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# Frontline Workers' Use of Discretion in the Implementation of National Health Insurance Scheme in Ghana

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**ABSTRACT**

The article examines frontline workers' use of discretion in the implementation of the National Health Insurance Scheme in Ghana. It answers two questions: 1) *how does discretion affect service delivery*? 2) *Whose interest does discretion serve in service delivery?* The article provides three contributions. First, it brings a new direction in the use of discretion in organisations in a developing world context. Second, it adds to 'how' and 'why' frontline workers use discretion. Finally, it reveals whose interest the use of discretion serves. It utilises qualitative methods to reveal both positively motivated and negatively motivated discretion relationships that exist between frontline workers and clients. Most of the negatively inclined discretion is exercised largely by frontline workers in public organisations. It concludes that most of the frontline workers' discretion serves the interest of their clients rather than service providers' self-interest or the interest of their organisations.

**KEYWORDS**

Frontline workers; discretion; national health insurance scheme; Ghana

## Introduction

The article examines two key issues: "how" and "why" frontline workers use discretion during public service delivery. Public service delivery refers to the provision of healthcare services at hospitals and clinics to health insurance clients in Ghana. Also, the paper examines the issue of whose interest the discretion serves. In this regard, the study answers two main questions: 1) *how does discretion affect service delivery?* 2) *Whose interest does discretion serve in service delivery?* The health insurance office is the first point of contact where health insurance clients go to register and renew their membership in the National Health Insurance Scheme (NHIS). The second point of contact is health facilities such as hospitals and clinics where the health insurance clients go to seek healthcare services when ill. This study contributes to the field of street-level bureaucracy by drawing some useful insights from the classic work of Lipsky (1980, 2010) and several scholarly works on street-level bureaucrats/frontline workers' discretion during public service delivery (Erasmus, 2014; Ehrhardt, 2017; Kipo-Sunyehzi, Attuquayefio & Sunyehzi, 2019; Brodkin, 2020; Campos & Peeters, 2021; Mohammed, 2021; Maynard-Moody & Musheno, 2022).

Street-level bureaucracy theory argues that frontline workers in bureaucracies do exercise discretion in service delivery. In this study, frontline workers include medical doctors, nurses, pharmacies, and health insurance officials among others, who provide healthcare services. These frontline workers are those who interact with health insurance clients on daily basis at offices and health facilities. The frontline workers exercise 'some discretion over which services are offered, how services are offered and the benefits and sanctions allocated to citizens' (Erasmus, 2014, iii71). This implies that some of the discretion exercised by these frontline workers may facilitate what we classify as 'cold' discretion ('cold' discretion facilitates or promotes access to healthcare services) or inhibit service delivery (which we termed 'hot' discretion (discretion that affects access to healthcare services). Some discretion may lead to more or fewer services or sanctions during service delivery.

In exploring the frontline workers' exercise of discretion using the case of national health insurance clients, we developed an analytic framework. This analytical framework is relevant as it guides our exploration and assessment of frontline workers' exercise of discretion in public and private healthcare organisations (hospitals and clinics) and how frontline workers' use of discretion affects clients (health insurance beneficiaries) access to public services (healthcare services). The analytical framework is illustrated in Figure 1.

Lipsky (1980) argues that the actions and behaviours of street-level bureaucrats or frontline workers become

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the policies of the organisations in which they work. Frontline workers/street-level bureaucrats (SLBs) can make and or unmake a policy and some of their discretion may agree or disagree with the policy intentions or directives (Lipsky (1980). But there are some challenges these frontline workers or SLBs face in their organisations in public service delivery: vague or ambiguous policy goals, insufficient resources (be it human, financial, or technical) at their disposal, and clients' higher demand for services, among others. Some of these conditions thereby forced the frontline workers to adopt some coping mechanisms or strategies in service delivery to ease pressure, stress or workload or cope with public service gaps or human resources deficits (Lipsky, 1980, 2010; Erasmus, 2014; Kipo-Sunyehzi, Attuquayefio & Sunyehzi, 2019; Campos & Peeters, 2021; Mohammed 2021; Kipo-Sunyehzi, 2022). The street-level bureaucracy theory is relevant in policy implementation, not only in public but also in private organisations (see Figure 1) on who gets what, how and why. This is what Clark and Wilson (1961) called the 'incentive systems in organisations. According to Clark and Wilson 'organisations distribute incentives' tangible and or intangible to individuals to motivate or induce them to contribute to some organisational activity.

