item	CITC	Alpha if Item Deleted	Cronbach α
P21	0.731	0.870	
P22	0.790	0.816	0.882
P23	0.796	0.813	
P24	0.760	0.877	
P25	0.833	0.851	0.900
P26	0.774	0.872	
P28	0.743	0.883	
P27	0.617	0.733	
P29	0.659	0.688	0.791
P30	0627	0.726	
P31	0.819	0.950	
P32	0.855	0.946	
P33	0.888	0.943	0.955
P34	0.869	0.945	
P35	0.880	0.943	
P36	0.839	0.948	

Source: the author

Table 5-11 Reliability Analysis of OI of Private Hospitals

Item	CITC	Alpha if Item Deleted	Cronbach α
P37	0.791	0.870	0.898
P38	0.680	0.887	
P39	0.716	0.882	
P40	0.787	0.871	
P41	0.730	0.880	
P42	0.644	0.892	

Source: the author

Table 5-12 Reliability Analysis of TI of Private Hospitals

Item	CITC	Alpha if Item Deleted	Cronbach α
P43	0.894	0.824	0.900
P44	0.644	0.914	
P45	0.689	0.901	
P56	0.894	0.824	

Source: the author

According to the data shown above, the Cronbachα values of all variables are close to or higher than 0.8 and CITC values are higher than 0.6. When the sample size increases, the Cronbachα and CITC are higher than those of pilot questionnaire, showing that the reliability of the scale is high.

5.4 Variable Factors Validation

The confirmatory factor analysis method and AMOS are used to test the convergent validity of variables of scales and meanwhile the fitness of the model is alsotested. According to Dong (2011), the modelfitness is measured by the following indices:

(1) the ratio of chi-square to the degree of freedom (X^2/df) is used to test the fitness between the hypothetical model and the observed data. When X^2/df<5, the goodness of fit is acceptable.

(2) GFI (Goodness-of-fit index) value ranges from 0 to 1, when the value is close to 0, the fitness between the hypothetical model and the observed data is poor. AGFI, as the name

implies, is an adjusted GFI value. When the GFI value fluctuates greatly due to the change in the sample size, the value can be adjusted through degree of freedom, number of observed variables and number of estimated parameters. When GFI or AGFI is greater than 0.9, the fitness is good. When GFI or AGFI is greater than 0.8, the fitness is acceptable.

(3) TLI-Tucker Lewis Index, when 0.9< TLI<1, the fitness is acceptable.

(4) CFI- Comparative Fit Index: when 0.9< CFI <1, the fitness is acceptable.

(5) RMSEA- Root Mean Square Error of Approximation is used to test the degree of unfitness between the hypothetical model and the observed data. The higher the value, the poorer the fitness is. When the RMSEA<0.05, the fitness is close; when 0.05<RMSEA<0.08, the fitness is good; when 0.08<RMSEA<0.10, the fitness is acceptable.

(6) RMR-Root of the Mean Square Residual: when RMR<0.1, the fitness is good.

5.4.1 Confirmatory Factor Analysis of theModel of Social Responsibility in the Sampled Private Hospitals

Table 5-13 Confirmatory Factor Analysis of the Social Responsibility Model in the Sampled Private Hospitals

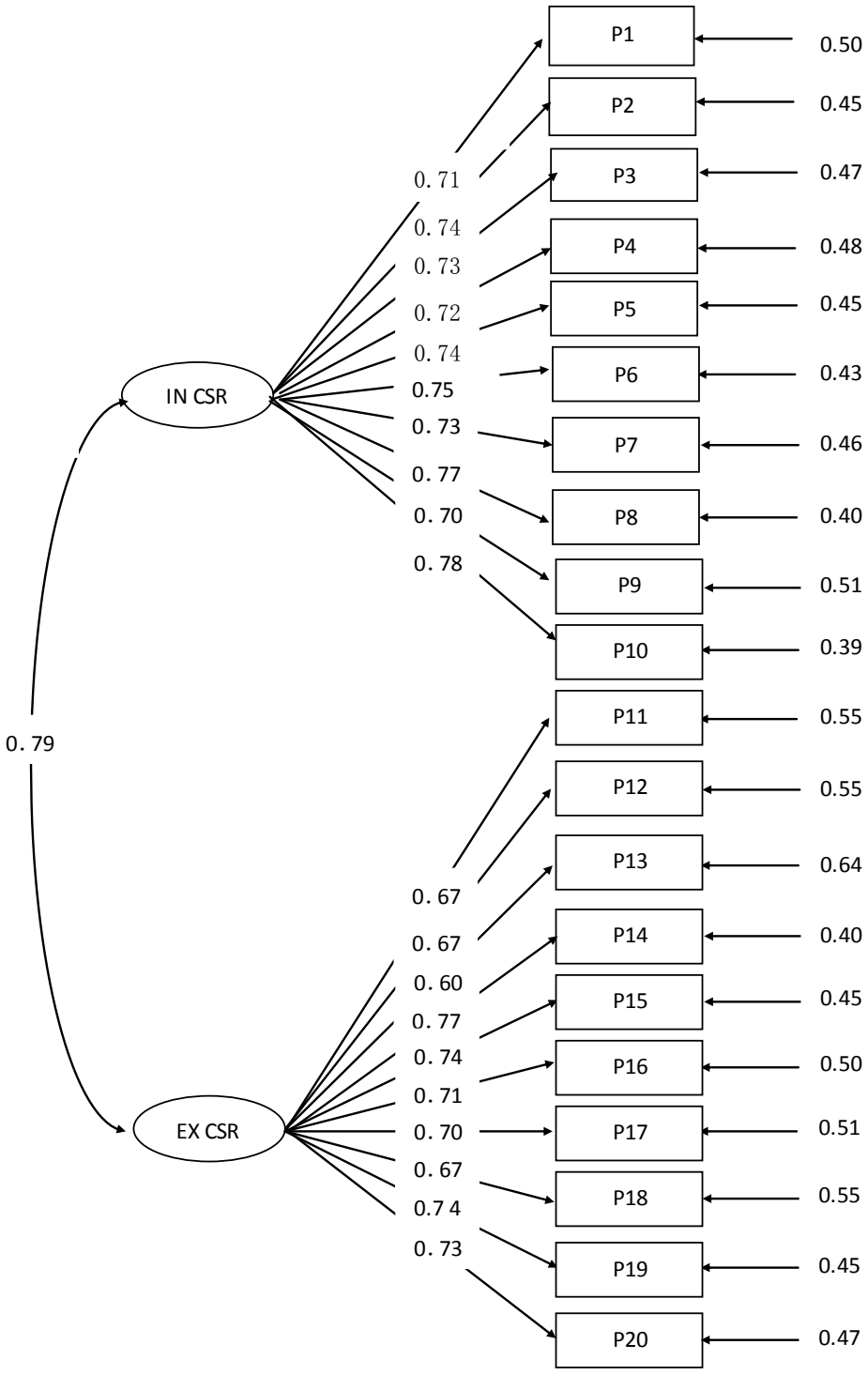
Model	X^2/df	GFI	AGFI	TLI	CFI	RMSEA	RMR
Bivariate	4.324	O.888	0.861	0.912	0.921	0.074	0.035
Univariate	7.971	0.749	0.69	0.814	0.834	0.107	0.052

Source: the author

While testing the model of social responsibility in the surveyed private hospitals, the univariate model and bivariate model are analyzed and contrasted. The univariate model means that the 20 items concerning social responsibilityin our sampled private hospitals share a single latent variable.

According to Table 5-13, the X^2/df of bivariate model is smaller than 5, while the X^2/df of univariate model is larger than 5, showing that the fitness of the bivariate model meets the research requirements while the univariate model does not. Meanwhile, the GFI and AGFI value of the univariate model are lower than those of the bivariate model. Thus, it can be seen that the bivariate model is better than the single variable model.

Figure 5-1 Confirmatory Factor Analysis of Private Hospital Social Responsibility



X^2=730.693,df=169,P-value=0.000,RMSEA=0.074

Source: the author

According to Figure 5-1, the standard loading of the20 items in the bivariate model is smaller than 0.8 and the error item value of each item is smaller than 0.5. Meanwhile, according to the data analysis results of bivariate model in Table 5-13, it can follow that the bivariate model of social responsibility in the private hospitals surveyedis valid.

