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RESEARCH ARTICLE

EXAMINING THE PERSPECTIVES OF NEPALESE SENIOR PUBLIC HOSPITAL MANGERS ON PROFESSIONAL CAPABILITY AND CAPACITY DEVELOPMENT: A DESCRIPTIVE QUALITATIVE STUDY

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ABSTRACT

The purpose of this paper is to identify the strategies for developing and unlocking the professional capability and capacity of senior hospital managers in Nepal. This research is the first published study outlining the self-perspectives of Nepalese senior hospital managers on their capability and capacity development.

The study utilised a qualitative descriptive design as the second phase of a larger sequential mixed methods research project. Data were collected from 11 senior hospital managers through semi-structured interviews conducted online via the Zoom online videoconferencing platform between August to October 2024.

Four key themes identified were: Stability, continuity and coherence; Practical and logistical constraints; Interference, conflict and control; and managing the mismatch between ability and expectations. Findings highlight breakages in work roles and pervasiveness of political and opportunistic individual actions alongside complex and lengthy bureaucratic processes that stifled senior public hospital managers working roles. Along with well-organised administrative procedures, appropriate compliance training for senior hospital managers is thought essential. Findings from this study may be broadly applicable to other under resourced countries in the Asia Pacific region.

KEYWORDS

Senior hospital managers; capability development; capacity development; Nepal

BACKGROUND

Well-functioning health systems enable countries to deliver the essential health care services required to maintain and improve population [1]. However, health systems do not operate effectively in isolation; they depend on a competent health management workforce to drive continuous improvement and ensure effective organisational performance [2]. In practice, many clinical practitioners, highly skilled in their clinical domains are promoted into managerial positions because of their career achievements rather than demonstrated managerial capability [3,4]. Without formal management training, these clinicians often enter leadership roles as novices, lacking the specialised competencies required for effective management practices. The scope of managerial responsibilities is extensive and in a rapidly evolving health sector, future clinical managers must demonstrate proficiency in management alongside their clinical expertise [5,6]. Yet, efforts to cultivate a competent health management workforce have been fragmented and largely insufficient, constrained by the absence of a coherent and strategically aligned framework [5,7]. Moreover, capability and capacity building initiatives across countries have been inconsistent, resulting in substantial variation in health management development and uneven progress in strengthening health management systems [5]. Such shortcomings are highly evident in under-resourced countries facing entrenched social and economic adversities, such as Nepal [7,8].

Nepalese hospital management roles have been operating without formal regulation, lacking specific registration or credentialing standards [4]. Additionally, clear competency criteria for hospital managers have yet to be properly defined as management positions are well occupied by senior doctors [4,8]. A lack of structured guidance in designing and developing training programs for hospital managers has contributed to reduced confidence in performing managerial roles. Without clear training frameworks, managers may struggle to build the necessary skills required to effectively do their job [9].

Senior hospital managers (SHMs) in this research refers to all department heads/ chiefs or managers who are at senior level and responsible for managerial functions. SHMs further reports to the hospital director, while the hospital director reports to the hospital management committee or directly to the Ministry of Health and Population, Government of Nepal [10,11]. A cross-sectional study using a survey questionnaire aimed at Nepalese SHMs was undertaken in Phase I of the study [9]. This built an understanding of the current competency levels and competency gaps identified by Nepalese SHMs in central level public hospitals in Nepal. To gain a deeper understanding regarding the barriers and enablers for SHMs to develop and demonstrate their managerial roles a follow up qualitative study was completed.

METHODS

The study utilised a qualitative descriptive design as the second phase of a larger sequential mixed methods research project aiming to identify strategies for development and unlocking of professional capability and capacity among SHMs in Nepal. Participants for this qualitative study were recruited purposively [12]. The target population was SHMs in four central level public hospitals in Nepal. Recruitment was restricted to those who completed the cross-sectional survey in the first part of the larger project. A total of eleven participants expressed interest in undertaking a research interview. After the eleventh interview the research team agreed that thematic saturation had been achieved [13].

