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From Mandate to Performance: A Critical Evaluation of the Punjab Healthcare Commission's Role in Addressing Medical Negligence in Punjab

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Medical negligence is one of the leading concerns for the healthcare system in Pakistan. Almost every year, there are millions of people, including patients and their families, suffers harms due to negligent medical treatment on the part of doctors, inadequate facilities provided by healthcare establishments, and often due to the conduct of unqualified practitioners. Aggrieved persons are often left with no effective redress. To address the issue of malpractice and maladministration, the Punjab Government took an initiative and established the Punjab Healthcare Commission (''PHC'') under the Punjab Healthcare Commission Act 2010 (''PHCA 2010''). The PHC was established as an independent regulatory body that was responsible for licensing, registration of all the healthcare establishments in Punjab province, and investigating the claims regarding medical negligence and malpractice. In view of these extensive regulatory responsibilities, a question persists as to how effective the commission has been in achieving its mandate. This research paper is a critical analysis of the measures taken by PHC to address medical negligence across Punjab, as well as highlighting the structural, procedural, and institutional hurdles that undermine PHC's role as a healthcare regulator. A comparative analysis is also drawn with international healthcare standards, followed by proposed reforms aimed at ensuring better functioning of PHC.

PUNJAB'S HEALTHCARE INFRASTRUCTURE

Punjab holds Pakistan's largest multi-tiered healthcare infrastructure comprising primary healthcare facilities, approximately 5,400basic healthcare units (''BHU's'') and around 600 rural healthcare units (RHC's). Whereas tehsil headquarter hospitals (''THQ'') and district headquarter hospitals (''DHQ's'') form part of secondary healthcare facilities, while tertiary healthcare is provided by specialized teaching hospitals and advanced medical institutes located primarily in urban centers. Many significant initiatives have been undertaken by the provincial government to improve and expand the healthcare infrastructure, but the rapidly increasing population has placed a burden on the healthcare system. Lahore is the principal medical hub providing healthcare services in the city as well as to patients from all across Punjab, while Lahore's population has reached approximately 14.1 million. This has widened the gap between demand for healthcare services and the system's capacity to meet those demands.

LEGAL FRAMEWORK OF COMMISSION

PHCA 2010 serves as the primary legislation that sets out the powers, jurisdiction, and regulatory framework of the Commission. Section 2 (xxii) PHCA 2010 defines medical negligence as a case where a patient sustains injury or dies as a result of improper treatment, with death determined based on an autopsy report.

Section 4 lays out all the functions and powers that the commission possesses under the PHCA 2010. Specifically, section 4(2)(e) and (g) empower PHC to investigate complaints regarding malpractice, maladministration, or any complaint regarding failure of a healthcare establishment to provide adequate service.

Under section 18 of PHCA 2010, the Commission can suspend the license of a healthcare establishment upon repeated cases of negligence.

Section 19 outlines two aspects in which a healthcare establishment can be found guilty of medical negligence (a) the establishment did not possess the human resources and equipment it professed to have, (b) the service provider failed to exercise reasonable competence using the skill actually possessed. Section 19(2) excludes known medical or surgical complications from the ambit of medical negligence.

Section 23 prescribes the complaint procedure, requiring an aggrieved person to file within sixty days from the date of knowledge of the cause of action, supported by a written affidavit.

Under section 29 PHCA 2010, all complaints are channeled exclusively through the PHC only.

Moreover, by virtue of powers given under Section 40 and Section 41 of PHCA 2010, the commission formulates regulations and rules to give effect to the provisions of the act. The Commission has formulated the Punjab Healthcare Commission Complaint Management Regulations 2014 (''PHCCMR 2014'') and Punjab Healthcare Commission Pricing Regulations 2023 (''PHCPR 2023'').

PHC'S COMPLAINT MANAGEMENT SYSTEM & PROCEDURAL BARRIERS

For the regulation and control of complaints regarding medical negligence, PHC exercises its powers given under PHCA 2010 as well as PHCCMR 2014 as a subsidiary authority containing detailed regulations outlining the framework. The primary section navigating the complaint procedure is section 23 of PHCA 2010, under which a complaint is required to be lodged within a 60-day timeframe.

Regulation 4(7) of PHCCMR 2014 bars complaints that are anonymous, time-barred, subject to pending litigation, or outside the PHC's jurisdiction. Complaints that survive this threshold proceed to a formal hearing under regulation 12, at which evidence is recorded on oath, and legal representation may be permitted at the presiding officer's discretion. Regulation 18 empowers the PHC to issue interim orders without notice where public interest demands, and Regulation 19 governs the disposal of complaints.

