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Street-level Bureaucrats' Coping Strategies and How They Affect Public Service Delivery in Ghana

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ABSTRACT Street-level bureaucrats (SLBs) are at the front of public social policy-making and implementation. This paper examines actions, behaviours and SLBs coping strategies in social service delivery. It uses interviews, documentation and observations with a comparative case study approach. It contributes to public social policy implementation in developing world context. It adds to street-level bureaucracy debates that actions and behaviour of SLBs are not only influenced by workload and working conditions but are influenced by their organisational culture. It moves away from the traditional public bureaucracy perspective and brings a new dimension on SLBs coping strategies within public-private organisational contexts. Findings suggest that organisational behaviour, interests, resources and culture influence the coping strategies SLBs adopt in organisations, which affect their clients' access to social services. Ironically, findings suggest SLBs in private organisations seem more inclined towards clients than their public counterparts. It concludes that the interest of clients should be paramount.

INTRODUCTION

Street-level bureaucrats (SLBs) directly or indirectly play crucial roles in the various stages of policy cycle-agenda setting, formulation, decision making, and implementation to evaluation (Howlett et al. 2009). Street-level bureaucrats are public service workers or key actors in the policy process who interact on a daily basis with individuals or clients (Edlins and Larrison 2018). There is extensive literature on strategies or mechanisms SLBs adapt to cope with their work from earlier scholarly works including Lipsky (1980, 2010) to recent works (Tummers and Rocco 2015; Tummers et al. 2015; Edlins and Larrison 2018; Pedersen et al. 2018). Also, recent literature on SLBs moves away from coping strategies of SLBs to the point of accountability. The impact of accountability on SBLs (Murphy and Skillen 2018), accountability from profit and non-profit oriented organisations perspectives (Lieberherr and Thomann 2019) as well as informal accountability of SLBs towards their citizen-clients (Pivoras and Kaselis 2019).

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Research Objectives

This research study explored the factors that affect social service delivery at the local level and how action, the behaviour of SLBs influence the implementation of a public social policy-National Health Insurance Scheme (NHIS) in Ghana.

Some scholars argue that some actions of SLBs diverge from the stated policy intentions-goals or objectives in developed and developing countries (Lipsky 1980; Makinde 2005). Lipsky (1980, 2010) elaborated some conditions of work that affect SLBs work outputs and outcomes. These include limited resources relative to workload, high demands for social services from clients or the citizens, ambitious organisational goals, or vague or conflicting goals and the involuntary nature of their clients (Lipsky 1980, 2010: 27-28). Other recent scholars share similar views with Lipsky on conditions that compel SLBs to adopt various coping strategies to cope with their work situations or manage their client's demands on a daily basis (Bender et al. 2018; Searcy 2018; Edlins and Larrison 2018; Pedersen et al. 2018). Examples of some of the coping strategies are 'rationing services' through 'creaming', worker bias against some clients and cases against organisational norms of non-differentiation (Lipsky 1980, 2010). Some include 'discrimination' against some groups based on race like 'black' or other colour on the provision of social

services (Einstein and Glick 2017; Searcy 2018). Some studies show SLBs controlling clients, or modifying policy goals (Ayee 1994; 2012; Ohemeng et al. 2012). Also, changing clients' perceptions, attitudes, beliefs and behaviours on some services provision (Smith and Brownell 2018) among other coping strategies or mechanisms of SLBs. These coping strategies are largely negative as they limit clients' access to social services.

On the contrary, some scholars like Nielsen argues that SLBs behaviour can be 'positively motivated' as SLBs are engaged in acts or ways that seek to maximise or gain 'job satisfaction' from such actions (Nielsen 2006: 861, 863). Nielsen further argues that SLBs are not only just compelled to cope due to working conditions but are also 'enticed' to cope (Nielsen 2006: 866). Furthermore, SLBs are engaged in actions or practices like rule 'bending' or 'breaking rules' for clients' or patients' interests, needs (Evans 2013; Cooper et al. 2015; Assadi and Lundin 2018). Thus, SLBs adopt coping strategies that aim to increase clients' access to social services.