DiIulio and DiIulio (1994) offer some organisational behaviour insights on 'principled agents'. They look at why some organisations exhibit what they termed the 'organisational cultures of principled agent' while other organisations show different organisational cultures like shirking roles, subverting rules or stealing on their jobs (DiIulio & DiIulio, 1994). The focus is on two actors one as an agent (for example the frontline workers at the hospitals and the clinics) and the other as a principal (for example the health insurance authority or health insurance clients in the new public management sense). In a principal-agent relationship, the agent is supposed to work for the principal. This implies that the street-level bureaucrats working in the hospitals and clinics are supposed to serve the interest of the health insurance authority-health insurance regulator or health insurance clients-who subscribed to the national health insurance scheme (see figure 1). However, in healthcare service delivery, it is difficult for the principal to know or monitor the agent who provides healthcare services. This means it may be difficult for the health insurance regulator (the National Health Insurance Authority (NHIA) to monitor the kind of services provided to the health insurance policy beneficiaries (clients). Also, in whose interest do the agents' (frontline workers) discretion serves or benefit, could the frontline workers' discretion serve their self-interest or serve the interest of NHIS clients? These are crucial issues the study addresses in a principal-agent relationship in public service delivery (DiIulio & DiIulio, 1994; Kipo-Sunyehzi, 2018).

## Why frontline workers use discretion

The focus here is on why frontline workers use discretion. Discretion is conceptualised as the exercise of controlled freedom (Evans & Hupe, 2020). It may also be viewed as the exercise of legitimate authority or judgement in the performance of a duty or the provision of public service by managers to clients or citizens (Sumadilaga et al. 2017). Frontline workers in bureaucracies or organisations do exercise substantial discretion in service delivery for various reasons. One, discretion is exercised depending on the specific context or the level of freedom given to the policy implementer or public service provider (Evans, 2010, 2016; Akosa & Asare, 2017). Discretion can also be exercised on grounds of "the tendency for public officials to make decisions with their intuition, or whims and caprices" (Yeboah-Assiamah, Otchere-Ankrah & Alesu-Dordzi, 2018, p. 3).

There is also a debate between policy rules and discretion as to which matters most and which should be the focus among policy actors (Taylor, 1993). Every policy has sets of rules and the rules are expected to

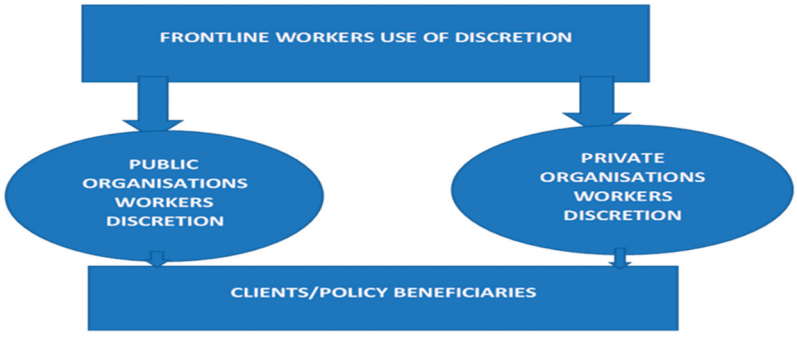


**Figure 1.** The Study Analytical Framework.

guide the delivery of the policy. Also, the application of the rules and policy instruments may call for the sound judgement of policy implementers' use of discretion. The conclusion is that policy 'rules cannot and should not be mechanically followed. This introduces some flexibility in the application of policy rules by policy-makers as well as policy implementers (Taylor, 1993, p. 213).

## How frontline workers use discretion

Literature shows frontline workers use discretion in diverse ways in their dealing with clients. Some discretion seems to favour clients in terms of their increasing access to social services (positive discretion) while other discretion affects clients negatively with less access to social services. There are some positive or negative affective attitudes towards clients which may be 'friendly' or 'confrontational' in service delivery (Keulemans & Van de Walle, 2020, p.88).

Lipsky argues that SLBs determine the nature of the eligibility criteria, the quality of services, and the number of benefits for the policy beneficiaries/citizens (Lipsky, 1980; 2010). Also, frontline workers serve as a "connection" between public services providers and those who receive public services-the citizenry (Smith, 2012, p. 431). Meyers and Nielsen (2012) emphasise the cordial working relationship between frontline workers and clients in the implementation of public policy (Meyers & Nielsen, 2012, p. 305).

On the other hand, there is the use of negative discretion which is associated or linked with "higher level pressures around resource scarcity and strict targets" to achieve (Alden, 2015). This kind of discretion affects clients (policy beneficiaries) access to services or it affects the willingness of policy implementers to implement a policy. Negative discretion is also exercised in other circumstances in terms of bad faith, from frontline workers toward their clients (Tummers & Bekkers, 2014; Tummers et al, 2015; Yeboah-Assiamah et al, 2018). Moreover, some frontline workers tend to discriminate between or among clients or show favouritism among clients through the use of discretion in service delivery. This kind of discretion in service delivery is what Sandfort (2000) says breaks public trust for frontline workers.