DATA COLLECTION

Data were collected through semi-structured interviews to allow flexibility in the interview process and enable participants to freely share their experiences and perspectives [14]. The interview questions were developed based on initial findings from the previous cross-sectional survey with the aim of exploring participants' perspectives on challenges and solutions at individual, team and organisational levels. The interviews were conducted online via the Zoom online videoconferencing platform between August to October 2024 and digitally recorded to aid transcribing. Consent was received from each participant before beginning the interview and revisited on completion of the interview process. Interviews lengths ranged from 30 to 45 minutes.

DATA ANALYSIS

The interviews were transcribed verbatim in Nepalese and then translated into English. NVivo version 20 was used to for data organisation and management during the analytical process. The interview data were analysed inductively using the six phases of reflexive thematic analysis as described by Braun and Clarke (2021) [15].

[1st Author] and [3rd Author] read the interview transcripts several times to familiarise themselves with the data. [1st & 3rd Author] independently coded the first three transcripts and then met to refine and consolidate these codes. The initial codes were then shared with all members of the research team and further refined following feedback. [1st Author] completed coding of the remaining eight interviews. [1st & 3rd Author] then met to discuss and collate these codes to generate initial themes and sub-themes. These initial themes were sent for review and feedback to the broader research team [2nd, 4th, & 5th Author] with minor amendments made. The themes were then named, and key illustrative quotes or passages of text were collated to support the explanation of themes during the writing phase.

RESULTS

The explanatory qualitative study including semi-structure interviews with SHMs comprised 11 participants (six females and five males). The participants' experience across various organisations ranged from up to five years (n=1), five to 10 years (n=6) and 11-20 (n=4) years.

Four key themes and 15 associated sub-themes were identified from the analysis of transcripts. The four themes highlight structural and procedural factors that the SHMs reported to influence their capacity to effectively fulfil their roles. For brevity and flow, the results presented in this paper have been outlined at the level of the overarching themes.

STABILITY, CONTINUITY AND COHERENCE

The theme of stability, continuity and coherence centres on a belief among SHMs that their capacity to perform their role effectively was compromised by interruptions and breakages in their roles. These interruptions took several forms. The most discussed factor, that of compromised stability, was the high rate of staff turnover within the teams led by the managers. The SHMs argued that this loss of continuity and stability inhibited their capacity to promote productivity within their service.

The available manpower is frequently changed so new manpower comes. The manpower who has learned some works are transferred elsewhere... As our hospital is a government hospital, none of the employees are permanent here…. New employees must be taught about everything … this causes difficulties. (SHM2)

The SHMs indicated that the establishment of permanent positions within the healthcare system assisted in promoting continuity and stability in their organisations. Whilst a permanent position for staff members guarantees ongoing employment in the Nepalese health system, it does not ensure ongoing stability within a particular working role. The participants stated that, typically staff members in middle or senior management roles are transferred to a different institution after a period of no more than two years. One participant (SHM8) discussed an approach they take to try and ensure stability in staffing by assisting their staff members to remain within their roles for a full two years.

In our department, the duration for transfer is set for two years. For two years, no one either comes or goes by transferring someone. I also do not propose to remove someone before he reaches two years in that post in the organisation and others will not come either. (SHM8)

Instability in working roles was not only encountered with team members but also by senior managers themselves. Most participants discussed challenges and frustrations brought about by the short-term nature of their appointment to a position. This was made worse where handover processes, to ensure continuity and coherence, have not been followed.

It's because there is no hand over system or there is no such thing to show the record that the department has done this

much till now …. If one asks, then I will say but there is no documented system mentioning that what I have done. Because of that, new staff need to go from zero again and when he/she reaches hundred percent then again, the management changes. (SHM7)

This frustration reflected concerns regarding both the quality and continuity of communication during times of handover. However, the importance and, at times, poor quality of communication was also discussed by participants in relation to the normal day-to-day working of their teams. For example, when communication was lacking, negative outcomes were described as occurring more frequently.

Conversely, in situations where effective communication processes were established, coherence, continuity of care and positive team dynamics were much more likely to be assured.

