

MODULE 9 | PLANNING SERVICES, UNDERSTANDING COSTS AND FUNDING CARE

Funding Care and Assessing Financial Sustainability

Practical hospital governance in Punjab, Pakistan

Match care commitments to reliable funding.
Protect patients when money is constrained.

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LECTURE

Make the funding plan as clear as the care plan

For the Medical Superintendent (MS): explain who will pay, when funds will arrive and how the hospital will sustain safe care.

- Map each funding source and its restrictions.
- Separate expected income from usable cash.
- Test costs, outcomes and annual affordability.
- Prepare a funding proposal with safeguards.

OFFICIAL SOURCE

A principle tied to a named law, standard or official guidance.

WORKING METHOD

A practical control or teaching format to adapt to the authorised system.

TEACHING CASE

An invented hospital example, used to practise applying the correct process.

Study output

A three-year funding plan, a monthly cash forecast and a short statement of the patient-access safeguards.

Module 9 | Presentation 4 of 4. Allow 45-60 minutes with exercises. All explanations are on the pages; check the cited sources before live use.

Keep the decision questions separate

A useful service can still have an unaffordable launch date or an incomplete approval file.

Value and affordability

- Value: does the option produce worthwhile health benefits compared with the alternatives and resources used?
- Affordability: can the responsible budget meet the expected payments in each period without an unexplained gap?

Authority and delivery

- Authority: which body can approve the service, expenditure, fees, contract and any movement of funds?
- Delivery: are staff, supplies, premises and supporting services available to turn funding into safe patient care?

A favourable cost-effectiveness calculation does not itself provide cash, an approved budget or permission to spend.

The funder, purchaser, provider and patient

These roles can sit in different organisations. One organisation may perform more than one role.

Role	What the role means	Question for the MS
Funder	Supplies money, for example through a public budget or a lawful grant.	What is the source, amount, purpose and expected timing?
Purchaser	Allocates money or pays providers for agreed care.	What service is bought, for whom, and under which terms?
Provider	Delivers the service using staff, facilities and supplies.	What resources and records are needed to deliver it?
Patient	Receives care and may face direct or indirect costs.	What is covered, and what barriers still prevent access?

Purchasing healthcare services is a financing concept. It does not replace the applicable procurement procedure for a hospital contract.

Sources: **F1**: financing functions | **F2**: strategic purchasing

How money reaches patient care

The World Health Organization (WHO) separates health financing into three main functions.

Function	Simple meaning	Why it matters
Raise revenue	Bring money into the health system through budgets, contributions or other sources.	More than one source may fund the same hospital.
Pool funds	Combine prepaid funds so the cost of illness is shared.	A person's treatment need is not limited to their own prepaid amount.
Purchase care	Allocate funds or pay providers for the services to be delivered.	Payment terms influence access, activity and provider behaviour.

For hospital management, trace the actual flow: source → approved purpose → authorised recipient → verified use.

Sources: **F1**: revenue, pooling and purchasing

Prepare one funding map for the service

This is a working register. The presence of a funding source does not prove authority to collect, retain or spend it.

Possible source	Record the evidence	Check the restriction
Public allocation or grant	Approved purpose, amount, financial year and release document.	Permitted items, reporting and any surrender conditions.
Scheme or purchaser	Current contract, covered service, rates and claim process.	Eligibility, caps, exclusions and valid period.
Lawful hospital receipts	Authority, approved schedule, collection and deposit route.	Retention, waiver and spending powers.
Donation or restricted grant	Acceptance approval, agreement, receipt and responsible officer.	Specified use, reporting, expiry and return conditions.

Add an owner, expected receipt date, confidence level and review date for each funding line.

WORKING METHOD | Illustrative material is identified in the text.

An institutional fund has rules

Where the Punjab Medical and Health Institutions Act 2003 applies, its fund provisions must be read with the applicable rules.