## Who benefits from frontline workers' use of discretion (whose interest is served)?

There is a debate among scholars on whose interest frontline workers' use of discretion benefits in service delivery. While some scholars or scholarly workers point to the benefits of policy implementers, others point to policy beneficiaries or in some cases both benefits. Tummers and Bekkers (2012, 2014) look at the effect of frontline workers' exercise of discretion in policy implementation. They identified two effects of discretion namely client meaningfulness and willingness to implement a policy. Frontline workers can exercise discretion that favour or benefit the policy beneficiaries or clients. Such discretion is termed differently, what Tummers and Bekkers (2012) called "client meaningfulness", what Palumbo et al. (1984) called meeting the "needs of the client", or what Kipo (2011) called the "exercise of discretion" in favour of health insurance clients in rural Ghana, or the environmental officers use of discretion "towards clients friendliness" to cope with work in Ghana (Crook & Ayee, 2006). The second effect of the use of discretion by frontline workers is when they are given a reasonable amount of freedom (autonomy) to implement a policy (Mutereko & Chitakunye, 2015). This may motivate the frontline workers to willingly carry out the policy, what Tummers and Bekkers (2012, 2014) termed the "willingness to implement a policy". For Zacka, the frontline workers or SLBs are the "mediators between state and society" in service delivery or the discretion to enforce a policy (Hassan et al, 2021). In such service delivery or provision, there is a dilemma between the moral disposition of frontline workers/ SLBs and the discretionary power they exercise in their dealing with clients (Zacka, 2017, p. 24). Three dispositions are identified by Zacka namely "indifference, caregiving and enforcement" (p.32). The indifferent frontline workers are those who religiously adhere to the rules and procedures in service delivery, and who are inflexible and less responsive to the needs of clients. The caregivers are the frontline workers who give more time, resources, care, and attention to the needs of some clients at the expense of other clients. Zacka's (2017) third disposition is the enforcers. These are frontline workers who give more attention to undeserving cases to prevent some abuse and avoid the risk of being insensitive to the needs of such clients.

## Research Methods

### *Research Design*

This article adopts a qualitative research design specifically a case study approach. A case study research approach/strategy guides the investigator

to understand the extent to which a phenomenon is present or how the phenomenon varies across cases (Flyvbjerg, 2006). This study examines a 'social phenomenon' (implementation of national health insurance scheme) in a 'setting' like organisations (health insurance office which is clients/beneficiaries' first contact point and hospitals and clinics as the second contact point (Yin, 2014). Also, a case study approach/strategy permits 'comparing and contrasting cases (Ragin, 1997, p. 2). In this study, the cases are the five organisations. The comparison is between the second contact point organisations (the two hospitals and the two clinics). This, Ragin, opines that when the cases are 'alike enough to permit comparisons'. There is a need to understand that the NHIS scheme office is where registration and renewal of membership take place (first point of contact). Then we compared the second contact point (the two hospitals and two clinics) to explain the variation in the use of discretion in public service delivery to health insurance clients or beneficiaries.

The evidence was obtained through 12 months of fieldwork in three-phase, namely preliminary work (2012), and major fieldwork (2013) and the final phase ended in October 2014. The lead researcher used multiple research methods to "generate new knowledge" through the synthesis of findings from different perspectives for purpose of triangulation, and complementarity to possibly reflect or help explain the complexity of the phenomenon (Greener, 2011; Bryman, 2012; Khan, 2012). Then the researchers used data triangulation to "strengthen the validity of inquiry" (Greene, Caracelli & Graham, 1989, p. 256). Next are the details of the data sources.

## Sources of Data

This article utilises data from multiple sources: in-depth interviews, focus group discussions, direct observations and documents. The rationale for the multiple qualitative research methods is to help answer questions about 'experience, meaning and perspective, most often from the standpoint of the participant' (Hammarberg, Kirkman & de Lacey, 2016 p. 499). As the study participants are interviewed in their 'natural setting' mostly in their offices or workplace. The study utilises the purposive sampling method in which participants (frontline workers) are 'purposively selected' from organisations (Creswell, 2014). The criteria used in the selection of the participants are based on the positions they occupy and their day-to-day involvement in the implementation of NHIS in the Tamale Metropolis of Ghana. The 33 in-depth interviews lasted from 40-60 minutes depending on the schedules of the participants. The use of interviews allows the lead researcher to 'probe for more detailed responses from interviewees' (Gray, 2009, p. 369-370). Also, the study utilises 'groups' interviews' where data is obtained from groups of frontline workers (Gray, 2013). Two focus group discussions with frontline workers took place in the two clinics (6:5 ratio) and they involved 11 participants. However, focus group discussions (FGDs) were not held in the two hospitals due to their tight time and busy schedules. Group members did not exceed seven. The reason for this number is for easy management of the FGDs. The lead researcher (lead author) who conducted the data collection engages the services of two assistants in the conduct of the two FGDs, the lead researcher moderates the discussions, one assistant does the recording and the other research assistant help with arrangements. The essence of the FGDs is that it gives insight into a ' real-life situation in capturing reality from the group in the actual community' (Twumasi, 2001, p. 64-65).

