MODULE 9 | PLANNING SERVICES, UNDERSTANDING COSTS AND FUNDING CARE

Planning Hospital Services and Setting Priorities

38

LECTURE

Practical hospital governance in Punjab, Pakistan

Define the need before choosing the solution.
Connect the service plan to staff, funds and results.

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SELF-STUDY PDF

Prepare a service plan that can be acted on

For the Medical Superintendent (MS): explain who needs the service, what should change and what the hospital needs to deliver it safely.

- Define the service problem using evidence.
- Compare feasible options and set fair priorities.
- Identify resources, dependencies and approvals.
- Turn an approved decision into measurable action.

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 concise service proposal with a clear need, options, resource plan and review measures.

Module 9 | Presentation 1 of 4. Allow 45-60 minutes with exercises. All explanations are on the pages; check the cited sources before live use.

The four lectures

Planning, capacity, cost and funding answer different questions about the same service.

Lecture	Main question	Practical result
38. Service planning	Which service problem should we solve?	A justified service proposal.
39. Demand and capacity	What can the service safely deliver?	A capacity and patient-flow plan.
40. Hospital costs	What resources does the service use?	A checked unit-cost calculation.
41. Funding care	How will care be paid for over time?	A funding and sustainability assessment.

An attractive proposal still needs clinical review, the correct authority and a workable funding plan.

WORKING METHOD | Illustrative material is identified in the text.

TEACHING CASE

A request for another diagnostic machine

Invented example: a department reports long waits and asks the MS to buy another machine.

The request	The department says the waiting list has grown. It expects new equipment to increase activity.
The uncertainty	The file does not show staffed sessions, breakdown time, referral criteria or report delays.
The decision	Should the hospital buy, improve the existing service, change the referral arrangement or combine these actions?
The first task	Define the problem and test its causes before committing to one solution.

The request identifies a proposed input. A service plan must explain the patient need and the whole delivery process.

TEACHING CASE | Illustrative material is identified in the text.

Separate requirements from planning tools

WHO means World Health Organization. Planning guidance can inform a decision without creating the power to approve it.

Source	What it contributes	What to check
Law and valid orders	Institutional mandate, powers and required approvals.	Which authority may decide this particular matter?
PHC standards	Applicable expectations for hospital governance and care.	Which manual and indicators apply to the service?
WHO guidance	Methods for organising services and considering quality and fairness.	How should the method be adapted to local conditions?
Working examples	A way to organise evidence and calculations.	Replace invented figures with verified hospital data.

A WHO method is not a Punjab spending rule. A planning score is not a substitute for the competent authority.

WORKING METHOD | Illustrative material is identified in the text.

The PHC planning baseline

PHC means Punjab Healthcare Commission. Its hospital Minimum Service Delivery Standards (MSDS) connect governance, plans and resources.

Indicator	Expectation in plain language	Evidence to maintain
108	Senior leadership establishes the hospital mission.	A documented mission and leadership involvement.
109	Strategic and operational plans support that mission.	Plans showing how the service will be delivered.
110	Budget allocation follows an authorised approval process.	The budget and the actual approval authority.
111 and 116	Monitor performance and address community responsibilities.	Measures, corrective actions and evidence of community work.

These indicators do not give every MS or Board identical powers. Keep the institution's actual authority on file.

Sources: **P1**: standard 19, indicators 108-111 and 116

Connect strategy to operational work

Suggested distinction between the planning documents. Use the institution's approved planning periods.

Level	Question	Hospital example
Mission	What is the hospital here to do?	Provide the care required by its mandate and population.
Strategic priority	Which important service result needs improvement?	Improve timely access to a defined diagnostic service.
Operational plan	Who will do what, with which resources and when?	Approve sessions, staff cover, reporting and review dates.
Daily control	Is the planned service actually functioning?	Check cover, equipment readiness and outstanding reports.

A strategic document needs an operational plan. A daily activity list needs a clear service purpose.

WORKING METHOD | Illustrative material is identified in the text.