Other scholars look at coping strategies of SLBs in service delivery differently not pessimistic or optimistic but a blend of the two contrary views, with the typology of coping strategies of SLBs. Some studies identified such typology of coping strategies 'moving towards clients', 'moving away from clients' and 'moving against clients' (Tummers et al. 2015; Tummers and Rocco 2015). These typologies are manifested in the application of rules, including rule-bending, breaking or rigid rule application in the provision or allocation of social services including healthcare. Other studies look at politics-bureaucracy dynamics in policy processes in a developing world context of SLBs (Makinde 2005; Ayee 2012; Ohemeng and Ayee 2012; Ohemeng et al. 2012).

Street-Level Bureaucrats Coping Strategies in Ghanaian Context

Crook and Ayee (2006) look at how street-level bureaucrats adapt to 'client-oriented' ways of working with elements of flexibility, responsiveness to clients or public needs as opposed to 'rule-oriented' ways of public service delivery. Their study focuses on Environmental Health Officers (SLBs) coping strategies. They adopted a comparative case study approach to service delivery in two cities (Accra/Kumasi) in Ghana (Crook and Ayee 2006). They analysed the influence of 'organisational culture' and attitude, 'politically protected privatisations' on SLBs ability to enforce environmental standards in communities. Similar studies look at behaviour, actions of SLBs, politicians in policy-making and implementation processes in Ghana and how such behaviours, actions affect public service delivery (Ayee 1994; Ayee 2012; Ohemeng and Ayee 2012; Ohemeng et al. 2012).

Andersen (2004) looks at attitudes of frontline workers/SLBs in a public hospital (Bolgatanga Regional Hospital) in Northern Ghana in relation to the kind of treatment given to patients, some received good treatment while those termed the 'villagers' received poor treatment. The study identified myriad of factors accounting for differential treatments for patients such as the 'bureaucratic aspects of hospital practice', 'bad attitudes' of hospital workers (SLBs) in relation to working conditions, professionalism and the 'social identities' of the health workers (SLBs). Other factors analysed include resource deficiencies, poor working conditions, underpayment and understaffing. These factors may explain why some health workers in Africa and Ghana, in particular, show some 'bad attitudes' towards patients at health facilities. These studies also explain how SLBs actions, behaviour and or discretion affect their clients' access to healthcare services (hospitals/clinics (Andersen 2004; Aniteye and Mayhew 2013; Atinga et al. 2018).

Agency and Stewardship Theoretical Perspectives

Agency and stewardship theories provide the explanatory frames for this study, not only at the organisational level but at individual levels. In this regard, the researchers look at individuals' motivations for their actions, behaviour during public social service delivery. The researchers explore principal-agent or principal-steward theoretical perspectives. The research study thus looks at the relationships in healthcare service provision: contractual relationships between health service providers as agents/steward and National Health Insurance Authority (NHIA) as principal (organisational level). The relationship at the individual level is between health workers

(SLBs) and patients/ clients (health insurance beneficiaries). The second individual-level relationship is between the NHIA workers (agents) and beneficiaries (principal) in new public management sense. The principal-agent theory is premised on the principle that the 'principal' contracts an 'agent' to perform some tasks. Studies established that the agent while serving the principal interest may have some other motives or interests' such as 'self-interest', 'self-regarding', 'self-seeking with aim of increasing or maximising his or her own income, leisure, time at the expense of principal (Foss 1995; Petersen 1995; Brinkerhoff and Bossert 2014; Kipo-Sunyehzi 2018; Baker 2019). The principal-agent theory is 'empirically tested' or used from the implementation lens of NHIS in Ghana. In this regard, this study explores the factors that affect principal-agent relationships. The principal-agent theory is based on the 'economic model of man' where humans are seen as being 'hyperrational' and 'opportunistic' (Niskanen 1971; Eisenhardt 1989). Studies show that the principal-agent relationships have some problems or challenges. These include 'moral hazards', 'adverse selection', 'multiple principals' syndrome' information asymmetries, 'ethical dilemmas' et cetera (Foss 1995; Petersen 1995; Brinkerhoff and Bossert 2014; Baker 2019).

Stewardship theory serves as an alternative to agency theory. The agency theory as explained earlier is based on 'economic man' while stewardship theory is based on the 'humanistic model of man' (Donaldson and Davis 1991). Humanistic in the sense that the steward has a need or a task to achieve, he or she works towards it and is self-motivated rather than financially motivated. Stewardship theory, the steward motivation is extrinsic towards a collective goal (Schillemans 2013). The steward does not shirk or engages in acts of self-seeking but exercises lots of trusts for the principle. Also, the steward is committed to the task of the principal.