Through the direct observation method, some data is gathered during service delivery at hospitals and clinics with daily interactions between frontline workers and their clients. These direct observations allowed the lead researcher (first author) to uncover everyday behaviour and what 'really happens' in healthcare delivery settings rather than relying on only interviews (Pope, Royen & Baker, 2002, p. 149, 151). Moreover, the lead researcher made extensive use of documents as an important source of data collection. In this regard, the researcher reviewed some relevant documents concerning the phenomenon under investigation-NHIS (Curry, Nembhard, & Bradley, 2009, p. 1446). Some of the administrative documents like reports, and organisational and unit charts were collected and analysed in terms of frontline workers' autonomy and freedom in the exercise of discretion during service delivery (NHIS) in the Tamale Metropolis of Ghana.

## Data Analysis

The qualitative data gathered in the forms of in-depth interviews and FGDs at the two clinics constitute what Hennink, Hutter & Baileyare (2020) called the 'textual data' which are written transcripts. The in-depth interviews and the two FGDs were transcribed as part of the data analysis. Also, the textual data obtained in the study are presented

**Table 1.** The five selected organisations and the study participants.

| Cases | Sub-Units | Frontline Workers | Total | Frontline Service Delivery Schedule |
|---|---|---|---|---|
| West | Administration | Administrator | | Facility NHIS Officer |
| Hospital | Out-Patient Department | Doctor | | In the consulting room |
| (Public) | In-Patient Department | Nurse | | Out-patient department |
| | Health Insurance Section | Laboratory Technician | | In Laboratory |
| | Laboratory | Pharmacies | | In Pharmacy |
| | Pharmacy | Folder official | (6) | In the NHIS folder office |
| SDA | Administration | Administrator | | In-charge of NHIS |
| Hospital | Out-Patient Department | Doctor | | In the consulting room |
| (Private) | In-Patient Department | Nurse | | Out-patient department |
| | Health Insurance Section | Laboratory Technicians | | In Laboratory |
| | Consultation | Pharmacies | | In Pharmacy |
| | Laboratory | Folder official | | In the NHIS folder office |
| | Pharmacy | Pharmacist | **(7)** | In Pharmacy |
| Bilpeila | Administration | Physician Assistant | | Facility In-Charge |
| Clinic | Out-Patient Department | Health Insurance official | | Facility NHIS Officer |
| (public) | Health Insurance Section | Folder Official | | In the NHIS folder office |
| | Consultation | Registered Nurse | | Out-patient department |
| | Pharmacy | Community Nurse | | Out-patient department |
| | Folder Office/Registrar | Midwife | | ANC/Postnatal care |
| | Midwifery | Pharmacy | 6/(7) | Pharmacy/Dispensary |
| Haj | Administration | Physician Assistant | | Facility In-Charge |
| Adams | Out-Patient Department | Administrator | | In-Charge of NHIS |
| Clinic | In-Patient Department | Folder Official | | In the NHIS folder office |
| (private) | Health Insurance Section | Registered Nurse | | Out-patient department |
| | Laboratory | Nurse | | Out-patient/ANC |
| | Pharmacy | Pharmacy | | Pharmacy/Dispensary |
| | **FGDs** | | 5/(6) | |
| Health Insurance Office | Information | Public Relation Official | | Registrations/Renewals |
| Metro | Clerical (Registration/Renewal) | Claims Official | | Vetting of Claims |
| Office Workers | | Information Official | | Info. Dissemination |
| | | Clerk | | Data entry/Inspection |
| | | | (4) | |
| Regional Office Workers | Monitoring | Monitoring Official | | Monitoring Facilities |
| | Information | Information Official | | Info. Dissemination |
| | Claims Processing | Claims Official | | In-Charge of Cheques |
| | | | (3) | |
| TOTAL PARTICIPANTS (FRONTLINE WORKERS) | | | **44** | |