Need, demand and use are different

These working distinctions prevent a busy clinic from becoming the only evidence used for planning.

Term	Plain meaning	Possible limitation
Health need	A health problem for which appropriate care may help.	Some people cannot reach the hospital to request care.
Demand	People seeking or being referred for a service.	Requests may be duplicated or clinically inappropriate.
Use	Care actually received during a stated period.	Low use may reflect limited capacity or access barriers.
Unmet need	Appropriate care required but not received.	It must be estimated using evidence, not simply asserted.

Use clinical assessment and population evidence alongside activity data. A visit count is not a population needs assessment.

WORKING METHOD | Illustrative material is identified in the text.

Define the population and service boundary

Suggested questions before estimating how much care is required.

01 People

Which patients and conditions does the proposed service cover?

02 Place

Which areas and referral hospitals send these patients?

03 Level

Which care belongs here and which belongs elsewhere?

04 Period

What baseline period and planning period are being used?

05 Access

Who is excluded or delayed by practical barriers?

06 Limits

What is outside the service, and where is it referred?

A tertiary hospital's referral population may cross district boundaries. Do not assign a population denominator without a defensible basis.

WORKING METHOD | Illustrative material is identified in the text.

Use several sources of evidence

Suggested baseline record. For each source, retain the definition, date, owner and known limitations.

Source	Useful information	Common error to avoid
Hospital activity	Referrals, completed episodes, waits and cancellations.	Counting repeat visits as different people.
Clinical review	Appropriateness, severity, outcomes and risks of delay.	Assuming all requests have equal clinical priority.
Population and referral data	Disease patterns, location and alternative providers.	Using an outdated population or incomplete catchment.
Patient and staff feedback	Travel, affordability, communication and workflow barriers.	Treating a few comments as a representative survey.

Cross-check sources. If a number is uncertain, state the uncertainty and how it will be reduced.

WORKING METHOD | Illustrative material is identified in the text.

Include people who do not reach the service

WHO's guidance on fair progress towards universal health coverage includes attention to disadvantage and financial protection.

Look beyond the current queue

- Check whether rural patients, people with disabilities or those with limited income face avoidable barriers.
- Assess travel, repeated visits, opening times and out-of-pocket costs. Use patient input alongside service data.

Make the effect visible

- Explain which groups gain access under each option and which may remain excluded.
- Record how the proposed pathway reduces barriers within the hospital's mandate and lawful resources.

A larger activity total does not show whether access became fairer. Define the population and the access measure.

Sources: **P4**: fairness, disadvantage and financial risk protection

Plan the complete care pathway

WHO service-organisation guidance emphasises coordination between services and levels of care.

Before and within the hospital

- Identify referral criteria, the first assessment, diagnostics, treatment and escalation when the service cannot meet the need.
- Agree responsibilities with the services that send and receive patients. Include communication and access to relevant records.

After the immediate episode

- Define reporting, follow-up, rehabilitation or continuing care as applicable. Name who responds to outstanding results.
- Check how a patient returns to the referring service and how urgent deterioration is communicated.

A new clinic should improve a pathway. Moving a queue to another department is not evidence of better care.

Sources: **P3**: service integration and referral coordination

Write a clear service specification

A service specification states what will be provided and under what conditions. This is a suggested structure.

01 Scope

The patients, services and exclusions.

02 Access

Referral, triage, appointment and transfer arrangements.

03 Care

Clinical responsibilities and approved care standards.

04 Support

Staff, diagnostics, pharmacy, IT and facilities required.

05 Quality

The safety, access and outcome measures.

06 Accountability

The service owner, reporting line and review process.

Agree the specification with the responsible clinical and operational teams. Avoid promises beyond the service's verified capability.

WORKING METHOD | Illustrative material is identified in the text.

Consult the people affected by the proposal

Suggested consultation plan. Record the response and what it changes in the proposal.