The study analytical framework focuses on public and private sector organisations, their work schedule (roles and positions) in terms of the cases they handle, their workload per day, work pressure and general working conditions. The researchers looked at how such conditions may compel them to adopt coping strategies in dealing with problems/challenges. Finally, the researchers attempted to analyse how the types of coping strategies affect clients' access to health care services at hospitals and clinics and health insurance office. The study's analytical framework is illustrated in Figure 1.

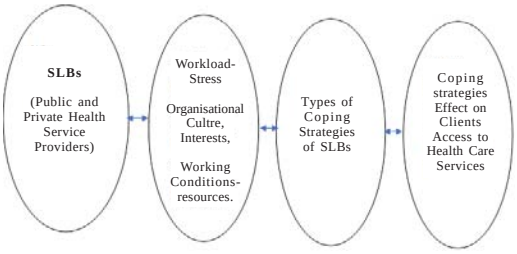

Fig. 1. Study analytical framework
Source: Author

METHODOLOGY

This research study adopts mainly a qualitative method. It specifically adopts a case study approach with 'detailed and intensive analysis of a single case' (Bryman 2012: 66). The single case being the National Health Insurance Scheme (NHIS) as a 'contemporary phenomenon' (Yin 2014) in Ghana. A comparative study involves the 'study of numerous cases along the same lines, with a view to reporting and interpreting numerous measures on the same variables of different individuals' (Greenstein and Polsby 1975: 8). A case may be individual, group or organisation (Merriam and Grenier 2019). The researchers compared four implementing organisations (two clinics and two hospitals) on public-private health service providers' basis. The rationale for using a comparative case study design/approach is to help discover similarities and differences in two 'contrasting cases' patterns in service provision, behaviours, attitudes towards clients. The researchers used three criteria in the selection of cases namely duration in operation, ownership and categories of health care services provided in Tamale Metropolis of Ghana as in Table 1.

In addition, the researchers purposively selected a number of service providers termed SLBs. Their actions, behaviours and attitudes matter most since they are healthcare service providers. The choice of 'purposive sampling' (non-probability sampling technique) was to enable us to obtain insights into certain practices, context, time

Table 1: Cases and the selection criteria

Cases	*Ownership*	*Years of operation*	*Types of services*
West Hospital	Public	18	5 services
SDA Hospital	Private	11	5 services
H. Adams Clinic	Private	26	4 Services
Bilpeila Clinic	Public	29	4 Services
NHIS Office	Public	11	Registration/ Renewal

Note: SDA-Seventh Day Adventist; H.-Haj; Five (5) service delivery areas at facilities- Out-patient, in-patient, diagnostics, pharmacies, theatre services.

and in line with research questions on SLBs (Gray 2009). The selection of the SLBs in the study was based largely on their positions and units occupied and the years of experience gain in the provision of healthcare services to NHIS clients. The categories of SLBs were selected in facilities and NHIS office are illustrated in Table 2.

There was a triangulation of data sources, with the rationale to increase the reliability and validity of findings. In this regard, extensive documents including annual reports, attendance registers, minutes of meetings, memoranda, charts among others were obtained in the field in addition to direct observations of SLBs healthcare service provision. One-on-one in-depth interviews were conducted at facilities/NHIS office. The researchers probed for more detailed responses from interviewees (Gray 2009: 369-370; Bryman 2012: 469). This was done through the use of a semi-structured interview guide with questions directed to SLBs, their coping strategies and how they enhance or inhibit healthcare services to clients. The fieldwork with SLBs took three stages: September-November 2012, February-July 2013 and July- October 2014. The researchers adhered to the ethics of research including informed consent of participants. They also obtained institutional permissions from Ghana Health Service and NHIA before we commenced the interviews in Ghana.

RESULTS

The results focused on politics, working conditions, action, behaviour and coping strategies of SLBs. The main research question is: *to what extent and how does the behaviour of SLBs influence implementation of NHIS?* These are key assumptions: *the more positive attitude towards the clients the better the health care services provided them and vice versa*. The other assumption is that *the higher (more) the workload of SLBs the less positive attitude towards clients*. The final assumption is that *SLBs adopt coping strategies to their advantage but at the expense of clients*. These assumptions were analysed qualitatively from fieldwork data gathered (empirical observations).

