CORPORATE SOCIAL RESPONSIBILITY: AN ALTERNATIVE MECHANISM FOR SUPPORTING PUBLIC HEALTHCARE IN DEVELOPING COUNTRIES

Zacharia Elias Lema ✉

PhD Student, Universiti Tunku Abdul Rahman, Faculty of Business and Finance, Malaysia

zacharia_elias@yahoo.com

Chong Yee Lee

Universiti Tunku Abdul Rahman, Faculty of Business and Finance, Malaysia

chongyl@utar.edu.my

Ng. Lee Peng

Universiti Tunku Abdul Rahman, Faculty of Business and Finance, Malaysia

nglp@utar.edu.my

Abstract

This article employs structural equation modelling to examine the effect of perceived stakeholders' expectations on companies' implementation of Corporate Social Responsibility (CSR) practices in supporting public healthcare system in Tanzania. Stakeholder theory is used to develop a conceptual model that allows empirical analysis of the relationship between perceived stakeholders' influence and companies' CSR practices. A sample of 437 private companies obtained through a stratified random sampling technique is used for statistical analysis. Findings show that perceived stakeholders' health and safety expectations can potentially influence company decision towards CSR practices in healthcare. The study contributes to the knowledge by testing empirically the potential influence that stakeholders may have on companies' CSR interventions. The results of this study provide useful insights to public policy makers and practitioners on how to promote stakeholder collaboration in order to attain strategic healthcare objectives.

Keywords: CSR, Stakeholders, Stakeholders' expectations, Public healthcare

INTRODUCTION

CSR is increasingly becoming important concept used by businesses to address social and economic challenges facing the society such as prevalence of chronic diseases (including HIV/AIDS, Malaria and Tuberculosis); rising medical costs; workforce shortages, infrastructure constraints and disruptive technologies (Mwamwaja, 2015; Thulkanam, 2014; WHO, 2016). CSR is also used as a remedy of the impact generated by companies' activities on their stakeholders such customers, employees, communities, government and the environment (Kasipillai & Rachagan, 2002).

Policy makers, practitioners and academics have long been debating on potential role of CSR in addressing various social and economic challenges. The debate has been extended to include stakeholders who are said to have an important role to play in arguing for and supporting companies to engage in effective and sustainable CSR practices (Freeman & Velamuri, 2006; Thulkanam, 2014). There is sufficient evidence in the literature on the positive relationship between CSR practices and stakeholders involvement in such practices particularly in areas such as environment (Ni, Wang, Flor, & Peñaflor, 2015; Waris & Muhammad, 2013), education (Rattanaphan, 2012; Waite & Mosha, 2006), financial support (Mwamwaja, 2015; Ngowi, 2015), and water and sanitation (GIZ, 2014). However, little attention has been given to examine the role of CSR practices and stakeholders engagement in healthcare, especially in Tanzania. Perhaps this is because healthcare has traditionally been provided mainly by the government and supported by public funds (Stott, Lema, Shaba, & Weir, 2011).

As the government alone can no longer meet the increasing demand for healthcare due to population growth and limited financial and human resources, private sector support is encouraged to complement government efforts in addressing the aforementioned healthcare challenges (White et al., 2013; WHO, 2016). In view of this, a multi-stakeholder collaboration is necessary in order to identify the required interventions, mitigate the associated risks and for developing a common strategy (Allen, Burkholder, & Gillenwater, 2013). However, various stakeholders may have different expectations on the role of private sector in supporting public healthcare therefore it is worthwhile to examine the extent to which stakeholders' expectations could motivate companies to engage in health related CSR practices.

This article provides empirical insights on potential influence of stakeholders' health and safety expectations on companies' management decisions towards CSR practices in healthcare. The paper attempts to answer the following research questions: (1) to what extent are private companies concerned about their stakeholders' health and safety? (2) What is the effect of stakeholders' health and safety expectations on companies' decisions to implement CSR practices in healthcare?

CSR PRACTICES AND STAKEHOLDER RELATIONSHIP

CSR and stakeholder involvement are two concepts that have recently gained attention in business management following the uprising public pressure on business participation in addressing social-economic challenges (Harley, Metcalf, & Irwin, 2014; Mwamwaja, 2015; Thulkanam, 2014; Waddock & Graves, 1997; Williams, 2012). Although the term CSR has been defined in various ways to suit different research contexts, it is generally understood as any business activity beyond the interest of the company, that aims at contributing to sustainable social economic development of its stakeholders (Agudo-Valiente, Garcés-Ayerbe, & Salvador-Figueras, 2015; Allen et al., 2013; Pedersen, 2006). Companies therefore tend to use CSR as a business arm to respond to their stakeholders' interests and demands (Burchel & Cook, 2006).

