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Theoretical and methodological foundations of delegating management powers in healthcare institutions

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Abstract. The relevance of this study is driven by the specific nature of healthcare institutions, which are characterised by a high level of professional autonomy among medical personnel, substantial responsibility for patients' health and lives, as well as strict regulatory constraints. The combination of these factors makes the issue of delegating managerial authority particularly significant, yet insufficiently explored both in theoretical and applied dimensions. The purpose of this article was to substantiate the theoretical and methodological foundations of delegating managerial authority within healthcare institution management in order to enhance the efficiency and effectiveness of administrative activities. The research methodology included general scientific and specialised methods, in particular the analysis and synthesis of scholarly sources, systemic and structural functional approaches, comparative analysis, generalisation, and logical modelling of managerial processes in healthcare organisations. The study refined the conceptual essence of delegation in the management of a healthcare institution as a complex administrative process involving the transfer of tasks, authority, and responsibility while maintaining an appropriate level of control and accountability. The article highlighted the specific features of implementing line and functional authority in the management system of healthcare institutions and identifies their advantages and limitations. Particular attention was paid to identifying the major risks associated with delegation, including insufficient staff competence, loss of managerial control, communication barriers, psychological resistance to change, professional burnout, reduced standardisation of medical care, as well as legal and ethical threats. The practical significance of the research findings lies in their applicability for healthcare managers seeking to improve delegation mechanisms by enhancing staff training, standardising administrative procedures, clearly delineating responsibilities, and strengthening systems of control and feedback

Keywords: professional autonomy; managerial responsibility; delegation risks; management efficiency

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Introduction

Contemporary transformational processes within healthcare systems are increasing the demands placed on the effective management of healthcare facilities. In their research on organisational development, V.H. Alkema *et al.* (2023) highlighted the necessity of implementing modern managerial approaches that enhance adaptability. Under conditions of decentralisation and the autonomisation of healthcare institutions, O.O. Shevchenko *et al.* (2021) argued that rising competition and limited resources necessitate a rational distribution of managerial functions. Furthermore, according to the World Health Organization (2025), such a strategic redistribution across different management levels is vital for strengthening national health systems. Consequently, the delegation of managerial authority emerges as a crucial mechanism for improving both the efficiency and effectiveness of managerial activities. In the management of healthcare organisations, delegation is viewed not only as an organisational necessity but also as a complex managerial process that involves the transfer of authority, responsibility, and resources while simultaneously maintaining oversight and accountability. Ineffective or merely formal delegation leads to managerial overload, reduced quality of decision-making, staff demotivation, and disruptions in internal communication processes, thereby undermining the overall functioning of healthcare institutions.

Despite the considerable body of research in the field of general management, the issue of delegating managerial authority within healthcare institutions remains insufficiently systematised. This gap stems from the specific nature of medical practice, the societal significance of healthcare services, the high degree of professional autonomy among healthcare workers, and the regulatory constraints that shape managerial decisions. These factors underscore the need for a more comprehensive theoretical and methodological elaboration of delegation as an integral component of healthcare management systems. This necessity determines the relevance and purpose of the present study.

The issues of delegation and the strategic distribution of authority in healthcare continue to attract considerable scholarly attention. Contemporary studies demonstrate that ineffective delegation is closely associated with missed nursing care, disruptions in care continuity, and compromised patient safety, emphasising the importance of wellstructured authority distribution within healthcare teams (Papathanasiou *et al.*, 2024). Similarly, analyses of organisational performance reveal that inadequate staffing, unbalanced workloads, and insufficient clarity in delegated responsibilities create systemic risks that negatively influence patient outcomes and organisational stability (Oliveira *et al.*, 2024). The World Health Organization (2025) emphasised that modern healthcare transformations require a fundamental rethinking of managerial authority. Digitalisation is reshaping managerial functions, creating demand for new models of decisionmaking, coordination, and functional responsibility within healthcare institutions. Furthermore, governance-oriented studies underscore the critical role of transparency, accountability, and multilevel coordination in improving managerial efficiency and strengthening the resilience of national health.

European scholars have increasingly focused on the critical link between managerial authority and organisational safety. In their recent analysis, A.-K.L. Hansen *et al.* (2024) demonstrated that an expanded span of control negatively affects a manager's capacity to ensure high-quality care, noting that increased workload stress often reduces supervisory effectiveness within complex hospital environments. Within the Ukrainian academic context, strategic documents emphasise ongoing reforms in healthcare governance. The Strategy for the Development of the Healthcare System of Ukraine until 2030 (2025) outlines modern approaches to coordination, distribution of authority, and strengthening managerial autonomy aligned with European integration processes. Analytical contributions further demonstrate that healthcare managers must increasingly reallocate routine operational responsibilities to focus on strategic decision-making, leadership development, and valuebased care (Sayyed *et al.*, 2024). Concurrently, recent scholarly interpretations of Mintzberg's work emphasise the necessity of collaborative rather than strictly hierarchical models of managerial interaction within healthcare organisations (Tian *et al.*, 2023).

Collectively, these studies form a contemporary theoretical framework that substantiates the need for systemic, evidencebased approaches to delegating managerial authority in healthcare organisations. Such approaches are essential for improving management performance, strengthening accountability, and enhancing the resilience and strategic capacity of healthcare systems. The aim of the article was to substantiate the theoretical and methodological principles of delegating managerial authority in healthcare management in order to enhance the overall efficiency and effectiveness of managerial activities.

Materials and Methods

The research was based on a comprehensive systematic approach and employed a combination of theoretical, analytical, and qualitative methods. The study was conducted in three interrelated stages to ensure the objectivity and reproducibility of results regarding the delegation of managerial authority in healthcare organisations (HCOs). The first stage involved an indepth documentary and theoretical analysis of the regulatory and conceptual framework of healthcare management. This included the study of national legislation, strategic governance documents, and international guidelines that outline the legal and managerial boundaries of authority distribution in healthcare. Key sources examined were the national regulatory framework shaped by public administration reforms in Ukraine (Shevchenko *et al.*, 2021) and contemporary WHO recommendations on strengthening health system governance (World Health Organization, 2025). The analysis focused on classical management principles such as the "scalar

chain" and "span of control", tracing how formal authority is transferred from senior executives to middle and lowerlevel managers. Foundational management literature, including M.H. Mescon *et al.* (1988), and modern Ukrainian academic contributions (Alkema *et al.*, 2023), supported the refinement of the conceptual essence of delegation as a process involving the transfer of tasks while maintaining ultimate accountability.

