

Accessibility assessment of hospitals in a metropolitan city of a developing country



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ABSTRACT

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Accessibility of hospitals is a fundamental human right, and with the increasing percentage of people with disabilities, hospital accessibility is becoming more critical to ensure their health and well-being. Most people with disabilities worldwide reside in developing countries. Pakistan, a developing country, has more than 10% of its population suffering from some form of disability, whether cognitive or physical. As this percentage continues to grow, it is essential for the government to develop policies that guarantee hospital accessibility for all. However, there exists a gap between policy formulation and practical implementation. This study focused on examining the accessibility conditions of various types of hospitals—public, private, and public-private partnership hospitals—in Lahore, the second-largest metropolitan city of Pakistan. The research employed both local and international accessibility standards to develop an assessment tool that evaluated five key areas within hospitals: parking, building entrances, corridors, toilets, and wayfinding. Thirteen hospitals were assessed using this tool, and the results indicated below-average compliance across all categories. The findings highlight the discrepancy between the creation of accessibility codes on paper and their actual implementation, emphasizing the need for the government to establish laws or regulatory bodies to ensure compliance and improve hospital accessibility for people with disabilities.

Contribution/ Originality: This study contributes to the existing literature by highlighting the gap between policies related to hospital accessibility and their implementation in Pakistan. It introduces a tool that compares local policies with those in developed countries, revealing significant policy and implementation gaps in accessibility to public healthcare facilities.

1. INTRODUCTION

Globally, the number of people living with disabilities exceeds one billion, with the majority (approximately 80 percent) residing in developing countries. These individuals encounter difficulties in areas such as healthcare, education, community involvement, and accessibility (World Health Organization, 2011). In Pakistan, physical accessibility is one of the major barriers faced by individuals when accessing healthcare facilities (Ashraf, Ashraf & Uzair-ul- Hassan 2020) and is a leading cause of poor health among people with physical limitations. Despite the fact that the majority of people with disabilities worldwide reside in developing countries, little attention is paid to the accessibility of healthcare facilities in these nations (Wachs & Kumagai, 1973).

Various conventions and organizations work globally to ensure equal rights for people in different parts of the world, and in addition to observing these international conventions, countries also develop their own local policies and practices to cater to the diverse needs of people with various physical abilities. However, in third-world countries, these policies mostly fail to bring any meaningful improvement in the lives of people with disabilities, proving merely to be words on a piece of paper (Gul, 2020).

To bring improvement in the accessibility of healthcare facilities, it is important to first examine their compliance with existing codes and accessibility laws. Therefore, this study aimed to examine the current physical accessibility conditions of healthcare facilities in Lahore the second-largest city of Pakistan as per the existing accessibility policies followed by the city, as well as the continuously evolving and increasingly comprehensive American Disability Act (ADA).

2. BACKGROUND

The term *accessible design* was derived from the ADA (Americans with Disabilities Act) standards published in 1991 (U.S. Department of Justice, 1991). Its definition has evolved over time, and it is defined as “the design focused on diverse users to maximize the number of potential users who can readily use a system in diverse contexts” (International Organization for Standardization, 2014). Dealing with accessibility is considered difficult while practicing building design (Rieger & Strickfaden, 2016) as it poses designers with a challenge while dealing with the complexity associated with designing accessible environments (Gossett, Gossett, Mirza, Barnds, & Feidt, 2009). To help them create empathy with people facing disabilities and understand the criteria in building codes and standards, people with disabilities are broadly categorized into three main groups (Watson, 2003).

1. Sensory impairments: These include vision, hearing, and speech impairments, including total or partial loss of function.
2. Dexterity Impairments: These include limitations in the use of their hands and fingers.
3. Mobility impairments: These include people who use walkers, crutches, canes, and wheelchairs.