**Note**: NHIS

verbatim ('verbatim transcript') and some data are presented in the form of tables as part of the data analysis. Some codes are also developed from textual data to capture the issues raised or main themes. Thus, the essence of the data analysis in this article aims at the description of events, and comparison of issues to identify core patterns in data on the use of discretion between the frontline workers of two hospitals and two clinics, categorising and contextualisation of the use of discretion in service delivery. The ultimate aim is 'theory development' (Hennink, et al, 2020, p, 209), which is to build on street-level bureaucracy theory. In qualitative research design, data may be analysed using different forms namely narrative analysis, discourse analysis, case study analysis, content analysis and grounded theory. As the study focuses on a single case (NHIS) and the issue of the use of discretion. Participants' informed consent is sought before interviews, and privacy and anonymity are respected. The five organisations, categories of frontline workers and positions are in Table 1.

## Results

### *The First Service Delivery Point (Health Insurance Office)*

#### *How Frontline Workers use Discretion in Public Service Delivery at Health Insurance Office*

These are some in-depth interview responses:

A health insurance official said this rhetorically:

> For what purpose is the health insurance law, is it to facilitate or frustrate the service delivery process?

Another frontline worker at a health insurance office had this to say on the use of discretion:

> We are supposed to work together with health service providers, if they fail to submit their claims on time, we should allow them, it is human to miss some targets or deadlines, so we need to give them another opportunity to submit their claims for processing.

The results show that health insurance officials exercised discretionary powers or decisions to facilitate the implementation of the NHIS in Ghana.

### How Frontline Workers use Discretion in the Selection of Indigent Persons

The selection of indigent members is in line with section 38 of the National Health Insurance Law where the sector Minister on the advice of the Health Insurance Council shall "prescribe a means test for determining persons who are indigent" (Government of Ghana-GoG, 2003, p.12). Indigent persons are core poor in society and should be selected through the application of the "means test" as beneficiaries of NHIS. It is the frontline workers (health insurance office staff) who determine who qualifies as an indigent (very poor) to be registered free for NHIS in Ghana.

Addressing the question of how frontline workers use discretion in the implementation of the NHIS, the frontline workers indicated that the restrictive nature of the "means test" made it difficult to identify and enrol indigent persons into the NHIS at the local level. One difficulty the frontline workers admitted to, is that it is difficult to verify exempt group members' incomes or earnings. In the mid of such difficulties and uncertainties, the frontline workers had to use their discretion. They then exercised their discretion using the living conditions of the indigent person(s) in the Tamale Metropolis as a criterion.

On the question of whose interest the use of discretion by frontline workers served in NHIS implementation in the Tamale Metropolis. Some direct observations and interview responses show that the frontline workers had to modify the strict eligibility criteria, especially the "means test" conditions to enable them to enrol more indigent persons into NHIS.

This is what a frontline worker in the health insurance office said in an in-depth interview:

> You are a researcher and you know the challenges in identifying indigents, everyone says I am poor so we have to decide who is indeed an indigent by looking into the person's background and sometimes their appearance in the selection of indigents.

This is what another frontline worker at the regional NHIS office said on the eligibility criteria:

> The reality is that the provision on indigents is too stringent and if we should go by it strictly many of the poor and vulnerable persons will be left out of our great health insurance scheme.

The responses from frontline workers at health insurance offices confirmed the use of discretion in various ways in the implementation of the NHIS in Tamale. The issue of whose interest the discretion served, the results show that most of the discretion used by the frontline workers served the interest of the policy beneficiaries (clients) against the self-interest of the frontline workers or their organisational interest.

### How Frontline Workers use Discretion in the Selection of Children and Persons below 18 years

Another area is the use of discretion by frontline workers in the selection of children and persons below 18 years. Regulations 56 says that "a person who is: (a) under eighteen years of age and both of whose parents or guardians are contributors; (b) under eighteen years of age and whose parent or guardian has been proven by the scheme to be a single parent or guardian" (GoG, 2004, p. 20).

The empirical evidence gathered through interviews and on-site direct observations reveal some difficulties in the application of Regulations 56. The frontline workers (health insurance workers) chose to use the provisions such as proven "single parent or guardian" to enrol more children into NHIS instead of using both parents to be registered members of the NHIS. This is what the frontline workers called *what works better* in getting more exempt group members into NHIS.

### How Frontline Workers use Discretion in the Selection of the Aged (70 years and above)

Another exempt group whose selection is critical is the aged (70 and above years). The National Health Insurance Regulations 56 (d) states that persons: "seventy years or over seventy years of age is not required to pay any contribution to a District Mutual Health Insurance Scheme" (GoG, 2004, p. 20).