Freeman & Velamuri (2006) asserted that, in the framework of stakeholder theory, CSR initiatives provide beneficial consequences for organizations by fulfilling their respective stakeholders' interests. The term stakeholder is used to refer to "any group or individual who is affected by or can affect the achievement of an organization's objectives" (Freeman & Velamuri, 2006 p.12). Stakeholders could be: customers, employees, communities, suppliers, shareholders, governments, NGOs, trade associations, academia, media etc (Agle et al., 2008; Donaldson & Preston, 1995).

According to Donaldson and Preston (1995), the interests of all stakeholders in a company have an intrinsic value and should not be underestimated when making corporate decisions. Scholars have also argued that if stakeholders are not involved in company decision making, they might not be able to express their concerns or share opinions on the role that businesses could play in addressing social-economic challenges such as health and social wellbeing (O'Riordan & Fairbrass, 2008; Thulkanam, 2014). A company may also misunderstand stakeholders' interests and demands. As a result, a company's CSR programme may be difficult to sustain due to misunderstandings between the management and other stakeholders (Holmqvist, 2009; Jackson, 2012; & Schwarzkopf, 2006).

Prior research has shown that, strengthening firm-stakeholder relations could help to address the legitimacy challenges faced by corporations and social-economic challenges faced by the society. For example, Lahtinen, (2014); Waris and Muhammad (2013); Deetz (2007) and Elkington (1997) argued that good relationship with stakeholders could increase company operational efficiency, employee morale, creativity, productive efficiency and service customization that might lead to business innovation and thereby create competitive advantage. Jörg, Andriof and Waddock (2002) and Campbell (2007) also observed that, by involving stakeholders in CSR practices, companies would be closer to their stakeholders and would support their social-economic needs while ensuring sustainability of their operations.

To contribute to the ongoing debate, this study builds on Donaldson and Preston's (1995) normative dimension of stakeholder model to empirically examine the influence that stakeholders' health and safety expectations may have on motivating private companies in Tanzania to address the country's healthcare issues through CSR practices. In other words, companies' perceptions about their stakeholders' expectations on health and safety issues are examined. Six stakeholder groups: customers, employees, community, government, trade associations and NGOs are selected for statistical analysis based on their activeness and influence on companies' CSR activities in Tanzania (GIZ, 2014; Mader, 2012; MoHSW, 2008).

Clarkson's (1995) categorization of stakeholders is used to group stakeholders in two categories: primary and secondary stakeholders. According to Clarkson (1995), primary stakeholders include "those without whose continuing participation the corporation cannot survive", whereas secondary stakeholders are "those who influence or affect, or are influenced or affected by, the corporation but are not essential for its survival" (Clarkson, 1995: p.106-107). In this study primary stakeholders include: customers, employees and communities while secondary stakeholders include: government, trade associations and NGOs. Figure 1 presents this study's conceptual model. The model depicts the potential influence of primary and secondary stakeholders on companies' CSR practices in healthcare.

Figure 1: Stakeholders' influence on company CSR practices in healthcare
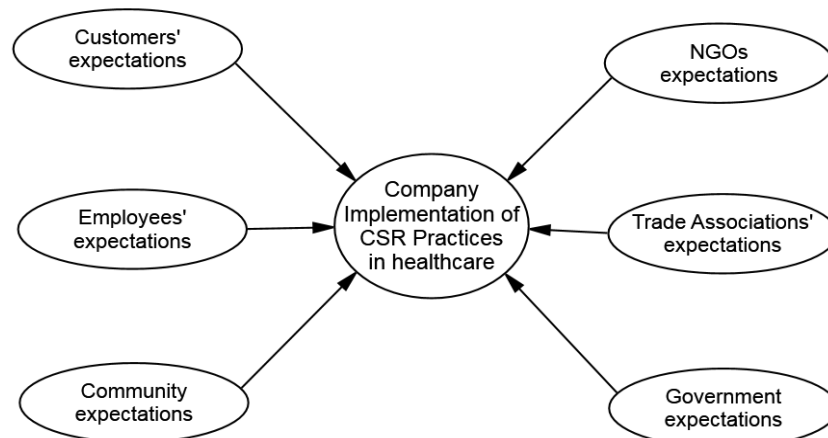
HYPOTHESIS DEVELOPMENT