Accessibility to public facilities, including healthcare facilities, impacts the overall satisfaction, health, and well-being of people with disabilities (Clarke & Nieuwenhuijsen, 2009; Faizan, 2018; Lund & Lexell, 2009) and is therefore considered the fundamental right of every individual (Brudney, 2016; Schraufnagel, Schraufnagel, & Schraufnagel, 2017). With the global increase in the percentage of people with disabilities due to population growth (Ashraf, Ashraf & Uzair-ul- Hassan 2020) and ageing (Verbrugge & Jette, 1994; World Health Organization, 2011), access to healthcare facilities is becoming even more important (World Health Organization, 2011). According to WHO, approximately fifteen percent of people with disabilities live in the southwest, with the majority residing in developing countries. Pakistan alone has more than 25 million people with some form of disability (Government of Pakistan, 2025). It is the responsibility of the government to provide these people with access to primary public facilities, including healthcare facilities. Therefore, several policies and laws are made to ensure that people with disabilities have equal access to built facilities, and these are continuously revisited and improved. For example, LDA - Building and Zoning Regulations exist in the city of Lahore, Karachi Building and Town Planning Regulations in Karachi, and similarly, other cities have their own codes or follow the codes of big metropolitan cities in Pakistan. However, in third-world countries, these policies fall short of bringing any meaningful change in the lives of people with disabilities by serving only as words on a piece of paper (Gul, 2020). Therefore, the aim of this study was to examine the code compliance of existing healthcare facilities in the second-largest metropolitan city of Pakistan Lahore. To achieve this goal, the objectives of the study were to: 1) review different sources containing accessibility codes and laws; 2) create an assessment tool using these sources; 3) select healthcare facilities in Lahore for accessibility assessment, ensuring representation of different types of facilities; and 4) assess these healthcare facilities in Lahore and examine their accessibility based on the created assessment tool.

2.1. Classification of Healthcare System in Pakistan

The Pakistani healthcare system is divided into three categories: public, private, and public-private partnership (PPP). The public sector, which is managed by the federal and provincial governments, provides healthcare through an organized tiered system (World Health Organization Regional Office for the Eastern Mediterranean, 2025). The federal level manages healthcare through institutions affiliated with specific ministries such as defense and railways. The provincial level includes primary care institutions responsible for preventive health care, vaccination, and treatment of frequently recurring illnesses. Second-level care centers provide general medical treatment, emergency care, and follow-up treatment for acute illnesses (Pakistan One Health Alliance, 2020). Tertiary care is specialized consultative health care, usually for inpatients and on referrals from primary or secondary health professionals. These centers handle advanced and specialized medical treatments for complex and chronic illnesses, typically involving specialist consultation and equipment (Specialized Healthcare & Medical Education Department, 2021).

The private sector encompasses formal and informal providers. Formal providers include licensed hospitals, clinics, diagnostic centers, NGOs, and private practitioners, which tend to offer faster and specialized care. Informal providers include homeopaths, traditional healers, and unlicensed practitioners, who are more available in rural and under-served geographic areas but might lack standardized medical education (World Health Organization, 2011).

The third category, which is public-private partnership (PPP), typically refers to healthcare facilities that operate with a mix of public and private funding, offering services at a cost lower than fully private hospitals but higher than those in the public sector. These institutions aim to provide quality care while remaining financially accessible to a broader segment of the population (Zaidi, 2019). The classification of healthcare facilities in Pakistan, along with examples of hospitals in Lahore, are shared in Figure 1.

