

DISABLING JOURNEYS

**The social relations of tourism for
people with impairments in Australia -
an analysis of government tourism
authorities and accommodation sector
practice and discourses**

SIMON ANDREW DARCY

BA, MEnvPl

**Being a thesis submitted to the University of Technology, Sydney in fulfillment of
requirements for the Doctor of Philosophy by Thesis**

December, 2003

TABLE OF CONTENTS

ABBREVIATIONS	I
CERTIFICATION	II
SYNOPSIS	III
ACKNOWLEDGEMENTS	VI
PREFACE	VII
1 INTRODUCTION	1
1.1 JUSTIFICATION FOR THE RESEARCH	1
1.2 SITUATING THE RESEARCH QUESTION	4
1.3 UNDERSTANDING THE LANGUAGE OF DISABILITY USED IN THE THESIS	5
1.4 DEFINING TOURISM.....	7
1.5 TERMINOLOGY	8
1.6 SCOPE OF THE THESIS AND LIMITATIONS	12
1.7 CONTRIBUTION TO THE BODY OF KNOWLEDGE.....	14
1.8 OUTLINE OF THE THESIS.....	15
2 HUMAN RIGHTS, DISABILITY AND STATISTICS IN AUSTRALIA	19
2.1 INTRODUCTION	19
2.2 THE INTERNATIONAL HUMAN RIGHTS CONTEXT	19
2.3 AUSTRALIAN DISABILITY LEGISLATION AND POLICY	22
2.4 DISABILITY STATISTICS COLLECTION IN AUSTRALIA.....	34
2.5 ENDING	40
3 DISABILITY MODELS AND DISCOURSES.....	43
3.1 INTRODUCTION	43
3.2 AN INTRODUCTION TO DISABILITY STUDIES	43
3.3 MEDICAL MODEL OF DISABILITY	45
3.4 INDIVIDUAL IDEALISM	48
3.5 SOCIAL MODEL	51
3.6 SOCIO-SPATIAL ORGANISATION	58
3.7 CRITIQUES OF SOCIAL APPROACHES	60
3.8 ENDING	64

4	DISABILITY AND THE TOURISM LITERATURE.....	66
4.1	INTRODUCTION	66
4.2	TOURISM THEORY.....	66
4.3	CONSTRAINTS THEORY	77
4.4	DISABILITY AND TOURISM RESEARCH – DEMAND	84
4.5	DISABILITY AND TOURISM RESEARCH – SUPPLY	97
4.6	DISABILITY AND TOURISM RESEARCH - COORDINATION AND REGULATION	105
4.7	ENDING	113
5	THEORETICAL FRAMEWORK AND RESEARCH QUESTIONS	116
5.1	INTRODUCTION	116
5.2	THEORY AND DISCOURSES	116
5.3	THEORETICAL FRAMEWORK	122
5.4	THE RESEARCH QUESTIONS	125
5.5	ENDING	128
6	RESEARCH DESIGN AND METHODOLOGY.....	129
6.1	INTRODUCTION	129
6.2	APPROACH TO THE RESEARCH PROCESS	129
6.3	ADDRESSING THE RESEARCH QUESTIONS	131
6.4	DATA SOURCES AND METHODS	135
6.5	DATA ANALYSIS AND PRESENTATION OF OUTCOMES	145
6.6	ROLE OF THE RESEARCHER	149
6.7	RESEARCH LIMITATIONS	150
6.8	VALIDITY AND RELIABILITY	151
6.9	ETHICAL CONSIDERATIONS.....	153
6.10	ENDING	153
7	FINDINGS I: TOURISM PATTERNS OF PEOPLE WITH IMPAIRMENTS.....	154
7.1	INTRODUCTION	154
7.2	LEVEL OF TOURISM PARTICIPATION BY PEOPLE WITH IMPAIRMENTS	154
7.3	COMPARISON OF TOURISM PARTICIPATION BETWEEN PEOPLE WITH IMPAIRMENTS AND THE NON-DISABLED	157
7.4	PEOPLE WITH IMPAIRMENTS AS A PROPORTION OF THE TRAVELLING PUBLIC.....	159
7.5	TYPE OF IMPAIRMENT AND TOURISM PARTICIPATION.....	159
7.6	NEEDS OF TRAVELLERS AND NON-TRAVELLERS WITH DISABILITIES	161
7.7	CONSTRAINTS TO TOURISM.....	162
7.8	THE INFLUENCE OF IMPAIRMENT AND OTHER SOCIO-DEMOGRAPHIC VARIABLES ON TOURISM PARTICIPATION	163
7.9	ENDING	169

8	FINDINGS II: TOURISM EXPERIENCES OF PEOPLE WITH IMPAIRMENTS.....	171
8.1	INTRODUCTION	171
8.2	CONSTRAINTS ENCOUNTERED BY THOSE WHO DO NOT TRAVEL	173
8.3	TRAVEL PLANNING AND INFORMATION CONSTRAINTS	175
8.4	TRANSPORT CONSTRAINTS TO, AT AND FROM DESTINATIONS.....	184
8.5	ACCOMMODATION CONSTRAINTS	201
8.6	CONSTRAINTS AT THE DESTINATION.....	213
8.7	OTHER CONSTRAINTS	225
8.8	ENDING	232
9	FINDINGS III: TOURISM AUTHORITIES AND ACCOMMODATION SECTOR PRACTICE	241
9.1	INTRODUCTION	241
9.2	TOURISM AUTHORITIES (TA) DISABILITY TOURISM INITIATIVES	242
9.3	THE ACCOMMODATION SECTOR	257
9.4	REGULATORY PROCESSES AND INDUSTRY RESPONSES	266
9.5	ENDING	285
10	DEVELOPING AN EXPLANATION FOR INDUSTRY PRACTICES	294
10.1	INTRODUCTION	294
10.2	DISCOURSES OF ACCESS.....	295
10.3	ORGANISATIONAL APPROACHES TO TOURISM AND DISABILITY	299
10.4	ENDING	315
11	CONCLUSIONS.....	319
11.1	INTRODUCTION	319
11.2	CONCLUSIONS ABOUT THE DETAILED RESEARCH QUESTIONS.....	319
11.3	THE CENTRAL RESEARCH QUESTION	329
11.4	COMPREHENSIVE TOURISM ACCESS MODEL (CoTAM).....	330
11.5	CONTRIBUTION TO THE BODY OF KNOWLEDGE.....	343
11.6	DIRECTIONS FOR FUTURE POLICY AND PRACTICE	344
11.7	REFLECTIONS ON THE RESEARCH PROCESS AND FURTHER RESEARCH	346
11.8	FINAL THOUGHTS.....	348
	REFERENCES.....	349
	LEGISLATION.....	349
	CASE LAW.....	349
	BOOKS, JOURNALS & OTHER SOURCES	349

APPENDICES

APPENDIX 1: CHAPTER 7 STATISTICAL TABLES	369
APPENDIX 2: ANXIETY TO ACCESS METHODOLOGY	379
APPENDIX 3: NATIONAL VISITOR SURVEY.....	382
APPENDIX 4: PEOPLE WITH DISABILITIES UNSCHEDULED INTERVIEW CHECKLIST	385
APPENDIX 5: ACCOMMODATION SECTOR INTERVIEW AND FOCUS GROUP CHECKLIST	387
APPENDIX 6: TOURISM AUTHORITY CHECKLIST	388
APPENDIX 7: ACCESS STANDARD’S STAKEHOLDERS AND ISSUES UNDER CONSIDERATION.....	389
APPENDIX 8: COMPARATIVE DISABILITY RATES	390
APPENDIX 9: THE FOUNDATIONS OF THE BUILT ENVIRONMENT	391
CONTINUOUS ACCESSIBLE PATH OF TRAVEL.....	391
PARKING	392
TOILETS.....	392
APPENDIX 10: DIAGRAMATIC REPRESENTATION OF AS1428.1 FOR ACCOMMODATION ACCESS	394
APPENDIX 11: AAA CHECKLIST FOR WHEELCHAIR ACCESSIBILITY IN HOTELS/MOTELS	396
APPENDIX 12: MILES & HUBERMAN (1994) TACTICS FOR VALIDITY & RELIABILITY OF QUALITATIVE DATA	397

LIST OF TABLES

TABLE 1: KEY EVENTS IN COMMONWEALTH DISABILITY LEGISLATION AND POLICY IN AUSTRALIA.....	23
TABLE 2: DISABILITY DISCRIMINATION ACT - OUTCOMES OF FINALISED COMPLAINTS.....	31
TABLE 3: ABS DEFINITION OF DISABILITY	35
TABLE 4: NUMBERS OF PEOPLE WITH DISABILITIES IN AUSTRALIA, 1981-1998.....	38
TABLE 5: DISABILITY BY MAIN CONDITION, AUSTRALIA, 1998	39
TABLE 6: DISABILITY BY DEGREE AND TYPE OF CORE RESTRICTION, AUSTRALIA 1998	40
TABLE 7: REVIEWS OF MODELS OF DISABILITY	44
TABLE 8: SECTORS OF THE TRAVEL AND TOURISM INDUSTRY	70
TABLE 9: DEFINING THE TOURISM INDUSTRY (TI) AND TOURISM AUTHORITIES (TA)	72
TABLE 10: LEISURE-TRAVEL BARRIERS OF DISABLED TOURISTS	83
TABLE 11: DEMAND RESEARCH SUMMARY TO 2001.....	85
TABLE 12: SUPPLY RESEARCH SUMMARY TO 2001	99
TABLE 13: SUMMARY OF COMMONWEALTH AND STATE GOVERNMENT INITIATIVES.....	106
TABLE 14: 1992 NATIONAL TOURISM STRATEGY DISABILITY ISSUES	108
TABLE 15: COMMONWEALTH MARKET SEGMENT PUBLICATIONS	109
TABLE 16: OVERVIEW OF THE RESEARCH QUESTIONS, DATA SOURCES AND METHODOLOGIES.....	134
TABLE 17: SAMPLE FRAMES, SAMPLES AND SAMPLE SIZES.....	135
TABLE 18: BLRA SUMMARY – DOMESTIC TOURISM IN LAST 12 MONTHS	164
TABLE 19: PLUM – SUMMARY – NO. DOMESTIC TRIPS IN LAST 12 MONTHS	165
TABLE 20: ACCOMMODATION ACCESS NEEDS – GENERAL, ROOM-SPECIFIC & BATHROOM-SPECIFIC.....	207
TABLE 21: EXTRA COSTS OF TRAVELLING AS A PERSON WITH AN IMPAIRMENT.....	232
TABLE 22: SUMMARY OF TOURISM CONSTRAINTS FROM CHAPTER 8.....	234
TABLE 23: COMMONWEALTH AND STATE GOVERNMENT INITIATIVE COMPARISON, 1990-2001	243
TABLE 24: GOLD MEDAL DISABILITY ACCESS STRATEGY FUNDING ALLOCATION.....	247
TABLE 25: ACCESSIBILITY OF NSW TOURISM PRODUCT, 2000	251
TABLE 26: ACCESSIBLE AMENITIES LEGEND – TOURISM QUEENSLAND	253
TABLE 27: HREOC, FEDERAL COURT, OTHER COURT AND COMPLAINT CASES	269
TABLE 28: HOTELS/MOTELS – ACCESSIBLE ROOM REQUIREMENTS, 1981-1996.....	278
TABLE 29: SUMMARY OF CONSTRAINTS IN RELATION TO TA AND TI PRACTICES	288
TABLE 30: RELATIVE POSITION OF TA AND TI (ACCOMMODATION) RE. POLICY APPROACHES.....	300
TABLE 31: POLICY APPROACHES TO DISABILITY TOURISM	301
TABLE 32: ACCESS STAKEHOLDERS	316
TABLE 33: SUMMARY OF TOURISM CONSTRAINTS	334
TABLE A1: RESPONDENT/SOMEONE ELSE IN HOUSEHOLD HAS DISABILITY BY TRAVELLERS/NON TRAVELLERS.....	369
TABLE A2: TRAVEL AFFECTED BY RESPONDENT DISABILITY OR LONG-TERM HEALTH CONDITION BY TRAVELLERS/NON TRAVELLERS	369
TABLE A3: NEEDS ASSISTANCE WHEN TRAVELLING BY TRAVELLERS/NON TRAVELLERS.....	369
TABLE A4: IMPAIRMENT CONDITIONS BY TRAVELLER/NON-TRAVELLER.....	369

TABLE A5A: BINARY LOGISTIC REGRESSION ANALYSIS – DOMESTIC TRAVEL (LAST 12 MONTHS)	370
TABLE A5B: PLUM – ORDINAL REGRESSION ANALYSIS – NO. DOMESTIC TRIPS (LAST 12 MONTHS)	371
TABLE A6: IMPAIRMENT TYPE * DOMESTIC TRAVEL IN THE LAST YEAR CROSSTAB & CHI-SQUARE	372
TABLE A7: DOMESTIC TRAVEL IN THE LAST YEAR BY GENDER (CHI-SQUARE TESTS)	373
TABLE A8: GENDER BY NO. DOMESTIC TRIPS INDEPENDENT SAMPLES T-TEST.....	373
TABLE A9: NO. DOMESTIC TRIPS AND AGE - ANOVA	374
TABLE A10: MULTIPLE COMPARISONS - DEPENDENT VARIABLE: NUMBER OF DOMESTIC TRIPS IN THE LAST YEAR - TAMHANE POST-HOC.....	374
TABLE A11: MAIN MOBILITY AID BY TRAVEL DEPENDENCE	374
TABLE A12: ACCOMMODATION (MAIN DEST) BY TRAVEL AFFECTED BY DISABILITY/HEALTH CONDITION (CHI-SQUARE).....	375
TABLE A13: ACCOMMODATION CHOICE BY MOBILITY AID (CHI-SQUARE)	376
TABLE A14: TRANSPORT USED TO ARRIVE AT MAIN DESTINATION - DERIVED * TRAVEL AFFECTED BY DISABILITY CROSSTABULATION.....	377
TABLE A15: TRANSPORT RECODED * MOBILITY IMPAIRMENTS CROSSTABULATION.....	378
TABLE A16: SAMPLING FRAME.....	379
TABLE A17: KEY DATA ITEMS FOR <i>ANXIETY TO ACCESS</i>	381
TABLE A18: G2 MODIFIED ABS DISABILITY MODULE	382
TABLE A19: KEY DATA ITEMS FOR <i>NATIONAL VISITOR SURVEY</i>	384
TABLE A20: STANDARDS AUSTRALIA AS1428.1 AND AS1428.2 REQUIREMENTS	392

LIST OF FIGURES

FIGURE 1: OVERVIEW OF THESIS STRUCTURE.....	17
FIGURE 2: THE TOURISM SYSTEM	70
FIGURE 3: A HIERARCHICAL MODEL OF LEISURE CONSTRAINTS	79
FIGURE 4: BARRIERS TO LEISURE PARTICIPATION FOR PEOPLE WITH DISABILITIES.....	80
FIGURE 5: CURRENT SITUATION OF DISABILITY TOURISM IN AUSTRALIA	114
FIGURE 6: THEORETICAL FRAMEWORK	122
FIGURE 7: HOLIDAY PARTICIPATION IN LAST 12 MONTHS BY DEGREE OF DISABILITY	156
FIGURE 8: COMPARATIVE TOURISM PARTICIPATION BETWEEN NON-DISABLED, PEOPLE WITH DISABILITIES, TRAVEL AFFECTED & THOSE WHO NEED ASSISTANCE IN THE LAST MONTH.....	157
FIGURE 9: TOURISM PARTICIPATION RATES FOR TRAVEL AFFECTED BY DISABILITY AND THE NON- DISABLED IN THE LAST MONTH.....	158
FIGURE 10: PROPORTION OF TRAVELLING PUBLIC BY LEVEL OF DISABILITY	159
FIGURE 11: TOURISM PARTICIPATION BY IMPAIRMENT IN THE LAST MONTH	160
FIGURE 12: DISABILITY NEEDS BY TRAVELLERS AND NON-TRAVELLER	161
FIGURE 13: TOURISM CONSTRAINTS OF PEOPLE WITH DISABILITIES	163
FIGURE 14: TOURISM ACCESS INFORMATION CHAIN – CONSUMER, INTERMEDIARIES AND SUPPLIERS	256
FIGURE 15: WHEELCHAIR ACCESS SYMBOLS.....	297
FIGURE 16: THE COMPREHENSIVE TOURISM ACCESS MODEL (CoTAM).....	331
FIGURE A1: BINARY LOGISTIC REGRESSION MODEL	369

ABBREVIATIONS

Abbreviation	Full Description
AAA	Australian Automobile Association
ABS	Australian Bureau of Statistics
ABCB	Australian Building Codes Board
ACROD	Australian Council for Rehabilitation of the Disabled
ADA	<i>Americans with Disabilities Act, 1990</i> (United States of America)
AHA	Australian Hotels Association
AQA	Australian Quadriplegic Association
AS1428	Australian Standards for Access and Mobility
ATC	Australian Tourist Commission
BLRA	Binary logistic regression analysis
BAPC	Built Access Policy Committee
BCA	Building Code of Australia
BTR	Bureau of Tourism Research
CAGD	Commonwealth Attorney General's Department
CDOT	Commonwealth Department of Tourism
CoTAM	Comprehensive Tourism Access Model
CTEC	Canberra Tourism and Events Corporation
DAP	Disability Action Plans
DDA	<i>Disability Discrimination Act, 1992</i> (Commonwealth)
CDFACS	Commonwealth Dept. of Family and Community Services
DTM	Domestic Tourism Monitor
DSA	<i>Disability Services Act, 1993</i> (NSW)
EPAA	<i>Environmental Planning and Assessment Act, 1979</i> (NSW)
HACC	Home and Community Care
HREOC	Human Rights and Equal Opportunity Commission
ICIDH	International Classification of Impairments, Disabilities and Handicaps
ICIDH-2	International Classification of Functioning, Disability and Health (sic)
IYDP	United Nations 1981 International Year of Disabled Persons
NAWG	National Access Working Group
NICAN	National Information Communication Awareness Network
NRMA	National Roads and Motorist's Association
NVS	National Visitor Survey
NTTC	Northern Territory Tourist Commission
ONT	Office of National Tourism
QTTC	Queensland Tourist and Travel Corporation
RIS	Regulatory Impact Statement
SATC	South Australian Tourism Commission
SOCOG	Sydney Olympic Games Organising Committee
SRDRN	Social Relations of Disability Research Network
TA	Tourism authorities
TAFE	Technical and Further Education
TDR	Tourism Destination Region
TGR	Tourism Generating Region
TI	Tourism Industry
TNSW	Tourism NSW
TQ	Tourism Queensland
TV	Tourism Victoria
TT	Tourism Tasmania
TTY	Tele-typewriter
WATC	Western Australian Tourism Commission
WADSC	Western Australian Disability Services Commission

CERTIFICATION

I, Simon Darcy, certify that the work contained in this Thesis has not been submitted for a degree at any other institution and that the work is the original work of the candidate except where sources are acknowledged.

Production Note:
Signature removed prior to publication.

Date: 15 December 2003

SYNOPSIS

Introduction

This thesis explores the citizenship rights of people with disabilities and their experience in relation to one activity and industry - tourism. It is proposed that people with disabilities living in Australia have been excluded, oppressed and disadvantaged by government, tourism authorities (TA) and tourism industry (TI), practice and discourses. This exclusion, oppression and disadvantage has been perpetrated by the government, tourism authorities and tourism industry, whose practices and discourses do not provide an equality of service provision for the group. From this position the central question addressed is:

To what extent are the tourism patterns and experiences of people with impairments in Australia unduly constrained by tourism authorities and tourism industry practice and discourse?

In taking direction from the social model of disability (Oliver 1990), the proposition deliberately uses the word impairments rather than disabilities as both a definitional and conceptual approach to the research. This is because the question tests whether the social relations produce the constraints that people with impairments face in negotiating tourism experiences and, hence, create disabling journeys. In other words, the disabling social relations transform the impaired person to the person with a disability in the tourism context. *Unduly* means that people with disabilities were not provided with an equality of service provision in comparison to the non-disabled.

Background and literature

The literature firstly provides a background on terminology used, human rights frameworks of Australian disability legislation and policy, and reviews disability statistics collection in Australia. This is followed by an outline of the major models and discourses for conceptualising disability, before the three main models are critically reviewed to provide an understanding of the major approaches to disability. These are the medical, social idealist and social models.

The disability and tourism literature documents a sporadic, ad-hoc and slow development of the field over the last 20 years. Empirically, the review reveals that large areas of disability tourism lack a substantial research base. While demand and supply have had some significant investigations, the role of government in the regulation and coordination of tourism has not been addressed. The geographic tourism systems should encompass all market segments but the subsequent review of research indicates that it has only begun to do so for people with disabilities. In many ways, the current treatment of disability in the tourism literature has been counter-productive. The research provides some understanding that the levels of tourism of people with disabilities are lower than those of the non-disabled, and the tourism constraints and needs of the group. Yet, there has been no subsequent explanation of why this group has the experiences that it has.

Method

The research design and methodology involves inductive inquiry utilising both quantitative and qualitative methodologies. This includes a multiple methodological approach involving secondary data analysis of major national and regional surveys, content/discourse analysis, in-depth interviews and a focus group. The secondary data sources involved the *Disability, Ageing and Carers Survey* (ABS 1993; 1998 n=42,000),

National Visitors Survey (BTR 1998 n=78,000) and *Anxiety to Access* (Tourism NSW 1998 n=2647). A content analysis is undertaken of the HREOC (2002) complaint cases, public hearings, public inquiries, disability action plans and disability Standards projects relevant to tourism. A content analysis is also undertaken of tourism authorities' disability tourism initiatives from 1990-2000. In depth interviews are undertaken with three separate populations that include people with disabilities (n=15), accommodation managers (n=10) and responsible officers from tourism authorities (n=3). A focus group of accommodation managers (n=23) is also undertaken. The data are analysed and interpreted using binary logistic regression, ordinal logistic regression, phenomenology, grounded theory and discourse analysis.

Findings

Patterns

In Australia, people with impairments travel at significantly lower rates than the non-disabled. Subsequently, they constitute proportionally less of the travelling public than their proportion of the Australian population. People with impairments do not perceive their impairment as the reason for their non-participation in tourism but attribute non-participation, or reduced participation, to a series of structural constraints encountered. The tourism requirements of the group are dependent on their impairment, with the most marginalised travellers being those with mental health, vision, speech, mobility and hearing impairments. Impairment related considerations (type, level of independence and mobility aid) together with socio-demographic considerations of age, lifestyle situation, income, and geographic region are all statistically significant influences on the likelihood of an individual having a tourism experience. However, the number of trips taken each year is influenced purely by socio-demographic rather than impairment related considerations.

Experiences

The next chapter documents the lived tourism experiences of people with disabilities and the outcome of these experiences on the individuals. The chapter is deliberately in-depth to let the voices of people with disabilities be heard. People with disabilities reflect on their tourism experiences through the stages of travel including planning, transport, accommodation, destination experience and other considerations. From these reflections, it becomes evident that a series of substantial tourism constraints unduly affected their opportunities, patterns and experiences. However, contrary to Smith's (1987) conceptualisation of barriers to leisure travel, this research finds that many of the constraints thought to be intrapersonal or interpersonal are largely structural. Further, the interrelationship of structural constraints creates a socio-spatial tourism segregation of people with disabilities.

Explanation

The social relations of tourism for people with disabilities are explained through two interrelated areas. The first seeks to explain why people with disabilities have the tourism experiences documented in the thesis. This is found to be a product of the discourses of access and accessibility. People with disabilities have a highly individualised understanding of access that share a common set of experiences. However, their discourse of access varies substantially different to that of the TA and TI. The TA and TI understanding of access is non-existent or overly simplified and does not provide the level or detail of information for people with disabilities to make informed decisions about accessibility. The simplified understanding of access is a combination of the development of the environmental planning process and the process of assessing accessibility. These are

compounded by the TA and TI having little understanding of their responsibilities under the DDA. The implementation of the citizenship rights of people with disabilities through the DDA further compounds the discourses of access because of the individualised and confidential complaints cases. The research reveals that a discourse of inaccessibility exists that is multi-faceted and inextricably bound with social and economic power of TA, TI, design, planning, construction and operations sectors, that, together with government regulators, shape the tourism environment.

The second seeks to understand why TA and TI behave the way they do towards people with disabilities. Four approaches emerge to the treatment of disability by TA and the accommodation sector. These are: do nothing; be seen to be doing something; react to legislative requirements; and identify as a market segment. What becomes apparent is that most of TA and TI do not have disability on the tourism agenda. Organisations omit, undertake token initiatives or set a low priority for disability. This is attributable to a series of preconceptions about people with disabilities that constitute a medical model worldview that results in ableist practices. This discourse is underpinned by a market ideology founded on yield that values market segments for their perceived profitability to the nation or corporation. This leads to managers of the TA and TI making decisions that deliberately exclude people with disabilities from an equality of service provision. Reinforcing this ideology is the lack of recognition of the human rights discourse of the Disability Discrimination Act, 1992 that has had little to no impact on TA and TI. In effect, there is a clash of values between the desire held by people with disabilities for citizenship (human rights and social model) and an ableist, market driven discourse of the TA and TI.

Comprehensive Tourism Access Model (CoTAM)

CoTAM is presented as a model of disability tourism experiences. The model consists of four interrelated components. These components are:

- A. People with disabilities and their tourism experiences (demand);
- B. Tourism industry (supply) and tourism authorities (coordination) practice;
- C. Government human rights framework of the DDA (regulation);
- D. An explanation for the experiences of people with disabilities through the discourses (market ideology; ableism; and power) and the social relations of access (discourses of access; development of the environmental planning process; and implementation of disability citizenship rights).

CoTAM is framed within the geographic tourism system (TGR ⇌ TRANSIT ⇌ TDR). CoTAM offers an opportunity to include social model and constraint theory within tourism system development. The model is inclusive of all stakeholder positions of demand, supply and coordination/regulation.

Conclusion

The central argument to emerge from this thesis is that disability is a social relationship – or rather a complex set of social relationships – between people with disabilities, and the organisations that control and administer the institutional and social environments in which they live. Tourism represents an important arena for social and cultural participation. Given the commitment by governments to ‘reduce disability’ it is thus critical to consider whether the relationships in the area of tourism are disabling or enabling. The thesis shows that the practices and discourses of tourism authorities and the tourism industry unduly constrain the tourism opportunities and experiences of people with impairments in Australia and create disabling journeys.

ACKNOWLEDGEMENTS

I am grateful to many people whose support made this thesis possible. In particular, I wish to thank the following:

- Foremost I would like to thank all those people with disabilities who contributed their time and experiences to the thesis for without their involvement this research would not be possible. I was overwhelmed by their generosity and their enthusiasm for travel. Secondly, I thank all those from government agencies and the tourism industry who contributed to this research directly and indirectly. In particular, those officers and managers of the tourism authorities and the accommodation sector who were willing to speak with me and provide an insight into the reasons for their organisation's behaviour towards people with disabilities.
- My supervisor Professor Tony Veal and co-supervisor Associate Professor Helen Meekosha (UNSW), for their guidance, support and professional mentoring. A Ph.D. cannot be undertaken without the sustained dedication of supervisors with an interest and expertise in the candidate's topic. Finding a supervisor is difficult but I was exceptionally lucky to find two supervisors whose interests and expertise complemented each other in a topic area that is interdisciplinary. I am deeply indebted to them for encouraging, enlightening and invigorating me over the long process that the Ph.D encompassed. I am particularly indebted to Tony for his interdisciplinary vision, theoretical rigour and his superb editorial eye.
- Dr David Pfeiffer, Resident Scholar at the Center on Disability Studies at the University of Hawaii at Manoa, for his encouragement to pursue the area of study, his invitation to present internationally and his engaging discussions. Sadly, David passed away in December 2003.
- The small band of scholars and practitioners who believe in the right of people with disabilities to enjoy tourism in every sense - Bruce Cameron, Dr. Pheroza Daruwalla, Jeff Heath and Dr. Beth Stark Foggin, to whom I am particularly indebted for their support, good humour and for fighting the good fight.
- The Social Relations of Disability Research Network for the critical space to inquire, present, question and nurture researchers with disabilities. To the core group members, Helen, Leanne, Lynne, Anne, Andrew, Karen, Judy and Mike, I wish to express my gratitude for your support and critical inquiry. I'd also like to acknowledge all those people who presented, attended and added to the diversity of the seminars, intellectually and socially.
- Dr Peter Petrocz, School of Mathematics UTS, for his direction and cheer with Chapter 7.
- Lawrence Franklin from Tourism NSW for having the insight to support the original study of the tourism patterns and experiences of people with disabilities. This support was continued by Jane Anderson with the development of the Disability Action Plan and implementation of disability awareness training.
- The Ageing and Disability Department of NSW for the provision of a research grant in 1999/2000 to investigate the supply side perceptions of providing goods and services for people with disabilities.
- The UTS Accelerated Doctoral Completion Leave Program of which I was a beneficiary. It provided a semester's teaching release that allowed a consolidated time to write up the research in Autumn Semester 2002.
- My colleagues in the School of Leisure, Sport and Tourism UTS, and in particular Tracy, Paul, Jennie, Stephen and Ravi, for their collegiality and cappuccino-related sustenance.
- To the examiners whose insightful thoughts have provided ideas for future publications.
- My family Karma, Tex and Monique who have been there supporting my academic endeavours throughout my life. Little Samuel J Darcy-Massey for reminding me that a Ph.D. is a Ph.D. and that there are many more important things like spending time with your nephew and learning the joys of Shrek, Bob the Builder, Spiderman & Nemo!
- Lastly, my wife Fiona for living through the Ph.D. melodrama with me, giving unconditional tender loving care when needed, and listening to my many rambling diatribes on the latest theoretical issue I was grappling with.

PREFACE

My interest in the problem derived from a chance involvement in research on the *Disabled People's International World Assembly* held in Sydney in December 1994 (Darcy 1995). Over 1000 delegates attended the World Assembly, approximately half of whom had disabilities. I thought that the World Assembly would be an opportunity to assess the delegates' experience of tourism in Australia and their perceptions of Sydney as an accessible city. This interest was both professional and personal. To an academic working in the area of environmental planning and public policy for leisure and tourism, the World Assembly delegates provided an outsider perspective on Australian responses to people with disabilities and the accessibility of Sydney as a destination. My interest was also as a person with a disability for whom the World Assembly was a turning point. It was my first experience of being part of the disability community in Sydney and was an event that stimulated my interest in advocacy, research and the politics of disability issues.

After the World Assembly had finished and I had completed gathering the questionnaire-based data, the preliminary results prompted a range of other questions. The major of these was 'what is known about the tourism experiences of people with disabilities?' Upon consulting the literature in Australia and overseas the answer emerged as a stark - 'not much'. This, in itself, was an insight into the status of disability and tourism as a focus of academic study and industry practice. From this position, I embarked on research into the tourism patterns and experiences of people with disabilities supported by Tourism NSW (Darcy 1998). In the time since this research began a lot more is known about tourism and people with disabilities. However, two recent incidents in the *Sydney Morning Herald* (MacLennan 2003) and the Commonwealth Government *Hansard* (Hansard 2003) highlighted that the struggle of people with disabilities for an equality of tourism service provision continues.

Production Note:

Signature removed prior to publication.

December 2003

1 INTRODUCTION

The twentieth century has been characterised by campaigns for equal rights and social justice by a number of groups including women, ethnic minorities, indigenous peoples, and gays and lesbians (Tiddy 2001a). Disabled activists have been portrayed as constituting the ‘last civil rights movement’. The rights of people with disabilities were not specifically mentioned in the United Nations (1948) *Universal Declaration of Human Rights* and did not receive formal international recognition until the United Nations (1975) *Declaration on the Rights of Disabled Persons*. The United Nations (1976) declared 1981 as the *International Year of Disabled Persons* (IYDP). The disability movement internationally faced a major challenge in the decade leading to and during 1981 (Meekosha and Jakubowicz 1999). It is now 27 years since the declaration and 22 years since the IYDP. In 1993, the UN General Assembly passed a resolution, *The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* (United Nations 1993), which adopted a social approach to disability, calling upon governments to provide for the equalisation of opportunities for people with disabilities in all aspects of their lives. The resolution identified recreation and tourism as target areas.

The first disability-specific human rights legislation in Australia was the Commonwealth *Disability Discrimination Act, 1992* (DDA). This Act complemented general State-based anti-discrimination legislation introduced during the 1970s. However, as other groups have found, formal declarations and domestic legislation do not guarantee social justice or equality. Rather, this requires political will, enforcement, education and changes in social and cultural attitudes and behaviour. This is not a simple task or a straightforward process, and is not fully recognised or understood by many of the organisations which are, or should be, involved and affected. Therefore, this thesis seeks to explore this process in relation to people with disabilities and their experience in relation to one activity and industry - tourism.

1.1 Justification for the Research

Disability and tourism is a significant problem from the point of view of the *demand* side (people with disabilities) and the *supply* side (industry) of the question, and in relation to the role of the *coordinating* and *regulating* sector (government). There are five underlying reasons why this is a significant problem.

First, as regards *demand*: significant numbers of Australians have a disability. The Australian Bureau of Statistics (ABS 1988; 1993; 1998) statistics show that substantial numbers of Australians have disabilities, and the level of disability in the community increased from 15 to 19 percent of the population from 1988-1998. This increase has been attributable partly to better data collection techniques, partly to medical advances and partly to people being more comfortable about identifying themselves as having a disability. There is also a significant relationship between ageing and disability: a person is 14 times more likely to have a disability by the time they reach 65 years than they were as a four year old (ABS 1998). Australia has an ageing population (ABS 1996) and the numbers and proportion of older people in Australia is growing dramatically (Commonwealth of Australia 2002). As Gething states:

The 'baby boomers' are the first generation to contain a substantial proportion of people with long standing disabilities. Advances in technology, medical care and community support mean that many people with a long standing disability who would once have died before reaching late adulthood are now having a life expectancy which approximates that of the general population (Gething 1999:2).

Therefore, any industry or government not addressing disability and ageing issues is at a significant future disadvantage in social and economic planning.

Second, also in regard to *demand*: from the point of view of people with disabilities, the DDA is a means to improve community participation and the attainment of *citizenship* rights. Citizenship rights originate through the UN human rights approach to disability (Donnelly 1989; Hastings 1997). Citizenship has been an issue of growing importance in Australian social debate throughout the 1990s (Cox 1995; Goldlust 1996; Winter 2000). The importance for people with disabilities is discussed in Hastings' (1997) reflections on the first five years of the DDA. She views the DDA as an agent of social change to improve the participation of people with disabilities and argued that the DDA was essential to people with disabilities attaining citizenship rights.

As Lynne Davis (1999) observes, the aim of the DDA, as outlined by Hastings, involving the process of operationalisation, has been promoted by advocacy groups in Australia to be a unifying concept for social change. For example, the Physical Disability Council of NSW (PDCN) has prepared position papers that discuss the components such as education, housing, health, communication, employment and recreation which are seen as crucial to community participation that are drawn together by the concept of citizenship (PDCN

1999). Recreation and tourism are part of the rights of citizenship and are seen as areas where individuals achieve self-fulfillment, rejuvenation and reward (Hutchison 1997). However, as Hutchison (1997:2) suggests: ‘citizenship is much more than: rights + empowerment + inclusion + getting a life. It is an intangible concept that includes all of these things, but something more. It is at the core of what it is to be human’. Yet, as Meekosha and Dowse (1997) note, the broader citizenship literature has not embraced disability in the same way as it has embraced gender, ethnicity and indigenous issues. Therefore, in this research the implementation of the citizenship rights of people with disabilities is examined through the operation of the DDA in a tourism context.

Third, as regards *supply*: there is currently little understanding of how the tourism industry itself views the provision of goods and services for people with disabilities. This extends the question of whether the industry is aware of the market potential of people with disabilities and those that travel with them. Awareness is a precursor for the industry to consider a group as a market segment. Further, there is little understanding of how the tourism industry has responded to the challenge of the DDA.

Fourth, as regards *regulation* and *supply*: the introduction of the DDA has brought with it a series of challenges to the providers of goods and services and for employers in Australia. Tourism is part of a service sector that must respond to its responsibilities under the DDA. There are differing implications for each sector of the industry, and in turn, each has a significant impact on the tourism experiences of people with disabilities. No evaluation or research of the tourism industry’s response to the DDA has been undertaken.

Lastly, as regards *coordination* and *regulation*: there are questions as to the effectiveness of the approach taken by government to the implementation of human rights legislation in Australia. In particular, its promotion of industry awareness, monitoring processes in regard to compliance and the relative power of industry stakeholders in influencing government policy have all been identified as issues (M. Jones and Basser Marks 1999; Thornton 2000; Handley 2001; Tiddy 2001b).

In summary, this emergent problem is worthy of research as it investigates:

- a large demographic group whose market characteristics are relatively unknown;
- the neglected idea of the role of tourism as part of citizenship rights;
- industry perceptions of supplying goods and services for this market segment;

- industry responsibilities and reaction to the human rights legislation; and
- the role of government in overseeing the implementation of the legislation.

1.2 Situating the Research Question

This thesis explores the following question:

To what extent are the tourism patterns and experiences of people with disabilities¹ in Australia unduly constrained by tourism authorities and tourism industry practice and discourse?

The actual tourism patterns and experiences of people with disabilities in Australia have been overlooked as a foundation for understanding the responses required from the supply and coordination/regulation sectors to provide accessible tourism experiences. The question suggests that without a sound understanding of the experiences and constraints faced by people with disabilities, government tourism policy cannot be formulated to address the issues and appropriate management practice cannot be implemented by the tourism industry to service the group. *Unduly* in this context, means more constraint than is the case for the non-disabled. In the worst cases, this involves circumstances that are deemed disability discrimination under the law. This thesis seeks to document, quantify and develop an understanding of and explanation for the tourism patterns and experiences of people with disabilities and to examine the level and types of constraints experienced in experiencing tourism.

Discourse refers to the ‘...assemblage of statements arising in conversation, mediated by texts, among speakers and hearers, separated from each other in time and space which take on the credibility of “truth” and which are constructed as knowledge by the powerful’ (Wearing 1998:7-8). Discourse refers to the social relations of, and link between, knowledge and power in tourism and the effect that this has on what is produced and practiced by tourism authorities and the tourism industry. In this context, discourse provides an insight into the world of the *other*, those who are excluded, oppressed or disadvantaged by a particular discourse (Foucault 1988). Disadvantage becomes evident through the ways that the tourism authorities and tourism industry practices have been constructed to produce shared meaning.

¹ In the following chapters the definitions of *disability* and *impairment* are examined. In Chapter 5 the word *disabilities* is replaced with *impairments* in the research question for definitional and theoretical clarification.

1.3 Understanding the Language of Disability Used in the Thesis

The language of disability is a contested arena. It is an important ideological and political concern for the people involved as it cuts across identity, stereotyping and strategies for social change. The approach that industry takes to people with disabilities and the basis of the welfare/human rights approach of government are reflected in the use of what is deemed 'appropriate' terminology. According to Corbett (1996:2), 'The power of language is overwhelming' and, as Corbett goes on to explain, language has a significant influence on attitudes and perceptions and, hence, policy and practice. Quite simply, as Kirkpatrick (1991), suggests, 'Words can destroy. What we call each other ultimately becomes what we think of each other, and it matters'. Kirkpatrick argues that language forms the basis for communication and the terminology used carries meaning. In many cases, the terminology used to describe people with disabilities has been laden with a devaluing discourse (Finlon Dajani 2001). However, as Corker and French (1999) and Linton (1998) suggest, language can also be the foundation for creating a disability discourse and can be used to change non-disabled stereotypes of disability and promote diversity as an organisational strength.

In common English language usage, there are two separate ways of describing individuals and disability. The first of these uses the terms, *person with a disability* (individual) or *people with disabilities* (collective). The philosophy of using 'person first' terms is that they place the emphasis on the person first and foremost and the disabilities, whatever they may be, second. The second way uses the terms, *disabled person* (individual) or *disabled people* (collective). The adoption of either of these terms is part of a political strategy. This has developed differently in different countries at different times and, hence, it needs to be acknowledged that these terms are premised on certain approaches to disability. As Oliver, a disabled social scientist from the United Kingdom, explains:

It is sometimes argued, often by able bodied professionals and some disabled people, that 'people with disabilities' is the preferred term, for it asserts the value of the person first and the disability then becomes merely an appendage. This liberal and humanist view flies in the face of reality as it is experienced by disabled people themselves who argue that far from being an appendage, disability is an essential part of the self. In this view, it is nonsensical to talk about the person and the disability separately and consequently disabled people are demanding acceptance as they are, as disabled people (Oliver 1990:xiii).

Many UK disabled activists support Oliver and argue strongly that the use of person first language constitutes a superficial attempt to provide equality that avoids the political reality of disabled people's oppression. They see the term, *disabled people*, as being a powerful signifier, indicating the disabling nature of society that produces *disabled people*. They argue that until society creates enabling environments then the term serves a political

purpose of highlighting the disabling nature of society (Swain *et al.* 1993).

Contrary to this position, in other parts of the English-speaking world notably Australia, the USA and Canada, the phrase *people with disabilities* is preferred as it places the emphasis on the person first and the disability second. It is argued that this is an important change in emphasis as all people wish to be dealt with as people first, not on the basis of the preconceptions others may have of them because of their race, religion, gender, sexuality or disability. *People with disabilities* does not separate the terms, only placing an order to their use. As Fine and Asch (1988:11) acknowledge, people with disabilities do not necessarily define disability as being central to their self-concept.

The term *people with disabilities* is used in this thesis as the accepted term for the Australian context (Hume 1994). Like Oliver (1990) this thesis adopts a social model approach to disability and recognises the disabling nature of society. In Chapters 7 and 8, the term *people with impairments* is used when investigating whether the social relations of tourism create disabling journeys and, hence, *people with disabilities* in a tourism context. However, as language is a function of history and politics, any direct quotation of sources referenced will maintain the integrity of the language used. Certain language usage is sometimes denoted by the inclusion of the term (sic) to indicate its historical or political context (e.g. handicapped (sic)). The only exception to this is for *disabled person* as the majority of the UK texts referred to use this term for the political reasons outlined above.

In taking direction from the social model of disability, as discussed in Chapter 2 and 3, the term *impairments* is used instead of *disabilities* for the empirical chapters (7 and 8), as both a definitional and theoretical approach to the research. This is because it is argued that it is the socially constructed constraints that people with impairments face in negotiating the planning of, and the undertaking of the tourism experience that creates *disabling journeys*. In other words, it is posited that it is the disabling practices of the tourism authorities and the tourism industry that transform the impaired person into the disabled person in the tourism context. The discussion on language is further developed in Chapter 2 through the examination of the World Health Organisation (WHO) *International Classification of Impairment Disability and Handicap* (ICIDH) and the implications that these have for constructing a medical model worldview or discourse of disability.

1.4 Defining Tourism

There are many ways to define and conceptualise *tourism*. Stephen Smith (1988:181) remarks that students of tourism must learn to accept the range of differing definitions of tourism and respect the reasons for these differences. For example, Leiper (1995:20) states that tourism is ‘The theories and practices of travelling and visiting places for leisure-related purposes’. Further, he sees tourism from a tourist’s behavioural perspective as a subset of leisure. His focus is on the ideas and opinions that shape tourists’ decisions to travel or not to travel, where to go or not go, and what to do or not do, and how they relate to others (tourists/ hosts/service personnel). Boniface and Cooper (2001:3) similarly recognise tourism as a distinctive part of leisure but introduce a geographic dimension to studying tourists’ leisure time activities on a continuum: *Home* → *Local* → *Regional* → *National* → *International*. However, leisure-based definitions exclude business-related and other forms of tourism that use the same infrastructure and may also incorporate a range of pleasure-seeking activities undertaken in the visitor’s free time.

In its most basic guise tourism comprises temporary, short term travel of people from the person’s usual place of residence to a destination and involves an overnight stay (Hall 1995; Leiper 1995; Goeldner, Ritchie and McIntosh 1999; Weaver and Opperman 2000; B.G. Boniface and Cooper 2001). The Australian government’s attempt to define tourism was the driver of Australia’s first national tourism policy (CDOT 1992), which adopted a demand-based economic approach that sought to quantify tourist expenditure in Australia and included both domestic and overseas tourists (Australian Government Committee of Inquiry into Tourism (AGCIT) 1987b; 1987a). In the AGCIT a *tourist* was defined as:

- a person who undertakes travel, for any reason, involving a stay away from his or her usual place of residence for at least one night; or
- a person who undertakes a pleasure trip involving a stay away from home for at least four hours during daylight, and involving a round distance of at least 50km; however for trips to national parks, state and forest reserves, museums, historical parks, animal parks or other man-made (sic) attractions, the distance limitation does not apply (AGCIT 1987a:11).

These definitions have underpinned Australian statistical collection of tourism by the Bureau of Tourism Research (BTR). For this thesis, therefore, a tourist is a person undertaking travel away from usual place of residence whether for day trip or overnight purposes (AGCIT 1987a). Yet, the preceding discussion does not adequately reflect the complex relationships that exist when trying to provide explanations of tourism for different groups. Weaver and Opperman build upon Goeldner, Ritchie and McIntosh’s

(1999) stakeholder context and state that:

Tourism is the sum of the phenomena and relationships arising from the interaction among tourists, business suppliers, host governments, host communities, origin governments, universities, community colleges, and non government organisations, in the process of attracting, transporting, hosting and managing these tourists and other visitors (Weaver and Opperman 2000:3).

This definition is inclusive of all the stakeholders required to understand the social relations of tourism for people with disabilities in Australia. These stakeholders fall into three main positions: the demand side, that analyses the experiences of the tourist (Murphy 1985); the supply side, that conceptualises tourism as a market and an industry (S. Smith 1988); and the coordination/regulation sector that seeks to minimise the excesses of the market mechanism (Hall 1998; Veal 2002). These definitions of tourism, tourist and the stakeholder approach to tourism form the basis for understanding tourism and people with disabilities in this thesis. This beginning is developed in Chapter 4 through the further understanding of the tourism system, tourism as a market and the government's role in tourism.

1.5 Terminology

From the introductory discussion, the following terms are used throughout the thesis and are defined for their particular use in the thesis.

ABLEISM

'refers to the ideas, practices, institutions and social situations that presume able-bodiedness, and by doing so, construct persons with disabilities as marginalised, oppressed and largely invisible *others*. This presumption, whether intentional or not, means that one's ability to approximate the able-bodied norm influences multi facets of life: such as the character and quality of interpersonal relations, economic prospects and the degree of physical and social access to various life spaces. Ableism entails a way of being that takes mobility, thinking, speech and the senses for granted, and which includes largely unconscious aversion to people and bodies that remind us the able-bodied norm is an ideal...that we are all mortal and subject to disease and death (see Young 1990). An ableist society, then, is one that tends to devalue people with disabilities, despite its good intentions on the part of many of its citizens to treat these others as equals' (Chouinard 1997:380).

ACCESS generally refers to a way, means or opportunity of approach. In this thesis, it is broadly used to refer to the human right to the fair and access to the benefits of citizenship. In this sense, ensuring access is a process of enabling people with disabilities to function independently and with equity and dignity through the delivery of universal products, services and environments (adapted from OCA 1998). The definition is inclusive of the

physical, sensory and communication dimensions of access. Access is also technically defined through the requirements of Building Codes of Australia (ABCB 1997b), the referenced Australian Standards for access and mobility (Standards Australia 1992a; 1992c; 1992b; 1998), and the spirit and intent of the DDA (HREOC 1998; Ozdowski 2001).

CITIZENSHIP is a unifying concept that involves an understanding of the basis of social participation in society. In most Western nations it is underpinned by a given rights framework and legislation enacted to protect those rights. For people with disabilities in Australia, the DDA prescribes what is fair and equal treatment before the law. However, as Hutchison (1997:2) notes, given certain rights are a starting point for citizenship which, she goes on to argue, is more than the sum of its parts - rights + empowerment + inclusion + getting a life - and is at the core of what it is to be human.

CONSTRAINTS are (disabling) barriers that limit the formation of tourism preferences (pre-trip) or inhibit participation (on trip) and, hence, affect tourism experiences (adapted from McGuire 1984; Jackson 1991).

DISABILITY from a social model perspective is defined as a complex set of *social relationships* imposed on top of a person's impairment due to the way society is organised. Hence, disability is the product of the social relationships that produce *disabling barriers* and *hostile social attitudes* that exclude, segregate and oppress people with disabilities and deny them their rights of citizenship. The social model regards disability as the product of the social, economic and political relationships (*the social relations*) rather than locating it as the fault of an individual's embodiment. This approach to disability separates impairment from the social relations of disability (Oliver 1990).

DISABILITY DISCRIMINATION occurs when a person with a disability is treated less fairly before the law than the non-disabled (HREOC 1994).

DISABLED PEOPLE/PEOPLE WITH DISABILITIES are terms used in this study to represent people with impairments who are discriminated against in their daily lives (Oliver 1990).

DISCOURSE, as used by Foucault, describes the nature of ideas, texts, media,

conversations and behaviour within social arenas that become truths. Foucault (1988) argues there are no truths but rather discourses that are socially constructed realities where knowledge and power are used by those in power to perpetuate their position.

GOVERNMENT is the term used generically when referring to the Australian Commonwealth government as a regulator through general legislation, policy and practice. This term is distinct from the role of the Commonwealth and state government as tourism coordinators through the various tourism authorities. The latter are referred to generically as *tourism authorities* (abbreviated to TA in this thesis). Other government departments or statutory authorities are referred to specifically in the public policy context discussed.

IMPAIRMENT is any loss of psychological, physiological or anatomical structure or function (adapted from ABS 1998:68). For example, the damage or lack of function of the spinal cord of someone with a spinal cord injury is an impairment.

MEDICAL MODEL is not so much a model but a cultural imperative or perspective that individualises the *problem* of disability and sees the *cause* of the problem emanating from the functional/psychological losses. The medical model defines disability as ‘any restriction or lack (resulting from an impairment) of ability to perform an action in a manner or within the range considered normal for a human being’ (ABS 1998:66).

NON-DISABLED are people without disabilities.

NORMALCY is a bio-physiological ‘scientific’ construct originating from the medical model that seeks to categorise individuals into a normal/abnormal dichotomy based on their bio-physiological deficits from the culturally constructed ‘norm’. The premier medical example is the WHO (1980; 1997) ICIDH. Such a construct is heavily laden with a medical model discourse and prejudices (Barnes et al. 1999:25).

OPPRESSION refers to the systemic political, economic, cultural, or social conditions of disadvantage and marginalisation that people with disabilities face in their day-to-day living. Abberley (1987:7) argues that to claim disabled people are oppressed requires that the inferior position is due to disability and is perpetuated by those benefiting the situation even after recognising the disadvantage. The disadvantages and ideologies that drive the disadvantage, are a product of history where the inferiority of people with disabilities

benefits other groups.

OTHER in the Foucauldian sense refers to those who are excluded, oppressed or disadvantaged by a particular discourse (Foucault 1988). For the purposes of this thesis, people with disabilities are considered and constructed as the *other* by ableist discourses. The ableist discourse creates an exclusionary difference based on people's impairments. This definition of other is inclusive of such concepts as *stigma* (Goffman 1963), *difference* (Thomson 1997), *oppression* (Abberley 1987) and *Other* (Young 1990) identified in social idealist, cultural representation or social model theory investigated in Chapter 3.

SOCIAL RELATIONS is a term derived from the social model definition of disability (see above) and used in this thesis to describe the social, economic and political relationships that create disability that are imposed on top of a person's impairment. Hence, disability is the product of the social relations that produce *disabling barriers* and *hostile social attitudes* that exclude, segregate and oppress people with disabilities and deny them their rights of citizenship (Oliver 1990).

TOURISM in this thesis has dual definitions. Firstly, it has a tourist-focused definition, namely the temporary, short-term travel of people from their usual place of residence to a destination for a day trip or overnight stay (BTR 1998). The strengths of this definition are in its simplicity, since it is the basis of Australian tourism statistics. Secondly, tourism can be defined from a stakeholder perspective as the sum of all the phenomena and relationships arising from the interaction of tourists, business suppliers, host governments, host communities, origin governments, universities, community colleges, and non-government organisations, in the process of attracting, transporting, hosting and managing tourists (Weaver and Opperman 2000:3).

TOURISM INDUSTRY (TI) refers to the aggregate of organisations which have a significant role in servicing the needs of tourists through the provision of goods and services. It includes any of the sectors identified by Leiper's (1995:28-29) seven sector model of the TI made up of accommodation (and associated hospitality), carrier (transport), attractions, tour operator, marketing, coordination and miscellaneous sectors. In the thesis, the abbreviation *TI* is used when referring to these sectors collectively unless specifically identified.

TOURISM SYSTEM refers to an interrelated functionalist *systems* approach (Mill and Morrison 1985) that has become a predominant way of conceptualising tourism in some academic environments. In this model, the tourist is at the centre of the system and, together with the other geographic core elements, operates within the broader sociocultural, economic, technological, physical, political and legal environments. The tourism system, as described by Leiper (1990) comprises five interdependent core elements (see Figure 2 Chapter 4). These are:

- at least one tourist;
- at least one tourist generating region (TGR) - where tourists originate from;
- at least one transit route region - how tourists get from the TGR to the TDR;
- at least one tourist destination region (TDR) - where tourists seek experiences; and
- a travel and TI that facilitates tourist needs (Leiper 1995:24).

1.6 Scope of the Thesis and Limitations

To date only two Ph.D. theses and one Masters thesis have been completed in English in the area of disability and tourism. They involved:

- role of leisure travel within the lives of people with disabilities (Foggin 2000);
- disability awareness training interventions on students/employees within the hospitality and tourism industries (Daruwalla 1999); and
- attitudes of destination marketing managers towards disability (Ross 1994).

Only Daruwalla's thesis was completed in Australia. No single thesis could research all the relationships of disability and tourism. As with the three theses cited above, this thesis could focus on disability and tourism from solely a demand, supply or coordination/regulation perspective. However, to do so would ignore the crucial issue of the nexus between these three perspectives. Only by considering all three sectors can an explanation of the social relations of tourism for people with disabilities be fully explored. Examining just one of the three sectors would enable a narrow field to be researched in more depth than has been possible in this thesis, where a deliberate decision was made to adopt a broad, system-wide, approach. The research begins with the lived experiences of people with disabilities at the centre of the research paradigm, but this is followed by an analysis of government TA initiatives, and the TI accommodation sector responses to disability. These analyses form the basis for an explanation of why the experience of tourism for people with disabilities in Australia is the way it is.

It is recognised that this thesis is longer than the prescribed length but this was felt

essential to let the voices of people with disabilities speak for themselves and to develop an explanation for their experiences.

The thesis is naturally limited by its dependence on geographically and culturally specific empirical sources. In regard to people with disabilities themselves, the population primarily studied in this thesis was Australians with impairments who had had tourism experiences or who had considered the possibility but decided not to travel. The study was subject to the limitations of sampling which affects most social science research, but it is believed that the individuals whose experiences are presented are broadly representative of the target population, and this is discussed further in the methods section (Chapter 6). In seeking an explanation for the tourism experiences of people with disabilities, however, published research findings on other populations were drawn upon, suggesting that the Australian experience is not wholly unique.

As regards the tourism industry, the case study of the accommodation sector was undertaken in the Sydney Metropolitan area with the assistance of the Australian Hotels Association (AHA) that represents mainly 4-5 star establishments. Some of these establishments are part of national and international companies, so it is likely, although not certain, that the findings have some applicability outside of the Sydney Region, but the findings may not be applicable to smaller establishments.

The government perspective was provided by first reviewing the relevant disability legislation and policy in Australia, second, analysing tourism authorities' disability initiatives and, third, interviewing relevant tourism authority officers. This, and the case-study material from legal cases, therefore represents a national perspective. Again, there are commonalities with situations in other countries, particularly in the area of human rights-based legislation, but there are also differences, which themselves can assist in understanding. In the main, however, the findings relate to Australia only.

Thus, strictly speaking, no claims for significance of the research can be made beyond these limitations. However, it is clear from the literature that many of the experiences of people with disabilities are common to a wide range of jurisdictions, at least in the English speaking part of the Western world. It is believed therefore that the thesis contributes to the broader understanding of the tourism experiences of people with disabilities.

1.7 Contribution to the Body of Knowledge

The academic contribution of this thesis is sixfold. First, the thesis contributes to the knowledge and understanding of the tourism patterns and experiences of a much neglected market segment in the Australian context. The thesis provides a world first comparison of the tourism patterns of people with disabilities and the non-disabled on a national level. The data highlights that people with disabilities have lower levels of tourism participation than the non-disabled. While impairment type is identified as a significant influence on tourism participation, people with disabilities do not regard their impairment as a reason for non-participation in tourism.

Second, the thesis applies the social model of disability to a new area of study, tourism. This provides a new cultural lens from which to view tourism from a disability perspective. In adopting a social model approach to tourism, attention is focused on the disabling tourism constraints of the group. This approach suggests that an understanding of the social model and constraints theory should be incorporated within tourism systems. This would offer an opportunity to develop enabling tourism environments within the tourism system that, in the past, has proved largely dysfunctional in its dealing with people with disabilities.

Third, the thesis provides an opportunity to reconceptualise previous understandings of tourism constraints for people with disabilities. It is concluded that the constraints encountered by people with disabilities are a product of the social relations of tourism in Australia rather than the fault of the individual's embodiment. Based on the findings of the thesis, a number of new structural categories of constraints are proposed. Further, the thesis shows that, while substantial tourism constraints exist for the group, these constraints are largely negotiated by the majority of people with disabilities in order to participate in tourism. However, while the constraints to participation may be successfully negotiated, the resultant phenomenology (discussed below) suggests that they are less satisfied with their experiences than the non-disabled. This research also provides insights for the further refinement of holiday and destination choice models and considerations for destination image from a disability perspective.

Fourth, the thesis has provides a greater understanding of the resultant phenomenology of their experiences. People with disabilities are frustrated by the travel planning process and disempowered by the by the lack of understanding of their needs by the TA and TI. It was

found that the transit experience, in particular, left them in a state of helplessness through the loss of independence and dignity. While wanting the benefits of tourism, those who continued tourism experiences are left in state of ongoing anxiety as to the likely constraints that they are to encounter at each stage of the journey.

Fifth, the social relations that produce the undue constraints are explained through an examination of TA and TI practice and discourse. In particular, the thesis includes the first policy analysis of government disability tourism initiatives and provides an understanding of the perceptions of the accommodation sector in servicing the group. It is concluded that the reasons for TA and TI behaviour is the fact that it is based largely on the medical model worldview and resultant ableist practices and discourses, the market ideology of tourism and the relative powerlessness of people with disabilities. Further explanation for the resultant tourism experiences of people with disabilities are found in the discourses of access, development of the environmental planning process and the implementation of the notion of citizenship through the Australian human rights legislation. The explanation is operationalised in the Comprehensive Tourism Access Model (CoTAM) in which constraints and social model theory is incorporated to address the dysfunctional nature of the tourism system for people with disabilities.

Lastly, the thesis presents evidence for an *embodied ontology* of tourism for people with disabilities. It does so through the exploration of the significant influences that impairment, mobility aid, support needs and socio-demographic variables have on the tourism patterns and experiences of the group. This understanding of individual circumstance further contributes to the understanding of the complexities of the disability tourism experience. The findings of the thesis suggest there is statistical support for incorporating the notion of agency within social model theory development.

1.8 Outline of the Thesis

The outline of the chapters is shown graphically in Figure 1 and an overview of each chapter is discussed in this section. Chapter 2 provides a theoretical background to human rights and examines the international declarations and the relevant Australian system of disability legislation and policy. The chapter concludes with a review of disability statistics collection in Australia, which is largely dependent on medical model international definitions of disability.

Chapter 3 provides an outline of the major theoretical models for conceptualising disability. It begins by reviewing the literature that discusses the major conceptualisations of disability. Three models are then critically reviewed, namely the medical, social idealist and social model. In addition, the relatively new academic work on the geography of disability is reviewed, which provides further insights into the socio-spatial dimensions of disability and tourism, and become emergent themes for the thesis.

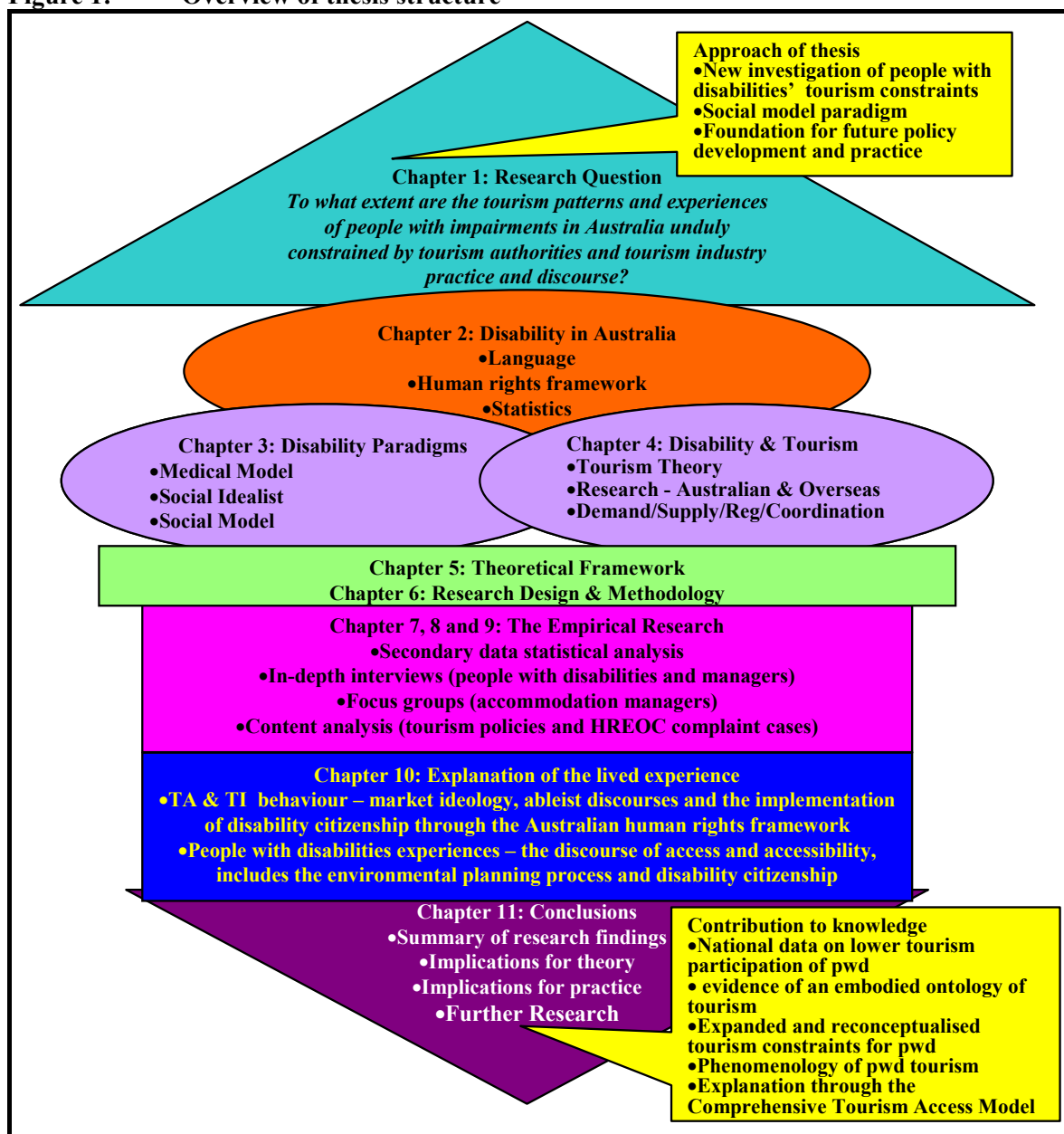
Chapter 4 begins by assessing the treatment of disability in tourism textbooks as a preliminary indicator of the relationship between disability and tourism. The chapter then reviews the tourism system model, the idea of tourism as a market and the government role in tourism marketing and development, as important constructs for the thesis. This is followed by a review of the existing disability and tourism literature, starting with specialist travel guides as well as anecdotal accounts of travel experiences. The chapter then critically reviews the substantive research available on disability and tourism generally and then particularly from a demand, supply and coordination/regulation perspective in Australia and overseas. Lastly, it evaluates the degree, breadth and quality of research in this area and discusses emergent themes and implications for the thesis.

Drawing on Chapters 2, 3 and 4, Chapter 5 defines the underlying theoretical perspectives and discourses used in the thesis, and develops a theoretical framework to assist in understanding the tourism disability relationship. The development of the theoretical framework draws mainly on: disability studies (impairment, disability, access, normalcy and ableism); leisure and tourism studies (constraints, tourism systems, tourism as market and government role in tourism); economics, public policy and politics (market ideology and power) post structuralist sociology (discourse analysis). The chapter concludes with the research questions to be addressed.

Chapter 6 outlines the empirical research design and the methodologies used. Given the range of research questions posed in Chapter 5, it was determined that the research design and methodological framework for the thesis would involve both naturalistic and positivist inquiry involving a number of sub projects, each requiring a specific methodology. The research uses inductive and deductive approaches through quantitative and qualitative investigations. The data sources are outlined and the steps used for each methodology are presented. This involves a multiple methodological approach utilising secondary data

analysis, content analysis, archival research, case studies, in-depth interviews and a focus group. Lastly, the ethical considerations and the limitations of the study are discussed.

Figure 1: Overview of thesis structure



Chapter 7 presents an account of the tourism patterns of people with disabilities in Australia through analysis of secondary data. The chapter firstly presents a statistical review of the tourism patterns and experiences of people with disabilities, followed by a comparison of the tourism patterns of people with disabilities and those of the non-disabled. The data are analysed to explore the impact of a range of impairment and socio-demographic variables upon participation. The last section of the chapter seeks to develop an understanding of the impact of an *embodied ontology* on tourism patterns.

Chapter 8 presents the findings of the qualitative research on the tourism experiences of people with disabilities and, hence, the constraints they face through the journey they seek to undertake. The approach taken provides a consolidated account of the tourism experiences by combining information from the data sources. The chapter concludes with a summary of the tourism constraints faced by people with disabilities.

Chapter 9 documents Australian tourism authority and accommodation sector practices and discourses in relation to people with disabilities. The practices of these two core sectors of the industry emerge from Chapter 8 as significant constraints to limiting tourism experiences of people with disabilities. An account of these service providers' practices contributes towards the development of and explanation for the lived tourism experiences of people with disabilities.

Chapter 10 draws upon the theoretical framework outlined in Chapter 5 and the empirical analysis to provide an analysis of the social relations of government, tourism authorities and tourism industry practice that shape the tourism environment in Australia. It is argued that this socially produced tourism environment creates the tourism constraints documented in Chapters 7, 8 and 9. The chapter first seeks to provide an explanation for the tourism experiences of people with disabilities through an examination of the discourses of access. The chapter then explores why tourism authorities and tourism industry behave the way they do, examining market ideology, the medical model worldview and resultant ableist practices, the human rights agenda and the social model in the policy and market contexts.

Chapter 11 concludes the thesis by summarising the evidence presented and offering a general model of the disability tourism experience. The Comprehensive Tourism Access Model (CoTAM) is explained through each of the major components: A. people with disabilities (demand); B. tourism authorities (coordination) and the tourism industry (supply); C. government (regulation) through the human rights approach of the DDA; D. contributing theoretical perspectives and discourses. The complexity of the social relations of the tourism environment for the group is then examined by reconceptualising tourism constraints for people with disabilities. The chapter concludes with a reflection on the research process and suggestions for further research.

2 HUMAN RIGHTS, DISABILITY AND STATISTICS IN AUSTRALIA

2.1 Introduction

This chapter provides a background to understanding disability in Australia through legislation, policy and statistical data collection. The chapter begins by providing a theoretical background to human rights and disability. This is an important foundation to understanding the international human rights framework of the United Nations (UN). The Australian government has responded through disability legislation and policy to this international human rights context. The chapter then reviews the Australian legislation and policy as a starting point for understanding disability and tourism to be presented in Chapter 4. The Australian system of legislation and policy uses a particular terminology that is very different to everyday language use. This terminology is the basis for the statistics gathered by government on the prevalence of disability in the community. This terminology has its origins in a worldview of disability through the World Health Organisation (WHO) categorisation of impairment, disability and handicap (commonly referred to as the ICIDH). The approach taken by WHO is the predominant model of understanding disability and has an overriding influence on how disability is conceptualised by society and, hence, government, TA and the TI. The WHO framework is operationalised by the ABS (1988; 1993; 1998) and is reviewed to understand this worldview and the prevalence of disability in Australia. This chapter foreshadows the debate about discourses of disability that involve the human rights, medical and social approaches to disability.