Initially, there used to be conflicts because the communication was not clear. Now we all discuss the issue in the group. Those who have conflict would forward their thoughts which would make things clear. … We discuss [these conflicts]*in our daily morning session for 15 minutes with all the responsible people …. Because of this our dynamics has improved, and harmony has maximised among the staff. (SHM1)*

PRACTICAL AND LOGISTICAL CONSTRAINTS

Several practical and logistical challenges were discussed by SHMs, expressing concerns that these obstacles undermined their ability to perform their roles effectively. One of the most frequently discussed constraints was the availability and assuredness of resources. Issues with insufficient budget allocations were highlighted as a key concern that could impact upon all elements of service provision.

We also lack the budget. It is a government institution. In one financial year, our budget was short. At that time, the budget was only for salary. Apart from that, tenders were to be made to buy goods, but that could not be done. For one year, we ran the hospital despite the scarcity. (SHM10)

Examples were discussed by SHMs in which they worked proactively with their hospital directors to address issues around budget shortfalls, recognising that this approach required a degree of compromise.

If there is crucial need, we usually talk to the director or head of the hospital through an application [for increased funding]. *They listen to us about our needs. Now we should be able to prioritise the requirement as per the need. It is not necessary that we get all the things as we say but they listen to us. (SHM4)*

One of the impacts of restricted budgets was difficulties in recruiting staff, leading to an overreliance on casual employees. This was problematic because the combination of staff turnover and casual workers means that staff lack the experience or the corporate knowledge necessary to perform the job well.

Concerns with the process for resource acquisition were also identified by several participants and compounded the challenges associated with insufficient budget allocations. Participants discussed a variety of strategies that they use to manage difficulties associated with resources acquisition. For example, one participant (SHM3) spoke about the importance of ensuring cooperation between the different levels and sections of the organisation, whereas another (SHM10) indicated that initiating tendering processes in a timely manner was key maintaining enough stocks of essential resources.

To run and manage an organisation the major thing is availability of authority [authorisation] *and resources. To provide the resources, all the concerned agencies must cooperate. Only giving the instructions to implement this and that but not giving any resources does not allow us (managers) to accomplish the task effectively. We cannot fulfill our objective. (SHM3)*

Once after facing lack of budget, we planned and opened tenders timely. If we open tenders in such a timely manner, there will be no shortage of goods. (SHM10)

Three SHMs described stockpiling strategies that they employed to guarantee availability of essential resources that might be needed urgently. Two of these SHMs worked in a rural context in which receipt of resources was not always guaranteed. Interestingly one of the SMHs (SHM9) discussed the importance of stockpiling as a critical resource management strategy in rural contexts but also recognised that this approach did not necessarily reflect the most efficient use of allocated resources.

Stocks are maintained for emergency drugs, and reagents … so we are maintaining a minimum stock of 3 months in the store for diagnosis. We are managing these things that way. Now it's efficacy and efficiency have created a little problem for us. But we are managing it in some ways. (SHM9)

Indeed, several geographical barriers associated with service provision specific to rural contexts were discussed. Participants described challenges associated with transport, infrastructure, logistics and staffing, highlighting the multiplicity of factors that complicate service coordination for SHMs in remote settings.

There is great difficulty. This hospital is in the entire hilly remote area of Nepal. Sometimes we are threatened by the public in the services we provide. When there is no logistic supply at the time and sometimes there is no internet, there are no lights, such things are many. We have faced many problems when equipment machines are broken, not maintained on time. (SHM11)

INTERFERENCE, CONFLICT AND CONTROL

The theme of interference, conflict and control focuses on a belief among SHMs that their ability to perform their roles effectively are sometimes compromised by internal interference, conflict, and restrictive hierarchical structures.
Some SHM's discussed concerns that interference in their working roles was often driven by self-interest among colleagues who had political or financial motivations.

If I try to do something, another person will stop me with political interest... If I take any proposal …, let's say it has a budget of around 10 lakhs [about 1.4 times the average SHM salary]. *If there is someone else with potential financial interest, they will manipulate the person above the director. … Due to politics, it will get manipulated and diverted by the higher authorities and do not allow to work... Because there is the economic interest – this is the problem. (SHM11)*

Challenges to being able to undertake their role as well as effective teamwork were also reported to arise due to opportunistic efforts from some individuals to enhance their chances of future promotion.