5.4.2 Confirmatory Factor Analysis of OC model

Table 5-14 Confirmatory Factor Analysis of OC Model

Model	X^2/df	GFI	AGFI	TLI	CFI	RMSEA	RMR
Quadvariate	4.357	0.92	0.889	0.954	0.963	0.074	0.032
Trivariate A	7.357	0.858	0.805	0.914	0.927	0.102	0.040
Trivariate B	5.723	0.889	0.851	0.936	0.946	0.088	0.041
Bivariate	8.285	0.830	0.776	0.901	0.915	0.110	0.051
Univariate	10.901	0.781	0.712	0.866	0.884	0.128	0.053

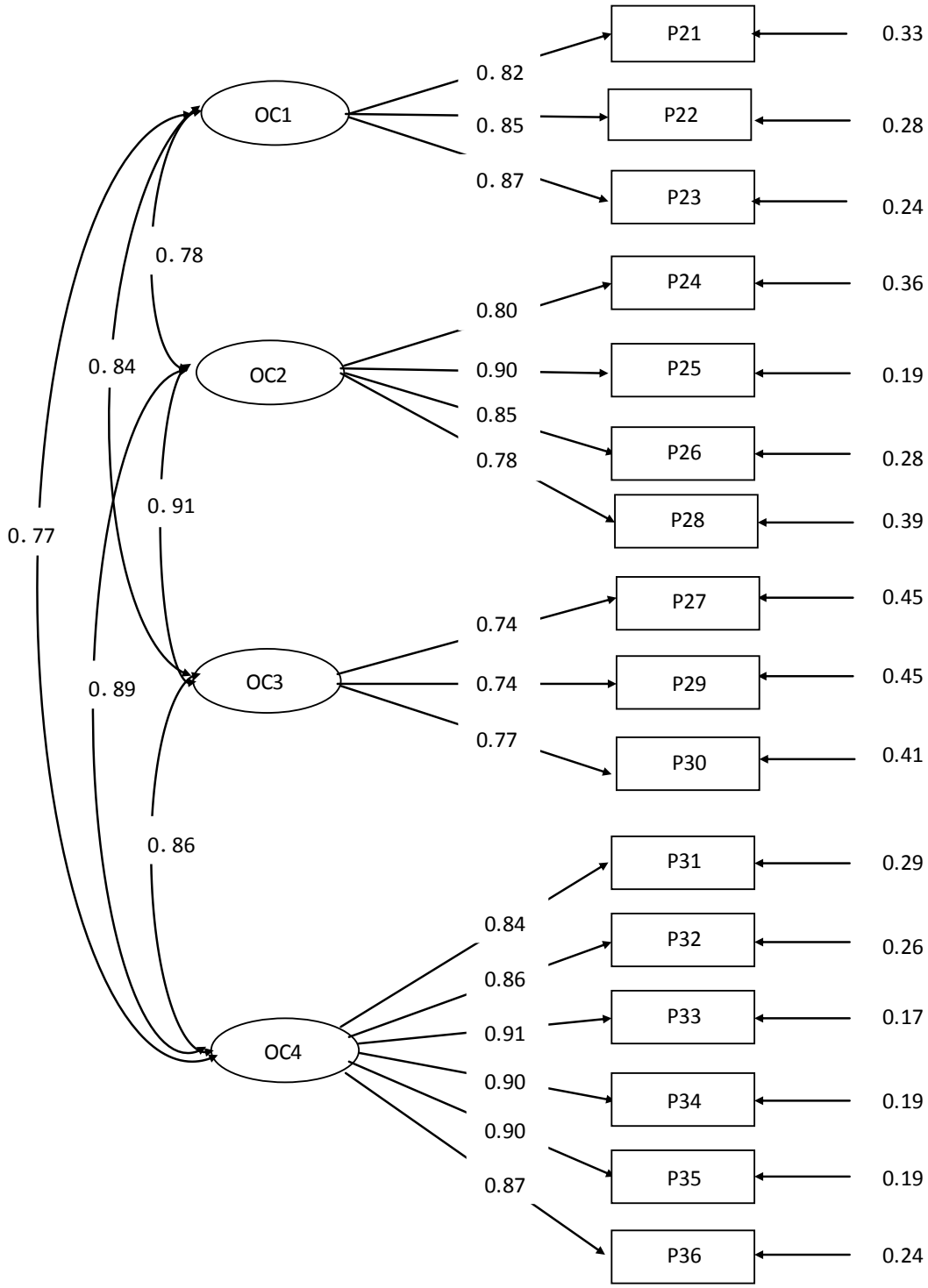
Source: the author

According to Table 5-14, only the X^2/df of quad-variate OC model is smaller than 5. The classification of quad-variate model is: OC1(P21, P22, P23); OC2(P24, P25, P26, P28); OC3(P27, P29, P30)；OC4 (P31, P32, P33, P34, P35, P36); X^2/df<5, GFI>0.9, AGFI>0.85, 0.95<TLI<1, 0.95<CFI<1, RMSEA<0.08, RMR<0.05: all the measurement indexes are within the acceptable limits. The classification of trivariate A model is: OC1(P21, P22, P23, P24, P25, P26, P28); OC2(P27, P29, P30); OC3(P31, P32, P33, P34, P35, P36); X^2/df>5, RMSEA>0.1, which means that the measurement indexesarebeyond the acceptable limits. The classification of the trivariate B model is: OC1 (P21, P22, P23, P27, P29, P30); OC2(P24, P25, P26, P28); OC4 (P31, P32, P33, P34, P35, P36); X^2/df>5: this measurement index is beyond the threshold and other indexes are poorer than those of thequad-variate model. The classification of the bivariate model is: OC1 (P21, P22, P23, P27, P29, P30); OC2 (P24, P25, P26, P28, P31, P32, P33, P34, P35, P36). Acording to the analysis results, all the seven measurement indexes of bivariate model and univariate model are beyond the acceptable limits. Thus, it can be seen that the quad-variate OC model has the best fitness.

According to Figure 5-2, the standard loading of four factors and16 items in the Quad-variables model is smaller than 0.8 and the error item value of all items is smaller than 0.5.

Meanwhile, according to the data analysis results of quad-variate model shown in Table 5-14, it follows that the quad-variate OC modelis valid.