2.2 The International Human Rights Context

The *Macquarie Dictionary Revised Third Edition* defines a right as: ‘a just claim or title, whether legal, prescriptive or moral, that which is to anyone by just claim: *to give one his right or his rights* (1997:1625)’. In this sense, a right is something that must be assertively claimed by individuals and groups and, subsequently, recognised by others as a legitimate claim. As Donnelly argues, all people are entitled to human rights on the basis of their humanity alone (Donnelly 1989). Human rights are political and moral in nature and state a belief or commitment to principles (Veal 2002). In the international human rights context, all members of the United Nations are signatories to the human rights declarations. Yet, it

is recognised that the human rights declarations are regularly and systematically violated (Donnelly 1989). While nation states have moral rights as signatories to the declarations, it is not until states commit to legislating national laws that these become positive rights (Cranston cited in Veal 2003:13). The remainder of this section places the human rights for people with disabilities in context to the relevant international declarations before reviewing Australian disability rights legislation.

As stated in the introduction, the rights of people with disabilities were not specifically mentioned in the United Nations (1948) *Universal Declaration of Human Rights*. They did not receive formal international recognition until the United Nations (1975) *Declaration on the Rights of Disabled Persons*. An extension of this initiative was that the United Nations (1976) declared 1981 as *the International Year of Disabled Persons (IYDP)*. Following the IYDP, the United Nations declared that 1983-1992 would be known as the *Decade of Disabled Persons*. This decade saw many individual initiatives by member states to address their particular disability issues. The end of this decade was marked with a United Nations (1993) General Assembly resolution proclaiming, *The Standard Rules on the Equalisation of Opportunities for Persons with Disabilities*. The resolution adopted a social approach to disability, calling on governments to provide for the equalisation of opportunities for people with disabilities in all aspects of their lives. The resolution identified recreation and tourism as target areas, stating that:

Tourist authorities, travel agencies, hotels, voluntary organisations and others involved in organising recreational activities or travel opportunities should offer their services to all, taking into account the special needs of persons with disabilities. Suitable training should be provided to assist that process (UN 1993:Rule 11 para 2).

Recreation and tourism have long been part of the United Nations' declarations (Veal 2002). The above United Nations' declarations deemed tourism as a social right of people with disabilities. Subsequently, the declarations were recognised by the World Tourism Organisation with the resolution *Creating Opportunities for Handicapped People in the Nineties* (World Tourism Organisation 1991). This resolution was a response to the 1980 *Manila Declaration on World Tourism, the Tourism Bill of Rights and Tourist Code* (World Tourism Organisation 1985) as well as the United Nations Decade of Disabled Persons (1983-1992). The declaration sought to recognise the right of equality of provision of tourism for people with disabilities. It did so by recognising the role of tourism in the rights of citizenship generally, and specifically, identifying people with disabilities as part of society, which has a desire to experience tourism. The resolution called for intergovernmental air and maritime transport organisations to improve access for people

with disabilities and the elderly. It also encouraged member states to develop regulations to facilitate the creation of new accessible tourism facilities and services or to adapt existing ones accordingly. However, the resolution stopped short of imploring operators directly to provide accessible facilities and services. It stated the principle in part 7 WHO were convinced that, 'in the long run, ensuring full access to tourism for handicapped persons will benefit the operational sector of tourism' (WTO 1991:2). However, WTO has not undertaken any further initiatives in this area.

The International Bureau of Social Tourism (1997) *Montreal Declaration* recognised that many people with disabilities live socially disadvantaged lives in which tourism is not a realistic possibility. The declaration focuses on the advantages of *social tourism*. The goal of social tourism is to provide access to tourism opportunities for disadvantaged groups. This involves a struggle against inequality/exclusion whether experienced by those who are culturally different, of limited means or abilities, or who live in developing countries. The social tourism movement is largely European and Canadian based. In Australia, opportunities for these groups are provided by government sport and recreation departments and non-profit organisations that provide holiday opportunities for disadvantaged children.

Central to the UN human rights declarations was the recognition that people with disabilities should enjoy the rights of citizenship of its signatory nations. The UN provides the foundation of citizenship through the international framework of human rights. Yet, as Hutchison (1997:2) stated human rights is only part of establishing citizenship for people with disabilities. Each country operationalises these rights under its own legislative and policy frameworks. These frameworks require governments to resource and regulate their implementation to empower people with disabilities in order to access the inclusive social participation that the frameworks are designed to achieve. Only when rights + empowerment + inclusion are evident can people with disabilities have the same access to life as citizens as do the non-disabled. Only then will people with disabilities know what Hutchison describes as 'the core of what it is to be human' (1997:2). As Honneth argues, moral rights need to be supported by positive rights as a precursor to citizenship:

What has emerged time and time again is that in order to be involved as morally responsible persons, individuals need not only legal protection from interference in their liberty but also legally assured opportunity for participation in the public process of will-formation. An opportunity they can only take advantage of if they have a certain standard of living. Thus, what is acceptable is a minimum standard of cultural education and economic security (Honneth 1995:117).

The Australian response to the UN declarations is examined in the next section through the relevant disability legislation and policy.

2.3 Australian Disability Legislation and Policy

Government or the *State* in Australia consists of a three tiered structure involving the Federal or Commonwealth government, six State governments and two Territory governments, and some 800 local government authorities (councils) (G. Davis *et al.* 1993). The *Commonwealth of Australia Constitution Act, 1900* (CA) (Comm) identifies the Commonwealth government's concurrent (Sec. 51) and exclusive (Sec. 52) powers with the States. The provision of disability specific services has been a responsibility of both the Commonwealth and State governments under the Constitution (Yeatman 1996). Each state developed its own legislation and policy, but as with any area, Commonwealth legislation takes precedent over state. With this brief context, a review of the development of Commonwealth disability legislation and policy is presented below. Table 1 presents a chronology of the major disability legislation and policy in Australia at the Commonwealth level. The following discussion identifies the most relevant legislation and policy and their relationship to tourism.

Before 1974, disability was largely seen as a health and welfare issue. With the introduction of the *Handicapped Persons Assistance Act, 1974* there was recognition that disability was more than a medical problem and involved social dimensions. Yet, little occurred socially until the IYDP. The IYDP was seen as a watershed event for the rights of people with disabilities in Australia. The IYDP was marked by Commonwealth (Adams 2000; Clear 2000:55) and state initiatives (NSW Dept. of Tourism 1981; Clear 2000:54). Importantly, the emerging disability political movement for the first time had been able to organise around a focal point (Clear 2000:55, 81). Adams (2000) documents the 1980 formulation of the Commonwealth government's disability awareness and education campaign *Break down the Barriers*. This campaign was a result of direct intervention by people with disabilities to protest against the proposed 'disability as inspiration campaign' that was to use world-renowned people with disabilities to head the campaign. Adams recalled his shock at a deposition of people with disabilities led by Elizabeth Hastings (later to become the Human Rights and Equal Opportunity Commission's (HREOC) first Disability Discrimination Commissioner) who were strongly opposed to the inspirational

campaign he proposed. They wanted a campaign based on the lives of ordinary people with disabilities ‘breaking down the barriers’ to community participation. The strength of their campaign convinced Adams to review the focus. Adams then had to sell this new campaign to the Federal politicians who had liked the inspirational campaign because of the high profile people to be used and were nervous about the confrontational nature of a campaign based on social change.

Table 1: Key Events in Commonwealth disability legislation and policy in Australia

Year	Legislation/Policy	Comment
1974	Handicapped Persons Assistance Act	<ul style="list-style-type: none"> • Recreation/tourism not recognised
1981	UN International Year of Disabled Persons (IYDP)	<ul style="list-style-type: none"> • A year of awareness raising activity • Changed the way government perceived people with disabilities (Adams 2000)
1983	Handicapped Persons Assistance Act Review	<ul style="list-style-type: none"> • Review to set new directions based on people with disabilities’ aspirations
1985	New Directions Report	<ul style="list-style-type: none"> • Recommended substantial changes to service provision based on greater accountability and more responsive programs
1986	Disability Services Act (replaced Handicapped Persons Assistance Act)	<ul style="list-style-type: none"> • Based on principles of individual need, equity & access. Objectives & outcome assessment. Recreation/tourism recognised
1985	Equal Opportunity Act	<ul style="list-style-type: none"> • Had no disability provisions
1988	Equal Opportunity Act	<ul style="list-style-type: none"> • Included disability provisions
1990 - 1992	Commonwealth/State Disability Agreement	<ul style="list-style-type: none"> • Clarified roles between the Commonwealth and state to avoid duplication of service provision • Funding formula for disability service provision
1991	Disability Reform Package	<ul style="list-style-type: none"> • An integrated support and payment system • Focus on increasing labour force participation
1992	Disability Discrimination Act (DDA) Enacted 1 March 1993	<ul style="list-style-type: none"> • Overriding and specific Commonwealth disability discrimination legislation
1994	Commonwealth Disability Strategy	<ul style="list-style-type: none"> • 10 year plan for Commonwealth departments and agencies to develop a philosophy of inclusion
1999	Human Rights Legislation Amendment Act No. 1 1999 Enacted 13 April 2000	<ul style="list-style-type: none"> • Rectified the anomaly that findings under the HREOC Act were not binding • Binding decisions needed to be heard in the Federal Court of Australia • Federal Court made a cost jurisdiction

Sources: Adapted from: HREOC 1994; Yeatman 1996; Lockwood and O’Meara 1999; Adams 2000

However, the Australian government’s own reporting to the UN highlights that it was not until 1986, with the introduction of the *Disability Services Act, 1986* (DSA), that disability services were conceptualised as broader community participation (United Nations 1996).

A. Disability Services Act, 1986 (DSA)

The DSA was the first disability specific legislation in Australia that moved from a purely welfare perspective to one of disability citizenship (Lockwood and O’Meara 1999). Under the DSA, the Commonwealth government provided grants for the provision of services to support people with disabilities to participate in community activities. The DSA sought to

promote choice in work and community life by maximising delivery of services in community settings and through the targeting of income support to assist people with disabilities in their pursuit of increased social and economic participation. Recreation, and implicitly, tourism, was incorporated into the DSA as an area of funded service provision (Sec. 7 & 9(2)(g)). Yet, the focus of DSA service provision in the 1990s has been on participation in the labour market (Meekosha and Dowse 2001; Carberry 2002). This appears to be a trend in Western countries where work is regarded as the defining element of citizenship (Abberley 1999). From a disability perspective, the assumption that being in the paid labour force is a necessary prerequisite for citizenship has been contentious (Barnes 1996b; Oliver and Barnes 1998; Priestley 1998; Gleeson 1999a).

B. Disability Discrimination Act, 1992 (DDA)

The IYDP, the DSA and the development of anti-discrimination legislation by the states provided foundation for greater participation by people with disabilities in the Australian community. However, the state based anti-discrimination legislation treated disability in an ad-hoc fashion (Ozdowski 2002). The momentum built over the 1980s gave rise to an Australian disability movement who orchestrated political campaigns based around the UN declarations (Clear 2000b). The calls to establish dedicated Commonwealth human rights based approach to disability in Australia were heard at the Commonwealth level (Hastings 1997). This would provide dedicated and uniform legislation that took direction from the UN Declarations and the American civil rights developments and the *Americans with Disabilities Act, 1990* (USA). The Australian Commonwealth government used its external affairs powers under the Constitution to establish the *Disability Discrimination Act, 1992* (DDA) concerning the UN Declarations and, hence, override any preceding state legislation. The DDA became the first disability specific legislation in Australia to provide protection for all Australians against disability discrimination and took effect on 1 March 1993.

The premise of the DDA was that disability discrimination happens when a person with a disability is treated less fairly than the non-disabled. The three key objectives of the DDA are:

- (a) to eliminate, as far as possible, discrimination against persons on the ground of disability in the areas of:
 - (i) work, accommodation, education, access to premises, clubs and sport; and
 - (ii) the provision of goods, facilities, services and land; and
 - (iii) existing laws; and

- (iv) the administration of Commonwealth laws and programs; and
- (b) to ensure, as far as practicable, that persons with disabilities have the same rights to equality before the law as the rest of the community; and
- (c) to promote recognition and acceptance within the community of the principle that persons with disabilities have the same fundamental rights as the rest of the community (Sec. 3).

Definition of disability

The DDA uses a functional loss list to define disability similar to the ABS (1998) definition discussed in Section 2.4 of this chapter. The DDA definition of disability is:

- (a) total or partial loss of the person’s bodily or mental functions; or
- (b) total or partial loss of a part of the body; or
- (c) the presence in the body of organisms causing disease or illness; or
- (d) the presence in the body of organisms capable of causing disease or illness; or
- (e) the malfunction, malformation or disfigurement of a part of the person’s body;
- (f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or
- (g) a disorder, illness or disease that affects a person’s thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour; and includes a disability that:
 - (h) presently exists; or
 - (i) previously existed but no longer exists; or
 - (j) may exist in the future; or
 - (k) is imputed to a person (Sec. 4).

The DDA definition is more inclusive of temporal elements, stating that people cannot be discriminated against because of a disability they ‘have now, had in the past, may have in the future or are believed to have’. It also includes people who may have the presence of disease-causing organisms in their body (e.g. HIV/AIDS and hepatitis). The HREOC accompanying notes interpret this Section of the Act to define disability under the following categories:

- | | |
|-------------------------------|---|
| • Physical; | • Sensory; |
| • Intellectual; | • Psychiatric; |
| • Neurological; | • Learning disabilities; |
| • Physical disfigurement; and | • Presence in the body of disease causing organisms (HREOC 1994). |

The DDA extends protection from discrimination to associates including carers, friends, relatives and co-workers of people with disabilities if they are discriminated against because of the person’s disability (Sec.31). People are also protected against discrimination where they are accompanied by an assistant, interpreter, reader, trained animal such as a guide or hearing dog; or use equipment or an aid, such as a wheelchair or a hearing aid (Sec. 9).

Areas of discrimination

The DDA implicitly makes it unlawful to discriminate against people with disabilities in

the following areas of life (Sec. 3):

- Employment;
 - Education;
 - Access to premises used by the public;
 - Provision of goods, services and facilities;
 - Accommodation;
 - Buying land;
 - Activities of clubs and associations;
 - Sport; and
 - Administration of Commonwealth government laws and programs.
- (HREOC 1994)

The implications for tourism providers are that all areas of the DDA are equally applicable. As a service driven industry there are particular requirements to ensure access to goods, services and facilities and public places that make up the customer service provisions of the industry. Not to provide access to all aspects of service provision is disability discrimination under Section 4 of the DDA, this specifically includes recreation, entertainment, transport and travel. Providers of goods, services and facilities cannot discriminate against people with disabilities, which means they cannot:

- refuse to provide people with a disability with goods, services and facilities;
- provide goods, services and facilities on less favourable terms and conditions; and
- provide goods, services and facilities in an unfair manner (Sec. 4).

Premises and public places as areas of discrimination

To be able to access goods, services and facilities, people with disabilities have a right to be able to enter the premises of goods, services and facilities providers. Premises under Section 4 of the DDA are defined as:

- (a) a structure, building, aircraft, vehicle or vessel; and
- (b) a place (whether enclosed or built on or not); and
- (c) a part of premises (including premises of a kind referred to in paragraph (a) or (b)).

The DDA makes it unlawful for public places to be inaccessible to people with disabilities if the non-disabled can access these areas (HREOC 1994). Public areas are central to the components of citizenship that are seen as essential for any tourism experience. Further, the requirement for fair treatment before the law extends to employment within these areas. Thus, a person with a disability should be able to enter and use all places that the non-disabled use. The provisions for making these areas accessible are governed by the Building Codes of Australia (ABCB 1996b) and the referenced Australian Standards (Standards Australia 1992c; 1993; 1999; 2001). The DDA has no provisions for automatically retrofitting older facilities. This only occurs if a major redevelopment or a change of use is proposed under environmental planning legislation.

Reasonable adjustment and unjustifiable hardship

The concepts of *reasonable adjustment* and *unjustifiable hardship* are central to the interpretation of the DDA and the complaint process, which determines outcomes when discrimination has occurred. Reasonable adjustment is any form of assistance or adjustment that is deemed necessary, possible and reasonable to ensure access to premises, practices, working arrangements, work methods, equipment or the work environment (to reduce or eliminate the effects of disabilities). The philosophy of adjustments is to provide an equal opportunity for people with disabilities to participate in community activities. The degree of adjustment is based on a range of interpretations under Sections 6, indirect discrimination, and 5(2), different accommodation or services (HREOC 2001c). An example of reasonable adjustment in a HREOC case was where a blind man seeking employment was able to install screen reading software on the company computer. Prior to his seeking employment, the company had a policy that only company-approved software could be installed. The reasonable adjustment was to amend the policy to include screen reading software (HREOC 2000). In an employment situation the test becomes whether a person can fulfill the *inherent requirements* of the job (M Jones and Bassar Marks 1999:196).

While reasonable adjustment seeks to promote equitable access, unjustifiable hardship is used to protect organisations from having to make major changes that may have excessive costs and dire consequences to a person or organisation. There are a number of circumstances considered in making unjustifiable hardship judgements under Section 11 of the DDA. The major ones include:

- the nature of the benefit or detriment likely to accrue or be suffered by any persons concerned;
- the effect of the disability of a person concerned;
- the financial circumstances and the estimated amount of expenditure required to be made by the person claiming unjustifiable hardship;
- in the case of the provision of services or the making available of facilities - an action plan given to the Commission under Section 64 (HREOC 2001c).

In *Cooper & Ors v Holiday Coast Cinema Centres Pty Ltd* [1997 HREOCA 32], the cinema company had failed to provide access to a new cinema in Coffs Harbour, NSW. They were found to have discriminated against wheelchair users in not providing equitable access to the cinema and were ordered to remedy the situation. The company made an application for unjustifiable hardship but this was rejected based on the overall cost of the development and the company's financial position. The Coffs Harbour cinema is now

wheelchair accessible. Conversely, in *McLean v. Airlines of Tasmania Pty Ltd [1996 HREOC 77]*, it was found that it would be an unjustifiable hardship for the Airlines of Tasmania to provide a support person to assist McLean, a man with quadriplegia, due to safety and resource reasons. It was ruled that if McLean wished to travel on Airlines of Tasmania he would have to travel accompanied by a support person. These cases and others are discussed in depth later in Chapter 8.

Complaint cases, HREOC hearings and Federal Court procedures

Under Section 69 of the DDA, people with disabilities have the right of complaint when they believe they have been discriminated against. The power of the DDA is that it extends the pre-existing and complementary State legislation by allowing individual or representative complaints. Representative complaints are complaints that can be made by a representative on behalf of an individual or a group of people with the same grievance (HREOC 1994). Complaints have been lodged in a range of tourism and recreational contexts to challenge discriminatory practices. These provisions have given people with disabilities a voice to redress individual injustices. Yet, this system has problems as the onus is on the individual to make the complaint, complaints are confidential and, hence, do not have a common law basis (M. Jones and Bassar Marks 1999; Thornton 2000; Handley 2001).

Upon receipt of a complaint, the HREOC determines whether the complaint comes under the DDA. If it does, then HREOC appoints an investigation officer who firstly writes to obtain the other party's story. The investigation officer then determines whether a complaint is substantiated. If it cannot be substantiated, the complaint is denied and no further action is taken unless the complainant wishes to take the matter to the Federal Court (discussed later). This process deters ill-informed complaints. If it is substantiated, then HREOC seeks to conciliate an outcome between the two parties. The conciliation process is informal and confidential and while a solicitor is not needed, both parties may engage a solicitor, advocate, friend or organisation to represent their interests. Ninety-five percent of complaints brought to HREOC are dealt with through staff investigation and conciliation (Hastings 1995; 1997). While the conciliation process was initially regarded as a fairer system, there are questions as to the equality of bargaining power between the parties and the private nature of the outcomes (M. Jones and Bassar Marks 1999; Thornton 2000).

Depending on the nature of the complaint, conciliation may result in payment of damages, job reinstatement or job promotion, an apology, changes in policies or practices and/or some other outcome (HREOC 1994). If complaints cannot be resolved through conciliation then the person with a disability or their associate can ask for the complaint to go to a public hearing (pre 13 April 2000) or have the complaint heard by the Federal Court of Australia. The advantage of a Federal Court decision is that it is binding on the parties whereas a HREOC ruling is not (Hastings 1995). As Thornton (2000:16) argues, a weakness of the complaint system is the confidentiality of the process that individualises the outcomes rather than contributing towards the challenging of the social norms of discrimination through the public reporting of outcomes. *Brandy v HREOC* [1995 HCA PLPR 19] determined that it was unconstitutional for HREOC to formally hear complaints and make binding decisions. Therefore, all complaints requiring an enforceable, legally binding and public decision must be heard by the Federal Court of Australia.

The Federal Court is a cost jurisdiction and people with disabilities risk having costs awarded against them. This action has effectively eroded the powers of the DDA and changed the power relationship from a disability complainant perspective (Thornton 2000; Handley 2001). This process disadvantages people with disabilities in relation to the economic and legal power of the corporations they seek redress. It is argued that this was one of a number of attacks on the integrity of the DDA and HREOC over the late 1990s. This began with the loss of the Disability Discrimination Commissioner as well as major funding cuts (DJ Boniface 1997; Pengelly 1997; Lagan 1998). An analysis of the process, complaint conciliations, HREOC public hearings (pre 2000) and Federal Court judgments are presented in Chapters 8, 9 and 10 to provide an understanding of disability discrimination in a tourism context.

Other mechanisms under the DDA

Under the DDA, there are three other mechanisms that are utilised to supplement the complaint process, address underlying institutional inequalities in Australian society and promote fuller participation in the community by people with disabilities (M. Jones and Basser Marks 1999). These are for organisations to develop *Disability Action Plans* (DAPs), the provision for the Attorney General to develop *DDA Standards* and for HREOC to call public inquiries. Each of these is briefly reviewed below.

The provisions of the DDA relating to DAPs are outlined in Sections 59-65. DAPs seek to

provide a strategic approach to identifying disabling practices and environments within organisations and provide an outcome based framework for addressing these constraints. The development of DAPs is voluntary for government but the Commonwealth and some state governments made their development compulsory with lodgment of DAPs to have taken place by 1999. Few complied with this deadline and government at both levels did little to resource the relevant authorities to enforce this deadline. The development of a DAP is voluntary for local government and the private sector (Villamanta Publishing 1997). While few DAPs have been lodged by these sectors, those that do produce them show a strong commitment to corporate citizenship. The other legal advantage of developing DAPs is that they may be considered in defence of a complaint or High Court action. Some 180 DAPs have been lodged with HREOC and are available online (HREOC 2002a). HREOC has produced a range of guides for the development of DAPs for government and the private sector (HREOC 1995b; 1995a; 1995d; 1995c). Chapter 10 reviews DAPs from relevant government departments and tourism businesses.

Section 31 of the DDA provides the power for the Attorney General to instigate research for consultation concerning the development of DDA Standards. It was thought that DDA Standards would provide a higher level of certainty for developers and operators and, hence, reduce delays and costs that may arise from the complaints system (HREOC 1993). Since the inception of the DDA, four DDA Standards have been considered but only one has proceeded to authorisation by the Attorney General. A draft DDA Standards for education (CDEST 2001) is in the advanced stages of discussion and consultation. A Draft Standard for employment was prepared but is not proceeding towards authorisation because of a lack of stakeholder consensus regarding the *Regulatory Impact Statement* (HREOC 2001e). Originally, the DDA had no provision for DDA Standards for access to premises. However, the provision of such a standard has received support from all stakeholders and the DDA was subsequently amended to allow a standard for access to premises to proceed. The Australian Buildings Codes Board (ABCB) has released a discussion paper on the issues surrounding the standard, the BCA review, the AS1428 and other issues surrounding harmonising the BCA and the DDA (ABCB 2001b). The proposed DDA Standards for access to premises will proceed after the ABCB process is finalised. The DDA Standards for accessible public transport was authorised by the Attorney General in 2002 after over six years of negotiation (CAGD 2002b). The DDA Standards for accessible public transport, and the proposed DDA Standards for access to premises have a range of implications for tourism, and are analysed in Chapter 10.

Lastly, HREOC has the power under Section 67 of the DDA to call a public inquiry for matters or issues deemed to be a concern for people in the community. This power has been used only infrequently with inquiries into cinema captioning, mobile phones, e-commerce and accessible taxi transport in NSW. The report on the public inquiry into accessible taxis in NSW (HREOC 2002c) has implications for tourism, and is further analysed in Chapter 8. The complaint cases and Federal Court hearings also form part of the data to be analysed as discussed in Chapter 8.

Scope and Summary of DDA

As Table 2 shows, during 2000/2001 some 505 complaints were finalised with 181 complaints successfully conciliated and 259 complaints terminated. This means that 36% of all complaints made are conciliated or 75 percent of all complaints deemed discriminatory by HREOC are conciliated. Some of the complaint cases not conciliated may have proceeded to either HREOC inquiries (pre 2000) or Federal Court actions (post 2000 see *Brandy v HREOC [1995]*). The most common reason for termination of a complaint was that it was trivial or misconceived (22%) or that there was no reasonable chance of conciliation (15%).

Table 2: Disability Discrimination Act - outcomes of finalised complaints

Outcome of complaint cases	Total No. of Cases
Terminated	259
Not unlawful	27
More than 12 months old	9
Trivial, vexatious, frivolous, misconceived, lacking in substance	110
Adequately dealt with already	15
More appropriate remedy available	23
Subject matter of public importance	1
No reasonable prospect of conciliation	74
Withdrawn	43
Withdrawn, does not wish to pursue, advised Commission	41
Withdrawn, does not wish to pursue, settled outside Commission	2
Conciliated	181
Administrative closure*	22
TOTAL	505

Source: (HREOC 2001c) *Not an aggrieved party, state complaint previously lodged

The major areas of complaint cases were employment (43%), goods/services/facilities (27%), education (8%), and access to premises (7%). HREOC publish both a register of complaints (July 1998-Dec 2001) and a summary of selected conciliated complaints (HREOC 2002a). Only after a complaint was deemed to have grounds for investigation, and a settlement cannot be reached in a conciliation hearing does a complaint go to a HREOC public hearing (pre 13 April 2000) or a Federal Court action (after 13 April 2000).

In summary, government, TA and the TI have a legal responsibility under the DDA and other State based complementary legislation not to discriminate against people with disabilities. This involves access to premises, access to goods, services, and employment. Yet, this section has documented that the implementation of the DDA is complex and contested by the stakeholders.

C. Other relevant legislation and policy

The DDA works in conjunction with complementary existing State legislation. Each state has its own anti-discrimination legislation that addresses disability along with broader discrimination issues involving gender, age, ethnicity, race and religious freedom (Tiddy 2001a). In NSW (NSW), for example, the Anti-Discrimination Act, 1977 (NSW) has disability inclusions. The Disability Services Act, 1993 (NSW) followed the introduction of the DDA to provide the same level of assurance for people with disabilities to access for state disability services as was previously available at the Commonwealth level through the DSA. Further, the NSW State government has adopted a whole of government approach to disability through the Disability Policy Framework (NSW Government 1998) that coordinates and regulates the provision of specific disability services.

Provisions for the built environment are also regulated through each State's environmental planning and development legislation. For example, in NSW the major regulatory legislation includes the Local Government Act, 1993 (NSW) and the Environmental Planning and Assessment Act, 1979 (NSW). This legislation makes calls upon the Building Codes of Australia (ABCB 1996b) and references the relevant Australian Standards (Standards Australia 1992c; 1993; 1999; 2001). The HREOC, through the powers of the DDA, has added power to the anti-discrimination laws by providing a focus of action by people with disabilities seeking redress for disability discrimination (HREOC 1994; 2000). The DDA has provided a mechanism for people with disabilities to challenge access barriers. This has not been without controversy and the ABCB (1997a) and HREOC (1998) published discussion papers aimed at harmonising the DDA, the BCA and the Standards. The power of the DDA's jurisdiction over state planning mechanisms has been further reinforced through a number of court actions (Ozdowski 2001).

Access and universal design

Central to the legislation and the thesis is the concept of access. *Access* is defined on page

6 and the definition is inclusive of the physical, sensory and communication dimensions of access. Access involves more than isolated considerations of buildings and involves the relationship between the built and natural environment, and private and public spaces. It involves a continuity of journey within and between the tourism sectors and a continuity space at the destination. Considerations for access require the inclusion of all disability groups and dimensions of access. For example, Commonwealth Department of Family and Community Services (CDFACS) (1999a) defines the physical access needs of people with vision, hearing, cognitive, mobility and manipulative disabilities. The department states that each disability group has a variety of access considerations. The NSW Government (1998) identifies the dimensions of access that restrict citizenship as physical, sensory and communication. To illustrate this, the most common recognition of the need to access a building is provision for people who use wheelchairs (e.g. ramps and lifts). However, there are other disability groups who need access to the built environment. For example, a person who is blind or has a vision impairment requires a series of physical cues such as tactile titles, raised lettering on signage, audio cues on lifts or Braille information pamphlets to navigate around a building. A Deaf person needs a TTY to communicate with an organisation and flashing lights in an emergency as they cannot hear or may not be able to feel the vibration of a siren. Such universal provisions make the environment accessible to all people (Aslaksen *et al.* 1997; Preiser and Ostroff 2001). Without these provisions a building is not accessible and effectively restricts their citizenship.

Effective access for people with disabilities requires inclusive planning processes (OCA 1999), and the implementation of universal design principles (Aslaksen *et al.* 1997; Preiser and Ostroff 2001). Universal design is the design of products, services and environments to be usable by all people, to the greatest extent possible, without the need for specialised design (Aslaksen *et al.* 1997). By principle, universal design seeks to maximise citizenship through targeting people of all ages, sizes and abilities. Quite simply, the use of universal design principles is seen as a far more effective and efficient means to plan communities. A universal approach is very different to the *special needs* approach that has dominated disability and access provision in Australia. Special needs reinforce disability and access as *other*, separated from *normal* citizenship. Universal design has been suggested to improve the citizenship rights of people with disabilities (NAWG 1999).

The implications of the relevant disability and access legislation, policy and initiatives form part of the analysis of the experiences of people with disabilities in a tourism context

in Chapters 8 and 10.

D. Summary and limitations of human rights approaches

It might be thought that the human rights approach provides the *complete solution* to eliminating discrimination against people with disabilities - but it does not. Even human rights causes with the highest profiles often experience great difficulty in translating principles, and legislation, into practice. For example, the rights of women, ethnic minorities, indigenous peoples and gays and lesbians, all have longer histories of rights protection but all still struggle to have their rights protected in contemporary societies. As Harvey (2000:89-90) notes with the UN declarations, many signatory nations are in gross violation of the social and economic rights of their citizens. Sometimes the cause is active resistance by entrenched interest groups. Sometimes it is lack of political immediacy. Sometimes the cause is passive resistance brought about by social, political or environmental inertia based on years - even centuries - of 'doing it the way we have always done it'. Generally, it is a combination of these reasons. The human rights perspective brings this problem to the fore but does not assist in understanding it or necessarily overcoming it. The human rights approaches are implemented in nation states through legislation from a 'top down' approach onto entrenched social practices (Tiddy 2001a:4). The best that the human rights approach offers is legislation and mechanisms for enforcing it. However, understanding active or passive resistance to the provisions of the legislation itself requires additional perspectives.

2.4 Disability Statistics Collection in Australia

The Australian human rights framework is a response to the UN declarations and provides the mechanism to address disability discrimination. In a similar way, the most recent disability statistics collection in Australia (ABS 1998) was based on World Health Organisation (WHO) categorisations. To understand the statistics that are collected on disability in Australia it is important to understand the discourse, terminology and definitions on which these are based. Three main terms are used: impairment; disability; and handicap (1980-1996) or core activity restriction (1997-2001) (WHO 1980; 1997). These terms are now discussed.

The WHO defines impairment as 'any loss or abnormality of psychological, physiological

or anatomical structure or function’ (ABS 1998:68). For instance, the damage or lack of function of the spinal cord of someone with a spinal cord injury is an impairment. Whereas disability is defined as ‘any restriction or lack (resulting from an impairment) of ability to perform an action in a matter or within the range considered normal for a human being’ (ABS 1998:66). Table 3 identifies the ABS list of limitations, restrictions or impairments that define a person as having a disability that has ‘lasted, or is likely to last, for at least six months and restricts everyday activities’.

Table 3: ABS definition of disability

<ul style="list-style-type: none"> • loss of sight (not corrected by glasses or contact lenses); • speech difficulties; • chronic or recurrent pain or discomfort causing restriction; • difficulty learning or understanding; • difficulty gripping or holding things; • nervous or emotional condition causing restriction; • disfigurement or deformity; • long term effects of head injury, stroke or other brain damage; • any long term conditions resulting in a restriction. 	<ul style="list-style-type: none"> • loss of hearing where communication is restricted (aid or substitute used); • blackouts, fits or loss of consciousness; • shortness of breath or breathing difficulties causing restriction; • incomplete use of arms or fingers; • incomplete use of feet or legs; • restriction in physical activities or in doing physical work; • mental illness or condition requiring help; • receiving treatment or medication for any long term conditions or ailments; and
---	--

Source: ABS 1998:67

As is seen, the term *disability* incorporates a wide range of conditions. A person with spinal cord impairment is defined as having a disability because of the effects of the resulting spinal cord injury, for example, on the use of legs, feet, other muscles and bodily functioning. Therefore, a person with a spinal cord injury would be regarded as having multiple disabilities. These categories are further complicated through individual variation because of the level of disability, a person’s embodiment and a person’s ability to cope and the assistance available to them (McAuley 1993:1). Under this medical model, the nature of disability is individualised to functional ability. It, therefore, may be of greater importance to have an understanding of the needs created by the impairment. WHO caters for this by the term, *core activity restriction* (previously *handicap*).

A core activity restriction involve ‘fundamentally important activities underlying all aspects of everyday life’ (ABS 1998:3). These core activities are:

- self care - bathing or showering, dressing, eating, using the toilet and managing incontinence;
- mobility - moving around at home and away from home, getting into or out of a bed or chair; and using public transport; and

- communication - understanding others and being understood by others (ABS 1998:4).

The other activities of everyday life are health care, transport, paperwork, housework, property maintenance and meal preparation. A person is considered to have a core activity restriction if he/she requires help, has difficulty, or uses aids or equipment with any of the core activities of everyday life. In the ABS survey, if a restriction to these core activities was present, he/she was assessed on the level of assistance required. The level of assistance for the core activities was categorised as (from most to least):

- profound (always needs assistance to perform one or more core activities);
- severe (sometimes needs assistance to perform a core activity);
- moderate (no help but has difficulty performing a core activity); or
- mild (no help but an aid is used to help perform a core activity) (ABS 1998:4).

Under these definitions, a person may have a disability but may not have a core activity restriction. A person with a disability may or may not be restricted in performing the core activities of everyday life. These levels of assistance affect the provisions that a person requires to live independently.

Using spinal cord injury as an example, a person who has an incomplete spinal cord injury of the fifth cervical vertebrae (C5) may be classified as having a disability but has mild restrictions to core activities and lives fully independently. However, another person of the same impairment level with a complete spinal cord injury is classified as having profound restrictions to core activities and requires much higher levels of assistance with most aspects of self care and mobility but not communication.

Time has been taken to explain these definitions as they are at the heart of debate between the medical and social models discussed in Chapter 3. Further, it is these definitions that are used by the ABS (1998) to provide estimates of the numbers people with disabilities in Australia. To sum up, impairment is the resulting loss of anatomical, psychological or physiological function (e.g. spinal cord injury). Disability is any identified restriction or lack of ability to perform an action resulting from the impairment (e.g. use of legs). A core activity restriction is a limitation to perform certain tasks associated with everyday life (e.g. mobility/walking).

A. *International Classification of Functioning, Disability and Health (ICIDH-2)*

WHO have revised the classification system over the 1990s to bridge the gap between the medical and social models (WHO 2001). Through the development of a universal biopsychosocial classification, they have sought to establish a common language for the area, to provide a scientific basis for comparative data collection and provide a systematic coding scheme for health information systems. The ICIDH-2 relates to '*Health Domains and Health-related Domains*' (WHO 2001:1) with the classifications changed to '*Body Function/Structure, Activities and Participation*'. While the definition and understanding of body function/structure remains the same as for impairment in ICIDH (WHO 1980; 1997), the additions of '*Activities and Participation*' include personal and environmental contextual factors (WHO 2001:9). The term *health conditions* then serves as an umbrella for impairments, activity limitations or participation restrictions and, hence, replaces disability conditions. WHO hope that this new classification system provides a unified and standard language and framework to be inclusive of the personal and environmental conceptualisations of disability.

It is argued by Bickenbach, Chatterji, Badley, and Ustun (1999) that ICIDH-2 presents a universal approach that may overcome the weaknesses of the earlier ICIDH (1980; 1997) and the criticisms it received from the disability movement that supports a social approach to disability (discussed in Chapter 3). Universalism views disability as part of human diversity, part of the continuum of humanity (Zola 1989; Bickenbach et al. 1999). Bickenbach et al. argue that this system offers a way to operationalise the concepts to produce some substantive research about the social phenomenon of disability which, they argue, the social approaches to disability have failed to produce. While there is potential for the operationalisation of these terms, ICIDH-2 has not been without criticism (Miles 2001; Pfieffer 2001). As Miles (2001) suggests, the exercise has done little to change the fundamental premise of the classification system. This is witnessed by the acronym ICIDH-2 while the name has changed to reflect, '*Impairments, Activities and Participation*'. As Miles notes, this is a signifier of WHO and the ICIDH-2 origins and continues the focus on the health and health-related domains where it,

...systematically groups different domains for a person in a given health condition (e.g. what a person with a disease or disorder does do or can do). It is one of the 'family' of WHO classifications, which provide the language to code a wide range of information about health.

In support of Miles' (2000) belief that WHO (2001) did little to change the medical based

approach, Wen and Fortune (1999) for the Australian Institute of Health and Welfare defined disability as ‘an umbrella term meaning *negative experience* (emphasis added) in any one or more of the draft ICIDH-2 dimensions (e.g. an impairment, activity limitation or participation restriction)’ (Wen and Fortune 1999:xv). This definition also falls into the medical model of disability that sees the cause of disability as the impaired body and, hence, any resulting ‘negative experience’ as a cause of the impaired body. Whether Bickenbach et al. (1999) or Miles (2001) is correct will only be known with future national data collection and research frameworks. This was outside of the scope of this thesis where the previous WHO (1980; 1997) classification systems were used for the Australian data collection. The ICIDH-2 may provide direction for the conclusions of the thesis. The ABS disability sources are now reviewed below.

B. Disability in Australia

In 1998 an estimated 3.6 million persons or 19.3 percent of the Australian population were classified as having a disability that affected their activities of everyday living. As Table 4 shows, disability increased as a proportion of the population from 1981-1998. Another 3.1 million persons had an impairment that had no impact on their everyday activities. However, the ABS notes that this group is likely to experience increased difficulties with activities of everyday living in the future.

Table 4: Numbers of people with disabilities in Australia, 1981-1998

Year	No. of persons	% of population	% severe restrictions
1981	1.9 million	13.2	3.5
1988	2.6 million	15.8	4.0
1993	3.2 million	18.0	4.1
1998	3.6 million	19.3	6.1

(Source: ABS 1981; 1988; 1993; 1998; E. Davis *et al.* 2001)

While the overall disability rate has been increasing slowly, the level of people with *severe restrictions* has had a much faster rate of growth. The reasons for this are not clear but it is an important public policy issue that the ABS is investigating further (E. Davis *et al.* 2001). As noted in the introduction, there is also a significant relationship between ageing and disability. It should be noted that the Australian disability levels are among the highest rates in the world. Very few nations have undertaken a census or survey work to determine the prevalence of disability in the community. Appendix 8 draws together the disparate sources on prevalence of disability and presents a summary of the known disability rates and the estimation of the numbers of people with disabilities in each identified country.

The average disability rate is 10%. In reviewing the disability rates, it should be noted that all countries use different methodologies, definitional constructs and operationalisation of disability. Further issues involve the difference between Western and Asian cultural attitudes towards disability (Miles 1982; 1996; 2000), geographic issues about the prevalence of disability in rural/urban areas and the prevalence of programs to prevent disability. Appendix 8 supports Charlton's (1998) estimate that there are 500 million people with disabilities living in the world today.

Table 5 lists disability by main *condition* in Australia. Some, 85 percent of all people with disabilities have physical *conditions* with the remainder having psychological *conditions*.

Table 5: Disability by main condition, Australia, 1998

Disability by type of impairment	'000	% of all disability
<i>Physical Conditions</i>		
Cancer/lymphoma/leukemia	60.0	1.7
Endocrine/nutritional/metabolic	81.5	2.3
Nervous system	180.7	5.0
Eye or Adnexa	112.8	3.1
Hearing	280.7	7.8
Circulatory	312.2	8.6
Respiratory	259.7	7.2
Digestive	68.2	1.9
Musculo-skeletal/connective tissue	1240.2	34.4
Congenital/perinatal	44.5	1.2
Injury/poisoning/other external	245.7	6.8
Other	194.7	5.4
<i>Sub Total</i>	<i>3081.1</i>	<i>85.3</i>
<i>Mental and Behavioral</i>		
Psychoses/mood affective	149.6	4.1
Neurotic/stress related	116.9	3.2
Intellectual/developmental	157.3	4.4
Other	105.3	2.9
<i>Sub Total</i>	<i>529.2</i>	<i>14.7</i>
Total	3610.3	100.0
(Source: ABS 1998:4 & 23)		

Of those people with disabilities, 2.8m or 15 percent of the Australian population are classified as having a core activity restriction. Core activity restriction affects the access needs of the individual. The degrees of core and specific activity restriction of the population are presented in Table 6.

Table 6: Disability by degree and type of core restriction, Australia 1998

Restriction	Population Estimate	Percent of Pop %
Support Status		
Profound	537,700	2.9
Severe	598,200	3.2
Moderate	660,300	3.5
Mild	1,031,800	5.5
Core Restriction		
Self care	514,400	2.8
Mobility	723,100	3.9
Communication	167,300	0.9
School/Employment	1,660,400	8.9
All Specific Restriction	3,155,900	16.9
All with Disability	3,610,300	19.3
Total Pop	18,660,600	100.0

Source: ABS (1998:14 and 25)

Significant numbers of the Australian population have disabilities that affect their ability to perform the core activities of everyday life. A further 3.1 million Australians have impairments that do not currently affect activities of everyday life but may do so in the future.

C. Summary of disability statistics collection in Australia

In summary, this section has reviewed the major terminology used by the WHO and, hence, the results of ABS statistical collection in Australia. This medicalised approach to disability has been viewed as contentious because it is based on the concept of *normality* and the definition of disability as being *abnormal*. As Chadwick (1994) argues, what constitutes ‘normality’ is not an objective measure but a subjective term open to social relations and cultural interpretation. This renders invalid assumptions underlying the medical model that impairment, disability and handicap are objective ‘scientific’ concepts. As Charlton (1998) states, there are 500 million disabled people in the world and he contends that disability is part of what is ‘considered normal for a human being’ as it is a representation of the diversity of human embodiment. These issues are central to the first articulation of a social approach to disability, and the difference in the definition of impairment and disability from the medical perspective. Further, as Barnes (1998:65) notes, these statistics produced by government refute ‘the idea that disability is a medical problem affecting a small proportion of the population’.

2.5 Ending

This chapter has provided two interrelated components to understanding disability in

Australia. Firstly, it has provided a *theoretical* backdrop to human rights and disability statistics collection in Australia. The human rights perspective is a set of ethical ideas that are internationally endorsed. The UN declarations are operationalised by some signatory governments. By their nature, human rights declarations and legislation tend to be ‘top down’ and imposed upon individuals and structures within the country of adoption. In Australia, the Commonwealth government’s international UN human rights obligations are enforced through the DDA. In general, these provisions should ensure the citizenship of people with disabilities in Australia, and this includes the right to tourism. The broad responsibilities of the DDA affect the government, TA and all businesses within the TI. This governmental regulatory activity should be effective in achieving equality of access but in practice, there are many failures where the legislative recognition of disadvantage has not been effective in bringing about social change. In respect to disability and tourism, there is a need to explore the *practice* to find where the sticking points occur with the implementation of the DDA.

Generally, if countries have legislation and policy on disability they develop statistics on the nature and scale of the phenomenon. If statistics are to be collected experts must be sought out to prepare definitions and taxonomies, and those experts have particular outlooks. In the case of the ABS, they based their data collection on the WHO ICIDH (1980; 1997). The WHO taxonomies are based on a medical approach to disability. Thus, two sets of theory underpin the legislation and available statistics on the phenomenon – human rights underpins the legislation while a medical approach to disability underpins the statistics. The human rights and the medical model worldview provide different responses to disability. Chapter 3 reviews the medical model of disability before examining the social model of disability.

Secondly, this chapter has provided an overview of relevant disability policy and legislation at a Commonwealth level. This background is drawn on in this thesis to develop an explanation for the experiences of people with disabilities through an Australian structural-historical context. In particular, the DDA complaint cases, Federal Court hearings and the DDA Standards form part of the data analysed in seeking to unravel the complex social relations that affect the experiences of people with disabilities. The remainder of the chapter reviewed the central role of terminology in developing an understanding of disability. A great deal of the Australian government’s approach to disability is founded upon the WHO classification systems for health and health-related

domains. The terms *impairment*, *disability* and *core activity restriction* underpin statistical data collection by the ABS. The WHO and ABS instruments strongly influence social responses to disability.

3 DISABILITY MODELS AND DISCOURSES

3.1 Introduction

This chapter reviews the contemporary models and discourses of disability to provide a theoretical base on which to understand tourism from a disability perspective. Firstly, it chronologically reviews the most influential models of disability and their contribution to conceptualising disability. Secondly, it provides a detailed examination of the medical model of disability introduced in Chapter 2 through the WHO definitions and ABS disability statistics. This serves as a precursor to understanding the polemic surrounding the medical model from a disability perspective. Thirdly, the chapter discusses two social approaches to disability and extends this discussion by examining the importance of the organisation of space in a tourism context. Finally, a number of weaknesses to the social approaches to disability are examined.

3.2 An Introduction to Disability Studies

Historically, people with disabilities have been treated vastly differently by societies throughout history (Mitchell and Snyder 1997; Longmore and Umansky 2001). Further, as Gleeson (1998) notes, the treatment of people with disabilities has differed from society to society within the same historical periods. Modern conceptualisations of disability developed through the involvement of Western medical professions during the 20th century, particularly with the medical advances during and after the two world wars. The theoretical models about disability came from the disciplinary backgrounds of medicine, psychology and social psychology. These disciplinary perspectives viewed disability as a problem residing with the individual. This was not surprising as these disciplines viewed people with disabilities largely as subjects of study, a process which involved little or no consultative process for the incorporation of the perspectives of people with disabilities themselves. The perspectives of people with disabilities were not understood, considered or valued and, hence, they were outsiders to the research process (Barnes and Mercer 1997).

From the 1970s a number of social approaches to disability theory developed that has become known as disability studies. Pfeffer (2001:29) offers a definition of disability studies as, ‘... the field which examines the experience of being disabled and the lives of

people with disabilities'. The models, paradigms and conceptualisations of disability have been reviewed by a number of writers and Table 7 provides a summary of these reviews and the basic features they attribute to the various models.

Table 7: Reviews of models of disability

Source	Models	Basic Understanding
Hahn (1986)	<ul style="list-style-type: none"> • Medical • Economic • Minority 	<ul style="list-style-type: none"> • Disability as functional loss • Disability as a socioeconomic issue (work) • Disability as oppressed minority
Oliver (1990; 1996)	<ul style="list-style-type: none"> • Individual (medical) • Social 	<ul style="list-style-type: none"> • Disability as functional loss • Disability as product of disabling environment
Bickenbach (1993)	<ul style="list-style-type: none"> • Biomedical • Economic • Minority 	<ul style="list-style-type: none"> • Disability as functional loss • Disability as a socioeconomic issue (work) • Disability as oppressed minority
Priestley (1998)	<ul style="list-style-type: none"> • Individual materialist (medical) • Individual idealist • Social materialist • Social idealist (constructionist) 	<ul style="list-style-type: none"> • Disability as functional loss • Disability as stigma (disabled/non-disabled) • Disability as product of disabling environment • Disability as cultural representation
Gleeson (1999b)	<ul style="list-style-type: none"> • Medical • Structuralist view • Idealism • Normalization • Historical materialist 	<ul style="list-style-type: none"> • Disability as functional loss • Disability as a socioeconomic issue (work) • Disability as stigma (disabled/non-disabled) roles • Disability as product of disabling environment
Pfieffer (2001)	<ul style="list-style-type: none"> • Old paradigm (medical) • Social constructionist • Social • Impairment • Oppressed minority • Independent living • Cultural studies • Continuum • Universal • Disability as discrimination 	<ul style="list-style-type: none"> • Disability as functional loss (disabled) • Disability as product of disabling environment • Impairment as the distinguishing difference • Disability as oppressed minority • Advocacy to remove barriers for independence • Disability as cultural representation • Many representations of disability on a continuum • Disability as part of human diversity • Disability as a form of discrimination

These reviews chart the overwhelming dominance of the medical model in influencing domain assumptions about disability held by society. The social approaches described in the reviews are critiques of the individualised medical model that permeates institutional practices and, in particular, informs government legislation and policy. The emergence of social approaches to disability emanate from the experience of people with disabilities themselves and provide a framework to understand these experiences from the disability perspective. It is not practical in this thesis to provide an extensive examination of social approaches to disability. However, several of these social approaches offer a framework for developing explanations for the tourism constraints of people with disabilities.

The main social approaches to disability can be summarised as individual idealist, social model and cultural representation. While cultural representations of disability are of major interest to many academics, and clearly affect public perceptions, attitudes and priorities, in the case of this study a more specific focus has been made on the tension between

medical and social models of disability. Recognition of the core discourses of the tourism environment in Chapter 4 points to the critical role played by these two discourses. While they may be further illuminated by a cultural exploration, such an additional investigation would divert the focus needed to effectively examine the medical and social modalities. As will become evident, it is these competing modalities that influence and structure the majority of the decision-making frameworks for government and industry planners, suggesting that cultural representation sits to one side of this critical point. This in itself would become a focus of further research.

The remainder of the chapter firstly reviews the medical model of disability as the dominant paradigm for conceptualising disability. This chapter then examines the major social approaches of individual idealism and the social model. A critique of these models is provided before the chapter concludes with a discussion of the conceptual basis for developing a framework for analysis for the thesis.

3.3 Medical Model of Disability

The *medical or individual model* of disability is not so much a model but a cultural imperative that has permeated society over the last two centuries (Barnes, Mercer and Shakespeare 1999b). In particular, the medical advances since World War II have improved the life expectancy of many people with impairments who would previously have died. The medical model became the accepted paradigm amongst those groups historically working with people with disabilities, including the medical profession, therapists, social workers and, more lately, the care workers. The dominance of the medical model is still evident throughout the Western world and its underlying definitional basis needs to be understood to comprehend the historical development of policy and, hence, community attitudes. As Oliver (1996) discusses, he does not believe there is a 'medical model' but a series of discourses that individualise disability. However, the term *medical model* has become the accepted term used in disability studies to describe and critique individualised accounts of disability.

The origin of the medical model can be found in medical studies that focus on disease as abnormal biophysical condition (Barnes et al. 1999b). This work was supplemented by studies by medical sociologists that focused on the social meaning of the *sick role* first outlined by Parsons (1951). Sickness poses a threat to the performance of *normal* activities

and people ascribed a *sick role* are temporarily excused from social obligations but must follow the directions of medical professionals to become well. However, people with long term illness and disability did not fit this role as they did not get well. They became regarded by society as deviant because of their disability and their inability to perform *normal* social functions. This has been described as the medical model's individualised account of disability. Oliver (1996:32) in his summary of the two components of the medical model argues that it:

Firstly locates the 'problem' of disability within the individual and secondly sees the causes of this problem as stemming from the functional limitations or psychological losses which are assumed to arise from disability. These two points are underpinned by what might be called 'the personal tragedy theory of disability' which suggests that disability is some terrible chance event which occurs at random to unfortunate individuals.

In this quote, Oliver (1996) identifies the two components of the medical model. The first located the *problem* of disability within the individual as their 'fault', and the second sees the *cause* of the problem as emanating from the functional/psychological losses supposedly arising from the *disability*. These points are founded on the 'personal tragedy theory of disability' (Oliver 1996:31), that disability is a terrible, randomly occurring event that strikes unfortunate individuals. It is this premise that sees medical intervention through treatment and rehabilitation as attempting to *normalise* disabled people.

Central to this is the paternalistic attitude of these groups towards disabled people. The paternalism manifests itself in the disabled person as *subject*, not worthy of consultation or, at times, even basic communication. The professions know best and are able to prescribe treatment and interventions to *normalise* the disabled person. The premise of what constituted normality is based upon a range of assumptions about humanity that are not articulated by the professions involved (Charlton 1998; Linton 1998). The professions believe that they know what is best for people with disabilities. The post World War II advances in medical techniques increased the lifespan of individuals who previously would not have survived. However, at the same time they provided a conundrum for these professions who were unable to *normalise* the effects of the impairments.

Finkelstein (1993) discusses the disabling effects of the rehabilitation process whose primary focus sought to normalise people with spinal cord injury by trying to make them walk again. Yet permanent impairment is unlike a curable illness, and the medical professions were unprepared for impairments that could not be normalised. People with disabilities were made to feel at fault for their impaired bodies. There is undoubted need

for medical intervention to stabilise the medical complications of congenital or traumatically acquired impairment. However, the rehabilitation process does require the medical professions to have an understanding of an impaired person's right to determine their future after being consulted and provided with information on which to make informed choices².

With the advancement in medical technology, more people with severe traumatic injuries and congenital impairments were able to live with what were once considered fatal conditions (Oliver 1990). The subsequent growth of other therapies surrounding the rehabilitation process brought a new group of professionals into contact with disabled people. These new groups worked closely with, and were advocates of, the medical system that sought to return these people to normality. Over time it has been argued that such intervention in people's lives by the caring professions brought about 'disempowerment, marginalisation and dependency' (Barton 1994:15) of the people they sought to help. The development of social services and the caring professions has done little to change the situation where the underlying philosophy meant 'taking responsibility for them, taking charge of them' (Morris 1993 cited in Barton 1994). In the Australian context, these issues are at the forefront of the agenda of disability advocacy groups where issues like the inflexibility of attendant care provision by government are still regarded as disempowering (PDCN 2002). These medicalised approaches to disability have permeated society and, hence, other professionals attitudes towards disability. *Professional cultures* affect what is produced and, hence, how appropriate these goods and services are for people with disabilities (Barnes et al., 1999:56; Lawton, 1993:180). The study of professional cultures also involves the study of power in the relationships that professionals have with those who they are dealing with and the environments, goods and services that they produce (T.J. Johnson 1972; Clegg 1989).

Summary

The medical model locates the disadvantage that people with disabilities face within the individual's physiological or psychological loss - their 'personal tragedy' and the fault of the individual. People operating within the medical model view disability as a product of the abnormal embodiment, rather than seeing impairment as part of human diversity. The

² These issues were recently debated in NSW with the organisation of the Premier's Making Connections Spinal Cord Forum that hosted Christopher Reeve. When originally announced the forum was to focus on the cure for spinal cord injury through the hope of stem cell research. However, after lobbying by local disability activists the forum was broadened to look at quality of life issues for living with spinal cord injury (Darcy 2003a)

medical model viewed people with disabilities' restrictions as resulting from their physiological or psychological loss. The medical model, in conceptualising disability as the individual's *personal tragedy*, regards people with disabilities as victims of circumstance of a medical problem to be dealt with in context of the acquired impairment and disability as the resulting functional losses. This creates a discourse where people with disabilities are blamed for their deviation from *normal* functioning and professional responses do not extend beyond treatment to normalise. This discourse regards able-bodiedness as a social norm and, hence, excludes people with impairments from citizenship. This exclusion is reinforced through the bureaucratisation of medicine, nationally and internationally, which required medically defined statistical information. The terminology used by the medical model of impairment, disability and core activity restriction (see Section 2.5) reflects the difference between the medical and social approaches. The medical model can be regarded as a discourse of attitudes, terminology and ways of operating which has dominated society's domain assumptions about disability.

3.4 Individual Idealism

This section reviews individual idealism, and the subsequent developments of normalization and social role valorization. Individual idealism developed from social psychology (Muloin 1999). It stems from the philosophy that social practices are largely the product of attitudes and beliefs. These attitudes and beliefs are developed through interactions between individuals in society and the experiences that result (Antonak and Livneh 2000). These experiences are anchored in a dualistic paradigm of normal/abnormal as opposed to *difference* signified by disability. Hence, disability is a product of society's negative attitudes towards the *difference* of impaired bodies (Fine and Asch 1988). These negative attitudes are communicated between parties in society and impact on not only how society views disability but also how disabled people perceive themselves within society through their interactions.

Goffman (1963) presents an interactionist's explanation of a disabled personality being formed through *stigmatised* social interactions. Within these interactions, Goffman views society as depicting 'physical deformities' (in which disability is categorised), 'blemishes of individual character' or 'tribal stigma of race, nation and religion' as having a negative 'stigma', that is, a socially undesirable attribute (Goffman 1963:205). Stigmata evolve during ritualistic interactions between parties where individuals become aware of their

stigmatised identity and, hence, position in society. This ‘undesired differentness’ sets an individual apart from ‘the normal’. The outcome is a ‘stigmatised personality’ brought about by a multitude of stigmatising encounters. The oppression of the disabled person in this case is both psychological (impact on the individual’s psychology) and social (how the individual interacts with, and is reacted to, in social situations). As Goffman states:

The term stigma, then, is used to refer to an attribute that is deeply discrediting... By definition, of course, we believe the person with a stigma is not quite human. On this assumption we exercise varieties of discrimination, through which we effectively, if often unthinkingly, reduce his life chances. We construct a stigma-theory, an ideology to explain his inferiority and account for the danger he represents, sometimes rationalizing an animosity based on other differences, such as those of social class. We use specific stigma terms such as cripple, bastard, moron in our daily discourse as a source of metaphor and imagery, typically without giving thought to the original meaning (Goffman 1963: 205).

As Barton (1994:11) observes, most disabled people have been subject to offensive responses stemming from negative stigma such as ‘horror, fear, anxiety, hostility, distrust, pity, over-protection and patronising behaviour’. An ‘innocent’ expression of these attitudes is seen in the derogatory labels that are learned by school children at a young age. To be called a ‘spastic, retard or a cripple’ is to be devalued and be regarded as less than ‘normal’. These terms draw heavily from the medicalisation of disability where the associated functional loss is connected with the attitudinal devaluing of disabled people. As Barton (1994) points out, these disablist stereotypes are often reinforced through the campaigns of charity and service organisations: non-disabled professionals schooled in the medical model dominate these organisations and perpetuate these stereotypes for fundraising purposes³. Frohmader (1999) and Meekosha (1999a) document the resultant tragedy of these negative attitudes manifested in human rights abuses of people with disabilities in Australia generally and of women with disabilities specifically.

Interactionist accounts of disability rely heavily on describing stigma with little explanation of how or why the stigma was produced. As Fine and Asch (1988:9) argue, ‘Disability is portrayed as the variable that predicts the outcome of social interaction when, in fact, social contexts shape the meaning of a disability in a person’s life’. Advocates of the individual idealism model point to the importance of educating society about disability in order to change attitudes and, hence, remove the negative attributes of the stigma. This is also the weakness of the model in that it does not incorporate an understanding of how negative stigmas are produced (Abberley 1987). Hence, interactionists do not offer

³ An example of these in NSW is the ‘Spastic Centre of NSW’ which retained its name rather than using the title it is incorporated as - the Cerebral Palsy Association of NSW

solutions to overcoming the way society oppresses disabled people (physical, economic and political). Shakespeare (1994) as well as supporting the point that the model offers no explanation of how these attitudes are formed, argues the model also lacks recognition of cultural differences in attitudes towards disability.

Antonak and Livneh (2000) note that the literature on attitudes towards people with disabilities suggests an attitude/behaviour inconsistency exists where awareness raising may change behaviour. Yet, to believe that behaviour could be changed solely by attitude change would be naïve. From a disability perspective, whether attitude changes or not, it is the change in behaviour that brings about improved social conditions. Another significant reason for behaviour change is found in the fear of the sanctions or repercussions that the human rights legislation has provided. Fishbein and Ajzen (1975) conclude that it may be impossible to change a person's attitude towards disability but it may be possible to change their behaviour with appropriate interventions or incentives.

Normalization and social role valorization

Most critics highlight that the individual social idealism assumes that disabled people need to conform to what society believes to be *normal*. Yet, little in the way of explanation of what is *normal* is discussed. An extension of this point, and of the individual idealist model generally, is *normalization*. Normalization was first put forward by Nirje (1969), Wolfensberger and Nirje (1972) and was later developed into *Social Role Valorization* (SRV) by Wolfensberger (1983). Normalization and SRV have had, and continue to have, a major impact in the human services area and on disabled people in particular. The major goal of normalization is the:

...creation, support, and defense of **valued social roles** for people who are at risk of social devaluation. All other elements and objectives of the theory are really subservient to this end, because if a person's social role were a socially valued one, then other desirable things would be accorded to that person almost automatically, at least within the resources and norms of his/her society (Wolfensberger 1983:234).

Wolfensberger (1983:235) argued that a person becomes *devalued* or *deviant* 'when they are not seen as having valued social roles'. Three consequences arise from this situation: 1. the devalued person is badly treated; 2. this bad treatment will take forms that express the devalued social role; and 3. how the person is perceived and treated will determine how the person behaves (e.g. a person treated as a criminal, will act as a criminal). In connecting normalization to idealism, Wolfensberger goes as far as referring to the perception of devalued social roles and the subsequent 'bad treatment' as the stigmata.

As with idealism generally, the point of contention for disabled people is what Wolfensberger identified as *valued social roles*. The underlying assumption of the theory is that the disabled person has a deficiency, abnormality or deviancy when compared to the *normality* of the rest of society. The theory supports a homogeneous society rather than recognising and valuing *difference*. In principle, the theory does not challenge the social world but does insist that wider social values need to be changed through community education. However, disabled people should also be helped to become as near to the norm of social behaviour as possible, resulting in them becoming non-resistant and socially passive.

Summary

In summary, the individual idealist model stresses the importance of recognising the role that attitudes, beliefs and the identity of normality have in understanding societal response to disability. Those who are different from the social norm are devalued and stigmatised. The response of the individual idealists is to affect change of people with disabilities, to normalise them, to better fit in with society's view of what is *normal*. The individual idealist analysis of disability relies on attitudes, beliefs and identities.

3.5 Social Model

During the 1970s disabled people began to 'find their own voice' (Barton 1994) and claim their right to speak and represent themselves in response to the dominance of the scientific medical model and idealist accounts of disability. With the emergence of the disability rights movement in the 1970s, disabled people re-conceptualised disability from a 'personal tragedy' that is the fault of the individual to a complex form of social oppression (Abberley 1987; Oliver 1990; Barnes 1991; Oliver 1996). The social model was developed largely in Britain (Union of Physically Impaired Against Segregation (UPIAS) 1975; Finkelstein 1980; Abberley 1987; Barton 1989; Oliver 1990; Barnes 1991; Shakespeare 1994) and emphasised the *disabling social environment* and prevailing *hostile social attitudes* rather than the individual and their impairment (Barnes 1996:43). While this last point suggests that the social model drew on an idealist account of disability, the *hostile social attitudes* were regarded as a product of social structures rather than a product of negative stigmas.

The social model draws its source from the document *Fundamental Principles of Disability* (UPIAS 1975). This document was the outcome of discussions between the UPIAS and the Disability Alliance, two organisations representing disability interests in the UK. As Oliver (1996:20) notes, the meeting was brought about due to fundamental differences between the UPIAS, a small organisation of disabled people, and the Disability Alliance, whose membership was dominated by established disability service organisations⁴. UPIAS (1975) succinctly identified the definitional separation between impairment and disability where:

In our view, it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society. Disabled people are therefore an oppressed group in society. To understand this it is necessary to grasp the distinction between the physical impairment and the social situation, called 'disability', of people with such impairment. Thus we define impairment as lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body; and disability as the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities. Physical disability is therefore a particular form of social oppression (UPIAS 1976:14).

The social model, while not denying an individual's impairment, states that the resulting disabilities are imposed on top of a person's impairment due to the way society is organised. Disability is the product of social relations that produce *disabling barriers* and *hostile social attitudes* that exclude or segregate people with disabilities from mainstream social participation. In essence, the social model defines disability as a social relationship. It firmly places disability on the social, economic and political agendas rather than locating it as the result of an individual's embodiment. This approach to disability separates the impairment from the social relationship of disability (Swain et al. 1993; Finkelstein 1993; Oliver 1990; 1996). Thus, the individual's body is not the cause of the person's problem: it is the oppressive social conditions that produce disability. As Barton (1998:56-57) states:

...to be a disabled person means to be discriminated against. It involves social isolation and restriction. This is because of an essentially inaccessible socio-economic and physical world (Finkelstein, 1994). Disability is thus a significant means of social differentiation: the level of esteem and social standing of disabled people are derived from their position in relation to the wider social conditions and relations of a given society. Particular institutions have a crucial influence on social status including the level and nature of employment, education and economic well-being.

⁴ This situation was paralleled in Australia where the formation of advocacy groups led by people with disabilities was brought about because of the lack of representation of the disability experience within impairment-based service organisations (Way 2002). Traditionally the service organisations were the voice of the disability industry and were dominated by medical, rehab or welfare professions. These organisations did not advocate for the position of people with disabilities but the interests of the organisations from the medically dominated discourse (Way 2002).

The social model challenges the foundation upon which the medical model is based. The model recognises that the *normal activities and roles* of the medical model take place within the social world, and that social relations affect an impaired person's ability to undertake the activities and roles. Charlton (1998) argues that impaired people are part of greater human diversity as evidenced by the estimated 500 million people with disabilities living in the world today. Impairment is essentially different to illness or sickness, since most people with disabilities live their lives outside of medical institutions and have periodic medical intervention when required. As Barnes (1998:65) notes, and as discussed in Chapter 2, national statistics produced by government on the prevalence of disability in the community refute 'The idea that disability is a medical problem affecting a small proportion of the population'.

Conceptualisations of *normalcy* have been at the forefront of debate within disability studies. As Chadwick (1994) and Shogan (1998) argue normalcy is not an objective *scientific construct* but a subjective term open to social construction and cultural interpretation. They challenge the underlying assumption of the medical model that impairment, disability and handicap are objective scientific concepts. The social model challenges the individualistic, normative value systems that have dominated social policy formation, implementation and evaluation.

The prevalence of these normative value systems, it is argued, have affected all areas of policy and brought about the *oppression* of people with disabilities. Oppression occurs when individuals are systematically subjected to political, economic, cultural or social degradation because they belong to a particular social group. Charlton (1998:8) believes that the oppression of people and groups of people results from structures of domination and subordination and, correspondingly, ideologies of superiority and inferiority. As Gleeson (1999:13) notes, society has in the past changed its attitude towards the institutional oppression of other groups in society such as women and indigenous groups, 'whilst continuing to ignore the material hardships and injustices to which they are subjected'. He goes on to argue that actions to redress discrimination must go beyond the attitude change that has characterised social idealist models and disability rights legislation by focusing on redistribution of resources to accomplish this.

To achieve this Finkelstein (1995) suggests that the social model takes direction from three elements:

- the lived experiences of disabled people;
- identification of disability as the combination of impairment and socially constructed barriers; and
- a conceptual clarification that facilitates a scientific attack on the barriers that oppress disabled people and therefore lead to their impoverishment and social dysfunction.

Unlike the previous models discussed, the social model begins with the lived experiences of the group. From these experiences, the socially constructed barriers are identified and, importantly, the model directs *scientific* attention onto the *disabling barriers and hostile attitudes* as a beginning to create *enabling environments* (Swain et al. 1993). It is these *disabling barriers* that are the site of oppression for, and which actively produce, *disabled* people. As Shakespeare (1993:253) notes, the social model refutes the label of victim, ‘instead focusing attention on the structural causes of victimisation. It is about the subversion of stigma: taking a negative appellation and converting it to a badge of pride’. As Abberley (1987:6) argues, the addition of oppression to the social model ‘is clearly an advance on the “personal tragedy theory of disability” and directly linked to the social relations under capitalism’.

In sociological terms, this view of disability constructed by an ableist hegemony has similarities to the view of the oppression of women, indigenous people, ethnic minorities, and gays and lesbians as constructed by a patriarchal, white, heterosexual hegemony (Barnes 1991; Morris 1991; Crow 1992; Barnes et al. 1999b). In all cases, the focus is on the ‘problem’ individual as child bearing, unproductive, lazy, deviant, or ill (Linton 1998). The social model challenges the individualistic, normative value systems that have dominated social policy formation, implementation and evaluation. However, as Abberley points out in discussing oppression as a general concept:

A crucial feature of oppression and the way it operates is its specificity, of form, content and location; so to analyse the oppression of disabled people involves pointing out the essential differences between their lives and those of other sections of society, including those who are, in other ways, oppressed (1987:7).