However, there is the implementation challenge of age determination by the frontline workers. Some interviews and observations with the frontline workers in the Tamale Metropolis reveal that access to birth certificates and other national identification cards for the aged appears to be difficult to get in Ghana. This situation thereby puts the frontline workers in an 'ethical dilemma' situation (Hupe, 2019), either to insist on their birth certificates or National identification (ID) cards or ignore the official documents and use other factors to enrol the aged into NHIS. In situations where the aged are not able to produce valid national identity cards or any valid document to support their age, the frontline workers in the health insurance office had to exercise some discretion to decide whether to accept them as aged to benefit from NHIS or to reject them as aged persons for their inability to prove their age with the right documents.

## The Second Service Delivery Point: Hospitals and Clinics

### Frontline Workers' Discretion during Health Service Delivery at Hospitals and Clinics

*The Two Hospitals.* The study found the frontline workers in the two hospitals (West and Seventh Day Adventist (SDA) exercised enormous discretion during healthcare service provision. The frontline workers permitted health insurance clients or beneficiaries to access healthcare services using the "temporal chit" (a short authoritative note from local NHIA) instead of a valid health insurance card. This discretion exercised by the frontline workers (local level implementers of the NHIS) violates the rule of 'verification' of beneficiaries' ID cards at the point of service delivery before they can access healthcare services (GoG, 2003, 2004). The acceptance of the temporal chit is a local initiative that has the support and approval of the health insurance office in Tamale. Also, there is the assurance that health facilities' monthly claims will not be affected when they accept clients with chits at the point of service delivery.

Another area noted for the use of discretion by frontline workers during service delivery is the outpatient department. The lead researcher observed the hospitals' frontline workers in the outpatient department (OPD) insisted on "first come first serve" to see medical doctors, physician assistants, and nurses in the consultation rooms or the laboratory but some categories of clients were exempted for various reasons. Some on-site direct observations reveal that some categories of persons did not follow the principle of "first come, first serve". The study found that some socio-cultural, economic and political factors influenced such use of discretion to grant some exemptions to some persons in Tamale. Per the culture of the Tamale people, a traditional leader cannot queue with the subjects. These are the persons who are exempted from the strict first come first serve principle: workers in uniforms, community leaders, top politicians, and big men/women based on interviews and direct observations. This kind of discretion that is exercised in favour of some clients (those exempted from queues) against other clients at the point of service delivery in Tamale fit into Zacka's 'caregivers disposition' (Zacka, 2017). For another group of clients, the frontline workers used their discretion to grant exemptions from the queues and the first come first serve are persons with special needs, the too sick and those who need emergency care. These persons also constitute Zacka (2017) third disposition called the 'enforcers'.

Some in-depth interview responses are presented. This is how a public hospital frontline worker (nurse) responded to the use of discretion during service delivery in the Tamale Metropolis:

> *My bro, do you expect officers in uniform to come and sit here for hours? They are on duty and need prompt attention so there is no need to allow them to follow all the processes.*

Another frontline worker (nurse) in a private hospital responded to the same issue of discretion.

> We do permit subscribers without an ID card to access health care, and we also respond promptly to emergencies, even in some cases we allow uniform persons to jump the queue but it is not the practice to permit all uniform workers to do so all the time. It is not fair to other clients.

There are some variations between the public and the private hospitals in terms of their frontline workers' use of discretion, while the public hospital frontline workers exercised more discretion in favouring some clients, the private hospital frontline workers are more careful in exercising their discretion that affects other clients in terms of access to healthcare services. Moreover, some empirical observations show in some circumstances in the healthcare service provision, the public hospital frontline workers resort to the use of bad language or shout at clients but such observations were not noted in the private hospital frontline workers. It was also observed that the level of discretion used by the frontline workers in the private hospital is influenced by religious factors, not discriminate against some clients in service provision, and not shouting or using abusive language, they claimed all people are equal before God and should respect all.

### The Two Clinics

Some implementation variations are noted between public and private clinic frontline workers in the use of discretion. This is what a frontline worker said in a FGDs in the public clinic:

> *We usually look at the case of the health insurance patient and decide on the referral. Most of the time, we refer them to West hospital in Zogbeli which is not far in terms of the cost of transport. But if the health condition is serious, we ignore the transport and we call for National Ambulance Service to pick up the patient to Tamale Teaching Hospital* (Public Clinic FGD (PCFGD1-6 # Public Clinic (PUC2).

A frontline worker in the private clinic also shared some views on why they exercised some discretion in service delivery. This is what the frontline worker said in a FGD at the facility:

> *In this clinic there are fewer cases of referrals, we have a well-equipped laboratory and dispensary and capable staff. However, when some cases are above the facility status, we either refer the clients to SDA hospital or in most cases we refer the clients to TTH* -Tamale Teaching Hospital (Private Clinic FGD PRCFGD1-5 #Private Clinic (PRC2).