The second stage applied structuralfunctional modelling and comparative analysis to distinguish the distribution of line and functional authority within multidisciplinary healthcare institutions. Particular attention was given to the practical implementation of delegation in clinical environments where functional authority – such as infection control, quality management, or clinical audit – intersects with linear administrative hierarchies. Spanofcontrol parameters were incorporated analytically based on findings of A.-K.L. Hansen *et al.* (2024), demonstrating how expanded managerial spans affect supervision quality, workload, and coordination processes in hospital management systems. Furthermore, the risks associated with delegation in clinical pathways and parallel authority structures were examined through recent international evidence on the managerial consequences of insufficiently defined responsibilities and their relationship to quality and safety (Papathanasiou *et al.*, 2024; Oliveira *et al.*, 2024).

The third stage relied on logical induction and qualitative risk identification to formulate managerial models for effective delegation under varying organisational conditions. Using fundamental management principles, particularly unity of command and parity between authority and responsibility (Mescon *et al.*, 1988), the study developed logical frameworks for delegating both routine operational tasks and critical, timesensitive clinical decisions. Qualitative synthesis enabled the identification of systemic barriers to effective delegation within HCOs, grouped into clinical risks (related to patient outcomes), legal risks (arising from shifts in responsibility), and psychological factors (such as lack of confidence, fear of liability, and burnout among staff). The analysis integrated recent crossdisciplinary findings on leadership effectiveness and managerial decisionmaking in modern healthcare systems (Sayyed *et al.*, 2024), as well as contemporary international perspectives on collaborative, nonhierarchical healthcare management models (Tian *et al.*, 2023). This triangulated methodological approach enabled the development of evidencebased recommendations for strengthening delegation practices through managerial training, standardised decisionmaking procedures, and enhanced feedback mechanisms in the context of ongoing healthcare decentralisation and governance reforms (The Ministry of Health of Ukraine, 2025).

Results and Discussion

Conceptual foundations of delegation in healthcare management

As was defined by I. Papathanasiou *et al.* (2024), delegation refers to the transfer of tasks and authority from a manager to a subordinate who assumes responsibility for their execution. The effective functioning of the complex interaction system between managers and subordinates within a healthcare institution does not presuppose that a single manager performs all managerial functions. This is attributed to the multilevel structure of healthcare management, the diversity of functional tasks, and the high dynamism of the external environment. Concentrating managerial authority in one pair of hands leads to overload, reduced quality of managerial decisions, slower decision-making processes, and diminished responsiveness to environmental changes. Additionally, the inherent limitations of individual managerial resources – such as time, competencies, and cognitive capacity – objectively necessitate the distribution of managerial functions across different levels and actors within the organisation. Delegation of authority enables the engagement of the professional potential of healthcare personnel, increases staff responsibility and motivation, supports the development of managerial competencies, and contributes to the formation of an effective system of internal communication. Collectively, these factors enhance the performance and resilience of the organisation, as noted by M.H. Mescon *et al.* (1988).

An integral component of delegation is authority itself, understood as the bounded right to utilise organisational resources and guide the efforts of subordinate employees toward completing assigned tasks. For instance, in a multidisciplinary healthcare institution, the chief executive officer may delegate to the head of a clinical department the authority to organise diagnostic and treatment processes within that unit. This includes planning staff workflows, forming duty schedules, allocating material and technical resources, and coordinating physicians and nursing personnel to achieve established quality indicators of medical care. At the same time, this authority remains limited, as the department head operates within the approved budget, institutional policies, and standards of medical care. Strategic decisions regarding institutional development, financing, and human resource policy remain within the purview of senior management.

A functionally decisive component of delegation, as defined by V.H. Alkema *et al.* (2023), is responsibility – an obligation to complete assigned tasks and to be accountable for the quality of their execution. The chief executive officer assigns to the head of a clinical department responsibility for ensuring compliance with clinical protocols and quality indicators. The department head must organise the work of physicians and nursing staff to guarantee timely and high-quality medical services, minimise medical errors, and ensure proper maintenance of medical documentation. Regardless of the fact that tasks are completed by subordinate staff, the department head bears personal accountability for the unit's performance. It is important to emphasise that authority is delegated to a position, not the individual who occupies it. When an employee changes roles, the authority associated with the previous position is terminated and replaced by the authority inherent in the new one. Building on this understanding of responsibility and the formal

allocation of authority within organisational roles, V.H. Alkema *et al.* (2023) distinguished between line and functional authority depending on the nature of delegation. The comparison of these types of authorities is summarised in Table 1.

Table 1. Comparison of line and functional authority in healthcare management

Criterion	Line authority	Functional authority
Nature	Hierarchical	Cross-functional
Decision-making	Direct, mandatory	Advisory or specialised
Scope	Within chain of command	Across departments
Example	Medical director → department head	Infection control service
Advantage	Clear accountability	Professional specialisation
Limitation	Rigidity	Potential conflicts

Source: developed by authors based on V.H. Alkema *et al.* (2023)

Line authority is transferred directly from a superior to a subordinate and then cascades to lower levels. It constitutes a legally sanctioned power enabling a manager to make decisions within the scope of their responsibilities without requiring additional approval from higher management. Delegation of line authority shapes the hierarchical structure of healthcare organisations – a scalar chain or chain of command. Modern healthcare leadership research emphasises that effective delegation requires clear delineation of administrative and clinical lines of authority, especially under conditions of organisational complexity (Spanos *et al.*, 2024). This aligns with contemporary views that leadership in healthcare must integrate collaborative, cross-functional, and adaptive decision-making to maintain quality and safety in dynamic clinical environments. An example of line authority in a healthcare institution is the managerial authority exercised by a medical director over departmental heads. The medical director has the right to issue mandatory directives regarding diagnostic and treatment organisation, staff scheduling, and adherence to internal policies and clinical standards. Department heads, in turn, exercise line authority over physicians, nursing staff, and junior personnel by assigning tasks, monitoring performance, and applying managerial measures within their competence. Thus, line authority establishes a clear vertical structure of governance within a healthcare institution, ensures unity of command, enables timely decisionmaking, and reinforces personal accountability for performance outcomes at each managerial level.