The hardships experienced by people with disabilities are central to the social model as the empirical evidence of *oppression*. Charlton (1998:8) argues that the oppression of people and groups of people results from structures of domination and subordination and, correspondingly, ideologies of superiority and inferiority. The constructions of *normalcy* and, hence, ableist discourses are about ideologies of superiority and inferiority and, hence, oppression. This discourse is described in detail in Young’s (1990) conceptualisation of the

five faces of oppression. The five faces of oppression are:

...exploitation, oppression that takes place in the process of labor; marginalisation, the inability or unwillingness of the economic system to incorporate a group of people in its political, economic, or cultural life; powerlessness, a group's lack of power or authority; cultural imperialism, the demeaning of a group by the dominant culture's values; violence, random or organised attacks on a group (Young 1990:48-65).

Oppression becomes a manifestation of the cumulative impact on an individual and groups in all aspects of their lives. Young (1990) describes this impact as creating *other*, a recognition of *the disabled* as a group whose expressed needs remain unmet. These ideas have been developed further in understanding disability as a product of cultural representation and are discussed in Section 3.7. Young, together with Abberley (1987), Oliver (1990) and Crawshaw (1994), all conclude that disabled people are oppressed and that those who materially benefit from the oppression support that oppression. Abberley (1987:7) suggests to argue disabled people are oppressed requires:

- empirical evidence that identifies that disabled people are in an inferior position to other members of society;
- that this is dialectically related to an ideology;
- that the disadvantages and the supporting ideologies are neither natural or inevitable; and
- that a beneficiary of the oppression be identified.

There is unquestionable empirical evidence on all major social criteria that disabled people are in a disadvantaged position (Barnes 1991; Gleeson 1998). A materialist view is that capitalism creates *disabling barriers* that oppress impaired people's participation in the community. This is not a natural outcome of a person's impairment but the product of capitalist structures that exclude disabled people from the production process. This exclusion is due to the benefits gained by the owners of capital, society in general and other potential workers. Abberley argues that:

...the 'problem' of disability is why these people aren't productive, how to return them to productivity, and, if that is not seen as economically viable, how to handle their non-productivity in a matter which causes as little disruption as possible to the overriding imperative of capital accumulation and the maximisation of profits (1987: 16).

Central to this is a notion of *normalcy* and propagation of the work ethic. Disabled people become part of a disadvantaged social group because the economic organisation of society excludes their participation. This is used by capitalism as a warning to others (the poor, ethnic and indigenous groups) to be productive or be marginalised. This draws on the medical model together with the ideological constructs of work and social organisation to force disabled people to internalise oppression and deny their individual and collective experiences (Abberley 1987; Oliver 1990). This forced normalising of their situation

oppresses the majority of disabled people who are unable to conform to this *norm*. The welfare state is used to provide minimal support for disabled people by focusing attention on their individual problems. The system perpetuates the existing work structures and social order that oppress them in the first place. Crawshaw outlines how the state, owners of capital and society in general benefit from the marginalisation of disabled people:

Firstly, changes to the present system are thought to be costly, so keeping things as they are avoids this expense. Secondly, disabled people are generally less productive members of the workforce, so it is better for capitalism they remain outside of it, productivity levels being all important. Non-disabled people within this disabling, capitalist society also benefit, with a higher standard of living, due to better employment prospects, and higher status as productive members of the workforce (for evidence of disabled people's status in society see Barnes 1991) (Crawshaw 1994:28).

Medical, health and welfare professionals have been the beneficiaries of this oppression. Priestley (1998) identifies some of the orientations of policy makers as favouring charity over civil rights, professional hegemony over user power, individual rehabilitation over collective needs and segregation over inclusion. Central to Priestley's ideas are the concepts of power and control. Professionals in these areas (medicine, therapies, 'caring' and social work) have sought to maintain control over the lives of disabled people. The social model challenges their right to control disabled people's lives. Control is inextricably linked to power and the social status. Change will not be easy or quick because, as Barton identifies, 'current conceptions, policies and practices are neither natural or neutral. They are a social creation and as such are subject to change' (1994:20). Those benefiting from disability (the professions) resist change and, hence, change does not occur without the struggle of those who are oppressed creating a resistance to the status quo.

While the conceptualisation of disability as 'personal tragedy' developed from those associated with the medical profession, this discourse has permeated Western institutional understanding of disability. The totality of this social exclusion of people with disabilities from citizenship is amply expressed by Chouinard's (1997:380) examination of ableism:

Ableism refers to the ideas, practices, institutions and social situations that presume able-bodiedness, and by doing so, construct persons with disabilities as marginalised, oppressed and largely invisible 'others'. This presumption, whether intentional or not, means that one's ability to approximate the able-bodied norm influences multi facets of life: such as the character and quality of interpersonal relations, economic prospects and the degree of physical and social access to various life spaces. Ableism entails a way of being that takes mobility, thinking, speech and the senses for granted, and which includes largely 'unconscious' aversion to people and bodies that remind us the able-bodied norm is an ideal... that we are all mortal and subject to disease and death (see Young 1990). An ableist society is, then, one that tends to devalue its non-able-bodied members, despite its good intentions on the part of many of its citizens to treat these others as equals.

The resultant ableist practices deliberately exclude people with disabilities from citizenship. The power and knowledge on which this oppression and discrimination is based is derived from the medical model conceptualisation of disability as the fault of the individual and their ‘personal tragedy’. The social model recognises the importance of knowledge and power in understanding social responses to disability and the development of public policy (Law 1994). As Corker and French (1999) identify ‘knowledge is not something that we *have*, but something that we *do*’ (1999:10), in other words it is dynamic. Linton (1998) goes on to argue that language forms the basis for creating a disability discourse that challenges the status quo of the medical model conceptualisation of disability.

Summary

The antagonist theory of the social model of disability is a challenge and sits in contrast to the protagonist medical model. It changes the conceptualisation of disability from a ‘personal tragedy’ that is the fault of the individual to a complex form of social relations that oppress and discriminate against people with disabilities. The following paragraph adapted from Albert (1995) illustrates how the social model challenges the conventional way that society conceptualises disability:

If you picture a flight of stairs leading up to a hotel with someone in a wheelchair sitting at the bottom and ask - ‘Why can’t this person get into the hotel?’ Most people, assuming the medical model, will reply ‘Because he or she is in a wheelchair.’ That is where the problem is located. If you then ask them to look again and say that it is the stairs that are causing the problem - turning an impairment into a disability, it is as if you have given them a new set of cultural lenses through which to see and understand the world.

The above example illustrates that the fundamental distinction between the medical model and the social model has its foundation in the difference between *impairment* and *disability* (UPIAS 1975). The social model changes the focus of disability from the agency of the individual to the social structure of society. In the above example, it is not simply that the stairs transform the impairment into a disability. Complex social relations brought about the construction of a building in a particular place and time that required people to move from one level to another via stairs. To develop an explanation for this situation involves a structural historical analysis of the political economy that produced the social world (Haralambos *et al.* 1996). Social model analysis focuses on disabling barriers, including hostile social attitudes, and the material relations of power.

3.6 Socio-spatial Organisation

Gleeson (1997; 1999b; 1999a) adds to the social approaches to disability by reviewing the role and organisation of space within the social experience of disabled people. He emphasises that in the social model, exclusion and social marginalisation must be seen as a *socio-spatial* phenomenon. Gleeson brings a geographer's perspective to disability, presenting a comparative analysis of impaired people among the feudal peasantry of England and the working class poor of colonial Melbourne. He articulates the proposition that the role of space in the production of disability should not simply be seen as related to poor environmental design. Instead, 'Space should be seen, rather, as a critical dimension of social processes which constitute the human environment' (Gleeson 1999:14). This incorporates not just a physically accessible environment but an environment where the social activities and relationships essential to community life, such as work, leisure and transport, are central to the creation of environments.

As Gleeson (1999:13) states, 'certain forms of socio-spatial organisation - such as the contemporary Western city - reflect and reinforce deeper, structural oppressions of embodiment characteristics defined by sexual orientation, gender, race and impairment'. Central to this view is the idea that space is an evolving cultural and historical construct that is a product of powerful social relations. He criticises disability studies for its simple focus on disablement as a product of the built environment as it fails to recognise the important social dynamics that allow the creation and occupation of space. By doing this, disability is reduced to a question of access divorced from the influence of the powerful social structures that created it. In turn, these forces create disabling environments.

Gleeson also points out that space can be organised to liberate these forms of embodiment. In doing so, he and others make a connection between feminist, and gay and lesbian analysis of social organisation of space and how these groups have sought to influence the production and occupation of urban environments (Chouinard and Grant 1995). Examples of successful minority group occupation are seen in the connection between San Francisco's Castro district and Sydney's Oxford Street (Abello and Parkinson 2001). This constitutes not only a physical occupation, but also an ownership of the social and cultural ownership of the economic driving force of the community. It involves an inherently political relationship where the gay and lesbian agenda is incorporated into all facets of social, cultural, economic and political planning. In Sydney's Oxford Street for example, local government operations have grown to incorporate the 'pink agenda' in all areas of

social and community planning - health and building regulations, town planning, financial contributions and involvement in the Chamber of Commerce (Massey 1999). Yet, ironically both neighbourhoods are highly inaccessible to people with disabilities (Abello and Parkinson 2001).

Gleeson's underlying tenet is that by only focusing on access to the built environment, disability studies fails to address the underlying social geographic forces, 'such as the commodity labour market or the land economy - which produce disabling environments' (1999:14). Disability becomes bound to the modes of production of a society. These are historically and culturally produced with the understanding that disability can not simply be reduced to that of impairment. Disability is a product of these processes. Gleeson (1998) suggests several questions must be addressed for the social model to explain the everyday reality of disabled people. These include what constitutes the social and economic environment, and how do these environmental factors structure notions of human normality?

As Chouinard (1997) articulates, these ableist practices result in the social organisation of space that creates *disabling environments* for people with disabilities. As with other oppressed groups, those in power lack the day to day experience of social exclusion. What cannot be imagined cannot be incorporated into the culture of production and social planning. To develop *enabling environments* requires an understanding from a disability perspective and the inclusion of this perspective within the culture of production and social planning. The fault of the individual espoused through the medical model of disability permeates professional discourses that then perpetuate the production of disabling environments and, hence, the exclusion of people with disabilities from their rights of citizenship.

Chouinard and Gleeson articulate what many disabled people may have assumed the social model did - connect the components of citizenship. These relationships have been investigated by other geographers (Hahn 1986; Chouinard and Grant 1995; Golledge 1996; Imrie 1996; Chouinard 1997; Cormode 1997; Kitchin 1998; Gleeson 1999b; Wilton 1999; D. Crouch 2000a; Imrie 2000b; Kitchin 2000a). People with disabilities experiences abound with the problems/frustrations of a disjointed social environment based on the organisation of space that accentuates the separation of home, work and leisure through a hostile public transport system that accentuates these separations. Advocacy groups may

have appeared to focus on access to built environment, possibly leading to a lack of articulation of the importance of organised social space incorporating all aspects of citizenship.

In the Australian context, the PDCN (1999a) prepared position papers that discuss a range of categories such as the built environment, transport, employment, attendant care, equipment and leisure that are drawn together by citizenship. As Moxon states in the introduction:

This document has grown out of two truths. The first is that people with physical disabilities want the opportunity to enjoy the rights of citizenship granted to all Australians. We do not want our achievements, hopes, aspirations and needs acknowledged only if and when those in authority choose to do so - and then as a 'special case'...Living with a disability on a daily basis is challenging enough without losing out on citizenship rights. It is frustrating and demeaning to be treated as second class citizens. The second truth that spawned this paper is that governments of all colours refuse to respond to the inequities we experience when attempting to participate in society. But it is not only governments that ignore the plight of people with physical disabilities - many social commentators also fail to notice our presence (PDCNSW 1999a:i).

The *Position Paper* was formulated to address citizenship concerns ignored by government and the private sector. It recognises that the powerful social institutions that must be changed to be inclusive of disability within their organisational cultures. Central to this is the need for access to the components of citizenship. This involves employment, public transport, the built environment and psychological manifestations of access to produce functioning social spaces.

3.7 Critiques of Social Approaches

This section reviews criticisms of social approaches to disability involving medical, history, gender, minority, impairment, the experience of the individual and cultural representation.

Medical criticism

Not surprisingly, some from the medical professions and WHO have been critical of social approaches to disability for failing to provide a framework for empirical investigation of disabling barriers. At the same time, WHO incorporated criticism of ICIDH-1 to revise its classification system to incorporate a biopsychosocial approach in ICIDH-2 (Section 2.4.1). As Bickenbach, Chatterji, Badley, and Ustun (1999) argue, ICIDH-2 represents a universal approach to disability (Zola 1989; Bickenbach et al. 1999) that offers a

framework to produce a substantive empirical scientific research base about the social phenomenon of disability. Others, like Harris (2000), argue that a purely social conception of disability is not possible as, ‘once the social dimension of disability have been resolved no seriously disabling features remain’. He states that this would be a denial of impairment and medical conditions and, hence, is inconsistent grammatically and logically.

Absence of history

Abberley, in commenting on the development of a social theory of disability, identifies that ‘absent is any significant recognition of the historical specificity of the experience of disability’ (1987:6). Barton also recognises the absence of historical perspectives of disabled people who were largely ‘...ignored, devalued and represented in largely passive and negative terms...They are viewed as the other or outsider. The asymmetrical power-relationship in which disabled people are placed and ‘significant others’ have defined their identities and needs’ (1994:9-10). As Finkelstein (1980) argued, the ‘disability paradox’ in Europe passed through three historical phases that have led to the social construction of disability: pre-industrialisation where disability did not exist; the industrial revolution where disability was socially constructed by a work based productivity norm; and the awareness that it is society that disables impaired people.

Gleeson’s (1998) historical analysis of feudal Britain and industrialised Melbourne concludes that disability has been a changing social experience due to the economic mode of organisation of a society. He goes on to suggest that the experience of disability occurred not only between historical periods but also between cultures within periods. In the context of the 21st Century, there is recognition of a difference between Western and Eastern conceptualisations of disability (Miles 1982; 1996; 2000) as there is in the Australian context between European and indigenous conceptualisations of disability (Ariotti 1999). Abberley (1999:6) observes that ‘It is above all a relationship, between impaired people and society. It follows that changes in society as a whole, which may not be directed at disabled people at all, can have profound implications for disability’.

Gendered, minority, impairment and the individual experience

Over the last two decades the social model has been subject to critiques for an omission of gender, other minority issues and the effects of impairment on the individual’s life (Crow 1992; Lloyd 1992; Morris 1993; Crawshaw 1994; Wendell 1996; Meekosha 1998; C. Thomas 1999; Pfeffer 2001; Shakespeare and Watson 2001). Most notably, writers such

as Morris (1991) note the lack of gender analysis, while Stuart (1993) and Begum (1994) suggest the need for inclusion of ethnic minority and race issues. Hearn (1991) and Abello and Parkinson (2001) discuss the need for the inclusion of gay and lesbian issues. Crow (1992) and French (1993) cite the failure of the social model to be able to incorporate the individual experience of impairment. Their criticism stems from a belief that that the social model denies recognition that the day-to-day realities of an individual's impairment include experiences such as pain, fatigue, medication and depression.

Shakespeare (1994) further reinforces the need for inclusion of the impairment experience by discussing the importance of the political separation of impairment and disability as the triumph of the social model over the medical explanations of disability. While it can be argued that the social model does not deny impairment, it does separate the individual experiences of impairment from the collective political organisation of disability. Crawshaw (1994:29), in commenting on Abberley's (1987) criticism of the social model of disability for not incorporating a social model of impairment, makes the following observation:

It also suggests that a life with impairment can only mean an oppressed life, and automatically leads to disability. However, removal of disabling barriers would end disability, the removal of impairment is not required. Impairment would remain but it would be without the oppression of disability.

This observation by Crawshaw reinforces the idea of oppression as being central to any conceptualisation of disability. An individual's experience of impairment is not so much separate from the resultant disabilities but experienced whether socially constructed disabilities exist or not. The importance of the social approaches to disability as an explanatory tool for understanding the social relations of disability is therefore undeniable. Oliver (1996) acknowledges the shortcomings of the social model and welcomes further contributions to developing a more encompassing model. However, he also reminds the critics that the social model was developed as a tool to help understand the experiences of disabled people in the world. It is not and was never meant to be an *explanation* of all people's individual experiences of disability. As Oliver states:

...for me it is important not to stretch the explanatory power of models further than they are able to go. For me the social model of disability is about personal experience and professional practice but it is not a substitute for social theory, a materialist history of disability nor an explanation of the welfare state (1996:41).

The embodied ontology

Like Crawshaw (1994), and more lately Thomas (1999), the above arguments about the

inclusion of impairment in the social model have been succinctly encapsulated by Shakespeare and Watson's (2001) critique of the British academic and political debates over social approaches. They have three central criticisms of the social model that focus on: impairment; the impairment/disability dualism; and the issue of individual identity. It is suggested that an *embodied ontology* would contribute towards developing a complexity and richness to the social model rather than the dichotomy of impairment and disability. Shakespeare and Watson conclude that an embodied ontology offers a starting point for disability studies to begin to develop a more adequate social theory of disability. As they suggest, developing an embodied ontology of disability needs to consider the following signposts in any theoretical debate:

1. Impairment and disability are not dichotomous but are different places and times on a continuum;
2. Disability should not be reduced to just a medical condition or to just social barriers alone - it is far more complex than this;
3. It remains vital to distinguish between the different levels of intervention in a disabled person's life (also Oliver 1996:36);
4. Disability studies should not forswear meta-narratives because disabling social relations are everywhere (see Fraser and Nicholson 1990 on feminism); and
5. Disability studies and the disability movement should seek to continue to understand who the disabled subject is as the majority of 'disabled people' have little involvement with either disability or the disability movement (Shakespeare and Watson 2001:22-23).

In effect, the embodied ontology challenges the dichotomies of impairment/disability and illness/health and offers a model that intertwines structure and agency.

Cultural representation

Shakespeare (1994) argues that the social model has not incorporated the role of culture in examining the oppression of disabled people. In short, he argues that it is not just the disabling barriers but also the social prejudice towards disabled people that is manifested in negative cultural representations. The Foucauldian conceptualisation of *other* has been used in poststructural cultural studies to analyse the cultural representation of disability. It builds upon the previous understandings of disability and oppression. Poststructuralism provides a way of understanding that while economic organisation is central to exploitation and marginalisation, powerlessness has a cultural context that may vary from society to society (Thomson 1997). Oppression becomes a manifestation of the cumulative impact on an individual and groups in all aspects of their lives. Young (1990) describes this impact as creating *other*, a recognition of *the disabled* as a group whose expressed needs remain unmet. Similarly, in an analysis of postmodern feminist theories of *other*, Aitchison (1999:136) discusses power as central to the understanding of the construction of *other* as

inferior. She calls for greater recognition of *other* to challenge hegemonic representations in leisure and tourism, and enhance the theoretical sophistication of the social-cultural context of leisure and tourism relations. Similarly, poststructural tourism theory offers potential insights into disability and tourism. In particular the discussions by Uriely (1997) of multiplicity of motivations and experiences, and Urry (1990:141) appropriate *other*. The duality of Uriely's (1997) and Urry's (1990) conceptualisation of multiplicity and *other* present areas for further research into the social relations and consumption of tourism for and by people with disabilities and non-disabled tourists. As foregrounded in the introduction to this chapter, the cultural representation of disability in tourism provides fertile ground for further research.

Summary of social approach critiques

The medical critique of the social model highlights the criticism that the social model has failed to provide a framework for empirical investigation of the barriers facing people with disabilities. This thesis offers an opportunity to operationalise a social model investigation of the barriers affecting the tourism experiences of people with disabilities. On another level, the social model offers a framework to develop an explanation for why these barriers occur. The remaining critiques are more a list of inclusions that the social model could take on board to develop a broader social theory from the dichotomous impairment/disability approach of the social model. In particular, the thesis offers an opportunity to investigate the influence of impairment and other socio demographic variables on tourism participation and non-participation. While the thesis will not undertake a historical methodology, it will investigate the structural-historical influences that affected the development of the tourism environment in Australia and the impact this had on the tourism experiences of people with disabilities.

3.8 Ending

The medical model focuses on the impairments of the individual's diagnosed disease, illness or trauma where disability is the assessed deficits of functional 'loss' caused by the impairment. Medical and associated professionals seek to intervene in the lives of people with disabilities in order to normalise their 'abnormalities'. These definitions create the dichotomy of normal/abnormal and, hence, are the origin for considering disability as *other*. This issue is at the heart of debate in disability studies as it creates a worldview that permeates society. Whereas disability studies and, the social model in particular, the

examines the experiences of being disabled and the lives of people with disabilities.

Individual idealism views disability as a product of interactions between individuals with disabilities and the non-disabled. These interactions create stigmatised identities through negotiated social roles. This approach isolates the experience of disability to the individual and their stigmatised interactions with society. The social model defines disability as imposed on top of a person's impairment through the disabling barriers (environments) and hostile social attitudes. It incorporates social attitudes as an important component of citizenship but because of the social relations rather than an individual's stigmatised interactions. The social model conceptualisation firmly places disability on the social, economic and political agendas rather than locating disability as the fault of the individual's embodiment. In doing so, it has re-conceptualised disability from a 'personal tragedy' to a complex form of social oppression.

This chapter has provided an insight into the competing discourses that frame disability in society today. From a disability perspective, the protagonist medical model has led to people with disabilities being excluded and marginalised from citizenship. The medical model represents the domain assumptions about disability, which are highly individualised and deeply entrenched within the government bureaucracies and social institutions that affect the lives of people with disabilities. The antagonist theory of the social model challenges the notion that disability is the fault of the individual and, instead, focuses attention onto the disabling barriers and hostile social attitudes that deny people with disabilities their citizenship.

The social approaches to disability have their critics. Those involved with collecting disability statistics argue that the social model has provided no conceptual clarifications on which to operationalise research about disability. From within disability studies, there has been a call to include an embodied ontology and to develop a greater structural-historical context. The discussion of the structural-historical context examined the importance of the organisation of space. The review could have also examined the emergent analysis of disability as cultural representation but because of the focus of the thesis this was not carried out. However, the cultural studies concepts of discourse, multiplicity of meanings are drawn on in Chapter 5. The foundations of this chapter are drawn on to determine the theoretical framework of the research in Chapters 5.

4 DISABILITY AND THE TOURISM LITERATURE

4.1 Introduction

This chapter critically reviews the existing disability and tourism literature and the extent to which it addresses disability. The chapter is divided into two sections: theory and empirical research. The examination of tourism theory begins by assessing the treatment of disability in tourism texts. This is followed by extending the definitions of tourism as outlined in Chapter 1 and by the conceptualisation of tourism as system, as market and the role government plays. The chapter then traces the foundations of disability-related leisure and tourism research through the leisure constraints theory. The empirical research on disability and tourism is examined from demand, supply and coordination/regulation positions. Within these three positions, the review is further organised chronologically and geographically into Australian and overseas research. This is done to show the development of the field and the differences between Australian and overseas research. The demand and supply positions are prefaced with a summary Table of the literature reviewed up to 2002. The Table for each documents the country of origin, year, method, sample size and impairment group/s. The body of the review will not discuss the method or sample size. It is recognised that the literature review draws mainly from English speaking countries. Non-English sources have been used where an English abstract could be provided. The chapter concludes by evaluating the extent, breadth and quality of research in this area and discusses emergent themes.

4.2 Tourism Theory

This section builds on the definitions of tourism outlined in Chapter 1, by examining the contribution that the conceptualisation of tourism as system, as market and the role government plays may make to the thesis.

A. Tourism textbooks

A starting point for reviewing the literature about people with disabilities and tourism is to examine the treatment of the issue in tourism textbooks. Most introductory tourism textbooks do not mention disability as part of the tourism system, or people with

disabilities as a market segment or the experiences of people with disabilities as part of tourist behaviour. For example, the two widely used Australian texts on tourism management are those by Leiper (1995) and Weaver and Opperman (2000). Neither makes any mention of disability in any context. Of those texts that include a reference to disability, the treatment follows a familiar pattern. Five are referred to below.

The third edition of Hall's (1998), *The Introduction to Tourism in Australia*, has 2.5 paragraphs under the heading 'Raising producer awareness'. Hall cites the study by Murray and Sproats (1990) but without discussing the findings and he states that tourism operators need to pay more attention to the 'aged and disabled' (Hall 1998:262). He then discusses the 1981 IYDP as an important event for focusing attention on the 'problems' of the aged and disabled. He concludes that the non-disabled need to accept that people of all ages with physical disabilities should not be segregated and further disadvantaged. In illustration, he quotes the call from Mills' (1983) for the disabled not to be regarded by the TI as an 'optional extra'. Mills suggests that well designed establishments will serve not only the disabled but are more attractive for 'able-bodied users' travelling with people with disabilities and make the holiday 'more restful and beneficial'.

Dickman's (1997) *Tourism: An Introductory Text* includes reference to disability in a section on 'Customer Relations'. Titled 'Special Customers', the section discusses the importance of determining ALL (her emphasis) relevant details when handling tourism arrangements for people with disabilities, and she identifies a range of these details. This is followed by an unaccredited summary of research carried out by Darcy (1995; 1996) on the experiences of people attending the World Assembly of Disabled Peoples' International conference held in Sydney in 1994.

Page's (1999) *Transport and Tourism* devotes three paragraphs to transport and disability in a section on health related issues. His treatment relies mainly on the work of Abeyratne (1995) on the international and US national air carriage for the transport of 'elderly and disabled persons'. He cites the five major considerations to improve the accessibility of airports discussed by Abeyratne and includes these as an Appendix. The five considerations are: 1. ground services to and from airports; 2. reserved drop off points close to main entrances; 3. adequate parking spaces for wheelchair users and covered passageways for conveyance to terminals; 4. improved flight information dissemination to the hearing and vision impaired; and 5. adapting all facilities and services to the needs of

the elderly and disabled. However, Page does not state that this was only the first stage of the issues facing people with disabilities in air travel covered by Abeyratne (1995:53,56-59).

B. G. Boniface and Cooper (2001:19) in the third edition of their text *Worldwide Destinations: Geography of Travel and Tourism*, in examining demand issues cite Lansing and Blood's (1960) list of five major reasons why people do not travel. They are: expense of travel, lack of time, physical limitations (such as ill health), family circumstances, and lack of interest. The recognition of ill health as a reason for demand suppression is illustrated with the example of 'handicap or disadvantage':

...perhaps the best known example of this is the social tourism movement, which is concerned with the participation in travel by people with some form of handicap or disadvantage, and the measures used to encourage this participation (cited in Boniface and Cooper 2001:20).

In presenting only a welfare or philanthropic perspective, Boniface and Cooper place disability outside of TI responses for the provision of facilities and services. By placing disability outside of the market context of the TI, they marginalise the group in their citizenship. This is quite at odds with general engagement with disability theory by the discipline of geography (Golledge 1996; Imrie 1996; Chouinard 1997; Cormode 1997; Kitchin 1998; Gleeson 1999b; Wilton 1999; Aitchison, MacLeod and Shaw 2000).

In the 8th edition of their text *Tourism Principles, Practices, Philosophies* Goeldner, Ritchie, and McIntosh (1999) summarise Woodside and Etzel's (1980) study into 'physical and mental conditions limiting travel'. They present two tables from the findings of the study that outline the major 'physical and mental conditions' and a comparative table of nights away from the household by handicapped persons and by persons without handicap. Goeldner et al. (1999) also included a section on the impact of the *Americans with Disabilities Act*, 1990 (ADA) on the TI and, in particular the transport sector. They attributed the introduction of the ADA for the substantial improved treatment of the group.

In summary, disability is largely absent from the textbooks used in tourism curricula in Western countries. The authors who include disability tend to identify 'disabled people' as a group worthy of TI's consideration and then quote one, or at most two, studies in a half-page section. The subject areas from which these sections appear vary from 'market segmentation' and 'customer service' to 'legal responsibilities'. All sections are sub-sections in sections on other 'serious' or 'mainstream' issues discussed.

B. Tourism system

The definitions of tourism used in the thesis are outlined in Chapter 1. The next step is to understand the interactions that occur when a tourist plans a trip and embarks on it. In the leisure literature, Clawson and Knetsch's (1966:33-36) major phases for outdoor recreation experience could be considered the precursor to most conceptualisations of tourism. Up until this time, it had been implicitly assumed that the on-site outdoor recreation activity was the total experience. For the first time, Clawson and Knetsch presented a recreation framework that included pre and post stages of the activity, involving:

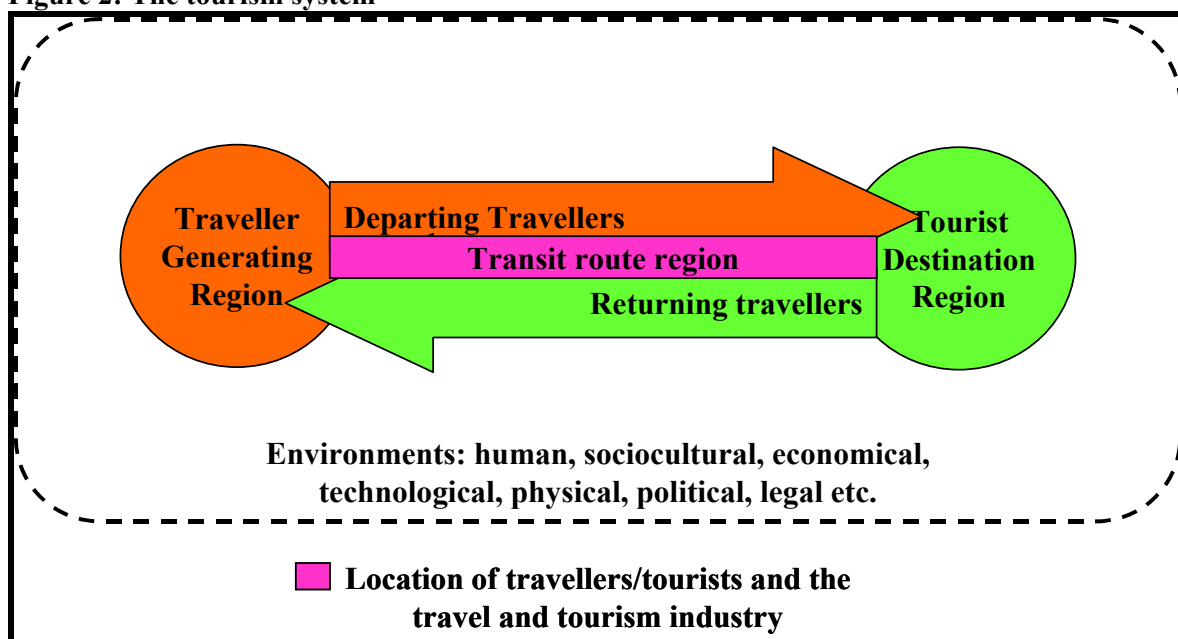
- anticipation and planning
- travel to the destination
- on-site experience
- return travel
- recollection and evaluation

This framework remains largely unrecognised in the tourism literature. The predominant way of conceptualising tourism has been through an interrelated *systems* approach (Mill and Morrison 1985). Figure 2 presents Leiper's (1995) widely cited tourism system. This geographic based tourism system comprises five interdependent core elements. These are:

- at least one tourist;
- at least one tourist generating region - where tourists originate from;
- at least one transit route region - how tourists get from the generating region to the destination region;
- at least one tourist destination region - where tourists seek their experiences; and
- a travel and TI that facilitates - tourist needs (Leiper 1995:24).

In this model, the tourist is at the centre of the system and, together with the other core elements, operates within the broader sociocultural, economic, technological, physical, political and legal external environments. As Hall (1998) discusses, government as a coordinator and regulator has a major role to play within the tourism system. Expositions of the tourism system, having explained the basic geographic framework, generally go on to explain the complexity of the *tourism industry*. Hall (1998:8-9) notes that defining the TI is not a simple task because the TI is a collection of inter-industry providers of goods and services. This is true whether using a demand-side (Murphy 1985; AGCIT 1987a; Leiper 1995) or supply-side (S. Smith 1988) definition. For the purposes of the thesis, the TI can be regarded as the aggregate of organisations that have a significant role in servicing the needs of tourists through the provision of goods and services.

Figure 2: The tourism system



(Source: based on Leiper 1995)

Leiper curiously locates the ‘travel and tourism industry’ only in the ‘Transit Route Region’, although Weaver and Oppermann, in their version of the diagram, seem to acknowledge that it is also located in the origin and destination regions. The expositions divide the industry into a number of sectors, as shown in Table 8. There are, however, variations in the number of sectors identified and the nomenclature used; in particular, Leiper includes the ‘coordination sector’, or TA, within his definition of the industry, while Weaver and Oppermann do not. The nature, scale, roles and operations of these industry sectors are generally described in some detail, but this is done in discursive style with the tourism systems model providing only a loose framework for the discussion. Weaver and Oppermann indicate that the various sectors have major, minor or negligible status in the origin, transit and destination regions of the tourism system. However, further exploration of the systemic functioning of the sectors within the overall model is not pursued.

Table 8: Sectors of the travel and tourism industry

Leiper 1995	Weaver & Oppermann 2000
Marketing specialist sector	Travel agencies
Carrier sector	Transportation
Accommodation sector	Accommodation Food and beverages
Attractions sector	Attractions
Tour operator sector	Tour operators
Coordinating sector	
Miscellaneous sector	Merchandisers

Sources: Leiper, 1995: 28-29; Weaver and Oppermann, 2000: 47

While this appears a deceptively simple system, Weaver and Opperman (2000) argue that the internal structure of the tourism system is far more complex than is suggested. This is due to the hierarchical nature of tourist flows where multiple destinations, transit regions and extensive travel within destinations occur. They go on to argue that the global tourism system must incorporate the complexity of endless individual experiences. The tourism systems model depicted in Figure 2 is a useful geographic framework for thinking about the tourism process. Yet, it is also limited in its treatment of the various elements of the industry. Indeed the seven sectors described by Leiper are not represented at all in the diagram. In the TGR, potential tourists' interests will be the retail sector of the TI and one subject to information flows about the TDR. In transit, the traveller interacts with the transport industry. At the TDR, the tourist interacts with the accommodation, hospitality and attractions sectors and directly with the host community. Lynch and Veal (2001:328) also discuss the deficits of the tourism system and address these through conceptualising the political processes, expenditure and information flows.

The weaknesses of the systems approach can be augmented through other frameworks. For example, a predecessor to the more widely cited Leiper is Mill and Morrison (1985). Theirs is a more market orientated tourism system that consists of four parts:

- the market: decision of the individual to travel or become a tourist;
- travel: the when, where and how of the individual's tourist behaviour;
- destination: the attractions and services that constitute the destination mix; and
- marketing: the importance of marketing as a stimulation to travel.

As with Leiper's system, the market based approach is centred on the tourist and the industrial responses to servicing their touristic needs. The other important component of the market-based approach is the importance of marketing as a tool to satisfy the needs of tourists and as stimulation for travel. The implications of tourism as a market are developed more fully in the next section.

In summary, the tourism system can be articulated from the following three positions:

- the demand side that analyses the experiences of the tourist (Murphy 1985);
- the supply-side that conceptualises tourism as a market and an industry (S. Smith 1988); and
- the coordination/regulation sector that seeks to minimise the excesses of the market mechanism (Hall 1998).

These three positions are used to review the research on disability and tourism. The tourism systems and market approaches are used in Chapter 5 of the thesis to develop a

framework for understanding the tourism experiences of people with disabilities.

C. *Tourism as a market*

In Table 9, the TI sectors outlined by Leiper (1995) and Weaver and Oppermann (2000) have been combined into one list, and the relationship between the *tourism industry* (TI) and the *tourism authorities* (TA), as used in this thesis, is indicated. Further, the table indicates the relative level of involvement of public sector and private enterprise in each sector, indicating that, despite significant public sector involvement, provision of tourism goods and services is overwhelmingly in the hands of the private sector. The table reflects the situation in Australia - the pattern of public-private sector involvement varies considerably from country to country.

Table 9: Defining the tourism industry (TI) and tourism authorities (TA)

Sectors	TI or TA	Public/private sector involvement		
		Private	Private & Public	Public
Travel authorities	TI	●		
Carrier sector	TI		●	
Accommodation sector	TI	●		
Food and beverages	TI	●		
Attractions sector	TI/TA		●	
Tour operator sector	TI	●		
Merchandisers & miscellaneous sector	TI	●		
Coordinating sector	TA			●

To what extent does the tourism literature provide a framework for potentially understanding and researching the industry's likely practices and discourses to people with disabilities? The situation in relation to the TI is discussed here and in relation to the TA in the next section.

Approaches to issues and groups by TA and TI are affected by their ideology. Ideologies in their simplest form can be thought of as sets of ideas about the way to organise the world (Veal 2002:20). Ideologies are constructed *truths* that become the basis for social action (Leach 1993). Hall (1998:88) identifies that tourism is largely a private sector industry. As a private sector industry, the TI adopts the capitalist market ideology of the private sector. Tourism is seen as an industry organised, like any other industry, to maximise financial return. Further, as stated by Elliott (1997:178), it is the TI which 'plays the leading role in the development of tourism and which provides most of the investment, capital stock of accommodation, hotels and resorts, theme parks, travel agents and tour guides and most of

the transportation'. This role is explicitly stated in the Australian Government Committee of Inquiry into Tourism (1987), that the provision of facilities and services to satisfy tourists should be done in a way to maximise financial returns. Even public sector operators, who have a primary function to serve local residents - for example railways in the carrier sector and museums in the attractions sector- tend to adopt a market ideology when considering tourism.

Financial return is based on serving the needs of tourists, or more specifically, the needs of certain tourists. A great deal of the practice, research and teaching agendas have focused on marketing and market segmentation as ways of identifying and attracting those tourists who will be most profitable for businesses of the TI (Kotler, Bowen and Makens 1998). Within the marketing literature, questions of demand and supply are interrogated but there is little discussion of the role that government plays in tourism and, importantly, as a coordinator of national marketing. As Elliott (1997) argues, this is surprising given that the TI would not survive without government. In an exception to this position, Middleton and Clarke (2001) discuss how the same marketing principles of the private sector can be applied to government tourism organisations. However, as they note, most government tourism organisations limit their role to promotion rather than the systematic private sector approach to marketing.

There is relatively little general tourism literature that expounds a business philosophy of financial return and profit maximisation. This is left to the specialist texts on management of, for example, clubs (Hing, Breen and Weeks 1998), attractions (Swarbrooke 2002), travel agencies (Davidoff and Davidoff 1988; Gee 1990) or hotels (Gee 1996; Raleigh and Roginsky 1999; Medlik and Ingram 2000; Ransley and Ingram 2000; Stutts and Wortman 2001; P. Jones 2002). For example, the text on attractions management (Swarbrooke 2002) covers markets, marketing, the business environment, human resource management, operations management and financial management. Such issues are potentially highly relevant to understanding the industry's attitudes towards customer groups, such as people with disabilities, but these topics do not feature in general tourism management texts, such as those reviewed in Section 4.2. Neither is the tourism research literature replete with studies of tourism managers' *world-views*, unlike other leisure industry sectors, such as the arts (Palmer 1998) and recreation (Cook and Szirom 1980; Neumayer 1993; Herbert 2000). Thus, as the tourism literature is not particularly enlightening on the mind-sets of tourism managers as private sector operators, the extent to which the broad business

environment, its ethos and constraints might influence managers' attitudes and practices in regard to people with disabilities, remains a matter for research.

As foreshadowed, the tourism literature reflects the private sector market ideology through the extensive treatment given to tourism *marketing* and *market research* (Holloway and Robinson 1995; Morgan 1996; Lumsdon 1997; Kotler et al. 1998; Dickman 1999; Middleton and Clarke 2001; Morrison 2001; Laws 2002). Of particular interest is the concept of *market segmentation*. This suggests that, rather than dealing with a *mass market*, tourism managers should, based on research, identify particular market segments with particular characteristics and needs. While the literature points the way, it never gets as far as identifying people with disabilities as one or more market segments. For example, Weaver and Oppermann (2000:180-205) identify four bases for segmentation: geographic, socio-demographic, psychographic and behavioural. While examples of particular market segments are given throughout the 25-page discussion, disability is not mentioned as a possible criterion for segment identification. This does not, of course mean that tourism managers have not, in practice, taken the principle of market segmentation, applied it more widely, and subsequently identified people with disabilities as a group - this also is a matter for further research.

In the classic market segment scenario, a particular market segment may be identified by the personal characteristics of its members, such as age or nationality, but members of the segment are also assumed to have, or found to have, common service requirements and similar tastes and are content to be serviced as an identifiable group. However, this is not always the case. For example, members of the segment 'independent traveller', almost by definition, do not generally wish to be serviced as a group with common needs. The 'seniors' segment consists of a wide range of socio-economic groups with differing tastes. This is likely to be the case with people with disabilities where while they have common needs, they also differ in their needs, not just according to their type of impairment but also according to their socio-economic, cultural characteristics and personal tastes. And while, for some purposes, people with disabilities seek recognition of their needs as people with disabilities, for most leisure and tourism purposes they are likely to wish to be treated as members of the general public and/or other appropriate market segments of which they are also a part (e.g. the 'youth market' or the 'Japanese market'). Thus market segmentation is not a single dimension, single solution approach to meeting needs and demands.

D. Tourism and the role of government

In the discussion of tourism as market, questions of demand and supply are interrogated, but there is little discussion of the government role in tourism. As Elliott (1997) argues, this is surprising given that the TI would not survive without government. However, there has been recognition that marketing principles can also be applied to the government and not-for-profit sector (Middleton and Clarke 2001). Within a capitalist market system of economic organisation the rationales for intervening in the market are clearly defined (W. Parsons 1995; Veal 2002). Government roles in tourism generally involve planning, legislation and regulation, government as entrepreneur and stimulation (Mill and Morrison 1985). However, in Australia these largely take place outside of the charter of the TA and are the responsibility of other government departments. TA are statutory authorities charged with specific tourism charters under Commonwealth and state legislation (G. Davis et al. 1993). This section reviews the TA role as coordinator for the Australian TI.

Government involvement in tourism has had a close relationship with the private sector as a way to improve the economic contribution of tourism to the host economies (Hall and Jenkins 1995; Veal 2002). This economic imperative is a consistent feature of national tourism policies across nations (Baum 1994; Elliott 1997). As Hall (1998) documents, this has been the situation in Australia at the Commonwealth and state levels. However, as Fayos-Solá (1996) argues the strategies for achieving the economic imperative have changed from pure marketing to product development through market segmentation to maintaining competitiveness. Yet, as Goeldner et al. (1999) suggests, the success of tourism destinations and hence, tourism policies, involve both competitiveness and sustainability. The TA charged with tourism marketing for competitiveness have little understanding of planning for sustainability, and the areas of government charged with planning for sustainability of tourism tend to have little understanding of marketing. This poses questions as to where disability would be addressed within tourism policy: marketing or planning?

This economic management rationale (Veal 2002) is complemented by a coordination role in overseas marketing of tourism to Australia (Hall 1998). In the Australian context, government has historically led the TI by coordinating tourism marketing and market research (Hall 1998). The coordination role was seen as necessary because of the fragmented nature of the TI. Coordination has been undertaken by TA established by Commonwealth and state governments with the specific charter to market international

tourism to Australia. This role has changed little since the inception of the TA. Recently, a greater emphasis has been placed on domestic tourism due to the series of external shocks since 2001, including September 11, the Bali bombing, SARS and the Iraq conflict (Tourism Forecasting Council 2003). The TA were deliberately established at 'arms length' from government to reduce bureaucratic control and promote a more 'marketable' corporate and, hence, private sector approach (King and Hyde 1989). This close relationship between TA and the TI was reinforced in 2002 with government tourism responsibilities being incorporated into the Commonwealth Dept. of Industry, Tourism and Resources.

The government legislation establishing the TA encouraged them to adopt the ethos of the private sector TI who they represent. The role of the TA has had an emphasis on marketing and market segmentation through the collective marketing of destinations and as the conductor of market research (Hall 1998). Within these roles, the TA is dominated by the private sector market ideology of yield where markets are segmented and chosen for the level of profit that is provided to the state per tourist captured (Hall 1998). This has been reflected in the marketing strategies of all Commonwealth and state TA (CDOT 1995; Clark 2002). While economists may argue over methodologies and the best ways of strategically planning to maximise yield, little else is considered by national tourist offices in their decision-making criteria (Calantone and Mazanec 1991). Perceptions of yield have changed over time as research about market segments was undertaken. For example, in Australia in the late 1980s there was a concentration by Australian TA on Asian inbound markets. However, it was not until the early 1990s that there was a differentiation made between high yield (Japan) and low yield (Korea) Asian markets (Griffin and Darcy 1997). Similarly, only after two significant research studies on the backpacker market (Pearce 1990; Loker 1993) did perception change to recognise the value of the backpackers (Commonwealth Department of Tourism 1995a; 1995c; 1995d; Haigh 1995).

It becomes apparent that a number of areas have been omitted in the examination of tourism as market and the role of government in tourism. These omissions may have implications for disability and tourism. Firstly, whether the perceptions of market segments by the decision-makers within TA and TI affect the tourism policy decisions and industry practice. Secondly, while it is acknowledged that the tourism lobby in Australia exerts tremendous influence over government (Craik 1991; Hall and Jenkins 1995), little evidence exists of how this occurs in practice. While the researcher acknowledges the

broad literature that exists in the areas of: power-based models of public sector decision-making (Dye 1975; G. Davis et al. 1993; W. Parsons 1995; Veal 2002); the influence of stakeholders in pluralist systems (Giddens 1989); and the determination of power in the political process (Haralambos et al. 1996), it is beyond the scope of this thesis to investigate these areas. Further, given the TA adoption of a private sector ethos, this theory may not be directly relevant.

4.3 Constraints Theory

This section brings together three different traditions: leisure studies; disability studies; and tourism studies, to review constraints to leisure and tourism for people with disabilities. Researchers concur that historically there has been systematic discrimination against people with disabilities in regard to access to leisure goods and services both in Australia (Sherry 2000) and internationally (Barnes, Mercer and Shakespeare 1999a). Academic analysis has shown that this discrimination constrains the citizenship of the group. Leisure research developed to understand people's behaviour in the leisure domain, while leisure constraints research has investigated the reasons for constrained participation or non-participation (Jackson and Scott 1999). From the early 1980s, constraints research became a distinct area of research within leisure studies, with its own traditions and literature.

The market ideology of tourism in Australia is significantly different to leisure studies that come from a tradition of critical neo-Marxist analysis. This latter tradition has fostered an examination of leisure in terms of its social, economic and political dimensions under capitalism (Clarke and Critcher 1985; Rojek 1985). A number of studies have analysed the ideology of government and the subsequent impact on leisure policies (Wilson 1988; Cushman, Purvis and Rickards 1991; Henry 1993). In particular, leisure studies have been interested in non-participation where tourism studies focus on participation. This section explores: a. the leisure constraints literature generally; b. its application to disability; c. the hierarchical model and constraint negotiation; d. Australian leisure constraint research; and e. the development of tourism constraints.

A. *Leisure constraints theory*

In the leisure studies literature there has been considerable academic debate about the use of the terms *constraints* and *barriers to participation* (Jackson 1988; Goodale and Witt

1989; Crawford, Jackson and Godbey 1991; Jackson 1991). McGuire (1984), among others, differentiated between constraints and barriers, seeing constraints as factors that affected a person's predisposition for participation in an activity, and barriers as those impediments encountered while attempting to participate or whilst participating. McGuire stressed that all constraints and barriers were interrelated and should be understood in relation to each other.

However, this distinction was lost as the term *leisure constraints* evolved through the 1980s to become the more inclusive term, used to encompass barriers and limitations to participation or non-participation (Jackson and Scott 1999). Jackson (1991:279) defined constraints as factors that limit the formation of leisure preferences or inhibit participation and, hence, affect leisure experiences. For the remainder of this section the terms are used interchangeably, depending upon the sources quoted. Crawford and Godbey (1987) identified three categories of leisure constraints:

- intrapersonal - lack of self-confidence, lack of encouragement, or lack of information about opportunities for leisure that affect preference or lead to a lack of interest in a particular type of leisure activity;
- interpersonal - associated with other individuals including lack of leisure partners or lack of social interaction skills; and
- structural - those that exist between individual preferences and participation in a leisure activity including lack of finances, lack of transportation, limited abilities, lack of time or architectural barriers.

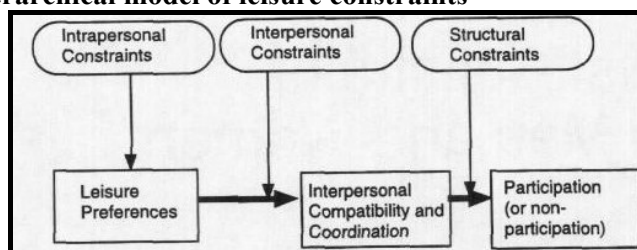
The three categories proposed by Crawford and Godbey (1987) were a major step forward in constraint research. Previous research had focused on barriers to participation, had been applied in nature, and consequently, had not considered the generic concept of constraints as a way of enhancing theoretical development of the field. The contribution to constraints research involved two interrelated points. First, recognition that constraints can only be understood in the context of leisure preference-participation. Second, that constraints do not affect preference for activity and participation but influence preferences, affecting preference and participation simultaneously. Yet, Crawford and Godbey's (1987) three categorisations were criticised because they were discrete and lacked a conceptual connection (Jackson and Scott 1999).

B. Hierarchical model and constraint negotiation

To overcome these criticisms, Crawford et al. (1991) proposed a hierarchical model of leisure constraints as progression from the discrete categorisations. Figure 3 shows that this

model integrates the three categorisations and views participants as negotiating a hierarchical sequence. The sequence moves from intrapersonal constraints affecting leisure preferences, to interpersonal constraints impacting on compatibility and coordination, to structural constraints as the last determinant of participation or non-participation. Crawford et al. (1991) concluded that the model also provides an understanding of how constraints affect the choices of those already participating.

Figure 3: A hierarchical model of leisure constraints



Source: Crawford, Jackson and Godbey 1991

The hierarchy of leisure constraints has been widely used as a model to explain participation and non-participation. The early empirical testing of the model suggested that there were anomalies to constraint research, where participation occurred despite the constraints (Jackson and Scott 1999). To address the findings of these studies *constraint negotiation* was proposed as an extension of the hierarchical model (Jackson, Godbey and Crawford 1993). Six propositions were developed to describe constraint negotiation where constraints are present but people negotiate constraints to participate (Jackson et al. 1993). These propositions consist of participation involving not the absence of constraints, but their negotiation. Variations found in reporting the experience of constraints also involved variations in negotiation of constraints. Unwillingness to change leisure behaviour can be partly explained as the result of previous successful negotiation of constraints. Anticipation of constraints may suppress participation and may also involve negotiation of, as well as the presence or intensity of, constraints. The strength of interactions between constraints and motivations for participation requires constraint negotiation initiation and outcomes. Further, Jackson et al. (1993) proposed a three-category typology of people's response to constraints: people who do not participate; people who, despite constraint, do not change their participation; and people who participate in an altered manner.

C. Disability, constraints and barriers

Research undertaken by Kennedy, Smith, and Austin (1991) on barriers to leisure for people with disabilities has categorised barriers similarly as intrinsic, environmental and

communication barriers. Figure 4 summarises this categorisation with a brief description of the meaning of each. These barriers incorporate the perspective of both people with disabilities and leisure providers. There has been extensive research on the leisure constraints of people with disabilities which suggests that constraints vary for individuals depending on their impairment, level of independence, race and gender (Hunter 1984; Wade and Hoover 1984; Bedini and Henderson 1994; Perry 1994; Henderson *et al.* 1995; Henderson and Bedini 1997; Dattilo *et al.* 1998; Bedini 2000; Oliva and Simonsen 2000; Rimmer, Rubin and Braddock 2000). Yet, as Smears (1996) noted in response to Henderson *et al.* (1995), much of this body of work has not been based on a disability perspective but a medical approach or on the researcher's theoretical position. This body of work has made assumptions about disability that focused on the individual's loss, although the findings of much of the above research consistently identified structural constraints as the major constraints identified by people with disabilities.

Figure 4: Barriers to leisure participation for people with disabilities

Category	Barrier and Description
Intrinsic (Intrapersonal):	<p>Lack of knowledge - about leisure programs, facilities, resources and other information are required for informed choice.</p> <p>Social ineffectiveness - some people with disabilities may have ineffective social skills.</p> <p>Health related issues - people with disabilities, like the rest of the community, may have health related issues that impact upon participation.</p> <p>Physical and psychological dependency - some people with disabilities have physical dependency due to their impairments, while others may have a 'learned' psychological dependency e.g. attendant assistance.</p> <p>Skill/challenge gaps - as conceptualised in 'flow' theory, skill/challenge gaps are a major consideration in leisure activity choice.</p>
Environmental (Structural):	<p>Attitudinal barriers - a variety of attitudinal barriers may be faced by people with disabilities. These include negative behaviour towards individuals (e.g. exclusion, verbal abuse, violence etc.), paternalism (e.g. treated as childlike, assumed decision-making roles etc.) and apathy (e.g. ignoring existence and, hence, inclusion).</p> <p>Architectural barriers - to the built environment. Effective legislation, design, planning and construction can overcome these barriers and is discussed in greater detail later.</p> <p>Rules and regulations barriers - in some situations rules and legislation have been enacted that deliberately discriminate against people with disabilities (e.g. International Air carrying regulations).</p> <p>Transport barriers - for people with higher support needs, there is a lack of suitable and affordable accessible transport.</p> <p>Economic barriers - people with disabilities experience much higher rates of unemployment (from the average to 99% depending upon a range of factors) and, therefore, are economically disadvantaged. Further, many impairments have additional costs that must be met by the individual (e.g. equipment, wheelchairs, personal care consumables etc.).</p> <p>Barriers of omission - this includes all those facilities, programs, policies and procedures that do not incorporate inclusive practices for people with disabilities (e.g. modified rules etc.).</p>
Communication (Interpersonal) barriers:	<p>Communication - can not be thought of as primarily intrinsic or extrinsic as communication involves reciprocal interaction between the individual and their social environments. Therefore, barriers arising can occur through the sender, the receiver or both. Further, people with disabilities can also have multiple disabilities that affect communication (e.g. speech, hearing, sight, cognitive, brain damage etc.).</p>

Source: (Kennedy, Smith and Austin 1991)

D. Australian disability leisure constraint research

A precursor to these models was proposed and tested by Brandenburg et al. (1982) in the Australian context. This model had a social psychological basis but incorporated socio economic considerations and key life events. This study became part of the development a distinct constraints research in leisure studies. A number of Australian studies have focused on the barriers to leisure participation for people with disabilities. However, none of these studies used the models proposed by Brandenburg et al. (1982), Crawford et al. (1991) or Jackson et al. (1993). The studies included:

- barriers to recreation participation for people with physical disabilities in the Newcastle area (Worthington 1993);
- the arts participation and disability (D. Walsh and London 1995; Accessible Arts and Australia Council 1999);
- the level of physical activity (Lockwood and Lockwood 1996);
- sport and recreation activity needs (Patterson; Hanley; and Auld 1996);
- leisure choices of the group (Dempsey and Simmons 1995);
- leisure and women with disabilities (Hanley 1996); and
- the role of social agents in constructing leisure opportunities for people with intellectual disability (Fullagar and Owler 1998).

These studies found that there were: lower levels of leisure participation among people with disabilities than the non-disabled; activities of a more sedentary nature; extra cost of participation; built environment issues; transport barriers; lack of information provision; absence of program inclusions; and restricted choice of activities. The Australian studies have shown that the leisure participation most commonly participated in by people with disabilities was home-based, passive, non-social and required minimal equipment or facilities (Lockwood and Lockwood 1999).

Other research has investigated the extra cost of disability as a major constraint to citizenship (Disability Task Force 1991; Physical Disability Council of Australia 1997; Australian Quadriplegic Association 1999; PDCN 1999; Frisch 2001). The findings of these studies were remarkably similar, with the additional costs of disability identified as:

- accommodation, including specialised construction or modifications, maintenance and running costs;
- mobility equipment (wheelchairs, crutches, orthopedic shoes etc.);
- attendant care needs;
- personal care equipment (shower chairs, commode, hoist, slings etc.);
- personal care supplies; and
- transport because of inaccessible public transport.

Australian research into the constraints facing people with disabilities has largely involved evaluation of government funded recreation programs under Commonwealth and state

disability services legislation. These programs have predominantly been for people with intellectual disabilities or people with multiple disabilities living in institutional settings (Lockwood and Lockwood 1999). Interestingly, there was little discussion of the sample population in the studies. Yet, the needs of disability groups vary and this should be an important consideration of research and policy formation. Further, as Dempsey and Simmons (1995) have noted, the problem with the definitional nomenclature for disability generally makes comparisons between studies almost impossible.

E. Tourism constraints

Constraints research is a distinct area of research within the field of leisure studies, which reflects the field's traditional public sector, welfare orientation. This orientation means that 'concern about barriers, non-participation in recreation activities and lack of leisure opportunities has always been an important progenitor of [public sector] park, recreation, and leisure' (Goodale and Witt 1989:422). Much leisure research has therefore been as concerned with the *non-participant* and reasons for *non-participation* as with the participant and reasons for participation. The orientation of much research in the field of disability studies is similar. By contrast, most research within the field of tourism studies has traditionally been predicated on the idea of the tourist as consumer and factors that stimulate or facilitate demand. While economic constraints have been included in demand models, the focus has been on the tourist who arrives at the destination, not on the would-be tourist who is left behind. Recently this has begun to change. While tourism research has not become welfare-orientated, tourism researchers have nevertheless begun to recognise that a wider consideration of constraints may lead to a better understanding of tourist motivation, decision-making and destination image and destination choice models (e.g. Woodside and Lysonski 1989; Witt and Wright 1992; Jenkins 1999).

Ralph Smith (1987) provided the first examination and categorisation of barriers to leisure-travel for people with disabilities. The barriers identified were similar to those identified by Kennedy et al. (1991) and were conceptualised as intrinsic, environmental and interactive barriers. Each of these groupings has sub-categories and is presented in Table 10.

Table 10: Leisure-travel barriers of disabled tourists

Intrinsic Barriers

- Lack of Knowledge
- Health-related Problems
- Social Ineffectiveness
- Physical and Psychological Dependency

Environmental Barriers

- Attitudinal Barriers
- Ecological
- Architectural Barriers
- Transportation Barriers – air travel*
- Rules and Regulation Barriers – international air regulations*

Interactive Barriers

- Skill-Challenge Incongruities
 - Communication Barriers – language*
-

Source: Smith 1987 (*tourism context differences to Kennedy et al. (1991) noted)

Smith's review involved no empirical work but drew together the considerable body of existing research on leisure barriers generally, people with disabilities specifically and the very limited literature on disability and tourism. The work drew largely on people with intellectual disability and presented the likely implications for leisure-travel. Although many of the areas in the framework were identical to Kennedy et al. (1991), several of the constraints (notably transport, rules and regulations, and communication) were specific to tourism. While Smith regards these as environmental, they can be identified as structural constraints specific to an industry sector and, hence, socially constructed due to policy and practices.

Smith (1987:386-387) concluded by stating that people with disabilities have the same motivations to travel as the rest of the population but barriers form a '...network of interrelated forces that limit an individual's opportunities to experience leisure'. He argued that a concerted effort needs to be made to reduce barriers to participation and this would not only increase leisure satisfaction but also the likelihood of travelling. Drawing on social-psychological approaches, Smith observed that barriers undermine the foundations of leisure by reducing perceived freedom of choice, accentuating attributions of intrinsic shortcomings and decreasing overall leisure satisfaction. Reducing these socially created barriers will, over time, lead to both greater satisfaction with tourism and a greater emergence and visibility of tourists with disabilities. As Albert states, this 'will have an educative effect upon every dimension of society' (Albert cited by Smith 1987:387).

The strength, and weakness, of Smith's categorisation is his reliance on the leisure literature, which at the time drew on the experiences of people with intellectual disabilities.

This arguably placed an emphasis on some barriers (intrapersonal) at the expense of others (structural) faced by other disability groups. Yet, there was little Smith could do to rectify this situation given the lack of any systematic research into the area. Smith challenged others to undertake empirical research on the tourism barriers that confront people with disabilities.

The more recent work on tourism constraints began with Kerstetter and Holdnak (1990) whose research remained isolated. However, by the late 1990s, there was recognition that the constraints approach offers potential insights into tourism (Dellaert, Ettema and Lindh 1998; Hudson and Gilbert 1999). Recently completed studies have begun to examine the constraints facing those undertaking particular leisure activities (D. Gilbert and Hudson 2000; Williams and Fidgeon 2000), seasonality (Hinch and Jackson 2000), older tourists (Fleischer and Pizam 2002) and those choosing particular environmental settings (Pennington-Gray and Gray 2002). Leisure constraints models (Crawford et al. 1991; Jackson et al. 1993) offer a framework for analysing inhibitors to tourism participation for people with disabilities. However, critiques of constraint models suggest that grounded analysis should be considered to examine emergent themes from people's experiences rather than defined by the researcher (Samdahl and Jekubovich 1997a; 1997b). Similarly, leisure constraints research has been criticised for its reliance on quantitative, survey based methodologies that focus on social psychological paradigms. The results of leisure constraints research could be regarded as the product of a particular kind of social science rather than as objective social science research (Jackson and Scott 1999).

The remainder of the chapter reviews the treatment of disability in the tourism research literature.

4.4 Disability and Tourism Research – Demand

Within the general literature, many individuals with disabilities have written about their tourism experiences (e.g. A. Walsh 1991; Yeend 1993; Stainburn 1997; Rushton 1998; Uelmen 1998; Destefano and Boon 1999; Simpson and Simpson 1999; Goossens 2001; Slade 2001). This body of literature presents individual anecdotes of tourism experiences and documents amongst other things, the constraints encountered. While not academic, the accounts offer potential source material to research the wider implications of disability and tourism. This potentially rich source has not, however, been pursued for this thesis.

Table 11 presents a summary of the demand research on disability and tourism undertaken in Australia and overseas. This section reviews the Australian transport related research as a precursor to the Australian and overseas tourism research. The transport related research is an important starting point for the facilitation of the tourism experiences of people with disabilities.

Table 11: Demand research summary to 2001

Study	Origin	Year	Method	Sample	Impairment
Woodside and Etzel	USA	1980	Postal household survey of members of the University of South Carolina Consumer Panel.	N=590 households N=60 pwd	Physical Vision Other
Murray and Sproats	Aust	1990	Postal survey	N=93 pwd and family	Not stated
Cavinato and Cuckovich	USA	1992	Survey Interviews	N=32 pwd 2 disability orgs 5 dis service orgs	Not stated
Burnett	USA	1996	Postal membership survey	N=307 pwd N=386 non-disabled	Mobility
Darcy	Aust	1998	Postal membership survey Qualitative feedback	N=2,647 100,000 words	Physical
Turco, Stumbo and Garncarz	USA	1998	Focus groups	N=4 focus groups	Physical Vision
English Tourist Council	UK	2000	Survey Interviews	N=254 N=18	Hearing Sight Mobility
Foggin	Canada	2000	In-depth interviews Ricoeur's Narrative Approach	N=16 interviews A sub-set of 3 were selected as being representative	Mobility
Burnett and Bender Baker	USA	2001	Postal readership survey Market segmentation	N=312	Mobility
Transport Research					
Faulkner and French	Aust	1982	Game simulation interview & secondary data analysis	N=60 pwd	Physical
Tisato	Aust	1997	Travel cost secondary data	NA	Mobility
Folino	Aust	1998	Focus groups, meetings and submissions	N=100	All
DDA Standards Project	Aust	2000	Open ended survey	N=6,000	All

A. Australian

Downie (1994a) reinforced Smith's (1987) call for greater empirical investigation of disability and tourism in his thorough review of public transportation issues facing people with disabilities in Australia. His chapter on tourism reinforced the view that tourism and disability in Australia has been an under researched phenomenon. Downie noted that the small amount of overseas research that had been carried out identified transportation as the major tourism constraint, followed by a lack of accessible infrastructure, physical access and information. He identified the lack of accessible public transport as an inherent weakness of tourism for people with disabilities in Australia. Downie's general

conclusions were that while there should be a steady growth in the level of domestic disability tourism and an increase in requests from overseas travellers with disabilities, there is a lack of statistical foundation to market planning. In conclusion he argued the need to undertake Australian research 'to ensure that future tourism market demands by people with disabilities can be met' (Downie 1994a:391).

The first Australian research undertaken was transport related. This is reviewed separately before reviewing the tourism specific research.

Transport research

Faulkner and French (1982) researched the impact of the introduction of the ACT *paratransit*⁵ system on people with disabilities. The findings of the study were that people with disabilities in Canberra made fewer trips than did the non-disabled. The introduction of paratransit services had a major impact on the travel patterns of wheelchair users. Yet, the cost associated with this form of travel was prohibitive in comparison to public transport. The existence of the paratransit system was nevertheless essential as 43 percent of respondents required assistance to use any form of transport and were unable to use current public transport. Other non-travel constraints for people with disabilities included access to buildings, low income/employment levels, low awareness of services and a range of intrinsic barriers. The research of Faulkner and French has implications for tourism, in that the provision of a paratransit system in the absence of an accessible public transport system did have a positive impact on increasing the citizenship rights of wheelchair users.

Tisato (1997) undertook a case study of the travel costs and affordability of transport for people with mobility disabilities in Adelaide. He used a range of secondary data to compare the costs of paratransit taxi travel to public transport and car travel. The findings demonstrated that travel costs for people with disabilities in Adelaide are significantly higher than for non-disabled public transport users. However, Tisato argues that when time costs are factored in with monetary costs then this disadvantage would see wheelchair users choosing paratransit taxi travel over bus travel (on longer trips but not on shorter CBD trips). The research was based on information supplied by the operators of the paratransit system rather than people with disabilities (Tisato 1997:178). Finally, Tisato presents a range of options for improving travel affordability for people with disabilities

⁵ Paratransit systems for people with disabilities operate in parallel to public transport systems. Paratransit systems are segregated, and in Australia, generally based on a subsidised taxi service of vehicles modified for wheelchair access.

including increasing the subsidy rates, cash transfers, non-modal travel subsidies, taxi deregulation and increased public transport cost recovery.

It was not until the publication of research by Folino (1999) and HREOC (2002c) that the extensive problems with the operation of the paratransit taxi systems were documented from a disability perspective. Folino (1999) drew on focus groups and open meetings in metropolitan and rural areas. This was the first time in the 20-year history of the system that the experiences of people with disabilities had been researched. Folino's research was part of the pressure that led to HREOC calling a public inquiry on paratransit systems. HREOC's (2002c) public inquiry accepted submissions from all stakeholders. The major finding was that the service provided to people with disabilities was inferior to that provided to the non-disabled. HREOC set a 5-year timeframe for the industry nationally to provide an equality of service. However, the inquiry noted that the industry had only recently moved towards performance standards and monitoring which made its investigation and future monitoring difficult.

The DDA Standards Project (2000) provided documentation of the constraints to public transport in Australia from a disability perspective. The report was based on responses by 6,000 people with disabilities and concluded that there was a 'ground-swell of support for accessible public transport amongst people with disabilities' (DDA Standards Project 2000:7). While not examining tourism, this study reinforced the validity of the constraints to paratransit systems identified by Folino (1999) and HREOC (2002c). Further, it linked the exorbitant extra cost of paratransit systems to people with disabilities as a factor affecting the level of disposable income available to participate in other community activities. In a tourism context, this research reinforced the validity of Downie (1994a), and the warning issued to travellers with disabilities about Australia that, 'Generally most types of public transport are inaccessible to those with partial or severe disabilities' (ATC 1995a:2).

In summary, Faulkner and French (1982) and Tisato (1997) did not question the oppressive nature of a segregated public transport system. In fact, both studies questioned the likely benefits of providing an accessible public transport system in their respective cities due to the major infrastructure cost of providing such a system. These assumptions did not incorporate disability perspectives in their research or investigate the benefits of improved access to public transport. This was essentially different to the documentation of the

disability experience of public transport and paratransit systems in Folino (1999), DDA Standards Project (2000) and HREOC (2002c). The Australian experience of accessibility of public transport appears similar to that of other Western nations (Revis and Revis 1978; Brjesson 1989; Cavinato and Cuckovich 1992; Almon-Hamm 1997; United Nations Committee on Transport 2000; Hine and Mitchell 2001; A. Porter 2002).

Tourism research

Only three Australian empirical studies have been conducted of people with disabilities and tourism. Murray and Sproats (1990) undertook an investigation of the tourism experiences of people with disabilities in Townsville. The findings were prefaced with a market estimate based on the ABS (1988) 2.6 million Australians with disabilities who were potential tourists. The demand research was based on a survey of the attitudes towards tourism to national parks and resorts held by tourists with disabilities and their families (n=93). While detailed statistical results were not provided, several of the findings are worth noting. The respondents visited national parks more than resorts but half had visited neither. Among those who had visited, there was a greater propensity to re-visit, thus Murray and Sproats (1990:13) argue, 'exposure to tourist experiences creates its own demand'. There was also a limited discussion of the barriers to tourism using economic, physical and attitudinal constructs. Mobility was reported as the major barrier encountered and respondents believed that other guest reactions to their disability were more negative than staff reactions. Murray and Sproats recommended increased provision of relevant information and encouragement of government and the industry to develop tourism opportunities.