The Role of Primary Stakeholders (Customers, Employees and Community) in Companies' CSR Practices

According to Clarkson (1995) primary stakeholders plays an important role for firm survival. For example, Pedersen (2004) argued that, in exchange of the price paid for the firm's goods and services, customers expect to be provided with high quality products that meets health and

safety standards. William, Parida and Patel (2013) asserted that customers can potentially affect social and financial performance of business firms if their concerns are left unattended. Along with previous studies, the following is hypothesized:

H1: Perceived customers' expectations on health and safety will positively affect company decision on CSR practices in healthcare

Employees are the interface between the firm and other stakeholders. Developing CSR practices that helps to improve employees' health and safety will result into low turnover and absenteeism and thereby improve productivity and employee morale and commitment (Alfermann, 2011; Esmaeelinezhad, 2015). Andriof and Waddock (2002) and Broomhill (2007) also argued that, companies with proper welfare policy are both financially and socially successful. With the view that employee wellbeing is vital to the company performance, this paper hypothesizes that:

H2: Perceived employees' health and safety expectations will positively affect company implementation of CSR practices in healthcare

The relationship between corporations and their surrounding communities is of paramount importance in developing effective CSR programmes (Berman, Wicks, Kotha, & Jones, 1999; Jamali, 2008). Freeman (1984) suggested that this stakeholder group can take different forms i.e. employees, customers, and suppliers hence a well maintained interaction among business firms and local communities is beneficial to both the corporations and the community itself. Various studies have argued that if CSR interventions are properly designed and managed, they could have significant contributions to their surroundings and thereby strengthen the relationship between firms and social communities (Cameron, 2010; Freeman & Velamuri, 2006; Ngowi, 2015). Studies by (Jamali, 2008; Mumbo, Korir, Kaseje, Ochieng, & Odera, 2012; Nishinaga, Lane, & Pluess, 2013) have also shown that community involvement in company CSR interventions had significant impacts in strengthening healthcare systems in Syria and Lebanon, Kenya, Netherlands and USA respectively. It can therefore be predicted that:

H3: Concerns over community health and safety will have positive and significant effects on companies' CSR practices in healthcare.

The Role of Secondary Stakeholders (Government, Trade Associations and NGOs) in Companies' CSR practices

Prior research has shown that secondary stakeholders (including government, non-government organizations and trade associations) could have some level of impact on the implementation of

CSR practices in healthcare (Bharti, 2013; Bhattacharya, Korschun, & Sen, 2009; Ngowi, 2015; Nishinaga et al., 2013). For example, through public policies and strategies, governments possess power (ability to influence corporate practices), legitimacy (as a regulator) and urgency (ability to seek for immediate attention). With these attributes, the government can affect the institutional framework that governs both public and private sector CSR interventions (Frynas & Stephens, 2014). The government could also establish regulations such as environmental protection laws, labour laws and occupational health and safety procedures to protect the welfare of the society ensure sustainable and effective CSR practices of companies in a particular sector or industry (Mwamwaja, 2015; Rweyemamu & Mwasongela, 2015; Tschopp, Wells, & Barney, 2012).

Similarly, NGOs and trade associations have an important role to play in promoting socially responsible business practices in healthcare. By virtue of their traditional mandate as "watchdog groups" (Waddock & Graves, 1997), this stakeholder group provides a strong support in terms of revealing the good and bad news regarding business operations, and can therefore influence other stakeholder groups such as government and community to take action against misbehaving firms (Doh & Guay, 2006). Through pressure imposed by NGOs and trade associations, companies will most likely engage in CSR activities that will have some positive effects on public healthcare support (Rhys, 2005). It is therefore important to examine whether private companies are concerned over these stakeholder groups, and if such concerns will have any effects on companies' CSR practices particularly in healthcare. The following hypotheses are predicted:

H4: Government expectations will positively influence companies to engage in public healthcare support through CSR

H5: There is positive significant relationship between NGOs' expectations and companies CSR practices in healthcare

H6: Perceived trade associations' expectations will positively affect company CSR practices in healthcare.