What the Act provides

- Section 13 permits the Board of Management to delegate its powers, duties or functions to a person or committee.
- Sections 14-15 provide for the institutional fund and for prescribed arrangements governing its use, budget, accounts and audit.

What the MS must establish

- Obtain the law and notification governing this institution. Then identify the current rules, financial delegation and approval route.
- Verify the authority for each receipt, fee, retention, waiver and use of money. A fund balance does not give the MS unrestricted powers.

An institution governed by a university Act or another specific framework may have different arrangements. Do not transfer powers by analogy.

Sources: **F6**: sections 13-15 and institutional applicability

Budget, release, cash and commitment differ

Keep these terms separate when reporting whether a service is funded.

Term	Plain meaning	Common mistake
Budget provision	An approved allocation for a purpose and period, within the applicable system.	Treating a proposed estimate as an approved amount.
Release	Permission or allotment that makes funds available under the release system.	Assuming the entire annual allocation is already released.
Usable cash	Money accessible through the authorised payment route for the intended purpose.	Counting a restricted balance as freely available.
Commitment	An obligation entered into, such as an authorised purchase order or contract.	Ignoring obligations because the invoice has not arrived.

Ask Finance to reconcile all four. Expected reimbursement and unapproved future grants are not cash available today.

WORKING METHOD | Illustrative material is identified in the text.

Fund the running service as well as the asset

Development and recurrent requirements need a joined-up plan. Their classification and funding route must be verified.

Before opening

- Identify construction, equipment, installation, training and commissioning payments, including their timing.
- Check the approved project scope, conditions and source of each payment. A project approval does not prove that funds have been released.

After opening

- Provide for staff, medicines, disposables, utilities, maintenance, software, quality checks and eventual replacement or disposal.
- Show who funds these costs after a grant or initial warranty ends. Obtain the necessary approvals before making new commitments.

A three-year plan can reveal an early gap. Extend the assessment over the useful life where later costs are material.

Sources: **F4**: budget formation and execution

Do not invent a fee to close a budget gap

Fee setting, collection, waiver and retention are separate decisions requiring the applicable authority.

Verify before collection

- Obtain the approved fee schedule, effective date, exemptions and collection arrangements. Identify who may change or waive charges.
- Ensure patients receive clear information and an official receipt. Reconcile collections with deposits and the authorised accounting records.

Report the underlying gap

- A shortfall should be presented with its cause, patient impact and lawful options. Do not assume an internal memo creates a new charging power.
- Check whether any proposed charge conflicts with a free-care policy, purchaser contract, donation condition or patient entitlement.

Fee revenue is not the same as service cost, and a published tariff is not evidence that the hospital may retain or spend every receipt.

Verify the patient benefit at the time of care

Use the current programme instrument and provider contract; a previous brochure is not sufficient.

01 Eligibility

Who qualifies, and how is eligibility verified?

02 Provider

Is this hospital and service authorised under the scheme?

03 Coverage

Which treatment, medicines and follow-up are included?

04 Limits

What exclusions, caps and patient charges actually apply?

05 Process

What approval, emergency and referral procedures apply?

06 Version

Record the effective date, source and person who checked it.

This lecture gives no current insurance entitlement or tariff. Resolve uncertainty with the authorised programme office and document the answer.

Payment methods create different incentives

These are general financing methods, not a claim that a particular Punjab programme uses them.

Method	Basis of payment	Risk to monitor
Line-item budget	Amounts for specified inputs, such as staff or medicines.	Needed activity may be difficult to support if allocations cannot be adjusted.
Global budget	A total amount for a defined period and scope of care.	Pressure to limit services or build waiting lists if demand exceeds resources.
Fee-for-service	Payment for each eligible service delivered.	Pressure to add unnecessary activity or bill services not supported by records.

These are possible incentives, not inevitable misconduct. Compare payment terms with actual access, quality and activity.