It was not until the 1998 postal survey of members of physical disability organisations by Tourism NSW (Darcy 1998), that a substantial investigation of the tourism patterns and experiences of people with disabilities in Australia was undertaken (n=2642 see Appendix 2 for methodology). In the previous 12 months, 75 percent of respondents undertook domestic trips and ten percent had undertaken overseas trips. Further, 70 percent had undertaken a day trip in the last six months. In general, it was found that respondents were not satisfied with their current level of tourism (74%). The major constraints identified in the study were grouped into economic, accommodation, destination, attraction, travel planning, information, transport, air travel, attendant and equipment. The study also produced the first Australian market estimates of the \$1.5bn annually spent on tourism, based on the survey data and the ABS (1998) disability statistics. This data source is

further interrogated in Chapters 7 and 8.

The Queensland Tourist and Travel Corporation (QTTC) held focus groups around Australia during mid 1998. The purpose of the focus groups was to investigate the potential of developing specialist tourism packages (fly - accommodation - transport - attractions) for people with disabilities wishing to holiday in Queensland. A range of people with disabilities and service organisations attended the focus groups. This was a major development, a TA recognising the needs of people with disabilities and their potential as a market. However, it was unfortunate that the findings of this report were not released publicly because the report was seen to be a competitive advantage for Queensland over other states (Miller 1999 pers. comm.).

The *Domestic Tourism Monitor* (DTM) (BTR 1988-1998) and the ABS short-term arrivals and departures monitor (ABS 2000a) had collected data about Australians domestic, day trip and overseas tourism patterns. None of these sources contained disability related information. The *National Visitor Survey* (NVS) (BTR 1998) replaced these sources. The survey of 78,312 households includes day trips, domestic travel and overseas travel. The 1998 NVS was the first to include a disability module on the respondent or other travellers in the respondents' travel party. However, the disability module was only included for 1998 and 1999, and subsequently dropped for subsequent surveys. The reasons for the exclusion of the disability module reflected the methodological concerns discussed in Chapter 6 (O'Halloran 2002). An analysis of this data source is presented in Chapters 7 and 8 of this thesis.

B. International research perspectives

While not empirical, Noble (1979) provided one of the first academic treatments of tourism provisions for people with disabilities. The paper identified the increasing numbers of travellers with disabilities, made the connection between disability and 'aged travellers', stated the need for the TI to undertake better provisions for the group, and suggested reasons for why this does not occur. The paper is historically valuable, as it shows in a Canadian context how the TI has changed from 1979 to the present day. It examines the responses of two non-government organisations to the transportation and accommodation needs of people with disabilities. The paper concludes with a call to create a 'barrier-free' tourism environment for travellers with disabilities.

Woodside and Etzel (1980) undertook the first empirical study on disability and tourism that sought to discover the role of physical and mental conditions on tourism vacation behaviour. The survey found that 10 percent of the 590 respondents to a household survey in the US State of South Carolina who had gone on a trip had a member of their party with a 'physical or mental condition'. The most commonly reported restrictions were heart conditions, use of crutches and old age. The constraints to tourism included: the lack and location of elevators at sightseeing and recreation facilities; availability of wheelchairs; types and weights of doors used to enter recreation sites and restrooms; and availability of attendants. It was noted that tourism parties with people with disabilities were unlikely to have different demographic characteristics or different experiences to other tourism parties. However, Woodside and Etzel (1980) concluded that there was a lower level of tourism in households with people with disabilities.

Durgin, Lindsay, and Hamilton (1985) were the first to refer to secondary data of the 35 million Americans with disabilities and to estimate that 13 percent of all travellers in the US had some form of 'handicap'. Yet, the tourism estimates referred to were not referenced. Durgin et al. (1985) used the disability statistics to reinforce the numbers of people with different disabilities who travel, despite the obstacles that they encountered and argued that the numbers were increasing each year. More detailed secondary data research followed this approach to identify the potential market significance or the lost opportunity, of not servicing people with disabilities' tourism needs (Touche Ross 1993; Kèroul 1995). These studies used secondary data about the level of disability in populations and extrapolated the implications for tourism. They did not undertake specific empirical research into the tourism patterns of people with disabilities or the implications of the lower levels of travel by people with disabilities as indicated by Woodside and Etzel (1980).

In a study focused on domestic tourism in the US, Cavinato and Cuckovich (1992) sought to understand the impact of the introduction of the ADA on transport and tourism. They viewed this legislation as a 'major step forward in opening opportunities for tourism for the disabled in the United States' (1992:51). Cavinato and Cuckovich conducted surveys of people with disabilities (n=32), and interviews with travel agents, tourism organisations, disability organisations, rehabilitation centres and disability service providers. They viewed accessibility in the widest sense to incorporate information, planning, transport,

lodging, restaurants, attractions, functional care and medical access. The findings recognised the importance of the linkages and coordination between these sectors, and sought to develop a substantiated understanding of the terms *disability* and *access*. They identified the major constraints to tourism for people with disabilities as over road buses, poor information dissemination, the legislation not covering some specific needs of people with disabilities and loopholes in the legislation. Cavinato and Cuckovich concluded that in the US there was no national information on the propensity of people with disabilities to travel and the domestic micro-elements of this study were further complicated by international travel.

The 1990s saw European and Canadian studies utilise secondary data to develop market arguments for the importance of disability to tourism (Touche Ross 1993; Kèroul 1995). These studies were part of the development of Canadian and European initiatives to improve tourism accessibility for people with disabilities. These reports were based on a range of assumptions about disability and tourism. For example, Touche Ross (1993) assembled secondary data estimates of disability in Europe, and extrapolated the likely size and spending power of the group. The estimates were predicated on ‘physical and financial ability to travel’. However, the operationalisation of these terms was problematic.

Burnett’s (1996) US study compared the preferred retail information sources for mobility-disabled consumers (n=304) and the non-disabled (n=386). The study found that information sources from disability organisations were the most important source, for people with disabilities, outside of family and friends. People with disabilities had significantly lower levels of mass media usage. The mobility-disabled showed a significantly greater negative attitude towards advertising than was the case for the non-disabled. Not surprisingly, this was reinforced by their desire for advertising to contain information relevant to them. The mobility-disabled valued ‘shopping efficiency’, ‘sales personnel’ and ‘store environment’ well above the non-disabled, while ‘product selection’, ‘credit availability’ and ‘price’ showed no significant differences between the groups (Burnett 1996:18). The study concluded by suggesting that the mobility disabled represent a unique market compared with the non-disabled, and discussing managerial implications relevant to the services marketer. These findings were similar to Capella and Greco’s (1987) US survey of seniors, which found the most important information sources were family and friends, and word of mouth. Moreover, travel agents were not an important source of information to either group.

Turco, Stumbo and Garncarz (1998) qualitatively examined constraints to tourism in Illinois for people with disabilities or 'conditions'. The methodology consisted of four focus groups conducted in 1997 and 1998 involving clients of independent living centres. Participants had a variety of impairments including cerebral palsy, spinal cord injury, post-polio, visual impairments, and mobility limitations. The constraints were reported for four major tourism sectors and are summarised as:

- attractions: environmental in nature and related to site inaccessibility;
- information resources: key informants - travel agents, family & friends, and Internet;
- transportation: damage to and loss of wheelchairs; difficulty in transferring between flights; the inaccessibility of airplane restrooms;
- accommodation: some hotel rooms were promoted as accessible but were not; fittings were inappropriately located (such as lamps and TVs); high front-desk counters; lack of non-smoking rooms; rooms were inconveniently located; many hospitality establishments within tourist destinations were inaccessible.

Turco, Stumbo and Garncarz's sectoral categorisations reflected the non-academic papers of the anecdotal accounts of the tourism experiences of people with disabilities and Tourism NSW's (Darcy 1998) review of the barriers that they face. These sectoral categorisations appear to be the way that people with disabilities organise and reflect upon their tourism experiences. This is similar to seminal work of Clawson and Knetsch (1966) on the stages of outdoor recreation experience.

The English Tourist Council (2000b) estimated the propensity of holidays by people with disabilities. The paper was prepared in response to the introduction of the UK *Disability Discrimination Act, 1995* and the Council's tourism strategy, *Tomorrow's Tourism* (English Tourism Council 1999). The market estimates were based on secondary data of disability in the UK and the tourism habits of people with disabilities through 18 qualitative interviews and a survey (n=254). The research suggested that 2.5 million people with disabilities would take a domestic holiday each year given the availability of accessible facilities. This figure did not include those who travel with them as carers, family or friends. The research concluded that the market potential was substantial and increasing with the ageing of the population. The key recommendations were that:

- disability awareness training of the TI should be undertaken to alleviate ignorance;
- an employment strategy for people with disabilities should be developed within the TI; and
- information provision needs to be systematically collected (ETC 2000b:6).

Foggin (2000) presented an investigation of the leisure tourism experiences of 16 Quebec

residents with disabilities. The qualitative methodology was informed by Paul Ricoeur's discussion of 'life and narrative' (Foggin 2000:6). Of the 16 narratives, three were selected as being representative of general types or situations of tourists with disabilities with respect to their level of ability, their style of tourism or their life-cycle stage. Based on the narratives, suggestions were made for 'possible activity' that might be undertaken by tourists, by the TI or by other segments of society including the academic world. Foggin argues that people with disabilities seek far more than different places and cultures in their tourism experience. Using the biographical method, her research provided a valuable insight into the role that tourism plays within the lives of people mobility disabilities.

Burnett and Bender Baker (2001) present the results of a market segmentation study that examined the tourism-related behaviour of mobility-disabled travellers in the US. The paper begins by reviewing secondary data and estimates the market potential of 50 million Americans with disabilities with a discretionary income of over \$200bn. Burnett and Bender Baker argue that this market is ignored by the TI because of a lack of understanding of disability needs and because of the confusion that surrounds the ADA. This confusion, they say, has seen businesses focused on the cost of providing access rather than understanding the needs of the market. The survey results (n= 312) suggest that segmenting the market by 'severity of disability' may be a valuable approach in predicting decision-making criteria. As severity of disability increases so does the importance individuals place on environmental, access and activity criteria (Burnett and Bender Baker 2001:10). However, their conclusions that people with severe disabilities travel differently, and for different reasons, do not consider the role of structural constraints on these behaviours.

A number of papers in languages other than English were located but not included in the literature review because of language issues. These included French and Italian papers discussing the social tourism movement in their respective countries (Champeaux 1987; Bas 1992). A number of French articles, including a special issue of *Espaces*, reported that people with disabilities' dissatisfaction with tourism experiences was due to the inability of the TI to meet their needs (Gagneux *et al.* 1999). Another survey estimated that the extra costs of tourism for people with disabilities were between 30-200 percent higher than for the non-disabled (Flavigny and Pascal 1995). One Dutch and two German articles discussed mechanisms for mainstreaming tourism opportunities for people with disabilities with the non-disabled (Verwegen 1989; Wilken 1997; Wilhelm 2000).

C. Demand research conclusions

The demand research has been sporadic since Woodside and Etzel's (1980) first empirical study. Progress has been slow in developing an understanding of the tourism needs of people with disabilities. In the Australian context, there is the lack of empirical research on disability and tourism with only two studies on the phenomenon, whereas the overseas research has been more plentiful, but sporadic and regionally based. A number of themes emerge from the literature. These are:

- size of the tourism market of people with disabilities;
- a comparison of tourism patterns of people with disabilities with the non-disabled;
- role of tourism marketing and the provision of tourism access information in tourism planning for people with disabilities;
- inaccessibility of the transport, accommodation and attractions sectors;
- disability market segmentation;
- impact of anti-discrimination legislation on goods and service provision;
- medical approaches of disability tourism research; and
- lack of an explanation for the experiences of people with disabilities.

1. Size of the tourism market

Durgin et al. (1985), Touche Ross (1993) and Kèroul (1995) attempted to quantify the level of tourism by people with disabilities in the US, Europe and Canada through secondary data estimates of disability and their physical and financial ability to travel. While these assumptions were flawed because they made assumptions about disability, they estimated that a substantial market existed. The estimates of Tourism NSW (Darcy 1998) and the ETC (2000b) took a more sophisticated approach by combining national disability statistics with survey findings of domestic tourism patterns for the preceding year. Each of these studies developed an argument for disability as a market firstly, by showing people with disabilities as a significant proportion of the population, and secondly, by providing evidence of their tourism patterns.

2. Comparison of the tourism patterns of people with disabilities and the non-disabled

The above studies do not provide comparisons with the non-disabled. Woodside and Etzel (1980) established that on a regional level, households with people with disabilities travelled less than non-disabled households did. Yet, no studies investigated the comparative travel patterns of people with disabilities and the non-disabled at a national level. This would provide a starting point to investigate whether there is a difference in tourism patterns, and if so, whether that difference is due to constraints experienced by people with disabilities.

3. Role of tourism marketing and the provision of tourism access information

A major constraint to travel planning is the way tourism marketing and information provision overlooks the needs of people with disabilities (Murray and Sproats 1990; Cavinato and Cuckovich 1992; Burnett 1996; Darcy 1998; Turco et al. 1998; Burnett and Bender-Baker 2001). People with disabilities identified that travel agents, TA and the other sectors did not meet their needs in the way tourism was marketed and, hence, the information that was provided to people with disabilities. This affected whether people undertook travel or had adverse experiences while travelling. Burnett (1996) reinforced that people with disabilities relied on alternative sources for information provision to the non-disabled. This research was reinforced by Tourism NSW (Darcy 1998) and Turco et al (1998) that identified word of mouth, family and friends, or previous experience as the main information sources for people with disabilities. Further, these studies established that the tourism access information that was provided was unreliable or inaccurate.

4. Inaccessibility of transport, accommodation, attractions and destination areas

Marketing and provision of information are closely associated with the subsequent accessibility of transport, accommodation and attractions sectors in providing satisfying tourism experiences. Without knowledge of or access to these sectors of the TI, people with disabilities were constrained in their tourism opportunities and experiences. All studies identified that people decided not to travel or encountered barriers to tourism once commencing a trip (Murray and Sproats 1990; Cavinato and Cuckovich 1992; Darcy 1998; Turco et al. 1998).

5. Disability market segmentation

Tourism textbooks omitted people with disabilities as a market segment. While the earlier secondary data studies were motivated to identify disability as a significant market segment, they did so in an unsophisticated manner. The emergence of disability as a consumer group drawing on market segmentation literature has not been a major paradigm in Australia where welfarism dominated government discourse and citizenship has galvanised disability advocacy groups. This is not the case in the US where the ADA compliance based approach to disability rights had put TI sectors on notice that the group had to be treated equally in the market (Kazel 1996; Andorka 1999; Worcester 2000; Baumann 2001). Market arguments have had a major impact on US corporate culture. These ideas were developed generally by Reedy (1993), Burnett (1996) in an information

context, and Burnett and Bender-Baker (2001) in a tourism context to provide a market segmentation approach for people with disabilities. Tourism NSW recognised that within disability there were distinct needs based on the dimensions to access of mobility, sensory and communication (Darcy 1998). Burnett and Bender Baker (2001) linked information provision to preliminary investigations of a market segmentation approach to disability. Their research suggests that the needs of people with mobility disabilities are different to the non-disabled, and that ‘severity of disability’ may be a valuable market segment identifier.

The last three themes that emerged were due to omission rather than inclusion.

6. Lack of assessment of the introduction of human rights legislation

A number of US studies and a UK study identified the introduction of the human rights legislation as an important event for improving tourism conditions for people with disabilities. However, it could be argued that while the ADA raised awareness that disability must be considered by tourism concerns, none of the papers assessed the impact on the tourism experiences of people with disabilities. This omission is addressed in this thesis by evaluating the effects of the introduction of the DDA on the experiences of people with disabilities and on the practices of TA and TI in Australia.

7. Tourism research founded on medical approaches to disability

It became apparent that many of the studies were not founded from a disability perspective. Several of the studies made assumptions about people with disabilities. These studies framed disability as a deficit of the individual and, hence, were medical in their orientation. This framing gave the sense that the circumstances facing people with disabilities were the ‘natural’ outcome of their impairments. While Tourism NSW (Darcy 1998) and Turco et al (1998) focused on the structural barriers to travel, it was Foggin (2000) who provided a refreshing insight into the role of tourism in the leisure lives of people with disabilities. In particular, she recognised that while change occurred in the tourism patterns of people who traumatically acquired mobility disabilities, it did not change their desire or reasons for travel. Following this direction, this thesis can present an alternative paradigm for viewing the disability tourism experience.

8. Lack of explanation for the experiences of people with disabilities

Yet, after reviewing the literature on the tourism experiences of people with disabilities,

the most notable absence was an explanation for why the experiences of people with disabilities are the way they are. This aspect has received no attention in the literature. It is more intriguing given the consensus that: people with disabilities constitute a significant proportion of the population; the introduction of human rights legislation; and a realisation that the TI sectors have done little to accommodate their needs. This thesis can provide an opportunity to explore an explanation for the tourism experiences of people with disabilities in Australia.

4.5 Disability and Tourism Research – Supply

This section chronologically reviews first the Australian and then the overseas tourism research. The role of the TA and TI in the provision of services for people with disabilities wanting to travel is critical. Before discussing the empirical research, an important non-academic source of information is briefly discussed. Tourism access guides are produced for practical and commercial reasons. They are, however, of interest from a research perspective because they represent attempts to gather systematic information, of varying quality, and provide some insight into industry provision.

There are two types of tourism access guides for people with disabilities. The first are those published by government agencies (London Transport 1993; Canadian Transport Agency 1997c; Virginia Travel Corporation 1997), and the second are those published by the commercial sector (Northern Cartographic 1988; A. Walsh 1991; Stanford 1999; G. Crouch 2000b; Illum, Lillard and Thompson 2000; Maxa 2001). Several of these have been Australian produced (Cooper 1994; Harper 1999; NRMA 1999; James and James 2000). However, they are based on varying assumptions as to the needs of people with disabilities. There is no clear distinction in the guides between types of impairment and, hence, the dimensions of access assessed by the guides. Further, the information collected is either self-reported by the operators reviewed or idiosyncratic to the individual collecting the information. A further type of guide focuses on the impairment of the traveller, the practicality of travelling taking into account these ‘shortcomings’ and the logistics of planning tourism with an impairment (Rosen 1997; Rous and Ward 1997).

There are a number of exceptions to these types of guides. In the Australian context, those developed by Australian Council for Rehabilitation of the Disabled (ACROD) (1994) and Cameron (1995; 2000b) are based on a systematic, third party assessment regime for

people with mobility disabilities, particularly wheelchair users, who want accessible experiences. The systematic assessment was developed to provide detailed tourism access information based on the Australian Standards AS1428 (Standards Australia 1992a; 1992c; 1992b; 1995; 2001). The provision of such information allows people with disabilities to make an informed decision about whether the premises are accessible for their needs.

Cameron (1995; 2000b) provides three other important features. First, he includes regional tourism information about transport, disability services, attractions, points of interest and accommodation. Second, a thorough access audit of the accommodation establishments reviewed is undertaken in which the property is set in context to the external environment (location, proximity to services, parking and drop-offs), through the reception, facilities and services, and the accommodation rooms. The audits are based on AS1428 and provide detailed measurements of the property rather than dichotomous checklists of compliance. Third, the measurements are then transformed into floor plans of the rooms and bathrooms to provide a visual representation of what people with disabilities will find upon checking in.

Of the overseas guides, Fodor's (1996) presents a systematic approach to providing tourism information for people with disabilities who want to holiday in 38 regions of America. It is the only guide to provide tourism access information for mobility, hearing and vision disabilities. While this approach is not as transparent as the floor plans provided by Cameron, it is nevertheless thorough and consistent. The most innovative feature of the book is the social approach to disability that it takes. The chief sponsor of the USA's *Americans with Disabilities Act, 1990* (ADA), Senator Tom Harkin, provides a foreword. Addressing tourism as part of disability citizenship rights, he states, 'Fodor's guide has taken the ADA yet another step forward by recognising that the basic principles of inclusion, independence and empowerment for people with disabilities are inviolate' (1996:xii).

The significance of all these publications is that they represent a beginning of disability awareness on the part of government and the private sector. The more comprehensive of the guides show an understanding of the underlying needs of the group, their information requirements and a sound methodology. The importance of the approaches used by ACROD, Cameron and Fodor is discussed further in the findings of the thesis.

Table 12 presents a summary of the empirical supply research undertaken in Australia and overseas. Only 12 studies were located, with six of these Australian, five U.S. and one European. Seven of the studies investigated particular sectors of the TI provisions for disability, two assess information provision by TA, two assess TI attitudes towards people with disabilities, and one focused on the employment of people with disabilities in the TI. The remainder of this section reviews this research.

Table 12: Supply research summary to 2001

Study	Origin	Year	Method	Sample	Impairment
Weiler and Muloin	Aust	1989	Letter requests/mail survey 18 Govt TA, 3 returned, 8 of the 15 replied	8 Australian Govt tourism authorities	Wheelchair
Muloin and Weiler	Aust	1991	Letter requests/mail survey 18 Govt tourism authorities, 2 returned, 14 of the 16 replied	14 Canadian Govt tourism authorities	Wheelchair
Murray and Sproats	Aust	1990	Access audit Interviews	23 motels audited 8 resort managers 8 NPWS managers	Not stated
Smith	USA	1992	Survey of employing people with disabilities Interviews	72 hotels and restaurants 2 tourism orgs 12 travel agents	Physical Deaf/Blind Not stated
Cavinato and Cuckovich	USA	1992	Interviews	80 facility and service providers	NA
Touche Ross	Euro	1993	Survey	Destination marketing managers	NA
Ross	USA	1994	Survey Interviews	8 cruise lines	Wheelchair Blind/Elderly
Gallagher and Hull	USA	1996	Telephone survey	488 establishments 32% response rate	Not stated
Upchurch and Seo	USA	1996	Survey of accommodation providers	4 sectors	General
WADSC	Aust	1997	Think Tanks of TI leaders	175 TAFE and University students enrolled in hospitality and tourism courses	NA
Daruwalla	Aust	1999	Pre and post testing of disability awareness interventions via individual and societal awareness scales	20 industry	All
O'Neill and Ali-Knight	Aust	2000	Interviews Survey	73 establishments	

A. *Australian*

Muloin and Weiler (1989) modified Clawson and Knetsch's (1966:33-36) major phases for outdoor recreation experience to investigate tourism and disability through a *5 Stage Model of Travel*. Weiler and Muloin (1989) completed empirical research on TA responses to the anticipation and planning stages of tourism. They investigated the response of Australian TA to a Canadian request for information about tourism to Australia by a person with a friend who was a wheelchair user. The letter requested access information on accommodation, transport, tours and information. Of the 18 letters sent, three were returned to sender, with eight of the other 15 receiving a reply. Of these, seven included letters:

- 2 were form letters that did not address the access inquiries;

- 2 forwarded the letter to other agencies;
- 4 sent a letter only or with enclosures that did not address disability needs;
- 4 suggested additional contact information and included brochures on accessible accommodation (2), attractions/facilities (3), and tour companies (2); and
- 1 said further information would be sent by surface mail.

Their results highlighted a lack of detailed information provision and understanding of the needs of people with disabilities by TA. Further, as Weiler and Muloin note, there was a great deal of difficulty and cost associated with obtaining the suggested information/guides. Yet, there was no assessment of the accuracy and reliability of the publications. In the other part of the study, Weiler and Muloin used two guides to assess the level of accessibility of accommodation and attractions, those produced by the Council of Disabled Motorists (1986); and the Commonwealth Department of Sport, Recreation and Tourism (1986). Only 133 establishments of 4,577 listed (2.9%) had accessible rooms. This was an accessible roomstock of 473 rooms out of 139,319 (0.3%). The CDSR (1986) listed 840 accessible attractions in Australia but estimating the proportion of accessible attractions was harder, due to the type of establishments (restaurants, theme parks, national parks etc.) considered attractions. While the methodology of assessing ‘accessibility’ for both these sources was flawed due to the self-reported nature of the information (discussed in Chapter 10), both reinforce the constrained choice that people with disabilities have in their holiday itineraries.

In a follow-up study, Muloin and Weiler (1991) used the same methodology to evaluate Canadian TA’s provision of information for people with disabilities. The findings were then compared with the earlier Australian findings. These suggested that the Canadian TA were better organised with access information and replied at almost double the response rate of Australian TA. However, the Australian TA were more willing to provide customised information that was requested in the letters. In neither study were the criteria for assessing accessibility of the information sources provided.

The previously mentioned study by Murray and Sproats’ (1990) focused on aspects of the TI in Townsville (Queensland). The research was based on the researchers’ audits of accessible accommodation (n=23), interviews with managers of these accommodation facilities (n=8), and interviews with national parks managers about their attitudes towards travellers with disabilities (n=8). The audits of accommodation found that only one establishment was independently accessible conforming to the Australian Standards of the day. The poor results of the audits were compounded by the poor attitudes towards the

accessible rooms revealed in the interviews with accommodation managers. In particular: little importance was placed on the accessible rooms; one motel used the room for a store room; two rooms were permanently let to non-disabled service families; and in one case, the roll-in shower features had been replaced to make the room more appealing to the non-disabled (Murray and Sproats 1990:11).

The interviews with the two groups of managers highlighted a lack of recognition of the size of the group and a perception of the group as not having market potential. What emerged was the perception of the group needs not being understood by managers, and the belief among the managers of those establishments without access that it was too costly to undertake modifications. However, all managers stated that they would welcome guests with disabilities and that if the market potential could be established then they 'would be more likely to develop extra services to cater for their special needs' (Murray and Sproats 1990:12).

In 1997 the Western Australian Disability Services Commission (WADSC) embarked on a joint government and industry project, *Accessing New Markets - Customers with Disabilities* (WADSC 1997b). This project was by far the most industry-orientated initiative seen in Australia to date, with industry players in tourism, hospitality, entertainment and retail sectors being brought together. The aims of the project were to raise awareness about customers with a disability, improve their quality of life experience and expand the business community's traditional customer base. The project employed industry 'think tanks' where industry managers and proprietors heard consumer experiences and then developed strategies to improve access to their facilities, services and products. The think tanks were supported by a media campaign in trade journals and industry specific publications that identified the issues facing customers with disabilities. The outcomes identified customer relations, information and physical environment as the major areas requiring attention. Approaches to customer relations were divided into three areas: staff attitudes; staff awareness; and education and training. Information provision involved knowledge of access standards, use of access symbols, the need to develop marketing to customers with disabilities, and the development of products outlining accessible services and facilities as the key areas for improvement. Physical environment issues involved the operationalisation of continuous pathways, the uncontrollable elements of building access, the financing of access and the development of an accessible business accreditation system as ways to move forward. The report made 27 recommendations and

proposed the development of recognition awards for best practice (WADSC 1997a). The only outcome has been the development of a disability awareness training resource (WADSC 2000a).

One common finding of all the TI studies is the need for TI awareness training. Daruwalla's (1999) study of disability awareness training interventions on TAFE and university hospitality students suggested that these types of training interventions are likely to produce a positive change in attitude towards people with disabilities. Such changes in attitude, the findings suggest, are likely to be more substantial when the disability awareness training incorporates contact with people with disabilities as well as information provision through lecture and video. Her study reinforced the findings by other researchers, that people who have had previous and/or ongoing contact with people with disabilities have positive attitudes towards them.

The final Australian study, by O'Neill and Ali Knight (2000), investigated the Western Australian TI perceptions of providing accommodation for people with disabilities. They also researched the level of accessibility of Western Australian hotels. The first part of the study included interviews with 15 hotel operators (hotel general managers and operational managers) from a range of two to five star properties, and interviews with 10 government, tourism and disability organisations. The major analysis concerned: the awareness of legislation; awareness of market potential; access and facility provision; recruitment and training; and marketing disability product. The outcomes of the findings focused on information provision, education and training, and accessibility issues. The second part of the O'Neill and Ali Knight (2000) study involved a questionnaire-based survey of 319 motorist association listed motels and hotels (n=72 22% return rate). The self-reported methodology was fraught with problems due to the technical nature of the BCA and referenced Australian Standards and the perceived threat of responding negatively to disability related information. In fact, the low response rate may be a better indicator of the lack of accessibility of the accommodation sector than the responses received.

B. International research perspectives

In the aforementioned US study, Cavinato and Cuckovich (1992) interviewed travel agents (n=12) and tourism organisations (n=2) about disability issues. Their findings suggested that travel agents did not have access to disability related information, the information they

did have was inaccurate and they had little understanding of the needs of travellers with disabilities. In conclusion, Cavinato and Cuckovich suggest that many of the problems experienced by people with disabilities and the lack of understanding by travel agents were due to there being no single acceptable definition of *disabled or accessible*.

Smith (1992) conducted a survey of the employment of the people with disabilities in the hospitality industry, based on the premise of a labour shortage in the tourism and hospitality industries. The US government also provided taxation incentives to hire people with physical and mental disabilities. Of the 405 questionnaires posted, only 72 were completed (18%). Some 43 percent of establishments currently employed or had hired people with disabilities in the past. These establishments were large organisations with a turnover of over \$1m/year. Of the people employed, the majority had a physical or hearing disabilities and some were blind. The establishments reported that most individuals did not require modifications to the workplace, most are employed in the food service area and some in supervisory roles. A number of issues were raised regarding the training required and the need for more information about the employment opportunities of people with disabilities. Smith (1992:24) concluded that employers regarded employees with disabilities as a valued asset.

The aforementioned report by Touche Ross (1993) also sought to increase awareness amongst facility and service providers and industry decision makers of the tourism potential of people with disabilities. The study surveyed 800 organisations across Europe but only 10 percent responded. Touche Ross argued that the findings suggest that there was an increasing awareness of the potential of the market but that this was concentrated amongst a small number of operators. A major constraint to the development of the market was the lack of consistent product across the sector, including a lack of information provision and marketing to this group. It is concluded that with good transport, accessible facilities, properly trained staff and the marketing of these products through 'the development of co-ordinated and consistent travel packages' (Touche Ross 1993:39), new markets might be expected to emerge.

The need for the types of disability awareness training discussed by Daruwalla (1999) in the Australian context to inform TI is evidenced in Ross (1994). His study of the attitudes of US destination marketing managers towards people with disabilities raised questions as to the problems of researching TI perceptions of employing people with disabilities. The

study tests Wolfensberger's (1983) social role valorisation theory (see Chapter 3). A survey instrument was administered to see if the individual attitudes of managers would affect the hiring of 'disabled workers' in destination marketing organisations. Touche Ross's findings suggest that Wolfensberger's model did not work with this group. He indicated that many managers would not hire people with disabilities and that they camouflaged their real attitudes towards the people with disabilities and, hence, hiring practices. This was done where managers perceived the need to maintain the organisation's image in the hiring of staff. Touche Ross speculates that this may be due to the perception by managers that the disabled have a 'poor appearance' to their customers and, hence, are not suitable for a service-based business. The findings also suggested that the managers were not fully forthcoming on this issue due to their awareness of the need to be 'politically correct'. Touche Ross suggests that future research will be problematic due to the attitudes held by the managers, the need to maintain the image of the organisation and their awareness of the punitive aspects of human rights legislation.

Two US studies in the mid 1990s were instigated to assess the impact of the ADA. Gallagher and Hull's (1996) telephone surveys of eight cruise lines investigated the types of accommodations and provisions for people with disabilities and the elderly. Written responses were requested but only three companies complied with this request. The remainder designated a customer relations or sales representative to respond after receiving a follow-up telephone call. Half of the cruise lines provided no accommodation for people with disabilities. Of the other half, accessibility varied from an understanding of wheelchair access to acceptance of guide dogs and provision for visual/vibrating alarms. It was also noted by the researchers that ships registered outside the US but operating within the US do not have to comply with the requirements of the ADA.

Upchurch and Seo (1996) undertook a survey of the US hotel and motel operators' compliance with the ADA. The study sought to measure: the level of physical compliance with the ADA; plans to meet or exceed ADA requirements; and barriers that impeded compliance. The findings from the 488 responses suggested firstly that total compliance had not been achieved in a range of the physical compliance factors (31%) including approach, entry/elevators and rooms. Secondly, there was a lack of understanding of the legislation, but the researchers did not regard this as a barrier to compliance. Thirdly, the accommodation sector regarded financial constraints as a major barrier to compliance. Upchurch and Seo's major conclusion was that accommodation operators must properly

market their products and services. Operators had not done this for people with disabilities but did it for other market segments. Lastly, Upchurch and Seo argued that accommodation operators needed to be aware that they have a social responsibility for meeting the needs of people with disabilities, as well as a legislative requirement to do so.

C. Supply research summary

Over the last 25 years, research on the TI perspective on supplying goods and services for people with disabilities has been sporadic and varied both within Australia and overseas. The research has had four foci: 1. self-reported assessments of the accessibility of TI product; 2. interviews that seek to document current TI approaches to people with disabilities; 3. instruments that review TI attitudes towards people with disabilities; 4. assessments of compliance with human rights legislation. The quantitative studies all had low response rates that may be indicative of the TI disinterest in disability tourism. The major difference between the US and Australian research was the impact of the ADA in shaping a research agenda. There was a commonality between overseas and Australian research that suggests that there is an under supply, or constraint of opportunities, for people with disabilities wishing to travel. This under supply or constraint is compounded by TI managers, who do not perceive people with disabilities as a market segment. Further, the research demonstrates the lack of understanding on the part of the TI in regard to the legislated responsibility to provide equality of experience for this group. Yet, none of these studies sought to explain why organisations act in this way.

4.6 Disability and Tourism Research - Coordination and Regulation

There has not been any review of government disability tourism legislation and policy initiatives in the literature. This work is undertaken in the Australian context in this chapter and Chapter 9. This section identifies the major Commonwealth and State government disability tourism initiatives. A brief introduction to Commonwealth tourism policy is then provided. Selected relevant overseas initiatives that seek to coordinate or regulate tourism are then reviewed to gauge Australia's policy development in this area. Table 13 presents a chronology of policy and initiatives, and includes a commentary on the focus of the initiatives followed by a brief discussion of the direction of these initiatives.

Table 13: Summary of Commonwealth and State government initiatives

Originating Body/Author	Year	Policy and Initiatives 1990-2000	Focus
Commonwealth			
Dept. of Tourism (CDOT)	1992	<i>Tourism: Australia's Passport to Growth, a national tourism strategy</i>	Issues
Dept. of Family and Community Services (DFACS)	1992	<i>NICAN established to provide info on tourism for people with disabilities</i>	Self reported accommodation information
Australian Tourist Commission (ATC)	1993	<i>Facts for the Visitor: Disabled visitors</i>	Basic fact sheet; Website
Office of National Tourism (ONT)	1999	<i>Facts for the Visitor: Disabled visitors</i>	
Office of National Tourism	1998	<i>Tourism- A ticket to the 21st century</i>	Market segment/potential of people with disabilities
Office of National Tourism	1998	<i>Tourism for All Campaign</i>	Market segment/potential approach to people with disabilities – case studies
Bureau of Tourism Research (BTR)	1998	<i>National Visitor Survey</i>	Includes disability module
Dept. of Family and Community Services	1999	<i>Gold Medal Access Strategy</i>	Award and Symposium series for Tourism and Transport orgs
Tourism Minister's Council	1999	<i>National Forum on Tourism and Access (Douglas 1999)</i>	Coordinating approaches across Commonwealth/State boundaries
Originating Body/Author	Year	Policy and Initiatives 1990-2000	Focus
Australian Capital Territory			
Canberra Tourism and Events Corporation (1999b) (CTEC)	1998	<i>Access Info</i>	Third party system of accomm and attraction information
Canberra Tourism and Events Corporation (1999a)	1999	<i>Access Info Website</i>	Access information transferred to the website
Canberra Tourism and Events Corporation (1999c)	1999	<i>Discovery</i>	One -off magazine featuring stories on accessible experiences
NSW			
NSW Dept. of Tourism	1981	<i>Tourism and disability stakeholder seminar</i>	IYDP seminar to improve tourism for the disabled (sic). Presented the different stakeholder positions
Tourism NSW (TNSW)	1998	Darcy (1998) <i>Anxiety to Access</i>	Reviewed previously
Tourism NSW	2000	<i>Disability Action Plan: 1 January 2000 to 31 December 2002</i>	Disability action plan (DDA)
Queensland			
Queensland Tourist and Travel Corporation (1998) (QTTC)	1999	<i>Accessible Queensland</i>	Extended listing of services for people with disabilities
Tourism Queensland (TQ)	2000	<i>A Guide to Accessible Caravan Parks in Queensland (J. Graham 2000)</i>	A guide of caravan parks based on an individual's experiences
Tourism Queensland	2000	<i>A schedule of providers of services and accessible public infrastructure</i>	A detailed listing of services and accessible public infrastructure
Tourism Queensland	2000	<i>Accessible Queensland Images</i>	A CD of disability tourism images
Tourism Queensland	2000	<i>Accessible Queensland Website</i>	Website of previous publications
South Australia			
South Australian Tourism Commission (SATC)	1999	<i>ACCESSIBLE: Making it easier to discover South Australia</i>	Policy document
South Australian Tourism Commission	1999	<i>Tourism Strategy for People with Disabilities</i>	Strategy from policy document
South Australian Tourism Commission	1999	<i>Disability access audits</i>	Third party disability access audits
Tasmania			
Tourism Tasmania (TT)	1997	<i>Tourist information for people with disabilities</i>	Basic listing sheet of accessible tourism products/disability contacts
Western Australia			
Western Australian Disability Services Commission (WADSC)	1997	<i>Accessing New Markets: TI Think Tank Report</i>	A report on TI think tank of providing services and facilities for people with disabilities
Western Australian Tourism Commission (WATC)	1999	<i>Accessible accommodation information</i>	Self reported information
WADSC	2000	<i>You can make a difference to customer service for people with disabilities</i>	A disability awareness training video
Victoria			
Tourism Victoria		<i>Disability Fast Facts</i>	Basic factsheet

A. Commonwealth Government tourism policy: a beginning

In Australia before 1992, there was no Commonwealth tourism policy, let alone one addressing disability issues. Earlier government reports had dealt with disability related to specific facilities in a tourism context (Department of Industry and Commerce 1982; Department of Sport, 1986; Department of Aviation 1987; Fraser 1987) and had sought to identify accessible infrastructure. The authors of these reports were ahead of the field in beginning to develop a foundation of information on which people with disabilities could base their tourism planning. However, the self-reported methodology of these reports relied on TI manager- provided information, was not based on any research into the underlying needs of people with disabilities and therefore, was based on assumptions about likely needs. This was compounded by the failure to differentiate between the different dimensions of access for people with different disabilities.

By the time of the publication of the *Kennedy Report* into tourism (Australian Government Committee of Inquiry into Tourism 1987a), the momentum had gathered for the first national tourism policy. This policy had been called for for 20 years but it was another five years before the national policy was launched. In *Tourism: Australia's Passport to Growth - A National Tourism Strategy* (Commonwealth Department of Tourism (CDOT) 1992), there was recognition of some of the inherent weaknesses of the Australian TI for people with disabilities. The contributing author for the disability part of the strategy was Helen McCauley, the national director of ACROD, who brought a wealth of disability related experience to this part of the policy. The policy adopted an issues based approach as summarised in Table 14.

Table 14: 1992 National tourism strategy disability issues

Issue	Reason/Strategy
Cost:	<p>Many people with disabilities have low incomes and are faced with additional costs:</p> <ul style="list-style-type: none"> • The need for an attendant • The need for accessible rooms • The need to travel by air rather than cheaper forms of transport • The need to travel around cities by taxi where buses and trains are not accessible
Staff Training:	<ul style="list-style-type: none"> • Many staff feel uneasy interacting with patrons with disabilities • There is a need for industry operators to provide staff with hands-on training sessions to give them more confidence in dealing with disabled persons
Information Base:	<ul style="list-style-type: none"> • Information available to disabled travellers is scattered and often out of date • There is a need for resources to maintain an up-to-date centralised database that provides information on the demand for, and supply of, disabled facilities • While specialised information listings can be useful, however, it may also be desirable from an efficiency perspective to integrate information for disabled travellers into the databases of mainstream accommodation, transportation and other tourist directories
Physical Access:	<ul style="list-style-type: none"> • Despite progress with building legislation, developers and architects would benefit from more detailed information on the requirements of disabled travellers
Transport:	<ul style="list-style-type: none"> • In Australia, the availability of cars, campervans, buses and trains with accessible features is not common • Further research is required into the market for such transport in Australia and international trends in improving disabled access to such transport

Adapted from CDOT (1992)

Yet, no strategy, timeline, indication of responsibilities or commitment of resources was attached to this policy so as to address these issues. Some five years passed before the Office of National Tourism (ONT) released a discussion paper (ONT 1997) and subsequent strategy, *Tourism - A Ticket to the 21st Century - National Action Plan for a Competitive Australia* (ONT 1998a). Under the heading, ‘To encourage the development of special interest market segments’ the government stated its intentions to:

promote the development of the arts and cultural tourism, indigenous tourism, sports tourism, educational tourism, tourism for seniors and people with a disability, and environmental and rural tourism (ONT 1998a:np).

This effectively marked a reorientation by the Commonwealth, away from identifying strategic issues and towards the development of specific market segments. Yet, as Table 15 indicates, since 1992 major policy and research initiatives have been undertaken for many of the other segments but not for people with disabilities.

Table 15: Commonwealth market segment publications

Segment	Policy, Strategy or Research
• Cultural tourism	Brokensha and Guldberg 1992; Haigh 1994; Coombes and Millar 1998; Foo 1998; Buchanan 1999
• Backpacker	Pearce 1990; Loker 1993; ATC 1995a; Commonwealth Department of Tourism 1995a; 1995c; 1995d; Haigh 1995; Buchanan 1998
• Indigenous tourism	Commonwealth Department of Tourism 1994c; Commonwealth Dept. of Industry Science & Resources 2000; Muloin, Zeppel and Higginbottom 2001
• Natural area or ecotourism	Commonwealth Department of Tourism 1993b; 1993a; 1994a; Manidis Roberts Consultants 1994; Blamey 1995; Commonwealth Department of Tourism 1995b
• Cruise tourism	Commonwealth Department of Tourism 1995e; Coombes and Millar 1998
• Rural/farm tourism	Commonwealth Department of Tourism 1993c; 1994b; Australian Tourist Commission 1995c; O'Halloran 2000
• Senior tourism	Queensland Office of Ageing 1998; Ruys and Wei 1998. Senior tourism was also presented as a major research and policy area for each inbound country of origin and as part of psychographic segmentation for domestic tourism.

While Table 15 lists mainly Commonwealth initiatives, similar strategic segmentation developments occurred in the states. Many of these market segments have now become mainstream tourism considerations. People with disabilities were again identified as a tourism market opportunity by a 2002 Commonwealth Dept. of Industry, Tourism and Resources (CDITR) discussion paper that states:

There are also significant opportunities for tourism products aimed at particular groups in the community, for example, seniors tourism, tourism for people with disabilities, and tourism aimed at 'enthusiast' niche markets (CDITR 2002:70).

Yet, no new initiatives have been announced. From this starting point for Commonwealth and state tourism policy, Chapter 9 analyses the disability tourism initiatives.

B. International perspectives

What becomes apparent from the literature is that there are a number of areas for international comparison: the implementation of international human rights legislation; design principles; and some academic research. Although cultural and legal contexts may limit international comparisons, common experiences do emerge and reinforce local, regional and national findings and recommendations. In particular, Australia can seek to 'benchmark' against best practice. A number of relevant initiatives have been undertaken that seek to regulate or coordinate the provisions of tourism goods and services for people with disabilities. This section reviews international airline initiatives followed by country specific reviews of Canada, the USA, Europe and the UK.

International airlines

A great deal of international focus has been on the regulation of air transport in relation to people with disabilities. Driedger (1987) highlighted the impact of international and national air regulations on the carriage of people with disabilities through her personal and professional experiences, supported by anecdotal accounts written by people with disabilities. Abeyratne (1995:56-59) subsequently reviewed the International Civil Aviation Organisation's efforts to facilitate air travel by the elderly and people with disabilities, and suggested that 76 structural changes were required to better cater for the 'group'. The European, Canadian and US authorities have attempted to operationalise these issues (European Civil Aviation Conference and European Conference of Ministers of Transport 1995; Canadian Transport Agency 1997a; 1997c; 1997b; Compart 1999). These issues transcend national boundaries where international agreements on aircraft design regulate the global airline industry. However, as Turco et al. (1998) and Tourism NSW (Darcy 1998) have observed, these air travel difficulties continue despite the introduction of a number of reforms (Ervin 1989; Fotos 1992; Compart 1999; Gotting 1999; G. Johnson 1999; Israel 2000; Armstrong 2001).

Canada

In Quebec, Kèroul, a disability organisation, worked with the Quebec Tourism Board and the local TI on a program to improve accessibility and service provision. This resulted in publications on the accessibility of buildings and customer service and the market potential of people with reduced mobility (Kèroul 1987; 1995). While these Kèroul initiatives are important, Quebec is one province of Canada and accessible tourism has not been adopted nationally or by other provinces. There is no Canadian human rights disability discrimination legislation.

USA

In the USA, approaches to accessible tourism were galvanised under the *Americans with Disabilities Act, 1992*. Several initiatives were highlighted at the Society for the Advancement of Travel for the Handicapped conference held in Florida in 1999 (cited in TGWRTA 2000). These were market-led through 'good practice' initiatives to comply with the ADA (Salomon 1992; Peniston 1996). The ADA is the most comprehensive and enforceable disability discrimination legislation in the world. This has produced a high level of compliance as evidenced by the agreements with major accommodation providers (Davies and Beasley 1994; Seal 1994; Peniston 1996; Salomon 1996; Andorka 1999;

Whitford 1999; Worcester 2000). The US government has no other disability specific tourism policies.

Europe, with emphasis on the UK

In a Europe-wide initiative, the English Tourist Board and Holiday Care Service (1990) launched the *Tourism for All in Europe* program in 1990. The program sought to improve the provisions of accessible tourism experiences for people with disabilities across Europe (Davenport 1991). This program has attracted a great deal of publicity across the European Union. Yet, as one commentator on the first *Tourism for All* conference held in Europe exclaimed: ‘this conference can be summarised by the call for “toilets, toilets, toilets”, which disabled people seem obsessed with!’ (F. Brown 1991:258). What was not understood is how very important toilets are when you are excluded from them. It suggests that there is at least a lack of understanding of the issues, or at worst a trivialising and disregard of their importance.

A number of significant meetings and conferences were organised in Europe including the European Civil Aviation Conference and European Conference of Ministers of Transport (1995) seminar on improving access to air travel for passengers with reduced mobility. While the seminar drew on the experiences of 200 delegates from three continents, the positions presented were largely those of government regulators, air transport industries and some disability organisations. There was very little opportunity for the voices of people with disabilities to be heard. The seminar concluded by recognising that there was a lot of work still to be done and ‘that the need to consult people with disabilities at all stages of planning and development cannot be stressed too highly’ (1995:129). The conclusions were circulated to governments, the aviation industry and the public.

The other outcomes of *Tourism for All* in Europe were the publication of a guide to improving the accessibility of tourism attractions, the European TI and the development of an accommodation accreditation scheme (Donaldson and Pickford 1994; European Commission 1996). Donaldson and Pickford (1994) provided the framework for the development of the European Commission (1996). The European Commission (1996) report was supplemented by secondary data from Touche Ross (1993) and included cross-references to building standards for access and mobility in European countries. The report included parts on:

- supplying tourists with tourism services (communicating with disabled clients;

- operators; travel agents; booking transport, accommodation and holiday packages);
- welcoming disabled tourists (accommodation; attractions; other needs); and
- further information (good practice; sources of information; technical building considerations; mobility, vision and hearing impairments).

Since this time in Europe there has been a focus on developing accessibility initiatives to tourism generally (Siegrist and Tenneson 2000), and accommodation initiatives in particular (Hasselt and Brussels 2001). Yet, the evaluation of these initiatives by Hasselt and Brussels (2001) indicates a number of underlying structural, policy and organisational communication issues that have not been addressed uniformly across Europe, including

- European building stock is not sufficiently accessible;
- information is inaccurate and inaccessible;
- tourism sector lacks information on accessibility and disability;
- information about accessibility not uniform;
- no inclusion of mobility, hearing, sight and understanding dimensions to access;
- accessibility labelling schemes are problematic; and
- uniform assessment methods and standards have not been adopted.

However, many countries have attempted to address these issues. While the UK provisions have been supported through the introduction of the *Disability Discrimination Act, 1995* this is not the case for all European countries. In the UK, a series of initiatives has been adopted to improve accommodation access and accreditation (English Tourism Council 2000a; National Tourist Boards and Holiday Care Service 2001). Importantly, these initiatives have been supported through the formation of the Hoteliers' Forum, an association of accommodation providers (English Tourism Council 2000a). The Forum's mission was to make the hospitality sector a leader in disability equality in the fields of service provision and employment, and to improve access to facilities, customer service and opportunities for employment, areas that have been TI responsibilities since the introduction of the UK *DDA*. Graham's (2001) CD-ROM *Welcoming Disabled Guests* developed from this initiative. The self-paced learning module covers three components: understanding disability; disability legislation; and customer service. *IndividuAll*, a hotel-based membership group and its strategic partners has since replaced The Hoteliers' Forum (I. Graham 2001).

C. Coordination/regulation summary

Air transport remains the single area of international review, with a range of other initiatives developing in isolation in other countries. In Canada, the initiatives involved an

ongoing partnership between a provincial TA and a disability organisation. The USA has relied on disability rights legislation to develop case law precedent and set compliance timeframes for TI groups. The UK and European initiatives have been driven by *Tourism for All* that started with a series of ad-hoc initiatives during the 1990s but developed a strategic agenda from 1999-2001. While the impact has been highly variable between European countries, the recent agenda on encouraging improved public transport, providing TI with information about improving access to accommodation and attractions, and developing accommodation accreditation systems is to be commended. What cannot be determined from these initiatives is whether they have improved the tourism experiences of people with disabilities, but they may nevertheless offer some direction for future Australian projects. Lastly, there has not been an evaluation of the Australian government's disability tourism initiatives in the literature.

4.7 Ending

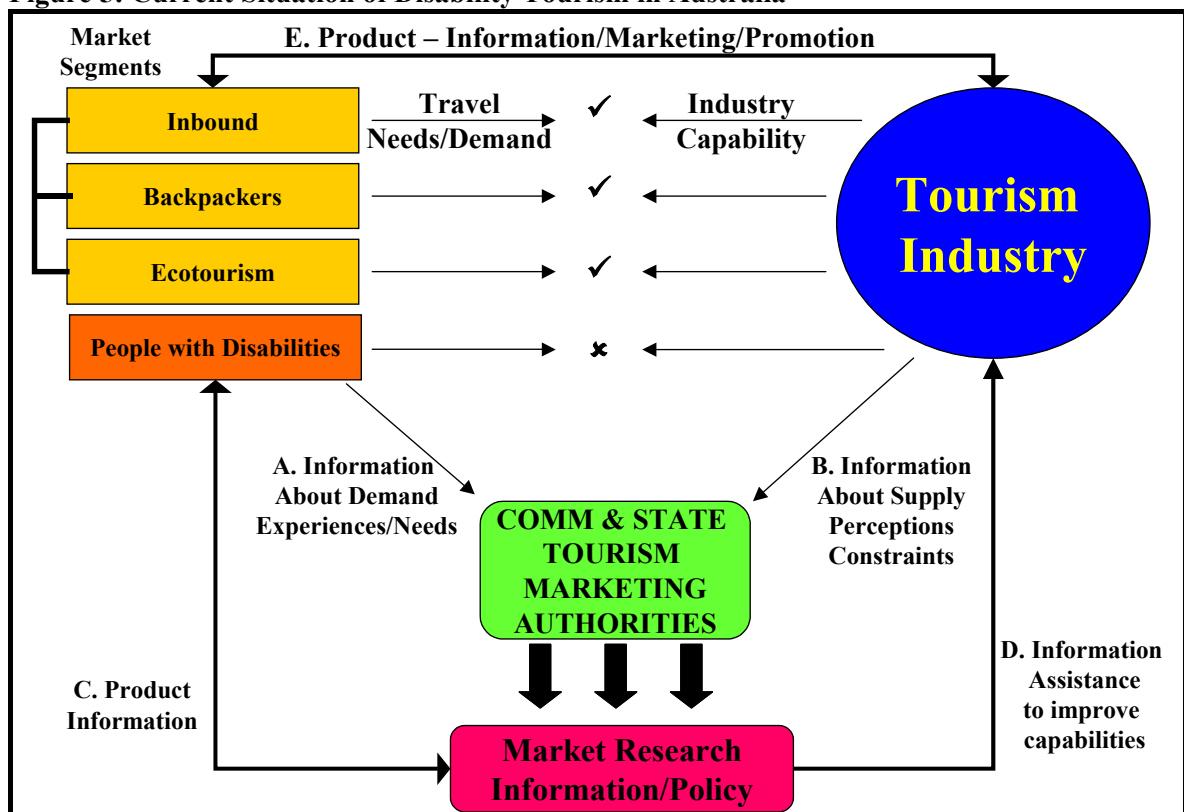
Firstly, this chapter reviewed the omission or passing treatment of disability in the tourism textbooks. Secondly, from this beginning, theory that could contribute towards the development of the research was investigated. This included tourism systems, tourism as a market, government role in tourism through the TA, and leisure constraints theory. Thirdly, the empirical research on disability and tourism was reviewed from a demand, supply and regulation/coordination perspective. This research was further divided geographically into Australian and overseas research. A number of conclusions can be drawn:

- The geographic systems model of tourism in theory should encompass all market segments but the subsequent review of research indicates that it failed to do so for people with disabilities;
- In many ways, the current treatment of disability in the tourism literature has been counter-productive as it has been underpinned by medical conceptualisations of disability rather than founded on the lived tourism experiences of the group;
- The review documents a sporadic, ad-hoc and slow development of the field over the last 20 years. Empirically the review reveals large areas of disability tourism that lack a substantial research base;
- Importantly, the anecdotal experiences of people with disabilities provided an awareness raising exercise to begin the learning process. This awareness shift has been met by some tourism access guides, local and regional, produced commercially and by the government. Yet, these have largely not provided the level of detail or all the dimension of access required by people with disabilities;
- From the demand perspective, only one study showed lower levels of travel on a regional level by people with disabilities compared with the non-disabled. Yet, this work has not been developed to a national level;
- From a supply and coordination perspective, the studies identified the lack of recognition that people with disabilities are a market segment;

- This was compounded by a lack of compliance by TA and TI to the legal requirements to provide an equality of service provision for the group;
- Other studies contributed to an understanding of the constraints and needs of the group;
- There has not been a subsequent explanation as to why they have the experiences that they have. There was little attempt by researchers to seek an understanding of the structural-historical factors that lead to the TI responses;
- The lack of an explanation was most obvious with the omission of research about the role of government as a coordinator of market research and information provision, the impact of legislative/policy on the TI and, hence, the tourism experiences of the group. The possible reasons for this situation are the subject of the rest of the thesis.

This review of the literature about disability and tourism in Australia and elsewhere suggests that there is a mismatch between the demand and supply, and the regulation and coordination of tourism provisions for people with disabilities. This situation is represented diagrammatically in Figure 5, and identifies how the TA and the TI meet different market segments needs through the provision of appropriate product (Link E).

Figure 5: Current Situation of Disability Tourism in Australia



The ticks indicate where the TI and TA are addressing the travel needs of market segments. The crosses indicate that the travel needs of people with disabilities are not being addressed. As Hall states, government TA have historically led the TI in Australia by coordinating the provision of research, information and marketing of tourism. This role has been undertaken by the combined efforts of the Commonwealth and State TA. The

coordination role is seen as necessary because of the fragmented nature of the TI. However, this situation has not been the same for people with disabilities although they have expressed their dissatisfaction to government and TA (Link A) and this has been well documented in the literature. There has been only limited evidence of research to address the group's dissatisfaction and the responses by TA (Link C) have been inappropriate, inaccurate or absent. The literature identified the lack of provision and interest of the TI in wanting to understand people with disabilities as a market segment (Link B). This is although government and TA have provided basic information about the needs of people with disabilities (Link D).

5 THEORETICAL FRAMEWORK AND RESEARCH QUESTIONS

5.1 Introduction

This chapter discusses the theoretical framework that directed the conduct of the empirical research and presents the research questions that the empirical research sought to address. Sections 5.2 and 5.3 draws together, builds and presents the unanswered questions identified in Chapters 2, 3 and 4. Section 5.4 identifies the research questions to be addressed in this thesis.

5.2 Theory and Discourses

In Chapters 2, 3 and 4, six theoretical perspectives were reviewed:

- the human rights and the regulatory role of government (Chapter 2);
- the medical model of disability (Chapter 3);
- the social model of disability (Chapter 3);
- the tourism systems model (Chapter 4);
- tourism as an industry/market and the role of government tourism authorities (TA) (Chapter 4); and
- leisure constraints theory (Chapter 4).

Bringing all of these perspectives together in one framework presents a considerable challenge, because they arise from a wide range of disciplines and view the phenomena of disability and tourism from diverse, and often conflicting, standpoints. In some respects, the various perspectives are complementary, the limitations of any one being at least partly overcome by some of the features of another. Attention has been drawn to these *limitations* in the discussions and conclusions in the above reviews in Chapters 2-4. As each perspective provides a partial picture, it is therefore arguable that together, they might provide something approaching a comprehensive view of the area of study. In the case of competing or conflicting perspectives, such as the contrasting social and medical models, examining both in the context of the same study presents the possibility of revealing which perspective is the more effective at explaining the phenomenon under study.

The various perspectives also vary in their level of conceptualisation. Thus the first, fourth and fifth listed are primarily concerned with social, structural issues, while the sixth is mainly focused at the individual, experiential level and the third seeks to span the individual (micro) and the structural (macro). Frequently in social research, studies are

either structural or individual/experiential, but, since there is invariably a reflexive relationship between structural forces and individual and collective experiences, social scientists are increasingly considering how these two levels of analysis can be brought together (Knorr-Cetina and Cicourel 1981).

The theoretical framework presented here seeks to establish the extent to which an explanation for the tourism experiences of people with disabilities can be found in the behaviour and practices of the TA and TI towards people with disabilities. An explanation for the experiences of people with disabilities is sought in a *discourse analysis* of complementary and contrasting perspectives. This is appropriate since discourse analysis can provide insight into the world of the *other*, those who are excluded, oppressed or disadvantaged (Foucault 1988). While each of the relevant theoretical perspectives and discourses was discussed separately in Chapters 2-4, it is recognised that they are interrelated. It is also acknowledged that there may be multiple truths and multiple explanations (Wearing 1998:145) for the tourism experiences of people with disabilities. The research issues and questions that each of the theoretical perspectives and discourses gives rise to are briefly summarised below, along with an exploration of the possibilities of combining approaches to overcome limitations of individual approaches and to build a comprehensive explanation.

The human rights perspective and the regulatory role of government

In Chapter 2 it was concluded that the implementation of human rights-based legislation tends to be a 'top down' process. The other perspectives utilised in this study can be used to provide a 'bottom up' view of the implementation or consequences of non-implementation of the DDA. Section 2.2 discussed how the Commonwealth government's international UN human rights obligations and the 1981 IYDP gave the momentum for the enactment of the DDA. In general, the provisions of such an Act should ensure the citizenship rights of people with disabilities in Australia, including the right to tourism. The broad responsibilities outlined in the DDA affect the government, TA and TI. Theoretically, this governmental regulatory activity should be effective in achieving equality of access and provision but, in practice, there are many failures where the legislative recognition of disadvantage has not been effective in bringing about social change. Exploring the *practices* involved in the implementation of the DDA in relation to disability and tourism offers a case study of such failures, their effects and the possibility of offering an explanation.

From this discussion and the discussion in Chapter 2, questions emerge at a number of levels:

1. What alleged discriminatory tourism practices have people with disabilities been subject to and successfully brought before HREOC and the Federal Court?
2. What omissions or practices by TA and TI gave rise to the complaint cases?
3. To what extent have the other mechanisms of the DDA been used to address issues of structural discrimination in the TA and TI?
4. What insights do the complaint cases and other DDA mechanisms offer as an explanation for the tourism experiences of people with disabilities in Australia?

The medical model of disability

As indicated in Chapter 3, the medical model is a discourse that arose from the medical, professional practice with people with disabilities, a discourse that regards disability as a 'personal tragedy'. While not inconsistent with the human rights perspective, particularly in regard to the WHO taxonomies which have been operationalised for data collection, the medical model has largely been limited to a micro-level, individualised understanding of disability. The focus of this study is not on medical practice but, as argued in Chapter 3, questions arise as to the extent to which the medical discourse permeates professional/managerial groups and other associated industrial sectors, and indeed society in general, thus providing a widely held view of disability, which results in ableist practices and discourses.

It is beyond the scope of this study to investigate the views of society at large, but from this discussion and Chapter 3 a number of questions emerge:

5. To what extent is the medical model worldview held - consciously or sub-consciously, fully or in part - by managers and administrators in the TA and TI?
6. If the medical model worldview is held by TA and TI managers, to what extent - and in what ways - does it influence policy and practice?
7. If the medical model worldview is held by TA and TI managers, to what extent does this result in resistance to social changes designed to improve equality of access?

The social model of disability

As discussed in Chapter 3, the antagonist theory of the social model of disability, in contrast to the protagonist medical model, places the lived experiences of people with disabilities at the centre of the research paradigm and focuses attention on the *disabling barriers* and *hostile social attitudes* that affect the experiences of people with disabilities. One of the criticisms of the social model is that it is theoretical and has not provided an adequate operationalisation of its underlying concepts for empirical research. There is a

need to explore the process as it works in practice. A further criticism that has been levelled at the social model is that, in focusing on barriers, it has failed to incorporate an *embodied ontology* of people with disabilities, and has therefore, tended to ignore the role of individual difference (type of impairment and socio-demographic characteristics). There is therefore scope not only to validate social model assumptions empirically as suggested by Bickenbach et al. (1999) but also to develop the social model as an empirically validated social theory.

From this discussion and Chapter 3 the following questions emerge:

8. What types of disabling practices - on the part of TA, TI and society at large - emerge from the tourism experiences of people with disabilities?
9. To what extent do impairment-related and socio-demographic variables have a significant influence on an individual's tourism patterns and experiences?
10. What are the social relations of tourism that provide an explanation for the tourism experiences of people with disabilities?

The tourism systems model

As discussed in Chapter 4, the tourism systems model provides a useful geographic model for examining tourism (TGR \leftrightarrow Transit \leftrightarrow TDR), which is inclusive of the demand, supply and, to a lesser extent, coordination and regulation processes. The geographical framework raises questions as to the varying nature of the demand/supply relationship at various stages in the tourism experience - planning/decision-making (at the TGR), in transit and at the destination (at the TDR). However, the tourist/provider processes, which take place within the system, are theoretically under-developed. There is a case for developing the tourism system to show explicitly *active*, operational tourist/customer interrelationships and also to question the inevitability of its functionality.

From this discussion and Chapter 4 a number of questions emerge:

11. What are the characteristics of the tourism demand/supply relationship for people with disabilities:
 - a. at the planning/decision-making stage;
 - b. in transit;
 - c. at the tourism destination.
12. To what extent can the tourism system be described as *dysfunctional* concerning the delivery of services to people with disabilities?

Tourism as an industry/market and the role of government tourism authorities (TA)

As discussed in Chapter 4, the market ideology may compound the medical model worldview and create a discourse to resist change to current TA and TI practice. In particular, the private sector market ideology of the TI, in combination with the medical

model worldview, which sees disability as a public sector medical/welfare responsibility, may lead TI managers to conclude that providing services for people with disabilities is not part of their responsibility. At best, it may be accepted only as a public sector imposition and not part of a routine business strategy. The market ideology is, in part, implemented through marketing and market segmentation research, as discussed in Chapter 4, and the implications of this for people with disabilities are discussed further in the next section.

As discussed in Chapter 4, TA are statutory authorities with charters to undertake specific tourism functions under Commonwealth and State legislation. In this sense they are part of government but have been set up at ‘arms length’ to promote and improve the economic contributions of the largely private sector TI to Australia. This economic management rationale is largely realised through a coordination role in marketing and market research in relation to domestic and international tourism. Yet, because the main TA role is marketing/promotion they generally adopt the same private sector market ideology as the TI. One of the ways in which the marketing role is operationalised is through market segmentation. In this sense, the questions to be asked of TA are similar to those to be asked of the TI because of their adoption of market ideology. It might be expected that the TA, an arm of government despite private sector orientation and relationships, would be more mindful of their responsibilities under the DDA. The human rights framework may then modify the market ideology, but this is not known and is a matter for further research.

The questions that arise from the discussion and Chapter 4 are:

13. To what extent does market ideology influence TA/TI attitudes and practices towards people with disabilities?
14. Has market segmentation research identified people with disabilities as a market segment?
 - a. If yes, what have been the TI/TA follow-up actions?
 - b. If no, what are the TI/TA explanations for this?

Leisure constraints theory

As discussed in Chapter 4, leisure constraints theory provides a framework to analyse leisure experiences of people with disabilities. In this thesis it is used to analyse the tourism experiences of people with disabilities. Moreover, the definition and categorisation of leisure constraints is used to operationalise the social model’s focus on *disabling barriers* and *hostile social attitudes*. For the purposes of the thesis, *constraints* are defined as *disabling barriers* and *hostile social attitudes* that limit the formation of tourism preferences (pre-trip) or inhibit participation (on trip) and, hence, affect tourism experiences. In this thesis the importance of Smith’s categorisation of barriers to leisure

travel (see Chapter 4) is recognised, but Crawford and Godbey's categorisation of interpersonal, intrapersonal and structural constraints that dominate the leisure constraints literature is adopted as the more appropriate framework for the study. The thesis examines whether people with impairments encounter constraints to tourism and, if they do, how the *hierarchical model of constraints* applies and how *constraint negotiation* occurs, if at all. However, the thesis takes direction from criticism of constraints theory and employs grounded analysis to examine emergent themes from the tourism experiences of people with impairments.

The social model could be enhanced through the incorporation of the leisure constraints categorisations that identify *intrapersonal* and *interpersonal* as well as *structural* constraints on leisure and tourism decision-making. Conversely, leisure constraints theory might be enhanced through incorporation of aspects of the social model, as its theory does not extend to analysing the *origins and causes* of constraints. It tends to concentrate on the individual's experience at the micro-level and/or implicitly views structural constraints only in a public sector provision context. Firstly, the value of the leisure constraints theory could therefore be enhanced if, in addition to merely identifying structural constraints, it were to be embedded in a wider managerial and corporate framework. This, drawing from the social model, could explore the ways that structural constraints are actually *produced* by the policies and practices of the TA and TI. Second, applications of the constraints model have hitherto considered only a *single* decision-making process in which constraints may or may not prevent participation in leisure activities. Linking the constraints model with the tourism systems model draws attention to the fact that there are numerous constrained decision-making processes throughout a tourism trip, not just at the initial point.

From this discussion and Chapter 4, the following questions emerge:

15. What tourism constraints do people with disabilities encounter at various stages in the tourism process?
16. How are these constraints categorised?
17. What do the tourism experiences of people with disabilities tell the researcher about the hierarchy and negotiation of tourism constraints?

Summary

Each of the theoretical perspectives and discourses discussed above potentially provides a partial insight into the relationship between people with disabilities and tourism. Each provides a way of looking at part of the picture and poses questions that are capable of

being explored by empirical study. A complete picture, however, calls for a bringing together of:

- perspectives which focus on the personal experience of the people with disabilities as potential and actual tourists and associated discourses;
- the market/service delivery process and associated discourses; and
- the human rights/governmental process and associated discourses.