Stakeholder	Question to resolve
Patients and referring teams	Where does the pathway fail, and what prevents access?
Clinical and nursing leads	What is clinically appropriate, safe and feasible?
HR, pharmacy and technical teams	Which staff, supplies, maintenance and backup are required?
Finance and planning officers	What will the option cost, how can it be funded and which route applies?
Authorised leadership / Board	Does it fit the mandate, priorities and available resources?

Consultation informs the decision. Record conflicts of interest and keep the actual approval responsibility clear.

WORKING METHOD | Illustrative material is identified in the text.

Compare more than one feasible response

Suggested options for a service problem. An option must be clinically and operationally realistic.

Option	What to examine	Main question
Improve the existing service	Scheduling, downtime, reporting and referral quality.	Can the current resources deliver more appropriate care?
Share or coordinate services	A lawful referral or service arrangement with another provider.	Will access, responsibility and continuity be reliable?
Expand local capacity	Additional staff, sessions, equipment or facilities.	Which extra resources are actually required?
Maintain the current arrangement	Its continuing costs, delays and risks.	What happens if the proposed change is not made?

Urgent safety failures need immediate action. Comparing options does not justify continuing an unsafe arrangement.

WORKING METHOD | Illustrative material is identified in the text.

Set priorities using explicit criteria

WHO identifies health benefit, disadvantage and financial protection as relevant to fair choices. The questions below are a suggested local comparison method.

Criterion	Question for the decision record
Need and benefit	How important is the problem, and what benefit is supported by evidence?
Fair access	Who is currently underserved, and how will this option help?
Safety and feasibility	Can the hospital deliver the service safely and reliably?
Cost and affordability	What resources are needed, and what else would those resources support?
Fit and accountability	Does the option fit the mandate, priorities and lawful approval process?

Explain the trade-offs. A high total score cannot waive a legal requirement or an unresolved safety condition.

Sources: **P4**: criteria for fair priority setting

Recognise the cost of choosing one option

Opportunity cost means the value of the best alternative use of a scarce resource that is given up.

Money is one scarce resource

- If the same lawful funding could support two competing services, choosing one may delay the other.
- Do not assume all funds can be moved. Restricted funds and budget heads have their own authority and conditions.

Capacity is also scarce

- A room, nursing team or theatre session allocated to a new service may become unavailable to an existing one.
- Record the displaced activity and patient effect. An unused-looking room may still be required for surge or safe separation.

The proposal should state what is gained, what may be displaced and how essential care will be protected.

WORKING METHOD | Illustrative material is identified in the text.

Check claims about a new service or technology

Suggested evidence questions for the responsible clinical, technical and financial reviewers.

01 Benefit

Which outcome improves compared with current care?

02 Evidence

How reliable and relevant is the supporting evidence?

03 Patients

Do the studied patients match the proposed population?

04 Safety

What harms, training and monitoring must be addressed?

05 Delivery

Can the whole pathway function with local resources?

06 Alternatives

Is there a simpler or less costly suitable option?

A supplier presentation is one source of information. Clinical evidence, independent review and the applicable approvals remain necessary.

WORKING METHOD | Illustrative material is identified in the text.

List the full resource requirement

Suggested resource map for a new or expanded service. Ownership should be assigned for each item.

Resource	What the proposal should include
People	Required skills, approved posts or cover, supervision, training and backup.
Facilities and equipment	Space, utilities, commissioning, servicing and replacement needs.
Supplies and support	Medicines, consumables, sterilisation, diagnostics, transport and waste handling.
Information and administration	Records, reporting, scheduling, billing where applicable and data protection.
Funding	Initial costs, continuing costs, lawful source and timing of funds.

Buying the main item does not establish that the service can run. Cost the dependencies as well as the visible asset.

WORKING METHOD | Illustrative material is identified in the text.

Find the limiting dependency

A dependency is something that must be available for another activity to work.

Map the sequence

- For a diagnostic session, check suitable patients, booking, trained staff, working equipment and timely reporting.
- Identify the step that currently limits safe output. Verify the reason using records and observation.

Test the proposed change

- Ask whether the option removes the limit or simply moves it. More tests may create a reporting backlog.
- Agree the support response before launch: for example, approved reporting time, repair cover or a referral backup.