Although these forms of interference were considered both unhelpful and unnecessary, SMHs who reported them also discussed employing a range of strategies to try to improve the situation, prior to an escalation to more senior levels of the organisation if required.

I try to talk face to face with the person with whom I have a conflict. But sometimes there will be such a negative perception that it is not possible to talk face to face. In that situation, I communicate on paper and sit quietly. Sometimes, if there are too many problems, I will inform the ministry above me. I inform that I have a problem because of this reason and sometimes I have tried to solve it by organising a meeting in the team. (SHM1)

Several SHMs discussed that top-down decision making, and bureaucracy stifled their creativity and autonomy. One SHM (SHM6) stated that their recommendations relating to staffing and training within their own department were often ignored or overridden by the Directors who are in a position a level above them. Given that these decisions would have a considerable bearing on the function of their team, the SMHs felt that their recommendations and preferences should have been given greater consideration.

If one has worked well in my unit and want to send them to the training as a motivation then, the director should say yes. Or if one didn't work so well and has damaged the position of the unit, if I recommend not to add this contract, the director should not add the contract. If he adds then, it will get worse…. If I recommended for their contract extension, it's not like that it will be surely implemented. I recommend it, but practically what top level wants that will only happen. (SHM6)

These SHMs argued that in instances where their recommendations were not accepted, they should be informed of the reasons underpinning the decision. When this did not occur, SHMs felt undervalued and disempowered. Beyond this, however, some SHM asserted that broader changes to organisational processes are warranted to enable greater emphasis on bottom-up planning to ensure responsiveness to specific departmental needs and greater autonomy in the fulfillment of their roles.

Some SHMs reported feeling hamstrung in their working roles due to lengthy and non-negotiable procedural requirements. One example related to the process of procurement whereby the timely purchase of required commodities products was delayed due to the lengthy bureaucratic processes.

Another SHM raised similar concerns regarding a continued reliance on slow and multi-layered bureaucratic processes and advocated for a shift towards more output focused approaches targeted at creating greater efficiency and effectiveness. SHM6 argued that the greater the number of hierarchical approval levels that are required, the greater the risk of diversion or dilution of resources eventually received.

Process must be less focused, and output should be more focused …. When I want to add some service then I need to raise a comment … I need to take it to the head of the department. The head of the department brings it to the hospital director, the hospital director brings it to the development committee, the development committee will see if it is a priority or not. The more channel is there, the more interests will be mixed. That interest can be diluted when it gets to the decision makers. (SHM6)

MANAGING THE MISMATCH BETWEEN ABILITY AND EXPECTATIONS

Several SHMs discussed frustrations with a mismatch between their abilities and the expectations in their roles. In some instances, this mismatch related to underuse of their potential when they had specific knowledge and skills that were not required in the organisation they had been transferred to. This appeared to be a by-product of the process of rotating SHMs every two to three years. One example of this was reported by SHM1, who described a diminished role scope after being transferred from a major specialist hospital to a different organisation where her extensive skill set wasn't required.

It seems that I cannot utilise the capability that I have. … Because I think that I could utilise my previous experience and the knowledge I had acquired in a bigger area …. But I cannot utilise my capacity. I believe I could work in more areas. The present space is too small. I have not been able to use my potential. (SHM1)

Conversely, SHMs discussed numerous situations in which they were expected to work beyond their professional skill sets. SHMs suggested that they are routinely expected to perform tasks that extend beyond their stated job descriptions resulting in uncertainty and anxiety as well as compromising the time required to undertake the stated managerial duties.

Regarding the job description, … it has not been disclosed clearly whether or how much even: we do not understand it well. There are times when we work beyond our responsibilities. There is not the same skilled manpower everywhere …. And it has been challenging when we need to work apart from our skills outside of our subject. It is difficult but there are situations where we must do it. (SHM5)

Even in their stated day-to-day managerial roles some SHMs reported being responsible for duties that they did not feel able to perform well.