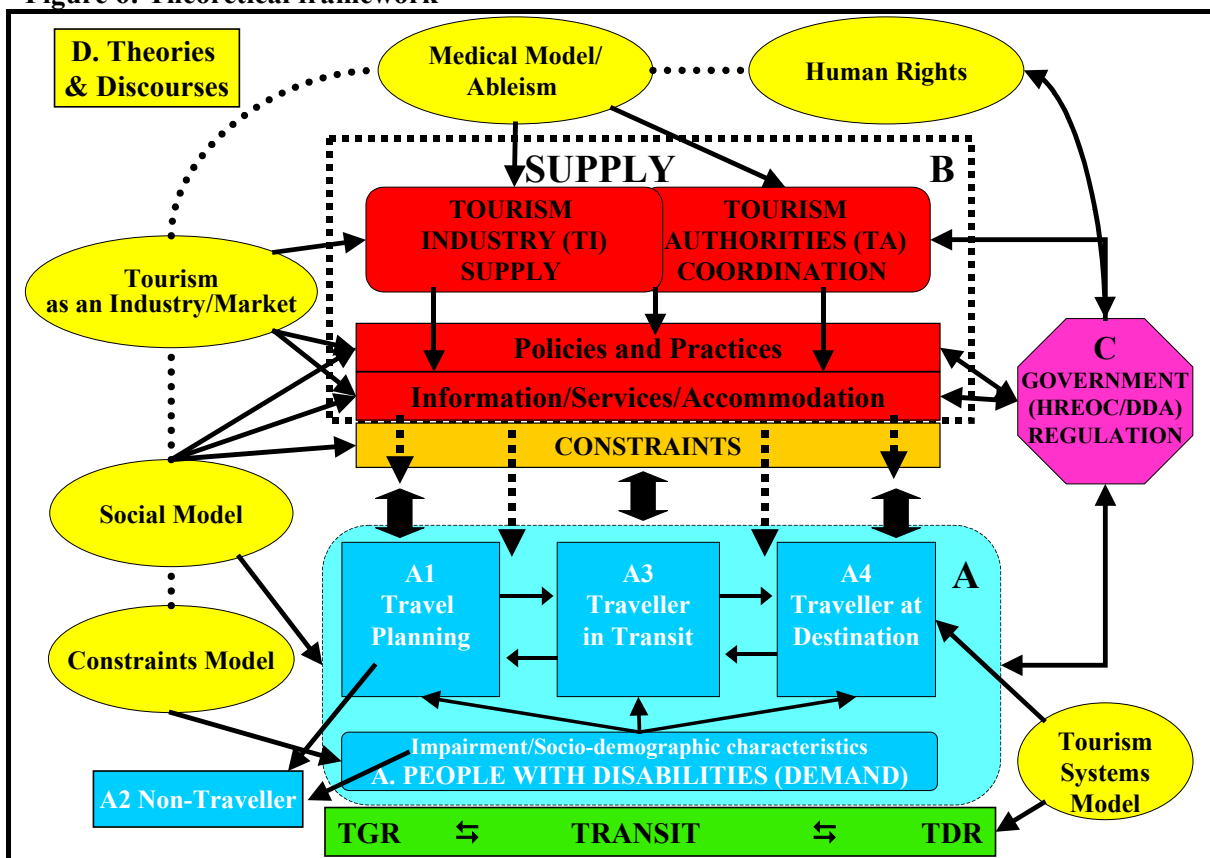
The following section presents such a composite theoretical framework as a basis for the empirical research that follows.

5.3 Theoretical Framework

Figure 6 presents the theoretical framework that has guided the research process. It expands upon the theoretical foundations and consists of four interrelated components:

- People with disabilities and their tourism experiences (demand);
- Tourism industry (supply) and tourism authorities (coordination) practice;
- Government human rights framework of the DDA (regulation); and
- Theories and discourses.

Figure 6: Theoretical framework



Each of these is briefly reviewed, together with addressing research questions not raised in the discussion of the theoretical perspectives and discourses in Section 5.2.

A. People with disabilities and their tourism experiences (demand)

The research paradigm is based on a social model approach of developing an understanding of the lived experiences of people with disabilities within the tourism system (TGR \rightleftharpoons Transit \rightleftharpoons TDR). The Research Question below, and later empirical Chapters 7 and 8, deliberately use the word *impairments* rather than *disabilities* as both a definitional and theoretical approach to the research. This is because the model investigates the social relations producing the constraints faced by people with impairments as they negotiate tourism experiences, the social relations that hence create *disabling journeys*. Component A in the diagram therefore depicts:

- A1 the individual at home (in the TGR), planning to travel
- A2 the individual for whom the combination of intrapersonal, interpersonal and structural constraints are too great and who therefore becomes a non-traveller
- A3 the individual who successfully overcomes the initial constraints and becomes a traveller in transit
- A4 the traveller/tourist at the tourism destination (TDR)

At each stage – planning, in transit and at the destination – the traveller seeks to consume services on offer from the tourism supply sector and this is represented by the arrows connecting directly the demand and supply parts of the diagram. In some cases, the service provided satisfactorily meets the needs of people with disabilities and this is represented by the dotted arrows with direct connection between the demand and supply sectors. In other cases the type of service provided or the lack of service represents a *constraint*, which may be absolute or negotiable, and these constraints are represented by the double-ended arrows between the demand and supply parts of the diagram. The links with ‘impairment and socio-demographic characteristics’ also indicate that these processes are likely to be influenced by factors such as income, age and household/family situation and the nature of the person’s impairment.

Apart from the leisure constraints questions (15-17) and the role of impairment and other socio-demographic characteristics (9) in Section 5.2, subsidiary questions arise with respect to the journey of people with disabilities through the tourism system generally and in comparison to the non-disabled:

18. What constraints do people with disabilities encounter when planning to travel – over and above those encountered by the non-disabled?
19. To what extent do such constraints result in the decision not to travel?

20. What is the resultant pattern of travelling/non-travelling, compared with the pattern for the non-disabled?
21. What particular constraints do people with disabilities encounter when in transit and what effect does this have on the quality of the travel experience?
22. What particular constraints do people with disabilities encounter at tourist destinations and what effect does this have on the quality of the tourism experience?

B. *Tourism industry (supply) and tourism authorities (coordination) practice*

Component B of the diagram depicts the Tourism Industry (TI) and Tourism Authorities (TA) as the supply and coordination side of the process. The focus is on their joint *policies and practices*, which result in the provision of a particular range of *services*. In this case, information, travel and accommodation services (which are used as case studies in the empirical investigation) are depicted. Apart from questions 13 and 14 from Section 5.2, the empirical questions that arise are:

23. What (information, travel and accommodation) services are provided by the TI and TA and to what extent are they designed to meet the needs of people with disabilities?
24. What is the rationale given by the TI and TA for the particular pattern of service provision made available to people with disabilities?
25. To what extent do the practices and rationales of the TI and TA service provisions for people with disabilities reflect their particular view of the tourism industry as a market and industry?

C. *Government regulation (HREOC/DDA)*

Component C of the diagram represents the government regulatory framework based on human rights legislation. Links are shown to the supply and coordination, since the legislation is intended to apply to the TA and TI practices through education, disability standards and public inquiries. The link with the demand side occurs through the provisions for people with disabilities to bring complaints cases and Federal Court actions to the HREOC (HREOC). Questions 1-4 from Section 5.2 adequately address the relationships in this part of the theoretical framework.

D. *Theories and discourses*

The diagram depicts the various theoretical perspectives and discourses which have been identified as relevant to providing an explanation of the disability/tourism nexus. All, with the exception of the medical/social model dichotomy and human rights, are adequately reflected in the questions in the Section 5.2. These theoretical perspectives give rise to two

further research questions:

Medical/Social model

26. To what extent can the constraints experienced by people with disabilities in seeking tourism services be seen as being caused by TA/TI policies and practices as opposed to the particular impairments of the people demanding the services?

Human rights

27. To what extent do human rights considerations influence the policies and practices of the TI and TA?

5.4 The Research Questions

The drawing together of the 27 questions raised in Sections 5.2 and 5.3 provides the detailed framework for the subsequent empirical investigation. The research reviewed in Chapters 2, 3 and 4 is fragmented and incomplete, but most of it points to the proposition that people with impairments are not as well served by the TA and TI as the rest of the, non-disabled, community. This results in restricted opportunities to enjoy tourism experiences and a generally lower quality of experience. As such, the central question to be addressed in this thesis is:

To what extent are the tourism patterns and experiences of people with impairments in Australia unduly constrained by tourism authorities and tourism industry practice and discourse?

As discussed previously, the research takes direction from the social model and deliberately uses the word *impairment* as a definitional and theoretical construct for the research. *Unduly* means that people with impairments are not provided with an equality of service provision in comparison to the non-disabled. This lower level of service provision can be seen as unjustified, both in terms of legal, human rights-based precepts and in terms of the tourism industry's own precepts of responding to market demands. Whether the undue constraint of tourism service provision could be explained as a market response is to be investigated, along with the evidence as to whether market research rigour has been applied to disability as to other market segments. Further, if a valid market research response has been applied, the TA and TI still have a responsibility under the DDA not to discriminate on the grounds of disability. Thus, this research seeks to:

- quantify the level of tourism among people with impairments, compared with the non-disabled;
- describe the quality of tourism experiences of people with impairments;
- describe the constraints/barriers which result in the above quantity and

- quality of tourism experiences; and
- develop an explanation for these experiences.

Sections 5.2 and 5.3 raised 27 research questions that are interrelated and overlapping. To provide a succinct examination of these relationships in the thesis, the questions raised have been summarised into four areas, major research questions and subsidiary questions:

Tourism patterns and experiences of people with impairments and the constraints that they encounter in their journey through the tourism system

1. Are people with impairments constrained in their tourism patterns and experiences in comparison to the non-disabled?
 - 1a. If so, what are the constraints at each stage of the tourism system?
 - 1b. How are the constraints categorised?
 - 1c. Do people with impairments negotiate the constraints to participate in tourism?
 - 1d. What are the social relations that produce the tourism constraints they face?
 - 1e. What do these constraints reveal about the functionality of the tourism system for people with impairments?

The effect of impairment and other socio-demographic considerations on tourism patterns and experiences

2. Within the disability tourism experience, to what extent do impairment and socio-demographic characteristics influence an individual's tourism patterns and experiences?
 - 2a. If they do, what insights does this provide for developing the social model as a theory?

The tourism market responses of TA and TI to people with impairments

3. What are the practices of the TA and TI towards service provision for people with impairments?
 - 3a. Do TA and TI practices produce the constraints on tourism opportunities and experiences identified in 1a, 1b and 1c above?
 - 3b. What are the rationales given by the TI and TA for the particular pattern of service provision made available to people with impairments?
 - 3c. What discourses offer an explanation for the practices, rationales and behaviour of the organisations and the individual managers involved?

The effect of the government human rights regulatory environment on people with impairments, TA and TI

4. What evidence does the government regulatory environment of the DDA (complaints cases and other mechanisms) provide on the tourism experiences of people with impairments?
 - 4a. What discriminatory tourism practices have people with impairments been subject to and successfully brought before HREOC and the Federal Court?

- 4b. What omissions or practices by TA and TI gave rise to the complaint cases?
- 4c. What influence has the DDA had on the practices and discourses of TA and TI?
- 4d. To what extent have the other mechanisms of the DDA been used to address issues of structural discrimination in the TA and TI?
- 4e. What insights do the complaint cases and other DDA mechanisms offer as an explanation for the tourism experiences of people with impairments in Australia?

The research questions developed in this chapter provide a framework for locating and structuring the empirical investigation. Question 1 addresses the lived tourism patterns and experiences of people with impairments, and the constraints that they face within the tourism system. It seeks to examine whether there are differences between the patterns of tourism for people with impairments and the non-disabled. The research analyses the tourism experiences of people with impairments to ascertain and categorise the constraints encountered while contemplating, planning or undertaking tourism. This analysis draws on the traditions of the social model to examine the Australian structural-historical processes of government, TA and TI practice. This process is theory building in that it seeks to add to existing conceptualisations of constraints to tourism, and explores the extent to which the tourism system includes/excludes the needs and restricts the tourism opportunities and choices of a particular group.

Question 2 provides the basis for an investigation of whether there is evidence that an *embodied ontology* of tourism exists, providing empirical evidence for the development of the social model as a social theory by incorporating a greater empirical understanding of these characteristics. The question also provides a focus for empirical investigation of the role of impairment, independence, mobility aid, gender, age, lifestyle situation, education and geographic region on the patterns of tourism of people with disabilities.

Question 3 reviews the experiences of people with impairments in context to the TA and TI practice and discourse. This is done firstly, through reviewing disability tourism initiatives of TA from 1990-2000. Secondly, the practices of the TI are analysed through a case study of the accommodation sector. Both these are subject to a discourse analysis of the approaches to disability taken by TA and TI. This involves an understanding of: the impact of medical model and resultant ableist practices; the impact of human rights frameworks; and the market ideology of organisations. Interrelated to the discourse analysis is an examination of the reasons for the tourism experiences of people with disabilities through a structural-historical analysis of Australian tourism responses to

disability.

Question 4 focuses on the effect that the Australian human rights legislation has had on the tourism environment since its enactment in 1992. The DDA is the focus of study for this question, adding to the analysis begun in Question 1 by reviewing the HREOC complaint cases and other relevant mechanisms that provide an insight into the implementation of the DDA. This question also focuses analysis on the role of tourism in the rights of citizenship and the degree and extent to which these rights have been constrained.

5.5 Ending

This chapter has presented a summary of the theoretical perspectives and discourses, the theoretical framework and the research questions for the thesis. It has done so through drawing on the literature reviews of Chapters 2, 3 and 4 to explain the approach undertaken by the thesis. This approach draws upon the social model of disability to present the lived tourism experiences of people with disabilities as the centre of the research paradigm. It then analyses these experiences using the leisure constraints theory. The thesis then seeks to develop an explanation for the tourism experiences of people with disabilities through a discourse analysis involving the medical model; market ideology; and human rights frameworks. These are set in context to the structural-historical development of the Australian tourism environment. Lastly, tourism provides a new context to apply the social model as most applications have taken place in government welfare or medical settings. The application of the social model to tourism provides a site to test and to redefine the model in an area dominated by a market ideology. The next chapter operationalises the research questions through the research design and an outline of the methodology.

6 RESEARCH DESIGN AND METHODOLOGY

6.1 Introduction

This chapter outlines the research design and the methodologies used to address the central problem and research questions presented in Chapter 5. Philosophically and methodologically, the direction of the study has been shaped by the review of the theoretical perspectives and discourses undertaken in Chapters 2, 3 and 4. The thesis involves inductive and deductive inquiries utilising both qualitative and quantitative data sources and methodologies. An overview of the approach to the research is discussed before considering each of the research questions identified in Chapter 5 and the data sources and methodologies best suited to addressing these. The data sources and methodologies used for the empirical research are then described in detail. In view of the range of questions addressed, the empirical research includes a multiple methodological approach involving secondary analysis of quantitative data, content analysis of interview data and legal case material, in-depth interviews and a focus group. The data was analysed and interpreted using a range of statistical techniques, and the processes for phenomenological, grounded theory and discourse analysis. Lastly, the validity, reliability, role of the researcher and ethical considerations of the research are documented before examining the limitations of the empirical study.

6.2 Approach to the Research Process

In this section, the rationale for the selection of data sources and methodologies used to address the research is outlined. While the major research question is in the form of a basic hypothesis and could be thought of as deductive, the emergent research design utilises quantitative and qualitative methods in a largely inductive, naturalistic framework (Patton 1990:192-194). The early stages of the research focused on the tourism patterns and experiences of people with disabilities without seeking to develop an explanation for these experiences. At that point, the research design sought to develop a triangulation of research methods popular in leisure research to link quantitative and qualitative methods (Henderson 1991:25) through the combination of data sources and between-method triangulation (Denzin 1989:237-243). However, as the complexity of the problem incorporated an explanation of the experiences of people with disabilities, other data sources and methodologies were incorporated for the series of iterations and interpretations

that were to follow.

Further reading of Denzin and Lincoln (1994) led to the conclusion that naturalistic inquiry could involve a series of interpretive practices without valuing any single data source or methodology over any other. Similarly, naturalistic inquiry can employ different theoretical frameworks or discourses and, hence, is appropriate for interdisciplinary studies that draw on their own disciplinary histories. Denzin and Lincoln, in developing a methodology to address these considerations, go on to describe a multi-methodological approach:

...as a bricolage, and the researcher as *bricoleur*...The bricoleur produces a bricolage, that is, a pieced together, close-knit set of practices that provide solutions to a problem in a concrete situation. "The solution (bricolage) which is the result of the *bricoleur's* method is an [emergent] construction" (Weinstein & Weinstein 1991, p.161) that takes new forms as different tools, methods, and techniques are added to the puzzle... The choice of which tools to use, which research practices to employ is not set in advance (Denzin and Lincoln 1994: 2).

Bricolage aptly describes the research process arrived at in developing this research. The process began in 1995 after the *World Assembly for Disabled People's International* where the interest in disability and tourism was initiated. Over the next three years, this interest was translated into a proposal for a quantitative investigation focusing on the tourism patterns of people with disabilities. This research became the foundation for the Ph.D. proposal. Over the period of the research additional data sources were added, together with the new methodologies of in-depth interviews, content analysis and focus groups, culminating in the use of newly acquired computer analysis and statistical techniques in 2002. The emergent *bricolage* involved the addition of new tools as they became available, new questions as they emerged and new iterations, interpretations and explanations as they became apparent.

This largely inductive inquiry drew on a recursive and iterative process where data collection, interpretation and analysis were undertaken through many cycles to make sense of the problem (Veal 1997:28-30, 131). This naturalistic inquiry helped to develop an understanding of the group experiences of people with disabilities that emerged from their tourism experiences. From this foundation, two sectors emerged from the constraints encountered as having a major influence on the experiences of the group. The TA and the accommodation sector were studied to understand their responses to the group and to develop an explanation for why they behaved the way they did and why people with disabilities had these experiences (Denzin 1989; Creswell 1998).

6.3 Addressing the Research Questions

This section firstly reviews each research question posed in Chapter 5 to indicate which type/s of data source or methodology would be best to answer each question. Secondly, it provides a summary of the specific data sources and methodologies to be employed for each research question.

Research Questions 1a-e: Tourism patterns and experiences of people with impairments and the constraints that they encounter in their journey through the tourism system

Question 1 addresses the tourism patterns and experiences of people with disabilities particularly the constraints they face within the tourism system. In particular, Question 1 seeks to determine the differences between the tourism patterns of people with disabilities and those of the non-disabled – that is whether people with disabilities take less tourism trips than the non-disabled. Quantitative data was required for these comparisons and this was found through a number of official data sources on tourism demand.

Questions 1a-c are concerned with identifying and categorising the constraints encountered at each stage of the tourism experience. Both quantitative and qualitative data sources and methodologies were employed through secondary data analysis, in-depth interviews of people with disabilities and a content analysis of complaint cases brought under the DDA.

Question 1d moves from the experience of the individual to consideration of the extent to which the tourism patterns and experiences described, and in particular the constraints encountered, can be seen as a product of the social relations of tourism for people with disabilities. Addressing this question involved further consideration of the material generated from Questions 1a-c above and the material generated in addressing Questions 3 and 4.

Question 1e concerns the implications of the findings of the research for our understanding of tourism systems. It was addressed by further consideration of the material generated from Questions 1a-d above, and the material generated in addressing Questions 3 and 4.

Research Questions 2a-b: The effect of impairment and other socio-demographic considerations on tourism patterns and experiences

Question 2 investigates whether the tourism patterns, experiences and constraints faced are

effected by a person's impairment and socio-demographic characteristics. To address Question 2, existing data sources were drawn on, mainly those that had been used in relation to Questions 1a-c. These established what influence: type of impairment; level of independence; type of mobility or other aid; gender; age; lifestyle situation; level of education; and geographic region had on the patterns of tourism of people with disabilities. In addition, in-depth interviews of people with disabilities were used to provide an understanding of the interrelationship of these characteristics, and their influence on the tourism patterns of people with disabilities.

Question 2a addresses the theoretical implications of the above investigation for the theoretical development of the social model.

Research Questions 3a-c: The tourism market response of TA and TI to people with impairments

Question 3 reviews the market responses of TA and TI to people with disabilities through their practices. Firstly, this is done quantitatively by a secondary data analysis of the accessibility of a tourism product database. Secondly, a content analysis is undertaken of the disability tourism initiatives of TA from 1990-2000. Question 3a then reviews these practices in light of the constraints on tourism patterns and experiences identified in Questions 1a-c.

Question 3b seeks a rationale for the pattern of service provision through the evidence presented in Questions 3 and 3a. This is supplemented by in-depth interviews of TA policy officers responsible for disability issues. Similarly, the practices and rationale for the pattern of service provision of the accommodation sector are investigated, using in-depth interviews and a focus group of managers.

Question 3c undertakes a discourse analysis of the evidence presented in Questions 3a and b of the approaches to disability by TA and TI through the theoretical perspectives and discourses identified in Chapter 5. This question is interrelated and overlapping to Questions 1d and 4e in understanding why people with disabilities have the tourism experiences they do.

Research Questions 4a-e: The effect of the government human rights regulatory environment on people with impairments, TA and TI

Question 4 presents evidence of the effect that the Australian human rights legislation has

had on the tourism environment since its enactment of the DDA in 1993. The DDA is the focus of study for this question, adding to the analysis begun in Questions 1a-d and 3a-c. Question 4a employs a content analysis of the complaint cases and Federal court actions taken by people with disabilities to identify discriminatory tourism practices. Subsequently, Question 4b reviews the evidence of Question 4a to reveal the practices and omissions of the TA and TI that led to the actions.

Questions 4c-d move beyond the complaints cases and Federal court actions to undertake a content analysis of other mechanisms used under the DDA that may have influenced the practices and discourses of TA and TI. In particular, the use of *Disability Action Plans* and the *Disability Standards* processes for accessible public transport and access to premises are presented for their tourism implications.

Lastly, Question 4e employs a discourse analysis of the theoretical perspectives and discourses presented in Chapter 5 to examine insights of the evidence presented for developing and explanation of the tourism patterns and experiences of people with disabilities. While this question concentrates on the implementation of the DDA in a tourism context, it also addresses the role of tourism in the rights of citizenship and the degree and extent to which these rights have been constrained in Australia. This question is interrelated to, and overlaps with, Questions 1d and 3c to provide an understanding of the social relations that produce the tourism constraints faced by people with disabilities.

Table 16 presents a summary of the specific data sources and methodologies required to address the research questions, and identifies in which chapters they appear. Research Questions 1d, 2a, 3c and 4e, that seek to develop an explanation for the tourism patterns and experiences of people with disabilities, are interrelated and overlapping. The main discussion for these questions is in Chapter 10 and draws on all the data sources and methodologies through the theoretical perspectives and discourses presented in Chapter 5.

Table 16: Overview of the research questions, data sources and methodologies

Research Question	EVIDENCE GATHERED	Chapter
1.	Patterns and Experiences of people with disabilities	
	Secondary data analysis:	
1	<ul style="list-style-type: none"> • <i>Disability, Ageing and Carers Survey</i> (ABS 1993) - holiday taking as an activity 	7
1	<ul style="list-style-type: none"> • <i>National Visitor Survey</i> (BTR 1998) – comparative tourism patterns of people with disabilities and non-disabled, and the requirements of the group; 	7, 8
1, a b, c, e	<ul style="list-style-type: none"> • <i>Anxiety to Access</i> (Darcy 1998) – tourism patterns and constraints to tourism opportunities and experiences; 	7, 8
	In-depth interviews with:	
a, b, c, e	<ul style="list-style-type: none"> • people with disabilities who do not travel, who wish to travel or who have travelled about the experiences and constraints encountered; 	8
	Content/discourse analysis of:	
a, b, c, e	<ul style="list-style-type: none"> • DDA complaint cases and Federal Court cases that document discriminatory practices in a tourism context (HREOC 2002a); 	8, 9
2.	Effect of impairment and other socio-demographic considerations	
	Secondary data analysis:	
2	<ul style="list-style-type: none"> • <i>National Visitor Survey</i> (BTR 1998) - the influence of impairments on tourism patterns; 	7
2	<ul style="list-style-type: none"> • <i>Disability, Ageing and Carers Survey</i> (ABS 1993) - an analysis of the influence of impairment, gender and age on holiday taking as an activity 	7
2	<ul style="list-style-type: none"> • <i>Anxiety to Access</i> (Darcy 1998) - an analysis of the influence of impairment and other socio demographic characteristics on tourism patterns; 	7, 8
	In-depth interviews with:	
2	<ul style="list-style-type: none"> • people with disabilities about the role of impairment and other socio demographic characteristics on tourism patterns and experiences; 	7, 8
3.	TA & TI practices and discourses	
	Secondary data analysis:	
3	<ul style="list-style-type: none"> • <i>Visnet</i> (Tourism NSW 2000) – statistical review of the accessibility of tourism product 	9
	In-depth interviews with:	
3, a, b	<ul style="list-style-type: none"> • Accommodation managers about their perceptions of supplying goods and services to people with disabilities 	9,10
3, a, b	<ul style="list-style-type: none"> • TA policy officers responsible for disability issues about the initiatives and behaviour of the organisation 	9, 10
	Focus group of:	
3, a, b	<ul style="list-style-type: none"> • Accommodation managers about their perceptions of supplying goods and services to people with disabilities 	9
	Content/discourse analysis of:	
3, a, b	<ul style="list-style-type: none"> • TA disability and tourism policy initiatives (Comm and State) 	9, 10
3, a, b	<ul style="list-style-type: none"> • Other documents, correspondence and media reports. 	9, 10
4.	DDA/HREOC strategies	
	Content/discourse analysis of:	
4, a, b, c, d	<ul style="list-style-type: none"> • DDA complaint cases, hearings, inquiries, Federal Court actions, Disability Action Plans, Disability Standards, and other strategies relating to tourism (HREOC 2002a); 	8, 9, 10

A. Populations, sample frames and samples

Table 17 presents a summary of the sampling frames and samples for each data source and methodology. The primary population for this study is all people with impairments in Australia. Supplementary to this group were two populations who may provide an explanation of the social relations of tourism for people with disabilities. They are TA and the accommodation sector managers.

Table 17: Sample Frames, Samples and Sample Sizes

Method	Sample Frames	Sample	Sample Size
ABS 1993	Household Survey 42,060 people From 15,717 households + 515 health care establishments (Printed '000)	WHO 1980 ICIDH list of conditions People with disabilities	42,060 7,075
BTR 1998	Household telephone survey 78,312 15 years and older List of conditions (based on ABS 1998)	A household sample of Australians List of conditions (based on ABS 1998)	78,312 7,300
Darcy 1998	8 organisations' membership lists of 8,700 people with disabilities based on a person self identifying as having a physical impairment,	Based on a person self-identifying as having a physical impairment and the mobility aid used. Includes people with multiple impairments	2,647
HREOC/Federal & other Court cases	All actions brought before the Australian legal system	Any example relevant to a tourism context. Involves all disability groups	18
HREOC complaint cases	All actions brought before HREOC	Any example relevant to a tourism context. Involves all disability groups	(approx) 150
People with Disability Interviews	Readers of <i>ParaQuad</i> magazine	People with impairments who read ParaQuad and responded to the advertisement	15
Accommodation Providers Interviews	Hotels identified as having accessible accommodation in TNSW (2000) and Cameron (2000)	Randomly selected hotels were contacted and those who consented to be interviewed	10
Accommodation Providers Focus Group	AHA members	Those members of the AHA who responded to an advertisement in the AHA newsletter to participate in the focus group	23
TA officers interviews	All TA officers responsible for disability	Those responsible TA officers who consented to be interviewed	3
TA policy analysis	All TA	Total population sampling	10

B. Timeframe of the research

For the purposes of the thesis, TA and TI practice is reviewed up to and including 2000. This date was chosen for two reasons. First, the majority of data collection on the tourism patterns and experiences of people with disabilities was completed up to and including in this period. Second, this was the year the Sydney Paralympics 2000 when it could be hypothesised that disability issues may have had a higher profile due to this one-off high profile elite sporting event for people with disabilities. This hypothesis could be a question for further research. With the experiences of people with disabilities and the policy analysis informing the TA and TI research, the interviews with tourism authorities and the accommodation sector occurred from mid 2001 to early 2002. The cycle of interpretive iterations began with the literature review, continued throughout the data collection and was completed predominately over the second half of 2002 and the first half of 2003.

6.4 Data Sources and Methods

This section outlines each data source or the process for each methodology and identifies

which Research Questions they address.

A. *Disability, Ageing and Carers Survey (ABS 1993)*

The ABS (1993) was the third in a series of national disability surveys (ABS 1981; 1988; 1993). The household survey of 42,000 people sampled 7,075 people with disabilities (ABS 1998). The data collected included socio-demographic, impairment and lifestyle variables. One of the lifestyle questions involved recreational activities away from home over the last 12 months and included *holidays*. This was the first time that the travel patterns of people with disabilities could be estimated in Australia. New analysis of this data source investigates the influence of gender, age and severity of disability on the likelihood of having a holiday. This data partially address the initial Questions 1 and 2 on overall patterns of tourism and on the influence of impairment, gender and age on tourism patterns.

B. *National Visitor Survey (BTR 1998)*

The main source of data for addressing the initial Question 1 was the National Visitor Survey conducted in 1998 by the Bureau of Tourism Research (BTR 1998), the first national tourism data to include a disability module. The module involved discussions with the ABS and the then National Office of Tourism (Legg 1997 pers. comm.). It made possible a comparison of travellers/non-travellers between people with disabilities and the non-disabled. The NVS is a household telephone survey of 80,000 Australian residents aged over 15 years and their tourism patterns for day, domestic and overseas trips (BTR 2001). Unlike the ABS (1993), it does not include residential facilities for the aged and its estimates are based on the Australian population who is 15 years and older. Appendix 3 presents the data items collected in the survey. The BTR has not published any of this data due to a number of methodological issues with the disability module (O'Halloran 2002 pers. comm.). The main reason was the self-reported nature of the *identified health conditions and impairment* for both respondent and other household members (see Appendix 3). However, the data offers a number of insights into comparative tourism patterns between the non-disabled and people with impairments, and the details of people with impairments travelling. The analysis was undertaken using CDMOTA, Microsoft Excel and SPSS. Hence, the analysis in Chapters 7 and 8 is a reworking of the primary data provided by the BTR (1998).

The researcher recognises the apparent contradiction of using secondary data sources (ABS 1998; BTR 1998) that are based on medical conceptualisations of disability. However, in noting the limitations of the sources, the secondary data can shed light on overall tourism participation patterns and offers the first opportunity to compare the tourism patterns of people with disabilities and the non-disabled. The remainder of the research design is guided by social model principles.

C. *Tourism NSW – Survey of People with Physical Disabilities (Darcy, 1998)*

The main source of data concerning constraints (Questions 1a-c) and the influence of impairment and other socio-demographic considerations (Questions 2 and 2a) was the Tourism NSW study which investigated the tourism patterns and experiences of 2,642 people with physical disabilities in 1998 (Darcy 1998). The self-completed postal survey drew its sample from those people with physical disabilities who were members of nine major organisations representing people with physical disabilities. This was felt to be the only viable method to reach a cross section of the population of people with physical disabilities in sufficient numbers. See Appendix 2 for the methodology and for a list of data items. The data was used for a secondary analysis of:

- quantitative analysis of the profile of tourists with disabilities, the constraints to tourism, requirements, and the influence of an *embodied ontology* on the likelihood of tourism;
- qualitative analysis of the 100,000 words open-ended responses to the following questions: What other information is required to better meet the tourism planning needs of people with disabilities? What, if any, barriers have you encountered when undertaking trips away from home? What suggestions/improvements could be made to enable tourism for people with disabilities? Use this space to make any further comments about your tourism experiences or the questionnaire. This data had not previously been analysed.

D. *In-depth interviews*

In-depth interviews were undertaken with three populations: people with disabilities; accommodation providers; and responsible TA officers. This section will outline the sample selection for each population and then identify the research process.

People with disabilities

The qualitative data set described in 6.4.3 addressing Questions 1a-c and 2 and 2a, was extended through undertaking in-depth interviews of people with disabilities. A breadth of

insights was provided by this data but left the researcher wondering about the deeper meaning behind some of the experiences. To extend the understanding of the previous data source and this impairment group, the sample frame chosen was the *ParaQuad* journal⁶. An advertisement that recruited people with disabilities for interview was placed in the summer 1999 edition. From this initial advertisement, 15 people expressed an interest to be interviewed. Each person was contacted, the aims of the research being discussed, and a further information letter was sent or emailed. The letter restated the aims of the research, outlined the ethical considerations and documented the voluntary nature of the research, participant anonymity and confidentiality. After one week, the people were contacted again to see if they still wished to be involved. If they did wish to be involved, a time was organised for the interview, if they did not, they were thanked for their interest. An interview time and venue was then negotiated with all who expressed interest given the options of being interviewed:

- by telephone;
- in their home;
- at their place of work; or
- at university (cab charge provided).

Of the initial 15 people who expressed interest, 12 people were interviewed. A further three people were recruited through the snowball and convenience sampling techniques (Patton 1990). The completed interviews ranged from 40 minutes to five hours in length.

Tourism authority officers

One of the two main sources of data for the practices and rationales of the TA that addressed Questions 3a-b was in-depth interviews of responsible tourism authority officers. If people responsible for disability policy and initiatives could be identified then contact was made via email. If no relevant disability material was located or a person could not be identified as having responsibility for the area, an initial email was sent to the Chief Executive Officer. The email outlined the purpose of the research and the information sought. One week later a letter containing the same information followed the email. The organisations included in the sample were:

- Australian Tourist Commission;
- Canberra Tourism and Events Corporation;
- Northern Territory Tourist Commission;

⁶ ParaQuad had the widest membership of any organisation as it administered the CDFACS' CAAS program. CAAS is a program for people with impairments who have continence related conditions and covers the major physical impairment groups.

- South Australian Tourism;
- Tasmania Tourism;
- Tourism NSW;
- Tourism Queensland;
- *Tourism Victoria; and
- *Western Australian Tourist Commission.

The TA that did not reply were contacted for a second time by letter and again no reply was received. The individuals who replied or those designated were contacted to establish the authority's responses to disability. This involved firstly, checking that all the relevant policy, programs and initiatives of the identified authority were gathered by the researcher. If these were not the only initiatives, further information was gathered as to the newly identified material. Secondly, this involved checking whether the person would be willing to be interviewed by the researcher. It was stated that interviews would be anonymous and confidential unless the organisation was willing to provide an official public response. For the purposes of the interview, an unstructured schedule interview of disability and tourism issues relevant to TA was formulated. This was forwarded to the individuals along with a formal request for an interview. Three interviews were carried out, four responded by letter or email, and two organisations did not respond in any format (denoted by an *).

Industry representatives and managers of accommodation

The experiences of people with disabilities identified the accommodation sector as a critical facilitator of the tourism experience and a decision was made to concentrate on one sector for this research rather than trying to address all sectors. Further, the populations of providers were those from the Sydney Metropolitan area. The sample drew on those establishments who had accessible rooms. This was critical, as it was operators of accessible facilities who could provide an insight into disability service provision. To interview people without accessible premises would have compromised the validity of the research. This was the main source of data for the practices and rationales of the TI that addressed Questions 3a-b.

People expressing an interest were then faxed or emailed a background issues sheet on which the interview would be based. The issue sheet was based on the supply side literature review. An unstructured schedule interview was formulated based on the literature review of supply issues. The people were informed that the interview would be anonymous and confidential. The following organisations were identified as key players in the accommodation sector in NSW:

- *Australian Hotels Association;
- Bed and Breakfast Council of Australia NSW;
- *Caravan and Camping Industry Association of NSW;
- *Hotel, Motel and Accommodation Association of Australia Ltd. (NSW);
- NSW Backpacker Operators Association;
- YHA NSW Inc.;
- *Tourism Council Australia;
- *Tourism Task Force.

All of these organisations had an introductory letter sent to them outlining the research and eliciting their support. The letter was accompanied by a supporting letter from Tourism NSW's CEO, Tony Thirwell, stating their support for the aims of the research. The organisations denoted with an asterisk (*) responded to the original letter. Subsequent attempts were made to contact the other organisations, and contact and discussions with these organisations led to the outcome described below. The AHA supported the research through commitment to involve members in the in-depth interviews and a focus group.

As discussed in the literature review there is no consolidated inventory of accessible accommodation in Australia. The best sources of reliable accessible accommodation information for Sydney were ACROD (1994) and Cameron (1995; 2000). These resources were used to frame a sample of accommodation managers to interview. The managers were drawn from 3-5 star establishments in the Sydney and Parramatta CBD. Ten in-depth interviews with accommodation providers were undertaken. This was supplemented with in-depth interviews of an inbound operator and a peak accommodation sector provider. Further, an in-depth interview was undertaken with a specialist accommodation reviewer focusing on their 1999 to 2000 experiences of informally interviewing and undertaking site visits to over 100 accommodation providers and attractions throughout NSW.

Initial contact was made via email, fax or telephone to general managers using the AHA contacts, who in turn suggested a more appropriate person based on familiarity with disability issues in that organisation. An email confirmation of the interview time and date was then sent, together with the unstructured schedule interview checklist. This was done to give managers the opportunity to think about the general areas and to make inquiries with other areas of the hotels if needed. In-depth interviews were conducted with the following types of managers:

- 1 Front Office Manager of a three star motel;
- 1 General Manager of a five star hotel;
- 2 Reservations Manager of four star hotels;

- 2 Sales and Marketing Manager of four star hotels;
- 2 Director of Sales of four star hotels;
- 1 Director of Business Development of a 4 star hotel; and
- 1 Public Relations Manager of a four star hotel

Each interview lasted between 15 minutes and two hours. The manager interviewed also showed the interviewer the accessible features of the hotel and the accommodation rooms specifically. However, it was not the purpose of the research to assess the accessibility of the hotels or rooms. This would have replicated other current projects (Cameron 2000b; Australian Quadriplegic Association 2001) and to undertake a thorough access audit of hotels is a research project on its own. However, the researcher is an experienced and qualified access auditor, and is a member of the Australian Planning Institute and the Access Institute of NSW. These skills provided further insight into the interview process.

Unstructured schedule interview and interview procedures

Each in-depth interview population had an unstructured schedule interview developed as the most appropriate format in which to undertake the interviews. This format offers flexibility in conducting the interview by varying question order, the time spent on each category and, where appropriate, by investigating other avenues identified during the interview but not covered by the schedule (Denzin 1989:105). Further, the unstructured schedule interview allows the schedule to be constructed in a language that recognises individual differences or industry practices and hence, the experience of the individual. For example, the terminology used to describe disability (e.g. disabled, handicapped, accessible etc.) used during the interview would be dependent on the language used by individual. This recognition was important to elicit the responses of each of the populations. This offered the interviewer the opportunity to engage in a conversation with the person rather than to ‘just interview them’. The conversational aspects involved the researcher sharing their personal experiences with the person being interviewed. This level of disclosure helped develop rapport. For the TA and TI, understanding current sector practice was central to the aim of research. Copies of the schedules are included in Appendix 4, 5 and 6.

For this study, all interviews were tape-recorded. Tape recording allowed the interviewer to concentrate on the context of what was said and how the words were expressed. The taped interviews were later transcribed and spot-checked for accuracy by the researcher. However, several of the interviews were difficult to transcribe due to the speech

characteristics of the people involved or due to the environment of the interview. Each person interviewed who wished to receive a copy of the transcript was forwarded a copy. In the letter or email that accompanied the transcript, the people were asked to perform two tasks. The first was to review the transcript to ensure that it accurately reflected their responses. The second was to take the opportunity to amend, delete or otherwise alter the text given that they had now had more time for deeper reflection on their responses. A reply-paid envelope was supplied with each transcript that could not be forwarded by email. Of the eight forwarded transcripts, two were returned. Both of the returned transcripts contained minor editorial comments.

E. Focus group of accommodation providers

The population, rationales and questions addressed were the same as for the in-depth interviews. The method differed in that a notice was placed in the AHA newsletter and posted to the AHA discussion list about the proposed focus group, and the subsequent accommodation and disability issues seminar⁷. People who expressed an interest were then faxed or emailed an agenda and background issues paper that the focus group would discuss (Appendix 5). The issues paper was based on the literature review and preliminary findings from the in-depth interviews. The sessions were attended by 23 people from 14 separate Sydney hotels.

The focus group was introduced by: Peter Booth, Dean of the Faculty of Business UTS; David Travers, Parkroyal Hotels and representing the Bass Group of Hotels; and John Bates, Policy and Planning Unit of Tourism NSW. The connections between academic research and TI practice were made by each of the speakers coming from their positions. Ravi Ravinder, a lecturer in tourism industry and marketing at UTS who has extensive tourism industry experience, facilitated the focus group. This was done to avoid any camouflaging of the managers' perceptions of disability that may have occurred if a person with a disability had facilitated the group (Ross 1994). The focus group was observed by the researcher to allow for further note taking and issue preparation for the seminar. Minutes of the session were taken by an assistant and issues placed on a white board for participants to view as they emerged. The focus group and seminar were closed with

⁷ The researcher to promote issues of good practice provided the disability and tourism seminar. This was an incentive to be involved in the research and a way of showing good faith to those who attended. An access tourism package was provided to each attendee that included Darcy (1998), NOT (1998) and Cameron (1995).

concluding comments from Tony Thirwell, Chief Executive Officer of Tourism NSW. The researcher, facilitator and research assistant then debriefed the session and made further notes. The minutes to both sessions were analysed for emergent themes by reading and keyword/phrase search.

F. DDA strategies

The DDA strategies were the main source of data for the effect of the regulatory environment on the tourism experiences of people with disabilities, and the practices of TA and TI addressed in Questions 4a-d. The HREOC complaint cases, public hearings (pre 13 April 2000) and Federal Court cases (post 13 April 2000), Disability Standards, Disability Action Plans and publicly available documents provided a fourth data source from which to investigate the phenomenon. These sources of data were available from the HREOC website (HREOC 2002a). The determination of whether the strategies were relevant to tourism was based on the definitions of tourism, tourist, tourism system, TI, and stakeholder approach to tourism identified in the literature. The inclusions were broad as people with disabilities could use a good, service, facility or public space in their own community or whilst travelling to another community. The DDA strategies drew from the transport, hospitality, accommodation, attractions and recreation sectors.

The availability of the HREOC complaint cases was limited to the summary of the cases available on the HREOC website. HREOC's Manager of Complaints was contacted by email and letter with a request to gain access to the complaint files. However, HREOC policy does not allow access to the files for any purpose but HREOC business due to the legal confidentiality of complaints (Mason 2002 pers. comm.). It should be noted that not all complaint cases have a summary posted and that this represents an incomplete record. However, HREOC tries to post summaries of the spectrum of complaint cases. The referencing of the complaint cases is also problematic due to HREOC only providing the year of the case up to 1999, and the month of the case from 1999 onwards. Where the complaint cases are referenced in the thesis, the suffix CC has been added to indicate that the source is a complaint case from the HREOC website and the month/year e.g. HREOCCC March 2000 (HREOC 2002a). Some 45 complaint cases and 18 court cases are directly referred. Table 27 provides a summary of the court cases and a sample of the complaint cases.

As well as the complaint cases, the development of Disability Standards and Disability Action Plans were used as case study to provide insights into the operation of the DDA. A case study is the analysis of a single case or multiple cases for the purposes of a description or generation of a theory, whereas case histories focus on the process. The case study analyses a case or body of cases for what can be said about an underlying or emergent theory or social process (Strauss and Glaser 1970 cited in (Denzin 1989:185). A case study will often merge with a case history; that is, case studies are based on case histories (Stake 1994:236-237).

The HREOC register of Disability Action Plans was reviewed for relevant TA and TI examples (HREOC 2002a). These were then examined to assess the approaches to disability, issues identified and strategic agendas for change. The *Disability Standards for Accessible Public Transport* and the proposal for a *Draft Disability Standard for Access to Premises* under the DDA provided insights into the complex social relations of these TI sectors. In particular, the process for the DDA Standards reveals the relative power stakeholders have in the decision-making process. They provided an explanation for the reasons that the experiences of people with disabilities are the way they are. The case studies drew upon publicly available documents, consultations and workshops carried out around the Standards to provide an understanding of the stakeholder positions of disability issues.

G. Government tourism policy analysis

The policy documents provided one of the two main sources of data for the practices and rationales of the TA that addressed Questions 3a-b. The population for this part of the study was all Commonwealth, State and Territory TA responsible for the planning and management of tourism. The organisations were the same as in D of this section. The research process involved:

- a review of publicly available information from the Commonwealth and State TA. These documents included annual reports, corporate plans, strategic marketing documents and web based material;
- responses and interviews from key personnel in each of these organisations as to their tourism and disability initiatives; and
- a review of the minutes of the first (and only) national forum of Commonwealth, State and Territory government tourism commission officers responsible for disability (Douglas 1999).

Any identified policies were sourced for inclusion in the analysis. The second stage of this

process was to contact the organisations by letter and email to provide information about their tourism and disability initiatives from 1990 - 2000. Any other policies identified were sourced for inclusion in the analysis. The insights that this information could provide would be enriched through an understanding of the disability market segment initiatives within the organisation. In-depth interviews were also undertaken to assist with understanding the complexity of organisation culture and the position of disability tourism initiatives.

6.5 Data Analysis and Presentation of Outcomes

Each data source had the following data analysis procedures undertaken.

A. Secondary quantitative data

The ABS (1993; 1998), BTR (1998) and Tourism NSW (Darcy 1998) data sets were analysed using the Statistical Package for the Social Sciences (SPSS) for Windows. The procedures used included frequencies, descriptives, cross tabulations and graphics. After preliminary statistical analysis, some variables were recoded to enhance the statistical power of the analysis (Veal 1997). Further statistical analysis was undertaken to assess the impact of demographics on the tourism patterns. This was firstly done using the chi-square, comparing means (independent samples t-test) and one-way analysis of variance (ANOVA). Significant findings ($p < 0.05$) are discussed within the thesis with the accompanying tables included as appendices where noted. However, these techniques can only provide an insight into the difference between categories of a single variable or relationships between two variables. Binary logistic regression analysis (BLRA) and ordinal regression analysis (PLUM) were employed to provide an understanding of the interaction between variables in a more complex model.

BLRA is useful for situations in which you want to be able to predict the presence or absence of a characteristic or outcome based on values of a set of predictor variables. It is suited to models where the dependent variable is dichotomous, in this case whether a person undertook domestic tourism (yes=1) or not (no=0). It is useful when a researcher wants to be able to predict the presence or absence of a characteristic or outcome based on values of a set of predictor variables. BLRA coefficients are used to estimate an odds ratio of influence for each of the independent variables in the model. This provides an analysis

of which variables had greatest influence in relation to the other variables. BLRA is applicable to a broader range of research situations than discriminant analysis (Agresti 1996; SPSS 2002).

PLUM is useful for situations in which you want to be able to predict the presence or absence of a characteristic or outcome based on values of a set of predictor variables. It is suited to models where the dependent variable is scale or ordinal, in this case the number of domestic trips undertaken in a year. Due to the range of domestic trips in the sample, the variable was reduced to an ordinal variable (0, 1, 2-4, 5-10 or over 10 trips) then a PLUM was undertaken. PLUM determines the significance of each of the independent variables in the model in relationship to each other (Agresti 1996; SPSS 2002).

B. In-depth interviews and open-ended survey responses

Initially, the data collected from the unstructured schedule interviews and open-ended survey responses was analysed by typological analysis. According to Howe (1988), typological analysis refers to the division of information into categories or groups ‘... on the basis of some canon for disaggregating a whole phenomenon’ (1988:314). In turn, each of these typologies formed a category in which to place data. Where appropriate, responses gathered during the interviews were used as direct quotations to illustrate and support aspects of the quantitative data collected. Each interview and open ended survey response was transcribed into Word files. The procedural issues for phenomenology or grounded theory techniques are now described.

Phenomenology

The starting point of the research was to examine the tourism patterns and experiences of people with disabilities. As discussed in Chapter 5, leisure constraints theory was used in conjunction with a social model approach to analyse the tourism constraints of the group. To aid in understanding of the outcome of the tourism constraints encountered for people with disabilities, *phenomenology* was used. Phenomenology seeks out what Husserl called *the essence of experience* (Holstein and Gubrium 1994; Creswell 1998). As Patton states, ‘... the phenomenological inquiry focuses on the question “What is the structure and essence of experience of this phenomenon for these people?” The phenomenon being experienced may be an emotion - loneliness, jealousy, anger’ (1990:69). The process of data analysis for phenomenology was adapted from Creswell (1998:54:54), was systematic

and included:

- epoche: the researcher puts aside their preconceived notions about the phenomenon and uses the voices of the participants to develop an understanding;
- lived experience: research questions are posed to elucidate the everyday lived experiences of the group;
- interviews: are used to investigate and reflect upon the participant's experiences.
- data analysis: statements are identified and are transformed into cluster meanings in phenomenological concepts. A general description of the experience is made from the transformations, the textual description of what was experienced (constraint/barrier/good time) and the structural description of how it was experienced;
- essence: a phenomenological analysis ends with the reader understanding the single unifying meaning of the experience.

All experiences have an underlying 'structure' and phenomenology provides an insight that gives the reader a greater understanding of what the experience is like for the group.

Grounded Theory

Once the *essence* of people's tourism experiences had been examined, the social relations of these experiences were analysed to explain this situation. This part of the research took direction from Samdahl and Jekubovich (1997a; 1997b) who strongly argued that *grounded theory* provides a less prescriptive framework for analysing leisure constraints. Grounded theory utilises various methodologies where meaning becomes constructed during the research process. Data analysis is ongoing and iterative (Patton 1990:66). The analysis seeks to construct a model identifying the interactions of people with disabilities with the TA and TI and, hence, the influence of government legislation, policy and initiatives on this area. The process of data analysis for grounded theory was adapted from Creswell (1998:57-58), was systematic and included:

- open coding: where the researcher forms initial categories of information about the phenomenon being studied. Within each category, sub-categories or properties are found, and the researcher looks for the extreme possibilities on a continuum to dimensionalise each property.
- axial coding: after open coding the researcher assembles the data in new ways. A coding paradigm or logic diagram is formulated that:
 - identifies a central phenomenon (central category about the phenomenal);
 - explores of causal conditions (categories or conditions that influence the phenomenon);
 - identifies specific strategies (actions or interactions stemming from the phenomenon);
 - identifies the context and intervening conditions (narrow and broad conditions that influence the strategies); and

- delineates the consequences for this phenomenon (the outcomes of the strategies).

The outcome of the process of data collection and analysis is a substantive-level theory for the tourism experiences of people with disabilities. This theory would form the basis of both understanding and improving tourism service delivery for people with disabilities. See the Comprehensive Tourism Access Model in Chapter 11.

Nvivo software package

The procedures of analysis for phenomenology, grounded theory and content analysis all used **Nvivo** software (formerly NUD*IST - Non-numerical Unstructured Data Indexing Searching and Theorising software). The text was prepared in standardised Nvivo format of rich text format Microsoft Word files. These files were then loaded into a *project* that allowed analysis of all interviews/documents at once. Once the project was loaded, the data was coded through word searches. Following coding, both the electronic and hard copy data sources were used in the process of analysis and interpretation. The typologies devised for each data source were then coded according to each of these major typologies. The data was then *worked* and *recoded*, where *sub-themes* began to develop for each of these major typologies. This iteration of coding, re-coding and working the data continued until the final sub-themes and categories evolved. These processes were made considerably easier using the Nvivo program as it allowed the relevant text data typologies to be retrieved in one file across all interviews and documents. Once this text was retrieved, direct quotes were selected.

For the purposes of analysis:

- each person interviewed was given a pseudonym for anonymity and confidentiality;
- each paragraph (a 'text unit') has been numbered for each person's interview or questionnaire response;
- when direct quotations are used, both the person interviewed and where the response appears in the text are clearly identifiable (e.g. Tim Pg 57); and
- for the questionnaire qualitative data, the transcription included the questionnaire number as well as the paragraph number (Qn 527 Pg 1027).

These identification processes provided both a clear reference point to the individual interviewed and the context in which their comments appear. The identification processes also provided an *audit trail* back to the original data.

C. *Content/discourse analysis*

Henderson (1991:91) describes content analysis as the process used to analyse records, documents, letters, transcribed conversations or any textual item. Content analysis is primarily a strategy of analysis rather than a data collection strategy. Hermeneutics refers to the ‘... interpreted meaning that results from a content analysis’ (Henderson 1991:93) and the content analysis undertaken for this research would draw upon the theoretical perspectives and discourses presented in the theoretical framework. As discussed in Chapter 5, discourse analysis is based on the nature of ideas, texts, media, talk and behaviour of social arenas that socially construct knowledge and power. In the tourism context, a range of sources was drawn upon including interview and focus group transcripts, personal communication, letters, brochures, directories, initiatives, policy documents and services. These all offer an insight into the discourses of government, TA and TI towards people with disabilities. The discourse analysis drew on the theoretical perspectives and discourses presented in Section 5.2 including: human rights; medical model (ableist discourses); social model; and market ideology.

6.6 Role of the Researcher

Disability studies challenges approaches that disempower people with disabilities within the research process. Other approaches did not understand, consider or value people with disabilities and, hence, they were outsiders to the research about them (Oliver 1999). Disability studies promotes an *emancipatory research* paradigm (Barnes and Mercer 1997). Some of the power-based considerations are the role of the researcher, the social significance of the researcher’s embodiment, validity of the research and the chosen research methods (Kitchin 2000b). The emancipatory approach can be summarised by a slogan used by people with disabilities, *Nothing about Us without Us* (Charlton 1998). Emancipatory research seeks to change the social conditions of people with disabilities through the research process.

The research was guided by emancipatory research principles (Stone and Priestley 1996; Barnes and Mercer 1997; Oliver 1999; Kitchin 2000b). The research was framed from a social approach that understands disability from a disability perspective. People with disabilities were central to the research philosophy and the research methods chosen. The research process was guided by the principles of emancipatory research through providing a high level of disclosure about the purpose of the research, providing individuals participating with background material and follow ups on any information requests. People

with disabilities were also provided with transcripts of the interviews for their approval and were offered copies of the completed research. The research has and will be used to develop enabling TA and TI practice that promotes empowerment of people with disabilities. This should lead to social change through the development of more inclusive practices by both groups and, hence, an increased involvement and quality of experience for people with disabilities. The researcher's ongoing involvement with TA, TI and other bodies has already affected the research and policy agendas of disability tourism. However, due to the nature of a Ph.D. thesis it was not possible to engage in participatory and collaborative outcomes of the research (Kitchin 2000b).

The relationship of the researcher to the participants involved more than disability dimensions. In interview situations, it is important to elicit the responses that are indicative of the social reality of the phenomenon and create a situation where participants feel comfortable to be themselves. However, inequalities in gender, age, ethnicity and sexual preference may influence interviewer dynamics and require consideration in research design and implementation (Fontanna and Frey 1994). Further, the researcher had to accept and respect the perspectives of the participants even when these views may have been contrary to the researcher's own views (Fontanna and Frey 1994). Practices were adopted based on the culture and language of the four in-depth interview and focus group populations.

As a researcher, where was I positioned within the research framework? As a professional, English speaking male, I need to acknowledge that my understanding and knowledge of *others* could be regarded as coming from a position of power. However, I am also considered an insider to the disability phenomenon as a person with an acquired spinal cord injury who uses a power wheelchair (Stone and Priestley 1996). My disability experience extends into the professional domain of tourism through environmental planning, policy and research. I am a University lecturer in leisure and tourism, a qualified environmental planner, access auditor and member of professional leisure and tourism associations. Further, I enjoy my personal tourism experiences and believe tourism participation is an important contributor to disability citizenship.

6.7 Research Limitations

The population primarily studied in this thesis was Australians with disabilities who have had tourism experiences or have decided not to travel. The study was limited to those

people with disabilities who responded to the researcher's call for people to be interviewed or those people involved in research undertaken for the secondary data sources. However, the literature suggests that there is a commonality of experience between people with disabilities from English speaking nations and, therefore, the outcomes of this thesis are applicable to the broad phenomena stated. In seeking an explanation for the experiences of people with disabilities, other populations were drawn upon. The accommodation sector case study was undertaken in the Sydney Metropolitan area with the assistance of the Australian Hotels Association, a body that represents mainly 4-5 star establishments. The broader government perspective was provided by reviewing firstly, the relevant disability legislation and policy and secondly, the tourism authorities' disability initiatives. No claims for significance of the research are made beyond these limitations.

6.8 Validity and Reliability

Validity is '... the extent to which the information collected by the researcher truly reflects the phenomenon being studied' (Veal 1997:35). As such, a valid indicator is one that measures what it is intended to measure (de Vaus 2002). According to de Vaus (2002), validity is assessed in three ways: criterion; content; and construct. Firstly, criterion validity involves the comparison of how people answered new questions to measure a concept against well-accepted, existing measures. As de Vaus (2002) discusses, such an approach can be problematic since there may be no existing well-established measures to check the new measure against. Thus, the validity of the existing measure is assumed when it may be invalid. Secondly, content validity emphasises the extent that the indicators measure the different components of the concept (de Vaus 2002). The validity of the indicators depends on the use they are put to rather than the indicators themselves (de Vaus 2002). In turn, the content validity of a measure depends on how the concept it is designed to test is defined (de Vaus 2002). The final assessment of validity is construct validity and it evaluates how well the measure conforms to theoretical expectations (de Vaus 2002).

This research uses a social model approach to understanding tourism from a disability perspective that had not been previously undertaken. This made having construct validity in the traditional sense impossible. However, a number of mechanisms were incorporated into the research design to enhance the validity of the research. An extensive literature (Chapters 2, 3 and 4) and secondary data review (Appendix 2 and 3) was undertaken to ensure the validity and reliability of the methods chosen to address the research questions. All instruments, unstructured schedule interview checklists and focus group briefing

papers were circulated for review to individuals with disabilities, disability organisations and tourism organisations who all had expertise in the area. Comments were incorporated into the final research design. The research employed a multi-methodological approach of data and methods for the tourism experiences of people with disabilities, procedures and the use of expert informants to provide comments on the research during the process.

On the other hand, reliability is ‘... the extent to which research findings would be the same if the research were to be repeated at a later date or with a different sample of subjects’ (Veal 1997:35-36). A measure would be if people answer a question in the same way on repeated occasions (de Vaus 2002). According to de Vaus (2002), reliability can be improved through the careful wording of questions, the consistent coding of responses and the use of multiple-item indicators. The most common way of ensuring reliability is to establish a series of procedures and protocols for data collection to cross-verify the information. The research process ensured reliability of data collection methods through clear procedures and protocols. This involved providing an overview of the research, establishing fieldwork procedures and a format for reporting. Communication occurred in written form and an explanation of the written form for those who may not have been strong English readers. The statistical analysis was undertaken using SPSS and was checked by Dr Peter Petrocz, School of Maths UTS.

The validity and reliability of the qualitative research used procedures set down by respected researchers (Creswell 1998; Fontanna & Frey 1994; Holstein & Gubrium 1994; Strauss & Corbin 1994; Miles & Huberman 1994) and used Nvivo software for analysis to establish an audit trail of the typologies and quotations used. Endnote bibliographic software was used to establish a rigorous referencing system for literature sources, complaint cases, notes and personal communication. In particular, Miles and Huberman (1994: 262-277) discuss 13 *tactics* for assessing the validity and reliability of qualitative research findings. Adopting all 13 tactics is virtually impossible for a single research project, and even more so in the current project which draws on several data sources and types. Appendix 12 indicates where certain of Miles and Huberman’s tactics were adopted in regard to each of the four data sources/types used. The table indicates that, while all of the tactics put forward by Miles and Huberman were not adopted, a number were utilised in the process of data collection and analysis. These strategies ensured the integrity of the material presented. However, as with any social phenomenon, this does not mean that replication of the results could be guaranteed as it is hoped that the social position of

people with disabilities will continue to improve.

Lastly, the validity and reliability of the research methods, data collection and results can also be judged by the publication of refereed journal articles, research reports and the citation of the work. A number of publications based on the research have been published in peer-reviewed journals and conferences (Darcy and Daruwalla 1999; Darcy 2002a; 2002b; 2003b), and by government organisations (Darcy 1998; 2000). These documents have been widely cited academically, by Australian government (ONT 1998b; CDFACS 1999b; SATC 1999b; OCA 2002; QT 2002), the ABS (Bray and Allison 2001) and internationally by the UN (UNCT 2000; Vignuda 2001).

6.9 Ethical Considerations

The research was guided by the ethics principles of the *National Health and Medical Research Council Statement on Human Experimentation and Supplementary Notes*. An application for ethics approval was made to the UTS Human Research Ethics Committee, which was approved on 18 February 1999 (Ref No. 99/08A). The research did not deviate from the granted ethics approval.

6.10 Ending

This chapter has outlined the research approach, data sources, methods and processes used to source, collect and analyse the data presented in the study. Finally, the validity, reliability, position of the researcher, delimitations and ethical considerations of the research have been addressed. In Chapters 7 and 8 the term *people with impairments* is used to signify that it is the social relations of tourism for people with impairments that creates disabling journeys and, hence, people with disabilities.

7 FINDINGS I: TOURISM PATTERNS OF PEOPLE WITH IMPAIRMENTS

7.1 Introduction

This chapter addresses that aspect of the theoretical framework which is concerned with the individual experiences of people with disabilities as they engage with the tourism industry at various stages in the tourism system model – the processes depicted as Component A in Figure 6. Using quantitative data, it seeks to establish the extent to which the patterns of tourism of people with disabilities differ from those of the non-disabled (Research Question 1). In addition it seeks to identify the constraints which are encountered in the tourism process (RQ 1a), how they are viewed by people who face them (RQ 1b), the particular ways in which people with disabilities negotiate, successfully, or unsuccessfully, to overcome the constraints encountered (RQ 1c). These matters are further explored in Chapter 8 using qualitative data. Further, the chapter seeks to examine the extent to which the person's impairment and socio-demographic characteristics influence his or her tourism experience (RQ2).

The analysis is based upon the data sources outlined in Chapter 6 and recognises the limitations of the ABS (1998) and BTR (1998) with respect their underlying medical model definitions of disability (see Section 6.4). All tables and figures presented in this chapter involve special tabulations and analysis not previously published. Each table and figure identifies the data source on which the analysis was carried out. The chapter is divided into the following areas of analysis:

- Level of tourism participation by people with impairments;
- Comparison of tourism patterns between people with impairments and the non-disabled;
- People with impairments as a proportion of the travelling public;
- Type of impairment and tourism participation;
- Needs of travellers and non-travellers with disabilities;
- Constraints to tourism; and
- Role of the embodied ontology of impairments and other socio-demographic variables on tourism patterns.

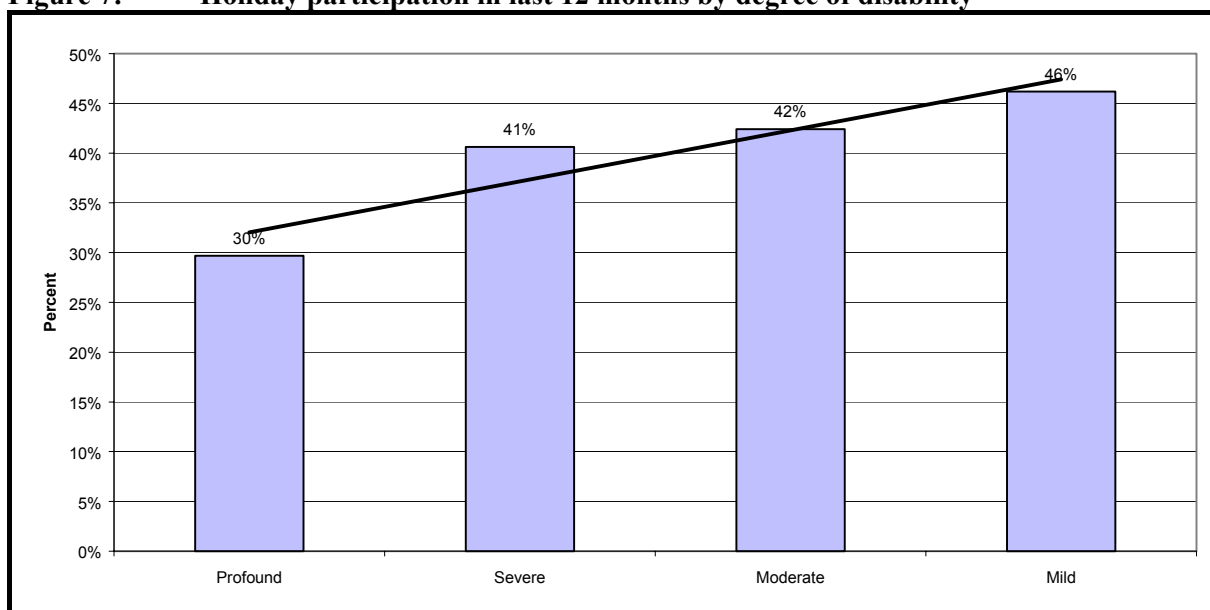
7.2 Level of Tourism Participation by People with Impairments

This section analyses the level of tourism participation by people with impairments through secondary data sources. In Australia, the first account of tourism patterns of people

with impairments was presented in the ABS (1993) *Survey of Disability, Ageing and Carers*. The survey asked about participation in a limited number of leisure activities undertaken 'away from home' in the last 12 months. Holidaying was one on these leisure activities. The survey did not define 'away from home' or 'holiday' so 'holiday' could relate to either domestic or overseas travel where people were away from home for at least one night. The survey showed that 43% of people with impairments had taken a holiday away from home in the last 12 months. This data source highlights the importance of the period of recall for each survey where there was no comparable data for the non-disabled as the period of recall for domestic trips collected by the *DTM* (BTR pre 1998) and the *NVS* (BTR post 1998) is one month. Further, this also highlights a difference between leisure and disability studies, and tourism discussed in Chapter 4. Mainstream tourism is not interested in the phenomenon of people not taking holidays or being unable to take holidays, so this data is not collected. In leisure studies and disability studies non-participation is a focus of research through constraints and the social model approaches, respectively.

Further analysis of these figures established significant relationships between the level of activity participation with *age*, *sex*, *disability* and the *degree of disability*. For example, the strongest of these relationships is shown in Figure 7 where the higher the degree of disability the lower their holiday participation rates. Only 30% of people with a profound degree of disability travelled in the previous 12 months compared with 47% of people with a mild degree of disability. Similarly, there were significant differences in travel patterns between impairment groups. People with sight (35%), psychiatric (35%), acquired brain injury (37%) and physical disabilities (39%) were least likely to travel, and people with hearing (44%), speech (44%) and intellectual disabilities (50%) were most likely to travel.

Figure 7: Holiday participation in last 12 months by degree of disability



Data Source: ABS 1993 Special Tabulations (n= 7,075 p=0.000)

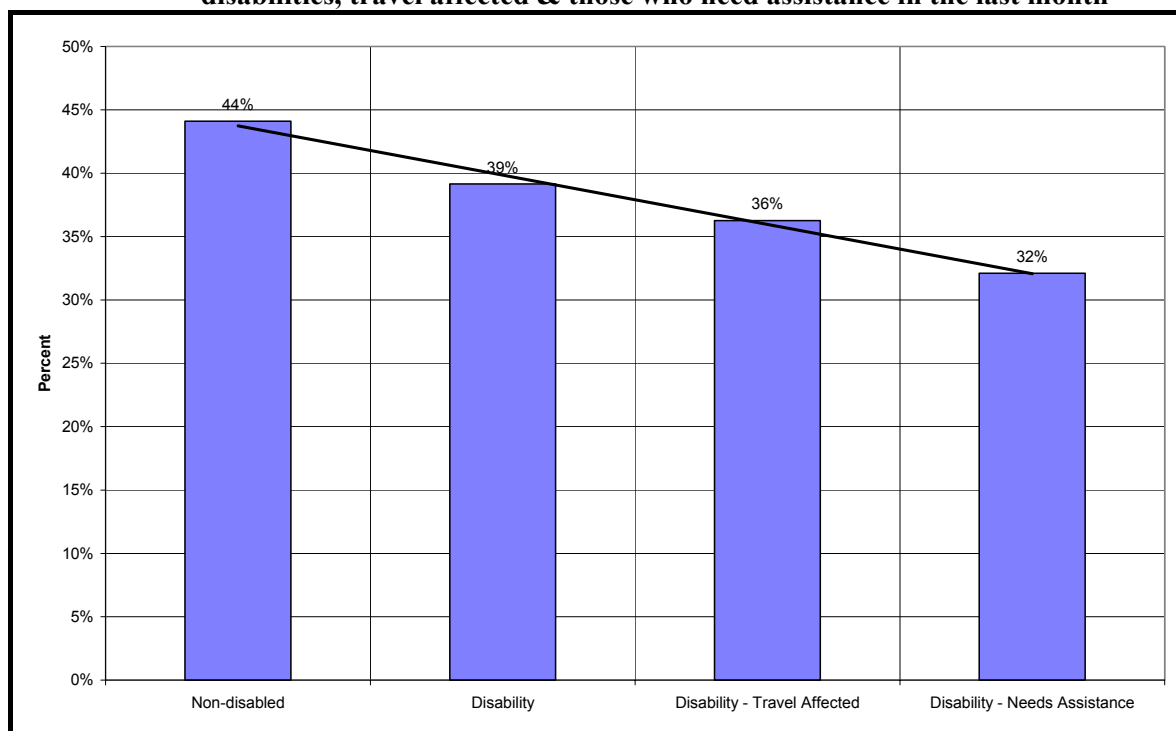
To understand these relationships further, a binary logistic regression analysis (BLRA) model was formulated using degree of disability as the most significant impairment indicator. The BLRA showed significant influences in holiday taking between the independent variables of *age*, *sex* and the *degree of disability* ($p < 0.05$ level Figure A1 in Appendix 1). Yet, there is no simple interpretation of this model as there is no uniform effect for all three explanatory variables. The probability of going on holidays changes for each of the explanatory variables depending on the values of the other two variables. This in itself provides an insight into the complexity of understanding disability tourism relationships.