METHODOLOGY

The targeted respondents of this study were top business executives: CEOs, managers and companies' spokes persons of private companies in Tanzania obtained from the Tanzanian Business Directory (ZoomTanzania, 2016). A two step approach was used: pre-test and pilot survey procedures were first carried out to enhance the validity and reliability of the

measurement items and study constructs. Exploratory factor analysis was employed on 127 pilot respondents to assess the unidimensionality of the theoretical constructs and for determining factor structure in the study constructs (Suhr, 2006; Williams, Brown, & Onsman, 2012). EFA resulted in suitable measurement items (Table 1) that were used for main survey.

The main survey involved a representative sample of 441 companies obtained through stratified random sampling technique. Proportionate sample was computed from the population of companies in sectors that had high contribution to the country's GDP: agriculture (29%), construction (13.6%), trade (10.7%), manufacturing (5.2%), transport and storage (4.3.%), mining and quarrying (4%), finance and insurance (3.6%), and information and communication (NBS, 2016). After data filtering the remaining 437 responses were analyzed by using structural equation modelling approach with the help of AMOS version 21.

A common method bias test was carried out using Harman's one factor model to ensure this study's model does not suffer from issue of measurement error (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). Principal axis factoring method was used, the number of factors was then fixed to 1 (Arif, Afshan, & Sharif, 2016). The result indicated that the total number of variance explained was below 50% (i.e. 36.19%). Hence data for this study is free of common method bias.

The measurement items for this study were compiled from previous similar studies (Duarte, 2011; Iatridis, 2011; Kim, 2009; Rais & Goedegebuure, 2009; Sweeney, 2009). CSR is measured by statements reflecting company interventions in improving social and economic wellbeing of its stakeholders e.g. customers, employees, communities and the government. The questionnaire was designed and structured to obtain relevant information about the company including: ownership structure, firm size, sectoral affiliation, company involvement in CSR practices, relevance of stakeholders in CSR practices, and the respondents' background information for statistical purposes. Each item in the questionnaire was measured using a five points Likert Scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree).

Table 1: Exploratory Factor Analysis Pattern Matrix

	Factors						
	NGO	TRA	CUST	GOV	EMP	CSR	COM
NGO5	.938						
NGO6	.902						
NGO4	.849						
NGO3	.828						
NGO1	.806						
NGO2	.730						

TRA2	.892				
TRA3	.822				
TRA1	.787				
TRA4	.724				
CUST4		.885			
CUST3		.860			
CUST2		.775			
CUST1		.722			
GOV1			.843		
GOV2			.840		
GOV3			.739		
GOV4			.719		
EMP4				.816	
EMP1				.757	
EMP2				.681	
EMP3				.613	
CSR2					.804
CSR3					.752
CSR1					.698
CSR6					.632
CSR4					.539
CSR5					.682
COM1					.931
COM2					.844
COM3					.510

Note: NGO = expectations of non-governmental organizations; TRA = expectations of Trade Associations; CUST = Customers' expectations; GOV = Government expectations; EMP = Employees' expectations; COM = Community expectations; CSR = Corporate Social Responsibility Implementation

RESULTS AND DISCUSSION

Assessment of the Measurement Model

A hypothetical measurement model was examined through a Confirmatory Factor Analysis (CFA) to validate the theoretical relationship between study constructs and its respective indicators.

To attain the final measurement model in Figure 2, three iterations were performed in AMOS. Four measurement items (CSR4, CSR5; COM3 and EMP3) were omitted due to low factor loadings that would inflict the validity and reliability of the model (Awang, 2015). Three types of validity indexes were assessed: construct validity, convergent validity, and discriminant validity. As shown in Figure 2, construct validity is achieved since the factor loadings for all measurement items are above 0.6 (Hair, Black, Babin, & Anderson, 2010).