Politics

On the issue of politics, the researchers found that politics appeared to more in the early stages of the policy (agenda setting, formulation and decision-making stages) than at the implementation stage. The researchers then tried to find out the role of politics during the implementation of NHIS in Ghana. SLBs in health facilities indicated that politics may only exist in the NHIS office. But NHIS officials responded that there is no politics in their job. They found that politicians and administrators of NHIS work together for mutual benefits and for the success of the policy (NHIS). Thus, politics appeared to have a mini-

Table 2: Participants (SLBs) and their sub-units for in-depth interviews

West Hospital		*SDA Hospital*		*HAC Clinic*		*Bilpeila Clinic*		*NHIS Office*	
Out-patient	(2)	Out-patient	(2)	Out-patient	(1)	Out-patient	(1)	Manager	(1)
In-Patient	(1)	In-patient	(1)	In-patient	(1)	In-patient	(1)	Accounts	(1)
Laboratory	(1)	Laboratory	(1)	Laboratory	(1)	Laboratory	(0)	MIS	(1)
Diagnostic	(1)	Diagnostic	(1)	Diagnostic	(1)	Diagnostic	(1)	PRO	(1)
Pharmacy	(1)	Pharmacy	(1)	Pharmacy	(1)	Pharmacy	(1)	Data	(1)
Total	6	Total	6	Total	5	Total	4	Total	5
Grand Total	26								

Note: MIS- Information Management System PRO- Public Relation Officer

mal role, the researchers only observed some forms of party politics in the area of transfer of health insurance workers particularly scheme managers. Politics is a sensitive area.

The Behaviour of SLBs at NHIS Office

The researchers interviewed SLBs in NHIS office on registrations and renewals of membership and how they cope with a large number of clients who visit their office for services like registrations and renewals. It is SLBs who determine clients who qualify for NHIS exemption policy during registration. Five SLBs in the NHIS office took part in the in-depth interviews on questions on the extent and how their behaviour affects the implementation of NHIS. Four out of the five agreed that their behaviour had both positive and negative effects on service delivery in areas such as clients' registrations and renewals of membership. Meanwhile one of them said their behaviour has only positive effects on service delivery. The follow-up question was interesting, they tried to answer 'how' their behaviour affect the services they provide to their clients. One of the four SLBs (line manager) made these comments on 'how' their behaviour affect service delivery:

You can see the pressure yourself, look at the congestions in the office and outside, all these people are there for either registration or renewal of their membership cards. As professionals, we will always try our possible best to contain the pressure and stress of work to make them happy. However, we sometimes lose control and say some things that may be unpleasant to our dear customers (SLBs, 1-3#4).

The SLB with the contrary view that their behaviour has only positive effects has this to say:

We are here because of subscribers; without them we will not be in employment or be here doing anything so their interest is for our interest and their happiness is our happiness. We have no option than to behave well and relate well with all who come here for renewals or registrations (SLB#5).

Interviews with SLBs in the NHIS office showed they were mindful of their behaviour towards clients. Thus, they indicated that positive actions, utterances and attitudes like a show of respect, kindness, politeness, smiles, timeliness in service delivery) have a direct effect of encouraging attendances for registrations and renewals. While bad behaviours like insults, shouts, rudeness, favouritism, disrespect towards clients make some clients go to neighbouring districts to access the same services like registration or renewal instead of Tamale Metropolis. One such district a number of SLBs mentioned is Savelugu-Nanton district which served as an alternative for dissatisfied clients. The SLBs indicated some bad attitudes were exhibited unintentionally due to heavy workload, work pressure, congestions couple with a limited number of staff to handle a large number of clients in the office. The researchers observed some of these positive and negative attitudes of SLBs in the NHIS office during fieldwork. They also observed that in some cases some highly placed persons jumped queues to be offered services promptly while the majority of clients remained in the queue.

The Workload of SLBs at NHIS Office

Besides interviews and on-site direct observations at NHIS office, the researchers used documents evidence extensively. They obtained Tamale NHIS annual reports from 2010 -2013. The reason for using 2010 onward annual reports was to avoid the errors in the calculations for registrations and renewals which were based on 'cumulative membership' for years before 2010. From 2010 onward calculations were based on 'active membership' for NHIS clients. Having obtained the yearly attendances for registrations and renewals, the researchers tried to divide each year figure by the number of days in that year (365 days for all but 366 days for 2012 leap-year) to get *workload per day*. We then divided the workload per day by the number of SLBs (staff) to get the *workload per head*. These simple calculations helped to have a fair idea on the workload per day and workload per head (number of cases per each SLB). These analyses are presented in Table 3.