This complaint management system emphasizes procedural compliance rather than accessibility. The documentary burden placed on complainants, the absence of any legal aid or facilitation mechanism, and the complexity of the process as a whole mean that the system is effectively accessible only to those who are educated, resourceful, and persistent enough to navigate it. The current framework places an unfair burden on the aggrieved person. This extensive documentary requirement affidavit, accompanied by medical records, CNIC, and receipts, assumes a level of documentary preparedness that many complainants, who have just lost a family member, simply do not possess. Medical records in Pakistan are routinely withheld, altered, or not provided by healthcare establishments, and the regulations do not impose any obligation on the healthcare establishment to proactively provide records to the complainant prior to the complaint being filed. Courts and forums then dispose of claims on purely technical grounds without ever examining the substance of the alleged negligence. Claims are thus disposed of on technicalities rather than on their merits. This illustrates that PHC laws must be more extensive and descriptive, and the PHC platform must be made suitable and helpful for aggrieved persons rather than subjecting them to such burdensome requirements.

The practical illustration of this procedural hurdle is evident in the case of Dr. Malik Muhammad Yaseen v. Justice of Peace, Additional Sessions Judge Kabirwala.[1] Here the complainant sought recourse through proceedings under section 22-A Cr.P.C. under which a person can seek order from Justice of Peace directing police to register an FIR where they have failed to act. This was followed by allegations of medical negligence. The Lahore High Court held that the grievance ought to have been pursued under the PHCA 2010, emphasizing that Section 23 prescribes a specific complaint procedure and that Section 29 bars other legal proceedings relating to the provision of healthcare services except under the Act. Although the Court correctly applied the statutory framework, the case nevertheless illustrates the practical difficulties faced by aggrieved persons in identifying and navigating the specialized complaint mechanism established by the Act.

Rather than facilitating access to justice, the procedural requirements serve as a means to delay the resolution of grievances where complainants first approach an incorrect forum before being redirected to the PHC. The sixty-day limitation period compounds this problem significantly. The rigidity of this limitation is also evident from a recent decision of Lahore High Court in the case of Dr. Talal Khurshid Bhatti v Punjab Healthcare Commission,[2] where even a qualified medical professional could not overcome the sixty-day bar despite arguing a recurring cause of action and progressive worsening of injury. The court held that neither subsequent expert medical opinions nor the continuing nature of harm could extend or revive the limitation period, and that condonation of delay is not a matter of right. If a doctor cannot navigate this framework successfully, the ordinary patient has little realistic prospect of doing so.

The procedural barriers identified above are not merely theoretical concerns but are borne out by the PHC's own published figures. According to data released by the PHC in its quarterly newsletter for the period July to September, of a total of 14,366 complaints received until 2018, only 33 were formally registered, and a mere 26 were disposed of. In the period from January to April 2018 alone, total complaints reported stood at only 1,305.[3] These figures are striking not for the volume of complaints received but for what they reveal about the system's capacity to process them. A regulatory body genuinely committed to accountability would treat a registration rate of this scale as a crisis requiring urgent institutional response. The PHC has not done so, and the numbers confirm what the legal analysis of this paper is trying to argue, i.e., the complaint management framework, as currently designed and operated, is failing the very population it was established to protect.

PUBLIC AWARENESS & LEGAL LITERACY – STRUCTURAL BARRIER

Another major issue is that PHCA 2010 is a relatively new legislation that requires an adequate level of public awareness, which is mandatory for the effective functioning of PHC as a regulatory instrument. Unlike general civil or criminal law, which enjoys a degree of popular familiarity through cultural exposure and institutional education, the PHCA 2010 operates within a narrow regulatory space that most citizens have never encountered. In a province where literacy rates remain a significant social challenge, the expectation that aggrieved persons will independently navigate a specialized healthcare regulatory framework is, in practice, unrealistic. The vast majority of patients and their families who suffer harm due to medical negligence are simply unaware that the PHC exists as a forum for redress. This knowledge gap reflects a structural failure to integrate public legal education into the Commission's operational mandate. A regulatory body whose existence and jurisdiction remain unknown to the very population it is designed to protect cannot function as an effective instrument of accountability. Until the PHC undertakes sustained, accessible, and multilingual public outreach, particularly targeting rural and low-income communities. The gap between the law on paper and justice in practice will remain wide and largely unabridged. The absence of meaningful public legal education is not merely an inconvenience but actually it is a structural failure that strikes at the heart of the PHC's regulatory purpose.