An example of line authority in a healthcare institution is the managerial authority exercised by a medical director over the heads of structural units. The medical director has the right to issue mandatory directives to department heads regarding the organisation of diagnostic and treatment processes, staff work schedules, and adherence to internal policies and standards of medical care. Department heads, in turn, exercise line authority over physicians, nursing staff, and junior medical personnel by assigning tasks, monitoring performance, and applying managerial measures within their scope of competence, as noted by A.M. Malik & E.G. Elorrio (2023). Thus, line authority establishes a clear vertical structure of governance within a healthcare institution, ensures unity of command, enables timely decision making, and reinforces personal accountability for performance outcomes at each managerial level (Spanos *et al.*, 2024).

An example of functional authority within a healthcare institution, according to E. Tsapnidou *et al.* (2024), is the authority exercised by managers and specialists of specialised services who have the right to influence the activities of other departments within the scope of their professional competence, even though they are not part of their direct line of command. For instance, the medical director or the deputy director for clinical services is vested with functional authority regarding the implementation and monitoring of compliance with clinical treatment protocols across all departments of the institution. As noted by V. Loving (2025), individuals exercising functional authority have the right to provide methodological guidance, request adjustments to diagnostic and treatment processes, initiate internal audits of the quality of care, and suspend the use of treatment methods that do not comply with approved standards, regardless of the line subordination of department heads. Similarly, the chief nursing officer exercises functional authority over nursing services in all structural units by establishing standardised requirements for patient care, maintaining sanitary and epidemiological safety, and managing the use of medical products. Thus, functional authority ensures professional specialisation in management, standardisation of processes, and improvement in the overall quality of healthcare institution operations.

Delegation process and managerial model

Digital transformation in healthcare further complicates these structures, necessitating flexible delegation models. To clarify how authority operates in such settings, different types of functional authority can be distinguished. Table 2 presents the main types of functional authority, along with their descriptions and examples.

Table 2. Types of functional authority

Type of authority	Description	Example
Legitimate	Based on formal position	Director authority
Advisory	Provides recommendations	Clinical committee

Table 2, Continued

Type of authority	Description	Example
Mandatory coordination	Requires approval	New clinical pathways
Parallel	Independent but simultaneous decisions	Protocols vs scheduling

Source: developed by authors

Legitimate authority in a healthcare institution is exemplified by the powers of the director of a municipal non-profit enterprise. Under the Law of Ukraine "Fundamentals of Health Care Legislation of Ukraine" (1992), the institution's charter, and the contract with the owner, the director has the right to independently issue orders concerning the organisation of the institution's operations. The director may also approve job descriptions, establish work schedules for structural units, and appoint responsible individuals for occupational safety and infection control without requiring additional approval from higher-level authorities.

Advisory authority within a healthcare institution is exercised, for example, by a clinical expert committee or a medical director who does not issue mandatory directives but provides professional recommendations for physicians and department heads. Based on the analysis of clinical cases, the committee may propose improvements to treatment protocols, the appropriateness of diagnostic methods, or modifications in managing complex patients. Recommendations are considered in clinical decision making but are not mandatory unless specified in internal regulatory documents. Likewise, the infection control service may develop recommendations to improve sanitary practices, which serve as the basis for managerial decisions (Tsapnidou *et al.*, 2024).

Mandatory coordination authority arises in situations where a functional manager must seek agreement or approval from line managers before implementing decisions. For example, when the medical director plans to introduce new clinical pathways, such decisions must be coordinated with department heads, as their implementation directly affects workflows, staff load, and the use of resources. The chief nursing officer likewise must coordinate revised standards or schedules with department heads to ensure continuity of care and prevent conflicts (Spanos *et al.*, 2024).

Parallel authority refers to decisions made independently yet simultaneously by a functional manager and line managers within a healthcare institution. For example, a medical director may develop new clinical protocols for chronic disease management, while department heads organise the work of their units in accordance with internal schedules and staff distribution. The medical director's decisions (regarding protocols) and those of the department heads (regarding operational organisation) function in parallel, complementing one another to ensure high-quality care. Similarly, the chief nursing officer may establish standards of nursing care for all departments, while department heads organise the allocation of nurses and staff rotations. Their decisions coexist: the chief nursing officer oversees adherence to standards, while line managers ensure their implementation (Loving, 2025; Aljamal *et al.*, 2025). Thus, parallel authority allows the integration of specialised expert functions with operational line management, enhancing the efficiency of healthcare institution performance. Under a manager's supervision, four types of units may operate (Fig. 1).

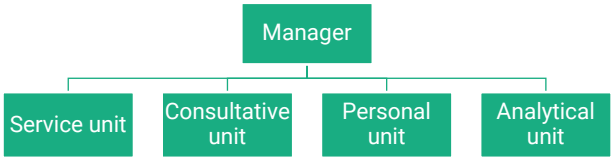

Figure 1. Types of specialised units in parallel authority
Source: compiled by the authors

A service unit is responsible for performing specific tasks (planning department, human resources department, labour and payroll department, accounting, procurement, etc.). A consultative unit consists of specially invited consultants working on a permanent or temporary basis. In healthcare institutions, this typically includes specialists who provide expert consultations to patients and recommendations to physicians across departments but are not engaged in continuous inpatient care. A personal unit includes employees who interact directly with the manager (secretary, assistant, aide, etc.). An information or information analytical unit provides the manager with essential communication and analytical support (Dougherty *et al.*, 2022).

Shortcomings in management often stem from a dual resistance: a manager's reluctance to delegate authority and a subordinate's unwillingness to assume responsibility. W. Newman (1955) identified specific barriers to effective delegation, which remain foundational to management theory. Building upon this framework, N. Baum (2025) further explored the psychological dimensions of these barriers, highlighting that managers often avoid delegation due to several internal factors. These multifaceted barriers can be systematically categorised into two perspectives: those originating from the supervisor and those originating from the subordinate (Table 3).