Figure 2: CFA Measurement Model
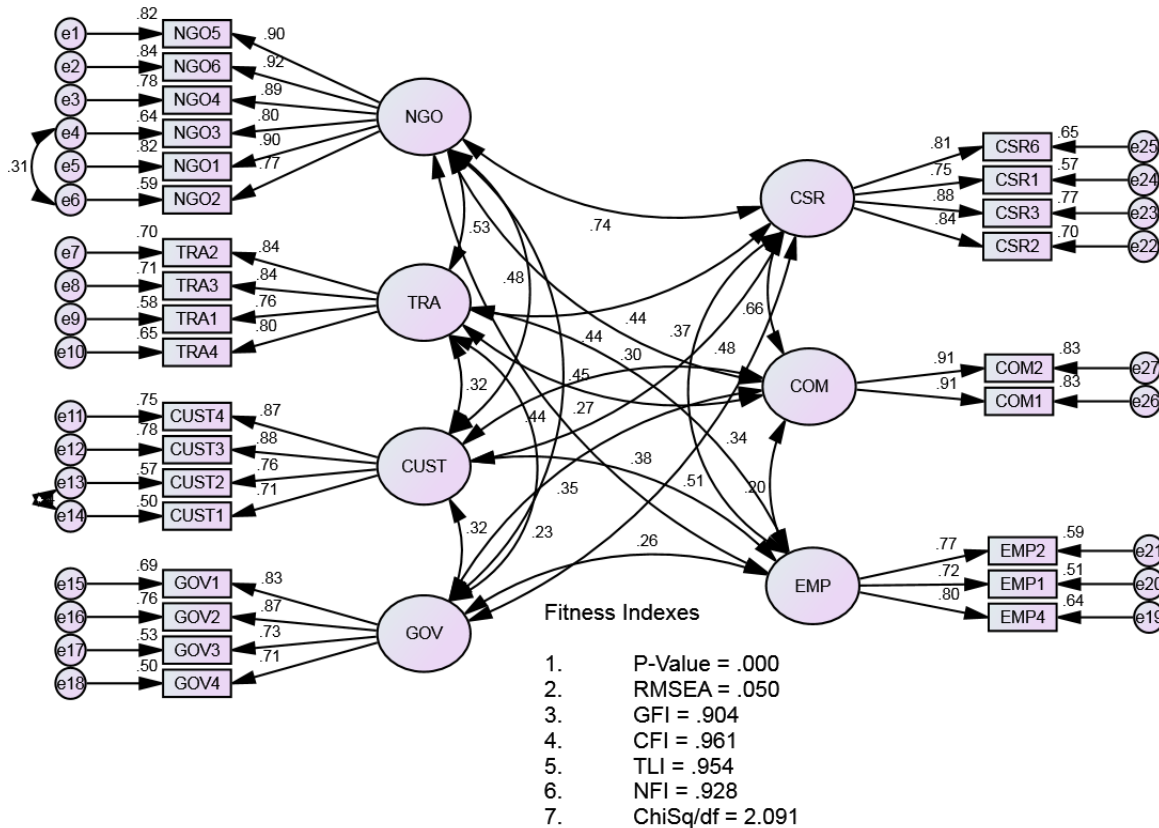
Convergent and discriminant validity as well as reliability were assessed by examining factor correlation matrix in Table 1. The average variance extracted (AVE) for all the variables were above the required threshold of 0.50, and the off diagonal values (the square root of AVE) are higher than their corresponding factor correlation values, hence it can be said that convergent validity and discriminant validity are achieved (Gasking, 2016; Hair et al., 2010). The Composite reliability (CR) was also assessed to see if the data is reliable. Results show that CR ranged between 0.807 and 0.955 above the accepted threshold of 0.7, hence data for this study is reliable (Hair et al., 2010).
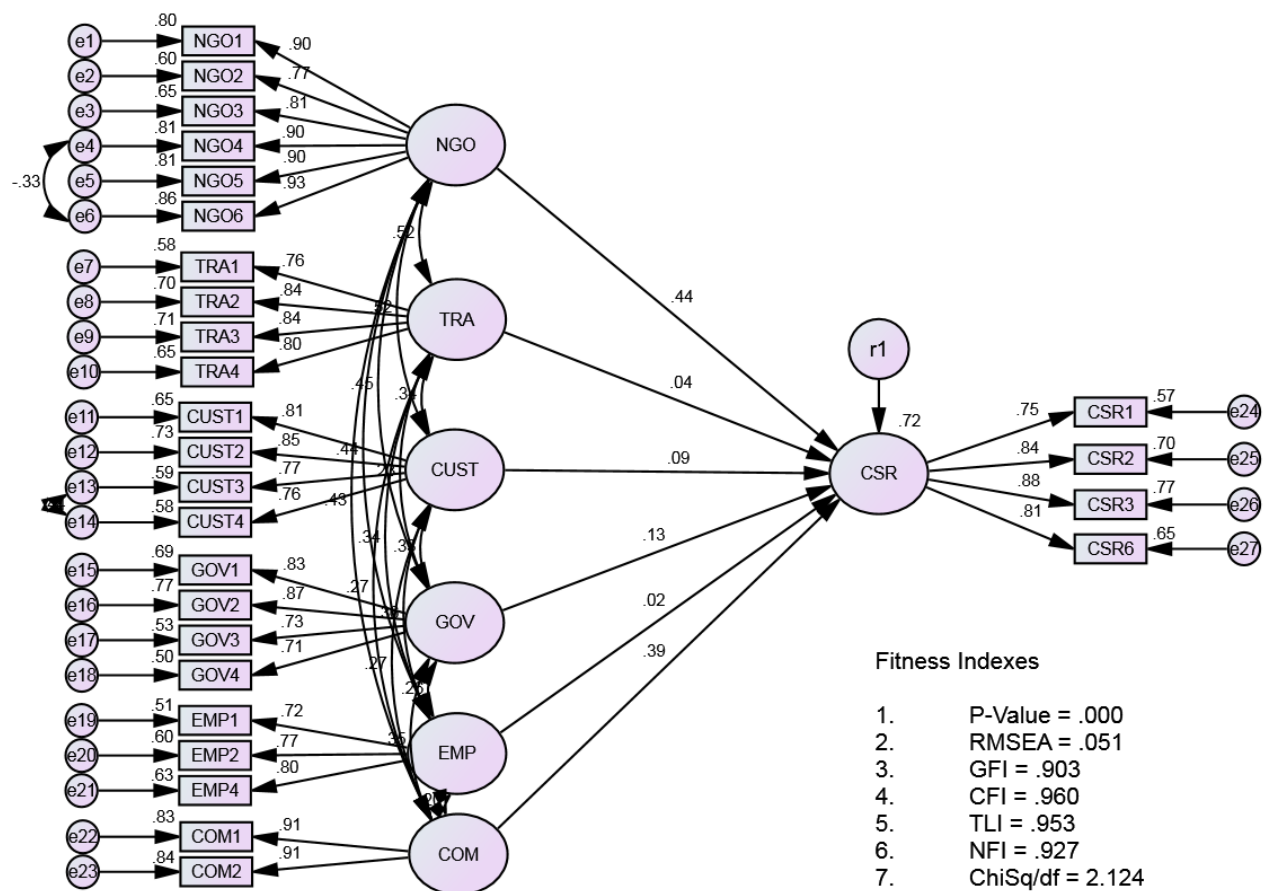
Table 2: Factor Correlation Matrix