Sources: **F3**: definitions and incentives

Define what the payment covers

An agreed payment may transfer some cost risk to the provider.

Method	Basis of payment	Risk to monitor
Case-based payment	A payment for a defined episode or case category.	Unnecessary admissions, early discharge or avoiding complex patients.
Capitation	A payment per enrolled person for a defined period and covered services.	Too little care, selection of lower-risk patients or shifting costs elsewhere.
Performance-linked payment	An additional payment linked to specified results or measures.	Focusing only on rewarded measures or recording results inaccurately.

For every method, specify quality safeguards, case definitions and valid records. No single method removes every incentive problem.

Sources: **F3**: mixed payment systems

Read the contract before forecasting income

The face value of a package is not automatically the hospital's collectible revenue.

Define what is being paid for

- Specify the episode, included supplies, professional services and follow-up. Check how repeat admission and unusually complex cases are handled.
- Identify tariffs, annual or case caps, deductions, submission deadlines, evidence requirements and dispute procedures.

Define who carries the risk

- Check who pays when prices rise, activity exceeds a limit, eligibility fails or a claim is disputed. Confirm terms rather than assuming the answer.
- Have the authorised finance, clinical and legal officers review the obligations. Forecast plausible receipts and delays, not only billed activity.

Payment terms cannot justify unsupported coding, unnecessary care or bypassing a required clinical safeguard.

Keep a claim traceable from care to receipt

Adapt this workflow to the actual contract and authorised information system.

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|---|------------------|---|
| 1 | Confirm | Verify the applicable benefit and approval process, including any specific emergency arrangements. |
| 2 | Document | Record care accurately; code only diagnoses and procedures supported by the clinical record. |
| 3 | Submit | Check the required evidence, amount, deadline and claim identifier before authorised submission. |
| 4 | Reconcile | Match the purchaser's decision and payment to the claim; investigate deductions and unresolved amounts. |

Never create missing clinical events to support a claim. Correct a genuine error through the approved, traceable record-correction process.

WORKING METHOD | Illustrative material is identified in the text.

A claim is not the same as cash

Invented claim batch. All figures are millions of Pakistani rupees (PKR).

Submitted	The hospital submits claims with a face value of 10.0.
Accepted	The purchaser accepts 8.0 and rejects 2.0. The rejection is under review; recovery is uncertain.
Paid	Only 5.0 of the accepted amount reaches the authorised account during the month.
Outstanding	Accepted but unpaid: $8.0 - 5.0 = 3.0$. Disputed: 2.0, shown separately.
Forecast	Cash received is 5.0. Forecast the expected timing of the 3.0; do not count the disputed 2.0 as certain.

Use the applicable accounting policy for formal recognition and write-off. This example is a management reconciliation, not an accounting rule.

Test the cash position before the next payment

Invented monthly forecast. All figures are PKR million; all listed receipts are usable for the listed payments.

Opening cash	Accessible unrestricted balance at the start of the month: 4.0.
Expected receipts	Public release expected: 10.0. Claim receipts expected: 5.0. These amounts still need timing confirmation.
Payments due	Payroll and other already-authorised obligations due during the month: 16.0.
Base forecast	$4.0 + 10.0 + 5.0 - 16.0 = 3.0$ closing cash if all receipts arrive before the required payments.
Delayed release	If the 10.0 release arrives next month: $4.0 + 5.0 - 16.0 = -7.0$. The immediate shortfall is 7.0.

A positive month-end figure can hide a mid-month shortage. Put each major receipt and payment on its expected date.

Escalate the gap before care is interrupted

A forecast shortfall is a request for an authorised decision, not permission to borrow or move restricted money.

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| 1 | Verify | Reconcile balances, unpaid obligations, restrictions and the realistic dates of receipts. |
| 2 | Protect | Identify urgent patient-safety risks and the clinical continuity arrangements needed. |
| 3 | Propose | Submit lawful options: confirmed release, approved reallocation, revised phasing or another authorised source. |
| 4 | Track | Record the decision, responsible officer and next review; update the forecast as cash actually arrives. |

Do not treat supplier credit as cost-free funding. It still requires authority, contract compliance and a plan to meet the liability.