Table 3 shows that in 2010, the NHIS office recorded average daily registration attendances of 101 clients. On the number of clients who visited the NHIS office to renew their membership, the average daily renewals were 95 clients. This shows NHIS office was overwhelmed with a total of 196 clients seeking both new registrations and renewals of their membership to NHIS. On total *workload per day* in the NHIS office, data shows

Table 3: Workload per day workload per head

Year	*2010*	*SLBs*	*2011*	*SLBs*	*2012*	*SLB*	*2013*	*SLBs*
Registration Attendance	37,201	11	33,976,	11	42,714	19	72,776	22
Average Daily Attendance	101	9 Reg-cases	94	8 Reg-cases	116	6 Reg-cases	199	9 Reg-cases
Renewal Attendance	34,253	11	46,043	11	58,040	19	80,895	22
Average Daily Renewals	95	8 Ren-cases	127	11 Ren-cases	158	8 Ren-cases	221	10 Ren-cases
Total Work Load Per Day	196		221		274		420	
Total Work Load per Head		17		19		14		19

Source: Annual Reports: Tamale Metropolitan Mutual Health Insurance Scheme (TMMHIS) 2010-2013

an increasing trend from 196 to 221, 274, 420 for clients seeking registrations and renewals for 2010, 2011, 2012, 2013 respectively. On the other hand, the total *workload per head* handling both registrations and renewals of membership moved from 17 cases per head (SLB) in 2010 to 19, 14, 19 for 2011, 2012, 2013 respectively. There was a little drop in a number of cases each SLB handled only in 2012.

Coping Strategies of SLBs at NHIS Office

Questions on 'how' SLBs cope with their workload and 'why' SLBs behave in the way they do in their workplace were asked and their responses were analysed. The aim is to help identify some coping strategies and the rationale behind such strategies in healthcare service provision. Five (5) SLBs in the NHIS office responded to these questions on coping strategies and their reasons. The following coping strategies were identified as presented in Table 4.

Table 4 results on coping strategies of SLBs show most SLBs (SLBs#2-5) were compelled to adopt strategies due to workload as ways to ease pressure and relax at the workplace. However, one of them (SLB#1) view those coping strategies as ways of making things work better and faster for clients at the workplace through rule-bending or rule-breaking and work flexibility.

The Behaviour of SLBs at Health Facilities during Health Service Delivery

Individual workers in organisations (public or private) are faced with a number of work-related issues and they are faced with everyday dilemmas in the delivery of public services to citizens. The individual workers in public organisations whom Lipsky termed 'SLBs are employees of organisations who are expected to 'pursue organisational goals' which sometimes conflict with their 'individual goals' (personal goals). The organisations in which they work are controlled by man-

Table 4: SLBs coping strategies in NHIS office in the implementation of NHIS in Tamale

SLBs	*Coping strategies*	*Reasons for coping strategies*
SLB#1	Rule bending to enrol more clients	To make things work faster for
	Separation of clients to meet special needs	insurance subscribers
SLB#2	Separate those on official duty from others	To differentiate subscribers
	Senior officials, high class from others	For faster services
SLB#3	Strictly first come first served basis	To make work easy
	Principles of equality and fairness	To relax a bit at work
	No payment for the past/present no services	To rigidly apply the rules
SLB#4	Applying eligibility criteria in line to Acts	To make sure clients do the right things
	The right amount of cedis before all services	before serving
SLB#5	Inspection of temporary chits, cards receipts of payments, invoices, break time	It helps to take some form of rest from work pressure
	Some sit outside the pavilion, some sit inside	To ease work frustration

Source: Fieldwork Interview Data: 2012-2014 at NHIS Office, Tamale-Ghana

agers (who may be administrators, medical directors, physician assistants as the case of hospitals and clinics). The managers are overly concerned with what is to be delivered (outputs) in organisations. Thus, the workers (SLBs) are expected to show their professional skills and competencies in the delivery of social services to their clients (Lipsky 1980, 2010). In this regard, the focus is on SLBs in the four selected hospitals and clinics. The researchers first looked at their behaviour in the workplace. Secondly, they looked at their workload (number of cases per day, per head). Thirdly, the researchers explored the issue of how they cope with their work in terms of workload and the rationale for such coping strategies.