Lecture 39 explains capacity calculations. Here, the planning task is to identify the whole delivery chain.

WORKING METHOD | Illustrative material is identified in the text.

Map the approvals for this proposal

Suggested authority check. The required route depends on the institution, service and funding source.

01 Mandate

Does the service fit the institution's governing framework?

02 Clinical

Who must approve the care model and clinical arrangements?

03 Regulatory

Which licences, registrations or other permissions apply?

04 People

Who can sanction posts, appointments or changed duties?

05 Financial

Who can approve the budget, expenditure and funding use?

06 Delivery

Which project, procurement and contract approvals apply?

Keep written evidence of the actual approvals. An internal meeting or a planning document does not create missing legal powers.

WORKING METHOD | Illustrative material is identified in the text.

Use the correct development-planning route

ADP means Annual Development Programme. Punjab's Planning & Development (P&D) Board issues guidelines for the relevant cycle.

What the cited cycle shows

- The 2026-27 guidelines use a medium-term outlook and require departmental portfolios through the Smart Monitoring of Development Projects portal.
- The stated stages include a strategy paper, concept notes for new projects, preparation of PC-I and approval by the competent forum.

What the hospital must establish

- Check the current year's instructions, departmental submission route, required forms and approval forum for this proposal.
- Keep project approval, budget provision, fund release and permission to incur expenditure distinct. Plan the later running costs.

Punjab ADP and the Federal Public Sector Development Programme (PSDP) are not interchangeable. Use the programme and instructions that actually apply.

Sources: **P5**: sections I-II; dated 2026-27 cycle

Project planning continues after construction

This is a role map of the Planning Commission forms, not an automatic sequence or a substitute for Punjab instructions.

Form	Main purpose	Hospital leadership question
PC-II	Survey or feasibility; may precede PC-I.	Which uncertainty needs investigation?
PC-I	Project proposal and appraisal.	Is the service justified and deliverable?
PC-III	Work, cash and progress reports.	Do work and spending match the plan?
PC-IV	Completion and handover.	Are the service and running funds ready?
PC-V	Performance after completion.	Is the project delivering its results?

Use the prescribed current form and route for the actual project. A completed building is not proof of a functioning clinical service.

Sources: **P6**: official PC forms, 2024 catalogue

Record risks with an action and an owner

Suggested risk register. Write a specific event and consequence, not only a general label.

Risk in the proposal	Control or decision needed	Evidence / owner
No trained backup during leave	Approve cover and verify competence before launch.	Clinical and nursing leads; roster and training record.
Consumables arrive late	Check lawful supply arrangements and safe contingency.	Pharmacy / stores; lead-time and stock review.
Maintenance is not funded	Confirm continuing cost and authorised support.	Technical and finance teams; funding and service plan.
Another service loses essential cover	Review displacement and revise the option if necessary.	Affected service leads; revised delivery plan.

Give each unresolved risk a decision date. A risk described as accepted still needs an authorised decision and monitoring.

WORKING METHOD | Illustrative material is identified in the text.

Separate inputs, activity and patient results

Invented diagnostic-service example. Each level answers a different question.

Level	Example measure	What it does not establish
Input	Two appropriately staffed sessions available each week.	That sessions actually took place.
Output	Number of clinically indicated examinations completed.	That reports were timely or care improved.
Service result	Time from accepted referral to an available report.	That every group benefited equally.
Safety / balancing measure	Repeat examinations, missed urgent cases or displaced work.	That a lower waiting time is safe by itself.

A balancing measure checks whether improvement in one area creates a problem elsewhere.

TEACHING CASE | Illustrative material is identified in the text.

TEACHING CASE

Write an objective that can be measured

Invented example. The numbers below are a proposed local aim, not a national standard or a predicted effect.

Population	Routine adult referrals accepted for the defined diagnostic service.
Baseline	The verified median referral-to-report time was 30 days in the last complete quarter.
Proposed aim	Reduce the median to 21 days within three months of the approved change.
Safeguards	Monitor long waits, urgent access, report quality and effects on other services.
Responsibility	The service lead reports progress monthly; authorised leadership reviews any unresolved constraint.