	CR	AVE	TRA	NGO	CSR	EMP	COM	CUST	GOV
TRA	0.885	0.659	**0.812**						
NGO	0.947	0.748	0.527	**0.865**					
CSR	0.891	0.672	0.442	0.745	**0.820**				
EMP	0.807	0.582	0.335	0.437	0.372	**0.763**			
COM	0.909	0.833	0.269	0.436	0.663	0.198	**0.913**		
CUST	0.881	0.650	0.322	0.476	0.478	0.379	0.302	**0.806**	
GOV	0.867	0.622	0.234	0.449	0.506	0.264	0.348	0.316	**0.789**

The model fitting process involved determining the goodness-of fit between the hypothesized model and the sample data. As shown in Figure 1, three types of goodness of fit indexes were evaluated. Absolute fitness: goodness-of-fit (GFI=.904); parsimonious fitness: Chi-square index (Cmin/df=2.091) and Root Mean Square Error of Approximation (RMSEA=.050 at PCLOSE=.489); and incremental fitness: confirmatory fitness index (CFI=.961), Normed fit index (NFI=.928), and Tucker-Lewis coefficient (TLI=.954). The results suggest that the hypothesized structure is consistent with the observed sample data.

Assessment of the Structural Model

Structural model in Figure 3 was examined to test the hypotheses developed in this research. Statistical analysis shows that, independent variables of this study (the influence of stakeholders' expectations) explain up to 72% of the variance in the dependent variable (companies' decision to engage in health related CSR practices). The structural model fits the data well since all of the goodness of fit indexes exceeds the recommended thresholds.