Figure 5-2 Confirmatory Factor Analysis of OC Model

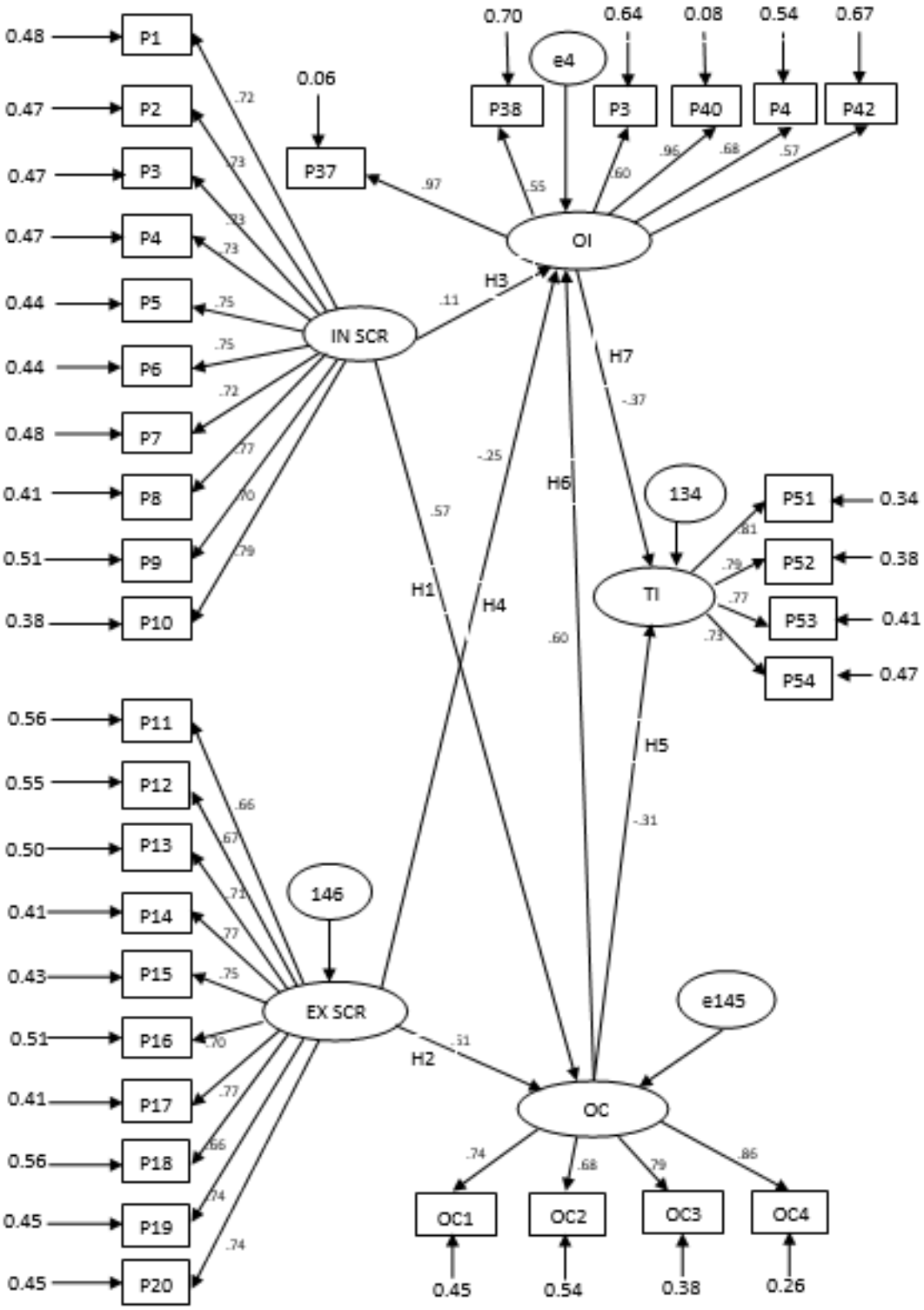


X2=426.961, df=98, P-value=0.000, RMSEA=0.074

Source: the author

5.5 Research Model and Research Hypotheses Validation

Figure 5-3 Structural Equation Model of CSR, OC, OI and T1 Relationship



Source: the author

Table 5-15 Data Validation based on SEM Model

Validation Path	**Standardized Path Coefficient**	**Significance Probability**
Internal CSR ⟶ OC	0.57	***
External CSR ⟶ OC	0.61	***
Internal CSR ⟶ OI	0.11	0.078
External CSR ⟶ OI	-0.25	***
OC ⟶ TI	-0.31	***
OC ⟶ OI	0.60	***
OI ⟶ TI	-0.37	***
Goodness of Fit	X^2/df 4.729, GFI 0.884, AGFI 0.831, TLI 0.904, CFI 0.913, RMSEA 0.078, RMR 0.042	

5.5.1 Model Preliminary Estimation and Evaluation

According to the structural equation model established using AMOS.20 (Figure 5-3) and the data analysis results depicted in Table 5-15 (X^2/df=4.729, GFI=0.884, AGFI=0.831,TLI= 0.904,CFI=0.913,RMSEA=0.078, RMR=0.042), except that for the AGFI value(=0.831), which is slightly beyond the threshold (>0.85), all other measurement indexes are well within the acceptable limits. Based on Breckler's research results, Jiang (2011) argues that the fitness of model can be evaluated using three kinds of indexes, including absolute goodness of fit index (X^2/df, GFI, RMSEA), comparative goodness of fit index (CFI, NFI) and adjusted goodness of fit index (PGFI, PNFI). It is generally believed if a model with good fitness is used to test the hypotheses, there must be at least more than one qualified measurement index.

Thus, it can be seen that the hypothetical model depicting the CSR, OC, OI and TI relationships is reasonable and meets the research requirement.

Table 5-16 Convergent Validity Analysis of the Theoretical Model Variables

Latent variables	Observed variable code	Standard factor loading	Error term	Average variance extracted	Composite reliability
INCSR	P1	0.72	0.48	0.546	0.923
	P2	0.73	0.47		
	P3	0.73	0.47		
	P4	0.73	0.47		
	P5	0.75	0.44		
	P6	0.75	0.44		
	P7	0.72	0.48		
	P8	0.77	0.41		
	P9	0.70	0.51		
	P10	0.79	0.38		
EXCSR	P11	0.66	0.56	0.516	0.914
	P12	0.67	0.55		
	P13	0.71	0.50		
	P14	0.77	0.41		
	P15	0.75	0.43		
	P16	0.70	0.51		
	P17	0.77	0.41		
	P18	0.66	0.56		
	P19	0.74	0.45		
	P20	0.74	0.45		
OC	OC1	0.74	0.45	0.622	0.868
	OC2	0.88	0.54		
	OC3	0.79	0.38		
	OC4	0.86	0.26		
OI	P37	0.97	0.06	0.552	0.875
	P38	0.55	0.70		
	P39	0.60	0.64		
	P40	0.96	0.08		
	P41	0.68	0.54		
	P42	0.57	0.67		
TI	P43	0.81	0.34	0.601	0.857
	P44	0.79	0.38		
	P45	0.77	0.41		
	P46	0.73	0.47		

Source: the author

According to Table 5-16, the standard loading of factors of the construct Internal Corporate Social Responsibility (INCSR) is smaller than 0.8, the error items are smaller than 0.51, the AVE (Average Variance Extracted) is close to 0.6, the composite reliability (CR) is larger than 0.9. In turn, the standard loading of factors of the construct External Corporate

Social Responsibility (EXCSR) is smaller than 0.9, the error items are smaller than 0.56, the AVE is larger than 0.5, the composite reliability (CR) is larger than 0.9. The standard loading of factors of Organizational Culture (OC) is smaller than 0.9, the error items are smaller than 0.55, the AVE is larger than 0.6, the composite reliability (CR) is larger than 0.85.The standard loading of factors of Organizational Identification (OI) is smaller than 0.9, the error items are smaller than 0.5, the AVE is larger than 0.55, the composite reliability (CR) is close to 0.9.The standard loading of factors of TI is smaller than 0.9, the error items are smaller than 0.5, the AVE is larger than 0.6, the composite reliability (CR) is larger than 0.85. The data above show that the correlational validity of variable factors of the research model is high.

Table 5-17 Factor Correlative Analysis of CSR, OC, OI and TI

Variable	**INCSR**	**EXCSR**	**OC**	**OI**	**TI**
INCSR	1.000				
EXCSR	0.723**	1.000			
OC	0.761**	0.777**	1.000		
OI	0.614**	0.537**	0.703**	1.000	
TI	0.547**	0.382**	0.500**	0.606**	1.000

Source: the author

Data in Table 5-17 signify that in private hospitals, the correlation between internal CSR and external CSR is 0.723**, which also denotes bilateral significance. The correlation between internal CSR and Organizational Culture is 0.761 (bilaterally significant). The correlation between internal CSR and Organizational Recognition is 0.614** (bilaterally significant). The correlation between internal CSR and Turnover Intention is 0.547** (bilaterally significant). The correlation between external CSR and Organizational Culture is 0.777** (bilaterally significant). The correlation between external CSR and Organizational Recognition is 0.537** (bilaterally significant). The correlation between Organizational correlation between Organizational Culture and Organizational Recognition is 0.703** Culture and Organizational Recognition is 0.500** (bilaterally significant). The correlation between Organizational Recognition and Turnover Intention is 0.606** (bilaterally significant). These results indicate significant correlations between.

Table 5-18 Discriminant Validity Analysis of CSR, OC, OI and TI

Variable	INCSR	EXCSR	OC	OI	TI
INCSR	0.770				
EXCSR	0.723	0.778			
OC	0.761	0.777	0.876		
OI	0.614	0.537	0.703	0.779	
TI	0.547	0.382	0.500	0.606	0.771

Source: the author

Data in Table 5-18 show that in private hospitals, the discriminant validity index of the internal CSR is 0.77, and such indices for external CSR, Organizational Culture, Organizational Recognition, and Turnover Intention are 0.723, 0.761, 0.614, and 0.547 respectively, and these results signify good discriminant validity. The discriminant validity index of the external CSR is 0.778, and such indices for Organizational Culture, Organizational Recognition, and Turnover Intention are 0.777, 0.537, and 0.382 respectively, and these results signify good discriminant validity. The discriminant validity index of the Organizational Culture is 0.876, and such indices for Organizational Recognition and Turnover Intention are 0.703 and 0.500 respectively, and these results signify good discriminant validity. The discriminant validity index of the Organizational Recognition is 0.779, and such index for Turnover Intention is 0.606, and these results signify good discriminant validity.

5.5.2 Test and Explanation of Research Hypotheses

Based on the SEM depicted in Figure 5-3 and according to the analysis results of Table 5.15, the test results of hypotheses are summarized and explained below:

H1: Internal Social Responsibility of Private Hospitals has a Positive Effect on Organizational Culture.

The standard path coefficient of H1 (IN CSR->OC) is 0.57 and significance probability*** (P<0.001), showing that IN CSR has a significant and positive effect on OC, therefore H1 hypothesis is supported.

H2: External Social Responsibility of Private Hospitals has a Positive Effect on Organizational Culture.

The standard path coefficient of H2 (EX CSR->OC) is 0.61 and significance probability*** (P<0.001), showing that EX CSR has significant and positive effect on OC, therefore H2 hypothesis is supported.

H3: Internal Social Responsibility of Private Hospitals has a Positive Effect on Organizational Identification.