WORKING METHOD | Illustrative material is identified in the text.

A funded service can still be unaffordable to patients

WHO links universal health coverage to both access to needed care and protection from financial hardship.

Identify the barriers

- Patients may face charges, medicines purchased outside, transport, repeat visits and income lost while seeking care.
- Ask whether entitled patients are turned away, incur unexpected payments or fail to complete care. Use confidential feedback and reliable records.

Act within the approved system

- Explain the verified benefit and any authorised charges clearly. Use the proper social-welfare or financial-assistance referral route.
- Report access gaps to the competent authority. Apply fair clinical and referral criteria; personal influence or purchasing power should not determine priority.

A hospital revenue target is not a clinical priority rule. Escalate a conflict between funding arrangements and safe, equitable access.

Sources: **F5**: access and financial protection

A donation creates responsibilities as well as resources

Acceptance, custody, use and reporting should be settled before a donation becomes an operating commitment.

Before acceptance

- Establish lawful acceptance authority, the actual need, donor conditions and any conflict of interest. Keep the decision and agreement on file.
- For equipment, confirm safety, suitability, installation, staff training, spare parts and ongoing supplies with the technical team.

After acceptance

- Record receipt and ownership, identify the authorised account or asset register, and track use against the agreed purpose.
- Identify the costs the donor will not pay and the end date of support. Obtain a sustainable funding decision before expanding dependence.

WHO donation guidance supports needs assessment and life-cycle planning; local law determines the approval and accounting route.

Sources: **F7**: donor and recipient responsibilities

A donated machine has an unfunded running cost

Invented diagnostic-service example. All figures are PKR million; prices are illustrative, not market estimates.

Offer	A donor offers a suitable machine valued at 20.0. The value is an in-kind contribution, not spendable cash.
Set-up cost	Installation, room preparation and training need 2.0 cash from the hospital.
Annual cost	Staff 3.0 + consumables 4.0 + maintenance 1.0 + utilities 0.5 = 8.5 each year.
Confirmed support	The example has an authorised recurrent allocation of 5.0 each year and no confirmed source for the balance.
Funding gap	Annual shortfall: $8.5 - 5.0 = 3.5$. Year-one hospital cash need is 10.5, including set-up.

In-kind value does not close a cash gap. Do not add the machine's 20.0 value to cash available for payroll or consumables.

Turn the offer into a sustainable decision

The donated-machine case requires more than an acceptance letter.

Submit a complete assessment

- Show the verified demand, likely workload, patient benefit, technical assessment and full-life resource requirements.
- Identify who will fund the 2.0 set-up cost and the annual 3.5 shortfall. Test maintenance, consumable supply and price risk.

Seek the competent decision

- Possible proposals include a revised donation, funded phased operation or another suitable service arrangement. Each needs its own assessment.
- Record acceptance conditions, responsibilities and review dates. If essential conditions cannot be met, present a reasoned recommendation before commitment.

Do not accept a restricted grant on the assumption that its purpose can be changed later. Any variation needs the required lawful approvals.

WORKING METHOD | Illustrative material is identified in the text.

Cost-effectiveness and budget impact are different

Both analyses need a clear comparator, population, time period, price basis and assumptions.

Question	What to compare	What the result does not prove
Cost-effectiveness	Extra resources used and extra health outcomes achieved compared with an alternative.	That the hospital has cash, capacity or approval to introduce the option.
Budget impact	The change in spending for the responsible budget over specified years.	That the service produces enough health benefit to justify the resources.
Funding plan	Expected authorised sources, restrictions and timing matched to the payments required.	That forecasts are certain or that unapproved future funds can be committed.