Figure 3: Structural Model Results

Fitness Indexes

1. P-Value = .000
2. RMSEA = .051
3. GFI = .903
4. CFI = .960
5. TLI = .953
6. NFI = .927
7. ChiSq/df = 2.124

Hypothesis Testing Results

Table 3 summarizes the hypothesis testing results. It can be observed that, except H1b for employees and H2e for trade associations, the rest of the other hypotheses are supported as evidenced by positive and significant influence of the following stakeholders' health and safety expectations: customers, community, government and NGOs on companies' implementation of CSR practices in healthcare.

Table 3: Hypothesis Testing Results

			Estimate	S.E.	C.R.	P	Result	Remarks
CSR	<---	CUST	0.089	0.016	2.137	**	Significant	H1 Supported
CSR	<---	EMP	0.023	0.035	0.558	0.577	Non-significant	H2 Not Supported
CSR	<---	COM	0.387	0.032	9.464	***	Significant	H3 Supported
CSR	<---	GOV	0.128	0.025	3.251	***	Significant	H4 Supported
CSR	<---	NGO	0.441	0.045	8.665	***	Significant	H5 Supported
CSR	<---	TRA	0.042	0.027	1.038	0.299	Non-significant	H6 Not Supported

Note: *** $p<0.001$; ** $p<0.05$

Primary Stakeholders and CSR Practices in Healthcare

As noted earlier on, primary stakeholders play a crucial role in supporting the existence of a company. Findings show that customers ($\beta=0.089$, $p=0.033$) and communities ($\beta=0.387$, $p=0.000$) have significant influence on companies' CSR practices. Consistent with the arguments of Duke and Kankpang (2013); Ngowi (2015) and Nishinaga et al. (2013), engaging with stakeholders such as customers and communities and taking into account their concerns, makes them feel they are part of the company and that their participation is mutual beneficial. The significant result in this study therefore suggests that companies in Tanzania feel responsible to these stakeholder groups. As Clarkson (1995) and Mitchell, Agle and Wood (1997) argued, primary stakeholders have the power and urgency to influence company decisions. Thus, customers and communities are potential stakeholder groups that could encourage companies to implement more CSR interventions in healthcare. Aspects such as: philanthropic contributions to improve community health facilities; supporting insurance schemes for the poor populations, and supporting public healthcare campaigns could be integrated in companies' CSR interventions.

On the other hand, statistical analysis showed that perceived employees' health and safety concerns have no significant effect on companies' implementation of CSR practices ($\beta=0.023$, $p=0.577$). While this is inconsistent with the findings of many researchers (Anene & Anene, 2013; Duarte, 2011; Esmaeelinezhad, 2015), the non-significant result could be due to

embeddedness of employee wellbeing indicators (e.g. occupational health and safety, compliance to labour standards, and equal and fair treatment) in the Tanzanian employment policies (MOL, 2004). These regulations require every organization in the country to abide to. It is therefore most likely that respondents of this study might have considered employee health and safety indicators as a legal requirement rather than a CSR practice. Thus, it is not surprising that there is no significant relationship between this stakeholder group and the implementation of CSR practices.

Secondary Stakeholders and CSR Practices in Healthcare

Government ($β=0.128$, $p=0.001$) and Non-government organizations ($β=0.441$, $p=0.001$) are found to have significant influence on companies' decisions to engage in health related CSR practices. Indeed, government policies and strategies may affect the institutional framework in which companies operate. Steurer (2009) argued that government involvement in CSR practices tend to encourage more private sector support in public policy. For example, through institutional frameworks such as (occupational health and safety (OHS) guidelines and labour laws that are meant to reduce the discriminant issues related to workers' health-status) could play an important role in guiding CSR interventions in healthcare (Zwetsloot & Mari-Ripa, 2012). Kasipillai and Rachagan (2002) and IOB (2013) asserted that through government policies that were geared towards CSR (for endorsing partnerships, facilitating and mandating) more CSR interventions were implemented in Singapore, Malaysia, Canada, Australia, and in the Netherlands respectively.