The standard path coefficient of H3 (IN SCR->OI) is 0.11 and significance probability is 0.078 (P>0.005), showing that IN CSR has positive yet insignificant effect on OI, therefore H2 hypothesis is basically supported.

H4: External Social Responsibility of Private Hospitals has a Negative Effect on Organizational Identification.

The standard path coefficient of H4 (EX SCR->OI) is -0.25 and significance probability*** (P<0.001), showing that EX SCR has a significant and negative effect on OI, therefore H4 hypothesis is not supported.

H5: Organizational Culture of Private Hospitals is Significantly and Negatively Correlated with Turnover Intention.

The standard path coefficient of H5 (OC->TI) is -0.31 and significance probability*** (P<0.001), showing that OC has a negative and significant effect on TI, therefore, H5 hypothesis is supported.

H6: Organizational Culture of Private Hospitals is Significantly and Positively Correlated with Organizational Identification.

The standard path coefficient of H6 (OC->OI) is 0.6 standard pa and significance probability*** (P<0.001), showing that OC has a significant and positive effect on OI, thereforeH6 hypothesis is supported.

H7: Organizational Identification of Private Hospitals is Negatively Correlated with Turnover Intention.

The standard path coefficient of H7 (OI->TI) is -0.37and significance probability*** (P<0.001), showing that OI has a significant and negative effect on TI, therefore H7 hypothesis is supported.

5.6 Chapter Summary

In this chapter, the recovered questionnaires were carefully selected for statistical data analysis and invalid ones were eliminated. The data of the sample were analyzed to examine whether they are consistent with the actual staffing structure of the surveyed hospitals. Then the validity of valid questionnaires was tested using Exploratory Factor Analysis (EFA) and factor analysis method; the internal consistency reliability was also tested and better results were achieved in comparison with the pilot questionnaires. The Structure Equation Model is established using AMOS and the sub-scales and aggregated scale were tested successively. The fitness, correlation and discriminant validity of all variables were tested. Finally, according to the analysis results and structural diagram, the research hypotheses are tested and interpreted.

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Chapter 6: Cross Analysis of Demographic Information

6.1 Overview

The items of CSR scale were used to evaluate the organization members' perception of social responsibility and their degree of active participation. The items of OC focus on evaluating the members' perception towards the working atmosphere. The items of OI evaluate employees' emotional attachment to the organization. Turnover intention shows a person's intention to leave, either because he/she is dissatisfied with the job or has found a better job somewhere else. However, an individual's perception, cognition, thoughts and behaviours are heavily affected by demographic factors such as age, knowledge and social status. Therefore, it is useful to conduct a demographic information cross analysis after the research hypotheses were tested.

6.2 Cross Analysis of Demographic Information's Influence on the Research Variables

The questionnaire contains six aspects of demographic information of respondents, including gender, age, education degree, post, professional title and administrative position. The education degree is classified into four types: junior college and below, bachelor, master and doctor. Considering that there are nearly 20 medical staff with doctor's degree in the three surveyed hospitals, and that all of them were included in the questionnaire survey but only one questionnaire was from a medical staff with doctoral degree, this makes it impossible to analyse the data of "education degree" using SPSS software in what regards demographic information cross analysis. Therefore, the influence of education degree of respondents on research variables was neglected.

6.2.1 Influence of Gender on Variables

The independent sample T test was used to analyse the influence of gender on research variables. The details are shown as follows:

Table 6-1 Variance Analysis of the Influence of Gender on CSR of the Private Hospitals Surveyed

Variable	Gender	MD	SD	*t*	*df*	*p*
IN CSR	Male	3.1608	0.68760	-3.053	605	0.002
	Female	3.3557	0.68164			
EX CSR	Male	3.3608	0.67544	-4.940	605	0.000
	Female	3.6685	0.66332			

Note: ①Male ②Female

Source: the author

According to Table 6.1, there are gender differences in perception towards the IN CSR of private hospitals (t=-3.053, p<0.01), with female medical staff's perception being stronger than male ones.

Similarly, there are gender differences in perception towards the EX CSR of private hospitals (t =-4.940, p<0.01), with female medical staff's perception towards EX CSR being stronger than male ones.

Table 6-2 Variance Analysis of the Influence of Gender on OC of the Private Hospitals Surveyed

Variable	Gender	MD	SD	*t*	*df*	*p*
OC	Male	2.9571	0.70063	-6.488	296.557	0.000
	Female	3.3984	0.80221			

Note: ①Male ②Female

Source: the author

According to Table 6-2, there are gender differences in perception towards the OC of private hospitals (t=-6.488, p<0.01), with female medical staff's perception being stronger than male ones.

Table 6-3 Variance Analysis of the Influence of Gender on OI

Variable	Gender	MD	SD	*t*	*df*	*p*
OI	Male	2.6111	0.76041	-3.115	605	0.000
	Female	2.8506	0.84223			

Note: ①Male ②Female

Source: the author

According to Table 6-3, there are gender differences in organizational identification (t=-3.115, p<0.01), with female medical staff's organizational identification being stronger than male ones.

Table 6-4 Variance Analysis of the Influence of Gender on TI

Variable	**Gender**	**MD**	**SD**	***t***	***df***	***p***
TI	Male	2.9412	0.92869	-3.266	605	0.001
	Female	3.2120	0.87257			

Note: ①Male ②Female

Source: the author

According to Table 6-4, there are gender differences in turnover intention (***t*** =-3.266**,** p<0.01), with female medical staff's turnover intention being stronger than male ones.

6.2.2 Influence of Age on Variables

Table 6-5 Variance Analysis of the Influence of Age on CSR of the Private Hospitals Surveyed

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
IN CSR	Inter- groups	7.085	3	2.505	4.	0.02	①>②; ①>③
	Intra group	288.088	603	0.478			① >④
	Total	295.173	606				
EX CSR	Inter- groups	7.247	3	2.861	5.	0.001	①>③; ①>②
	Intra group	249.361	603	0.4414			① >④
	Total	256.609	606				

Note: ①Under 25 ②26-35 ③36-45 ④Above45

Source: the author

According to Table 6-5, there are age differences in perception towards the IN CSR (F =4.943, p<0.05). Through post hoc test, the perceptions of the respondents under 25 towards IN CSR are stronger than those between 26 and 35 ($MD_{①-②}$=0.23207, p<0.05), significantly stronger than those between 36 and 45 ($MD_{①-③}$=0.31208, p<0.01) and stronger than those above 45 ($MD_{④-①}$=0.22351, p<0.05). There are significant age differences in perception towards the EX CSR (F =5.842, p=0.01). Through post hoc test, the perception of respondents under 25 towards EX CSR is significantly stronger than those between 26 and 35($MD_{①-}$

②=0.18068, p<0.01), those between 36 and 45 (MD①③=0.30178, p=0.01) and than those above 45 (MD①④=0.32666, p=0.01).

Table 6-6 Variance Analysis of the Influence of Age on OC of the Private Hospitals Surveyed

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
OC	Inter- groups	35.397	3	11.793	19.190	0.00	①>②;①>③;①>④
	Intra group	370.556	603	0.615			② >③; ②>④
	Total	405.945	606				

Note: ①Under 25 ②26-35 ③36-45 ④Above 45

Source: the author

According to Table 6-6, there are significant age differences in organizational culture (F =19.272, p<0.01). Through post hoc test, the perception of the respondents under 25 towards OC is significantly stronger than those between 26 and 35 (MD①②=0.33390, p<0.01), those between 36 and 45 (MD①③=0.65567, p<0.01) and those above 46 (MD①④=0.72221, p<0.01). The perception of the respondents between 26and 35 towards OC is significantly stronger than those between 36 and 45 (MD②③=0.32178, p<0.01) and than those above 45 (MD②④=0.38832, p<0.01).

Table 6-7 Variance Analysis of the Influence of Age on OI

		Sum of square	*df*	Mean square	*F*	*p*	Post hoc test
OI	Inter- groups	5.563	3	1.854	2.726	0.043	①>②,①>④
	Intra group	354.4	603	0.588			
	Total	388.4	606				

Note: ①Under 25 ②26-35 ③36-45 ④Above 45

Source: the author

According to Table 6-7, there are age differences in organizational identification (F=2.726, p<0.05). Through post hoc test, the organizational identification of respondents under 25 is significantly stronger than those between 26 and 35 (MD①②=0.22566, p<0.01) and those above 46 (MD①④=0.26759, p<0.05). The organizational identification of respondents between 35 and 45 is significantly stronger than those between 26 and 35 (MD②①=0.11581, p<0.05)

Table 6-8 Variance Analysis of the Influence of Ageon Turnover Intention of Medical Staff in the Private Hospitals Surveyed

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
TI	Inter- groups	3.262	3	1.087	1.363	0.253	
	Intra group	354.436	603	0.588			
	Total	388.419	606				

Note: ①Under 25 ②26-35 ③36-45 ④Above 45

Source: the author

According to Table 6-8, there are no gender differences in turnover intention of medical staff (F =1.363, p>0.05).