LITIGATION HURDLES & MISCHARACTERIZATION OF COMPLAINTS

The most troubling feature of the PHC framework is that, rather than deterring negligent healthcare providers, it disproportionately burdens the very individuals who have already suffered harm. Beyond the 60-day time limitation requirement problem as discussed above, there is a broader issue of forum confusion and mischaracterization of complaints that also amounts to structural barriers faced by PHC performance as a regulatory body.
A convenient method of litigation pursued by aggrieved persons for a medical negligence claim is under writ jurisdiction, mainly because it is capable of attracting direct and easy intervention of the High Court. But this is not an appropriate direction for prosecuting malpractice or medical negligence cases; for such, the only appropriate platform is the PHC itself. The right way to claim medical negligence against any healthcare establishment or healthcare service provider is through the PHC, which has special powers to investigate and impose penalties on healthcare service providers. This practice bypasses the PHC entirely, which is the designated and empowered forum for investigating medical negligence and imposing regulatory penalties under Section 29 OF PHCA 2010.

The issue of forum confusion has been expressly recognized by the Lahore High Court. In Dr. Riaz Qadeer Khan v. Presiding Officer, District Consumer Court, Sargodha[4], the Court held that allegations of medical negligence, maladministration, and malpractice fall within the exclusive jurisdiction of the Punjab Healthcare Commission. The Court observed that the Commission possesses specialized statutory powers to investigate complaints and impose penalties upon healthcare service providers, whereas Consumer Courts lack jurisdiction to adjudicate such matters. Rather than obtaining a determination on the merits of their grievances, complainants often find themselves entangled in preliminary jurisdictional disputes that ultimately require the matter to be recommenced before the PHC.
This pattern of forum confusion has significant consequences for the coherence and effectiveness of the PHC regulatory framework. When cases are adjudicated through writ petitions rather than through the PHC mechanism, the specialized investigative and regulatory powers of the PHC, including the appointment of inspection teams, expert consultation, and penalty imposition, are bypassed entirely. The High Court, hearing such petitions, is typically not in a position to conduct the kind of detailed factual and clinical inquiry that medical negligence cases require. Furthermore, the prevalence of writ petitions in medical negligence matters suggests a systemic lack of confidence in the PHC as an effective forum for redress. This is itself a damning indictment of the PHC's performance. When those PHCs consistently resort to constitutional litigation instead of their own mechanisms, it reflects a failure to establish the Commission as a credible, accessible, and effective regulatory authority.

Moreover, mischaracterization of the claims issue also significantly undermines the effectiveness of the PHC's complaint management system. Often, cases involving negligence on the part of hospital management or administrative staff are framed as one of medical negligence when the legally correct and appropriate characterization would be maladministration. Conversely, in cases where the conduct of a doctor amounts to malpractice, meaning improper, unskilled, or unethical professional conduct that causes harm, such complainants often framed as a general negligence claim rather than identifying it correctly as malpractice. These two are legally distinct concepts. When a complaint is wrongly framed, it is usually disposed of not on its merits but on a technical objection of legal characterization, ultimately leaving the aggrieved person without any substantive remedy despite the existence of a genuine and legitimate grievance. The result is that meritorious cases are routinely lost, not because the underlying facts do not disclose any wrongdoing, but simply because the complainant, lacking legal knowledge and guidance, used the wrong legal label when filing their complaint. The root cause of this issue is the same as that which underlies other failures identified in this paper: failure of proper public awareness.

The PHC's failure to establish a clear, accessible, and guided complaint registration mechanism that assists complainants in correctly identifying and framing the nature of their grievance is a serious institutional failure. Until PHC bridges the gap of awareness, the complaint management framework will continue to filter out legitimate grievances on technical grounds, and the PHC's mandate of accountability will remain substantially unfulfilled.

LACK OF COMPENSATORY MECHANISM FOR AGGRIEVED PERSONS

There is no provision in the Act for compensation to be awarded to the aggrieved person out of the fine collected. Fines go to the Commission's own fund rather than to the victim, meaning that the financial consequences of negligence are entirely decoupled from the harm caused. This creates a situation where the PHC's penalty mechanism serves an administrative and regulatory function but provides no civil remedy to the person who has actually suffered the loss. The absence of any compensatory mechanism in the PHC framework is one of its most glaring structural deficiencies, and one that pushes aggrieved persons toward the civil courts, which is a forum that is slow, expensive, and equally inaccessible to most victims.