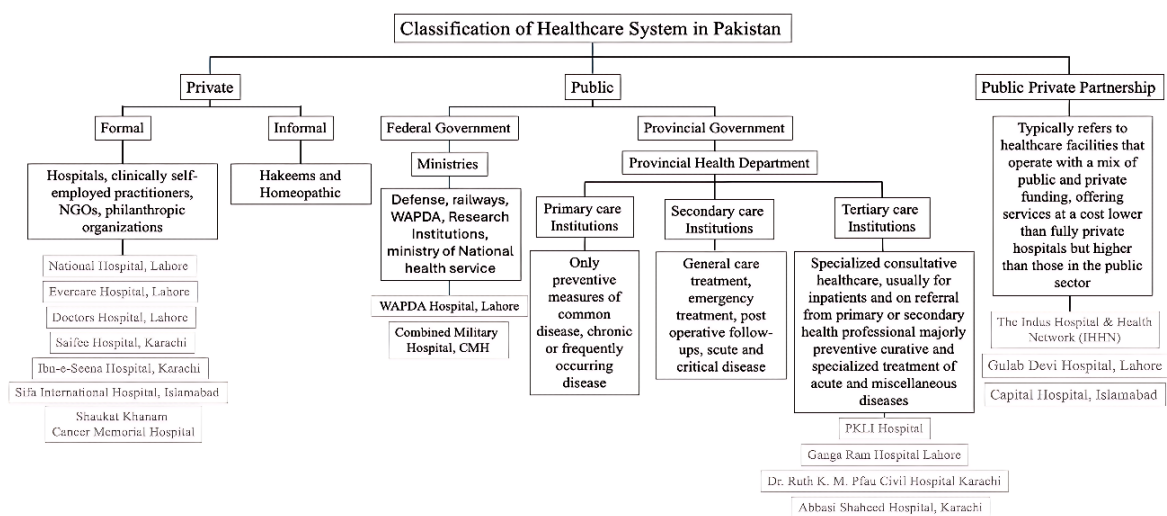


Figure 1. Classification of the healthcare system in Pakistan.

3. METHODOLOGY

In designing the accessibility assessment tool, the study followed the approach of Faizan (2018), which provided a helpful template for the assessment of built environments. Local accessibility codes, along with accessibility codes from developed countries, were used to create the assessment tool for this study. The primary sources utilized to develop the accessibility assessment tool included the Lahore Development Authority (LDA) Building and Zoning Regulations (Lahore Development Authority, 2019), the Building Codes of Pakistan (International Code Council, 2021), and the ADA Standards for Accessible Design (U.S. Department of Justice, 2010). Due to differences in the design of various healthcare facilities in Lahore, the scope of this study was limited to public spaces within each facility. These include the nearest parking area, the route from parking to the building entrance, the building entrance itself, wayfinding systems, and corridors.

Each of the three sources was reviewed to collect the standards pertaining to these parts of healthcare facilities. Some of the standards were the same in all three sources, whereas some were present in one or two sources. Table 1. Shows the assessment tool created after reviewing all three sources, i.e., Lahore Development Authority (LDA) Building and Zoning Regulations – 2019, Building codes of Pakistan (International Code Council, 2021), ADA Standards for accessible design (U.S. Department of Justice, 2010). Table 1 also highlights the sources from which these standards are retrieved. A total of 61 standards were included in the assessment tool using these three sources mentioned above. Out of these, 15 standards were extracted from LDA Building and Zoning Regulations-2019, 29 from the Americans with Disabilities Act, 7 from the 2021 Building Codes of Pakistan, 1 from both LDA Building and Zoning Regulations and the 2021 Building Codes of Pakistan, 4 from the 2021 Building Codes of Pakistan and the Americans with Disabilities Act, 2 from LDA Building and Zoning Regulations and the Americans with Disabilities Act, and 3 from all three sources.

Table 1. Accessibility assessment tool.

No.	Sources	Design Feature	Present/ Absent/ Not Applicable
Parking			
1		One car space should be provided for 1400 sq ft of floor area, and for spaces requiring between twenty and fifty parking spots, at least one dedicated parking spot should be provided for people with disabilities.	
2	 	At least 10%, but not less than one of the care recipient and visitor parking spaces provided to serve outpatient hospital facilities, should be accessible.	
3		The width of accessible parking slots shall not be less than 12 feet, inclusive of a 48-inch-wide accessible aisle.	
4		Access aisle shall join an accessible route.	
5		Two parking spaces shall be permitted to share a common access aisle.	
6		Access aisles shall not overlap the vehicular way. Access aisles shall be permitted to be placed on either side of the parking space, except for angled van parking spaces, which shall have access aisles located on the passenger side of the parking spaces.	
7		The width of accessible aisle is 60”.	
8		Accessible aisle is marked so as to discourage parking in them.	
9		Access aisle is at the same level as parking space	
10		Access aisles shall extend the full length of the parking spaces they serve.	
11		The width of an accessible reserved parking space for adapted motorcycles/tricycles shall not be less than 6 feet.	
12		Provision of accessible route for parking facility.	
13		In the case of a multistorey indoor parking, either an accessible elevator or an accessible ramp should be provided.	
14	 	Accessible parking spots should be provided in clear view of the facility near accessible entry.	
15		Individuals on wheelchairs or using braces and crutches are not compelled to wheel or walk behind parked cars while using the accessible spots.	
16		Direct access for pedestrians from the parking structure to the building or facility entrance should be accessible.	
Building Entrance			
17	  	At least one entrance of the building should be accessible to wheelchair users.	
18		Clear identification of accessible entrance using international symbol of accessibility.	