6.2.3 Influence of Rank on Variables

Table 6-9 Variance Analysis of the Post's Influence on CSR of Private Hospitals

		Sum of squares	*df*	Mean square	*F*	*P*	Post hoc test
INCSR	Inter- groups	10.330	3	3.443	7.289	0.000	②>①; ③>①
	Intra group	284.843	603	0.472			
	Total	295.173	606				
EXCSR	Inter- groups	9.873	3	3.291	8.043	0.000	②>①; ②>③
	Intra group	246.736	603	0.409			
	Total	256.609	606				

Note: ①Physician ②Nurse ③Medical Technician ④Management Personnel

Source: the author

According to Table 6-9, there are significant rank differences in medical staff's perception towards INCSR (F =7.289, p<0.01). Through post hoc test, the perception of nurses towards INCSR is significantly stronger than that of physicians ($MD_{②-①}$=0.29989, p<0.01); the perception of medical technicians towards INCSR is significantly stronger than that of physicians ($MD_{③-①}$=0.28050, p<0.01). Similarly, there are significant rank differences in medical staff's perception towards EXCSR (F =8.043, p<0.01). Through post hoc test, the perception of nurses towards EXCSR is significantly stronger than that of physicians ($MD_{②-①}$=0.29241, p<0.01) and stronger than that of medical technicians ($MD_{②-③}$=0.17620, p<0.05).

Table 6-10 Variance Analysis of the Influence of Post on OC in the Private Hospitals Surveyed

		Sum of squares	*df*	Mean square	*F*	*P*	Post hoc test
OC	Inter- groups	30.691	3	10.230	16.439	0.000	②>①,③>① ②>③,
	Intra group	475.254	603	0.622			
	Total	405.945	606				

Note: ①Physician ②Nurse ③Medical Technician ④Management Personnel

Source: the author

According to Table 6-10, there are significant post differences in medical staff's perception towards organizational culture (F=16.439, p<0.01). Through post hoc test, the perception of nurses towards OC is significantly stronger than that of physicians ($MD_{②-①}$=0.51886, p<0.01) and stronger than that of medical technicians ($MD_{③-②}$=0.26590, p<0.05). The perception of medical technicians towards OC is stronger than that of physicians ($MD_{③-①}$=0.25296, p<0.05).

Table 6-11 Variance Analysis of the Influence of Post on OI of Medical Staff

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
OI	Inter- groups	10.178	3	3.393	5.044	0.002	①>②,①>③,①>④
	Intra group	405.611	603	0.673			
	Total	415.789	606				

Note: ①Physician ②Nurse ③Medical Technician ④Management Personnel

Source: the author

According to Table 6-11, there are post differences in medical staff's organizational identification (F=5.044, p<0.05). Through post hoc test, the organizational identification of nurses is significantly stronger than that of physicians ($MD_{②-①}$=0.25684, p<0.01). The organizational identification of medical technicians is also stronger than that of physicians ($MD_{③-①}$=0.24085, p<0.05). The organizational identification of management personnel is stronger than that of physicians ($MD_{④-①}$=0.45845, p<0.05).

Table 6-12 Variance Analysis of the Influence of Post on TI of Medical Staff

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
TI	Inter- groups	17.605	3	5.868	7.581	0.000	②<①
	Intra group	466.791	603	0.774			
	Total	484.396	606				

Note: ①Physician ②Nurse ③Medical Technician ④Management Personnel

Source: the author

According to Table 6-12, there are significant differences concerning the rank in medical staff's turnover intention (F =7.581, p<0.01). Through post hoc test, the turnover intention of nurses is significantly stronger than that of physicians ($MD_{②-①}$=0.39732, p<0.01).

6.2.4 Influence of Professional Title on Variables

Table 6-13 Variance Analysis of the Influence of Professional Titles on CSR of the Private Hospitals Surveyed

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
INCSR	Inter- groups	5.632	4	1.408	2.927	0.020	①<④; ②<④
	Intra group	289.541	602	0.481			
	Total	286.694	606				
EXCSR	Inter- groups	10.146	4	2.536	6.195	0.000	①<④; ②<③
	Intra group	246.463	602	0.409			②<④; ③<④
	Total	256.609	606				

Note: ①Ungraded ②Primary title ③Inter-mediate title ④Vice senior title ⑤Senior title

Source: the author

In Chinese hospitals, doctors have different technical titles according to their experience and technical level, including primary title, intermediate title, vice senior title and senior title. The doctors with higher technical titles usually charge higher medical fees than doctors with lower titles.

According to Table 6-13, there are differences in the perception towards IN CSR (F =2.927, p<0.05) depending on the professional title of the respondents. Through post hoc test, the perception of ungraded respondents towards IN CSR is significantly stronger than that of those with vice senior title ($MD_{①-④}$=0.29795, p<0.01). The perception of respondents with

primary title towards IN CSR is significantly stronger than those with vice senior title (MD②-④=0.23366, p<0.01). Similarly, there are professional title differences in perception towards EX CSR in the private hospitals enquired (F =6.195, p<0.01). Through post hoc test, the perception of ungraded respondents towards EX CSR is significantly stronger than those with vice senior title (MD①-④=0.24806, p<0.05); the perception of respondents with primary title towards EX CSR is stronger than those with inter-mediate title (MD②-③=0.15795, p<0.05) and significantly stronger than those with a vice senior title (MD②-④=0.37430, p<0.01); the perception of respondents with inter-mediate title towards EX CSR are stronger than those with vice senior title (MD③-④=0. 21635, p<0.05).

Table 6-14 Variance Analysis of the Influence of Professional Titles on the OC of the Private Hospitals Surveyed

		Sum of squares	*df*	Mean square	*F*	*P*	Post hoc test
OC	Inter- groups	34.488	4	8.622	13.973	0.000	①>③, ①>④, ①>⑤
	Intra group	371.457	603	0.617			②>③, ②>④, ②>⑤
	Total	405.945	606				③>④

Note: ①Ungraded ②Primary title ③Inter-mediate title ④Vice senior title ⑤Senior title

Source: the author

According to Table 6-14, there are professional title differences in perception towards OC of private hospitals (F =14.005, p<0.01). Through post hoc test, the perception of ungraded respondents is significantly stronger than those with inter-mediate title (MD①-③=0.32164, p<0.01), those with vice senior title (MD①-④=0.67612, p<0.01) and those with senior title (MD①-⑤=0.64176, p<0.01).

The perception of respondents with primary title is significantly stronger than those with inter-mediate title (MD②-③=0.29033, p<0.01), those with vice senior title (MD②-④=0.64481, p<0.01) and those with senior title (MD②-⑤=0.61044, p<0.01); the perception of respondents with inter-mediate title is significantly stronger than those with vice senior title (MD③-④=0.35448, p<0.01).

Table 6-15 Variance Analysis of the Influence of Professional Titles on the OI of Medical Staff

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
OI	Inter- groups	5.966	4	1.491	2.191	0.069	
	Intra group	409.823	602	0.681			
	Total	415.798	606				

Note: ①Ungraded ②Primary title ③Inter-mediate title ④Vice senior title ⑤Senior title

Source: the author

According to Table 6-15, the professional title exerts no influence on organizational identification (F =2.191, p>0.05).

Table 6-16 Variance Analysis of the Influence of Professional Titles on the TI of the Medical Staff

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
TI	Inter- groups	6.195	4	1.549	1.950	0.101	
	Intra group	478.201	602	0.794			
	Total	484.396	606				

Note: ①Ungraded ②Primary title ③Inter-mediate title ④Vice senior title ⑤Senior title

Source: the author

According to Table 6-16, the professional title has no influence on the turnover intention (F =1.950, p>0.05).

6.2.5 Influence of Administrative Position on Variables

Table 6-17 Variance Analysis of the Influence of Administrative Positions on CSR of Medical Staff

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
IN CSR	Inter- groups	2.767	2	1.384	2.858	0.058	
	Intra group	284.236	604	0.471			
	Total	286.694	606				
EX CSR	Inter- groups	3.377	2	1.689	4.028	0.018	①>②
	Intra group	253.231	604	0.419			
	Total	256.609	606				

Note: ①Lower level post ②Head of department ③Hospital leader

Source: the author

According to Table 6-17, the administrative position exerts no difference in perception towards INCSR of private hospitals (F=2.612, p>0.05).However there are administrative position differences in perception towards EX CSR (F =4.046, p<0.05). Through post hoc test, the perception of respondents with lower level posts is significantly stronger than heads of departments ($MD_{①②}$=0.18994, p<0.01).