Unfortunately, in the next ABS survey (1998), ‘holiday’ as an activity was omitted. This was possibly due to the BTR including a disability module in the NVS, which is reviewed later in this chapter. The findings from the ABS survey (1993) has immediate implications for the research question in that researching disability and tourism has a greater deal of complexity depending upon how disability was conceptualised and operationalised. For example, the definition of disability as impairment may capture people whose participation in the community may not be constrained. These relationships are examined in more detail later in this chapter.

7.3 Comparison of Tourism Participation Between People with Impairments and the Non-disabled

It was not until the BTR NVS (1998) that a comparison of the level of travel and non-travel could be made between people with impairments and the non-disabled. This survey was the first Australian national tourism survey to include a disability module (see Section 6.5.2). Figure 8 uses the BTR *traveller/non-traveller* construct that is a summary of domestic, outbound and day trip tourism for the last month. It shows that there was a significant difference in the level of tourism between the non-disabled (44%) and people identifying as *having a disability* (39%). This difference in the level of tourism widens when taking into account those people identifying as having a disability. However, this construct offers no guidance or definition of what *travel was affected by disability* entails. Tourism participation falls to 36%, and further falls to 32% if the *person requires assistance to travel* from another person or a technical aid (See Table A1, A2 and A3 in Appendix 1 for the original data sources). It should be noted that in Figure 8, people whose travel was affected and needs assistance are subsets of people identifying as having a disability or long term health condition.

Figure 8: Comparative tourism participation between non-disabled, people with disabilities, travel affected & those who need assistance in the last month

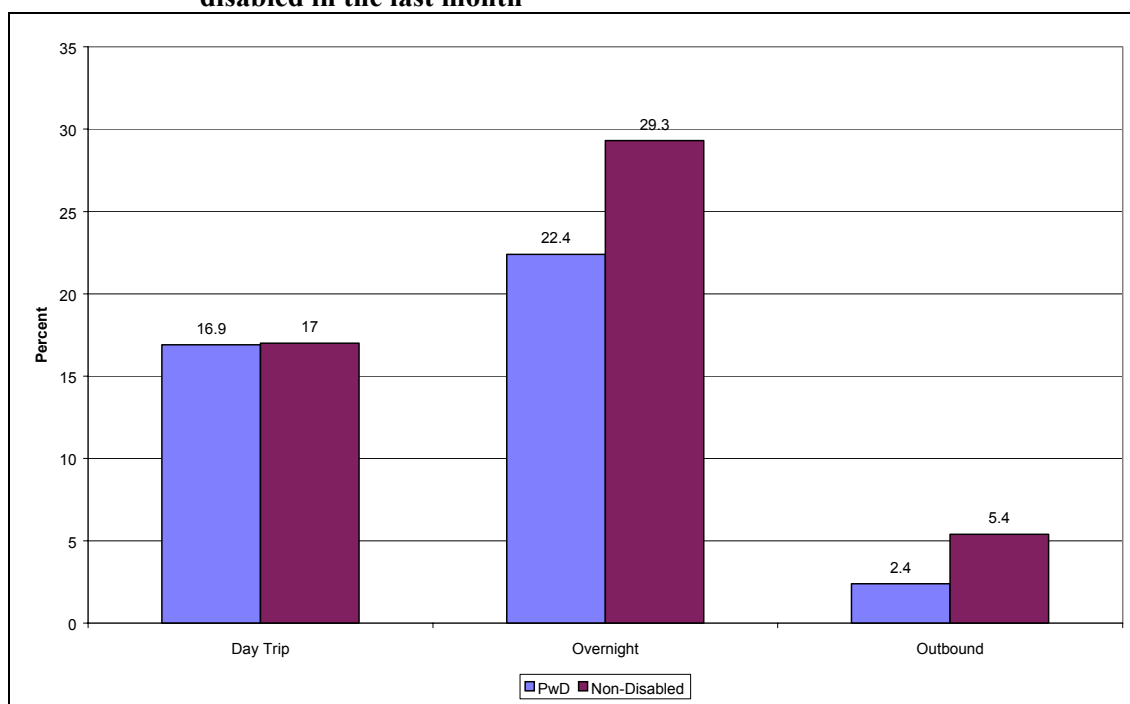


Data Source: BTR 1998 Special Tabulations (n= 78,312 p=0.000)

Figure 9 isolates the group for whom *travel affected by disability*, so as to quantify the level of participation between people with impairments and the non-disabled for each type

of trip rather than using the BTR construct of *traveller/non-traveller*. While the rate of day trips was similar with the non-disabled, people with impairments undertake overnight trips 24% less and outbound travel 56% less than the non-disabled. A chi-square analysis showed that these relationships were significant for each type of travel ($p=0.000$). This may suggest that people with impairments undertake day trips at a higher comparative rate due to the reduction of constraints encountered with this type of travel. The reasons for this are examined later in the chapter.

Figure 9: Tourism participation rates for travel affected by disability and the non-disabled in the last month



Data Source: BTR 1998 Special Tabulations (n=8,458 p=0.000 for each)

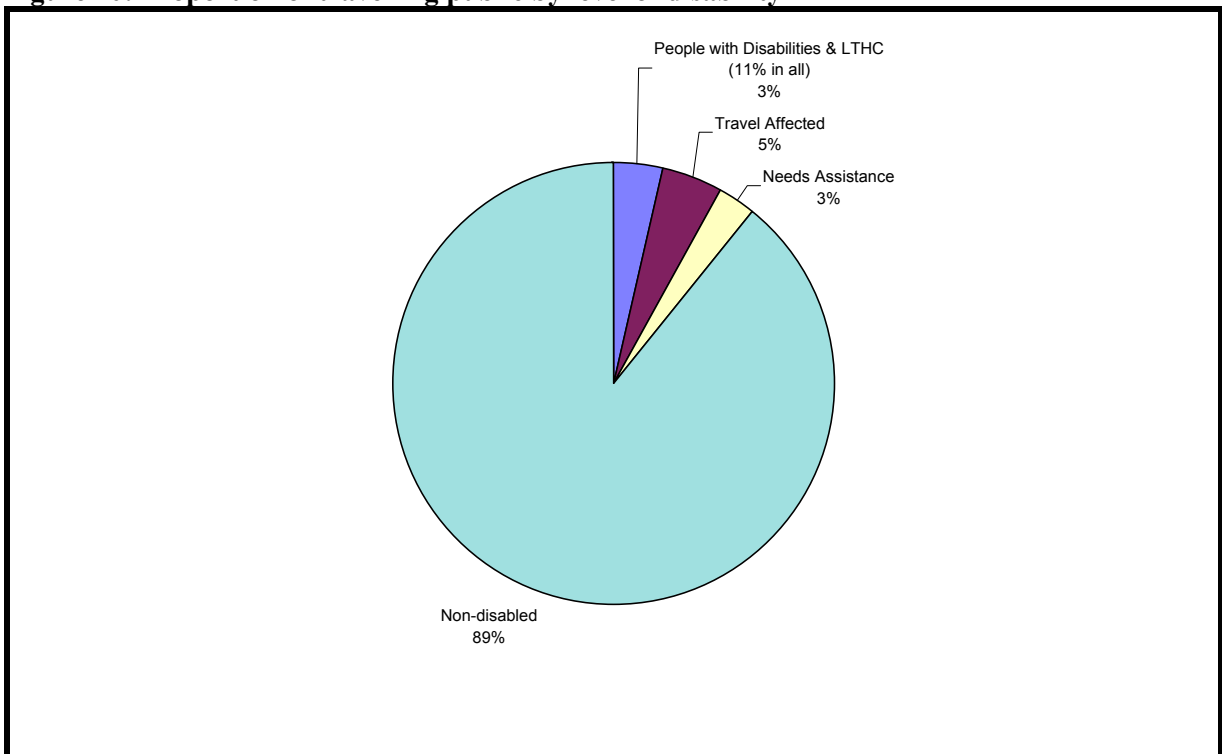
The BTR module did not take into account the level of support needs of response. Using the ABS and WHO construct of the *severity of disability* those people identifying themselves as having a disability would include those with ‘mild’ to ‘profound’ disabilities. Effectively respondents identifying as having a disability in the BTR research may have been classified as having an impairment when the ABS construct if it did not impact on core activity restrictions. Considering this with the previous evidence from the ABS (1993) about participation and degree of disability, the BTR estimate could be an underestimate of the level of non-travel by people with impairments, due to:

- a general non-response bias due to the methodological features of the disability module;
- the self-identification of respondents as having a disability when their core activities were not restricted; and
- the tendency for people with impairments with higher support needs to travel less.

7.4 People with Impairments as a Proportion of the Travelling Public

A further way to assess the relative patterns of participation for people with disabilities is to determine disability as a proportion of the travelling public. Figure 10 presents the proportion of travellers who have a disability, those people whose travel was affected by disability and the non-disabled. Some 11% of respondents whom identified themselves as having a disability or long term health condition had been on holiday in the last month. Of those people, 4.6% had their travel affected by their disability and a further 2.8% needed assistance from an attendant or an aid when travelling. This proportion is significantly lower than the 19.6% of the Australian public with a disability (ABS 1998). The difference could be considered far greater given that the ABS defines disability as a *functional loss* that affects everyday living. Using this definition, the above data should only include those people who indicated that their impairment affected their travel, which was 7.6% of travellers.

Figure 10: Proportion of travelling public by level of disability



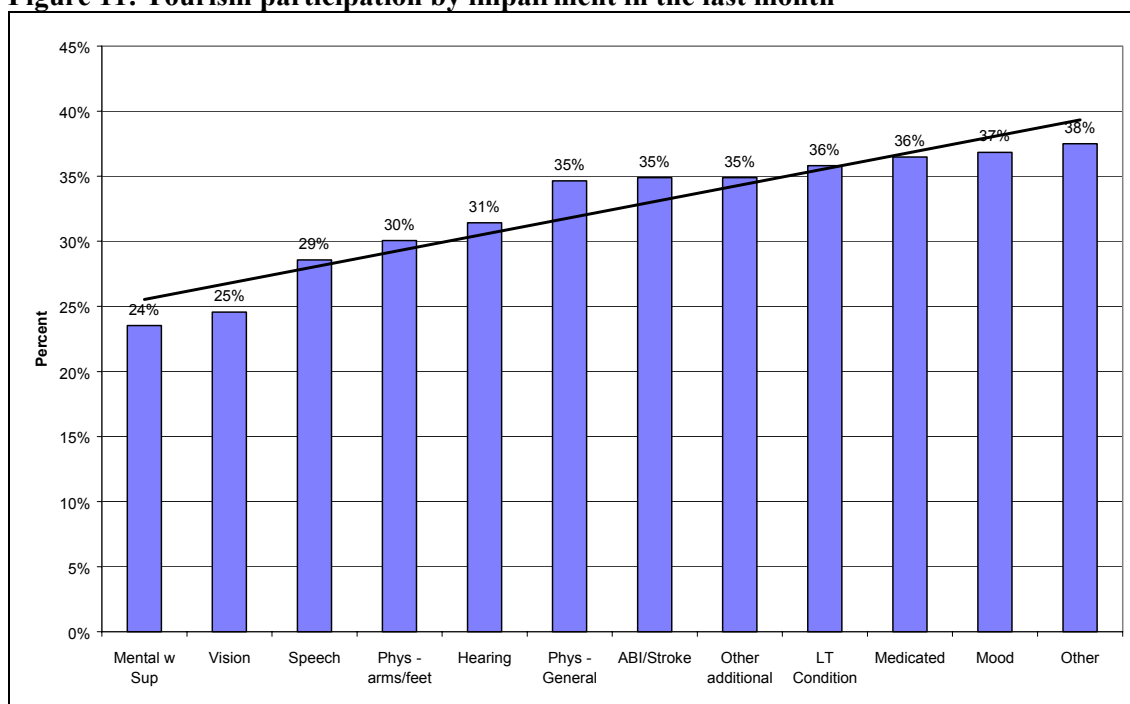
Data Source: BTR 1998 Special Tabulations (n= 78312)

7.5 Type of Impairment and Tourism Participation

The BTR (1998) data confirms that people with impairments have lower participation in

tourism than the non-disabled and are therefore underrepresented as a proportion of the travelling public. The lower tourism participation rates of people with impairments are further emphasised through an examination of the rates of tourism participation between impairment groups. Figure 11 presents tourism participation by types of impairment (See Table A4 in Appendix 1 for the original data source). It identifies people with mental health, vision, speech, physical affecting arms and/or legs, hearing, physical general and acquired brain injury/stroke impairments as travelling significantly less than the non-disabled. Due to the methodological issues of the disability module used (see Appendix 3) what is not apparent in this Figure are people with multiple impairments. For example, a person with cerebral palsy could identify speech, physical affecting arms and/or legs and physical general impairments.

Figure 11: Tourism participation by impairment in the last month



Data Source: BTR 1998 Special Tabulations (n= 5741)

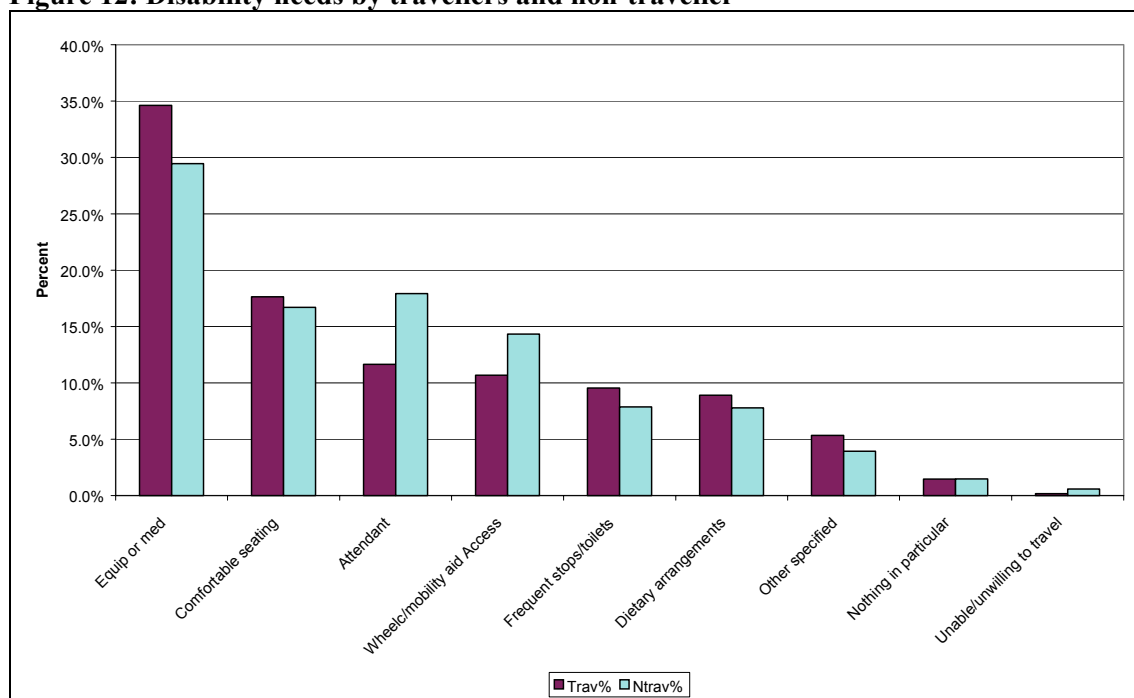
As discussed in Chapter 3, most people with impairments are medically stable and manage the effects of their impairments within their daily activities and most may not travel if they are experiencing significant health problems. As indicated in Figure 11, people with mental health issues who require assistance experience the lowest level of travel. These people more often than not experience episodic periods in which their impairment impacts upon their daily activities. During these times, it is unlikely that they would undertake travel. However, some people with mental health issues live with the effects of their

impairment every day and plan their lives around managing these effects at home or while holidaying. After this group, people with vision, speech, mobility and hearing impairments were the least travelled.

7.6 Needs of Travellers and Non-travellers with Disabilities

A starting point to understanding the reasons for these lower rates of tourism participation by these groups can be found in Figure 12. This list of travel needs presented was not particularly disability specific, extensive or socially investigative. Most people would like comfortable seating, frequent stops/toilets and dietary arrangements to suit their needs. The other travel needs provide a basic indication of constraints. Equipment/medication (35%) was regarded as the most needed travel requirement. It was unfortunate that these two items were combined as certain impairment groups have specific needs and this area is examined further in Section 7.7 and Chapter 8. Travellers then indicated that people requiring an attendant (12%) and access for a wheelchair or other mobility aid (11%) were the other major travel needs. Yet, it is interesting to note the three areas where needs of the non-traveller exceeded those of people of who travelled. These were people requiring an attendant (18%) and those needing wheelchair access (14%). While all the needs and constraints of non-travellers indicate an area of latent demand, these last two areas suggest that these are overwhelming constraints for these people.

Figure 12: Disability needs by travellers and non-traveller



Data Source: BTR 1998 Special Tabulations (n= 5741)

Figure 12 also shows that contrary to the conventional wisdom that people with impairments are unable or unwilling to travel, very few people with impairments (0.6%) perceive themselves as being unable or unwilling to travel just because of their impairments. This suggests that the majority of people with impairments (99.4%) have a desire to travel that was constrained by the social relations of tourism in Australia rather than the inherent nature of their impairment. This suggests that this attitude originates from ableist discourses that views disability as the problem of the individual rather than the product of social relations. Section 7.7 and Chapter 8 will document these constraints.

As discussed in Chapter 6, the BTR disability module had a number of weaknesses. This limited the explanatory uses of the data source to a comparison of people with impairments and the non-disabled, an examination of the comparative travel between impairment conditions and a basic understanding of their travel needs and constraints. The following data source provides a more valid and reliable data source to analyse the constraints to tourism, detailed tourism needs, and an avenue to explore the relationship of demographic variables on tourism patterns.

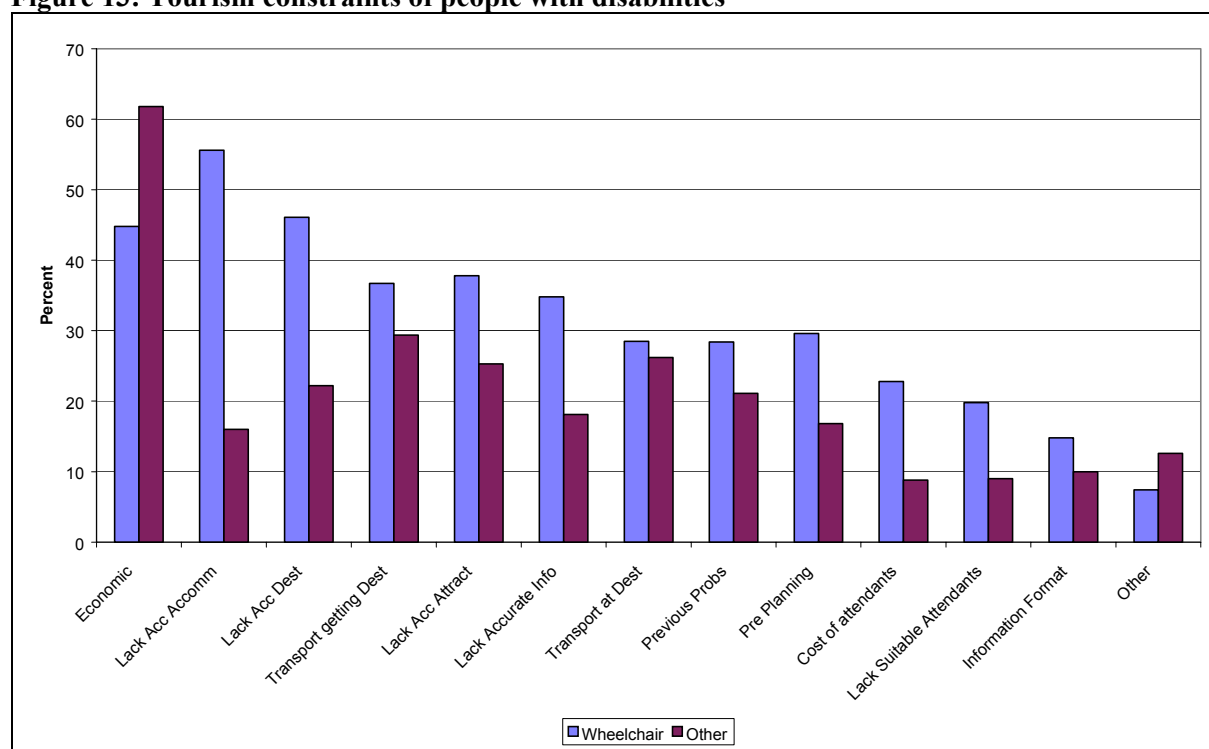
7.7 Constraints to Tourism

Very little detailed research on the actual tourism patterns and experiences of Australian people with impairments was undertaken prior to the 1998 Tourism NSW survey (Darcy 1998). As discussed, the study was based on a sample of 2642 people with mobility impairments. It established that in the previous 12 months 75% undertaken domestic tourism and 10% had undertaken tourism overseas. Further, 70% had undertaken a day trip in the last six months. Some 74% of people with impairments were not satisfied with their current level of travel. Their dissatisfaction was due to the constraints of undertaking travel, the constraints encountered while travelling or the travel requirements of the group not being met. These constraints are explored through a re-analysis of the quantitative data in this section and Chapter 8, and through an analysis of the lived experiences of the group (in Chapter 8).

Following from needs identified in Figure 12, it was not surprising that people with mobility impairments had much higher levels of demand for accessible accommodation, accessible bathroom and attendants. Further, they identified specific equipment needs at

higher level than indicated in Figure 12. Figure 13 identifies that some of the disability needs for tourism corresponded to the constraints to tourism crosstabulated by mobility aid. Overall, economic factors were identified as the major constraint to tourism. Non-disabled travellers also identified economic constraints as a major constraint (Woodside and Lysonski 1989). However, the other constraints cited involved a series of considerations that are a product of the social relations of tourism. In particular, the interaction between the lack of accessible accommodation (41%); lack of accurate information (29%), previous problems with tourism (26%) and pre-planning issues (25%) created insurmountable constraints for some. Further, there were statistically significant differences ($p=0.000$) between the constraints for the variables of mobility aid and travel dependence. This finding strongly suggests that the higher the support needs of the individual the more complex their travel planning due to the environmental and organisational constraints that they encounter.

Figure 13: Tourism constraints of people with disabilities



Data Source: Darcy 1998 Special Tabulations (n= 1881 p = 0.000)

7.8 The Influence of Impairment and other Socio-demographic Variables on Tourism Participation

The initial exploration of the influences of socio-demographic characteristics on domestic patterns of tourism (Section 7.2) provided some evidence that tourism experiences differ as

a result of an individual's circumstances, including impairment and other socio-demographic characteristics. This section builds on that exploration by examining the relationship of impairment type, independence level, mobility aid, gender, age, lifestyle situation, education and income using the Tourism NSW survey data. This analysis contributes to developing an understanding of whether within the social model approach to disability tourism experience; there is evidence of an *embodied ontology* of tourism. It has been suggested by critiques of the social model that it needs to acknowledge individual experience of impairment and other minority issues if it is to develop as a more complete social theory.

Binary logistic regression analysis (BLRA) and ordinal regression analysis (PLUM) models, as outlined in Section 6.6.1, were used to investigate the influence of a number of independent variables on two dependent variables used to indicate level of tourism participation.

The first dependent variable indicates whether or not respondents had taken at least one domestic tourism trip in the last year. Table 18 (full Table A5a in Appendix 1) presents a summary of the results from the BLRA for the binary (yes/no) dependent variable 'domestic tourism in the last 12 months'. Seven of the nine independent variables, namely mobility aid used, travel independence, age, income, impairment, lifestyle situation and geographic (metropolitan/non-metropolitan) region of residence, were found to be statistically significantly related to the dependent variable. These relationships are further examined below, where the 'odds ratio' is discussed for each of the categories of response. An odds ratio of less than one means a person is less likely to travel whereas an odds ratio greater than one means a person is more likely to travel.

Table 18: BLRA Summary – Domestic tourism in last 12 months

Variable	Df	Significance P	Influence - Exp(B)/ (Odds Ratio)
Age	1	.000*	.913
Geographic region of residence	1	.000*	.452
Lifestyle situation - Low	3	.000*	1.493
High			2.548
Mobility aid	1	.003*	.633
Income	1	.005*	1.158
Impairment – Low	9	.006*	.571
High			2.567
Independence	1	.015*	1.447
Education	1	.322	1.050
Gender	1	.763	1.043

Data Source: Darcy 1998 Special Tabulations (n= 1806)

* = significant at the .05 level

The second dependent variable refers to the number of trips taken by those who did participate. Table 19 therefore (full Table A5b in Appendix 1) presents the PLUM model results for the dependent variable ‘number of domestic trips in the last 12 months’, excluding all cases where no trips were undertaken. The independent variables, income, education, reason for travelling 1 - sport, reason for travelling 2 - business, age and geographic region of residence were found to be statistically significantly related to the dependent variable. Further discussion of each of the independent variables is presented below. In cases where a significant relationship was found between the tourism participation variable and an independent variable, the term ‘influence’ is used in a statistical sense – the dependent variable is said to be ‘influenced’ by the dependent variable. To arrive at the conclusion that the independent variable *actually* influences the dependent variable, in this case participation in tourism, that is, to decide on causality as opposed to just a statistical relationship, requires further theoretical discussion, which is the task of Chapter 10.

Table 19: PLUM – Summary – No. domestic trips in last 12 months

	Wald	df	Sig.
Threshold [NDOMTR = 1]	1.333	1	.248
[NDOMTR = 2]	37.335	1	.000
Age	15.584	1	.000*
Income	5.345	1	.021*
Education	7.203	1	.007*
Gender	.583	1	.445
Independence	.392	1	.531
Mobility aid	.074	1	.786
Urban/rural region of residence	33.996	1	.000*
Impairment	1.319	1	.633
Reason for travel 1 – business	23.401	1	.000*
Reason for travel 2 – sport	7.981	1	.005*

Data Source: Darcy 1998 Special Tabulations (n= 1496)

* = significant at .05 level

A. *Impairment*

The BLRA identified impairment as a significant influence on taking a domestic holiday. This relationship was exacerbated by the level of dependence of the person with the impairment. As crosstabulations revealed, people with brain injury/stroke (89%), cerebral palsy (85%) and quadriplegia (84%) have substantially higher levels of travel dependence than other impairment groups (See Table A6 Appendix 1 for the original data source). People not able to travel independently travel less than people with impairments who travel

independently do. For example, of those undertaking domestic tourism there was a major influence on the likelihood of travel based on a person's impairment. People with brain injury/stroke (62% and odds ratio 0.886) and bone-related impairments (70% and odds ratio 0.571) were the least likely to travel.

People with cerebral palsy were most likely to travel (89% and had the highest odds ratio 2.567). Further investigation showed that this group had higher levels of group travel with other people with impairments. This pattern may be explained through people with cerebral palsy having access to organised travel opportunities through their service organisations, group homes and/or other programs. While not collected by this data source people with cerebral palsy have had a history of institutionalised living in Australia. This has changed in the last two decades through the policy of deinstitutionalisation where a greater proportion of this group live in group homes supported by Home and Community Care (HACC) programs or service organisations. Within the group home environment, holidays are scheduled on a regular basis. However, this does not necessarily mean that these people were more satisfied with their tourism experiences. This was because many of these experiences were not to places that they wished to go, with people that they wished to go with or at the time that they wished to go. In other words, they had little control over their holiday experiences.

B. Level of independence and mobility aid used

Level of independence refers to whether people with impairments identified that they could travel independently. This variable was a significant influence on people undertaking domestic tourism (BLRA $p=0.015$). Seventy percent required the assistance of an attendant while the remainder were able to travel independently. Those travelling independently were far more likely to have undertaken a trip (odds ratio 1.447) than those travelling with an attendant. Of those travelling with an attendant, 51% were female and 49% were male. Other issues surrounding travelling with an attendant are discussed in Section 8.7.

The main mobility aid used affects an individual's mobility and access requirements. This variable was a significant influence on the likelihood of taking a holiday by mobility aid. For example, wheelchair users had significantly lower levels of travel than other mobility aids users (odds ratio 0.633). When this variable acts together with independence (see Table A11 Appendix 1), attendant use was substantially higher (79% of wheelchair users)

and they travelled at significantly lower levels. Effectively, these people with higher support needs had lower levels of domestic tourism. This lower level of travel was repeated for overseas travel with 17% of those able to travel independently undertaking overseas travel as opposed to only 9% of those requiring attendant assistance. The only difference in this pattern was for day trips in the last six months. People who could travel independently undertook a slightly lower number of day trips (1.2% less) than dependent travellers. Day trips may be used to compensate for their lower level of away from home travel.

C. Gender

The ABS (1993) BLRA as reported in Section 7.2, concluded that gender, age and degree of disability were interrelated variables that influenced the likelihood of people with disabilities taking a holiday. The findings for this analysis were that gender was not regarded as a significant influence on taking a domestic trip or the number of trips undertaken. Prior to undertaking the BLRA and PLUM a pattern was identified by the crosstabulation of gender and domestic trip was that there was a slightly higher proportion of females (78%) undertaking a domestic trip in the last year than males (76%). However, this was not to a statistically significant level (Table A7 Appendix 1). Similarly, gender by itself was found to be a statistically significant consideration in the number of domestic trips undertaken each year (Table A8 Appendix 1) with males taking on average 4.64 trips per year and females 3.97.

D. Age

Age was a significant influence on undertaking a domestic trip and the number of trips undertaken. The significance of age as a contributing factor in the patterns of tourism by people with impairments was further investigated through recoding age and undertaking an ANOVA of the number of domestic trips undertaken. Table A9 (Appendix 1) indicates that there was a statistically significant different number of trips taken between the age groups. This was further reinforced by the 'Post-Hoc Tamhane test' that showed that there are significant differences between the 60 and older age group (lower levels of tourism) compared to both the 25-39 and 40-49 year age groups as indicated in bold Table A10.

E. Lifestyle Situation, Income and Education

Both lifestyle situation and income were significant influences on domestic tourism. Further crosstabulations showed that only 21% of the sample were employed and only 9% of those people who travel with an attendant were in full or part-time employment. Access to employment affects a person's income and it has been noted in several studies that people with impairments have far less opportunity for paid employment and, hence, earn far less than the average income (Barnes 1996a; Gleeson 1998). The data reinforced the literature and showed that those in full-time employment and part-time employment were more likely to undertake domestic tourism (odds ratio 2.1). The resultant lack of disposable income was highlighted by the fact that 55% of people earn less than \$10,000 a year, with 71% earning less than \$20,000 a year. Education and income were significant influences on the number of trips each year. Consequently, the reason for trips were significant influences on the number of trips undertaken, with business and sports travellers' travelling more frequently than other people with impairments do. The group who travelled most frequently were people in full or part-time education (odds ratio 2.5), and suggests that time, opportunity and a supportive family are variables of influence.

In noting these figures the author is not endorsing the oppressive values espoused by an economic form of organisation that marginalises people with impairments from the production process. However, it recognises this *disabling constraint* on the ability to access tourism goods and services of their choice in a market economy. This lack of access to paid employment, and the resultant low incomes, radically constrains a person's ability to travel where even moderate costs are involved. This also restricts the tourism choices available to them, as well as the frequency and duration of trips.

F. Geographic region

Geographic region of residence⁸ – that is, whether the respondent lived in a metropolitan or non-metropolitan area - was a significant influence on both the likelihood of domestic tourism and the number of domestic trips in a year. Some 86% of all people identifying disability/medical as the main reason for tourism came from non-metropolitan areas where they were more likely (odds ratio 1.3) to undertake a domestic trip and more likely to have more domestic trips. People from non-metropolitan areas have less access to medical

⁸ The geographic variable originally contained some data from other states of Australia. This data was excluded and the remaining data recoded into Sydney metropolitan or non-metropolitan areas

services within reach of their residence. Quite simply people with health related conditions living in rural areas have to travel. For many, this involved organising aircraft flights for medical appointments and connecting transportation (Qn 2319 Pg 2114). In other cases it involved needing ‘information regarding accommodation in close proximity of treatment area and suitable parking at accommodation and medical centre’ (Qn 2501 Pg 2324).

7.9 Ending

This chapter brings together a number of disparate data sources and undertakes a series of special tabulations to throw light on the tourism patterns of people with impairments. The key findings can be summarised as follows (with reference to the relevant research question in brackets):

- The level of tourism participation of people with impairments is significantly lower than for the non-disabled. This is true for day trips, domestic holidays and overseas trips. Thus, people with impairments constitute proportionally less of the travelling public than their proportion of the Australian population. (RQ 1)
- Some 99% of people with impairments do not perceive their impairment as the reason for their non-participation in tourism but attribute this to the other constraints encountered. (RQ 1)
- The most significant constraints faced by people with disabilities when considering travel or actually travelling are:
 - for wheelchair users: lack of accessible accommodation, lack of accessible destinations and economic/cost factors;
 - for others: economic/cost factors, transport to and at the destination and lack of accessible attractions. (RQ 1a)
- Despite the constraints faced, the number of people with disabilities who actually travel indicates that they do successfully overcome them, although often only with difficulty – but the processes involved are explored in later chapters. (RQ 1c)
- The tourism requirements of the group are dependent on their impairment. The most marginalised travellers were people with mental health, vision, speech, mobility and hearing impairments. Impairment related considerations (type, level of independence and mobility aid) together with age, lifestyle situation, income and geographic region were statistically significant influences on the likelihood of an individual having a tourism experience. However, the number of trips taken each year was influenced by general socio-demographic considerations rather than impairment-related considerations. (RQ2)

Overall, the chapter provides quantitative evidence to illustrate the interaction of demand and supply in the context of disability and tourism. It quantifies the extent to which people with disabilities are constrained in regard to travel and explores the multiplicity of both

structural and intrapersonal constraints and their inter-relationships. These matters are further explored in the following chapter using qualitative data.

8 FINDINGS II: TOURISM EXPERIENCES OF PEOPLE WITH IMPAIRMENTS

8.1 Introduction

This chapter addresses a similar range of issues and questions as considered in Chapter 7, but draws on different data sources to do so. Thus it seeks to explore in qualitative detail the constraints faced by people with impairments at each stage of the travel process in order to address the first group of research questions, concerning the nature of the constraints faced (Research Questions 1, 1a-e), and the second group, concerning the effects of types of impairment and socio-demographic characteristics on tourism patterns. In addition, the human rights dimension is partially explored through examination of Human Right and Equal Opportunity Commission (2002a) complaints cases, thus beginning to address research question 4a on discriminatory practices suffered by people with impairments. The chapter therefore examines further the interface between demand and supply (Components A and C in the conceptual framework - Figure 6) from the consumer's point of view.

As detailed in Chapter 6, the chapter draws on in-depth interviews with people with impairments; reanalysis of qualitative and quantitative data from the Tourism NSW study; quantitative data from the 1998 BTR survey; and the HREOC complaint cases (see Table 16 in Chapter 6). The chapter presents the qualitative data using the Nvivo *audit trail* procedures and references the HREOC complaint cases as discussed in Chapter 6 (HREOCC Year and month if identified). It analyses the tourism experiences of people with impairments through leisure constraints theory presented in Chapter 4.

The approach taken in this chapter is to provide a consolidated understanding of the tourism experiences by combining the information from a number of data sources. The chapter documents the experiences of this group through the journey they undertake. The headings that emerge from the grounded approach reflect the sequential process of undertaking a journey. This reflects the stages of travel and the tourism system discussed in Chapter 4 and incorporated into the diagrammatic conceptual framework presented in Figure 6. The most severe constraint occurs when the individual decides that it is 'all too hard' and therefore does not travel at all. Those who do not travel are therefore the focus of the first section of the chapter and this is followed by a further four sections which broadly

follow the stages of the tourism system, and a final section covering constraints which are present at all stages in the system. The sections are therefore as follows:

- constraints encountered by those who do not travel;
- travel planning and information constraints;
- transport constraints to, at and from the destination;
- accommodation constraints;
- constraints encountered at the destination; and
- other constraints.

Hence, *Research Questions 1a, 1b, 1c, 1e, 4a and 4b* are addressed through the grounded approach of all the stages of travel in context to the tourism system, and build upon the partial answers of the quantitative findings on tourism constraints in Chapter 7. This involves the qualitative analysis of the Tourism NSW data source, in-depth interviews with people with disabilities and a content analysis of the HREOC complaints cases, inquiries and Federal Court actions. Whereas *Research Question 1* quantitative outcomes are largely restricted to a comparison of people with impairments and the non-disabled through information sources, transport and accommodation patterns.

Research Question 2 builds upon the quantitative findings of Chapter 7 through the qualitative experiences of people with impairments. In particular, this focuses on those who do not travel and who regard impairment as an intrapersonal constraint to travel. However, as Section 8.2 reveals, impairment is inextricably interrelated to the other socio-demographic characteristics and provides further considerations for *Research Question 2a*.

The chapter concludes with a discussion of the *essence* of the tourism experiences of people with impairments (phenomenology) and a summary of the tourism constraints revealed by the research. This chapter reviews only those constraints with tourism specific implications and, hence, all issues raised regarding general access to the built environment are dealt with in Chapter 10 as part of the explanation for the lived experiences. A summary of the findings with respect to the foundation components (continuous pathway, parking and toilets) of the built environment is found in Appendix 9.

Quotations from the open-ended written comments from the Tourism NSW survey questionnaires are referred to by questionnaire number (Qn) and text paragraph number (Pg) – for example: Qn 120, Pg 1200. Quotations from the in-depth interviews are referred to by pseudonym and transcript paragraph number - for example: Bill, Pg 46.

8.2 Constraints Encountered by Those who do not Travel

A starting point to understanding the tourism experiences of people with impairments was with those who had not had a tourism experience. In Chapter 7 it was established that, while the precise level of non-travel varied with each data source, it was clear that people with impairments have lower levels of tourism participation than the non-disabled and that the most marginalised non-travellers with impairments are those requiring attendants and wheelchair access. This section reviews the constraint themes which emerged from the analysis of the qualitative data and were associated with non-travel. They fall into two groups: a. economic constraints; and b. impairment, independence, family and attendant-related constraints.

A. *Economic constraints*

The constraint most frequently identified from the BTR survey evidence presented in Chapter 7 was economic (51%) – being a combination of high costs and low income. This reflects previous studies in Australia (Gleeson 1998) that found that people with disabilities have higher levels of unemployment, a greater reliance on government pensions and, hence, live in poverty at higher levels than the non-disabled. For many respondents tourism is considered a luxury: ‘I do not travel because I can’t afford it. It costs every cent just to live from one pension day to the next, there is none left over for holidays or trips’ (Qn 2588 Pg 2405). For others, the constraint was not just a simple economic one but a complex interaction between impairment diagnosis, employment termination, personal relationships, level of pension and lifestyle situation:

I do not travel as in having a holiday. I only got one holiday in 16 years of marriage, two weeks at Tuncurry ten months after my MS diagnosis. I had to give up my employment in 1986. Have been on DSS support pension since leaving my ex-husband in May 1992. A 30 minute drive to my widowed male friend’s house on Friday nights since March is the highlight of my week (Qn 174 Pg 129).

For others whose situation was not as constrained by living on a pension, cost was still a consideration, ‘...travelling is expensive anyway...’ (Beth Pg 126). As a person with a recently acquired impairment, Beth has other priorities to address before travelling. Developing a routine to her life, attendant assistance and other requirements make the idea of doing all these things away from home seem impossible.

B. Impairment, independence, family and attendant-related constraints

In Although it was found in Chapter 7 that only 0.6% of people with impairments did not travel due to their impairment (Figure 12), some individuals do regard their impairment as a constraint to undertaking tourism. For these people the ‘medical condition is such that I find travel in itself unrealistic’ (Qn 502 Pg 398). The belief is that their embodiment is a constraint to experiencing tourism, ‘I am confined to a wheelchair due to Rheu-Arthritis and travelling is just too difficult... I am sure there are many people like me who would rather stay at home than have the hassle of going out’ (Qn 1446 Pg 1109).

Yet, the relationship between impairment and travel is not a simple one. As Section 7.6 demonstrates, the variables of age, income, education, lifestyle situation, dependence, geographic region, mobility aid requirements and the impairment are all considered significant influences on tourism. It means that tourism is limited because of the impairment and family situation, and that the appropriateness and cost of the tourism products on offer reduce the travel choices:

Being a quadriplegic, on a full pension and with three children it is very hard to travel great distances and find suitable accommodation at a reasonable price - almost impossible. That’s why we do not travel very much at all (Qn 364 Pg 287).

For family members and carers of people with high support needs, a holiday was generally something that they could not imagine, ‘Travelling away with Jonathan is an enormous effort - and no holiday - because of his extremely high support needs’ (Qn 1792 Pg 1443). While it was not considered a holiday for those providing personal support for Jonathan, whether Jonathan felt the same way needs to be considered. Jonathan may have his own desires to travel and to have a break from the family members who care for him. Yet, his perspective remains a largely unexplored phenomenon as the broader policy direction focuses on the carer (an important issue) rather than the needs of people with impairments themselves.

The role of personal care and attendants is fully explored in Section 8.7 below. However, there is no doubt that these issues have an impact upon whether people do or do not travel. In another case, a partner who had provided personal care for his wife and an income for the family was no longer in a position to do so because of acquiring an impairment himself. As the woman so eloquently describes, this had a dramatic impact on their situation, ‘Before my husband’s chronic heart condition, he gave me freedom with care. Two disabled people = trapped’ (Qn 1302 Pg 1003). Personal care issues, attendants and

respite all add to the complexity of going on a holiday. In Chapter 7, Figures 12 and 13 identify attendants (18%), the extra costs of attendants (18%) and the lack of suitable attendants (16%) as significant reasons for non-travel. These situations increase in complexity with the degree of dependence and if an attendant is a family member. As the above quotation indicates, if a family member provides all personal assistance on a trip then their 'holiday' would not be a holiday for them. Conversely, for people with impairments to be placed into respite care institutions may provide a break for the family member but it does not necessarily provide a holiday for them. The complexity again increases:

...We know of no facilities where we can travel to together which would provide accommodation for both of us, with help to care for patient and appropriate facilities to give carer some relief... Placing patient in respite care...is unsuitable as is no holiday for patient. The carer would not be happy to leave patient (Qn 54 Pg 41).

In many cases, the only option that people believe is available to families is a respite placement. Yet, this is inappropriate for the person with a disability who is not ill. This situation is also not ideal for carers who express feelings of guilt about leaving a family member in an institutional setting. Apart from these reasons, the respite situation is inappropriate because it ignores the desire for people with impairments themselves to have a holiday.

The complexity of the situations described in this section involves the interrelationships between intrinsic, intrapersonal and structural constraints. This involves a series of iterations in which the intrinsic, intrapersonal and structural constraints are negotiated prior to tourism being undertaken.

8.3 Travel Planning and Information Constraints

Planning for a trip involves many decision-making processes. The experiences of people with impairments revealed that a greater level of planning is required to undertake a trip than for the non-disabled. As Annabel expresses it, it is, '...the frustration I guess of having to put so much planning into a travelling trip which almost exhausts you before you start' (Annabel Pg 481). Annabel indicated that it was not only the level of planning required but also the frustration and level of effort involved in obtaining information related to her needs that exhausted her as an individual. The factors that contributed to these feelings of frustration and exhaustion included: finding relevant access information sources; obtaining accessible accommodation guides; identifying informed travel agents; and broader communication issues. These factors are discussed in turn below.

A. Tourism access information sources

It becomes apparent from respondents' comments on travel planning that the traditional information sources that the non-disabled use are generally not used by people with impairments. The latter indicated that they used: previous experience; word-of-mouth from friends and relatives; disability organisations; and direct contact with tourism industry organisations. Quite simply this was, 'because I've been there before or someone's recommended the place' (Andrew Pg 66). They bypassed guidebooks, TA, tourist information offices and travel agents. The preferred sources offer the security of knowing that another person with similar needs has found the establishment or service suitable. These findings are supported by other research on information gathering by people with impairments and the non-disabled (Burnett 1996), and by seniors (Capella and Greco 1987).

Respondents recognised that tourism information sources do not identify or provide the detail that they require on *access* provisions as a starting point for their travel planning. As one person stated:

Most brochures at travel agents list lots of motels and resorts. But few (if any) note if they are wheelchair accessible. Also, 'what to do/ where to go' brochures do not state what is or is not accessible for people in wheelchairs. Holiday Islands - resorts - ships - places like Kakadu, Cape Tribulation etc. (Qn 914 Pg 722).

Therefore, many people with impairments have had to become resourceful travel researchers to plan trips and to satisfy their information needs. Tourism access information needs for individuals vary depending upon the impairment, aids and support needs. This level of travel planning is extensive as described by Steven:

We have found out that you have to ring up and speak to the people concerned. You actually call the motel/hotel even if they are in England. I sent off an information sheet for them to fill in and send back. Then going on information that they sent back, I then called every hotel we decided to stay in and talked to them. And even then, they still got it wrong. But you have to. They are not fussed, travel agents (Steven Pg 249).

Such an exercise for the non-disabled would be regarded as excessive but as Steven noted, even after this process, the information indicating an accessible facility did not always equate to an accessible experience. Steven's was not an isolated experience, as Annabel explains, after she and a friend decided to embark on a life long ambition of a major overseas trip:

So it started 6-8 months before the actual trip took place...the investigative work... From virtually the very next day...how, when, why and the best way to do things, and it took the

most incredible planning and foresight to even get it off the planning into reality. I went to the Flight Centre...I had been recommended to a particular person there... the putting together of a seven week trip to Europe with a stopover in San Francisco on the way. After the months of planning we finally took off. And that is where the trouble started (Annabel Pg 27-44).

The planning undertaken by an experienced traveller like Annabel was exhaustive. It involved a travel agent, a specialist disability travel consultant and her skills as an ex-president of a disability organisation. However, as she stated, 'that is where the trouble started'.

For others, planning involves partners and other family members organising the trip through intermediaries and then *double-checking* all of the information received. Kristy's husband determines firstly where they wish to travel to and then:

...my husband travels a fair bit so he's quite good at talking to airlines and negotiating...You find out the manager at the hotel and then we start on this rigmarole of ringing. You know, ringing one person and you find out this, and then you clarify it with the next person...it sort of seems to evolve into a million phone calls and discussion and then checking. We'd check usually a couple of times when we went up there with actually what we'd organised and what was actually going to occur (Kristy Pg 84).

The phone calls and the double-checking have become the norm for people with impairments wishing to travel. The sense of frustration is exacerbated when searching mainstream holiday literature and realising that access has not been considered. To many people with impairments this signifies a TA and TI not interested in their needs:

It seems if you use a wheelchair, you cannot browse through holiday literature and decide on a holiday that takes your fancy. You must decide on a destination, gather all the information required and if not suitable, start again. If a service provides comprehensive information, we are not aware of it. Even the 'Seven Wonder of NSW' brochures had no mention of w/chair accessibility (Qn 1853 Pg 1505).

The Tourism NSW 'Seven Wonders' marketing campaign influenced these people but, upon investigating the brochures, they found no information related to their needs. When a major marketing campaign by the TA does not include information for people with impairments then it is not surprising that they become disheartened. For others travel information sources are a mystery. For example Justin, who lives in a rural area, does not have access to the Internet and recently acquired a disability, declared: 'I'm not on the net or anything so I don't have much access to any web sites...I don't have a great deal of information to know where's good and where's not' (Justin Pg 303).

Without the requisite skills and technology to identify, contact and gather the information

required for their tourism needs, people do not have a sound foundation for their trips. The critical elements involve accurate and detailed accommodation-specific and destination-specific information. Accurate and detailed information is critical to the decision-making process: 'One of the reasons I do not travel as much as I'd like is because the information you get is wrong or inadequate' (Qn 2304 Pg 1916). This is crucial in relation to accommodation since, if appropriate accommodation cannot be located, the choice of destination will inevitably have to be revised. Only when accommodation has been located is transport information and detailed information about the destination required.

The result of this process can be that people decide they do not feel sufficiently secure with the information they have to be able to commit to the trip. Many people who are ready, willing and able to travel are frustrated in their efforts to maximise their holiday experiences because of a lack of information about accessibility to mainstream tourism product. The mainstream tourism brochures rarely include access information and this further excludes people with impairments and their travelling companions:

I have an able-bodied wife, two young children and have the money to do things, but it is often difficult to get ideas on what we can do as a family. I do not need special disabled holidays but would like to know about 'normal' holiday activities that a 'wheelie' could also enjoy. The guidebooks from Tourism NSW such as 'Short Breaks' and 'Country Holidays' are very good. Disabled access information in them or something separate for disabled people would be good (Qn 440 Pg 348)

B. Accommodation guides

The guides published by the state based roads and motorists' associations provide one of the major sources of accommodation information. For example, in NSW it is the National Roads and Motorists Association (NRMA) *Accommodation Guide* (NRMA 1999). For the non-disabled these guides are a standard resource for accommodation information. Yet, as Steven states, the guides are only a starting point for people with impairments, 'In Australia we use the NRMA guide and the wheelchair symbol or wheelchair assistance symbol. We use that as a first resort, then we give those places a ring...' (Steven Pg 749).

Others have been disappointed and found the guides 'a waste of time' (Bill Pg 315). The reasons for these complaints are multi-dimensional. A common area for discontent about the guide is the use of two wheelchair access symbols. The first uses the universal symbol of a wheelchair to signify *independent* wheelchair access and the second has a non-disabled person standing behind the wheelchair symbol signifying access *with assistance*.

The differentiation between independent access and access with assistance has never been

clearly articulated in the guides and leads to problems, ‘That is a fault in the NRMA’s accommodation guide, putting these wheelchair symbols for accessible access. But, even when they aren’t, you go to the owner or the manager and they have no idea’ (Tim Pg 1729). Tim’s point raises the question, how does the NRMA determine the level of accessibility? Michael suggests that the process is ad-hoc: ‘...it is so hit and miss. You only have to pick up the NRMA accommodation guide and go out and try and test some of these accessible venues to find out exactly how haphazard the assessment process has been’ (Michael Pg 65).

Chapter 10 proposes an explanation for these situations but the outcome is that the inaccuracy of information produces a range of unsatisfactory experiences. Most of these unsatisfactory experiences are because expectations are raised as to the accessibility of the accommodation, sometimes through direct contact with the facility. When this expectation is not met, people are understandably disappointed. The greater the inconvenience the angrier respondents were. As Don’s experience illustrates, these inaccuracies have a range of repercussions on the individuals involved:

I haven’t used NRMA for years because I had a real problem with NRMA, found that a lot of the motels and whatever they recommended weren’t as accessible as they had indicated. I’d find that I’d get there and there was a small step in, one I got to and the actual toilet was behind the bathroom door and I had to get them to take the door off! (Don Pg 248).

While a small step into a room may seem minor to the non-disabled, for people with impairments it leads to a loss of independence as assistance is then required to use the room. In another case Tim (Pg 1733), on the basis of NRMA advice, booked accommodation that in fact turned out to be inaccessible. He needed to find alternative accommodation when he arrived at his destination but was unable to do so. The consequences of such situations are discussed in Section 8.5.

C. Travel agents

Most non-disabled people plan their trips using TA and TI distribution channels. The public faces of these channels are travel agents. Yet, the experiences of people with impairments suggest that travel agents are used infrequently. As Tim (Pg 1617) states, ‘...I don’t know anyone (with a disability) who has arranged travel with a travel agent’. The reasons for this are many but mostly involve previous, unsatisfactory experiences. Others were told by a travel agent that they would be better off finding out the information themselves and effectively had their business turned down:

I recently visited a local travel agent with my day group to gather holiday information. I was given a lot of brochures for resorts and package deals, within Australian and overseas. When we asked about wheelchair access, we were told we would have to contact the individual resort ourselves. Needless to say, the idea has been shelved, no-one has the time to do a survey of accessible transport, destinations etc. So we will probably stick with the few we do know (Qn 1853 Pg 1505).

This response is typical for many people with impairments who decide to holiday where they have always gone rather than seek out new holiday experiences. This reduces the risk of having a disappointing tourism experience. Others, like Andrew, who booked a trip through a travel agent, found that ‘...we tried the travel agent to go to New Zealand and *that’s when we came unstuck*’ (Andrew Pg 560). There is a multiplicity of reasons why this occurred. The most commonly cited incident involves, ‘inaccurate information from travel agents’ (Qn 2471 Pg 2272) that results in people having to do the work themselves, ‘I’ve always found out info for myself’ (Qn 2471 Pg 2272). As others noted, the information required from travel agents is not necessarily complicated but requires basic ‘knowledge...of accessibility details for places they promote’ (Qn 2342 Pg 1966). Once an understanding of the accessibility can be provided then, ‘travel agents must be better informed of “disabled” facilities in hotels and location of disabled rooms’ (Qn 490). This is because in the most basic sense, people with impairments have been disappointed as ‘some travel agents and moteliers think if you can get in the door of a motel room it’s accessible, same with the bathroom facilities’ (Qn 1584 Pg 1227).

In other cases, it was due to a lack of understanding of impairment needs. This can lead to situations that overlook disability considerations, ‘Because I do not have an obvious disability, travel agents often skip over the problems, forgetting that a short walk for them is a long walk for me!’ (Qn 7 Pg 8). In other circumstances, the information discussed with the travel agent had not been communicated with other parties. This leads to travelling issues, ‘...the airline was not informed of my wheelchair and life support equipment and had to make on-the-spot arrangements’ (Qn 2305 Pg 2088). The outcome of these situations is catastrophic to the desires and self esteem of those involved where, ‘we were refused assistance and left to attend the plane ourselves. As we tried doing so it caused us humiliation and I haven’t been on a plane after that’ (Qn 2359 Pg 1998). These negative experiences are reinforced to a point where people like Kristy do not even consider using a travel agent because ‘I wouldn’t trust a travel agent unless they were living with someone who was disabled or they were. They just do not realise to be honest...I’d want to be very sure that they really knew what they were talking about’ (Kristy Pg 371).

It seems that only when another person with an impairment has recommended a travel agent are others willing to trust their expertise. As Annabel identifies:

It is a matter of us sussing out a travel agent, or getting a recommendation from somebody...I dealt with this girl at Traveland, and she went out of her way to help me...But most agencies...have been quite rude, they have been very off-putting. They don't want to go to the trouble of helping anybody with a disability because they know it involves more than the usual punching it into the computer... It requires a little bit of work, a little bit of effort (Annabel Pg 467).

However, there are situations where people with impairments feel they do not have the expertise, information or wherewithal to organise their trip and engage the agents. This may involve trips to multiple destinations or overseas destinations where tourism access information is not freely available or language is a further barrier. As Tony suggests, resultant experience remains the same:

...overseas trips are generally done by the travel agent. Obviously, you know, I'm not going to ring Singapore...so that's done by an intermediate party. And always with disastrous effect. Now, we got to Paris, all fully arranged by the travel agent, everything accommodated for disabled accommodation except the two foot steps into the building which made a total height of almost four feet. My wife dragged me up there and then to get to the reception there was another couple of steps! ... We get in the lift and the lift wouldn't hold me - it was too small...just stuck in Paris, nowhere to stay, nothing. The point I'm making is you have to rely on the third party and it's not always done properly (Tony Pg 433 and 434).

Yet, as the experience of Jenny and John who both have high support needs suggests, this does not have to be the case:

Well, what we did for our honeymoon to Tasmania...the Tasmanian Information Centre...has an actual travel agent that organises holidays...that travel agency did organise all our accommodation. We told them the things that we needed, and spent a lot of time researching what would be accessible and what wouldn't. That was amazing. We couldn't believe that they helped us do that (Jenny Pg 199).

The difference between these experiences appears to be, firstly, a willingness on the part of the travel agent to listen to the needs of the traveller, and secondly, a willingness to negotiate these needs with the tour operator. However, the reason why some travel agents are willing to provide an adequate level of service and some are not is a matter for conjecture. Even after a person has these positive experiences, it may only take one negative experience for them to abandon using travel agents. Don, a person who travels extensively for work, had a good relationship with one travel agent but after a change of location his new experiences had been negative:

...Traveland I used to use quite a lot...They understood my needs because I used the same agency all the time and they were great. But since coming here for the last six years I tend to do it myself, I had a couple of experiences with travel agents here in Sydney. They

didn't really understand disability (Don Pg 233).

People with impairments have also recognised that there may be a need for a specialised travel agency, 'A specialist travel agent would be a good idea!' (Qn 1572 Pg 1217). Businesses have developed to meet the needs of some impairment groups. However, most organisations specialise in group travel for people with cognitive impairments. These alternatives offer people with impairments an opportunity for group travel where they had previously relied on family members. Tours are provided for people with mobility impairments but generally have conditions relating to personal care. For one person, this involved trips with sporting groups and a specialist tour organiser:

My travelling is usually with my parents...I have travelled overseas (NZ) and to Brisbane with a disabled sporting group who organise the whole trip and personal care. I did an 18 day tour with Cumalong Tours...It would be good if there were a few more companies offering holidays for disabled people so there was more variety of destination and prices might be more competitive (Qn 1738 Pg 1355).

As the quotation suggests, the itineraries can be limited and the prices regarded as considerably higher than competitive non-disabled packages. Cameron (2000) identifies 22 organisations that provide such services. Other consultants provide expertise for wheelchair users. Yet, this involves another level of intermediary as Annabel documents:

I had been recommended this particular travel agent at Parramatta by able bodied friends who had travelled and used her and said how good she was. I went there and I then got all my brochures. I paid Mr. Ian Cooper (Barrier Free Travel) my fee of \$50 to help me find accessible hotels. The Flight Centre set up an itinerary, where it would be best to go in the time I wanted to. I then went through Ian who supplied me with...hotels. Then between Barrier Free Travel and the Flight Centre we coordinated these hotels. This particular girl proved to be as valuable and terrific as everyone had told me she was (Annabel Pg 35).

While the reason for the involvement of the mainstream travel agent and the specialist travel organiser is not articulated, it was probably due to the increased level of discounting that mainstream agents can access. Yet, this still came at an added price to Annabel. Many of those interviewed suggested mainstream agencies need expertise, require education and should be more active in seeking out this information.

For others the situation would be improved 'if you have good quality staff at travel agents' (Annabel Pg 481). Some of this may be alleviated through the TI having disability awareness training, so that front line staff has a greater understanding of disability and access. This is necessary because, 'people in the travel industry often have a strange perception as to what is accessible, e.g. if you can get into the motel room, it's accessible without consideration to the bathroom' (Qn 2470 Pg 2201). This links education,

understanding and operationalisation of complex concepts. It is not surprising that travel agents who have no formal access or disability education within their curriculum have no understanding in an operationalised context (Weiler and Muloin 1990).

D. A question of tourism access information responsibility

Finally, this raises the issue of who is responsible for the provision of tourism access information. Is it individual businesses, the individual TI sectors, TI pressure groups or Commonwealth and State TA? Many people suggested that disability organisations could extend their role in publicising accessible travel anecdotes through their journals (Qn 1535 Pg 1187). Others, like Jenny (Pg 1255), suggest that people with impairments empower themselves through the development of information sharing systems via the web or email. However, neither of these suggestions address the problems of the absence of information, or the unreliability of information provision through the ad-hoc nature of the self reported systems. These issues were represented by a number of HREOC complaint cases (2002a).

E. Broader communication issues - HREOC on telecommunications and alternative information format provision

A number of significant cases, carrying implications for communication and information provision by the TA and TI, has been brought before HREOC by people with impairments. *Scott v Telstra Corporation; DPI(A) and Australian Association of the Deaf v Telstra Corporation [1997]* sought remedy from Telstra (Australia's major telecommunication provider) for not providing tele-typewriters (TTY) for deaf subscribers. He sought the provision of TTY as fair and equal treatment for deaf subscribers as Telstra provided telephones to hearing subscribers. As Mr. Scott explained, 'they refuse to give me a means of answering the phone, like a hearing person. This is unfair. All I want is equality in the service I use'. Telstra, by not providing TTYs, made deaf people's participation difficult in all forms of community activity requiring communication with other parties. In particular, information access is a prerequisite for all forms of citizenship and the lack of access to a TTY or to an organisation having a TTY directly discriminates against deaf people.

Similarly, *Maguire v SOCOG (Ticket book) [1999]* and *Maguire v SOCOG (Internet) [2000]* established that information provided in hard copy and on corporation websites must be accessible to people who are blind or have print disabilities. Maguire complained that he was discriminated against by SOCOG because they would not provide information

in Braille. According to the transcript, SOCOG made this decision because of ‘costs and percentages’. Secondly, SOCOG had discriminated against Mr. Maguire in not complying with *W3C Guidelines* for accessibility of websites. The principles for website accessibility involve complex issues of impairment specific inclusions. An understanding of each impairment’s inclusions can alleviate the areas of conflict and provide environments, products and services to service all groups (HREOC 2001e).

These issues have to be considered by the TA and TI, as general information provision must incorporate alternative formats like TTY, Braille, audiotape and electronic (HREOCCC Oct 2000). Information kiosks that use visual interfaces are particularly disabling for these groups (HREOCCC 1998). Access to information covers a range of issues for people with vision, hearing and mobility impairments and design must incorporate physical and communication dimensions of access. These are all services that people need to be able to access in their homes and destination areas in order to exercise their rights of tourism citizenship. This was highlighted with a number of complaint cases brought by Deaf people against hotels in 2000/2001 where TTY and captioning services were not provided (HREOCCC 2002)

8.4 Transport Constraints to, at and from Destinations

After travel planning, ‘transport is crucial in a holiday...It is a crucial link’ (Tim Pg 928). The first concern is travel from home to the destination, but once at the destination, the tourist needs to be able to explore the immediate surrounds via pedestrian access and by the means of public transport. The tourist also needs to undertake day trips to the areas of interest close to the destination region, which generally involves day tour operators. Tourists may also wish to hire vehicles to explore the destination and surrounding areas at their leisure. Once the time at the destination is over, the tourist must transit back from the destination region. If these transportation links fail at any stage then the tourism experience is compromised.

The general constraints to transport are reviewed below. The material is presented in four sub-sections, beginning with a profile of tourism transport use based primarily on BTR survey research, followed by sub-sections dealing in turn with: private vehicles, hire cars and taxis; public transport; and air travel.

A. Profile of transport use

The 1998 BTR survey revealed a statistically significant difference between people with impairments and the non-disabled in the main mode of transport used to reach a destination (Table A14 in Appendix 1). The major differences were that people with impairments had a lower use of air transport and higher uses of both rail and bus/coach than the non-disabled. Private motor vehicle use was the dominant mode for both groups (77%) with people with impairments having a marginally higher use. Yet, there is a significant difference between the mode of transport used to reach the destination and mobility aid (see Table A15 in Appendix 1). Wheelchair users used air travel more frequently and used alternative forms of transport including special purpose taxis, community transport and other due to the mainstream public transport being inaccessible. Conversely, people using other mobility aids had a greater choice of public transport options and were significantly more frequent users of bus/coach and train. Similarly statistically significant relationships were found in regard to transport used at the destination, albeit with a number of notable differences. Wheelchair users were restricted to destinations where there was a greater degree of pedestrian access and they used taxis more than other groups. People with other mobility aids were able to continue their use of public transport.

Given the level of inaccessibility of both public transport and private operators of tourism-related transport, private motor vehicle use simplifies travel planning.. The provision of an accessible public transport system was one of the top two responses when BTR survey respondents were asked about possible solutions to the constraints encountered and suggestions for improvement to travel. Comments from survey respondents included the need for improved access to all public transport and day tour operators. These areas are examined below through the lived experience of people with impairments.

B. Private vehicles, hire cars and vans

Private vehicles offer people with impairments freedom to participate in the life of their communities. For those people who can drive themselves, cars provide the means to avoid social isolation where public transport is not available or not accessible. These issues are accentuated in rural areas, where paratransit systems are not available. As Justin explains, ‘Yeah, its great (a car). When I first came home I was living out of town about 10-15km and I didn’t have a car then and you just drove yourself mad not being able to do anything. It’s great to have a vehicle’ (Justin Pg 207). The car has also provided convenience for

travelling when he has needed to attend family functions and visit friends in Sydney (Justin Pg 275).

The car offers a basic convenience to travelling and in its simplest form this involves day trips where, 'Day trips are more our thing. *Just hop in the car and go*. Sometimes the destination is suitable, sometimes not. Pot luck can be exhausting, but also exciting' (Qn 1600 Pg 1239). This sentiment encapsulates the spontaneity and lack of planning needed for day trips. Even when using cars, for many people with impairments overnight travel requires a greater level of travel planning that can detract from spontaneity and the sense of adventure. For example, even when using car travel the route to the destination becomes crucial as, 'everything is checked out along route, regarding suitable accommodation and toilet facilities' (Qn 589 Pg 452). The convenience of car travel for overnight trips also involves equipment, 'I really need to be traveling in my own vehicle because of equipment. You've got to take a shower chair, your wheelchair and all that sort of stuff. Jumping on a plane and hoping that everything's arrived is definitely not the go' (Justin Pg 280). The car becomes more than a mode of travel, it is an important facilitator of the equipment needed for personal care and provides a sense of control that other modes of transport do not offer. Some people with impairments are forced to travel with the equipment because it is either not provided at the accommodation or it can not be rented at the destination region (see Section 8.7.3 for equipment issues).

Closely related to convenience is cost. Without a private vehicle or one to rent people with mobility impairments have to rely on a paratransit taxi system (see Section 8.4.4) for their travel arrangements. As Annabel suggests, having a private vehicle or being able to hire a car or modified van was a major advantage from an experiential, convenience and cost perspective when compared to paratransits:

Well, you always incur additional cost because you do have to seek out alternate forms of transport, which make it more expensive. Like hiring a car because to get taxis everywhere would just prove prohibitive. ...to catch a taxi from the hotel to Port Douglas would cost an arm and a leg. I can't jump on the bus that comes to the hotel and takes all the other tourists up to Port Douglas. I have to get a car to do that. You have always got that additional expense rather than being able to get onto the normal tourist type buses that pick you up. Sometimes food is an additional thing as well. You can't afford to be eating in a restaurant all the time, and you can't always get out to go for a meal because you are staying 20 kilometres out of town (Annabel Pg 377).

Convenience also equates to freedom of opportunity when travelling to explore destination regions and the nearby environs. These opportunities offer a dynamic dimension to what would otherwise be a static holiday experience. Tim was given this opportunity through an

operator who offered accommodation and an accessible van for use, ‘We had been to the Gold Coast, stayed at Teneriff for a couple of days, took their van down to Byron for the week, went back to the Sunshine Coast for a couple more days and then flew back to Sydney’ (Tim Pg 602-610). The use of the van facilitated a multiple destination trip that would otherwise have been single destination. The multiple destinations and the associated coastal travel from the Gold Coast to Byron Bay and back to the Sunshine Coast provided Tim with a sense of adventure. This involved what many Australians regard as the quintessential coastal road trip.

Toilets, parking and servicing the car

While convenience is the major advantage of cars, travelling long distance also involves a number of constraints. These barriers involve finding accessible toilets, accommodation along the route, servicing of the vehicle and the location of suitable parking. In the case of the following person, the barriers encountered while travelling by car in Australia have affected their destination choice for their next major self-drive holiday, ‘I have driven and travelled extensively in Australia and USA. The USA provides access far more consistently...In Australia it is very difficult...For these reasons our next major driving holiday is in the USA’ (Qn 2678 Pg 2483).

From the tourism-generating region, through road transit to the destination, people with impairments are reliant upon the environments in which they travel. They have to use the infrastructure of these areas. Once in the vehicle and travelling long distances people with impairments need access to toilets. One of the issues that people with impairments identified was that service stations did not have accessible toilets. ‘I feel there is a place for a ‘directory’ of suitable toilets for disabled people...It would be good to encourage petrol companies to spend a little money to improve facilities as garages are the obvious stopping places’ (Qn 1024 Pg 813). As Justin explains, finding suitable toilets has its problems in rural areas:

... they just don’t have anywhere where you can find a wheelchair toilet. That’s fine you know if you’re traveling in a car and you can just go out of town and have a leak or something but if you need to use your bowels and there’s no wheelchair toilet, what do you do? (Justin Pg 383).

While the primary role of service stations is not to provide toilets for people with impairments, this has been a recognised secondary service for the non-disabled. The servicing of vehicles belonging to people with impairments has also become problematic

with the demise of driveway service (Qn 2691 Pg 2495). Without the certainty of being able to get vehicles serviced adequately on long trips, people may be reluctant to travel.

Another issue crucial to cars was parking. Parking is examined in detail in relation to destination access (Appendix 9) but it is very much linked to transport issues. In metropolitan areas this may involve issues of closely located accessible parking or the added cost of having to pay for parking stations. It also involves the proximity, the adequacy, and the continuous pathway of approach. For example, Bill who is an avid 4WD participant, finds that with his reduced mobility the location of parking close to accommodation was essential:

...our 4WD club went to Lake Blyle which is up near the Lithgow area, and I thought that I would look for a hotel at Rydell and made enquiries over the phone ... told them that I had mobility problems and they led me to believe not a problem. We arrived at the beautiful old hotel, over 150 years old, but it has outside toilets for the bar use, and I would like to park the car near where I could access the hotel best but I had to park the car about 600 yards away (Bill Pg 255).