The researchers asked the SLBs (the health workers) at the four facilities how their behaviour affects their clients' access to health care services.

The *Private clinic* three (3) SLBs answered this question while two declined on the grounds they were not comfortable to share their behaviours towards clients. All the three-sounded positive and said they did all their best to always be nice to their clients to encourage them to attend their clinic to access health care services. They said that fostering good human relations with clients was important. They indicated their job orientation at a private clinic is to promote these virtues towards clients: friendliness, fairness, and the spirit of cooperation with clients in the implementation of NHIS in Tamale Metropolis. This summarises three SLBs views who commented on behaviour in a private clinic:

We are here because of our clients, without them, there will be no work, no money and we will have no option than to stop the operation of the clinic in Bayanwaya (SLB1, 3#2).

Public clinic four SLBs interviewed on their behaviour towards clients answered the question. They were interesting responses from the four SLBs (health workers) in the public clinic. The workers indicated they were all professionals: physician assistants, general nurses or midwives or other paramedics and they allow their professional codes of conduct to guide their practices. They also indicated that they were supposed to be friendly to their clients but in some cases, there is the need for clients to know their limits in such friendliness during health care service delivery. They further indicated that they may resort to harsh words if clients go contrary to their rules. This was what one SLBs said on behaviour towards their clients in the public clinic:

We consider the health needs of clients first and always try our best to meet such needs. But at some points, things do not work well and we turn to shout at them or say something that our clients may not be happy but we have to do that to bring order and sanity in the ward or at the OPD (SLBs1-3#4).

The researchers also solicited the views of SLBs in *private hospital* on their behaviour towards their clients. The six SLBs in their units shared their opinions, views and experiences on how their behaviour affects clients' access to health care services: consultation (out-patient department), diagnostic (ultra-scan), laboratory tests, pharmacies and in-patient (admission) services. Most of them linked organisational culture to their behaviour, where they see themselves as doing services for humanity with godliness. This phrase was frequently used: 'service to God is service to mankind'. This was explained in the context of religion like services to human beings are services offered to God. As such health services must be done well for an 'eternal reward'. A senior SLB in-charge of the ward (in-patient department) in the private hospital has this to say:

Can we pay for the air we breathe? All these natural things are provided free for the comfort of humanity by God. As such we ought to use whatever we have wisely and properly to serve our fellow humans and our reward may not only be on earth but heaven for the good services to human beings (SLBs2-6#1).

The six SLBs in *public hospital* shared their experiences and said they were constrained by many problems or number of challenges from procurement procedures to bureaucratic bottlenecks, absenteeism of some workers, meagre salaries, promotion issues among others. These notwithstanding, they still try all their best to promote the interest of clients before their own. The six SLBs indicated that their clients sometimes blame them for use of bad language, neglect of duty, rudeness or impoliteness but they discounted those accusations and indicated that their clients' statements were mere perceptions as a result of misinformation. This is what SLB said in a public hospital on their behaviour towards clients during health care service delivery:

Those of us in the public hospital, we are well trained and well-disciplined health professionals, we are regulated by our various councils, this made us be mindful of misconduct toward our patients. If there are shouts or some form of insults in the labour ward you should understand the situation ok and not generalised it (SLB1-5#6).

Even though the quote above was made by the sixth SLB, but most shared similar views from the interview the researchers had with them on how they behave towards their clients. They indicated that bad language was not part of the practice of the public officials (SLBs) but a mere perception.

The Workload of SLBs at Health Facilities (Hospitals/Clinics)

The researchers looked at a number of clients that attended each facility in relation to the number of SLBs. The aim is to find out which facility SLBs has more workload (clients' attendance) as in Table 5.

Table 5 shows the private hospital (SDA) had higher average daily attendances from 2009 to 2012 compared to its public hospital (WH) counterpart for the same period except in 2013. By implication, private hospital SLBs might have experience more daily workload than the public hospital SLBs. The overall picture is that the private hospital had more workload (daily clients' attendance) with less staff in handling the large numbers of clients while the public hospital experienced fewer daily clients' attendance (less workload) but with more SLBs. On the other hand, the private clinic had more workload (more clients' attendance for healthcare) relative to its staff strength (number of SLBs) than public clinic (with fewer clients but more SLBs).