Table 6-18 Variance Analysis of the Influence of Administrative Positions on OC

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
OC	Inter- groups	12.698	2	6.349	9.751	0.000	①>②
	Intra group	393.248	604	0.651			
	Total	405.945	606				

Note: ①Lower level post ②Head of department ③Hospital leader

Source: the author

According to Table 6-18, there are significant differences in perception towards organizational culture (F =9.506, p<0.01) depending on administrative position. Through post hoc test, the perception of respondents with lower level posts towards OC is significantly stronger than that of heads of departments ($MD_{①②}$=0.37383, p<0.01).

Table 6-19 Variance Analysis of the Influence of the Administrative Positions on OI

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
OI	Inter- groups	0.986	2	0.493	0.718	0.488	
	Intra group	414.803	604	0.687			
	Total	415.789	606				

Note: ①Lower level post ②Head of department ③Hospital leader

Source: the author

According to Table 6-19, the administrative position of respondents does influence organizational identification (F =1.050, p>0.05).

Table 6-20 Variance Analysis of the Influence of Administrative Positions on TI

		Sum of squares	*df*	Mean square	*F*	*p*	Post hoc test
TI	Inter- groups	9.829	2	4.915	6.255	0.002	②>①;①>③;②>③
	Intra group	474.567	604	0.786			
	Total	484.396	606				

Note: ①Lower level post ②Head of department ③Hospital leader

Source: the author

According to Table 6-20, there are significant administrative position differences in turnover intention (F =6.815, p<0.01). Through post hoc test, the turnover intention of heads of departments is significantly stronger than those with lower level posts ($MD_{②①}$=0.22587, p<0.05); the turnover intention of medical staff with lower level posts is stronger than that of hospital leaders ($MD_{①②}$=0.82625, p<0.05); the turnover intention of heads of departments is significantly stronger than that of hospital leaders ($MD_{②③}$=1.05212, p<0.01).

6.3 Chapter Summary

In this chapter, t test and Anova statistical methods were used based on SPSS software to conduct the demographic information cross analysis of respondents. According to the data analysis results shown in the above 20 tables, it can be seen that the demographic factors have varying degrees of influence on the research variables.

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Chapter 7: Discussion, Conclusions and Limitations

7.1 Overview

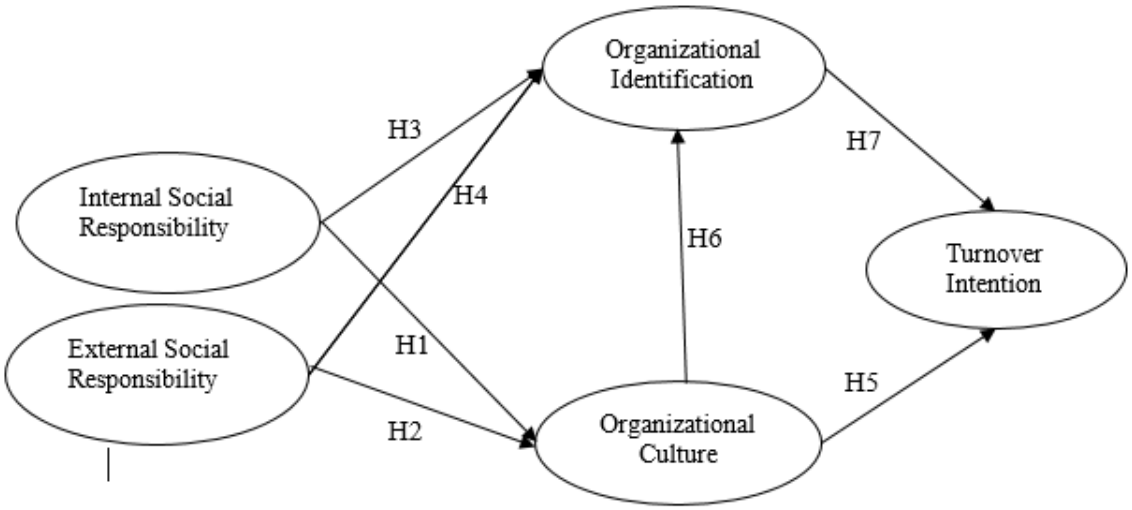
This chapter makes a systematic summarization of the research, including the research conclusions, theoretical contribution, research significance, research limitations and research prospects.

7.2 Research Discussion and Conclusions

Based on the studies on CSR and organizational culture by previous scholars, combining the current situation of Chinese private hospitals and primary data extracted from 607 responses from three private hospitals in Ningbo city, this study put forward the general research hypothesis that CSR has a positive effect on the OC and OI and developed an empirical research to test this hypothesis. Meanwhile, the negative correlation between OI/OC and TI discovered by previous scholars has been tested in the context of the private hospitals surveyed.

Lasting for three years, the study collected 607 valid questionnaires from three large not-for-profit general private hospitals, tested the research model and hypotheses and finally verified that the research model was founded. But among the seven research hypotheses, H3 is slightly inconsistent with the conclusion and H4 is not supported.

Figure 7-1 Research Conclusion Model



Source: the author

The research conclusions are presented below:

First, the social responsibility of private hospitals, including INCSR (for example, shareholders, employees) and EXCSR (for example, patients and their family members, industry regulators) has a significant and positive effect on organizational culture. The conclusions meet the research expectations and fully support H1 (The internal CSR of private hospitals is positively correlated with organizational culture) and H2 (The external CSR of private hospitals is positively correlated with organizational culture).

The social responsibility of hospitals essentially refers to the values of hospital culture. When private hospitals fully and properly fulfill their social responsibility, the value orientation of hospital culture can be strengthened. The common value orientation can enhance the cohesion of hospitals and pull all medical staff together to make concerted efforts towards common goals. Meanwhile, incorporating the social responsibility into the hospital culture can effectively restrict the behaviors of medical staff and promote their self-awareness and motivation to fulfill social responsibility, thus creating a unified and harmonious environment inside hospitals. The CSR-based organization culture can promote the medical staff's active participation, improve individual capability and give play to the guiding role of team. When medical staff meets the needs of patients and society by performing social responsibility, the satisfaction of patients and their family members will be improved and the hospital image will be promoted. Meanwhile, the hospital becomes more adaptable to the change of external and internal environment in business activities.

Second, the internal CSR of private hospitals has positive effect on the organizational identification of medical staff, but the standardized path coefficient that tests the hypothesis is 0.11 and the significance probability is 0.078 (P>0.05), indicating that the positive effect is not significant. This conclusion is basically consistent with research hypothesis H3 (the internal CSR of private hospitals is significantly and positively correlated with organizational identification of medical staff). However, the conclusion that the external CSR of private hospitals is significantly and negatively correlated with organizational identification of medical staff is completely opposite to the research hypothesis H4 (the external CSR of private hospitals is positively correlated with organizational identification of medical staff).

Based on these two conclusions, telephone and personal interviews were conducted with eight persons in the three hospitals surveyed, including one hospital leader, one physician and one nurse in A hospital, one investor and one hospital leader in B hospitaland one hospital leader, one physician and one nurse in C hospital, at the same time, the related references were also reviewed.

Concerning the conclusion corresponding to hypothesis H3, the following questions were discussed: is there any contradiction between the evaluation items of internal social responsibility of private hospitals or any problem in fulfilling social responsibility? Why does the internal CSR of private hospitals have insignificant effect on the organizational identification of medical staff?

After discussion, the reasons specifically for H3 were identified: the main stakeholders of internal CSR of private hospitals are investors and medical staff. Currently, because of unsatisfying economic benefits and unstable investment from investors for years, private hospitals in China have to depend on their own efforts and on the hard work of medical staff to meet basic survival needs. During this process, the interests of medical staff and shareholders are not properly coordinated and meanwhile the responsibility priority and responsibility content for shareholders and medical staff are not clearly defined. This may explain why the internal CSR of private hospitals has not a significant effect on OI.

Concerning the conclusion corresponding to hypothesis H4, the question was discussed: Why does the external CSR of private hospitals reduce the OI of medical staff instead?

After discussion, the following reasons specifically for H4 were identified:

(1) Under the influence of Chinese traditional culture, people-oriented thought is popular in China. For instance, governments adhere to the tenets of serving the people wholeheartedly, and many enterprises take “market supreme and customer first" as their slogan. Most hospitals

in China, including the three surveyed hospitals, herald the principles of 'put patients first', but in fact, when medical staff is required by investors or managers to put patients first and render quality and efficient services, their basic rights are actually sacrificed and workload is increased. Especially when doctor-patient relationship becomes increasingly tense and doctor-patient conflicts frequently occur, the legal rights and interests of medical staff are even compromised. Currently, medical staff is not only the performer of EXCSR but also the object of INCSR, however their rights and obligations are not properly balanced and sometimes even mutually conflicting. When medical staff holds the tenet of patient-oriented unwillingly, their identification with the organization is actually reduced. In this case, the core spirit of 'patient first' is actually not applicable. The reason for this may be that private hospitals fail to attach great importance to the most important stakeholder according to the actual condition when performing social responsibility.