Table 3. Barriers to effective delegation in healthcare management

Factors leading to managers' reluctance	Factors leading to subordinates' resistance
Overestimation of capabilities	Fear of criticism and responsibility
Lack of confidence in managerial abilities	Low self-confidence in performing new or complex tasks

Table 3, Continued

Factors leading to managers' reluctance	Factors leading to subordinates' resistance
Distrust of subordinates' competence and reliability	Lack of necessary information, resources, or authority to complete tasks
Fear of risk and accountability for subordinates' errors	Excessive workload and inability to take on additional responsibilities
Absence of effective control mechanisms for monitoring delegated tasks	Lack of incentives or motivation for assuming additional responsibility
High-risk nature of healthcare decisions	Insufficient competence or experience in performing delegated tasks
Lack of clear standards, protocols, or regulatory support	Uncertainty in situations where procedures or guidance are not clearly defined
High level of legal and financial responsibility	Reluctance to assume responsibility associated with financial or legal consequences
Presence of conflicts of interest or political/organisational pressure	
Crisis or emergency situations requiring centralised decision-making	

Source: compiled by the authors based on W.H. Newman (1955), N. Baum (2025)

One primary reason is the "self-enhancement bias" – the belief that "I can do it better myself" – which leads to an overestimation of one's own capabilities. Conversely, a lack of confidence in one's managerial abilities or a fundamental distrust of subordinates can also inhibit the process. Additionally, N. Baum (2025) noted that a fear of risky decision-making and the absence of selective control mechanisms, which are necessary for the early detection of threats, further contribute to this reluctance. Healthcare managers may further avoid delegation in situations involving high stakes decisions – those directly affecting patient life and health, such as the assignment of complex or high-risk treatment procedures, surgical interventions, or the use of new techniques, where errors may carry severe consequences. Insufficient staff competence may also hinder delegation if subordinates lack the necessary knowledge, skills, or experience to make independent decisions within delegated authority. Delegation may also be avoided when clear standards or protocols are lacking, or when there are no regulatory or internal documents defining the task, meaning any mistake could lead to legal or clinical consequences. High levels of responsibility and risk – for instance, procurement of expensive medical equipment, contractual agreements, or licensing – can further limit managers' willingness to delegate, as pointed by S. Khan (2024). Delegation is also withheld in situations involving conflicts of interest or political pressure, where personal involvement of the manager is required due to internal or external political, financial, or social factors. Finally, a chief executive officer will typically avoid delegation during transitional or crisis situations – such as epidemics, emergencies, or technical failures – when centralised and rapid decision making is more effective than distributed authority (Aljamal *et al*., 2025).

Subordinates may also refuse to accept delegated authority. This most often occurs due to a lack of initiative and fear of addressing problems independently. Low self-confidence and fear of criticism are likewise common reasons for declining delegated responsibilities. A lack of necessary information and resources, excessive workload, and an absence of additional incentives may also hinder effective delegation, as noted by A.M. Hassan *et al*. (2024). In a healthcare institution, subordinates may refuse delegated authority in situations of insufficient competence or experience. For example, a junior physician or nurse may decline to make independent decisions regarding the use of new and complex treatment methods if they have not completed appropriate training or clinical rotations. A senior nurse may refuse a request from the department head to coordinate activities across several units during equipment repairs when no approved procedures exist. A physician may also decline to sign procurement documents for expensive medical materials or pharmaceuticals due to the associated financial responsibility and managerial oversight. Excessive workload can likewise lead to refusal; for instance, a nurse may decline additional responsibilities for organising shift schedules for the entire department due to staff shortages and the impossibility of performing all duties effectively.

Principles of effective delegation

Following the systematisation of key barriers to effective delegation presented in Table 3, it is important to consider not only the factors that hinder delegation, but also the principles that ensure its successful implementation in practice. While the identified barriers reflect typical challenges faced by both managers and subordinates, overcoming them requires adherence to well-established management principles. Therefore, to complement the analysis of barriers, Figure 2 illustrates the key six principles of effective delegation in healthcare institutions, which serve as a conceptual framework for improving managerial practices and minimising the impact of the aforementioned limitations.

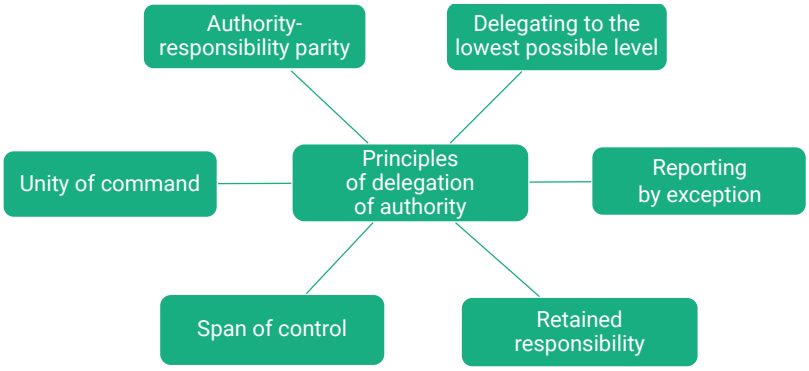

Figure 2. Key principles of effective management delegation in healthcare institutions
Source: compiled by the authors based on World Health Organization (2025)

According to the principle of unity of command, an employee should receive authority only from one superior and be accountable solely to that person. For example, a general practitioner in an outpatient clinic receives assignments related to patient management only from the head of the therapeutic department and reports exclusively to them, rather than simultaneously to the medical director or another department manager. Another principle underlying delegation is the principle of span of control. The span of control refers to the number of subordinates directly managed by a supervisor. At higher management levels, this number typically ranges from 4 to 8 employees, and at lower levels from 8 to 15 (Hansen *et al.*, 2024). For instance, the head of a surgical department supervises 10 physicians and 5 nurses, which corresponds to the span of control appropriate for mid-level management. The medical director does not assign the department head responsibility for an additional 20 physicians from other units to avoid excessive managerial burden.