There is a *paradox*, SLBs in both public and private hospitals complained of heavy workload but it turns that those with the most clients and the smallest number of SLBs is the private hospital, which turns to complain less and is most friendly and polite towards their clients than a public hospital. On the part of the two clinics, their SLBs complained less about the workload compared to those in the hospitals. It was interesting to observe that some public clinic officials complained about the workload on some days particularly, on Wednesday but such a complain on some days was not noted in private clinic (which has fewer SLBs but with more workload).

Coping Strategies of SLBs at Health Facilities (Hospitals/Clinics)

This question was asked of SLBs in the hospitals and clinics: 'how do you manage to cope with your workload and other challenges at the workplace? The aim of the question is to solicit views, opinions and experiences of SLBs at the local level who are directly involved in day to day implementation of NHIS. In this regard, we used largely in-depth interviews and a few direct observations. The various coping strategies SLBs mentioned during interviews at health facilities are summarised in Table 6.

Table 6 shows that the public hospital SLBs coping strategies are ways to make clients do what is right or to calm them if they put up unfriendly behaviour while waiting for health services. The clients are either put away or made to

Table 5: Facilities yearly out-patient department attendance and number of SLBs

Facilities	*Yearly OPDS attendance SLBs*					
	2009	*2010*	*2011*	*2012*	*2013*	*Size*
Public Hospital (WH)	42,046	47,460	54,067	55,659	66,758	184
Average Daily Attendance	**115**	**130**	**148**	**152**	**183**	
Private Hospital (SDA)	42,444	55,058	84,711	81,593	59,750	112
Average Daily Attendance	**116**	**151**	**232**	**223**	**164**	
Public Clinic (BC)	4,565	3503	4,292	4549	3914	23
Average Daily Attendance	**13**	**10**	**12**	**12**	**11**	
Private Clinic (HAC)	14,621	18,678	20,226	18,598	-	17
Average Daily Attendance	**40**	**51**	**55**	**51**	-	

Source: Fieldwork Data: Health Facilities Out-Patient Department Attendance Records, 2009-2013

Table 6: SLBs coping strategies at health facilities during health service delivery

Health facilities	*Coping strategies*	*Reasons for coping str.*
Public Hospital	Shout to calm patients, uniform staff first	Creaming/no need to spend more
(West Hospital)	Rules application as in Acts/Regulations	time, for conformity
Private Hospital	Client-oriented practices (friendliness)	Use of funs, jokes for relaxation
(SDA Hospital)	Non-discrimination-service to God-Man	To make clients happy
		To serve clients better
		To stop clients complains
Public Clinic	Use of shift to ease pressure at the workplace	To relax a bit from the stress
(Bilpeila Clinic)	Politeness to clients but sometimes shouts	To calm them by shouts
Private Clinic	Clients attendance as a source of a revenue	No discrimination
Haj Adams Clinic	Flexibility, politeness and Friendliness	To offer more services

Source: Fieldwork Interview Data: 2012-2014 at Health Facilities (Hospital/Clinics), Tamale-Ghana

act appropriately during health service delivery. The private clinic SLBs coping strategies seem to be friendly and moving towards clients and use of humour or funs to make clients happy. The public clinic SLBs coping strategies seem to be both moving towards clients and moving away from clients through politeness and shouts while private clinic SLBs do not adopt creaming or discrimination as they are moving towards clients.

DISCUSSION

Results showed SLBs in public and private hospitals exercised discretion in the provision of healthcare services to their clients, similar empirical observations among SLBs in NHIS office. The SLBs in NHIS office exercised enormous discretion in the selection and application of the eligibility criteria on exempt group members (persons exempted from payment of the premium). The results are consistent with Lipsky theorisation that SLBs exercise so much discretion as not only policy implementers but as 'actual policymakers' through their choices and interpretations of policy (Lipsky 1980, 2010; Makinde 2005; Kipo-Sunyehzi 2018).