(2) According to the demographic information analysis, the perception of medical staff aged 26-35 towards CSR is stronger than that of those aged 36-45 and above 46. However, the organizational identification of medical staff aged 26-35 is lower than that of those aged 36-45. Currently, the medical staff aged 26-35 accounts for a large proportion of the total employees in surveyed hospitals. Meanwhile, they are also the first generation of only child under the one-child policy. Many studies have shown that the only child of this generation has been spoiled, pampered and over-protected by indulgent parents since childhood, so when they grow up they are often self-centered and lack the ability to effectively communicate and well cooperate with others (Zhang, 2015). When they play a dual role as the performers of EXCSR and the objects of INCSR, they cannot properly find a balance between efforts and reward, which reduces their organizational identification.

(3)When doctor-patient conflictsoccur, whichisfrequentin China, most medical staff feels nervous and suffersfrom asense of lack of safety. Currently, due to the malicious hype by some media, the year-on-yearmountingmedical expenses and the patient's high expectations on doctors, the relationship between doctors and patients has become increasingly tense. As a result, doctors previously honored as *Angels in White* have now become the target of public criticism and people even become jittery at the mention of doctor (Medical Group, 2016). Under these circumstances, the medical staff has to be always in the state of self-protection whenatwork. Meanwhile, having been misunderstood and feeling aggrieved for a long time, they grow dispirited and show resistance when fulfilling the "patient-centered" based external responsibility, which eventually reduces their organizational identification.

Mayo Clinic and Baptist Health Care, as described in Chapter Three, two world's leading Health Care behemoths, define core values as "the needs of the patient come first" and "staff-centered" respectively, signifying that the two hospitals give priority to different stakeholders when fulfilling social responsibility. Interestingly, both hospitals have excellent performance, thus it can be argued that although the two core values do vary from each other, neither is superior to the other. Or as the great Chinese leader Deng Xiaoping put it, "it does not matter whether the cat is black or white, as long as it catches mice". Similarly, it does not matter whether the core value is 'staff-centered' or 'patient first', as long as it is helpful to optimize organizational culture, strengthen organizational identification and promote the organization's development.

Third, the standardized path coefficient (OC->OI) is 0.60, indicating the OC of private hospitals has significant and positive effect on the OI of medical staff. This conclusion is consistent with research hypothesis H5 (the OC of private hospitals is positively correlated with the OI of medical staff). This conclusion has been abundantly studied by foreign and Chinese scholars and proved to be true in different sectors.

Meanwhile, this conclusion indicates that, based on the results of the surveyed hospitals, China's private hospitals may have the same organizational characteristics as other enterprises have, which is reflected in the four dimensions of organizational culture of private hospitals, namely, consistency, involvement, adaptability and mission. The organization identification of medical staff is developed in the organizational culture and the values in organizational culture of private hospitals are the most important element to help foster OI among medical staff. The organizational identification of medical staff depends largely on the alignment of individual and organizational values. The sense of success, belonging and survival of medical staff is developed based on the good hospital culture, harmonious and steady working environment, good hospital reputation and image as well as the hospital's goals that can promote individual development. Therefore, strengthening the cultural management of private hospitals can enhance the organizational identification of medical staff.

Fourth, the standardized path coefficient of (OC->TI) and (OI->TI) is -0.31 and -0.37 respectively, indicating that the OC/OI of private hospitals is significantly and negatively correlated with TI. These two conclusions are consistent with research hypothesis H6 (The OC of private hospitals has negative effect on the TI) and research hypothesis H7 (The OI of private hospitals has negative effect on the TI), which are also consistent with the conclusions previously achieved by many foreign and Chinese scholars.

Besides, this study has explored the antecedent variables of turnover intention of medical staff in private hospitals, including the perception of organizational culture, participation in organizational culture construction and organizational identification. As with other organizations, and verified organizational culture and organizational identity negative correlation with turnover intention. Good organizational culture can create a harmonious organizational climate in favor of good teamwork, coordinate and align the values and goals of organizational members, improve the social credibility and competitiveness of private hospitals, and increase the cohesion of private hospitals and the sense of belonging and accomplishment of medical staff, thus reducing the turnover intention of medical staff. The core values of private hospitals guide its mission and vision. When the medical staff makes concerted efforts to accomplish the hospital's mission and achieve its vision, they will have strong sense of pride. Therefore, good organization culture of private hospitals can reduce the turnover intention of medical staff. The organizational identification of medical staff in private hospitals is reflected in the high alignment of individual and hospital's goals, proper coordination of individual and hospital's interests as well as the sense of survival, belonging and success. When the medical staff has the perception of oneness with and belongingness to the organization, they will feel proud of the organizational membership and be motivated to remain a part of the organization, thus reducing their turnover intention.

7.3 Theoretical Contribution

In this study, the relationship between CSR and OC as well as the functions of CSR has been put forward. Meanwhile, the hypotheses that CSR has a significant and positive effect on OC have been proposed and empirically tested and found to be true. In addition, the antecedent variables of OC, including the core values, mission, vision, have been explored, providing guidance for information collection.

The hypothesized relationship between CSR and OI has been proposed, but the research conclusion is quite the opposite. Although the conclusion shows that the EX-CSR of private hospitals is significantly and negatively correlated with OI, it offers a reference for other scholars and relevant theoretical research in other fields.

The results of this study may provide theoretical foundation for the research on CSR of private hospitals and other organizations.

7.4 Contribution to Practice

From the perspective of CSR functions, the study puts forward and tests empirically seven hypotheses, which may provide decision-making basis for private hospitals as how to perform social responsibility, build good organizational culture, improve organizational identification and reduce the turnover intention, as listed below:

First, the validated seven hypotheses show that properly fulfilling social responsibility can help promote or construct good organizational culture. When heat waves of cultural management have surged in most hospitals, the conclusions offer practical guidance for hospitals as to how to define the core values, mission and vision of organizational culture.

Second, the conclusion that the external CSR of private hospitals has a negative effect on organizational identification may contribute for managers to realize the importance of the responsibility priority of CSR. Currently, when most hospitals uphold the "people first" principle, the investors and managers of private hospitals should contemplate what principles they should follow based on the actual conditions of hospitals: is the service tenet of "patient-oriented" more important or does the "staff-centered" management philosophy really matter?

7.5 Research Limitations

Although the findings in this study may have theoretical and practical significance, the study is still greatly limited as a result of a variety of conditions, which are summarized as below:

First, the stakeholders in CSR research model have not been subdivided into 3rd level, making it impossible to further analyze which stakeholder (shareholders, employees, patients or regulators) contributes most to the negative correlation between EXCSR and OI and the insignificantly positive correlation between INCSR and OI.

Second, although the dimensions of OC have been subdivided and the internal factor analysis has been conducted, the relationships among factors are not analyzed, which makes it difficult to identify which dimension of OC is mostly affected by CSR.

7.6 Future Research Prospects

Based on the research conclusions and limitations, future studies may be further conducted in the following several directions:

First, based on the research model in this study, subdivide the dimensions of CSR and OC of private hospitals into the second-level, deeply study the relationships between CSR and OC/OI, and discover the relationships among all second-level dimensions, making the research results more meaningful to actual work.

Second, thoroughly study the CSR of private hospitals, including responsibility content, responsibility objects, and responsibility priorities and make a solid theoretical and empirical research on how to effectively optimize and construct a good organizational culture in private hospitals in China.

Third, fully explore the reasons for the negative correlation between EX-CSR and OC, and lay effective theoretical foundation for the management of private hospitals.

Fourth, based on the validated theoretical model in this study (Figure 7-1), making cross-region and wide coverage comparative research to achieve more universally valid research conclusions.

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Appendix Ⅰ

The outline of interviews

1. How long have you been working in the private hospital?
2. Do you know the concept of CSR?
3. Do you agree that the management of private hospitals which applied CSR have positive effects?
4. Currently, the turnover intention of personnel in hospitals is relatively high, do you think it will be improved if hospitals introduced the management concept of CSR?
5. Do you think the CSR of private hospitals is different from the CSR of public hospitals?
6. Could you please choose several dimensions that closely related to the turnover intention of personnel in the table below?