Use the health-economics team for a formal evaluation. A simple illustration teaches the question; it does not replace a full appraisal.

Sources: **F8**: Chapter 2 | **F9**: economic efficiency and affordability

Compare additional cost with additional benefit

Invented programmes A and B each serve 500 comparable patients over six months. All costs are PKR.

Measure	Programme A	Programme B
Relevant total cost	3,000,000	4,000,000
Patients meeting the same defined health target at six months	300	350
Additional cost of B	4,000,000 – 3,000,000	1,000,000
Additional patients reaching the target	350 – 300	50

Assume equal follow-up, comparable groups and the same cost boundary. These are teaching assumptions, not clinical evidence.

Calculate the incremental cost-effectiveness ratio

Incremental means the change from one option to the other. ICER is the extra cost divided by the extra effect.

Formula	ICER = (cost of B – cost of A) ÷ (effect of B – effect of A).
Calculation	1,000,000 ÷ 50 = PKR 20,000 per additional patient reaching the defined six-month target.
Interpretation	Choosing B uses an extra PKR 1.0 million to obtain 50 additional target achievements under these assumptions.
Do not confuse	B's average cost per target achievement is 4,000,000 ÷ 350 ≈ 11,429. That is a different question.
Decision	No universal accept/reject threshold is supplied. Consider other uses of the funds, uncertainty, equity, capacity and affordability.

An outcome must be clinically meaningful and measured consistently. This target-based ratio cannot automatically compare unrelated disease services.

Build a budget-impact calculation step by step

State the budget-holder's perspective: for example, the hospital's own additional cash spending.

1	Baseline	Describe the spending and activity expected if the proposed change is not introduced.
2	New option	Estimate realistic uptake, extra running costs and one-off start-up payments by year.
3	Difference	Subtract baseline spending from spending with the change, including genuine costs avoided.
4	Test	Vary uncertain volume, prices, launch timing and savings; identify where additional funding is required.

Deduct a cash saving only when an actual payment will be avoided. Show released staff time or capacity separately; it is not cash unless spending falls.

Sources: **F9**: financial consequences and affordability

A three-year budget-impact estimate

Invented service change. PKR million, at constant prices; no inflation or discounting in this teaching calculation.

Annual hospital spending	Year 1	Year 2	Year 3
Without the change: baseline	10.0	10.0	10.0
With the change: running costs	12.0	14.0	16.0
One-off set-up payment	2.0	0.0	0.0
Total with the change	14.0	14.0	16.0
Additional budget required	4.0	4.0	6.0

Total additional spending over three years = 4.0 + 4.0 + 6.0 = PKR 14.0 million. Annual funding still needs separate confirmation.

Stress-test the three-year plan

Use the previous example. Assume the base funding plan covers the extra 4.0, 4.0 and 6.0 million exactly.

Price risk	Test a scenario in which all new-option running costs are 10% higher in each year.
Keep fixed	The example's baseline remains 10.0 per year and set-up remains 2.0 in year one only.
Revised running	$12.0 \times 1.10 = 13.2$; $14.0 \times 1.10 = 15.4$; $16.0 \times 1.10 = 17.6$.
Revised impact	Year 1: $13.2 + 2.0 - 10.0 = 5.2$. Year 2: $15.4 - 10.0 = 5.4$. Year 3: $17.6 - 10.0 = 7.6$.
Extra gap	Beyond base funding: 1.2, 1.4 and 1.6; total 4.2 million. This is a scenario, not a probability or price forecast.

For a real plan, justify which items change, model annual prices and test delayed receipts separately. Avoid applying the same risk adjustment twice.

The funding proposal must answer six questions

Use a concise decision paper with supporting calculations and source documents.

01 Need

Which patients need the service, and what is the current gap?

02 Option

What will change, and why is this option preferred?

03 Cost

What are the start-up, running and later life-cycle costs?

04 Source

Who pays, under which authority and on what dates?