19		△	All steps on a flight of stairs shall have uniform riser heights and uniform tread depths. Riser heights shall be a minimum of 4 inches (100 mm) and a maximum of 7 inches (180 mm). Tread depths shall be at least 11 inches (280 mm).	
20		△	Open risers don't exist.	
21		△	Nosing shall extend 1 1/2 inches (38 mm) maximum over the tread below.	
22		△	Stair treads and landings subject to wet conditions shall be designed to prevent the accumulation of water.	
23		△	Top of gripping surfaces of handrails shall be 34 inches (865 mm) minimum and 38 inches (965 mm) maximum vertically above walking surfaces, stair nosing, and ramp surfaces.	
24	○		Use of contrast color for the entrance door as compared to the surrounding surface so that it is distinguishable by persons with visual impairments.	
25	○	△	A ramp is provided if there is level change at entrance more than 1/2".	
26	○		A ramp of 4 ft width is provided when there is a level difference at entrance.	
27	○		The gradient of the ramp is 1:6.	
28		△	The slope of the ramp is not steeper than 1:20.	
29	○		Railing is installed for the comfort of persons with disabilities.	
30	○		The distance between parallel handrails for the ramp does not exceed 72 inches.	
31		△	Handrails are provided on both sides of stairs.	
32		△	Handrails are provided on both sides of ramp.	
33		△	The width of the door is at least 32" for the wheelchair user.	
34		△	Openings more than 24 inches (610 mm) deep shall provide a clear opening of 36 inches (915 mm) minimum.	
35		△	Operable parts shall be operable with one hand and shall not require tight grasping, pinching, or twisting of the wrist.	
36	□		Automatic Entrance door is provided for building occupancy number of 300 or more.	
37	□	△	A passenger loading zone is provided at the accessible entrance	
Bathrooms/ Toilet				
38	○□	△	A toilet/stall for disabled persons is provided.	
39	○		Provision of daylight in every toilet, water closet, urinal stall, and bathroom through one or more openings in external walls.	
40		△	Width of accessible bathroom stall should be at least 60".	
41		△	The distance between floor and lower end of bathroom mirror is 40" maximum.	
42	□		Provision of grab bars in accessible bathroom stall.	
43		△	The side wall grab bar shall be at least 42 inches (1065 mm) long, located a maximum of 12 inches (305 mm) from the rear wall, and extending a minimum of 54 inches (1370 mm) from the rear wall.	
44	□		The side wall grab bar shall be at least 30 inches (1065 mm) long, located a maximum of 6 inches (305 mm) from the rear wall.	
45		△	Wheelchair accessible compartments shall be 60 inches (1525 mm) wide minimum measured perpendicular to the side wall, and 56 inches (1420 mm) deep minimum for wall-hung water closets and 59 inches (1500 mm) deep minimum for floor-mounted water closets measured perpendicular to the rear wall.	
46		△	if the approach is to the latch side of the compartment door, the clearance between the door side of the compartment and any obstruction shall be 42 inches (1065 mm) minimum. Doors shall	