Since we are technical people, we may be experts in technical field, but we are not experts in other things. Now, from maintenance to infrastructure, all these things we are not perfect. (SHM5)

Some SHMs pointed to the importance of education and support to grow and unlock their managerial and leadership capacity as needed to perform the variety of roles expected of them. SHMs believed, however, that opportunities for education in managerial and leadership development have been limited in Nepal, impacting negatively on their capacity to perform well.

Interestingly, SHMs suggested that the education and training provided to them are typically oriented toward disease management or technical features of their roles, rather than managerial skills development, which is often underfunded. *The budget is reduced; many needs and expectations of the organisation must be covered from a small budget. Mainly our budget allocation is based in the core function. Other non-core functions are not considered. Now there is no situation to develop our own skills. (SHM8)*

One participant identified an example of hospital management-related education provided by the Nepalese government but highlighted the limited access to and long waitlists for this education and a tendency for it to be offered to individuals in higher level of management.

SHM4 discussed a different management related training opportunity that had been undertaken and positively reviewed by a few colleagues. SHM4 believed that this training should be prioritised and provided to all SHMs in hospitals.

I have heard that the management training of the staff college is a must. Some of our colleagues have also joined that training. That should be prioritised and given to all the senior managers of the hospital. (SHM4)

The need to be provided with education to support technical updates was also identified as a priority for some participants. SHM3, for example, stated that their technical and leadership knowledge had become outdated and suggested that periodic updates were required to enhance their potential.

We have certain limitations in recent technical system. We are not updated to it … it's all about online/virtual thing and I am little lacking to such things, …. So, if the organisation could provide me with some trainings and exposure then I can be more competent … Trainings and knowledges related to current affairs and digital things could help me to better land in the leadership role. (SHM3)

There was some difference of opinion among SHMs as to the way in which ongoing education should be provided. Some expressed a view that training should be mandated and built into organisational processes, pointing to the additional burden of having to seek training for oneself.

The organisation can support by giving trainings time to time. But here we must search for it ourselves, we must make an effort. (SHM5)

Others indicated that it would be better to be able to self-select education appropriate to their own needs and allocated roles but emphasised the need for organisational support with this.

It would be helpful if the organisation could facilitate in participating at national and international conference, we could take the initiative ourselves. And if the organisation could nominate the name of staff for training, then it would be better. (SHM10)

A few SHMs stated that the absence of educational opportunities contributed to a loss of professional motivation, suggesting that it reflected a broader lack of recognition of the hard work that is put into the SHM roles.

Importantly, one participant highlighted the risks to individual mental health that can occur because of SHMs performing their role. This concern reflects a need for greater personal and pastoral support for SHMs due to the challenging and dynamic nature of their working roles.

Emotional matters and mental health also need to be focused …. How do a manager feel and his thinking also should be considered. … The manager is also under stress, now what is the reason why this happened to him... It's important to identify the cause behind it. I feel that mental health and emotional issues need to be addressed. (SHM10)

DISCUSSION

This qualitative descriptive study explored the barriers for SHMs in central level public hospitals in Nepal in demonstrating their managerial competencies and capabilities. The findings highlighted several structural and procedural factors that SHMs reported to influence their capacity to effectively fulfil their managerial roles.

This study revealed that the instability of SHMs and their working team has undermined SHMs productivity and jeopardised their ability to accomplish their managerial tasks. The short-term nature of hospital management appointments resulted in high staff turnover, unpredictability, lost productivity, shifting responsibilities and lack of handovers. The approach taken by one SHM through advocating his team member to remain in their working roles for designated period, has been helpful in ensuring stability and continuity in staffing. These findings suggest a need for a degree of predictability in the working roles of SHMs and their teams along with arrangements for structured promotion. Turato et al. (2024) reinforce this by stating that provision of structured progression opportunities reduces uncertainty and improves retention of health professionals [16].