The principle of retained responsibility means that only the superior of the delegating manager can relieve them of responsibility. Delegation is a process of distributing responsibility to subordinates, but delegating responsibility does not absolve the manager who delegated it. For example, if a subordinate forgets to complete a task, both the subordinate and the manager share accountability. If a chief physician delegate monitoring of surgical room sterility to a senior nurse, and a violation occurs leading to patient infection, responsibility lies both with the senior nurse and the department head who delegated the authority. The principle of authority-responsibility parity states that the scope of delegated authority must correspond to the assigned duties. If a manager assigns a task to a subordinate, they must provide adequate authority for task completion, including the right to use necessary human and financial resources. The principle of reporting by exception requires subordinates to report to their superior only actual or anticipated deviations from expected outcomes. The principle of delegating authority to the lowest possible level states that tasks, according to D.A. Radhakrishnan & M. Suresh (2025), should be assigned to the lowest organisational level capable of performing them effectively.

Delegation in management offers numerous advantages that contribute to more efficient organisational performance, staff development, and the achievement of strategic goals. In the management of healthcare institutions, delegation provides significant benefits for enhancing organisational efficiency and productivity (Sayyed *et al.*, 2024; Spanos *et al.*, 2024). Managers can concentrate on strategic and high priority tasks by delegating routine and operational responsibilities to subordinates, thereby optimising their use of time. For example, a hospital director may delegate to the senior nurse the supervision of shift schedules and daily staff assignments, allowing the director to focus on strategic planning for institutional development. Similarly, a department head may distribute the workload and delegate the organisation of routine patient examinations to junior physicians, enabling faster completion of appointments while preventing managerial overload.

Delegating tasks supports increased motivation, as employees feel trusted and responsible. Through delegation, staff gain opportunities to develop new skills and knowledge by performing unfamiliar tasks (Tsapnidou *et al.*, 2024; Cesilia *et al.*, 2025). For instance, a senior physician may delegate consultations involving new diagnostic methods to a junior colleague, providing them with valuable experience and contributing to professional development. A nurse may be assigned responsibility for organising preventive vaccinations within the department, increasing motivation by reinforcing trust and accountability. Delegation also strengthens teamwork and collaboration, fostering trust between managers and subordinates. For example, a department head may delegate to the senior nurse the responsibility of supervising other nurses' compliance with clinical procedures, demonstrating confidence in her competence. A surgeon may delegate the organisation of pre operative patient preparation to medical residents, enhancing interaction and coordination between clinical and academic staff (Loving, 2025; Samokishchuk, 2025). As previously emphasised, the purpose of delegation is the effective use of resources, optimisation of human capital, and consequently, improved productivity. For example, a senior nurse may delegate the collection of laboratory samples to junior nurses, ensuring optimal

utilisation of each staff member's skills. A laboratory manager may delegate routine analyses to technicians, allowing the manager to focus on more complex examinations and thereby improving overall departmental productivity (Hansen *et al*., 2024; Augustyn *et al*., 2026).

Delegation enables chief executives to enhance management and oversight by freeing up time for the development and implementation of strategic initiatives. For instance, a department head may delegate monitoring of sterility standards to nurses, allowing more focus on evaluating the effectiveness of treatment processes (Malik & Elorrio, 2023). Delegation encourages employees to propose new ideas and solutions, fostering innovation within the organisation. The distribution of tasks also helps identify inefficiencies and improve operational processes. For example, a laboratory manager may assign younger staff the task of exploring new methods for automating analyses, stimulating innovation (Dougherty *et al*., 2022; Tsapnidou *et al*., 2024). A department head may delegate oversight of patient examinations to nurses, enabling them to identify workflow delays and optimise processes. A multi perspective approach to delegation allows a hospital director to assign the preparation of resource allocation options to both the financial and medical departments, thus obtaining diverse viewpoints to support sound decision making. Similarly, a department head may delegate the development of treatment protocols for complex patients to specialised experts (such as cardiologists or gastroenterologists), improving the quality of clinical decisions (Spanos *et al*., 2024; Sayyed *et al*., 2024).

Delegation enhances an organisation's ability to respond quickly to change and adapt to new circumstances. For example, a medical director may delegate to senior staff the task of adjusting work schedules during an epidemic, enabling timely responses to evolving conditions. The distribution of tasks and responsibilities also prevents dependency on a single individual and ensures organisational resilience – for instance, when a department head delegates the organisation of vaccination procedures to nurses, ensuring continuity of operations and reducing vulnerability to staff absences (Oliveira *et al*., 2024; Augustyn *et al*., 2026). Delegation of routine and operational tasks helps managers reduce stress and prevent burnout. A hospital director may delegate the organisation of daily briefings to deputy directors, reducing personal workload and increasing the deputies' professional standing (Smirnova & Chabaniuk, 2021; Hansen *et al*., 2024).

Delegation also enables employees to feel valued and significant, enhancing job satisfaction and loyalty. Staff gain new opportunities for career growth and advancement when, for example, a nurse who supervises departmental shifts through delegated authority acquires managerial experience and becomes eligible for promotion to a senior position (Layek & Koodamara, 2025; Samokishchuk, 2025). Thus, effective delegation of authority in management enhances organisational performance, supports employee development, increases motivation, and fosters favourable conditions for innovation and organisational growth (Spanos *et al*., 2024; Cesilia *et al*., 2025).

In summary, the application of clearly defined delegation principles, combined with an awareness of typical barriers, creates a coherent framework for improving managerial effectiveness in healthcare institutions. The integration of unity of command, appropriate span of control, retained responsibility, authority-responsibility parity, reporting by exception, and delegation to the lowest competent level ensures that tasks are distributed rationally while maintaining accountability and control. When these principles are consistently applied, delegation becomes not merely a managerial technique but a strategic tool that enhances organisational adaptability, optimises the use of human resources, and strengthens professional development. Ultimately, effective delegation contributes to sustainable organisational performance and supports the delivery of high-quality healthcare services.