The public clinic frontline workers had more autonomy in their job performance and exercised more autonomy within their units and between units and therefore, exercised more discretion than their private counterparts. Also, the study noted some discrimination among clients in the public clinic than in the private clinic in terms of insults (some abusive language) and shouts at some clients in service delivery. Moreover, the findings show that there are more referrals of NHIS clients to other health facilities for diagnostic services and other services in the public clinic than in the private clinic. The private clinic appears more customers (clients) oriented in their discretion to attract more health insurance clients to the facility than noted in the public clinic. The more the clients, the more the revenue (health insurance claims) for the private clinic. This action may be in line with their organisational 'incentive system' or act as the 'principled agent' in the implementation of the NHIS in Tamale (Clark & Wilson, 1961; DiIulio & DiIulio, 1994).

### *"How" and "Why" frontline workers (street-level bureaucrats) exercise discretion at the two points of Contact (at the health offices, clinics, hospitals, and "Whose Interest" their discretion serves in the public service delivery*

This section summarises the answers to the "how" and "why" questions and "whose interest" the use of discretion serves in the implementation of NHIS. Some empirical observations obtained from 12 months of fieldwork in Tamale, Ghana are presented in Table 2.

## Discussion

The study found that there are varied reasons why frontline workers used discretion or exercise discretionary powers in service delivery in general and in service delivery in Ghana's context.

The empirical evidence supports the practice where health facilities that are not able to submit their monthly claims forms within the "stipulated period" are permitted by health insurance officials to submit them at a later date (GoG, 2003; 2004; 2012). The health insurance frontline workers used their discretion to receive the monthly claims forms from health facilities-hospitals, and clinics beyond the period. This discretion is what Meyers and Nielsen (2012) said frontline workers exercise discretion beyond formal authority. The frontline workers at the health insurance office indicated that there is a need to apply flexibility in the application of the rules of the game to facilitate the implementation of the national health insurance scheme. Another discretional power exercised by the frontline workers is in their determination of

**Table 2.** How frontline workers use discretion, why they use it and for whose interest.

| Organisations | How frontline workers or SLBs exercise Discretion. | Why they exercise Discretion? | Whose Interest does it serve? |
|---|---|---|---|
| Orgs 1-5 | Acceptance of temporal chits in place of health insurance cards | To increase clients access to healthcare | Served clients with no identity cards |
| W. Hosp. | First Come First Serve principle | Strict rule-following | Served clients only |
| West Hospital | Sometimes the principle is waived for some clients but not others | Rule-breaking as appropriate/demands | Served clients |
| SDA | First Come First Serve principle | Not so rule-following | Served clients |
| Hospital (Private) | Sometimes the principle was waived for some clients, but not for others who seek emergency healthcare services. | Rule-breaking as necessitated/needs | Served clients |
| Bilpeila Clinic (Public) | Choice of the facility for referrals | To access healthcare | Served clients |
| | Clients sitting arrangement | To see a doctor/nurse | Served Clients |
| | Clients' differentiation for services | What client deserve | Served Clients |
| Haj Adams Clinic | Equal treatment for all clients | Fairness and equality | All clients |
| Health Insurance Offices-District & Regional | Flexibility in the application of the eligibility criteria for all clients | To enrol more exempt group members | Served interest of exempted clients |
| | The acceptance of claims forms from hospitals and clinics after the stipulated period has elapsed | To facilitate the implementation of NHIS at the local level | Served health facilities' interest (hospitals/clinics) |

**Source**: Fieldwork evidence on frontline workers' or SLBs' use of discretion in Tamale, Ghana

indigent persons, which supports Lipsky's (1980) arguments that it is the "street-level bureaucrats" (frontline workers) who determine who qualify, they determine the nature, the quality of service to be provided as benefits and sanctions for clients/beneficiaries.

Literature support that in most cases policy 'rules cannot be mechanically followed' and should not be followed mechanically (Taylor, 1993, p. 213). There may be some flexibility in the application of policy rules not in the manner envisaged by the policymakers but in some situations in the direction of policy implementers (Taylor, 1993). This is the situation where Lipsky (1980) says that policy implementers are the actual policymakers. As Lipsky argues that public policies are "actually made in the crowded offices and daily encounters of street-level workers" (Lipsky, 1980, p. xii). Frontline workers may also exercise discretion depending on their freedom or autonomy in the work environment (Evans, 2010, 2016; Akosa & Asare, 2017). These situations may constitute what this study termed positively motivated discretion. On the other hand, they are situations or contexts where the frontline workers' use of discretion may be capricious- the whims and caprices against policy goals/intentions (Yeboah-Assiamah et al, 2018). Such may be termed negatively motivated discretion during public service delivery.