Challenges and frustrations brought about by the short-term nature of SHMs own appointments were made worse due to the non-adherence to the existing handover processes. The lack of formal handovers reported by SHMs, needs immediate attention to implement and adhere to the existing handover protocols. As supported by the Australian Commission on Safety and Quality in Health Care [ACSQHC] (2025) executing structured handover protocols along with clear documentation systems is essential for ensuring the transmission of consistent and accurate information [17]. McCarthy (2025) also emphasises organised handover approaches can mitigate risks associated with fragmented information exchange thus strengthening patient safety [18]. Whilst Nepal Health Service Regulations, 1988 requires proper documentation of duties, responsibilities and assets during managerial transitions, [19] the actual problem is its implementation. Similarly, Nepal Public Health Service Regulations, 2020 mandates that the institutions maintain service continuity during leadership changes [20] but lack of adherence to policies and procedures have led to frustration and inefficiencies with inferior communication strategies resulting in unfavourable outcomes and decreased morale of SHMs. To assist SHMs through transition, mentorship and peer networks should be encouraged thus fostering adaptive leadership skills [21]. Kreps (2016), reinforces the importance of a collaborative work culture for empowering team members to communicate, share their thoughts, and reduce misunderstandings whilst improving patient outcomes and organisational coherence [22]. Complementing this, structured workshops on communication skills focussing on conveying crucial information confidently and precisely needs to be implemented.

Senior hospital managers' report that budget related issues have impacted their management role with the need to compromise with hospital directors. Suggestions for overcoming lack of funding include optimising resource allocation, acquiring government grants, and exploring public-private partnerships [23]. As well as this, systematic budgeting approaches and tailored allocation mechanisms are crucial in sustaining health service delivery [24]. SHMs discussed their concerns with the processes associated with resource acquisitions and viewed it to compound the challenges associated with insufficient budget allocations. Different strategies have been employed by SHMs to overcome these challenges, such as ensuring cooperation between the different levels and sections of the organisation, initiating tendering processes in a timely manner for maintaining enough stock of essential resources.

This study identified that rural location impacted management practice since the timely receipt of resources was not always guaranteed. SHMs discussed the importance of stockpiling as a critical resource management strategy in rural contexts but also recognised that this approach may not adequately reflect the most efficient use of allocated resources. This research has demonstrated that geographical difficulties, restricted transport facilities and low staff numbers impact service provision. These context-specific difficulties highlight the importance of government strategies including prioritisation of transport infrastructure, regional collaboration and targeted resource issuance to enhance healthcare [25]. The need for prioritisation of strategic investment in logistical support systems in rural and underserved areas along with multi-sectoral collaborative approaches [25] would help to address infrastructure barriers and assist SHMs in their managerial role.

The study identified that the casual staffs, competing interests and power struggles stifled autonomy of SHMs and hindered institutional coherence. Such challenges require SHMs to have critical leadership skills to navigate these challengers as well as remain proactive and resilient. This is a similar finding to Clarke et al. (2021) who emphasised political skills for aiding health managers in engaging stakeholder negotiation, utilising contextual knowledge and having impact on policy processes [26]. Similarly, Agostini et al. (2023) also identified that resilient hospital mangers are well prepared for handling both acute disturbances and chronic stressors including politically intensified situations whilst maintaining service standards [27]. The identification of strategies proactively employed by SHMs during handling difficult situations prior to needing to escalate issues to senior directors further supports the importance of developing resilient and proactive SHMs.

SHMs felt undervalued and disempowered when their recommendations regarding their department were overridden or ignored by senior directors. The lack of transparency and respect for SHM knowledge has undermined SHMs confidence eroding trust as well as reducing team morale. Psychologically safe environments are places where professional input is encouraged and respected. Such approaches are important for promoting participatory governance whilst strengthening accountability and improving cohesion of the health workforce in dynamic and resource-sensitive circumstances [28].

SHMs identified multi-layered bureaucratic processes as an impediment to effective and efficient management advocating for transition toward output-oriented and adaptive approaches. SHMs also discussed that broader changes to organisational processes are warranted to enable greater emphasis on bottom-up planning to ensure responsiveness to specific departmental needs and greater autonomy in the fulfillment of their roles. These findings highlight the significance of empowering SHMs through government reforms, prioritising transparency and flexibility in the interests of productive and accountable service delivery through the dynamic hospital system.