Risks, associated with delegation of authority and possible consequences

Delegation of authority in the management of healthcare institutions is an important tool for enhancing the timeliness of managerial decisions and ensuring the continuity of clinical and diagnostic processes. At the same time, this managerial mechanism is associated with a number of risks that may negatively affect the quality of medical services, organisational efficiency, and patient safety, which are summarised in Table 4.

Table 4. The risks of delegation of authority and possible consequences

Risk category	Description	Consequence
Clinical	Errors due to low competence	Patient safety issues
Organisational	Loss of control	Inefficiency
Communication	Misinterpretation of tasks	Delays
Psychological	Burnout, resistance	Low motivation
Legal	Undefined responsibility	Liability risks

Source: developed by authors

One of the key limitations is the insufficient level of professional competence among personnel to whom managerial or clinical-organisational functions are delegated. Assigning authority to employees who lack adequate qualifications, experience, or training increases the likelihood of errors in decision making, disruption of patient care pathways, and deviations from approved clinical standards (Hassan *et al*., 2024; Augustyn *et al*., 2026). The

absence of continuous professional development, clear job descriptions, and internal protocols further complicates effective implementation of delegated tasks. A significant risk is the loss of managerial and clinical control. When the boundaries of responsibility between administrators, physicians, and nursing staff are not clearly defined, functions may be duplicated or "zones of irresponsibility" may emerge. This negatively affects compliance with treatment standards, sanitary and epidemiological requirements, and managerial procedures (Smirnova & Chabaniuk, 2021; Hansen *et al*., 2024).

Communication inconsistencies within the institution also play a critical role. Insufficient information exchange between administrative and clinical staff during the delegation process may lead to misinterpretation of assigned tasks, delays in service provision, and increased organisational errors. The lack of systematic feedback prevents timely adjustment of managerial decisions and contributes to the accumulation of structural problems (Malik & Elorrio, 2023; Spanos *et al*., 2024).

Another important category of limitations is formed by psychological factors and staff resistance. In healthcare practice, delegation is often perceived as an additional burden without corresponding financial or professional incentives. Increased responsibility for treatment outcomes and the potential medico legal consequences of errors may cause reluctance among staff to accept new functions or participate in managerial decision making (Smirnova & Chabaniuk, 2021; Samokishchuk, 2025).

Psychological overload and professional burnout are also common outcomes of irrational task distribution. Concentrating a large number of tasks among a small group of specialists reduces work capacity, worsens performance quality, and decreases staff motivation (Hansen *et al*., 2024; Layek & Koodamara, 2025). Ignoring individual strengths, specialisation, and experience negatively affects employee engagement. A particularly serious risk is the reduction of standardisation in medical care. Poorly implemented delegation may lead to variability in the execution of identical functions, contradicting the principles of evidence-based medicine and standardised clinical protocols (Dougherty *et al*., 2022).

Delegation may also become a source of internal organisational conflict, especially between departments or professional groups. Competition for resources, influence over decision making, and status within the management system can harm the psychological climate and impede interprofessional collaboration (Spanos *et al*., 2024; Cesilia *et al*., 2025). Another critical limitation arises from legal and ethical risks. Assigning authority without proper regulatory grounding may result in violations of legislation, licensing requirements, and professional standards. Delegating decisions that directly influence diagnosis, treatment, and patient safety is particularly risky, as it increases the likelihood of medical errors and legal disputes (Augustyn *et al*., 2026). In summary, irrational distribution of managerial and functional authority within healthcare institutions leads to imbalanced workloads, inefficient use of human resources, and deteriorating institutional performance. Therefore, delegation should be implemented based on clearly defined competence criteria, regulatory documentation, and systematic oversight (Malik & Elorrio, 2023; Layek & Koodamara, 2025).

To minimise the disadvantages of delegation, several measures must be considered. First, employees must receive the necessary training and skill development prior to delegation (Augustyn *et al*., 2026). For example, in a paediatric clinic, a nurse may complete advanced training in injections and patient management so that, after training, the physician can safely delegate certain procedures. Clear instructions and expectations must also be defined for delegated tasks. In a surgical ward, for instance, a physician may prepare a step-by-step operating room preparation protocol for junior staff to ensure clarity and prevent errors (Smirnova & Chabaniuk, 2021).

In family medicine clinics, department heads may conduct weekly meetings with nurses to review work results, correct mistakes, and provide guidance on delegated responsibilities, thus ensuring regular monitoring and feedback, as pointed out by R. Samokishchuk (2025). Tasks should be delegated considering employees' abilities, qualifications, and interests. For example, in a dental clinic, an assistant with a strong interest in orthodontics may be assigned to assist with bracket placement, aligning tasks with competencies and enhancing motivation (Cesilia *et al*., 2025). Building trusting relationships also enhances delegation effectiveness. For instance, in a therapeutic outpatient clinic, the department head may organise team-building activities and regular meetings where employees can discuss challenges, fostering trust and enabling safe delegation of complex tasks (Spanos *et al*., 2024; Loving, 2025). Modern reforms in the healthcare delivery system – driven by decentralisation, digitalisation, growing competition, and limited resources – objectively increase the importance of effective management within healthcare institutions. Under these conditions, the delegation of managerial authority emerges not as an auxiliary tool, but as a key mechanism for ensuring managerial effectiveness, organisational resilience, and the quality of medical services.

The specific nature of the healthcare sector, which is defined by high professional autonomy among medical staff, significant societal expectations, and strict regulatory requirements, necessitates adapting general management approaches to the unique characteristics of the field. Consequently, delegation must be grounded in systematic, evidence-based principles that take into account both organisational and clinical dimensions of healthcare activities. Thus, the delegation of managerial powers in the healthcare system should be viewed as a strategic management instrument aimed at optimising resource use, improving the effectiveness of managerial decisions, ensuring the quality and safety of medical services, and strengthening the institutional capacity and resilience of the healthcare system as a whole.

The findings of this study demonstrate that the delegation of managerial authority in Ukrainian healthcare institutions is a multifaceted process that significantly influences organisational performance. The analysis confirms that effective delegation enhances managerial efficiency by enabling leaders to concentrate on strategic development, which is particularly relevant in the context of the ongoing healthcare reform in Ukraine (Shevchenko *et al*., 2021). Unlike a routine redistribution of tasks, the proposed competence-based approach ensures that professional autonomy is balanced with strict accountability.