PHC'S ROLE IN CONTROLLING EXORBITANT CHARGING BY THE PRIVATE HEALTHCARE SECTOR

Another most consequential yet under examined dimensions of the PHC's mandate is its responsibility to regulate and control the prices of healthcare services charged by private healthcare establishments. This responsibility flows directly from Section 40(2)(m) PHCA 2010 as well as through PHCPR 2023, which empowers the Commission to make regulations regarding control of prices of healthcare services. PHCPR 2023 introduces a pricing mechanism applicable to all healthcare establishments across Punjab, encompassing public, private, charitable, trust, semi-government, and autonomous facilities. At the core of the framework is an activity-based costing model. Under Regulation 4, each healthcare establishment is required to conduct a comprehensive costing exercise through a chartered or cost accountancy firm registered with the SECP or State Bank of Pakistan, covering all commonly undertaken procedures, other procedures, and ancillary facilities, and to submit the resulting data to the PHC with a profit margin not exceeding 20%of actual cost. Approved prices constitute the maximum ceiling chargeable to patients, with establishments at liberty to charge any lower amount. PHC is further empowered to verify, re-assess, or validate costing data it finds inaccurate or exaggerated, and to notify rationalized prices accordingly. PHC also establishes a dedicated Pricing Cell responsible for enforcement, monitoring, and periodic price revision, with the authority to seal premises, stop services, and impose fines for violations. Transparency obligations under Regulation 7 require all healthcare establishments to display approved prices publicly at their main entrance. Regulation 10 provides a degree of internal appellate review. Despite having all such regulations, the issue still remains unsorted as PHC only reviews the cost determination mechanism of hospitals rather than standardizing healthcare charges. Private hospital manages the bill, and the only regulation PHC manages is a total 20% capping regulation on the overall cost of the Hospital. Private hospitals vary widely in scales thus overhead cost determination also varies. This illustrates that PHC laws themselves are flawed and lack efficacy. Not only this that patients been subject to such unjust and excessive charging for the basic healthcare facilities and services, but the fact that providing healthcare to citizens is the fundamental obligation of any welfare state, and instead of facilitating citizens and ensuring that quality healthcare service is provided to them, PHC has even failed in maintaining healthcare charges at a reasonable and affordable rate.

THE PHC IN COMPARATIVE PERSPECTIVE

No regulatory framework can be meaningfully evaluated in isolation. To assess whether the PHC is delivering on its mandate, it must be measured not only against its own statutory objectives but against the standards that comparable regulatory bodies and international health governance frameworks have established as the baseline of effective healthcare regulation. The comparison is intended to demonstrate that the deficiencies identified in this paper are the product of regulatory design choices that are neither inevitable nor beyond remedy.

The Care Quality Commission ‘’’CQC’’ of England provides the most instructive institutional comparator. Both the CQC and the PHC serve as primary healthcare regulators in their respective jurisdictions, yet the regulatory models they have adopted diverge in ways that are directly relevant to the failures this paper has documented.

The CQC evaluates providers across five qualitative dimensions: safety, effectiveness, care, responsiveness, and leadership, and publishes performance ratings that are publicly accessible and carry real reputational consequences for healthcare providers. Whereas the PHC operates through a compliance-based model anchored in Minimum Service Delivery Standards, issuing or revoking operating licenses on the basis of baseline criteria rather than qualitative performance assessment. Patients in England can, before engaging with any provider, consult an independently verified assessment of that provider's quality. No equivalent mechanism exists in Punjab.

Moreover, the CQC's enforcement posture is proactive and unannounced. CQC conducts inspections on a rolling basis without prior notice, ensuring that compliance reflects actual institutional practice rather than curated performance. On the other hand, PHC's enforcement activity, as this paper has established, remains largely reactive, triggered by individual complaints rather than systemic oversight. That a substantial proportion of the PHC's operational capacity is consumed by raids against illegal clinics and unqualified practitioners is itself an indicator of the distance between the two regulatory environments and of how much further the PHC must travel before it can meaningfully direct its attention toward the quality and accountability standards.

Beyond the institutional comparison with the CQC, the PHC's performance must also be assessed against the standards the World Health Organization ‘’WHO’’ has established as the international baseline for effective healthcare regulation.

The World Health Organization's (‘’WHO’’)Framework on Integrated, People-Centered Health Services, adopted at the Sixty-Ninth World Health Assembly in 2016, offers a benchmark against which the PHC's performance must be measured.[5]

WHO prescribes five interdependent strategies for effective health regulation, and the PHC falls short of each one that matters most here. The requirement regarding accountability is both the rendering of account by publishing meaningful performance information and the holding to account through rewards and sanctions that deliver tangible relief to those who have suffered harm. The PHC does neither. On equitable access, WHO identifies reaching disadvantaged populations facing barriers of income, education, and geography as the cornerstone of universal healthcare; yet PHC's complaint framework remains accessible only to those educated and resourceful enough to navigate it alone. **Page 8-10**

On community engagement, WHO framework calls for civil society participation and strengthened public involvement in healthcare governance; the PHC has made no structural provision for either. On information systems, the framework treats centralized data infrastructure as a prerequisite for meaningful regulatory oversight. For PHC's reactive, complaint-driven model, this standard seems impossible to meet. And on financial protection, the framework requires payment systems that shield patients from undue out-of-pocket expenditure, an objective the PHC's cost-based pricing model is structurally ill-equipped to achieve. Commission does not fall short of WHO standards in one isolated respect; instead, it falls short across every dimension the framework identifies as essential to a regulatory body that genuinely serves its population.