People feel that they are forced to use private vehicles due to the TI not providing discounted and accessible package holidays. 'Another area is the high cost of travelling in my own car, as my wife and I cannot take advantage of the wonderful package trips to all parts of the country at discounted prices. Fluctuating petrol prices and cost of maintenance etc. make regular travelling a bit tough' (Qn 2691 Pg 2495). As suggested, if accessible packaged trips were available at the TI discounted rates as they are for the non-disabled, then people with impairments would use them.

Hire vehicles

Those who reach the destination region by means other than private vehicle may wish to have the advantages of having a vehicle at their disposal. Many people with impairments expressed the desire to be able to hire cars with hand controls and vehicles modified for wheelchair access. For some, this only involves having hand controls fitted to a standard car. Hand controls allow people with lower limb impairments to drive vehicles with their hands. For other people it involves, '...some sort of vehicle which was a modified van or a stretch type taxi that I can get into, staying in my wheelchair' (Tim Pg 878).

A number of complaint cases have been brought against hire car firms for not providing cars fitted with hand controls on request, and particularly in rural centres (HREOCCC 1996). Yet, as Tony notes, there are still issues of equality of provision where, '...they do not charge you for the hand controls, but they get you by charging for the automatic' (Tony

Pg 526). While the fitting of hand controls has become standard practice for most major rental companies over the last few years, modified van rental remains sporadic throughout Australia. There still has not been a recognition that differential charges should not apply between a vehicle with manual or automatic transmission or an accessible van.

The equality of provision extends to the types of vehicles available and the level of access provided. In Samantha and Steven's case this involved, '...looking for a camper-van but no one would rent out a camper-van with two lots of wheelchairs' (Steven Pg 237). At other times, hire car companies can think that they are doing people a service by 'upgrading' to a better car. However, this was problematic when Samantha and Steven needed a station wagon but were upgraded to a sports car that was inappropriate for Samantha's mobility requirements and equipment needs (Samantha and Steven Pg 639).

C. Public transport and commercial tourist transport

While some people with impairments choose the extra convenience of cars, many are forced to use private vehicles because there is not an equitable public transport system in Australia. Finding accessible transport to a destination can be fraught with difficulties as Beth discovered when trying to plan her first trip away as a person with an acquired impairment:

...we phoned up Sydney Railway Station to ask for information about catching a train to the Blue Mountains. And he said it is tricky...we could arrange to get you into a carriage, at this end, but I'm not sure whether you can get out of Katoomba Station. I said, that's not terribly helpful (Beth Pg 70).

Beth was confronted with transport constraints trying to reach Sydney's number one day trip destination. Effectively people with impairments are unable to travel to the Blue Mountains by public transport (bus or rail) or by any of the day tour operators. Outside of private vehicle use people with impairments must either use the paratransit system or hire a vehicle. This places people with impairments at a significant travelling disadvantage to the non-disabled from a convenience, cost and experiential perspective.

This study confirmed the validity of Downie's (1994b) extensive review of public transport and disability in Australia. Since this report, three simultaneous complaint cases have been undertaken against proposed government bus purchases in NSW, SA and WA. These were all due to the proposed purchases of new fleets of Scania low floor buses that were not wheelchair accessible (HREOCCC 1995). For example, *Magro v NSW State*

Transit highlighted the restriction to citizenship that lack of accessible public transport causes and the discrimination faced by people with impairment in comparison to the non-disabled. These complaint cases argued that public transport should provide an equality of provision for people with impairments.

Arguably, these three complaint cases had the impact of providing the beginning of accessible public transport systems throughout Australia⁹. Shortly after these actions occurred, the process for the development of a *Draft Disability Standard for Public Transport* under the DDA was initiated (Section 10.4.2). The importance of public transport in facilitating tourism in Australia can not be overstated. However, the constraints imposed on people with impairments by an inaccessible public transport system have been well documented (Downie 1994b; HREOC 1999; DDA Standards Project 2000; United Nations Committee on Transport 2000; Corcoran 2002b). The remainder of this section reviews the tourism specific transport issues of day touring and paratransit systems.

The day touring experience

Tim enjoys tours but, ‘...you are totally excluded from tour buses like Perth by day/night where you are picked up by a bus, you travel and sightsee, they put you down on a river cruise but you can’t do it’ (Tim Pg 1172). As Tim rightly observes, this is because the river craft are not accessible. Yet, the DDA applies to tour companies to provide accessible day trips by coach and ship. As Beth (Pg 74) identifies, in Australia’s main tourist destination the Blue Mountains people with mobility impairments are unable to book accessible day trips on any transport system. People are restricted to using paratransits or hiring accessible vehicles and undertaking segregated trips. Accessible day trip operators or transport to attractions are significantly cheaper than paratransit options and have a range of other important tourism benefits.

People with impairments who use paratransit systems are excluded from social interaction with other tourists and the experiential expertise of the operators. As Steven and Samantha reinforce, it is far more than a mode of transport:

Get on a bus...the best time that I had has been with other tourists that just happened to be there, you know, have a chat with somebody and talk about normal, touristy type things. And rather than being segregated, going in special purpose taxis or in a van by yourself

⁹ While the DDA complaint actions have been successful with government bus, rail and ferry services they have been less successful with the adoption of wheelchair accessible vehicles by private operators. For example, in NSW it has been estimated that while 20% of the government bus fleet is accessible, only 1% of private bus services are accessible (NSW Department of Transport 2000).

where you do not get that social interaction (Steven Pg 363).

Apart from buses, many complaints cases have related to mobility access to rail services (e.g. HREOCCC 1994). This has been problematic as much of the infrastructure was built during the nineteenth century. For example, the Sydney City Rail Network system has only 7% of stations as *Easy Access* stations (CityRail 2001). In particular, people are disadvantaged if they wish to travel to non-metropolitan areas of Australia. A number of complaint cases have brought attention to the rail carriages on long haul routes for:

- inappropriate provision of wheelchair spaces (HREOCCC 1994);
- lack of accessible sleeping quarters in new carriages (HREOCCC 1996);
- lack of accessibility of long haul travel carriages (HREOCCC Feb 2001); and
- accessible toilets only in the 1st class cabin area (HREOCCC Oct 2000).

While most complaint cases involved issues of equality of access, the last complaint case was also an issue of differential pricing available to people with impairments. These problems are compounded where buses have been contracted for service on lower capacity routes to replace existing rail services. Once general access (ingress and toilets) is addressed, then people with impairments will embrace an improved choice of transport options. 'Now that CountryLink trains are accessible with toilets we are trying them for the first time later this year' (Qn 646 Pg 514).

People complained that most watercraft lacked any accessibility (Qn 2321 Pg 1891). Even if watercraft are accessible, experiences are constrained by the type of wharf provision. Many wharves are still fixed wharves rather than floating pontoons. A floating pontoon offers people with impairments a level of access not found with fixed wharves (Public Works and Government Services Canada 1994; Sport and Recreation Victoria 1997). This leads to situations where, 'Even with a companion - access onto vehicles is still extremely difficult, or impossible...Even the cruise lines have special cabins - since ships - but they do not advertise this' (Qn 901 Pg 714). A highlight of Annabel's trip to the USA was a visit to San Francisco's Fisherman's Wharf and an associated boat trip (Annabel Pg 79). Annabel had similar day trips in Sienna and Venice where the quintessential tourism experience would not be complete without such a trip. Her Australian experience was somewhat different as operators manually lifted Annabel and her wheelchair aboard the vessel. As Annabel attests, there are a number of personal and occupational issues to consider with this method:

But I guess the one thing that did worry me up there was the fact that you do have to be lifted up onto the boat to go out onto the reef. Of course *I am always fearful of being lifted*

because I have had one major spinal injury. I don't want another one! ...when I got onto the boat and saw the flight of stairs I had to be lifted down, that was a little worrying (Annabel Pg 335).

Tim (Pg 69) and Don (Pg 288) had similar experiences with reef tours, staying on Green Island, going out on glass-bottomed boats and on semi-submersibles. The experiences identified that people with impairments must make daily safety decisions about accessing tourism experiences if they are not made accessible. In these cases, it involved the risk of being lifted on and off a vessel and the danger of the vessel's staff dropping them. The risk was also one of occupational health and safety for the workers. The major reef operators out of Cairns had to discontinue the practice of manually lifting people with impairments on and off vessels after several worker's compensation claims. Some operators overcome these constraints by incorporating universal access principles into newly designed vessels (Quicksilver 2000).

In other cases, people with impairments accessed watercraft by providing their own ramps. In Jenny and John's case this involved, '...two portable ramps that we take...we used them down in Tassie to get on a boat to go up the Franklin River, which was really good' (Jenny and John Pg 746). While the outcome was a successful experience, it was reliant on people with impairments providing innovations for what the non-disabled would consider was required of any tourism provider. Further, Jenny and John's experience would not have been possible for other people with impairments without the provision of their own ramps.

Apart from day trips to see the sites and cruises, many people wanted access to pleasure boats to self direct their tourism experiences. As with other forms of transport, 'I would like to travel using trains and boats - however both these means are inaccessible - when I talk about boats I refer more to pleasure cruise boats other than ships' (Qn 2527 Pg 2363). In Sydney, for example, there was only one accessible charter boat for hire. Tony provided his own solution by owning a boat to facilitate the holiday experience as 'we do a lot of fishing when we go away on the boat' (Tony Pg 796). The lack of accessibility of tourism related watercraft is a major constraint to tourism experiences, given that Australia is an island nation, many of its attractions are located on the coast and many recreational activities are water based. This places people with impairments at a significant disadvantage to the non-disabled.

Paratransit taxi services

For people with mobility and vision impairments, the lack of an accessible public transport system means that their only accessible transport option is paratransit taxi services. Two studies have reviewed the operation of Sydney and Australian paratransit systems in the last five years (Folino 1999; HREOC 2002c). The conclusions of both studies indicated that service levels for people with impairments were significantly worse than for the non-disabled. This research reinforces the validity of those findings. The remainder of this section reviews the tourism specific implications of paratransit systems.

Jenny and John viewed a holiday as an opportunity to take a break from using the paratransit system, 'because we probably think that we want to have a break from using cabs. Get away from taxi drivers, sometimes they drive you mad' (Jenny and John Pg 425). Others, like Bill, identified the frustration that many people feel in having to rely on taxis when travelling away from home, 'You're totally reliant on it. You have to bloody find a taxi to get to and from these places' (Bill Pg 74).

Most metropolitan areas of Australia have a paratransit system but there was a high degree of variability between service provision in non-metropolitan areas. In metropolitan areas, the length of the trip was a determinant of whether accessible taxis would accept the job. This was Don and June's experience in Melbourne, '...when we were at the hotel, we just found going to and from the tennis a little difficult there, trying to get the cabs to do short trips' (Don Pg 95). The non-disabled could have used alternative means to reach the event but without other accessible transport options or an accessible streetscape, people with impairments are restricted to their accommodation by the inefficiency of the paratransit system.

Each state operates its own taxi subsidy scheme as an equity measure to offset an inaccessible public transport system. Each of these state-based schemes subsidises taxi use to different degrees. In the case of the taxi subsidy schemes, this led to a disadvantage for people who used these systems when travelling. One person pointed out that 'The benefit of the taxi transport subsidy scheme should follow through to all states of Australia' (Qn 339 Pg 269). There were no reciprocal arrangements between states for the use of vouchers when people were travelling until 2000. This led to people paying full taxi fares when interstate.

Even with the taxi subsidies (30-50% off full fares), using taxis as a main mode of transport while travelling is expensive. As one person stated, ‘The cost of getting anywhere usually means taxi or hire car and is therefore much more’ (Qn 2489 Pg 2300). Don and June’s experience of wishing to see the sites highlights these issues, ‘We wanted to get around and see a few things, go down Flinders Island, go up the tall timbers, go up the Great Ocean Road...but we couldn’t find a tour company with an accessible bus that would take us’ (Don Pg 272). Without equality of access to day tours people are reliant on the paratransit system. In the tourism sense, Don and June’s trip to Melbourne and their desire to explore the attractions could not be met by the operators. Don and June decided that it would be too expensive to do this by taxi and did not see these sites.

The inequity and cost issues aside *Adams v Arizona Bay Pty. Ltd., Charlie Habib and Bunge Pty. Ltd. [1996]* highlighted some of the problems that people with impairments using paratransit systems face daily. In this case, it involved dependency and intimidation where the driver intimated that a taxi service for people with impairments was significantly different to one for the non-disabled, the provider being in a position of power. As he stated:

I’m doing you fucking cripples a favour picking you up anyway’. Mr. Adams went on to allege that he asked Mr. Habib a few times to stop the car but Mr. Habib drew alongside Mr. Adam’s house and said ‘this is my fucking company and I make the fucking rules’. Mr. Adams further alleged that he said then that he held a M40 card and would call Vicroads to check his rights and change to another taxi service. At this Mr. Habib said ‘you do that, I’ll make your fucking life suffer. No one is able to help you. *Adams v Arizona Bay Pty. Ltd., Charlie Habib and Bunge Pty. Ltd. [1996]*.

During every journey in a taxi, people with impairments are at the mercy of the driver. This degree of vulnerability is higher than for the non-disabled due to the nature of securing the wheelchair into the taxi. If this is not done correctly, the individual’s safety is at risk. In Annabel’s case this involved:

I got in expecting to be strapped in ...but nothing, absolutely nothing... You are sitting facing the opposite door, so he shoots off, they drive like maniacs, and he goes around the first roundabout and I ended up lying on my back with my feet touching the top of the roof of the cab (Annabel Pg 97).

The non-disabled would simply not travel with this person again. However, people with impairments are often faced with a single paratransit provider in the destination region. For example, in Byron Bay (North Coast of NSW destination) there were only two accessible paratransit vehicles. The operators of these vehicles did not like night work and, hence, anyone holidaying at this destination was restricted to travelling in the vehicles during the

day. These types of constraints directly affect the tourism experiences that people can have.

D. Air travel

This section addresses the air travel constraints of cost, boarding and disembarking, seat allocation, onboard personal care issues, equipment handling and customer service. A series of complaint cases were brought concerning about the general accessibility of airport terminals and facilities (HREOCCC 2001 April) involving continuous pathways, parking and toilets. These detailed issues are discussed in Appendix 9 and are not dealt with in this section.

Cost

Before 1996, there was an extra cost imposition for people with impairments who needed to travel with an attendant. An extra ticket would have to be purchased for the attendant and this added to the cost of tourism. Qantas recognised the inherent discrimination of charging an attendant the price of an extra ticket. To redress this situation Qantas, together with the NICAN established the *Carers Concession Card* (Qantas 1996). The card offers 50% discount on all full domestic airfares for people with high support needs and the carer. The card was subsequently recognised by other carriers who offered identical provisions. However, people commented that the 50% fares should be available on discounted fares, which are substantially cheaper than full domestic, to offer an equality of service provision.

Boarding and disembarking

The method of boarding and disembarking from the aircraft was a focus of criticism by people with impairments. This had to do with the boarding procedures and method of transfer onto the plane. As Justin describes, the process is without dignity:

You get stuck in those bloody, shitty airport wheelchairs and you can't go anywhere. It might be for half-an-hour, and if you're stuck without access to your own chair, in one of those aisle chairs that you can't actually push around and go to the bathroom or get yourself a feed...it's a loss of independence...I'm self-catheterised, so if you don't get to the bathroom, you piss your pants; It's not the best way to be (Justin Pg 357-361).

Due to the aisles of aircraft not being wide enough to accommodate a standard wheelchair, people with mobility impairments must be transferred from their wheelchair before boarding onto an aisle chair. The aisle chairs are significantly smaller and narrower than a

standard wheelchair, lack the provisions for self-propulsion and are not comfortable. In Justin's case, prolonged time in an aisle chair resulted in a loss of independence and could result in incontinence as he is unable to access a toilet to manage his bladder routine. Yet, transfer to the aisle chair is only the beginning of what many people described as harrowing. The process of boarding and disembarking involves more than discomfort for the individual involved and those travelling with them in that it can directly affect sense of self, 'my husband's self esteem plummets as we make our way through crowds waiting to board' (Qn 339 Pg 269).

The boarding and disembarking process involves what people with impairments describe as *the first on, last off syndrome*. People with impairments are required to board aircraft as much as 45 minutes before the non-disabled. This is due to the confined nature of the aisles, the use of the aisle chair and the need to transfer people from the aisle chair to the aircraft seat (see HREOCCC 2001 April). This does have the advantage of maintaining dignity and privacy from the curiosity of non-disabled passengers given that the transfer process from aisle chair to aircraft seat can involve readjustment of clothing and seating position. Some people likened these experiences to being a freak in a circus with everybody staring at them. After the aircraft has landed, people with impairments only disembark after non-disabled passengers. The length of time this takes is dependent upon the management issues discussed in the rest of the section. However, the result can be that people with impairments may spend at least an hour extra on an aircraft.

The other aspect of the aisle chair involves those people who require assistance transferring from their wheelchair to the aisle chair. Most major Australian airports employ porters to assist people with impairments and older people to board and disembark from aircraft. In regional areas, this role of assistance falls to baggage handlers, cleaners or anyone else who is available to offer assistance. The level of expertise and training can vary tremendously. The results can be less than satisfying where:

You get the odd one who is quite rough, and they pick you up like a sack of potatoes. They do not really have any idea of safe lifting and positioning, they just dump you and walk off. I have had that happen before, that was terrible...As soon as you get out of your motorised chair, you often feel very vulnerable. You can't move anywhere (Jenny and John Pg 553-559).

This creates a sense of helplessness that most people have overcome through their adjustments to a disabling society. When these situations arise, it creates a sense of loss. For some, they may never fly again. For others, their future travel choices are restricted to

modes of transport where their independence can be maintained. Jenny also has a fear of flying and being told of the procedures for exiting from aircraft in an emergency situation does little to diminish her feelings of helplessness: ‘They don’t make you feel very good when they say to you, in the case of an emergency you are last out of the plane!’ (Jenny and John Pg 711).

These safety issues formed part of a complaint case brought against Airlines of Tasmania. The options of travelling to country and regional areas for people with higher support needs were further restricted by *McLean v. Airlines of Tasmania Pty Ltd [1996 HREOC 77]*. Mr. McLean sought to maintain his independence in regional air travel and alleged, ‘...that AT has discriminated against him, on the grounds of his disability, by imposing a condition of travel upon him that he must be accompanied by a support worker’. The Commissioner found that because McLean was a person with high support needs, he would be required to provide his own support person. It was also found that it would be an unjustifiable hardship for AT to provide such a person.

The finding was due to safety reasons outlined in: the *Civil Aviation Authority Regulations*; the *Civil Aviation Orders*; and *Resolution 700 of the International Air Transport Commission*. It significantly restricts people with higher support needs from travelling independently. This places a further cost burden on the individual to hire an attendant and pay for their airfare even though they have an attendant to get them on and off the aircraft at each end of the journey. The finding was reinforced where it was found lawful to require a woman with epilepsy to be accompanied on a long international flight (HREOCCC Oct 1997).

Seat allocation

All members of the public contest the allocation of seats. However, for people who transfer into aircraft seating, this issue involves the physical constraints of plane design where the aisles are narrow. As Tim (Pg 662-686), a wheelchair-using quadriplegic explained, this involves a series of actions for him to be seated comfortably:

They sometimes allocate you to the most appropriate seat...not too far down the aisle and one with an armrest that lifts up. But not all the planes have got armrests that lift up. My very first flight they put me right down the very back. I had to squeeze all the way down the aisle to the back seat. Because I can’t transfer myself, I have to be lifted over the armrest by the carer and the porters at the airport ...one gets on the legs, and the other on the back and transfers me across.

The importance of the flip-up armrests is essential for people who need to transfer to aircraft seats. This is because only certain rows of seats have armrests that lift up out of the way to allow for unhindered transfer from the aisle chair to the seat. Without this, the porters must lift the person over the arm of the chair. This can cause injury to the person but is also an occupational health and safety issue for porters. People with impairments who require this consideration check and double check with airline booking authorities that these details have been recorded. Many people expressed similar desires as Don to improve aircraft design:

I think for a start, the provision to stay in your own wheelchair within an aircraft would be brilliant. If they could...lock you down somehow within the aircraft, it would make life a lot simpler. But barring that, using the current aisle wheelchairs, access seats by making every isle seat a flip-up arm (Don Pg 395).

While international air regulations are unlikely to allow people to travel in their wheelchairs, the requirement for all aircraft seats to have flip-up arms is sensible. This would alleviate the anxiety experienced by people with impairments when getting assurance about the allocation of the seating rows. Similarly, it was suggested that people with impairments could be allocated the bulkhead seating that has extra leg space. Yet, people with impairments are specifically excluded from these seating allocations as they coincide with emergency exits and it is argued that people with impairments may pose an emergency risk of blocking these areas.

Personal care issues and onboard toilets

Once the correct seat has been located, the arms raised and the porters ready to transfer, there are other considerations for personal comfort:

I put my cushion that I use on my wheelchair onto the plane seat and transfer across ...It clips around the seat and then it has got this 10cm wide, vinyl-covered, padded band that goes around your chest and attaches to the seat. Got my cushion, got the seat belt, got the armrest, *got me comfortable!* (Tim Pg 662-686).

To the non-disabled these procedures may seem unusual, but to a person with lower body paralysis this is essential to protect skin condition against pressure. For this purpose, many people use specialist cushions. For a person like Tim who also has upper body paralysis, the chest belt provides stability while travelling in the plane. This is because aircraft seatbelts are lap belts and do not provide upper body support.

Air travel also has a series of health issues for the non-disabled which have been highlighted by the recent publicity about deep vein thrombosis. For people with

impairments, any health issues need to be managed along with the inherent health issues arising from air travel. For many like Tony, ‘...I mean twenty-four hours in a plane is not good for you, I get swollen ankles and stuff like that...but nothing really serious’ (Tony Pg 582). For Annabel the effects of rheumatoid arthritis make travelling an uncomfortable experience that is exacerbated by poor seating allocation:

...when I am taken on board, I am placed in the middle aisle again... with no leg row...with a leg that couldn’t bend, I had nowhere to put my leg. I said to the steward, I cannot sit here for twelve hours...so my legs were out in the aisle, with a twisted back. I couldn’t even put a seat belt on (Annabel Pg 87).

A major issue of flying for many people with impairments was that ‘planes should have toilets that are wheelchair-accessible, both within Australia and overseas flights!!’ (Qn 536 Pg 414). Even with the newer aircraft design that offers an accessible toilet, it is so far below the Australian Standard as to be effectively unusable for people with only moderate support needs. As one person stated, ‘On previous overseas trips I have found getting to the toilet extremely difficult because of the tiny size of plane toilets. It’s put me right off travelling by plane’ (Qn 603 Pg 468). For people with higher support needs, the use of the toilet requires cabin staff on the flight to provide the onboard aisle chair. The person then has to be transferred by the cabin crew from the aircraft seat to the aisle chair. The aisle chair then has to be moved from the seating location into the accessible cubicle. Yet, even where accessible cubicles to are provided instances have arisen where the aisle chair has not been provided and the person has had to be carried to the toilet. This situation led to embarrassment and physical discomfort (HREOCCC 2001 July).

The accessible cubicle consists of an extended curtain to offer privacy. People with impairments deal with this reality in many different ways. It is a complex issue involving the mobility of the individual and their continence regime. Some people live within this constraint by not drinking and effectively dehydrating themselves during travel as in Jenny’s case:

I don’t think that I could get into a toilet in a plane...I have got a normal bladder function but I tend to hold on for a very long time. Which is very useful, but I guess for a lot of people it’s very difficult to fly. If it’s an overnight flight, I do not know that I am able to get through (Jenny and John Pg 637).

Air travel is generally dehydrating and without fluid intake, people with impairments risk more significant dehydration and other side effects (Rous and Ward 1997). This provides a constraint on where they travel to because of flight duration. For Kristy (Pg 302), this has meant ‘flights we catch are only about an hour long so I do not have to access them

(toilets)’. Others cannot live with these restrictions and fly in fear of not being able to get to the toilet on aircraft. This degree of angst is a part of travel that the non-disabled never have to experience.

Equipment handling/damage

When people travel by air they must take all of their equipment with them. Apart from the logistical dimension to the exercise, some people reported ground staff reacting in less than a professional manner. For Jenny and John (Pg 541) this involved, ‘the airports generally freak out when we get there as we have a hoist, a commode, two portable ramps, both chairs and back pillows’. In other cases, there have been procedural issues about booking flights with extra equipment based on the *Air Navigation Act*. This has led to complaint cases about oxygen for people with respiratory impairments and power wheelchair batteries for people with mobility impairments. Both cases involved a misunderstanding by ground crew as to the procedures to accommodate these inclusions. The resolution of these cases involved changes in booking policy and procedures to avoid undue delays or refusal of entry onto flights (HREOCCC 1997; 2001). The equipment issue also relates to the secure stowing of wheelchairs once a person has been transferred onto an aisle chair. As Tim explains, he has a procedure for ensuring a safer passage in the luggage hold for his wheelchair:

The back of my wheelchair actually lifts completely out. So it lies flat. And the armrests it’s got can be raised or lowered...I actually take the armrests out and put them on the seat of the chair. The control box, I actually take it off the chair and take it into the plane with me...That is the most vulnerable part of the chair...(Tim Pg 726-730).

Many people with impairments reported having their equipment damaged. When this is their wheelchair and they are on the way to a destination this can end the holiday experience. Some people reported being unable to continue their trip as replacement equipment was not available at the destination. Further, airlines have a limit of \$1600 on damaged luggage and unless people have specifically taken out insurance on higher priced equipment, they are only covered for this limited amount. Most power wheelchairs cost in excess of \$10,000 and damage can easily exceed this limit.

Customer service

The role of trained porters for transferring people was seen as essential by respondents. Once a person had been placed on an aisle chair it was ideal to board and seat them in as short a time as possible. Porters need to be available to assist when needed, need to be well

versed in transfer techniques and need to be comfortable working with people with impairments. Without these prerequisites, the service offered to people with impairments might be unsatisfactory. In Don's case his experience of air travel was spoiled by a series of indiscretions:

I found the airline was really quite rude, in that June and I went to get on the plane and he yelled down the corridor, 'I've got a couple of carry ons here'... That whole bad attitude to the customers' rights.....not realising that people with disabilities know what they're talking about and deserve respect (Don Pg 308).

These experiences are directly related to the daily management practice at airports. Even after all staff undergoes disability awareness training, major oversights can occur. Many people related experiences of arriving at a destination or on the way back home only to be left on the plane for a prolonged period before disembarking. The delays of up to three hours were caused by a breakdown of communication about people with impairment being on the flight and the lack of available porters to disembark passengers. These delays created further complications with missed connecting flights and ground transport.

Most of these experiences related to people with mobility and vision impairments. However, there was one relevant case of a person who had panic attacks. The travel insurance company originally refused to pay their claim believing a clause of the agreement excluded these people. Upon conciliation, the company changed their decision and honoured the insurance agreement (HREOCCC 1996). Lastly, Annabel offers an insight into the tremendous changes that have taken place in the years that she has been travelling by air:

I have to say that I could find no fault at all with the treatment and the facilities provided by Qantas from the moment I checked in at the airport in Sydney. In the past, I had gone on board planes where my brother had actually had to lift me on board international flights because the crew wouldn't do it. So, it was such an amazement to me that seven years later the crew couldn't do enough for you and provided me with anything that I needed (Annabel Paragraphs 45-51).

8.5 Accommodation Constraints

After a person has decided to undertake a trip to a given destination, the first priority is to locate appropriate accommodation. Many respondents reported that they had changed their destination choice because they had been unable to locate accessible accommodation. Accommodation is the critical determining factor in holiday choice. Only when they had located what they negotiated to be accessible accommodation inclusive of travel needs, would respondents book their trip. As the person travels towards the destination, his or her

mind is invariably filled with anxiety about whether the accommodation will be suitable for their needs. Upon arrival, their first priority is to get to the accommodation and assess whether it meets the expectation derived during travel planning. This section presents a profile of accommodation use derived from survey evidence, and discusses accommodation access experiences and the requirements for accessible accommodation.

A. Profile of accommodation use

The 1998 BTR survey indicated that there is a significant relationship between impairment and accommodation choice (See Table A12 in Appendix 1). People with impairments stay at friends or relatives homes (52%) at a significantly higher rate than do the non-disabled (44%). The other accommodation type where people with impairments have higher use rates is staying at own property and hospital visitation. Yet, there are very different patterns of accommodation use dependent upon the needs of people with impairments. For example, for those people with mobility impairments, 90% of wheelchair users and 70% of people travelling with attendants required *accessible* accommodation and were unable to stay at friends or relatives homes. The meaning of accessible accommodation is examined as the chapter progresses and developed further in Chapter 10. A significant relationship exists between mobility aid used and accommodation choice (See Table A13 in Appendix 1). The most noticeable difference in accommodation choice was staying with friends and relatives, with 42% of people who use mobility aids other than wheelchairs using this option as opposed to 28% of wheelchair users. Hence, wheelchair users had higher levels of commercial accommodation use than others, using 4-5 star hotels (22%), 2-3 star motels (19%) and the renting of holiday accommodation (7%). People using other mobility aids generally had a greater range of accommodation use through B&Bs, caravan park/camping, cruise ships/boats and backpacker hostels.

B. Accommodation access

The first part of this section further explores the matters discussed in Section 8.3 above on travel planning and information sources. Outside of peak holiday seasons, the non-disabled may choose not to pre-book accommodation but instead source accommodation as their trip progresses. For others, accommodation guides published by the national and state motorist associations become their accommodation Bible when travelling. As previously discussed in Section 8.2, people with impairments are unable to rely on these sources of accommodation information and, hence, approach finding accessible accommodation with

a great deal of trepidation. People with mobility impairments generally, and people with high support needs in particular, identified a range of barriers associated with finding appropriate accommodation.

Accommodation information inaccuracy is a prominent issue. Forty-five percent of wheelchair users using commercial accommodation found access information to be inaccurate. Finding out detailed and accurate information about accommodation is a prerequisite for travel planning. The provision of detailed access information is essential for people with impairments to be able to make informed decisions about the appropriateness of accommodation for their requirements. The provision of inaccurate information has graver consequences than not providing information. This is because inaccurate access information can prove disastrous for holiday planning as the following person highlights:

Arrived in Canberra at 8pm to find that the 4-star motel with a disabled unit has two steps to gain entry...plus hob and sliding screen on shower, great info, great holiday. I guess there are no politicians in wheelchairs (Qn 439 Pg 346).

The accessibility of accommodation is critical for people with impairments, wheelchair users generally and people with high support needs in particular. If a person can not get into a room, they have no option but to try to locate other accommodation or to go home. This situation simply does not arise for the non-disabled. The process for people with impairments is a major issue as the accommodation information sources provide incomplete information. The likely options of finding alternative accommodation are easier where a greater level of accommodation stock is available. Yet, even in the major metropolitan cities of Australia no consolidated, systematic inventory of accessible accommodation exists. To find alternative accommodation requires the person to begin cold-calling other establishments. In regional centres there may be no other option but to leave the destination:

On our last trip away, we rang and checked with the place about wheelchair accessibility and were assured it was fully accessible. However, upon arrival there we discovered the door was not wide enough to fit my wheelchair, the step which I was told was only four inches high was in fact closer to 14 inches high. My wife checked inside and discovered there was no way possible to get to the bed or even move inside with the wheelchair. When this was mentioned to the manager, their response was they had nothing else and the information in the NRMA directory was incorrect. They suggested we travel 40km back and try there. However, we were lucky and found accommodation at a motel just down the road. They were only too pleased to help us and informed us that they had heard many complaints about the other place (Qn 976 Pg 779).

While it was not explained as to how these travellers got 'lucky', this incident highlights the inaccuracy of information received and that direct contact is no guarantee of

accessibility. There are accessible establishments that for whatever reason have not documented and communicated their access information. The result of this omission for people with impairments is that a viable option is unknown. From the proprietor's perspective, the accessible room may be under-utilised and viewed as a business liability. These experiences were supported by a complaints case where a motel agreed to access modifications to its motel rooms that including provision of shower chairs, the installation of body sprays in all shower recesses and new and accessible power points. The respondent also agreed to improve staff training in assisting wheelchair users through engaging a local disability organisation (HREOCCC 1997).

The frustration, desperation and despair that these experiences highlight drive people to check and recheck accommodation details before travelling. If the individual is not able to locate another appropriate accommodation then the rest of the tourism experience cannot be undertaken and they would have to return home. The remainder of this section examines the detailed provisions that people with impairments identified as being essential in an accessible accommodation.

C. What constitutes accessible accommodation?

How can people with impairments and accommodation providers have such different understandings of *access*? For people like Kristy, whose impairment affects her mobility she stipulates her access requirements as ground floor accommodation:

We've been stuffed around quite a few times and we've been really aware of making sure that what they say is in fact actually going to eventuate...even though you think you already have. It's amazing what goes wrong nevertheless but you know we've gone places where the unit was on the ground floor and then it was actually booked out or something and you have to go upstairs...we've stood our ground and refused to move our bags... (Kristy Pg 88).

The experience of being 'stuffed around' when requesting accessible accommodation is a common one. Kristy's experience is disconcerting in that a request for ground floor accommodation would be the most basic of access requirements but even this request could not be relied upon within the booking process. As Tim suggests, what people with impairments may regard as an information issue has a much broader organisational context:

...You go to the owner or the manager and they have no idea, they have had one woman arrive in a wheelchair who can actually walk and they say, 'oh yeah, we've had somebody in a wheelchair' (Tim Pg 1729).

As Tim suggests, if the owner or manager is unsure of the level of access of their property then this cannot be communicated with any degree of reliability. Many people with impairments said that staff reported that they had disabled facilities that had been successfully used by ‘the disabled’. However, many staff may have had limited experience with people with impairments and generalise based on a single experience. This generalisation becomes compounded where staff, managers and owners may not understand the function of the inclusions in an accessible room. People with impairments consistently mentioned this lack of knowledge of disability and access as a reason for their experiences. It is not surprising that many of the general public hold the belief that all wheelchair users can walk if they need to. To develop an explanation of these issues, the perceptions held by accommodation managers about people with impairments are examined in Chapter 9.

The next level of access requirement is ground floor accommodation with level access. As one person states, ‘The percentage of ground floor accommodation with no steps is very small’ (Qn 2474 Pg 2276). Many hotels, motels and resorts have rooms with a single step into them with only the ‘disabled rooms’ being threshold free entry. Don suggests that this is more than a physical access issue, involving social consequences for people with impairments interacting with other guests:

...I think too few resorts provide good access. They may provide one or two rooms but that doesn’t allow you to get around the resort all that well. Why can’t all rooms within a resort be adaptable and at least visitable (Don Pg 407).

For example, Novotel Twin Waters Resort Coolum was built so golf buggies could be used to access all areas of the resort. This inadvertently produced a largely accessible resort based on the continuous pathway. However, of the 100 ground floor units only two are wheelchair accessible with the other 98 having a single threshold step entrance. This effectively makes the rooms unvisitable and unusable for wheelchair users. This limitation of access to designated *disabled facilities* means that guests with impairment have restricted social interaction with other guests.

The next criterion after level access involves ingress and egress from the room. The method of access to rooms requires little consideration by the non-disabled but can offer insurmountable issues of independence for people with impairments. Don’s experience highlights some of these issues for people with limited hand function:

Door heights or door handles are a real pain. As a person who has very limited hand

function, I find it difficult to operate those mini cards entry door locks...I have had to punch a hole in the top of the card and put a little bit of string through it so I can hook my finger in and whip it out. If they have got a lever handle door knob on the outside, I can get in...that's if the door closer isn't too heavy but even with the Crown Plaza Canberra, the inside door knob is round so I can't get out. Very smooth, satin finish and I've got to ring the porter to come and open the door when I want to get out of my room! *That's just bloody nonsense*, even then getting them to remove the door closer - the hotels won't do it. They insist on fire regulations and that makes it very hard (Don Pg 144-146).

Don's point also raises issues of conflicts between access and fire regulations. Once inside the room the next criteria is the organisation of space to maximise circulation. Many people related that they physically change the configuration of the room for their needs. This may involve removing furniture excess to their needs or changing the position of the bed. As Tim identifies, apart from the size of the room it depends what is in it and the group who he is travelling with where, '...I might want two single beds or a double' (Tim Pg 349-357). The detail of access requirements for rooms should not just be considered as an architectural issue. Rather, it is an issue of spatial use for people with impairments. This involves an understanding of designing rooms that accommodate use by people of all abilities. In Don's case, this involves a multitude of considerations to promote independent access:

Light switches at a reasonable height, wardrobes with hangers actually down at a reasonable level rather than six foot in the air, with long detachable coat hangers. I take my own coat hangers away because I can never get a coat hanger on and a table within the room that you can actually get to. I was delighted to see the Crown Plaza had taken out their previously low desk, a fixed desk, and put in a table that has 700mm clearance underneath so I was able to wheel in. That was a perfect height for me to access my meal or writing or doing whatever I needed to do there...I usually try and get a telephone with a longer cord so that I put that on the bed when I'm there on my own (Don Pg 160).

With these design issues incorporated, Don was able to independently use the room. For others, it involves modifying the height of the bed to allow access for people with mobility impairments (arthritis or back problems) or so the bed is at a height that is easy to transfer from a wheelchair. As Andrew suggests this can involve makeshift modifications where:

In fact we went to the Western Plains Zoo just before Christmas because I am a keen photographer, went with a couple of others from the camera club and I just said when we got there, 'Well the bed's a bit low. Can we pack it up on a few bricks?' Next thing the girl was out finding bricks and we packed it up. It wasn't any problem...(Andrew Pg 590).

Room and bathroom accessibility is critical not only for ease of maneuverability but because of personal care issues, the interaction with an attendant (if needed) and the equipment required for personal care. If personal care tasks cannot be carried out successfully and reliably then the tourism experience will not be possible. This level of accessibility then requires a greater level of communication with the intermediary or

accommodation provider:

My needs aren't that great but...I went to a friend's wedding up in Alice Springs at Lasseter's Casino, asked for a disabled room...but when I got there the door to the bathroom opened inward and it opened straight in onto the toilet. Once you got in there with a wheelchair, you couldn't shut it behind you because there wasn't enough room. You couldn't get onto the toilet so I had to get them to take the door off the bathroom just so I could use the bathroom and the shower...It was meant to be a disabled room. They were more than helpful and in the end it didn't wind up being a problem, but ...if you ask for a disabled room you expect to be able to go in and do your thing (Justin Pg 53-61).

There were literally hundreds of paragraphs highlighting individual needs of people. What emerged from this data was what constitutes access to accommodation. The most important access features and, hence, information requirements involve the dimensions and organisation of space at the establishments. Table 20 presents the accommodation access considerations.

Table 20: Accommodation access needs – general, room-specific & bathroom-specific

Accommodation General	Room-specific
<ul style="list-style-type: none"> • Parking; • Drop off points at reception; • Continuous pathways - * from parking or drop off throughout all hotel facilities and to the room; • Kerb ramps throughout grounds; • Door widths; • Door stops weight; • D type door handles; • Reception counter height • Assistance with luggage if required; • Table height in restaurants • Circulation space in corridor; • Circulation space in all rooms; • Access signage; • Directional signage; • High contrast surfaces; • Good lighting levels; • Appropriate hand rails; • Slip resistant surfaces; • No steps into rooms (<5mm); • 	<ul style="list-style-type: none"> • Uncluttered furniture layout; • Window position; • Location of cupboards, fridge, TV, clock radio, microwave, telephone, ironing equipment, air cons etc.; • Access to balconies; • Table heights; • Bed heights, circulation space; • Clearance under beds; • Access to room controls from bed;
	Bathroom-specific
	<ul style="list-style-type: none"> • Hobless roll in showers; • Lever taps; • Mirror location; • Hand basin positioning and bench space for toiletries; • Space under the hand basin; • Adequate shower chair or bench; • Location of handrails; • Toilet height and positioning (distance from walls and front clearance from obstructions); • Hand held shower hose and length of hose; • Non-slip floor surface; •

Source: thesis findings

This type of information was not available, was not provided accurately when requested or was misunderstood by the property managers. Inaccessible rooms and bathrooms result in experiences that are ‘soul-destroying, exhausting and you are left with the feeling “why did I bother?”’ (Qn 1291 Pg 991). The experiences create a cynicism about the general TI. A great deal of these experiences are because, ‘just so many do not know what is required as far as access’ (Qn 2576 Pg 2401). The remainder of this section provides specific detail about accommodation room accessibility.

Bathroom

There were many problems identified with access to accommodation ranging from minor access dilemmas, to the room not being wheelchair independent, to bathrooms not being accessible. Bathroom accessibility is critical and can effectively make the rooms unsuitable for people with mobility impairments. The most basic of these issues for people with mobility impairments is that a bathroom has a roll-in hobless shower for wheelchair or commode access. Again, there were communication problems between people with impairments and the accommodation providers as to what constitutes an accessible bathroom:

...For our honeymoon several years ago my wife (who is not disabled) rang some of the top hotels in Sydney and many did not hire rooms designed for use by disabled people. The Inter Continental Hotel said it did and we specifically checked three or four times to ask if the shower was accessible...when we arrived we discovered the shower was over the bathtub and they expected my wife to sit me on the bench they provided. We left... (Qn 2304 Pg 1916).

After a roll-in hobless shower has been secured, there are a number of other inclusions that constitute an accessible bathroom (Table 20). While not all people with impairments use all of the features, they are included to maximise use by the majority of individuals with impairments. The provision of these facilities needs to be incorporated with an understanding of the spatial use of bathrooms as highlighted in the following:

Hand rails are either poorly positioned or non-existent. I recently visited a country motel and took my own shower stool only to find I could not access the shower compartment because of the height of the hob at the entrance to the shower and the non-existence of hand rails which would have facilitated my entering the shower cubicle. Often, no shower stool or chair is provided and vanity units are too high to permit a person in a wheelchair to use them without making one hell of a mess or making a mess of themselves while washing or even cleaning teeth. My wife has regularly had to top and tail me because bathrooms have been inaccessible (Qn 458 Pg 356).

As this person expresses, the layout of the bathroom impacts on wheelchair users. What appears logical to the non-disabled becomes highly inappropriate to a wheelchair user. A wheelchair user requires a 1550mm turning circle, 750mm vertical leg clearance and 650mm horizontal leg clearance to use hand basins and vanity units. If these are positioned incorrectly, or if the door is swung the wrong way, then the spatial use of a bathroom is compromised. The toilet is the other area where major issues arise. For Don, this involved the use of a commode chair where, 'Certainly being able to get a shower commode chair over the toilet, so that you can actually use the loo' (Pg 149-153) is essential. However, too often toilets are outside of the standard height of 460-480mm and are unusable for commode users. The seriousness of this issue cannot be overstated and was an area of

noted distress. Don then needs to carry out the other essential tasks of self-care:

A roll in shower, a hand held hose, I need a sink that I can actually get my knees under, rather than having fascia boards underneath the sink and vanity so you can't wheel under the sink. Otherwise if I try and clean my teeth, have a wash, do what ever, I finish up getting my shirt and my trousers very wet... And I need the razor plug to be in an accessible position rather than over behind the sink or up too high (Don Pg 149-153).

Once people have undertaken their daily ablutions, they are free to explore the rest of the accommodation or destination.

Public facilities in hotels

Many people reported all types of public facilities in hotels being inaccessible. Kristy for example was excluded from the swimming pool, tennis and other recreational areas while her children and husband were involved in activities. Many of these experiences led to complaint cases where motel, hotel and caravan park facilities proved unsuitable for people with impairments even though the respondents had checked with the organisations during a booking process and prior to attending. These facilities included swimming pools, gyms, public toilets and conference facilities (HREOCCC 1995, 1997 and Jul-Dec 1999). In another complaint case, a female wheelchair user had been discriminated against because staff at a restaurant in a major Sydney hotel advised her that there were no accessible toilets and that she would have to go to another building. However, when the complaint was lodged it became apparent that there were accessible toilets at the hotel but on the car park level. This was a case where management had failed to communicate access information to front line staff. It also raises the issue of equality of access where the non-disabled had access to toilets in more appropriate locations than people with impairments (HREOCCC 1996).

Hotel approval processes

The issues to do with the built environment of accommodation go beyond the TI and involve the environmental planning and approval processes. A complaint case brought against a local consent authority occurred when a female wheelchair user noted that a motel that was recently completed did not comply with standard access requirements. She alleged that the consent authority had failed in its duty to adequately ensure access compliance. The complaint was conciliated with the consent authority advising that all access requirements had been rectified and that the consent authority would be more vigilant in the future (HREOCCC Jul 2000). A similar case involved a heritage-listed restaurant where local planning authorities thought that the heritage listing excluded

disability and access provisions. This was not the case (HREOCCC 1998). These are good examples where the owners of the buildings may have thought in all good faith that they complied with access regulations only to discover otherwise after completion of the development. This complaint cases reinforces the broader duty of consent authorities to comply to access requirements in the BCA, Australian Standards and the DDA.

People with impairments have used the DDA to halt hotel development where the design would have excluded people with impairments. While developers regarded the disruption to their plans as extraordinary, the outcome of such injunctions has ensured that the completed developments were available to all community members. This is far more effective and efficient than seeking remediation after development has been completed. Hundreds of complaints cases this involves a series of access issues – to the front entrance, the gaming room and lack of accessible toilet facilities (HREOC 2002a).

Remediation works are inefficient because they are more costly than if carried out when the development was first undertaken and are disruptive because of loss of business. From a disability perspective, the outcome of poor design and planning practice not only limits citizenship but can lead to physical harm. A woman with cerebral palsy, who is a wheelchair user, was joining friends at a hotel when she toppled down an internal step which was not signed and fell out of her wheelchair (HREOCCC Jul-Dec 1999). This case highlighted the relationship between access and safety as the individual was injured due to the poor access inclusions that had been approved by Council. For many people with impairments, this relationship with safety is implicit to their understanding of access. Without an accessible environment, people with impairments must risk unsafe practices to participate. These issues are also discussed in the transport section earlier in the chapter.

Volume, class, cost and location of accommodation

A series of interrelated issues involves the number of accessible rooms available, the class of accommodation, location and the cost of accommodation. Locating an accessible room is only one aspect of the issues that people with impairments face as ‘Usually it’s the expensive 4 and 5 star hotels/motels that have the facilities’ (Qn 1584 Pg 1227). The result of this is that, ‘Holiday costs for the disabled are increased because you have to book high priced accommodation’ (Qn 2474 Pg 2276). The reason that most accessible accommodation is found in the higher class of accommodation is due to a multiplicity of factors affecting the regulation of the built environment and the requirements for the

provision of inclusions for access and mobility. These are fully examined in Chapter 10. However, the outcome is the concentration of accessible accommodation in 4/5 star hotels:

I find that to get a good quality access room, particularly if you're staying for more than one night, you've got to go to at least a four star or five star facility. With the smaller motels and cheaper hotels, their access rooms are just not up to a standard that you could cope with for more than one night, so consequently you are paying a couple of hundred dollars rather than \$80-100 a double....You can't stay in caravan parks, so generally the cost of the accommodation is higher, and because you're in those sort of places, the cost of your meals is higher. (Don Pg 254).

The cost issue is compounded for those people who need to travel with attendants. This is because a second room is required and, hence, the accommodation cost of the trip is doubled. If a lower cost accommodation could be found, then the likelihood of travel increases for those with economic constraints, and the frequency and duration of travel may increase for those who already travel. Tim (Pg 449) identified that accommodation is the base from which you experience the destination and there is little sense on spending too much money on this part of travel if quality budget accessible accommodation can be found.

For a person with higher support needs who travels with an attendant, the intersection between accommodation and cost issues becomes critical as suggested earlier by the profile of accommodation use. However, the pattern of accommodation use is deceiving, as use and desire are different. If the choice of accommodation types for people with mobility impairments is restricted it affects the type of experience they can have, the frequency of experience and the kind of experiences that they desire:

I would like to travel more in Australia but to find accessible accommodation is time consuming and always more expensive. May be if caravan parks could have a few cabins with access - as well as cheaper units/flats houses - plus good access to water or a swimming pool (Qn 578 Pg 442).

Others have already attempted to expand their experiences but found that the access inclusions at other categories of accommodation are not appropriate for their requirements:

I find ground floor flats or motels are easiest for me. I have tried caravan parks but find not enough railing on the two steps of their cabins or else the steps on the caravans are just too high for anyone with disabled legs (Qn 863 Pg 690).

Even without the cost differentiation between the classes of accommodation, this situation creates a constraint of choice of accommodation type where, 'I can't backpack, I need high class hotels/motels with accessible rooms and amenities' (Qn 358 F 28 Muscular Dystrophy Full-time Work). She is articulating another form of discrimination that a non-

disabled woman would not be subjected to - the equality of provision of the class of accessible accommodation. Invariably, this restricts the type of social experience that she may otherwise have, as the psychographic of travellers staying in 4 to 5 star hotels is different to those staying at backpackers.

A number of people with impairments made observations about the relative location of rooms within establishments. In all cases, this involved the accessible rooms having the poorest location at establishments. For Tim this involved a 'big balls up' where:

All the rooms were supposed to have a view, and the accessible room had a view of the highway. So I had no sleep for the night...they only had two rooms on the highway side, the accessible rooms. All the other rooms had the view of the Perth city skyline looking over the river...they think that the answer is to put the accessible rooms farthest from the facilities, as they won't get many people to stay, and if they do, well (Tim Pg 405-413).

Hotel design has deliberately disadvantaged people with impairments in favour of the non-disabled when it comes to the quality of the location of accessible rooms. As Don states:

I don't know of a hotel access room I've been in other than the Crown Plaza, Terrigal that you actually got a view of the water, if you're near water that is. The one in the Novotel in Woolongong looks out over the air conditioning plant; the one in the Park Royal in Darling Harbour looks straight on to the office building next door... (Don Pg 425-426).

This is supported by John's exclamation, '...why are they the furthest away from the views? Why is it never their best room?!' (John Pg 1177). The other example given was the Park Hyatt, a premier hotel in Sydney known for its unobstructed views of Sydney Harbour and the Sydney Opera House. It has three 'disabled rooms'. None of these rooms has a Sydney Harbour or Sydney Opera House view instead they have a view of a rear roadway. Why would you stay in a premier location and take an accessible room without a view?

There have been a number of complaint cases brought before HREOC because of price differentiation between the costs of a standard room and an accessible room. A number of establishments were requiring an additional payment on top of the standard accommodation rates for hotel rooms and cabins on a cruise liner (HREOCCC 1995; 1997; 1997; 2001). In all cases, the organisations did not understand that this was a discriminatory practice. The outcomes involved changes to charging policies and incorporated a greater level of disability awareness within customer service training.

8.6 Constraints at the Destination

Once accessible accommodation has been secured, people with impairments can start to enjoy the tourism experience that most people take for granted. However, this assumes that the destination has accessible transport, built environment, attractions, day tours and all other considerations that contribute to an enjoyable tourism experience. These requirements to explore a destination intersect with the individual's desires and their needs to facilitate this experience. While these will vary for every individual, some commonalities underpin these experiences. Further, people with impairments face a commonality of constraints that prevents them from experiencing the full potential of a destination, as a non-disabled person can. This section reviews the common requirements and constraints people with impairments experience at destinations, under two headings: a. the destination experience; and b. customer service.

A. *The destination experience*

Tony was asked to summarise why he regarded a trip to Byron Bay as his peak tourism experience:

(The Wheel Resort)...it was beautiful. I reckon it was the best holiday that we ever had. It was totally accessible, number one, number two, its location was excellent. Byron Bay was a very desirable place to go and visit. Probably there was a little bit of salesmanship from the original owners, very, very good people, very easy to get on with...It was good that way (privacy) and I took my son up there at one stage too for a surfing trip and stayed there, so it's not a bad spot – it was quite easy to get around town. (Tony Pg 158-161).

Tony identified that the priority for this peak tourism experience was a sound accommodation base. For people with mobility impairments, any destination is secondary without this accommodation foundation. The destination cannot be experienced without accessible accommodation. In this case, *The Wheel Resort* (now known as the *Byron Bay Rainforest Retreat*) had built a reputation for providing people with impairments with quality accommodation set in a pleasant, private environment that also offered social opportunities. Central to the experience were two owner/managers who understood their markets and were 'very good people'. This involved an inclusive attitude towards people with impairments, gays and lesbians and people travelling with pets. The philosophy of the resort was that all cabins were built inclusive of access requirements, had a requisite level of privacy and that all people were welcomed with the same degree of congeniality. The resort was set on a property that offered wheelchair accessible tracks through the bush, a ramped pool with pool wheelchair, barbecue/socialising area and an accessible spa. The

resort offered a range of equipment (electric bed, hoist, commode chairs, shower chairs etc.) at no extra cost. This equipment would normally have to be taken to or hired at the destination (Section 8.7). With inclusive accommodation as a base people felt secure and able to explore the township and surrounding environs. It needs to be restated that before this can happen the information about the accommodation must be available with the requisite level and detail of information.

The other aspect of Byron Bay that made it appealing to people with mobility impairments was the general accessibility of the township. Tim's experience of Byron Bay involved:

...some of the contacts for taxis and transport, and what transport's available, town maps, where you can go for information...get a town map showing you the best route for the access...you could get around there pretty good...we went for a bit of a stroll along the beach there. It was nice (Pg 645-648).

This in itself shows the interrelationship of the role that information, the built environment, common domain and transport play in the accessible tourism experience. These interact to provide an enabling continuous journey for people with impairments or to create disabling journeys. In this case, the resort is located five minutes drive from the town centre but the resort had an accessible mini van available for guests. The local taxi service had two accessible taxis. Once at the town centre people were able to navigate the main strip, cultural/entertainment facilities, the Byron Bay Beach Hotel and the extensive beachfront park with barbecue facilities. These are the town centre's tourism attractors.

As discussed in the previous section, transport can have a major influence on destination choice. Firstly, many people would only go to destinations where they could drive their private vehicles. This geographically constrains destination choice dependent upon each individual's comfortable driving distance from their residence. This constraint was due to their perceptions of:

- the lack of accessibility or suitability of public transport to get to destinations;
- the lack of accessibility of destination transport; and
- fear of a hostile destination environment that lacked a continuous pathway of access.

The other component to the 'accessibility' of Byron Bay is the alternative social scene. Unlike some people's experience of boarding a plane and feeling like a freak in the circus, people with impairments may feel more accepted in a town where nothing is out of the ordinary and difference is accepted. The identifiers of impairment (e.g. guide dog, prosthesis, mobility aid, hearing aid, slurred speech or gait) become just another part of a

person's identity accepted along with the 'surfing' and 'feral' lifestyles that are signified through differing dress, hairstyle, tattoos, piercings, drug use and attitude.

Others like Don and June sought destinations where the accommodation - common domain - attraction nexus enabled them to utilise pedestrian access rather than rely on transport. 'We try and find a hotel or resort that's near places that we can access without having to get other transport...because we find that trying to organise cabs to do short trips...can be too expensive for a start, but also they may not even turn up (Don Pg 186-188)'. This is supported in the profile of transport used at destinations where wheelchair users had a higher reliance on pedestrian/wheelchair access at the destination than other users. The role that improved public transport may play in facilitating people with impairments to move around a destination could be tested by future research. However, it could be hypothesised that there is a difference between metropolitan and non-metropolitan areas. In Don and June's case, their needs were fulfilled through stays in Melbourne, Alice Springs and Terrigal (NSW central coast). The integrity of the experience that they sought was similar but varied due to the streetscape and the transport requirements.

What made Don and June's experience different was that they are members of the Holiday Inn Club and facilitate their experience through the corporation fulfilling their accommodation needs. Don had a chance telephone call from the Club annual membership at a time that he was organising their honeymoon. He had already obtained quotations direct from the Crown Plaza Terrigal as to the cost of a week's accommodation. By taking out membership he would receive substantial discounts on the rates he had already negotiated. The accessibility of the rooms had already been verified. For further trips he discussed their accommodation access needs with Holiday Inn and provided the general destination they wish to stay. Holiday Inn provided the closest accommodation to the destination. The loyalty to the corporation was established through a special membership offer that provides substantially discounted accommodation and discounted food eaten at the hotel restaurants. As Don states, '... they found the accessible hotel for me at a reasonable rate... I got a good rate there (Melbourne) I found the staff the facilities, its location and everything else was fantastic. Really worked well for me' (Pg 89-91).

The spatial organisation of destination has a major impact on people with impairments' enjoyment of tourism experiences. Once the attractions of a destination have been investigated, there is an expectation that people with impairments should be able to access

them. However, this is not always the case. As Annabel expresses, this is another of the ongoing sources of frustration:

...it is more the frustration of not being able to access a fantastic place, where there is a fantastic exhibition, and you simply can't get in because of your disability, because there is no access there for you. And you have to watch all the able bods being able to walk in and you just can't do it (Annabel Pg 481).

The reasons for attractions being inaccessible involve the spectrum of considerations covered by the environmental planning processes. These considerations are discussed in Chapter 10 and Appendix 9 identifies the essential inclusions for an accessible environment. Yet, Tim related an example about a trip to Cairns and his *death defying* ordeal in accessing the popular and tourism award winning Kuranda Skyrail where:

...I have gone to get into it, and they tip my chair back. I have got my front wheels on, I'm driving forward and, being a narrow doorway, it actually caught the control function (on the power wheelchair), and I've tipped back on a steep 25 degree angle. I couldn't control the control button and the gondola is still moving! So I've got the front wheels up on top of the gondola floor and it's moving, and I am stuck, and couldn't control the chair. Ohhh, like panic stations...What got me was, that won an award for tourism (Tim Pg 113-130).

Skyrail was the recipient of the best major attraction at the Australian tourism awards (1997) and the Queensland tourism awards (1997-99) (Skyrail Pty Ltd 2002). Yet, Tim's experience highlights a lack of inclusion of people with mobility impairments. The exclusionary practice could have been avoided through better design and an environmental planning process that was aware of disability and access issues. What makes this situation ironic was that Skyrail forms part of a day trip from Cairns via the Kuranda Rail that was built in the 1800s. The Kuranda Rail offers wheelchair access and Skyrail, which began operating in 1995, does not. These issues continually hinder people from the quintessential tourism experience that destinations offer for the non-disabled. The outcome of these situations means that people must continually negotiate access through compromise:

On our holidays we do not restrict our activities to things 'absolutely accessible' for the wheelchair. We have found people only too willing to help overcome access problems wherever possible - to the point of loading us onto a boat by fork lift as the ramp was too narrow, and organising accommodation that was accessible elsewhere when we enquired (Qn 646 Pg 514).

The *can do* attitude of both parties is to be commended. However, it should not be encouraged. As in the examples identified in the transport section earlier, this creates a risk for both parties. Operators need to appreciate that these design issues result in impacting on the independence of people with impairments by putting, 'the occupant through the embarrassment and inconvenience of someone having to help' (Qn 1853 Pg 1505). It is about not only independence and the desire to participate without assistance but the

experience of being treated differently. The difference in treatment in this case was firstly, the woman had to enter through a segregated entrance, and secondly, she was seated so that the pedestrian thoroughfare was obstructed. She had to duck and weave as non-disabled patrons tried to reach their seats. Thirdly, she was denied access to social spaces, refreshments and toilets unless accompanied by a staff member.

The above is an example of how the organisation of space is central to the experiences that people with impairments have in social settings. The same principles apply to the internal design of buildings, access in and around buildings, common domain areas surrounding buildings and the streetscapes that links these individual units together. An inhospitable environment places people with impairments at the mercy of an unforgiving and unthinking public. Beth and Annette's experience of a trip to the cinema illustrates this:

...They were the most selfish group of rotten people. They had all obviously decided that I was mentally deficient as well as being in the wheelchair...which really gives me the shits. And this woman said to Annette, 'Why don't you move the trolley out of the way so people can get by?' And Annette very bravely said, 'Look it is not a trolley, it's a wheelchair and my mother wanted to move out of the way for everybody, but the people moved too quickly and there is lots of space for you to get around'. And this woman said 'yes, but in single file and I'm with my family'. And I thought, how could people be so petty about things. A lot of people came by and they were very disgruntled and I decided that this was Double Bay, this is a lot of dissatisfied, silly people (Pg 459).

This experience of attending a cinema is one example that provides an insight into the nexus between the built environment, social attitudes and the lack of dignity afforded to people when these circumstances collide. The cinema was designed so that only one cinema had access provided for people with mobility impairments. Effectively, they are excluded from half of the shows, and unlike the non-disabled, must phone to check which cinema a particular movie is playing in. This does not take into account whether the cinema provides hearing loops or captioning for people with hearing impairments. Beth's experience of being referred to as *a trolley* was similar to Ben Elton's literary creation in *Gridlock* of Deborah, a wheelchair user, who was denied access to a pub as she would constitute a *fire hazard* (Elton 1991:141-157). It is far easier for people to depersonalise the constraints facing people with impairments and blame the individual for the obstruction than to recognise the discrimination of the system that produces disabling environments. In this case, the cinema has only level access to one cinema, has no integrated seating, hence, the only viewing position for a wheelchair user is located on the pedestrian access routes.

As already documented in the transportation section, major barriers to enhancing the

tourism experience are the lack of day trip operators and guided tours that are accessible for people with impairments. As one person stated, some of the major barriers are, ‘Not being able to join tour groups comprised of people without disabilities. Come on tourism authorities of Australia. Lift your game! What about a policy of inclusion? There is little point in being able to get to a major tourist centre and then not being able to join others aboard coaches to visit major attractions’ (Qn 2355 Pg 2158). Apart from the points raised in these observations, guided tours facilitate the interpretation of the destination features and greatly add to the experience that people get from understanding the natural or cultural heritage of an area. Yet, for people with impairments these options are not available as Jenny and John (Pg 73) explain:

I guess that sometimes if we were to think about going on a guided tour we would probably not think that’s a good idea. Because...you are not sure if they are going to accessible places and that turns you off actually investigating that option...if people who did do tours advertised that it was accessible or parts of it were accessible, that would help. If we hear that it’s accessible we will go and try it out.

If the commercial operators are not providing or promoting these opportunities then people with impairments must find their own activities to undertake while travelling. For some ‘it would be an absolute pleasure to be able to sit on a tourist bus and just look’ (Qn 901 Pg 714) while others want ‘walking tracks in the mountains designated wheelchair accessible such as near Govett’s Leap’ (Qn 2166 Pg 1752). However, it is discovering what is available to do in an area that many find frustrating. As one person suggested, ‘It makes one feel very welcome and accepted to find wheelchair parking available...a sign publicly displayed...’ (Qn 2166 Pg 1752). People want ‘information for everyday activities such as fishing and swimming would also be good’ (Qn 653 Pg 522). Tony’s solution is a one stop shop to find out where to stay and what there is to do that is accessible in an area:

So, if there was some way that I’m going to Cootamundra next Wednesday for work, I would love to know that at Cootamundra there’s a theme park and it’s accessible and the motel is totally accessible. Have some way of looking that up on the net... (Tony Pg 386).

This solution may alleviate some of the frustration found when trying to organise a variety of holiday experiences. In Kristy’s case, this involved not being able to see her children playing tennis at a resort:

We went up the Gold Coast last year with my children to a place that had a kids club. I wanted to see the kids play tennis and my husband and I wanted to have a big giggle but it was up a mountain of stairs, so I couldn’t possibly get up there. It never occurred to me that the tennis court would be up a mountain of stairs and *basically was excluded from access*...then we had to walk a long distance to get into the pool where we had to get up and down stairs. It can be that there’s a long way to go to get access to what you want to do (Kristy Pg 223).

Kristy wanted to share the experiences of a coastal holiday with her children and spent time, ‘trying to find information on hotels and the environments of places we are going that would make it suitable for us ...to function as a family. How far is it from the place you’re staying to the beach? Is it up a hill, down a hill?’ (Kristy Pg 68). Kristy’s need for information to plan activities was to enhance the family experience through providing an essential environmental focus of the trip. The solutions are far more complex when it comes to access to the natural environment. People with mobility disabilities have no less desire to experience the outdoors but there are conflicts between access and the environment (Griffin Dolon 2000). These tensions exist throughout the community where the national parks are managed primarily for conservation but with recreational use as a secondary objective. It is assumed that people with impairment may not wish to access the natural environment because of the nature of the terrain. This is dependent upon the abilities of the individual, the natural environment and the nature of access.

Technology has provided a way of regaining freedom and accessing environments that would otherwise remain inaccessible to them. Bill maintains his love of the bush through his use of a 4WD, ‘They mean a lot of things. They mean freedom, escape. I love the bush. My biggest problem is that I do not have the mobility to get out into the bush. That is why I have a 4WD...I love my 4WD’ (Bill Pg 54). The 4WD allows Bill to maintain contact with activities learnt in his childhood and to develop his relationship with his son. By being able to access natural environments Bill can pass on his love of the bush to his child in the same way that he learnt the activities from his father as a child. Yet, the National Parks and Wildlife Service does not take a disability perspective into account when it views issues surrounding access to natural areas by 4WD. These issues affect Bill’s access to national parks with his 4WD:

...but I find so many obstacles put in front of me through the State Government regarding access with 4WD...I rang and suggested several times that I would love a guided tour through a national park. You get a convoy of vehicles led by national parks. Commentary by CB radio, you get the local history and everything. I would love to do the Great Northern Road. But you speak to them about 4WD vehicles and they get the hackles up. Oh no, we have to look after bushland, the 4WD destroys our environment... (Bill Pg 54 and 377).

In other contexts, people with impairments wished to be involved in popular outdoor recreation activities. The facilitation of these activities requires basic interventions to access the outdoor experience. Yet, this was denied for some of our most popular pastimes:

I like fishing – salt water or fresh, and it is very difficult to ascertain beforehand whether there are spots suitable for a wheelchair. There are lots of good fishing areas on the coast

and inland but where do you find a spot to fish from in a wheelchair? (Qn 244 Pg 193).

The same situation exists with historical areas where access requirements may conflict with the need to maintain the authenticity of resource. While these situations create barriers for people with impairments, interaction with the cultural environment, lateral thinking and a positive attitude can enhance the experience:

It is frustrating that many places of historical interest etc. are not accessible but that is a penalty of being in a wheelchair and sometimes can't be helped. One thing you have to pack first is a sense of humour, the fact that you may not be able to see everything you would like and that sometimes others have to be your eyes through description and pictures (letter accompanying Qn Pg 2505).

Even when a destination's built environment, transport and attractions are universally accessible, customer service can affect the experience of people with impairments.

B. Customer service

Tourism is a service industry and respondents offered a range of insights into the quality of service that they have received. Language is a facilitator of tourism experience and a number of overseas travellers noted communication issues as a constraint to travelling in non-English speaking countries. This needs to be noted, as non-English speaking tourists with impairment would experience the same communication difficulties travelling in Australia. However, what many people observed as the most upsetting aspect of their experiences was 'people's ignorance is what hurts' (Qn 208 Pg 165). Simply, disability and access had not been considered within service provision. Andrew believes people with impairments need to state their needs and the TI will respond:

Well, they're in the service industry. That's the name of the game. You state what your needs are and it's up to them to provide them. I've had really positive experiences apart from the guy in Queensland who didn't want to give us the disabled room even though he had other accommodation available (Andrew Pg 584).

Customer service is also about the attitude staff have towards providing customer service and making people feel at home. Some people with impairments travel with personal care equipment and require modifications to the rooms. When staff are trained to accommodate people's needs, these requirements can easily be undertaken. A common requirement for people with mobility impairments is for bed heights to be adjusted for independent use:

A low bed makes it very difficult for transferring, even though I have got somebody helping me. It might be alright getting into the bed because you can go down...It is the getting out, because that person then has to stoop over much more, to lift higher to get you up into the chair. I did notice again that that hotel in Cairns, that if the bed height is not suitable then they chock it up for you...they are wonderful. They couldn't do enough to

help you in respect to making the room even more accessible. (Annabel Pg 299).

Yet, not everybody's customer service experience has been as positive as Annabel's. Many of the experiences documented identify customer service practices that would be deemed discriminatory under the DDA. The remainder of this section reviews the customer service issues of staff attitude, smoke free environments and assistance animals addressed in complaint cases brought before HREOC.

Staff attitude

In some instances the discrimination experienced by people with impairments was direct and unconscionable. There was the case of a man with burn scars, who had been told by staff in a shop that he was 'scaring other customers away', and to leave the shop (HREOCCC 1996). In other cases, it involves less favourable treatment where a person with a disability is not treated in the same manner as the non-disabled. One such complaint case was of a wheelchair user at a hotel where it was alleged that staff demanded he move from where they were sitting and provided them with less favourable treatment because of the disability. The complaint was settled without admission of liability when the respondent agreed to pay a sum of money, to write a letter of apology to each complainant and to submit an article on disability discrimination to the relevant TI journal (HREOCCC 1996).