			be located in the front partition or in the side wall or partition farthest from the water closet. The door shall be self-closing.	
	Wayfinding			
47	○		Directional and informational signs are available that provide direction to or information about functional spaces.	
48	○		Directional wayfinding is available in the parking.	
49	○□	△	Wayfinding and directional signage include tactile and braille lettering/signs.	
50		△	Signs have characters in contrast color to the background.	
51		△	Signs have non-glare finish.	
52	○	△	Clear identification of accessible entrance using the international symbol of accessibility.	
53	□	△	Parking spaces are identified by the international symbol of accessibility.	
54	□		Passenger loading zones are identified by the international symbol of accessibility.	
55	□		Bathrooms are identified by the international symbol of accessibility.	
56	□	△	Entrances are identified by the international symbol of accessibility.	
57	□		Directional signage indicating the route to the nearest accessible element is provided at inaccessible entrances and bathrooms.	
58		△	Parking space identification signs shall be 60 inches minimum above the finish floor or ground surface measured to the bottom of the sign.	
	Corridors			
59		△	The width of the corridor is a minimum of 36 inches for wheelchair users.	
60		△	For a two-way corridor, the width of the corridor is 60 inches.	
61		△	The pattern on the floor is not visually confusing, especially in the areas of level change.	
Notes: ○ Design specifications from LDA Building and Zoning Regulations-2019 □ 2021 Building Codes of Pakistan △ Americans with disability Act				

To assess accessibility across healthcare settings in Pakistan, both public, private, and PPP healthcare facilities were included in the study. An overview of the various types of healthcare facilities considered is presented in [Figure 1](#). A convenient sampling technique was employed to select the facilities, ensuring a practical and time-efficient approach to data collection. The healthcare facilities included in this study are shown in [Table 2](#).

Table 2. List of hospitals assessed using the accessibility assessment tool.

Public hospitals	No. of beds
Hospital 1	2399
Hospital 2	1500
Hospital 3	550
Hospital 4	500
Hospital 5	1196
Hospital 6	1686
Hospital 7	1030
Private hospitals	
Hospital 8	435
Hospital 9	250
Hospital 10	1250
Hospital 11	250
Public-private partnership hospitals	
Hospital 12	1500
Hospital 13	600

A standardized assessment protocol shown in Table 1 ensured consistency in capturing key measurements related to accessibility features. Each facility was evaluated using this protocol to determine its compliance with established accessibility standards, as outlined in the assessment tool. Design elements within each facility were categorized as either compliant, non-compliant, or not applicable based on their alignment with these standards. Some facilities have well-marked main entrances, which were used for code compliance, whereas some facilities are very spread out with different blocks. For these facilities, outpatient blocks and their main entrances were used to record compliance with the tool. The selected facilities were visited and assessed in June and July 2023 with the help of the accessibility assessment tool.

4. RESULTS

The percentage compliance of each hospital with the overall accessibility assessment tool was calculated. Table 3 shows the overall percentage compliance of each hospital with the accessibility assessment tool. The results indicated that Hospital 13, which is in the PPP category, had the highest compliance (45.28%) with the accessibility assessment tool, followed by Hospital 4 (40.68%), which is a public hospital. Hospital 1, also a public hospital, was the least compliant with the tool (22.41%), followed by Hospital 8, which is a private hospital (23.73%).

Table 3. Percentage compliance of each hospital with the accessibility assessment tool.

Hospitals	Yes	No	N/A	Percentage compliance (%)
Public hospitals				
Hospital 1	13	46	3	22.41
Hospital 2	17	43	2	28.81
Hospital 3	16	44	2	27.12
Hospital 4	24	36	2	40.68
Hospital 5	15	45	2	25.42
Hospital 6	19	41	2	32.2
Hospital 7	22	39	1	36.67
Private hospitals				
Hospital 8	14	46	2	23.73
Hospital 9	15	45	2	25.42
Hospital 10	22	38	2	37.29
Hospital 11	23	38	1	38.33
Public-private partnership hospitals				
Hospital 12	16	37	9	30.77
Hospital 13	24	30	8	45.28

Table 4. Code compliance percentage of different parts of the hospitals with the Accessibility Assessment Tool.