05 Risk

What happens if costs rise or funding arrives late?

06 Evidence

How will access, quality, spending and results be checked?

Distinguish funds already approved from amounts requested or merely expected. Give the exact decision required from the competent authority.

WORKING METHOD | Illustrative material is identified in the text.

Use a funding schedule that shows the gaps

Illustrative entries for a decision paper; amounts and dates must be populated from the actual case.

Requirement	Evidence needed	Decision if unresolved
Initial asset and set-up	Approved cost, source, release and implementation timetable.	Seek the relevant approval and confirmed funding route.
Annual staff and supplies	Workload-based estimate and recurring funding responsibility.	Identify the annual gap and submit feasible options.
Claim-funded activity	Valid contract, collectible amount and expected receipt dates.	Test a lower collection rate and a longer payment delay.
Later maintenance or replacement	Coverage, expiry dates, estimated cost and responsible budget.	Schedule the future funding decision before support ends.

A three-year estimate does not provide permission to spend for three years. Record the approvals needed for each financial period.

WORKING METHOD | Illustrative material is identified in the text.

Monitor service, money and access together

A suggested monthly dashboard. Investigate changes before describing them as success or failure.

Measure	Read it with	Action when the position worsens
Activity and waiting time	Need, capacity, case complexity and staffing.	Identify the constraint and propose safe corrective action.
Costs and commitments	Workload, price changes and unpaid obligations.	Revise the forecast and explain the cause of the variance.
Claims and cash received	Accepted, disputed and overdue amounts shown separately.	Resolve documented errors and escalate payment delays.
Patient access and quality	Entitlements, complaints, outcomes and avoidable interruptions.	Correct unsafe barriers and report any policy or funding gap.

Higher income alone does not prove better care. A balanced report shows patient results and unresolved risks alongside financial performance.

WORKING METHOD | Illustrative material is identified in the text.

Prioritise fairly when resources are limited

Prepare transparent service-level options for the authorised decision-maker.

Explain the trade-off

- Show which patient groups benefit, the expected health effect, costs, feasibility and the effect on existing services.
- Identify urgent safety needs, unmet need and avoidable inequity. Record uncertainty and the services displaced by the proposal.

Protect the decision process

- Use agreed clinical and policy criteria, document reasons and manage conflicts of interest. Arrange the required review or appeal route.
- Do not turn a funding comparison into personal bedside rationing. Escalate clinical risk through the responsible team and governing authority.

A priority decision should remain open to review when evidence, available resources or patient needs change.

Three funding decisions to test

Write your answer and the reason before turning to the next page.

1. Donated asset

A machine is free to acquire. It needs 2.0 million set-up and has a 3.5 million annual running-cost gap.

What must the proposal resolve?

2. Value and cash

An option has a favourable health-benefit comparison. Its first-year payments exceed confirmed funding by 4.0 million.

Can value alone justify commitment?

3. Receipts

Claims of 10.0 million are submitted. Only 5.0 million is received; 3.0 is accepted but unpaid and 2.0 is disputed.

How much cash has arrived?

Write the required evidence, the remaining uncertainty and the authority needed. All figures are invented.

Answers and reasons

Use the evidence, the calculation and the cited source.

1. Resolve the full funding and operating plan

Identify the lawful acceptance route, source of the 2.0 million set-up payment and annual 3.5 million gap. Confirm safe operation, maintenance, supplies and the costs beyond the initial support period.

2. Keep value, affordability and authority separate

No. Present the benefit and the 4.0 million gap together. Seek an authorised funding or phasing decision; the calculation itself supplies neither cash nor permission to incur expenditure.

3. Cash received is 5.0 million

Track the 3.0 million accepted but unpaid amount by due date. Keep the disputed 2.0 million separate and assess possible recovery. Do not count the full 10.0 million as usable cash.

Good funding management makes the constraint visible early enough for a lawful, safe and informed decision.