FROM MANDATE TO PERFORMANCE - A REFORM AGENDA FOR THE PHC

The structural and procedural flaws identified throughout this research paper must be remedied. Some proposals are made as follows: First, foundational reform required is that PHC should establish a centralized digital patient data portal, as under the current framework; the documentary burden imposed upon complainants is burdensome and serves as a major barrier to complaint registration. A mandatory digitization regime must be introduced under which all hospitals will be required to upload and maintain patient records on that portal. This would shift the burden of evidence preservation from aggrieved patients to healthcare providers, where it properly belongs. Furthermore, for effective enforcement of this reform, it must be accompanied by amendments in PHCA 2010 that penalize the failure to upload a patient record on a portal. This would not only facilitate individual complaints but would also provide the Commission with a reliable and comprehensive data infrastructure for systemic regulatory oversight.

The same data infrastructure would, in turn, enable the second reform proposed here, i.e., a Programme of regulatory audits conducted by the PHC across registered healthcare establishments. Currently, the PHC's enforcement activity is triggered by individual complaints rather than proactive institutional oversight. This would also transform PHC from a passive adjudicatory authority to an active regulatory authority. The audit records drawn from the centralized portal would reflect actual operational practice rather than curated institutional performance. This model is consistent with the CQC's inspection regime in the United Kingdom, where unannounced inspections form a core component of the regulatory framework, and its adoption by the PHC would represent a significant step toward the proactive accountability standard the WHO framework demands.

Another practicable reform concerns the proceedings mechanism. PHC should adopt a virtual hearing model on platforms like Zoom meetings that would enable complaints to be heard virtually via video conference; mandatory proceeding recording would serve as evidence in any subsequent court proceedings; and provide complainants who seek judicial review or civil redress with a documented evidentiary foundation that the current framework entirely fails to create.Virtual hearings would also accelerate disposal rates, reducing the procedural delays that presently compound the hardship already experienced by aggrieved patients.

Beyond procedural reforms, PHCs must also take initiatives to ensure credibility and public trust. An independent third-party verification of the PHC's regulatory performance that is conducted by the experts of the World Health Organization would provide the kind of authoritative, internationally credible assessment that internal reporting simply cannot replicate. However, the financial burden of such reform is acknowledged, but the PHC, through the Government of Pakistan, should approach the WHO and formally request technical and financial assistance in this regard.

Where international engagement proves unfeasible, domestic credibility can be sought through partnership with reputable firms that conduct third-party verifications (''TPVs'').

PHC must also take initiatives for public awareness. The PHC's own figures show that complaint registration remains strikingly low. To close this gap, the PHC should build formal public-private partnerships (''PPP'') with civil society organizations, bar associations, and patient advocacy groups capable of reaching communities that state institutions routinely fail to serve. At the institutional level, every registered healthcare establishment should be required, as a condition of its license, to display the PHC's complaint procedure and patient rights prominently on its premises in Urdu and the relevant regional language.

These reforms are not ambitious overreach; instead, they are long overdue. The PHC was created to stand between vulnerable patients and a healthcare system that too often fails them, and it has the legal authority to do exactly that. What it has lacked, for too long, is the institutional commitment to use that authority meaningfully. The patients of Punjab, who approach hospitals not as informed consumers but as people in pain, in fear, and in need, deserve a regulator that meets them where they are. These reforms are simply the minimum that commitment requires.

[1] 2017 P Cr. L.J Note 192 [Lahore (Multan Bench)] Dr. Malik Muhammad Yaseen v Justice of Peace/Additional Session Judge, Kabirwala

[2] PLD 2026 LAHORE 1 Dr. Talal Khurshid Bhatti v Punjab Healthcare Commission

[3] Punjab Healthcare Commission, Quarterly Newsletter (July to September)& (January to April) 2018

[4] PLD 2019 Lahore 429 Riaz Qadeer Khan v Presiding Officer, District Consumer Court, Sargodha

[5] World Health Organization, Framework on Integrated, People-Centred Health Services (Report by the Secretariat, Sixty-Ninth World Health Assembly) 2016

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