The empirical evidence supports the assumption that: *the more the workload of SLBs, the less positive attitude towards clients.* These observations were mainly noted among SLBs in public organisations (public hospital, clinic and NHIS office). The public SLBs largely exhibited more negative attitudes towards their NHIS clients during social service delivery. These strategies include creaming (prompt services to some clients), rationing of clients (go and come back next day) and services (long waiting), discrimination among clients based on social status, work or tribal connotations or location (against 'villagers'), rigid application of rules among others. These coping strategies simply suggest SLBs 'moving away' or 'moving against' their clients. These findings are consistent with the views of earlier scholars like Lipsky (1980, 2010) and other recent works/findings (Tummers and Rocco 2015; Tummers et al. 2015; Einstein and Glick 2017; Edlins and Larrison 2018; Pedersen et al. 2018; Searcy 2018; Smith and Brownell 2018). However, the SLBs in the private organisations (private hospital and clinic) exhibited largely positive attitudes towards their clients despite the higher workload per day, workload per head.

The findings on the SLBs in the private organisation are consistent with other studies findings on positively motivated coping strategies of SLBs (Nielsen 2006; Evans 2013; Cooper et al. 2015; Assadi and Lundin 2018). The private hospital behaviour was largely influenced by their organisational culture rooted in their religious practice: 'service to God is service to Mankind'. Private hospital SLBs adopted more clients-oriented practices like politeness, friendliness where they put the interest of clients above all other interests. Also, the private hospital SLBs were found with the practices like 'rule-breaking', 'rule mending' to meet the health needs of their clients. Similar findings were found among the SLBs in the private clinic. Results suggest the private clinic SLBs actions, behaviour and coping strategies were financially motivated- to attract more clients to their clinic to increase attendance. Thus, attract more claims from NHIA.

Results showed mixed feelings on the assumption that *SLBs adopt coping strategies to*

their advantage but at the expense of clients. The empirical findings, observations did not support this assumption fully, it was noted some SLBs in both public and private organisations (health facilities) adopted some coping strategies that were in favour of their clients (access to health services in the health facilities-hospitals and clinics and NHIS office).

However, the assumption is partly right in the behaviour exhibited by SLBs in the three public bureaucracies (NHIS office, public hospital and clinic) and their coping strategies were typical of Lipsky theorisation. As their SLBs actions, behaviours and coping strategies were out of job frustration, workload and stress. The public bureaucracies SLBs coping strategies were more towards agency (self-interest against principal interest) than stewardship (more trust, loyalty and promoting principal's interest). The reason being the SLBs were more of protecting their interest against clients' interest (principal). These findings concur with other studies findings (Donaldson and Davis 1991; Foss 1995; Petersen 1995; Brinkerhoff and Bossert 2014; Kipo-Sunyehzi 2018; Baker 2019).

Contributions to Knowledge on how Street-Level Bureaucrats Work/Coping Strategies

This research study contributes to the existing literature in policy implementation in developing world context. It adds to how SLBs work and their working conditions in a developing world context, specifically on the coping strategies SLBs adopt from public-private organisational perspectives. Besides stress, it identifies other factors like organisational culture, interests, resources and politics as 'influencers' in the delivery of public services to their clients in Ghana.

CONCLUSION

This research study concludes that despite the more workload of SLBs in the faith-based private hospital, SLBs appeared more friendly, courteous and client-oriented than their counterparts in public health facilities. The religious practice of 'service to God is service to mankind' played a key role in terms of their organisational culture. The rationale was to make their clients happy, reduce their complaints and frustrations while they seeking healthcare services at the facility. It concludes that financial motivation is an influential factor to the positive attitudes exhibited by SLBs in private organisations than those exhibited by their counterparts in the public sector. The findings in this research study will hopefully assist policymakers, health insurance authority and policy practitioners to be mindful of the importance of every policy process. An error in one affect all, a wrongly selected agent may do more harm to the principal than good.

RECOMMENDATIONS

This study though largely qualitative provides useful grounds for future studies in Ghana on SLBs actions, behaviour and their coping strategies along north-south dimensions. It is also hoped future studies may utilise quantitative methods like surveys and across-countries studies on SLBs coping mechanisms from gender lens instead of organisational theory-based. Future studies may also investigate more into this 'sensitive' area of the politics in the implementation of NHIS in Ghana or elsewhere.

LIMITATIONS

This study may suffer from geographical limitation but the findings are transferable from one context like Northern Ghana to Southern Ghana, and from Ghana to other countries with similar settings.

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