Hospitals	Parking	Building Entrance	Bathrooms	Wayfinding	Corridors
Public hospitals					
Hospital 1	0	42.11	0	16.67	100
Hospital 2	0	50	11.11	25	100
Hospital 3	0	45	11.11	25	100
Hospital 4	0	80	22.22	25	100
Hospital 5	0	45	0	25	100
Hospital 6	6.67	55	11.11	25	100
Hospital 7	0	60	0	58.33	100
Private hospitals					
Hospital 8	0	35	11.11	25	100
Hospital 9	0	50	0	17	100
Hospital 10	0	60	44.44	25	100
Hospital 11	6.25	50	55.56	33.33	100
Public private partnership hospitals					
Hospital 12	0	76.92	33.33	0	100
Hospital 13	18.75	66.67	55.56	41.67	100

In addition to overall compliance with the assessment tool, percentage compliance with the codes related to each part of the facility included in the study, i.e., closest parking of the healthcare facility, the route from parking to the entrance of the building, building entrance, wayfinding, and corridors, was also calculated and is shown in Table 4.

The results indicate that Hospital 13, which is in the PPP category, has the highest percentage compliance (18.75%) with codes related to parking, followed by Hospital 6 (6.67%) and Hospital 11 (6.25%). The rest of the hospitals did not follow any of the codes related to parking accessibility. Hospital 4, a public hospital, had the highest compliance (80%) with accessibility codes related to building entrances, followed by Hospital 12 (76.92%) and Hospital 13 (66.67%). Both Hospital 12 and Hospital 11 had the highest percentage compliance (55.56%) with accessibility codes related to bathrooms, followed by Hospital 10 (44.44%) and Hospital 12 (33.33%). For wayfinding, Hospital 7 had the highest percentage compliance (58.33%) with the codes related to wayfinding, followed by Hospital 13 (41.67%) and Hospital 11 (33.33%). The corridors of all hospitals complied with the accessibility codes related to corridor design.

The paper also examined the percentage compliance of each hospital with the accessibility codes from each of the three sources included in the study, i.e., Lahore Development Authority (LDA) Building and Zoning Regulations – 2019, Building codes of Pakistan (International Code Council, 2021), and ADA Standards for accessible design. The results are shared in Table 5.

Table 5. Percentage compliance of hospitals with the accessibility codes from each of the three sources.

Hospitals	2021 Buildings Codes of Pakistan	LDA building and Zoning regulations – 2019	ADA standards for accessible design
Public hospitals			
Hospital 1	13.33	10	36.11
Hospital 2	6.67	30	35.14
Hospital 3	6.67	25	35.14
Hospital 4	20	40	45.95
Hospital 5	13.33	15	37.84
Hospital 6	13.33	35	38.89
Hospital 7	26.67	38.1	43.24
Private hospitals			
Hospital 8	6.67	15	33.33
Hospital 9	6.67	15	29.73
Hospital 10	26.67	35	45.95
Hospital 11	33.33	33.33	45.95
Public private partnership hospitals			
Hospital 12	26.67	25	42.42
Hospital 13	26.67	55	50

5. DISCUSSION

This study focused on providing evidence-based evaluation of the physical accessibility of public, private, and public-private partnership hospitals in a large metropolitan city of Pakistan. To achieve this, an accessibility assessment tool was created using both local accessibility codes and accessibility codes from a developed country, i.e., Lahore Development Authority (LDA) Building and Zoning Regulations 2019, and Building Codes of Pakistan (International Code Council, 2021), ADA Standards for accessible design (U.S. Department of Justice, 2010).

The findings of the study provide valuable insights into the accessibility policies and codes that exist locally and internationally, and the extent to which these are followed in hospitals in Pakistan. The results highlight disparities in the compliance with accessibility codes and the provision of physical accessibility in different hospitals under various ownership types. None of the hospitals was even 50% compliant with the assessment tool used in this study. However, both public-private partnership (PPP) hospitals included in this study had more than 30%

compliance with the tool, suggesting that these hospitals might benefit from both the regulatory oversight typical of public institutions and the resource flexibility and innovation capacity often associated with private entities (Alumran, Almutawa, Alzain, Althumairi, & Khalid, 2021; Irfan & Ijaz, 2011). Followed by PPP hospitals, half of the public hospitals included in this study had more than 30% compliance with the assessment tool. This highlights the findings of previous studies that private hospitals provide better services and infrastructure because they aim to retain their customer (patient) satisfaction, which could lead to patients preferring these hospitals in the future as well (Gilbert, Lumpkin, & Dant, 1992).