State exactly when the clock starts and stops. Report the longest waits as well as the median.

TEACHING CASE | Illustrative material is identified in the text.

Prepare the measurement plan before launch

Suggested specification for a small service dashboard.

Field	What to record
Measure and definition	The question, numerator and denominator where relevant.
Data source and period	The register or system, reporting period and extraction method.
Baseline and aim	The starting value and the justified, approved improvement aim.
Review and responsibility	Who checks accuracy, who reviews results and when.
Action threshold	What finding requires investigation or an authorised change.

An improvement aim is not automatically a clinical threshold. Keep clinical escalation criteria under the responsible clinical governance process.

WORKING METHOD | Illustrative material is identified in the text.

Turn the decision into a delivery sequence

Suggested implementation order after the relevant approvals. Some preparation can run in parallel.

1	**Prepare**	Confirm authority, funding, staff, facilities and support arrangements.
2	**Verify**	Check readiness, training, documentation and referral communication.
3	**Start**	Begin within the approved scope; monitor the first operating period closely.
4	**Review**	Compare actual delivery with the aim and safeguards; act on the findings.

WHO facility-level guidance links an assessed baseline, an action plan and repeated measurement. Adapt the working sequence to the service.

Sources: **P2**: facility-level actions

Complete the readiness check

Suggested checks before the authorised start date. Evidence should come from the responsible teams.

01 Authority

Required decisions and permissions are documented.

02 People

Competent staff and backup are available.

03 Environment

Equipment, utilities and safety arrangements are ready.

04 Supplies

Required medicines and consumables are available.

05 Pathway

Referral, escalation, reporting and follow-up work.

06 Funding

The initial and continuing funding arrangements are clear.

An opening date is not proof of readiness. Escalate a missing safety condition and use the approved contingency.

WORKING METHOD | Illustrative material is identified in the text.

Use a pilot to answer a defined uncertainty

A pilot is a limited test of an authorised service arrangement, with a stated scope and review point.

Define the test

- State what is uncertain: for example, whether a revised booking process reduces unused appointments.
- Set the period, patient group, responsible team, measures and stop or escalation conditions.

Decide after review

- Check outcomes and unintended effects. Determine whether to continue, change, expand or stop through the proper authority.
- If the activity is research, obtain the applicable research and ethical approvals. Calling it a pilot does not remove those requirements.

A small test can reduce uncertainty. It cannot excuse missing permissions, unsafe care or an unfunded commitment.

WORKING METHOD | Illustrative material is identified in the text.

TEACHING CASE

Return to the request for another machine

Invented findings from the diagnostic service. These observations guide the next decision; they do not establish the best option for every hospital.

Finding	Meaning for the proposal	Next action
Existing machine is available	A second machine may not address the present limit.	Verify the available staffed time and maintenance record.
Approved sessions are cancelled for lack of cover	Staffing limits actual service delivery.	Assess safe cover and the effect on other work.
Reports wait for review	The pathway has another constraint.	Agree a reporting arrangement and monitor delay.
Demand remains high after appropriate triage	Additional capacity may still be needed.	Compare a revised service with a fully costed expansion.

The defensible decision is conditional on the evidence. Do not buy equipment merely because it is the first option proposed.

TEACHING CASE | Illustrative material is identified in the text.

Prepare a concise proposal for decision

Suggested summary for the competent institutional or departmental authority.

01 Problem

The population, unmet need and verified baseline.

02 Options

Feasible alternatives and the reasons for the preference.

03 Resources

Staff, support, facilities and full cost implications.

04 Funding

The lawful source, timing and unresolved funding gap.

05 Risks

Dependencies, approvals and effects on other services.

06 Decision

The exact approval requested, conditions and review date.

Attach the supporting analysis. A decision-maker should be able to identify what is requested without reconstructing the entire file.

WORKING METHOD | Illustrative material is identified in the text.