Three-level Index Evaluation System of Stakeholder-based Public Hospital Social Responsibility (final version)

Ⅰ-1 Core stakeholders	Ⅱ-1 Investors of public hospitals	Ⅲ-1 Debt to assets ratio Ⅲ-2 Net asset growth rate Ⅲ-3 Business expense /business income per one hundred yuan Ⅲ-4 Average length of stay and occupancy rate of beds Ⅲ-5 Annual outpatient visits, number of surgical operations, and number of admission and discharge Ⅲ-6 The ratio of drugs and expensive consumables to total revenue Ⅲ-7 Satisfaction of society and patients Ⅲ-8 Medical quality and safety system and its implementation Ⅲ-9 Performance evaluation and comprehensive objectives management system
	Ⅱ-2Senior managers	Ⅲ-10 Reasonable hospital governance structure Ⅲ-11 Standard bonus-penalty and promotion system Ⅲ-12 Clear and reasonable salary Ⅲ-13 Steady capital investment Ⅲ-14 Reasonable policy and implementation efficiency
	Ⅱ-3Physicians	Ⅲ-15 Reasonable and contribution-matching salary Ⅲ-16 Opportunities of getting involved in decision-making Ⅲ-17 Safe working environment and working hours Ⅲ-18 Perfect social security and welfare system Ⅲ-19 Continuing education and encouraging scientific research innovation system Ⅲ-20 Reasonable bonus-penalty and promotion system
	Ⅱ-4 Patients and their family members	Ⅲ-21 Reliable medical services Ⅲ-22 Complaints and dispute settlement procedures Ⅲ-23 Per capital outpatient and hospitalization expenses

		Ⅲ-24 Patients' interests and rights, e.g. protection of rights to know Ⅲ-25 Price transparency, eliminate supplier-induced demand Ⅲ-26 Expenses reduction and exemption policy for poor patients
Ⅰ-2 Expectant stakeholders	Ⅱ-5 Department of Health Investigation	Ⅲ-27 Comply with laws and regulations; operate by law Ⅲ-28 Provides public health services Ⅲ-29 Emergency management and medical relief for emergency events Ⅲ-30 Support agriculture and train basic level medical staff Ⅲ-31 Medical ethics construction and implement performance evaluation system
	Ⅱ-6 Third party payer	Ⅲ-32 Strictly review the medical requirements of insured patients by rules
	Ⅱ-7 Ordinary employees	Ⅲ-33 Reasonable manning quotas and position settings Ⅲ-34 Reasonable salary and timely allowance payment Ⅲ-35 Perfect social security and welfare system Ⅲ-36 Good working environment Ⅲ-37 Continuing education and training opportunities Ⅲ-38 Standard bonus-penalty and promotion system Ⅲ-39 Fair employment Ⅲ-40 Put in place assistance system for workers in difficult situation
	Ⅱ-9 Drugs and medical equipment suppliers	Ⅲ-44 Fulfill contract and pay fees in time Ⅲ-45 Fair, open procurement and bidding system
	Ⅱ-10 Creditors	Ⅲ-46 Fulfill contract; repay and pay interests in time Ⅲ-47 Information transparency and Good faith cooperation
Latent stakeholders	Interested social groups	Ⅲ-48 Support professional association work and maintain professional image Ⅲ-49 Be kind to media and information disclosure Ⅲ-50 Mutually beneficial cooperation and fair competition

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Appendix Ⅱ

Questionnaire about Private Hospitals

Dear Mr/Mrs,

Would you like to spare a few minutes to fill out this questionnaire carefully and authentically! We will inform you that your answers will be kept strictly confidential and used only for academic research. Thank you very much for your support and cooperation!

1. Personal information

(1) Gender: A. Male B. Female

(2) Age: A. Under 25 B. 26- 35 C. 36-45 D. Above 46

(4) Highest education: A. Junior college and below B. Bachelor C. Master D. Doctor

(5) Post: A. Doctor B. Nurse C.Medical Technician D.Managerial Personnel

(6) Professional title: A. Ungraded B. Primary title C. Intermediate title
D. Vice senior title E. Senior title

(7) Administrative post: A. lower-level post B. Head of department C. Hospital leader

2. Items for Evaluation

Could you please score the following items using the scale of 1 to 7 to express your approval degree, with "1" representing "Strongly disagree", and"5" representing "Strongly agree"? (Note: Unless otherwise specified, the hospital mentioned in the below table refers to that you are working for.)

Dimensions		Items	Strongly disagree	Partially disagree	Neither agree nor disagree	Partially agree	Strongly agree
			1	2	3	4	5
Internal Responsibility	Responsibility	1. My hospital enjoys sound economic benefits and maintains good development speed.					
		2. My hospital has good social benefits and high level of patient satisfaction.					
		3. My hospital is well-structured with a high level of work autonomy.					
		4. My hospital has reasonable post setting and manning quotas and legal working time.					
		5. Employees in my hospital enjoy a safe working environment with safety protection for special posts.					
Internal Responsibility	Responsibility	6. My hospital pays all kinds of social insurances for all employees.					
		7. My hospital gives full support to further education and development of employees.					
		8. All employees in my hospital have opportunities to take part in the decision-making of issues concerning hospital management and development.					
		9. My hospital uses medicine rationally and treats patients in an appropriate manner, and the average medical expenses are not more than other local hospitals in the same level.					
		10. There are few medical disputes in my hospital due to its convenient and quality medical services.					

Dimensions		Items	Strongly disagree	Partially disagree	Neither agree nor disagree	Partially agree	Strongly agree
			1	2	3	4	5
Corporate Social Responsibility	External Responsibility	11. There are transparent, fair complaints and dispute settlement procedures in my hospital.					
		12. My hospital has favorable policies for poor and special patients.					
		13. My hospital complies with laws and regulations and operates by law.					
		14. My hospital places great importance to medical ethics and moral education of medical staff, and has perfect education program and evaluation system.					
		15. My hospital proactively undertakes public health work such as prevention and control of infectious diseases and epidemic diseases.					
		16. My hospital strictly complies with medical insurance policies and has never been punished by the medical insurance sector.					
		17. Any patient whose full or partial medical expenses are covered by the third party has been treated in the most appropriate manner.					
		18. My hospital strictly implements the environmental management system such as energy saving and sewage treatment.					
		19. My hospital always organizes free medical consultation and treatment and carries out community disease prevention and health education.					
		20. My hospital actively participates in the learning activities organized by professional associations.					

Dimensions	Items	Strongly disagree	Partially disagree	Neither agree nor disagree	Partially agree	Strongly agree
		1	2	3	4	5
Organizational Culture	21.Most employees in the hospital have sense of ownership and are enthusiastic about their work.					
	22.My hospital strongly advocates achieving common goals through concerted efforts and teamwork.					
	23. My hospital encourages cooperation across departments and tries to get everyone involved in the business plan.					
	24. My hospital gives full support to employees' education and training to satisfy their needs for further study and development, making them more competitive.					
	25.My hospital's employees have common values, strong sense of identification and clear expectations for the future.					
	26. My hospital's leaders are competent enough to help employees to reach broad consensus and reconcile different views in key issues					
	27. The division between departments or medical teams in my hospital is not a barrier for them to closely cooperate.					
	28.The management departments and medical departments in my hospital cooperate closely.					
	29. My hospital is proactive in understanding and trying to meet the needs of patients.					
	30.The needs and advices of patients promote the reform in my hospital and directly affect the decisions of senior managers.					

Dimensions	Items	Strongly disagree	Partially disagree	Neither agree nor disagree	Partially agree	Strongly agree
		1	2	3	4	5
Organizational Culture	31. My hospital can deal very well with its competitors and other changes in business environment.					
	32. My hospital has clear mission, which provides guideline for our work.					
	33. My hospital has clear strategic objectives and all employees are working hard to make them real.					
	34. My hospital has clear vision, which keeps employees in high spirits and self-motivated.					
	35.My hospital has clear stage objectives to achieve and we closely follow the progress.					
	36.My hospital's objectives are ambitious and practical.					
Organizational Recognition	37. I always tell others that I am working for a good hospital.					
	38. Staff's individual interest and that of the hospital are easily coordinated.					
	39. Staff's individual objectives and those of the hospital objectives are easily coordinated.					
	40.We are still willing to work in this hospital, although we don't earn much.					
	41. As the hospital's staff, I do not need to worry about my future.					
	42. I can feel the hospital's care for me.					

Dimensions	Items	Strongly disagree	Partially disagree	Neither agree nor disagree	Partially agree	Strongly agree
		1	2	3	4	5
Turnover intention	43. I have never intended to quit my present job.					
	44. I'm sure I won't quit my job to work in other hospitals within 2 years.					
	45. If I continue to work in this hospital, the career prospect will be very good.					
	46. I never notice other recruitment information.					