This study focused on five parts of each hospital, which were assessed with the help of an accessibility assessment tool that focused on parking, main entrance, bathrooms, wayfinding, and corridors. The findings are shared in Table 4. Out of all five parts, the parking facility of ten out of thirteen hospitals had zero compliance with the accessibility codes in the tool. Some of the hospitals included in this study were very old, and with the continuously increasing demand for parking and lack of ample space to accommodate this increasing demand, these hospitals were suffering from accessibility issues in parking (Aziz, 2014). However, with newer and private or PPP hospitals, the lack of accessible parking shows that accessibility in parking is not considered important enough. Regardless of codes and policies to ensure accessible parking, the hospital management decided not to follow those accessibility codes.

After parking, the majority of hospitals showed very little compliance with accessibility codes related to bathrooms, followed by very little compliance with wayfinding. Similar results were found in other studies conducted in different cities of Pakistan. Rehman, Ullah, Gul, Shaikh, and Iqbal (2022) highlighted parking issues, lack of proper wayfinding, and inaccessible toilets in government hospitals in Peshawar. Mumtaz et al. (2023) assessed three tertiary care hospitals in three major cities of Pakistan, i.e., Lahore, Islamabad, and Rawalpindi, and found a lack of proper signages and issues with accessibility of entrances in most of these hospitals. The findings show that a lack of appropriate wayfinding and toilets are highlighted as major concerns not just in Lahore but in many other cities of Pakistan. Lack of accessibility in these different areas of the hospitals not only impacts the hospital visit experience of people with disabilities but also discourages them from visiting hospitals in the future to receive proper healthcare (Ahmad, 2013).

The study also conducted percentage compliance of each hospital with codes from each of the three sources, i.e., Lahore Development Authority (LDA) Building and Zoning Regulations 2019, Building Codes of Pakistan (International Code Council, 2021). ADA Standards for accessible design, as shown in Table 5. The results indicate that each of the hospitals had the highest compliance with the accessibility codes from the ADA. This could be because ADA is the most detailed of all three sources included in the study and contains the maximum codes in the accessibility assessment tool created for this study (Table 1). Hospitals showed very little compliance with LDA and Building Codes of Pakistan, indicating a lack of management to ensure that public facilities adhere to local accessibility codes.

6. CONCLUSION AND FUTURE IMPLICATIONS

Accessibility to public facilities is a basic human right of every citizen, and it is the duty of the state to ensure this access on an equal basis (United Nations, 2006). In addition to Pakistan ratifying the United Nations Convention on the Rights of Persons with Disabilities (CRPD), the Supreme Court of Pakistan passed a landmark ruling in 2020, requiring federal and provincial governments to ensure accessibility for people with disabilities. This study aimed to examine the existing accessibility conditions of different types of hospitals in the second-largest metropolitan city of Pakistan, Lahore. Thirteen hospitals were visited using an accessibility tool as shown in Table 1. to check the compliance of different parts of these hospitals with both local and international accessibility codes. The findings of the study indicate below-average compliance of each of the hospitals with the accessibility assessment tool. These results indicate that, regardless of the presence of accessibility laws and codes, hospitals lack

proper accessibility arrangements for people with disabilities. The study highlights the need to not only establish accessibility codes but also develop rules and laws to ensure that these codes are properly followed by public facilities. While the study focused on thirteen hospitals, the consistency of the results suggests that the lack of accessibility is a significant issue that might also exist in other hospitals not included in the study.

The study had its limitations. It focused only on the hospitals in the city of Lahore. Therefore, the results cannot be generalized to other areas. Also, the study only focused on the accessibility of public areas of hospitals, i.e., parking, building entrance, toilets, wayfinding, and corridors. Future studies can investigate the accessibility of patient rooms, physicians' rooms, examination rooms, waiting areas, etc. In addition to physical accessibility, perceived accessibility of hospitals by people with disabilities is also important to improve accessibility conditions for those who experience these barriers.

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Competing Interests: The authors declare that they have no competing interests.

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