Broad dissatisfaction and diminished motivation among SHMs were identified due to misalignment between their professional capabilities and role expectations. Similar to previous research [4,29] access to training was limited and predominantly oriented toward clinical and technical competencies development. The need for organisational leadership development reinforces findings by Chadwell et al., 2012 [4] and Pokhrel et al., 2025 [9] who recommend a multidimensional approach, targeting management competencies, specific to the context and roles required of SHMs. Research evidence suggests mentorship, peer collaboration, and the opportunity for expert consultation are other strategies for increasing manager competency [30]. These mechanisms strengthen managerial skill acquisition, reinforcing the ability of health managers to negotiate complex health systems. At an organisational level work is required to define SHMs roles, responsibilities and expectations. Thus, policy makers, and SHMs need to develop adaptable, context-specific role descriptors as well as training and mentorship opportunities to support SHMs in their managerial role.

SHMs identified that stress when undertaking their role can impact mental health. Previous research [31] has highlighted that managers experience stress in their roles due to expectations placed on them, the level of responsibility to meet high standards with limited resources and additional bureaucracy when trying to implement change. This study did not aim to investigate psychological safety and future research in this area is recommended.

STRENGTHS AND LIMITATIONS

This study provides a rich understanding of an under-researched context related to SHMs in central level public hospitals in Nepal. The incorporation of current SHMs perspectives assures that the explored topic is connected to current real-world practice. Practical suggestions for improving the hospital management system and workforce policy development, may aid in hospital management reform. While this study does not propose detailed policy solution, a follow up study involving national-level policy makers is planned to examine the system-wide strategies and feasible interventions. This sequential approach ensures that any proposed solution s are grounded in both managerial experience and policy authority, rather than relying on generic or superficial recommendations.

Results may be impacted by personal bias. Utilising reflexivity in data interpretation along with identifying consistent patterns by comparing evolving themes, the research process reduces potential individual bias [32].

The focused scope on central level public hospitals in Nepal sets the findings within the bounds of a defined cultural and operational circumstance. Findings from this study may be broadly applicable to other under resourced countries in the Asia Pacific region. However, challenges identified in this study, including limited budgets, staff turnover, reliance on casual staff, burnout and rural service delivery issues are not exclusive to under resourced countries or LMICs, rather the distinguishing feature is the degree of resource constraint, managerial autonomy, and system capacity within LMIC settings. The intention is not to identify LMIC challenges as unique, but to provide context specific insight into how these widely recognised issues manifest within the Nepalese hospital system and how they shape the managerial capabilities of SHMs.

CONCLUSION

The findings highlight the nuanced barriers for the development and demonstration of managerial competencies and capabilities required for SHMs roles. Managerial effectiveness is multidimensional and influenced by workforce instability, practical and logistical constraints, interference and conflict and the mismatch between ability and expectations. Breakages in work roles and sabotage of formal handover processes contributes to undermining SHMs managerial performance, with a need for predictability in SHMs and their team dynamics and role accountabilities. Operational capacity of SHMs can be significantly constrained because of geographical and logistical challenges particularly those arising in rural and underserved regions. Overall government investment in infrastructure, transport, and the health management workforce is required to enable appropriate service provision.

Moreover, the pervasiveness of political and opportunistic individual actions alongside complex and lengthy bureaucratic processes requires development of well-organised administrative procedures, defined promotional pathways and appropriate compliance training. Discrepancy between organisational expectations and managerial ability lead to professional frustration, warranting documented role expectations, targeted skill development, system level support. Given the multidimensional, complex and stressful nature of SHMs roles, pastoral and personal support mechanisms are required for long-term hospital management workforce resilience.

Ethics Statement:

Ethics approvals were obtained from Nepal Health Research Council (NHRC-545/2023) and James Cook University Australia Human Ethics Research Committee (H9203).

Conflict of Interest Disclosure:

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