The study reveals that the coexistence of line and functional authority creates a unique management environment. The importance of line authority for ensuring unity of command is evident; however, as shown in the authors' results, functional authority plays a crucial role in standardising clinical processes. This aligns with the global trends identified by S. Spanos *et al*. (2024), who emphasise that navigating complexity in modern healthcare requires leaders to possess advanced competencies in cross-functional coordination. The authors' data supports the argument that hierarchical structures must become more flexible to respond to operational disruptions.

A critical aspect identified in the research is the impact of delegation on staff motivation and the risks of professional burnout. It was found that unclear division of responsibilities often leads to "zones of irresponsibility" and psychological resistance. This correlation is further supported by the work of K. Smirnova & A. Chabaniuk (2021), who highlighted that staff demotivation in modern conditions is frequently a consequence of poor organisational communication and emotional overload. By integrating human resource development into the delegation model, healthcare managers can mitigate these risks and enhance institutional resilience. Furthermore, the results emphasise that delegation is not merely an administrative technique but a strategic tool for ensuring the quality of medical care. The identified connection between structured delegation and adherence to clinical standards reinforces the idea that delegation must be strictly regulated. This perspective expands upon the management theories discussed in work of B.W.C.A. Tian *et al*. (2023), suggesting that the "myths of healthcare management" can be overcome through transparent oversight and robust feedback systems.

In conclusion, the identified risks and limitations associated with the delegation of authority highlight the necessity of its careful and structured implementation within healthcare institutions. While delegation offers substantial benefits in terms of efficiency, flexibility, and staff development, its improper application may lead to clinical errors, organisational dysfunction, communication breakdowns, and legal vulnerabilities. Therefore, a balanced approach that combines clearly defined competencies, regulatory support, effective communication, and continuous monitoring is essential. By aligning delegation practices with both managerial principles and the specific requirements of the healthcare sector, institutions can mitigate potential risks while preserving the advantages of decentralised decision making. Ultimately, well-regulated delegation serves not only as a mechanism for task distribution but also as a strategic instrument for ensuring patient safety, organisational stability, and the sustainable development of healthcare systems.

Conclusions

The study has established that the delegation of authority is an essential management tool in healthcare institutions, aimed at enhancing managerial efficiency, rationalising the distribution of functions, and ensuring continuity of clinical and diagnostic processes. It has been determined that delegation in healthcare organisations is a complex process that involves not only the transfer of tasks but also the assignment of corresponding authority and responsibility, with managerial control necessarily retained. The effectiveness of this process depends on the level of professional competence of the staff, the clarity of regulatory frameworks, and the quality of internal communication.

The research has shown that the use of line and functional authority within healthcare management systems ensures a balance between timely decisionmaking and adherence to standards of medical practice. However, this requires clear delineation of areas of responsibility among managers, physicians, and nursing staff. It also has been substantiated that violations of the principles of authority – responsibility parity, unity of command, optimal span of control, and accountability lead to reduced effectiveness of managerial decisions, increased complexity in coordinating staff activities, and heightened organisational risks. The study also has identified that delegation in healthcare institutions is accompanied by specific risks, including insufficient staff training, loss of managerial and clinical control, communication inconsistencies, psychological resistance among employees, professional burnout, decreased standardisation of medical care, emergence of internal conflicts, as well as legal and ethical violations. It has been demonstrated that these risks are systemic in nature and can negatively affect not only organisational efficiency but also the quality and safety of medical services.

Prospects for further research in this area include the development of effective delegation models that account for the organisational maturity of healthcare institutions, the type of facility (primary, secondary, or tertiary care), and specific human resource capacities. Additionally, the evaluation of delegation effectiveness requires further study, particularly through the development of a system of quantitative and qualitative indicators. Such indicators would allow for determining the impact of delegation on the quality of medical services, managerial risk levels, and staff satisfaction.

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Conflict of Interest

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References

[1] Aljamal, B.A., Nimer, M., Zroog, S.A., & Alkhaldi, M. (2025). Leadership styles in health crisis management. *International Journal of Science and Research Archive*, 16(1), 226-233. doi: 10.30574/ijsra.2025.16.1.1541.

[2] Alkema, V.H., Sumets, O.M., & Kyrychenko, O.S. (2023). *Management of a healthcare institution: A textbook*. Kyiv: University of Economics and Law "KROK".

[3] Augustyn, R., Demkiv, I., & Omelchenko, Yu. (2026). Improving the management of human resources potential in healthcare institutions. *Herald of Khmelnytskyi National University. Economic Sciences*, 350(1), 532-538. doi: 10.31891/2307-5740-2026-350-73.

[4] Baum, N. (2025). The road less traveled: The route to effective delegation. *Healthcare Administration Leadership & Management Journal*, 3(2), 86-89. doi: 10.55834/halmj.6382704810.

[5] Cesilia, R., Paramarta, V., & DeSousa Guterres, A. (2025). Analysis of transformational leadership relationships, work motivation, and employee performance in healthcare facilities. *MORFAI Journal*, 5(1), 22-28. doi: 10.54443/morfai.v5i1.2526.

[6] Dougherty, S., Lorenzoni, L., Marino, A., & Murtin, F. (2022). The impact of decentralisation on the performance of health care systems: A non-linear relationship. *The European Journal of Health Economics*, 23, 705-715. doi: 10.1007/s10198-021-01390-1.

[7] Hansen, A.-K.L., Jacobsen, C.B., & Dalgaard, V.L. (2024). Span of control and well-being outcomes among hospital frontline managers: Too much to handle? *BMJ Leader*, 9(1), 31-35. doi: 10.1136/leader-2024-000978.

[8] Hassan, A.M., *et al*. (2024). The role of nursing leadership delegation in managing workload and staff shortage during crisis: A systematic review. *International Journal of Medical Toxicology & Legal Medicine*, 27(3), 182-189.

[9] Khan, S. (2024). *Effective delegation of authority: A cornerstone for operational excellence in healthcare business*. Retrieved from https://www.linkedin.com.