Prepare a service funding brief

Use a non-confidential real case or the invented examples in this lecture.

1. Funding map

List sources, restrictions, authority, confirmed amounts and expected receipt dates.

2. Forecast

Show three years of additional spending and a monthly cash forecast for the first year.

3. Decision paper

State the gap, alternatives, patient safeguards, required approvals and monitoring plan.

Review with the clinical lead and Finance. Ask an independent colleague to reproduce the calculations and challenge the assumptions.

Use verified, non-confidential figures. Mark unapproved amounts clearly and keep the source date next to each key assumption.

Before recommending a new funding commitment

The service proposal and its funding plan should remain consistent.

01 Purpose

The patient need and service boundary are explicit.

02 Powers

The governing law, delegations and approvals are identified.

03 Full cost

Start-up, running and later costs have an owner.

04 Cash

Timing, restrictions and unpaid obligations are visible.

05 Fairness

Access and clinical safeguards are part of the proposal.

06 Review

Named officers track spending, quality and results.

Module 9 links service planning, capacity, costs and funding. Revisit each part when the workload, design or funding terms change.

WORKING METHOD | Illustrative material is identified in the text.

Sources and continued use | 1

Select a source title or its official-source link to open the document.

F1

Health financing: core functions

WHO overview of revenue raising, pooling and purchasing. Used for basic financing concepts; it does not establish a Punjab hospital's spending powers or patient entitlements.

World Health Organization | Topic overview | [Official source](#)

F2

Purchasing health services for universal health coverage

Policy brief, 2019, WHO/UCH/HGF/PolicyBrief/19.6. Explains strategic purchasing: services, providers, payment arrangements and the use of information.

World Health Organization | 2019 | [Official source](#)

F3

Analytical guide to assess a mixed provider payment system

WHO/UHC/HGF/Guidance/19.5, 2019. Used for payment incentives and the need to align different funding flows. Payment methods here are general concepts, not a statement of Punjab's current schemes.

World Health Organization | 2019 | [Official source](#) | [WHO payment-method definitions](#)

Educational material by Dr Qurban Hussain Khan. Source editions are stated; verify later amendments and applicable institutional orders before live use.

Sources and continued use | 2

Select a source title or its official-source link to open the document.

F4

Public financial management and health financing

WHO explanation of the links between budget formation, execution, expenditure control and health financing. The registers and cash-flow examples in this lecture are working methods.

World Health Organization | Health Financing and Economics | [Official source](#)

F5

Universal health coverage: financial protection

WHO questions and answers, 11 June 2013. Used for the principle that access to needed services and protection from financial hardship are both essential. No scheme-specific benefit or coverage limit is reproduced.

World Health Organization | 2013 | [Official source](#)

F6

Punjab Medical and Health Institutions Act 2003

Official Health Department copy. Sections 13-15 address delegation, the institutional fund, budget, audit and accounts. Use only where applicable; check the institution's current law, rules and notifications.

Government of Punjab | Specialized Healthcare and Medical Education | [Official source](#)

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Sources and continued use | 3

Select a source title or its official-source link to open the document.

F7

Medical device donations: solicitation and provision

Second edition, 29 July 2024, ISBN 9789240093621. Used for recipient needs, safety, responsibilities and the resources needed throughout a donated device's life.

World Health Organization | 2024 | [Official source](#)

F8

Economic evaluations of immunization programmes

WHO guide, second edition, 2019, WHO/IVB/19.10; Chapter 2. Used for general evaluation and budget-impact concepts. The hospital calculations are invented teaching examples.

World Health Organization | 2019 | [Official source](#)

F9

Budget impact analysis

Explains the difference between economic efficiency and the financial effect on a payer's budget. Used for the general method; the three-year hospital example and assumptions are original teaching material.

Austrian National Public Health Institute | WHO Collaborating Centre PPRI | [Official source](#)

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