Similarly, the power possessed by NGOs and their legitimate interests in promoting responsible business practices, could influence companies to implement CSR programmes that will have positive effect on the country's healthcare system. For example it was noted that through collaboration with NGOs and civil society organizations (CSOs), over 2000 women that suffered from obstetric fistula after childbirth received treatment (Vodacom Tanzania, 2016). GIZ (2016) also reported that under special agreement between companies, NGOs, CSOs and the government, more than 30,000 rural farmers and their families in Tanzania have been enrolled in community health funds to protect them from financial devastation should they become ill. These results suggest that the influence of secondary stakeholders plays an important role in encouraging private sector support in healthcare. Through consultation with the government, NGOs and CSOs, strategic CSR interventions could be developed to help achieve the country's healthcare objectives.

On the other hand, findings show that companies' perceived concerns on the expectations raised by trade associations have no significant influence on companies'

implementation of CSR practices in healthcare (β=0.042, p=0.299). Despite its notable contribution of trade associations in supporting firms and enhancing CSR practices for sustainable development elsewhere, the relatively weak business associations in Tanzania could be the possible reason for non significant results. TRBN (2014) asserted that business associations in Tanzania were faced with resource capacity challenges. Waite & Mosha (2006) also noted that trade associations are weak financially and lacks appropriate mechanisms for engaging with their respective members i.e. companies; hence their influence on companies' CSR activities may not be strong enough. Nevertheless, as noted earlier on, trade associations represent business interests in forums with other stakeholders such as workers' unions and government authorities. As such, business associations are the coordinators of business integrity and accountability, and therefore their role should not be underestimated (TRBN, 2014; Waite & Mosha, 2006). This study is of the view that empowered trade associations would enhance business integrity and accountability that might in turn lead to more CSR interventions in healthcare and eventually a healthier society.

CONCLUSION

This research has empirically examined the effect of perceived stakeholders' expectations on companies' implementation of CSR practices in healthcare. Findings show that companies in Tanzania are concerned about both primary and secondary stakeholders' health and safety expectations. The significant effect of perceived stakeholders' expectations: customers (β=0.089, p=0.033), communities (β=0.387, p=0.001), government (β=0.128, p=0.001), and NGOs (β=0.441, p=0.001) suggest that these stakeholder groups can positively influence companies to engage in CSR practices for public healthcare support. On the other hand, the non-significant relationship between perceived employees' concerns and companies' CSR practices (β=0.023, p=0.577) is due to integrated employee wellbeing indicators in the country's institutional framework. As such, all activities intended to enhance employee wellbeing are regarded as a law compliance rather than CSR practice. It was also found that, not all trade associations are strong enough to convince companies to practice CSR in healthcare, hence insignificant result (β=0.042, p=0.299). Nevertheless, trade associations could play an important role in promoting integrity and responsible business practices that might induce companies to practice CSR in supporting public healthcare.

Overall, most of the hypotheses developed for this research are supported (H1, H3, H4 and H5). These findings reaffirm this study' contribution to the body of knowledge through an empirically tested stakeholder model that shows how companies are concerned about their stakeholders' expectations and the effect of such expectations on companies' implementation of

CSR practices in healthcare. A reliable and validated structural equation model developed in this research could be used as an initial source of knowledge for future researchers interested in examining the relationship between companies' CSR practices and stakeholders' participation in such practices.

One of the limitations of the current study is on the assessment of the magnitude and impact of companies' CSR interventions on stakeholders' wellbeing which were not examined and documented in this paper. Perhaps future researchers could investigate on this and provide useful insights for both policy makers and CSR practitioners to estimate how the implemented CSR practices had improved stakeholders' wellbeing. In addition, this study's results were generated from cross sectional data. Social and economic conditions of businesses change over time, these conditions might have significant impact on companies' CSR practices. The institutional framework that governs CSR interventions of companies might also change and influence companies' management decisions. Therefore, longitudinal study could be useful to detect the changes and help policy makers and practitioners to forecast future CSR interventions and develop viable strategies.

To the policy makers and practitioners, the implications of this research are twofold: firstly, it is recommended to ensure stakeholders are involved in companies' CSR practices so that they can share their opinions on CSR development and sustainability for an equitable population health. One way would be to establish an association that can represent each stakeholder's interests. For example, consumers' advocacy groups could represent consumers' interests; trade unions for employees, and civil society organizations and NGOs could represent communities. Secondly, CSR coordination units and campaigns could be established at various levels including the national level, sector level up to the company level so that more CSR interventions can be developed and coordinated to ensure positive impact in the country's healthcare system.

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