On how discretion affects service delivery in the implementation of the NHIS in Tamale, the study established that the frontline workers (officials) in the health insurance office exercised discretion beyond their formal authority, as they received the monthly claims forms after the "stipulated period" for submission elapsed. This study finding is consistent with some previous studies (Mensah, 1998; Meyers & Nielsen, 2012; Hupe, 2019). Also, this study found that frontline workers in health insurance office "exercised substantial discretion" in the application of the eligibility criteria for the social policy (NHIS), especially in the selection of exempt group members like indigent persons (poor), children and those below 18 years and the aged (70 years and above persons). This finding on the substantial exercise of discretion by frontline workers/SLBs concurs with earlier works (Lipsky, 1980, 2010). Moreover, such a substantial exercise of discretion turns to favour some clients (exempt group members). Also, the findings show that the use of discretionary powers cut across the categories of frontline workers in Table 1 and it is consistent with earlier work (Hupe, 2019).

Moreover, on how the frontline workers exercise discretion in service delivery, the study found that it is the frontline workers who determined who is an indigent person, who is aged or who decides to use a single parent instead of both parents for benefits. Thus, the frontline workers are found in an 'ethical dilemma' on who benefits and who does not benefit from the NHIS in terms of free registration (enrolment). These findings concur with Zacha (2017) and Hupe (2019).

Frontline workers in other organisations like hospitals and clinics also exercised enormous discretion at work during public service delivery to their clients particularly allowing clients to access healthcare services using temporal chits instead of health insurance ID cards. This constitutes what this study called the "cold" or positive relationship between frontline workers and clients. The "cold" relationship gives clients more access to healthcare services without hindrance. This finding collaborates with these works or agrees with earlier findings (Lipsky, 2010; Tummers & Bekkers, 2012, 2014; Tummers et al, 2015; Akosa & Asare, 2017).

There is the question of whose interest the use of discretion by frontline workers served. Some frontline workers violated the *first come first serve* principle and then allow some clients especially those in uniforms, politicians, some big men and women, chiefs, and some dignified persons in society to jump queues to have quick access to healthcare services when they visit facilities at the disadvantage of other clients. This is what this study termed "hot", negative discretion or what Zacka (2017) termed the "caregivers disposition". These findings in the study are consistent with other studies' findings (Tummers & Bekkers, 2014; Zacka, 2017; Yeboah-Assiamah et al. 2018). Lastly, on the issue of whose interest the use of discretion by the frontline workers served in the implementation of the NHIS, the findings from multiple sources (in-depth interviews, focus groups interviews, on-site direct observations and review of documents at the five organisations show that most of the discretion exercised by the frontline workers turn to serve the interest of their clients (policy beneficiaries) than serving the interest of frontline workers or their organisations' interest as presented in Table 2. The study noted that there may be some variations among the clients whose interest the frontline workers' use of discretion served, yet it is clear that most of the discretion exercised in the study favour clients (be it exempt group members, the privileged ones in society, or those with specialised

health needs) than the interest of the frontline workers or their organisations.

## Conclusions

### *Implications of Findings to Society, Limitation and Future Research*

The findings imply that the socio-economic status of health insurance clients plays a key role in the determination of the kind of healthcare services offered or received at health facilities. So, the clients are treated based on their health needs, emergency or the kind of discretion exercised for the categories of clients that are context-specific. This study contributed to the street-level bureaucracy theory. Also, the findings show that the implementation process (public service delivery) approach is more toward the bottom-up approach than the top-down approach. The actions and behaviours of local-level policy actors matter most. Moreover, this study adds a new dimension by addressing how, why and whose interest is served in the use of discretion by frontline workers in a developing world context of Ghana and may be relevant or applicable or transferable to countries with similar setting to Ghana on frontline worker use of discretion. Theoretically, it makes meaningful contribution to add that most of the discretion favour clients. Thus, the study concludes that public policies are made by those at the frontline level and not those at the legislature (parliament)-at the top (national level) as in most democratic states.

The main limitation of this study is that it is limited to one geographical area (Northern Ghana) and recommended future research should extend the coverage to Southern Ghana with more cases. Future studies may be extended to countries with a similar setting to Ghana as a cross-country study. A quantitative study may also be necessary for the generalisation of findings instead of relying more on qualitative data sources which emphasise the transferability of findings.

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The authors declare no conflict of interest.

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## Ethics

Ethical approval was waived by the ethics committee but with institutional permission.

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