Review the service after the initial launch

A functioning service needs continuing review as demand, staff, costs and clinical practice change.

Check what actually happened

- Compare planned and delivered activity, access, quality and costs. Explain variances using evidence.
- Check whether the original need remains and whether other services or patient groups were affected.

Make a recorded decision

- Continue, revise, expand or reduce the arrangement through the competent authority. Reassess funding and capacity before expansion.
- If a service is reduced or transferred, arrange a safe patient pathway, communication and record handover.

Review results as well as activity. A service can be busy while failing to address its intended purpose.

WORKING METHOD | Illustrative material is identified in the text.

Three planning decisions to practise

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

1. The new asset

A donated machine is offered. No trained operator, maintenance budget or supply arrangement is confirmed.

What must the proposal establish before acceptance and use?

2. The activity total

Visits rose by 20%. The file calls this a 20% increase in the number of people needing care.

Which definitions and records must be checked?

3. The waiting time

A pilot reduces the average wait, but urgent referrals are delayed and another clinic loses nursing cover.

Is expansion justified by the waiting-time result alone?

For each case, identify the evidence needed, the decision authority and the effect on patients.

TEACHING CASE | Illustrative material is identified in the text.

Answers and reasons

Use the service evidence, the planning criteria and the relevant authority.

1. Establish the whole service requirement

Check acceptance authority, clinical need, staffing, safety, recurring costs, supplies and support. A free asset does not create a free service. Do not use it until the applicable conditions are met.

2. Separate people from encounters

Check unique patients, repeat visits, referral changes, coding and the reporting period. An increase in visits may reflect more contacts per patient. It does not by itself establish population need.

3. Examine the adverse effects

Review clinical priorities, displaced care and the full waiting-time distribution. Correct the safety and cover problems before considering authorised expansion. One favourable average is insufficient.

These answers apply the working methods in the lecture. Live clinical and administrative decisions require the relevant evidence and authority.

Prepare one service-planning brief

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

Define the need

Choose one service problem. Record the population, baseline and limitations in the evidence.

Compare options

Describe feasible responses, their resource needs and effects on other services.

Request a decision

State the preferred option, required authority, funding questions and review measures.

Ask a clinical lead and a finance or planning officer to test the brief. Record the corrections and remaining uncertainties.

Continue with Lecture 39: Demand, Capacity and Patient Flow.

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.

P1

PHC Minimum Service Delivery Standards for Hospitals

2024 cover; CG-01MS-Ed2-01092023. Standard 19, indicators 108-116: mission, plans, authorised budgets, performance, organisation and community responsibilities. Use the manual applicable to the hospital.

Punjab Healthcare Commission | Official catalogue | **Official source**

P2

Quality health services: a planning guide

WHO, 2020. The facility-level guidance addresses baseline assessment, improvement aims, teams, action plans and measurement. It is planning guidance, not a Punjab statutory delegation.

World Health Organization | **Official source** | **Facility-level actions**

P3

UHC service planning and models of care

WHO service-organisation guidance, consulted 4 October 2026. Supports coordinated care across services and referral networks. The hospital examples and worksheets in this lecture are original working methods.

World Health Organization | **Official source**

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.

P4

Making fair choices on the path to universal health coverage

WHO consultative-group report, 2014. Addresses fair priorities, health benefit, disadvantage and financial protection. These principles do not create a local fee, entitlement or spending power.

World Health Organization | **Official source**

P5

Guidelines for Formulation of ADP 2026-27

Punjab P&D Board, No. 1(45)PO(ADPF)P&D/2025-26. Sections I-II address the planning framework and submission stages. This is a dated cycle: check the applicable year, instructions and approval forum.

Government of Punjab | Planning & Development Board | **Official source** | **Current P&D instructions**

P6

Planning Commission forms: PC-I to PC-V

Official catalogue includes the 2024 forms. Used for the roles of feasibility, project appraisal, progress, completion and later performance. Federal reference: confirm the applicable Punjab forms and approval route.

Government of Pakistan | Planning Commission | **Official source**

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