[10] Law of Ukraine No. 2801-XII "Fundamentals of Health Care Legislation of Ukraine". (1992, November). Retrieved from https://zakon.rada.gov.ua/laws/show/2801-12#Text.

[11] Layek, D., & Koodamara, N.K. (2025). Motivation on contextual performance in healthcare settings: The influence of work engagement and transformational leadership. *International Journal of Healthcare Management*, 1-14. doi: 10.1080/20479700.2025.2520945.

[12] Loving, V. (2025). Optimising doctor-administrator leadership dyads in healthcare organisations. *BMJ Leader*. doi: 10.1136/leader-2024-001127.

[13] Malik, A.M., & Elorrio, E.G. (2023). Governance and management in healthcare organizations: Their different roles in driving safety and quality. *International Journal for Quality in Health Care*, 35(3), article number mzad046. doi: 10.1093/intqhc/mzad046.

[14] Mescon, M.H., Albert, M., & Khedouri, F. (1988). *Management (3rd ed.)*. New York: Harper & Row.

[15] Newman, W.H. (1955). *Administrative action: The techniques of organization and management*. Englewood Cliffs: Prentice-Hall.

[16] Oliveira, R., Santinha, G., & Sá Marques, T. (2024). The impacts of health decentralization on equity, efficiency, and effectiveness: A scoping review. *Sustainability*, 16, article number 386. doi: 10.3390/su16010386.

[17] Papathanasiou, I., Tzenetidis, V., Tsaras, K., Zyga, S., & Malliarou, M. (2024). Missed nursing care; prioritizing the patient's needs: An umbrella review. *Healthcare*, 12(2), article number 224. doi: 10.3390/healthcare12020224.

[18] Radhakrishnan, D.A., & Suresh, M. (2025). Leadership during crisis in healthcare: A systematic literature review. In *Information systems for intelligent systems* (Vol. 430) (pp. 535-544). Singapore: Springer.

[19] Samokishchuk, R. (2025). Models of motivation of medical workers in modern conditions. *Economy and Society*, 78. doi: 10.32782/2524-0072/2025-78-147.

[20] Sayyed, A., Sahu, S., Kanyal, D., & Sable, S. (2024). Effective leadership strategies in healthcare: A narrative review. *Multidisciplinary Reviews*, 8(3), article number 2025090. doi: 10.31893/multirev.2025090.

[21] Shevchenko, O.O., Rabotnikov, S.P., & Heiko, O.V. (2021). Improving the mechanism of public governance of the healthcare system in Ukraine: Issues of public policy in the context of reform. *State and Regions*, 4(74), 99-104. doi: 10.32840/1813-3401.2021.4.15.

[22] Smirnova, K., & Chabaniuk, A. (2021). Causes, consequences and ways to overcome staff demotivation in modern conditions. *Economy and Society*, 32. doi: 10.32782/2524-0072/2021-32-30.

[23] Spanos, S., Leask, E., Patel, R., Datyner, M., Loh, E., & Braithwaite, J. (2024). Healthcare leaders navigating complexity: A scoping review of key trends in future roles and competencies. *BMC Medical Education*, 24, article number 720. doi: 10.1186/s12909-024-05689-4.

[24] The Ministry of Health of Ukraine. (2025). *Strategy for the development of the healthcare system of Ukraine for the period up to 2030*. Retrieved from https://healthstrategy2030.com.ua.

[25] Tian, B.W.C.A., Catena, F., Agnoletti, V., Lusenti, C., Bravi, F., & Carradori, T. (2023). Book review: Managing the myths of health care by Henry Mintzberg. *Discover Health Systems*, 2, article number 18. doi: 10.1007/s44250-023-00030-0.
[26] Tsapnidou, E., Kelesi, M., Rovithis, M., Katharakis, G., Gerogianni, G., Dafogianni, C., Toylia, G., Fasoi, G., & Stavropoulou, A. (2024). Transformational leadership – quality achievements and benefits for healthcare organizations: A scoping review. *Hospitals*, 1, 87-103. doi: 10.3390/hospitals1010008.
[27] World Health Organization. (2025). *Strengthening health systems governance*. Retrieved from https://www.who.int.

Теоретико-методологічні засади делегування управлінських повноважень у менеджменті закладів охорони здоров'я

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Анотація. Актуальність даного дослідження зумовлена специфікою діяльності закладів охорони здоров'я, які характеризуються високим рівнем професійної автономії медичного персоналу, значною відповідальністю за здоров'я та життя пацієнтів, а також жорсткими нормативно-правовими обмеженнями. Сукупність цих чинників робить проблему делегування управлінських повноважень особливо значущою та водночас недостатньо дослідженою як у теоретичному, так і в прикладному аспектах. Метою статті було обґрунтування теоретико-методологічних засад делегування управлінських повноважень у менеджменті закладів охорони здоров'я для підвищення ефективності та результативності управлінської діяльності. У процесі дослідження було використано загальнонаукові та спеціальні методи, зокрема аналіз і синтез наукових джерел, системний та структурно-функціональний підходи, порівняльний аналіз, узагальнення, а також логічне моделювання управлінських процесів у закладах охорони здоров'я. У результаті дослідження уточнено сутність делегування в менеджменті закладу охорони здоров'я як складного управлінського процесу, що передбачає передачу завдань, повноважень і відповідальності із збереженням належного рівня контролю та підзвітності. Розкрито особливості реалізації лінійних і функціональних повноважень у системі управління закладами охорони здоров'я, визначено їхні переваги та обмеження. Особливу увагу приділено ідентифікації основних ризиків делегування, серед яких недостатня компетентність персоналу, втрата управлінського контролю, комунікаційні бар'єри, психологічний опір змінам, професійне вигорання, зниження рівня стандартизації медичної допомоги, а також юридичні й етичні загрози. Практична цінність отриманих результатів полягає у можливості їх використання керівниками закладів охорони здоров'я для вдосконалення механізмів делегування шляхом підвищення рівня професійної підготовки персоналу, стандартизації управлінських процедур, чіткого розмежування відповідальності та посилення системи контролю й зворотного зв'язку

Ключові слова: професійна автономія; управлінська відповідальність; ризики делегування; ефективність управління