White v Crown Casinos Ltd. [1995] raised the issue of refusing service to people with impairments because they appear intoxicated. White has an acquired brain injury (ABI) that affects his gait and speech, and makes him appear intoxicated when he is not. On two occasions he had difficulties entering the Casino. The Commissioner held that there was no direct discrimination because if a person without ABI had manifested the same symptoms as Mr. White, the Casino would have reacted in the same manner. This meant that no less favourable treatment would have been afforded to the non-disabled in similar circumstances due to the Casino having to comply with the Liquor Act and it had done so in a reasonable manner. In a similar complaint case, a woman with a speech impediment believed that she had been refused service at a club because her impairment made her appear intoxicated. In her case, even after she produced a doctor's letter explaining the situation service was still refused. In this case, conciliation led to the club apologising and arranged for provision and acceptance of a card authenticating the woman's impairment (HREOCCC Jul 2000). These cases highlight the need for disability awareness training for

customer service staff to recognise the inherent behaviour of impairment groups.

The equality of provision extends to tour companies where a number of complaints provide an insight into the requirements for an equality of experience. The first involved a guided tour experience where two Deaf people who were to attend a tourist adventure experience indicated that they required Auslan (Australian Sign Language) interpreting or a printed copy of the commentary provided (HREOCCC Oct 2000). This was not provided and an introductory video was not captioned. The tour company is now providing these inclusions and trialing a hearing loop on the tours.

Similarly, a Deaf person made approaches to a conference organiser stating their need for Auslan interpreters but was told the interpreters could not be provided. However, after the intervention of the NSW Anti-discrimination Commission, interpreters were organised for the duration of the conference (NSW Anti-Discrimination Board 2001a). People with high support needs or those with cognitive impairments sometimes require the assistance of attendants. A number of cases have highlighted the discrimination of charging the attendant to assist the person at conferences or events (Gregory 1999 and HREOCCC 1996).

For others, negotiating travel arrangements around their medical requirements involves intricate instructions. This process is compounded by staff attitude although they may be correct in their interpretation of the law. With a more diplomatic approach both parties would be in a better situation where:

I tried to explain to a senior staff member at Harvey World Travel my need to take up two place seats because of my stiffened legs. This travel agent told me that if the plane was not full, then I would be able to have two seats, but unless I wanted to pay for the extra seat, he could not assure me of the two seats. He curtly told me that he did not think this was discriminatory because other people often bought two plane seats - fat people for instance, and people who travel with large musical instruments (letter sent with questionnaire Pg 2507).

Smoke-free environments

A relatively new area of complaint cases has been for the establishment of smoke-free environments. People with respiratory conditions are unduly affected in smoking environments and a number of complaint cases have drawn media attention. *Francey and Meeuwissen v Hilton Hotels of Australia Pty Ltd [1997]*, where Francey and Meeuwissen were attending Julianna's Nightclub in the Sydney Hilton. After a stay of about three-quarters of an hour, they left the nightclub due to Meeuwissen being seriously affected by

environmental tobacco smoke. Discrimination was alleged on the grounds of Meeuwissen's disability, cystic fibrosis, which had led to a double lung transplant in 1994 and she still had asthmatic tendencies. The affects of environmental tobacco smoke are serious:

I started to wheeze and produce mucus. This doesn't happen these days unless there is environmental tobacco smoke...I felt pain and discomfort...When I started struggling to breathe I looked around and saw some women smoking. I went to the women's toilets fairly quickly because I hoped that it would be a safer place. I was feeling pretty distressed physically.

The Commissioner found that Francey and Meeuwissen had been discriminated against and that a finding of unjustifiable hardship could not be sustained. Compensation was paid to both parties. In relation to the remediation of the environmental tobacco smoke, a further inquiry was held, *Francey and Meeuwissen v Hilton Hotels of Australia Pty Ltd (Outcome)* [2000] where the Commissioner found that:

I conducted a public inquiry in an attempt to find a solution which would mean that the discrimination against the complainants did not continue. Essentially, this process was unsuccessful, as no viable method was proposed to prevent the impact of environmental tobacco smoke on the complainant.

The Commissioner found that it would be inappropriate to ban smoking from hotels. Concurrently and subsequently, a number of other complaints were raised about environmental tobacco smoke. Other complaint cases led to the Melbourne Cricket ground establishing smoke-free areas and facilities for asthmatics (HREOCCC 1995) and a shopping centre management establishing a total smoke-free centre (HREOCCC 1997). Another conciliation case identified that the installation of equipment for smokefree areas needs to then be used, maintained and policed. It was found that a club that had smoke removal systems and smoke-free areas had not correctly implemented them (HREOCCC 1997). The momentum of these cases has been carried forth by the anti-smoking lobby with the improvement of conditions for people with impairments as a by-product.

Assistance animals

An area of ongoing complaint is that of discriminating against people who use assistance animals. This was first tested in *Jennings v Lee* [1996] where Jennings was denied access into a restaurant because of her seeing-eye dog. A number of similar complaint cases have been heard over the ensuing years involving taxi services (HREOCCC 1996), restaurants (HREOCCC 1995), clubs/pubs/bars (HREOCCC Aug 2000) and public transport (NSW Anti-Discrimination Board 2001b). Three tourism specific cases are discussed.

Most non-disabled people are familiar with guide dogs used by the blind but the complaint cases suggest that they are not aware of the implications of Sec. 9 of the DDA. The first case involved a tour operator who refused to allow a man who was blind to be accompanied by his guide dog on a day tour. The operator argued that the tour and mini bus was not an appropriate place for an animal because of the lack of space and cramped conditions. The complaint was settled without admission of liability when the operator apologised, agreed to a change of policy to permit guide dogs in future and paid compensation (HREOCCC 1996).

These cases have become more complicated over the years as impairment groups other than blind people started to use assistance animals as hearing, companion and therapy animals. In *Brown v Birss Nominees Pty Ltd [1997]*, Brown was denied accommodation at a caravan park because he was a Deaf person who used a hearing dog. The caravan park owner had a rule that no animals were allowed there but was unaware that this could not extend to assistance animals. The impact of this type of incident should not be underestimated as, 'Mr. Brown gave evidence that he was most apprehensive about further travel as a result of these events, and that since September 1994 he has only travelled once'.

Similarly, a man with an intellectual disability was refused access to public transport with his therapy dog. The complainant further alleged harassment by other travellers and being scrutinised more closely by public transport staff than were other passengers. The outcome was that a letter was issued to the man by the public transport provider, explaining that the dog was able to travel with him on public transport. The public transport provider also reviewed their policy on companion and therapy animals accompanying passengers (NSW Anti-Discrimination Board 2001b; 2001a).

While the complaint cases in this section identify disability discrimination, many examples never reach hearings. This does not mean that disability discrimination is isolated in customer service provision. Many of the experiences documented in this research would be legally regarded as disability discrimination but people with impairments have not taken actions. This does not mean that the incidents are of no consequence to the individuals but is an indicator of a lack of knowledge or awareness of what constitutes disability discrimination. It may also be a conscious decision not to fight the complaint case because of the time, financial and emotional resources needed. In the end, everybody wants to be

treated fairly before the law. When this is done, people with impairments acknowledge the benefits that quality customer service has on their tourism experiences where, for example, ‘everyone had a smile for me and helped me. Bless their souls’ (Qn 1648 Pg 1275).

The exclusionary practices identified in this section involve considerations of whether the TI are being *politically correct* in their treatment of people with impairments (Ross 1994) and whether people with impairments are considered *appropriate other* for social consumption by non-disabled tourists (Urry 1990:141).

8.7 Other Constraints

In addition to the constraints already identified, people with impairments face a range of other constraints which are considered here. These are considered under four headings: a. impact of impairment and family relationships; b. personal attendant services; c. equipment and aids; and d. cost of travelling with an impairment.

A. Impact of impairment and family relationships

Section 8.2 identified the reasons for non-travel where the health related effects of impairment are a consideration. Yet, the isolation of impairment as a reason for non-travel is overly simplistic. Sections 7.1, 7.6 and 8.2 indicate that there are a number of significant influences on the likelihood of people with impairments engaging in tourism. However, there is a complexity to the interrelationships between these variables, the desire to travel and the offerings of the TI. While the interrelationships of these variables are complex, some people with acquired impairments interviewed recognise the impact of the impairment upon their previous travel patterns. This affects not only the individual but also the family group. As Kristy explains the evolution of her impairment has affected what she feels comfortable doing within the limits of her endurance. This in turn impacts on the choices open to the family in a tourism sense, ‘...we’d like to obviously extend that...my disability has been evolving and...everyone has kind of got in a grind because I’m not entirely sure what we are expecting all the time’ (Kristy Pg 351).

Their travel has been less adventurous than it may have been previously. Kristy’s experience of the routine of her impairment impacts upon taking risks and going beyond a known comfort zone. She hopes that when the health related effects of the impairment have stabilised she and the family will be able to undertake travel further afield. For other

people like Beth, just beginning to contemplate tourism as a person with an acquired impairment, there is a multitude of considerations involving a lack of knowledge and experience:

Well, it means bathrooms, hoists, that sort of thing. Lilianfel's (hotel) idea of what they call handicapped facilities was slow closing doors. And I thought I do not need a slow closing door. I need a hoist, to get out of my chair... We've got to hire a bus to get up there... it was 190 dollars a day, which is a lot of money. My mother doesn't drive anyway, so it wouldn't have worked. I suppose we could have got a taxi to the train, then got this other taxi to the hotel (Beth Pg 74).

This was very different to Kristy's experience of impairment-related constraint, in that almost every aspect Beth identified is a structural constraint. For people with recently acquired impairment, learning to live a new lifestyle has its own challenges before tourism can be considered. The role that impairment plays a role in family relationships also means a dislocation of the family tourism experiences that they used to share:

I haven't looked into travelling to any places... in the twelve months that I have been in the wheelchair... I have been getting to just operating at this level... Getting to the library, getting to the shops... concentrating on that... when a holiday came around my husband and kids went off on their own. But it was on a holiday that I perhaps wouldn't have enjoyed that much anyway. Because I don't ski, so I would have been sitting in some lodge somewhere getting fatter, eating and drinking (Beth Pg 62).

While Beth justifies the holiday as one that she 'wouldn't have enjoyed that much anyway' she recognises that this was a change to the family tourism patterns of the past. Beth's situation is set against a family history of extensive travel, 'We have done a lot of travelling... that last trip that we did, we went to Israel, Europe and America' (Beth Pg 29). Yet, this previous tourism experience also places a doubt in her mind as a person with an impairment because, 'In fact, I haven't ever seen a wheelchair on any of the flights that we have been on. I have never seen anybody disabled' (Beth Pg 29). While Beth discusses future plans she does not do so with any confidence:

...my youngest child Annette... has got three languages. She is very keen to go to Italy, and that was something that I had always hoped to be able to do, would be to travel with her. Now, I couldn't imagine doing that flight, which wouldn't be as enjoyable as when I was an able bodied person, with a wheelchair (Beth Pg 29).

Whether Beth will regain her confidence for tourism may depend on her early tourism experiences. This in turn will affect the dynamics of family holidays. As Beth describes, her tourism relationship with her husband Bruce has changed dramatically since her impairment:

It would be delightful to just go away with Bruce and we could certainly do with a break... Oh god it must be about three and half years. So we haven't even been alone. He does a lot of interstate travelling, and I used to do a few trips with him, which was fun, because I was usually free, and we would use frequent flyers. I would stay in a nice hotel

and I used to really enjoy that. But he feels apprehensive about doing all that now. He is not sure how it works, or that it would work. I am sure that it would (Beth Pg 699).

These interpersonal and family dynamics become further complicated the higher the support needs of the individual. For those who require assistance with personal services, this involves many considerations that the non-disabled and other people with impairments do not have to negotiate.

B. Personal attendant services

To preface this section, the terminology used by people with impairments in discussing personal attendant services included carers, helpers, nurses and attendants. These terms are used interchangeably in the section depending upon the terminology used by people with impairments. The use of attendants can involve activities such as getting in and out of bed, dressing and undressing, toileting, bathing, feeding and any other self-care issues required in daily living. Family, friends, partners, parents, voluntary organisations, service organisations, government home and community care programs (HACC), and private fee for service agencies can provide these services. The situation varies according to individual circumstances but is dependent upon the impairment, age, gender, cost and cultural background.

For people who are unable to travel independently, personal attendant issues are a major constraint to travelling. Without an attendant, the tourism experience can not take place. However, travelling with an attendant creates a range of other considerations. At the very least, there is the need to pre-plan and organise travel with another person or organise this assistance at the destination. If the attendant is not a friend or family member, there is the added cost of hiring an attendant for the desired hours or for the trip. This situation is critical as evidenced by the following statement, 'I would travel more if I could have an attendant travel with me - feelings of security. The cost of paying for such wages on top of their travel costs, accommodation etc. would be prohibitive' (Qn 158 Male 41). In this case, the cost issue is balanced with the psychological security offered by travelling with an attendant.

If an attendant is unable to travel with the person then attendants must be organised to be available at the destination. This creates its own problems. Firstly, can attendants be hired at the destination for the type of service and for the times needed? Secondly, with

unfamiliar attendants there is a question as to their suitability for the duties required. This is due to the personal nature of attendant services. People with impairments become anxious about taking 'pot luck' hiring attendants at destinations. An inappropriate attendant can physically or psychologically ruin the tourism experience. Finding suitably proficient attendants is only the first step for many people requiring these services. The technical proficiency must then be matched with finding attendants appropriate to the individual situation. This includes issues related to skills, age, temperament and discretion. These are all considerations when living with a person for 24 hours a day, and for the duration of the trip. As one person noted, 'Holidays are only as good as the carer that is in attendance' (Qn 408 Pg 324 Male 30).

In the worst case scenario, people with impairments can be physically and sexually abused by the people that they hire to assist with their personal attendant needs. In the case of Don, this involved sexual assault while on an overseas trip, many thousands of kilometres from home:

...I had one instance where a carer tried to sexually abuse me. I wear a uridome (external male catheter) and needed that changed. He started interfering with me in the process... I told him to leave and rang the agency immediately, told them he was a pervert, a creep and that I didn't want to see him again. He said he was coming the next morning and they agreed to get rid of him and provided another carer who turned up that next morning. Max the creep turned up as well and insisted on coming into the room, which Greg the new attendant wouldn't let him. ...It was very awkward, you're vulnerable when you travel particularly because you do not know who's coming into your room. (Don Pg 116).

Don's situation highlights the vulnerability of people requiring these services, whether they are in their home environment or travelling. As can be imagined for a person who has had these experiences in the past it would become a major constraint to travel in the future. At the very least Don and people like him would be highly anxious as to the likely assistance that they had planned on receiving in an area. This expectation could only be alleviated upon meeting the individual attendant and ascertaining their suitability.

The economic cost of attendants involves both the direct costs (hire of the person on an hourly, daily or weekly basis) and the indirect costs (petrol, airfares, accommodation, meals etc.). As another person noted:

The problems encountered in travel for people with disabilities are primarily the cost. The person with the disability who lives in an institution pays the accommodation costs of themselves, the costs of the carer, the wages of the carer and for all food and entertainment. This is unfair. (Qn 1886 Male 19).

Because of these difficulties, many people have to rely on family and friends for any sort

of holiday. This creates its own problems and dependencies. For some the reliance on family, the perception of the constraints that is encountered while travelling and the assistance required means that they decide not to travel. As one person states, 'I hate to be a burden on my family, asking for assistance so I stay at home' (Qn 2347 Pg 1976). For others it involves a search for their own identity that comes with developing and exploring their independence where, 'I travel only with family and would like to travel more but with attendants about my own age and not always with family' (Qn 1815 Female 23).

Yet, many people would be unable to travel if they had to negotiate attendant care on a commercial basis. Without the commercial hiring of attendants, the interpersonal dynamics of managing friendships must be incorporated into travel planning. For Annabel this has involved an ongoing friendship and long term tourism partnership:

I have never done it on a professional basis. The attendant that goes with me is a personal friend. We do not look for me to pay for her to accompany me on the basis of a daily payment. What I do is pay airfares, and things like that. She may contribute towards the hotel expenses. When we go out on touristy things, she will pay her way and I will pay my way. So it is more on a friendship...it reduces the costs... because I have to be honest with you. *I doubt if I could afford to go if I have to go for a full time attendant* (Annabel Pg 371-375).

For others, all these issues are interrelated where availability and cost lead to an uncomfortable reliance and the intrusion on friendships that is exacerbated by this situation:

Probably the most difficult barrier for me to go away is finding an attendant/carer. Family and friends are not suitable and Home Care is not available overnight. If a friend does come away with us, we feel like we have to pay for their trip as well as finding some way of giving them wages! It is so expensive to pay double price, but difficult if you do not pay for them because you feel like a burden. My partner is also severely disabled and we are currently planning our honeymoon - we cannot find any scheme or organisation which would assist us with carers so we can go away (Qn 965 Pg 771 Female 25).

This quotation also recognises the inflexibility of current HACC options. These have been further accentuated with the policy and budgetary contraction for respite care, the loss of use of Home Care staff for trips away, and the lack of places available for the Commonwealth funded attendant care programs. Jenny finds the situation frustrating and suggests that there needs to be greater flexibility in the way that personal care is delivered:

Over the last few years, Home Care have become so much more restrictive. We had a Home Carer who was casual and we were going to go away for three days. She was willing to come with us, and could she just be paid that amount of hours that she would have been paid normally, but just do it at the South Coast rather than here? No, no! They are not flexible or innovative (Jenny Pg 299).

Even without these policy issues, negotiating an attendant to travel with a person involves a whole series of issues as Jenny identifies:

We negotiate with carers who are available to travel. Which is a big deal in itself, because most people either have families, have commitments, have boyfriends, have a whole range of things. Do not have enough money, or time, or just feel funny about going away with us...We can pay you this amount of hours through Attendant Care, and we can work it out that way... Then other times it has just been friends that have gone away with us. But that is usually for quite a limited time, because it is quite hard for friends to have them being a carer and a friend. That is a really big issue for us (Jenny Pg 243-255).

Once this component of the trip has been negotiated there is still no guarantee that the attendant will fit in to the individual's requirements. 'We want a holiday and we don't want to be entertaining our carers and we have gone away with people who were not relaxed enough' (John Pg 265) and, hence, the experience was less than satisfying. As Jenny observes, 'you tend to find out some things that you do not know about people before you go away, and that becomes an issue' (Jenny Pg 277). While Jenny and John both have impairments and their own personal histories of attendant issues, having a third person involved on a trip provides another consideration when one member of a couple involved is non-disabled.

As a person who has recently acquired her impairment, Beth's need to organise personal care has become a dynamic that must be managed with her relationship. Apart from her own needs for privacy Beth must consider her relationship with her husband, 'I would find a third person rather intrusive. Organising that side of it daunts me and I think, Oh God, that's a real headache, if you got to find somebody you hope that they will understand your problems' (Beth Pg 679). Beth's desire for tourism and need for a personal attendant must be balanced with her husband's need for privacy. At this point in her adjustment to living with a spinal cord injury, the situation has been too difficult to contemplate.

The non-disabled can have no understanding of this aspect of travelling with a disability.

C. Equipment and aids

Equipment needs are based on the impairment and support needs. The logistical considerations when preparing for a trip involve judgments as to what equipment needs to be taken with people to the destination region. Determining the availability of equipment for use or for hire at destinations is a major issue in making these decisions. If people are unsure as to the availability of equipment at destination regions, then they are left with

three options: do not travel; take all the equipment on the trip; and/or stay at establishments that supply equipment. Many people noted that if a reliable system of equipment loan/hire was in place at destinations, this would offer people a greater freedom to travel. Yet, hiring equipment at the destination is another added cost and is not appropriate for people with customised items. The major equipment and aid needs are:

- | | |
|-------------------------|--|
| • Wheelchairs; | • Scooters; |
| • Hoists/Lifters; | • Battery chargers; |
| • Monkey bar (for bed); | • Electric beds; |
| • Bed raisers; | • Portable ramps; |
| • Commodes; | • Shower chair; |
| • Raised toilet seat; | • Monkey bars |
| • Assistance animals; | • Audible signals; |
| • Hearing loops; | • Visual signals; and |
| • TTY; | • Respiratory equipment (nebulisers/oxygen) |

Source: thesis findings

Taking equipment requires greater planning, space, reliance on private vehicles (for some) or organisation with carriers. This has implications for the mode of transport, distance to the destination, appropriateness of accommodation and attendant care issues. As one person suggests, it is little wonder some people do not travel at all:

You don't leave home as you would need at least a trailer to take all you need: hoists, commode chair; chair recharger, night bottles; day bags; domes; milton, medication; clothes, someone to load/unload, park all of the above, shop, cut up food, give enemas, wipe bum, shower, wash and dry, put uridome on properly so it doesn't leak, dress on bed, put in chair, pull out creases in pants, strap feet on footplates, do hair, see that you don't fall out of chair for the day and put back to bed at night. Repeat the same again tomorrow. *Why would you want to leave home to do that elsewhere?* (Qn 436 Pg 344 Male 33).

D. Cost of travelling with an impairment

All sections in this chapter have identified the extra costs attributable to travelling with an impairment. The single greatest extra cost is where people with higher support needs require an attendant. Attendant needs occur throughout the tourism experience and are compounded where people also need to travel with equipment. These extra costs occur on top of the economic constraints faced by the group. The extra costs are further extenuated by the institutional discrimination within TA and the TI. This is due to the lack of understanding of disability and access issues and the subsequent exclusion of these people from discounted packaged trips. Table 21 categorises and summarises the extra costs.

Table 21: Extra costs of travelling as a person with an impairment

Category	Explanation
Attendant	<ul style="list-style-type: none">• to travel with people with impairments who are unable to travel independently• doubles accommodation• doubles air travel• sustenance allowance• wages (on costs – insurance, superannuation etc.)
Transport	<ul style="list-style-type: none">• use of paratransit systems where public transport was inaccessible• extra air ticket where attendant was required• extra tickets when disability requires additional seating• use of paratransit systems where commercial tours are inaccessible
Accommodation	<ul style="list-style-type: none">• higher class accommodation to obtain accessible rooms• budget rooms not available
Products on offer	<ul style="list-style-type: none">• can not access cheaper packaged product due to access considerations• higher price accommodation and transport where not packaged
Equipment	<ul style="list-style-type: none">• hire at destination
General	<ul style="list-style-type: none">• higher meal costs when staying at higher class accommodation
Attractions	<ul style="list-style-type: none">• payment for attendant where ticket policy not compliant to DDA

Source: thesis findings

8.8 Ending

This chapter has presented the tourism experiences of people with impairments from the perspective of the social model of disability and utilising the framework of leisure constraints theory and the tourism system model. It has focussed on the interaction between demand and supply - Components A and C of the theoretical framework - and has begun to provide answers to a number of the research questions. These are discussed in turn below.

Are people with impairments constrained in their tourism patterns and experiences compared with the non-disabled? (RQ1)

The qualitative findings of this chapter together with the quantitative findings of Chapter 7, show the levels of tourism participation of people with impairments in Australia differ significantly from those of the non-disabled, due to a range of additional constraints faced.

Nature of the constraints faced at each stage of the tourism system (RQ 1a) and their categorisation (RQ1b)

The constraints identified at each stage of the tourism system are presented in Table 22. Table 22 draws together three frameworks: Smith's leisure-travel barriers of tourists with disabilities; leisure constraint categorisations; and the tourism system. Chapter 11 discusses a reconceptualisation of tourism constraint categorisations that incorporates Smith and leisure constraint categorisations, in light of social model theory. Table 22 predominantly highlights that, while some constraints are encountered at specific stages

only, many are experienced in all three stages of the tourism system.

It is also clear that the majority of the constraints faced by people with impairments over and above those faced by the non-disabled are structural. Hence, it can reasonably be concluded that the difference in tourism patterns is brought about primarily by the social relations of tourism and the *disabling tourism environments* created for people with impairments. This is apparent with each of the considerations where destination choice is not a product of tourism desire but an outcome of accessible tourism information, accessible and dignified transport and availability of accessible rooms.

Table 22: Summary of tourism constraints from Chapter 8

CATEGORY (Intrinsic) (Smith 1987)	CONSTRAINTS EVIDENCE FROM THIS THESIS INTRAPERSONAL	TOURIISM SYSTEM		
		TGR	TRANS	TDR
Lack of knowledge	<ul style="list-style-type: none"> • Significant constraint for non-travellers or with recently acquired disabilities • Similarly, for associates or service providers who organise trips 	✓ ✓	✓ ✓	✓ ✓
Health related problems	<ul style="list-style-type: none"> • The industry doesn't recognise the difference between disability and illness • Inflexible booking arrangements to minimise pain and discomfort • Lack of temperature controlled environments 	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Physical and psychological dependency	<ul style="list-style-type: none"> • Reliance on full time carers or attendants (see also of attendant care programs) • Dependency on monopolised personal care and paratransit services 	✓ ✓	✓	✓ ✓
(Communication)	INTERPERSONAL			
Skill-challenge incongruities	<ul style="list-style-type: none"> • TI assumptions of ability limited pwd choices of what was offered. • Risk involved in participating due to lack of access to environments 	✓	✓ ✓	✓ ✓
Communication	<ul style="list-style-type: none"> • Non-disabled aversion to communicating with people with disabilities • Attendants as communication facilitators • Disability as an <i>appropriate other</i> to be gazed upon 	✓ ✓	✓ ✓ ✓	✓ ✓ ✓
(Environmental)	STRUCTURAL			
Lack of information	<ul style="list-style-type: none"> • All dimensions of access, accuracy, detail, presentation and format • Complexity of operationalising the above • Discourses of access creates a different meanings for individuals 	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Organisation communication of access	<ul style="list-style-type: none"> • Communication of tourism access information to staff at all levels of organisations • Inclusion of tourism access information in generic marketing/target marketing • Dimension of access, particularly vision, hearing, cognitive or psychiatric • Provision of alternative communication technology and formats 	✓ ✓ ✓	✓ ✓ ✓	✓ ✓ ✓
Economic circumstance	<ul style="list-style-type: none"> • Economic constraints disadvantaged a disproportionate number of people • Affects ability to travel but also the frequency, duration and choice of trip. 	✓ ✓	✓ ✓	✓ ✓
Cost	<ul style="list-style-type: none"> • Double cost for those travelling with an attendant • Accommodation due to accessible rooms only available in higher class • Paratransit systems are more expensive than public transport • Equipment hire (commode, hoist etc.) 	✓	✓ ✓	✓ ✓ ✓
Attendant care	<ul style="list-style-type: none"> • Resources and flexibility of HACC programs away from residence • Availability of attendants • Suitability of attendants for the individual 	✓ ✓	✓ ✓	✓ ✓ ✓

(Environmental)	STRUCTURAL (continued)			
Socio-spatial =	<ul style="list-style-type: none"> • Destination – Sum of architectural, ecological, transport, attitudinal and rules & regulations 			
<i>Attitudinal</i> +	<ul style="list-style-type: none"> • Customer service exclusion through non-provision • Customer service exclusion through inappropriate language use and unfair treatment • Assumptions about abilities of travellers with disabilities; • Attitudinal exclusion = segregated tourism experience; 	✓	✓	✓
<i>Ecological</i> +	<ul style="list-style-type: none"> • Destination accessibility (see Architectural & Appendix 9) • Access to area attractions/activities/services/natural areas • Independent and dignified spatial use • Linkages between transport, the natural and built environments. 		✓	✓
<i>Architectural</i> +	<ul style="list-style-type: none"> • Basics of parking, toilets and a continuous pathway were absent (Appendix 9) • Finding appropriate accommodation • Bedroom and bathroom requirements as foundation components to tourism • Access to other areas of hotel • Discourses of access of accommodation – equality of provision 	✓	✓	✓
<i>Transport</i> +	<ul style="list-style-type: none"> • Lack of accessible public transport provision • Available class of transport provision • Heavier reliance on private motor vehicles & paratransit as mode of transport • Lack of day tour operations (coach, rail & watercraft) result in segregated experiences 	✓	✓	✓
<i>Rules and regulations</i>	<ul style="list-style-type: none"> • Relevant environmental planning legislation not implemented correctly • Results in the <i>nuisance or fire hazard</i> interaction of pwd and the non-disabled • Aircraft access regulated through international agreements 	✓	✓	✓
Air transport	<ul style="list-style-type: none"> • Airline information management of the needs of people with disabilities; • Loss of travel independence and dignity through boarding procedures; • Seating location and retractable arms; • Personal care issues and lack of accessible toilets; • Equipment handling and damage on flights; and • Ground staff awareness and OH&S training. 		✓	✓

Source: thesis findings

How are constraints negotiated? (RQ 1d)

At the TGR in the planning stage, people expressed a frustration with trying to find the tourism access information they required to make informed decisions about the suitability of transport, accommodation and the destination region. This involved firstly the lack of access information within generic sources. Secondly, the detail, quality, reliability and presentation of available information were poor. People did not use retail travel agents due to previous problems experienced or because travel agents had rejected people with impairments as customers. This resulted in people being forced to rely on word of mouth or family and friends for information. Only when this had been done could they feel confident in their planning. The result of these experiences was an emotional exhaustion, as people had to alternate from one information source to another in trying to satisfy their tourism access information needs about transport, accommodation and destinations. In particular, wheelchair users could not proceed without information about the accessibility of accommodation. The situation was compounded by the different understandings of access by the individual, the TI and TA. The tourism access information constraints, added to the retail travel agents' exclusionary practices, culminated in people with impairments being unable to access the economic discounts of packaged tours.

In transit, the lack of accessible public transport severely constrained tourism opportunities to, from and at destinations. Many travellers noted that all forms of public transport are so problematic that they restrict their travel to destinations where they can drive. Their reasons for driving included a greater sense of control, being able to travel with their equipment and the dignity that driving provided to the transit experience. Leaving mainstream public transport aside, the disabling aircraft environment created a loss of independence and dignity due to the embarking and disembarking procedures that were dictated by aircraft design and international air safety legislation. This led to people expressing a sense of helplessness until they were reinstated to their independent embodiments (wheelchair, scooter, assistance animals etc.). For a proportion of people this did not occur, as their equipment was damaged or lost in transit. The loss of dignity, independence and sense of helplessness continued until the situation could be rectified. In the worse cases, their tourism experience could not continue and they returned to the generating region. The outcome of these transport constraints affects the ability of some to participate because of the costs associated with using paratransit systems and because there are restricted tourism options to destinations accessible by car.

Upon arrival at a TDR, people were decidedly anxious as to the accessibility of their accommodation. For a significant proportion of people, their access expectations were not met due to the multiplicity of meanings ascribed to access. The outcome was ‘soul-destroying, exhausting and you are left with the feeling “why did I bother”’ (Qn 1291 Pg 991). All this occurred before destination experiences could take place. For some people their tourism experiences ended at the inaccessible accommodation and they returned to the TGR because alternative accessible accommodation could not be found. The accommodation constraints affect people with mobility impairments to a greater degree than other impairments due to the spatial requirements for wheelchair circulation and, in particular, roll-in hobless showers.

If these constraints were negotiated, the destination experience involved a complex interaction between the built and natural environments, and tourism services that enable or disable tourists with impairments. These *socio-spatial* components of citizenship involve far more than access to the built environment and involve social interaction through the availability of inclusive tours and customer service behaviour. Without all these components to citizenship, the essence of the destination experience is lost. In these cases, people with impairments merely visited an area rather than experiencing the sense of place. They were disabled by the constraints encountered. Once ready to explore destinations, people exhibited a pragmatic *can do* attitude to constraint negotiation. This involved recognition that the destination would not be perfect and they sought to negotiate the constraints as they arose. Yet, for other people the need for assistance was embarrassing and disempowering. For many, this led to a loss of enjoyment where their participation was constrained and, hence, was substantially different to the non-disabled.

All the preceding constraints have significant implications for tourism decision making and destination choice processes for the group (Woodside and Lysonski 1989; Witt and Wright 1992; Jenkins 1999). The outcomes of these experiences were that a proportion of people with impairments decided that tourism was far too daunting to undertake and they did not progress past attempting to negotiate planning their tourism experience. For others there was recognition that their experiences were substantially different to the non-disabled, which led to a sense of ongoing frustration. The result of these feelings for some people was that they can no longer ‘take it on the chin’, that the constraints encountered were overwhelming, and that they decided not to travel again. Many others related that their

experiences have meant that they will only visit those places that they have visited before and found satisfactory. They no longer have the desire to seek new destinations and experiences as they wish to avoid the possibility of encountering disabling tourism constraints.

For those who continue to negotiate the tourism constraints there was a general sense of foreboding and anxiety as to what they would experience at the different stages of tourism. This is very different to the natural expectation experienced by the non-disabled before a trip. For people with impairments these feelings of anxiety exist on top of feelings of expectation. This anxiety is felt every day of their trip as they anticipate the likely constraints that they may face as they seek new experiences. Yet, despite these negative experiences, the opportunities tourism offers people with impairments are considered by most to be worth continuing to pursue. They do so by negotiating their tourism experiences around the constraints that they encounter.

This chapter and the level of tourism participation identified in Chapter 7 have shown that the experiences of people with impairments are substantially different to the non-disabled. In all facets of tourism, people with impairments are not provided with an equality of service provision and, as the HREOC cases show, are discriminated against in a tourism context. This is due to a series of omissions by the TI. The outcome of this situation is that people with impairments must expend time and energy negotiating tourism constraints to ensure that their trip has a greater probability of success. This negotiation occurs at each stage of the tourism system and at each new experience sought. This list of constraints is not encountered by the non-disabled as they have their needs met by the TA and TI. From the evidence presented, a five-category typology of tourists with impairments emerged:

1. Those who have never considered undertaking a tourism trip because they perceive their impairment as too great an intrapersonal constraint to travel;
2. Those who have never considered undertaking a tourism trip because they perceive the intrapersonal and structural constraints as too great a barrier;
3. Those who have undertaken tourism trips but no longer do so because of the intrapersonal and structural constraints that they encountered in the past;
4. Those who continue to undertake tourism trips but no longer seek new tourism experiences because of the structural constraints that they encountered in the past; and
5. Those who continue to seek new tourism experiences and negotiate the constraints as they arise.

The social relations which produce tourism constraints (RQ1d)

The social relations – economic, ideological, professional and cultural relationships and

practices - that give rise particularly to the structural constraints listed above are the focus of Chapters 9 and 10.

Implications of the findings for the functionality of the tourism systems model (RQ1e)

Based on the findings of this research, three conclusions may be drawn about the functionality of the tourism system model.

First, the typical presentation of the tourism system in the literature *implies* that the system functions smoothly. The tourism literature is in fact replete with examples of ‘non-functionality’ of the tourism system, including problems to do with environmental impacts and sustainability, social impacts, customer service issues and tourism-related crime, but these are generally not discussed in the context of the tourism systems model. The idea that identifiable groups of travellers or potential travellers might be routinely frustrated and denied adequate services has been considered in relation to lone women travellers, but is generally alien to the philosophy of a smoothly functional tourism system. This research suggests that the value of the tourism system model would be enhanced if it were used as a framework for considering not only how the tourism process *works* but also in what ways it does *not* work, and why.

The second conclusion that might be drawn concerning the tourism system model is a development of the first, namely that the model does not represent the ‘non-tourist’ – that is, the would-be traveller who, for a variety of reasons, is denied the opportunity to travel. In cognate disciplines and fields of study such as economics and leisure studies, unmet demand or non-participation play an important theoretical or policy role, but this is not the case in tourism studies and the tourism systems model in particular.

The third conclusion is that, in concentrating on the spatial dimension of tourism, the tourism system model fails to represent the *actors* in the system – particularly the consumers and the providers of tourism services.

The three conclusions reinforce the dysfunctional nature of the tourism system for including the requirements of people with impairments. This was highlighted in this chapter by not only their experiences but also the examples of disability discrimination documented in the HREOC complaint cases. The tourism system has failed to be inclusive of people with impairments.

The effects of impairment and socio-demographic characteristics (RQ 2)

The findings of this chapter built upon the quantitative findings of Chapter 7 and revealed that of those who do not travel, a small proportion regards their impairment as an intrapersonal and interpersonal constraint to travel. However, as Section 8.2 reveals, impairment is generally closely intertwined with other socio-demographic characteristics. As the experiences of people with impairments reveal, what many regard as intrapersonal or interpersonal constraints, are structural constraints when analysed through the social model of disability. In a sense, these people had taken on a medical model worldview, blaming their impairments for the structural constraints imposed by a *disabling society*. This was particularly so of those denied employment opportunity, where the greatest inhibitor to tourism was economic constraint and not the nature of their impairment. With *enabling tourism practices*, most of these people could have participated in tourism.

Implications for the social model of disability (RQ 2a)

The implications for social model of disability are that agency and structure are closely related and need to be considered in relation to each other to develop the social model as a theory. This is necessary for understanding the complexity of the impairment/disability relationship or as Shakespeare and Watson (2001) prefer, the *impairment/disability continuum*.

9 FINDINGS III: TOURISM AUTHORITIES AND ACCOMMODATION SECTOR PRACTICE

9.1 Introduction

The aim of this chapter is to examine the policies and practices of the tourism industry (TI) and the Commonwealth and state tourism authorities (TA), which collectively constitute the supply side of the tourism system (Component B in the theoretical framework shown in Figure 6), and to explore how they relate to and shape the tourism demand/supply process as it affects people with impairments. In addition it considers the extent to which the regulatory measures of government, and their human rights principles (Component C in the theoretical framework) impact on the actors on supply side of the tourism process, notable the TA and TI. Specifically, the chapter addresses the research questions which are concerned with the responses of the TA and TI towards people with impairments as actual and potential customers (Research questions 3, 3a-b) and what such responses tell us about TA and TI policies, practices and philosophies.

The chapter also considers the fourth group of research questions outlined in Chapter 5. These are concerned with: the human rights-based regulatory environment and the evidence which its operation offers in relation to the tourism experiences of people with disabilities (RQ 4); identifying discriminatory practices revealed by the processes (RQ 4a); identifying the omissions and practices of the TA and TI (RQ 4b); assessing the influence of the DDA on the practices and discourses of the TA and TI (RQ 4c); the influences of 'other mechanisms' of the DDA (RQ 4d); and the extent to which this evidence offers an explanation for the tourism experiences of people with impairments (RQ 4e).

Chapters 7 and 8 identified the range of constraints affecting the tourism experiences of people with impairments. Two areas of TA and TI practice that gave rise to a number of constraints were identified for examination in this chapter. The first involves the market research, information provision and marketing practices of TA, which tend to act on behalf of the tourism sector as a whole. The second is the all-important accommodation sector that has been identified as a particularly critical facilitator for people with disabilities.

The marketing activities of the TA and the practices of the accommodation sector were selected because of their importance to people with impairments, as established in earlier chapters, and because they have been relatively neglected in existing research. Other

aspects of industry practice which merit consideration includes customer service attitudes, transport and the environmental planning frameworks that affect the built environment. While customer service attitudes are an important issue, other research has previously examined aspects of this issue (Ross 1994; Daruwalla 1999). Transport is not solely the responsibility of the TI and involves the complexity of government and private sector provision, meriting a study in its own right. Similarly, environmental planning frameworks, while clearly affecting tourism destination experiences, involve more than just tourism considerations and are the responsibility of local authorities through state environmental planning frameworks. However, the environmental planning framework is reviewed to some extent here and in Chapter 10 in the context of the regulation and control of the accommodation sector.

The chapter considers first the Commonwealth and state TA tourism initiatives, then responses of the accommodation sector to the needs and demands of people with disabilities and, lastly, the regulatory processes and industry responses.

9.2 Tourism authorities (TA) disability tourism initiatives

The issues that emerged in Chapters 7 and 8 reinforced the Chapter 4 conclusion that people with disabilities have been overlooked as a 'market segment' by the TA. The result is that many of the critical components available to other market segments to plan their trips and required by the TI to develop product are absent for people with disabilities. This resulted in the deficiencies experienced by people with disabilities in trying to plan their trips and their subsequent tourism experiences. As discussed in Chapter 4, governments have historically led the TI in Australia by coordinating tourism marketing through the TA (Hall 1998). Drawing on documentary sources, supplemented by interviews with key TA personnel, this section documents the disability tourism initiatives of the Commonwealth and state TA.

In its 1992 strategic policy statement, the Commonwealth Department of Tourism (CDOT 1992) identified the broad issues affecting disability and tourism in Australia. Some of the inherent problems and weaknesses in existing arrangements were identified as costs of providing facilities, staff training, information base, physical access and transport (Table 14). The salience of many of these issues has been reinforced and their scope substantially extended through the findings of this thesis. Subsequent policy statements (ONT 1997;

1998a) moved away from an issues-based approach to identify disability as one of a number of emerging *special interest market segments*. This approach sought to: ‘Promote the development of the arts and cultural tourism, indigenous tourism, sports tourism, educational tourism, tourism for seniors and people with a disability, and environmental and rural tourism’ (ONT 1998a). This was the only mention of these policies in the 1998 document, which did not provide a strategic agenda to implement them. Yet, since 1992, policy and research initiatives had been undertaken for many of the other the other segments mentioned (see Table 15) but not for people with disabilities. This superficial approach continued with the most recent federal government discussion paper that states:

There are also significant opportunities for tourism products aimed at particular groups in the community, for example, seniors tourism, tourism for people with disabilities, and tourism aimed at ‘enthusiast’ niche markets (CDITR 2002: 70)

This sentence is the only mention of disability in the document. It provides a further indication that policy *development* for disability and tourism has remained largely invisible at the Commonwealth level.

Table 13 identified the Commonwealth and state initiatives that are reviewed below to analyse the ableist discourse inherent in the Commonwealth government actions and inaction. These initiatives are broadly categorised here in Table 23 to provide an overview of the areas of Commonwealth and state initiatives and, together with the listing of research projects in Table 11, to form the basis of the following analysis.

Table 23: Commonwealth and State Government Initiative Comparison, 1990-2001

Initiative	NICAN*	ATC	Com	ACT	NSW	NT	QLD	SA	TAS	VIC	WA	Total
a. Disability Tourism Strategy or Disability Action Plan					✓			✓				1
b. Industry awareness campaign			✓✓									2
c. Information provision & marketing												
Fact Sheet		✓	✓						✓	✓		4
Brochure – integrated						✓						1
Self reported/on-line info	✓			✓	✓						✓	4
Third party access audit				✓				✓				2
Market-specific information							✓					1
Image Library							✓					1
d. Tourism Disability Research					✓		✓					2

Source: thesis findings * Funded by Dept. of Family and Community Services

The review of the TA initiatives is based on a review of published and unpublished literature and Internet sources as checked against TA officer interviews. We can therefore

be confident the list of initiatives identified is exhaustive, with the possible exception of WA and Victoria, for which it was not possible to obtain interviews. However, even in these cases, annual reports, other reports and Internet sources have provided an extensive review of the data.

A. *Disability tourism strategies/Disability Action Plans*

Two state-based examples exist of a developed strategic approach to tourism and disability, one a strategic plan developed in South Australia and the other a Disability Action Plan developed in New South Wales.

In 1999, the South Australian Tourism Commission produced its *Tourism Strategy for People with Disabilities* (SATC 1999b), which sought four outcomes:

1. ensure South Australia is positioned as an accessible tourist destination for people with disabilities;
2. ensure people with disabilities are able to easily access being South Australian tourism product;
3. ensure people with disabilities are able to make an informed decision on tourism products in South Australia; and
4. ensure the TI is aware of the benefits and the need to be responsive to the requirements of people with disabilities (SATC 1999a:6-7).

For each of these outcomes, there was a series of performance measures. However, no timeframes or responsibilities were assigned to achieve the outcomes. The SATC produced an accompanying brochure (SATC 1999a) outlining examples of accessible regional attractions and experiences but it included only passing references to the accessible features of the attractions and experiences listed. To improve the situation the SATC commissioned a selected audit of tourism products for people with disabilities (SATC 2000; Porter 2001). The audit employed an access consultant to assess a selection of tourism products identified by a State Tourism Access Forum established to oversee these initiatives. The forum included people with disabilities and TI expertise. However, the project was only funded for 12 months and further funding was not forthcoming to implement the results (G. Porter 2001 pers. comm.). A member of the forum subsequently stated his dissatisfaction with the non-implementation of a project that the forum group had worked on for a year (Heath 2002 pers. comm.).

The DDA provided a mechanism for organisations to address systemic disability and access issues through Disability Action Plans (DAPs). Tourism NSW is the only TA to have lodged a DAP to date (Tourism NSW 2000a). DAPs set out a strategic agenda that

includes timeframes and responsibilities for improving disability access to facilities, services and employment. The NSW response was brought about by the general NSW government requirement for all agencies to formulate a DAP, so it was not undertaken voluntarily by Tourism NSW. Despite the existence of the DAP, product development in NSW has remained dormant, even though the recommendations of the DAP identified product development as crucial to providing opportunities for people with disabilities to travel in NSW. Tourism NSW has, however, supported a number of third party information sources (Cameron 2000b; Australian Quadriplegic Association 2002).

A further initiative that had the potential to lay the grounds for a strategic and national approach to disability issues was a 1999 meeting of Commonwealth and State Tourism Commission policy officers called to discuss disability and tourism issues, prompted by the Sydney 2000 Olympic and Paralympic Games (Douglas 1999). However, nothing occurred as a follow-up to this meeting, although the minutes suggest that the group were aware of many of the key issues that have been identified in this research.

B. Industry awareness campaigns

Two projects have been identified aimed at increasing general industry awareness of disability as a tourism issue. Both were Commonwealth initiatives.

The Commonwealth Office of National Tourism, *Tourism Challenge: Access for All* (ONT 1998b) publication appeared in the form of a set of 26 pages of loose-leaf information sheets with both hard copy and Internet distribution. The kit detailed marketing, accommodation, transport, contact information and training practices, together with an explanation of relevant legislation and good practice examples. The objective of the project was to assist the TI to better address the needs of tourists with a disability. The project emphasised the economic benefits of providing services for people with disabilities. The rationale was that it would lead to the provision of more products by TI and, hence, opportunities for people with disabilities. The project had no published objectives and there were no resources to implement the project beyond the hard copy and Internet distribution. No outcomes of the initiative are known.

In 1999, the Commonwealth Department of Family and Community Services (CDFACS) and the Office of the Prime Minister initiated the *Gold Medal Disability Access Strategy*

(CDFACS 1999c). In a similar vein to the above ONT initiative, this document was designed to raise industry awareness of the economic benefits of improving access to facilities, goods and services for people with disabilities. The documentation consisted of a 'launch kit' of four one-page fact sheets for each of four key areas: employment; premises; tourism; and transport. The sheets referred to previous data sources (ABS 1998 and Darcy 1998) but no new information collection was envisaged.

The strategy was launched by the Minister for Family and Community Services, Senator Jocelyn Newman, who stated:

In 1999 getting it right surely involves harnessing the combined effort of the whole community. We just cannot afford to discount the talents of any group in the community, especially people with disabilities. True, the days are long gone when people with disabilities were shunned by the community, but we still have a long way to go to translate this community acceptance into a commitment to equal access for everyone (Hansard 1999).

The strategy was marketed using the slogan, *Access the Advantage* and included a National Access Symposia Series, information provision, and the Prime Minister's Gold Medal Access Awards (CDFACS 1999c). The strategy did not indicate objectives, outcome measures, timeframes or responsibilities. This was highlighted when Senator Lyn Allison (AD, VIC) raised a series of questions in the Senate concerning the funding of the strategy (Hansard 2000). The Minister was questioned about whether the government had set targets for the number of new businesses to provide access to people with disabilities and what were the timeframes under consideration. She responded, 'No, due to the wide variety of circumstances affecting individual businesses' (Hansard 2000).

Apart from the demonstrated lack of accountability of the strategy, there were also problems with its conceptualisation. In the foreword to the strategy, the Prime Minister stated: '...in the lead up to the Sydney 2000 Olympic and Paralympic Games, the demand for access to facilities, goods and services by people with disabilities will certainly increase, from Australian residents as well as from overseas' (CDFACS 1999c). This appeared to dismiss participation by people with disabilities in the community unless these events occurred. This apparent view was reinforced by the fact that the program was only funded for one year up to the period of the 2000 Games. The Olympic and Paralympic Games became the focus for government to be seen to be doing something about disability and access issues over a short time period. While the government made use of the strategy for publicity about disability and access issues, it had very little involvement from

disability groups. There was no formal consultation process with the disability sector. The Minister explained the lack of involvement of and consultation with people with disabilities as being not needed because the strategy was an ‘awareness campaign for business’ (Hansard 1999; 2000). This awareness-raising exercise for business was provided at a time of cutbacks in federal funding to other essential services to people with disabilities and the ongoing deliberations on the CSDA. The budget for the project became a major point of parliamentary debate (Hansard 2000). Table 24 presents the funding breakdown for the program.

Table 24: Gold Medal Disability Access Strategy Funding Allocation

Component	Cost \$	Percent	Actual/ Estimate
Strategy launch:	60,288	2.9	actual
Launch Satellite broadcast to State/Territory:	26,950	1.3	actual
Eight Access Symposia in capital cities:	430,000	20.5	est.
Information activities:	372,000	17.7	est.
Awards process:	225,000	10.7	est.
Administrative costs:	870,000	41.4	3 yr est.
Awards Presentation	114,000	5.4	est.
Unallocated	2,000	0.1	est.
Total	2,100,238	100.0	\$2.1 million

Source: Hansard 2000

The focus of the strategy was on the Prime Minister’s Awards. The awards accounted for 16% of the budget. From a disability perspective, the criteria for the awards could be seen to be rewarding people for complying with the DDA (Beale 1999). Further, the awards excluded disability service providers who were regarded by the disability community as having best practice. The rationale for this was that the awards were to encourage *mainstream* businesses to begin to provide services for people with disabilities.

The strategy proposed to hold eight one-day symposia aimed at the business community, with 21% of funding allocated for these. Only four symposia were actually held, and no explanation has been given as to why the series was not completed or what became of the unallocated funds. No indication was provided as to the number of attendees to the symposia that were held.

This was the only funded Commonwealth disability tourism project and its target was the TI. However, there were no measured outcomes and, as far as is known, it resulted in no material improvement to the situation of people with disabilities travelling in Australia. A signifier of the direction of the strategy was that only one member of the steering

committee was a person with a disability or had disability tourism expertise (CDFACS 2000).

C. Information provision and marketing

By far the greatest number of responses to disability by Commonwealth and state TA has been through the provision of disability tourism information. This section firstly reviews these initiatives in the following categories: fact sheets; integrated brochures; online sources; access audits; market specific information; and disability representation in TA image libraries.

Fact sheets

The most basic form of information provision has been fact sheets on tourism for people with disabilities who wished to travel in Australia (ATC 1993; 1995; Tourism Tasmania 1997; ATC 1999; Tourism Victoria 2000). The pattern of information provision was similar for each TA, with basic listings provided on public transport, taxis, equipment, attendant/nursing services, specialist tour operators and disability organisations. These were provided within a 2-10 page format. Little thought, however, went into the usability of this information from a disability perspective or from the perspective of the organisations listed. For example, when the Australian Tourist Commission fact sheets were published in 1995, the ATC did not inform any of the listed organisations that they were being published and distributed, domestically and internationally (Culyer 1996). This led to organisations not being ready to respond to specific tourism inquiries as well as the dissatisfaction on the part of prospective tourists who made inquiries that were inadequately handled.

Typical of the published fact sheets were those produced by Tourism Tasmania (1997), which provided a more extensive listing than the ATC, was regionally specific and included accommodation information that had been cross-referenced with that provided by NICAN (2000), the AAA and a local ParaQuad listing. As with similar publications (NRMA 1999) discussed in Chapter 8 by people with disabilities, the document did not discuss the criteria for accessibility and information provision and the information was self-reported by operators. Tourism Tasmania stated that the listing was ‘... a comprehensive database on services and facilities likely to be used by visitors with disabilities’ (Wells 2002 pers. comm.). However, Wells states three reasons that it did not

take the next step of publishing a full guide because:

1. the number of accessible tourism products and public facilities was very limited;
 2. the information was provided by property owners, without any professional independent inspection/assessment;
- disability organisations warned of the potential for liability claims should any of the information published prove to be incorrect; and
 - the potential to hand over the database to the private sector to develop on a commercial basis was subsequently explored, but without result.

Integrated brochures

The Northern Territory Tourist Commission (NTTC) was the only authority to indicate that it included information for the disabled in its general tourism brochures. The NTTC's (2001) main tourism brochure included two sections of listings of disability information. The first identified *disabled access* for parks and reserves facilities, including the universal symbol for access where it believed facilities were provided, but the meaning of *disabled access* was not discussed. The second section, the NT accommodation directory, noted *wheelchair access in room* and whether properties were *accessible by wheelchair* but the meanings were not discussed. The spokesperson for the NTTC stated that:

In addition, NTTC brochures all contain a reference to the NTTC's Holiday Centre (Please refer to 'Exploring the Territory' - cover pages). All travellers are encouraged to contact the Centre, and the Centre's travel consultants provide more detailed information on the services and facilities available for any special needs in each location of interest (George 2001 pers. comm.).

The use of *special needs* signifies that accessible product was regarded as an extra rather than as part of general service provision. This also assumes that the centre's consultants understand disability and access, and have the detailed information on destination services and facilities. However, when the researcher made an inquiry with the Holiday Centre, the operator suggested it would be better to contact establishments directly, as they did not have any further detail about *disabled access*. This experience reflects the documented tourism experiences of Chapter 8 and suggests that, unless an organisation has developed a disability access culture, then responses to such enquiries will continue to be less than satisfactorily handled. The NTTC spokesperson concluded his comments by stating that, 'NTTC do not provide services for the public as we are primarily a marketing organisation' George (2001 pers. comm.), indicating a marketing discourse that does not understand the key importance of access information to people with disabilities tourism needs.

On-line information

On-line information is of increasing importance in all tourism marketing. Here four examples of TA initiatives on tourism access are reviewed here, two national and two state-based.

The most notable outcome of the 1992 national tourism strategy (CDOT 1992) from the point of view of tourism and disability was that the CDFACS established and provided ongoing funding for NICAN, an organisation chartered to provide information on arts, recreation and tourism for people with disabilities. NICAN's funding has remained static since its inception with a secretariat of three people. The activity most relevant to tourism was an online database of accessible leisure experiences, including a listing of tourism accommodation (NICAN 2000). After 10 years of operation, the database relies on self-reported evaluation by establishments or *ad hoc* feedback on the accommodation from people with disabilities.

In 2000, the ATC posted the listings of tourism products from its hard copy *Fact Sheets* (ATC 1995b; 1999) onto its web-site. The site included no discussion of what was regarded as an *accessible* product and provided no detail as to what accessible inclusions establishments had. Information on many of the *accessible* products was misleading at best, with, at worst, some being highly inaccessible (Cameron 2000a). The other worrying aspect of the web-site was the language used when describing people with disabilities. The website reverted to the practice of using the term *the disabled*. As discussed in Chapter 1, it is generally accepted in Australia that the use of this phrase creates a sense of *other* and alienates people with disabilities from the rest of the community. Further, it contravenes media guidelines for the use of person first language in the Australian context (Hume 1994).

The Western Australian Tourism Commission (WATC) did not respond to requests for information for this research, although the WATC web-site included information on accessible accommodation (WATC 2001). While the detailed checklist of information took account of most access requirements based on AS1428, there were problems with the coverage of the self-reported information. Only 42 accommodations throughout WA were listed as having provided access information and none in the greater Perth and Fremantle areas even though another third party guide indicates that there are at least 13 accessible accommodations in this area (Cameron 2000b).

The Tourism NSW *Visnet* database (Tourism NSW 2000b) provided the only source which was sufficiently comprehensive to facilitate the calculation of the overall level of accessibility of the tourism sector state-wide. Apart from the information available in the 1980s and early 1990s, as discussed in Chapter 4 (Section 4.5), virtually no other information exists on the accessibility of the accommodation sector in Australia. *Visnet* categorises NSW products into attractions, accommodations, events and tours. As with most other sources, the information was self-reported: the operator ticked a field identified as *disabled* and provided whatever detail they wished in the *access disabled* field. No format for the provision of information was provided. Table 25 summarises the data from the database.

Table 25: Accessibility of NSW tourism product, 2000

Product Category	Total	No. Accessible	% Accessible
Accommodation:	4550	532	11.7
General Facilities and Room/Service General		323	7.1
General Facilities only		446	9.8
Room/Service General field only		394	8.7
Events:	1603	13	0.8
Attractions:	1968	624	31.7
Tour:	530	10	1.9
Total	8551	1179	13.7

Source: TNSW *Visnet* 2000b

The proportion of accessible products in all sectors can be regarded as low with the most accessible being attractions (32%) and accommodation (12%). However, only 2% of tours and 1% of events were identified as being accessible. Even if tours and events significantly under-reported levels of accessibility because of a general lack of understanding of what constitutes accessibility these are significant constraints to opportunities for people with disabilities. Similarly, Ashton (2000) in access auditing SA product found only 7.5% identified themselves as accessible.

While 12% of accommodation establishments indicated that they had accessible rooms, the database did not include information on the number, location or level of accessibility of the accessible rooms. The information in the *access disabled* field was therefore all but useless for people with disabilities planning a trip. The additional comments range from vague statements, such as ‘wheelchair friendly’, ‘full disabled facilities’, ‘Access for disabled’, to uncertain levels of accessibility indicated by ‘ground floor accessible’ and ‘ramps and toilets’. This contrasted with the most detailed descriptions of some accessible facilities:

‘Pool and spa with hoist, commodes, lifts, fully adjustable self-catered kitchens with electronic cook tops, removable storage shelves, bathrooms feature hobless showers, 1/4 turn batwing taps, fixed and hand held showers’. The form used to collect information for the database did not include a template to ensure the systematic collection of the type of information that could be used by people with disabilities to make decisions.

Access Audits

Two examples of access audits have been identified, one national and one state-based.

The project *Access Info* was a joint initiative of the Canberra Tourism and Events Corporation (CTEC), the Australian Council for the Rehabilitation of the Disabled (ACROD) and NICAN. It sought to collect up-to-date information on accessible tourism in Canberra. The approach taken was to establish a list of accommodation, attractions and things to see and do, and undertake an access audit of these. The audit list was based on an AS1428.1 but the published results did not present the detailed information collected. The information was used to create an online database of accessible tourism product in Canberra (CTEC 1999a). This was supplemented with a one-off promotional magazine, *Discovery* (CTEC 1999b), which was the first attempt to present a view of a destination from the point of view of people with disabilities. The magazine presents editorials and stories featuring disability celebrities (e.g. Louise Sauvage) show casing their Canberra experiences (Jensen 1999).

Similarly, the South Australia Tourism Commission (2000) undertook detailed access audits of selected product throughout the state, including tours, visitor information bureaux, attractions and accommodation establishments. A consultant sent letters to over 2500 operators who had an existing contract with the SATC offering an audit service for those who considered themselves accessible (Ashton 2000). Only 7.5% responded and 6.5% of those who expressed interest had their product audited. The audits were detailed, based on AS1428 and in some cases provided photographs of critical components. However, further funding was not forthcoming and the results of these audits were not made publicly available (G. Porter 2001 pers. comm.).

Market-specific information development

One example was found of a tourism marketing authority developing a detailed data source specifically for people with disabilities as a market segment. In 1998 the Queensland

Tourist and Travel Corporation (QTTC) developed the document *Accessible Queensland* (QTTC 1998) which provided regional listings of: information services; suppliers of mobility and hygiene equipment; personal care providers; and suppliers of transport services. However, information on accommodation was not included. The resource was subsequently provided online (Tourism Queensland 2000b) and was followed by a regional listing of providers of services and accessible public infrastructure Tourism Queensland (2000b). The compilation of these sources was based on telephone surveys and written correspondence to ascertain access inclusions. However, the documents had no discussion of what *accessible* was. Interestingly, each publication had a section four times the length of the methodology section providing caveats concerning the validity of the information collected, the freedom from liability of Tourism Queensland and the quality of the services and facilities listed.

The lack of information on accommodation was partially addressed in a supplementary study on caravan parks undertaken by person with a disability (Graham 2000). The project sought to provide a high level of detail about the accessible amenities provided by each caravan park. The methodology used provided an *accessible amenities legend* that included ten symbols and descriptors, as shown in Table 26.

Table 26: Accessible Amenities Legend – Tourism Queensland

Symbol	Descriptor	Description
EX	External access	Accessible amenities are located outside the park's amenities block and are suitable if assistance is required
IN	Internal access	Accessible amenities are located within the park's amenities block and are unsuitable if assistance is required
UN	Unknown access	Amenities are accessible but it is unknown whether the toilets/showers are located externally or internally to the amenities block
W	Wheelchair accessible	Accessible amenities have ramped or level access and are flat and spacious inside
OB	Obstacle	Obstacles such as small step or steep ramp hinders access
H	Handrails	Hand rails fitted around toilet and/or shower
S/SF	Shower seats/benches	Shower seat: S = removable chair or stool SF = folding bench seat;
B	Bath	Bath fitted with hand shower
E	Emergency	Emergency alarm button fitted
CAB	Cabin	Park has cabin/cabins available with disability access amenities

Source: Graham 2000: 3

The symbols were then interpreted via a *Legend and Comments* column identifying the caravan parks with these facilities in the regions of Queensland. This information appears, however, to be nonsensical. For example, a random selection from the source provided the following codes for a caravan park in the Fraser Coast Region: UN, W, H, S. This translates to:

- amenities are accessible but it is unknown whether the toilets/showers are located externally or internally to the amenities block (UN);
- accessible amenities have ramped or level access and are flat and spacious inside (W);
- handrails fitted around toilet and/or shower (H); and
- removable chair or stool (S).

The problem with the methodology was that the data collection was not based on a broad understanding of disability or access requirements. It did not draw on the detailed provisions of AS1428 or, apparently, on any previous research. At best, it provides a logical provision of information for Graham himself, who explains that he has a degenerative impairment and the genesis for the project developed out of his and his wife's desire to purchase a caravan and travel. While Graham should be encouraged to fulfil this desire it does not excuse Tourism Queensland for not engaging professionals with requisite access auditing skills and a broader understanding of disability. If the communication of relevant information is to be provided then a sound methodology must be used. As Graham himself states,

During a later tour of Queensland, we again found very little information on suitable accessible tourist destinations and caravan parks. Also, the information that was available was incomplete and in most cases, inaccurate. Another problem was the gathering of bits of information from a number of sources and trying to separate the good information from the rubbish (Graham 2000:3).

Unfortunately this was another example of the poor quality of information provided and, despite Queensland Tourism's best intentions, did little to improve the quality and detail of information required by people to make informed tourism decisions.

D. Image library disability representation

Linked closely to information provision and marketing is the issue of image availability. Only three organisations had disability images in their image libraries. As a signifier of the ATC's lack of interest in disability tourism, there were only two images of disability subjects in its library of 50,000 images. This was trivial compared with the representation of other market segments - for example, there were 1200 images relating to the gay and lesbian market (ATC 2001). Tourism Tasmania held six images of accessible product (Tourism Tasmania 2001). Only Tourism Queensland had developed an accessible tourism images library to enhance its product offerings and were used in its brochures and online (Tourism Queensland 2000a). Further, Tourism Queensland offered the CD-ROM of images free for other parties to use with acknowledgment.

E. Access Information: collection and dissemination issues

Two key issues should be noted at this point in relation to access information collection and dissemination. The first is the reliance on self-reported information and the second is the issue of information supply and distribution chains. These are considered in turn below.

Reliance on self-reported information

Invariably information on access was collected by mail from tourism facility operators themselves. The alternative - collection of data by independent assessors – is, of course, considerably more expensive, and slower.

There were two main problems associated with self-reported information from a disability perspective. First, the level of response by TI was generally very low, resulting in gross under-reporting of facility availability. For example, on the only two databases where the accessible accommodation could be determined, 88-93% of accommodation providers did not respond to the request for information (SATC 2000; Tourism NSW 2000b). In the case of the WATC (2001) example, as indicated earlier in this Chapter, only 42 establishments were listed for the whole of WA and destination areas known to have accessible accommodation were not represented. Where access audits were conducted, it was found that there were anomalies between self-reported information and the actual level of accessibility (Ashton 2000), confirming the value of such audits and the experiences of people with disabilities documented in Chapter 8. (However, in the two cases where third party access audits were completed they have been deficient, either in the level of detailed collected (CTEC 1999a) or in lack of funding for full operationalisation (SATC – see Porter 2001, pers. comm.).

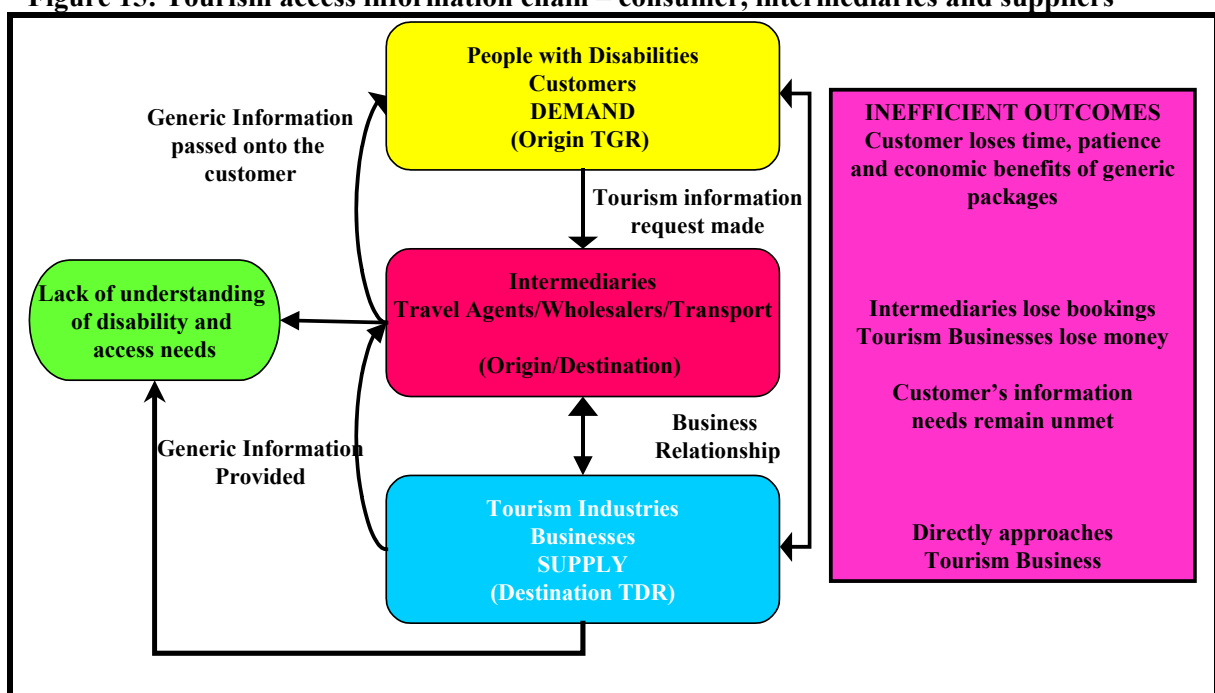
The second problem with self-reported information was that there was no uniformity or system of information provision to the self-reported sources (NICAN 2000; Tourism NSW 2000b). Reasons for the low level of self-reporting in the TI were explored in Section 9.2.

The role of information supply and distribution chains

The complexity of the social relations of tourism access information extends to the supply chain used by the TI. For packaged tourism products people with disabilities must deal

with intermediaries rather than airlines and accommodations directly. Figure 15 presents the supply chain between people with disabilities, intermediaries and suppliers and identifies the inefficiencies highlighted by people with disabilities in Chapter 8. This adds another group to the list stakeholders who require an understanding of disability and access. Yet, Chapter 8 documented the poor experiences people with disabilities had with travel agents as intermediaries. Apart from adding to the complexity of organising a trip this adds a further cost disadvantage. People with disabilities are excluded from the discounted rates that packaged tourism products offer the non-disabled who book through travel agents.

Figure 15: Tourism access information chain – consumer, intermediaries and suppliers



F. Disability tourism research

Table 11 in Chapter 4 indicates that the only published, Australian TA-sponsored tourism and disability-related research is the 1998 NSW *Anxiety to Access* project (Darcy 1998), the findings from which are reviewed in Chapters 4 and 7 and which provided the qualitative data reported on in Chapter 8. Much market research is undertaken by federal and state TA but since the results are generally treated as commercial in confidence, the extent to which disability has been researched as a market segment is not known. Although not a TA, Table 12 identified the WADSC (1997b) industry think tanks that provided a regional TI understanding of disability issues and led to the production of a disability awareness training package for the TI (WADSC 2000).

Mention should be made here of a major Australian tourism research initiative launched in 1997 and still on going, the *Cooperative Research Centre for Sustainable Tourism* (CRC Sustainable Tourism). CRC Sustainable Tourism is a multi-million dollar program of research involving all Australian TA, some 17 universities and a number of TI partners in a program of research on sustainable tourism (Keppie 1997). To date none of the scores of funded projects has been concerned with disability and tourism issues and none of the state-based research 'nodes' includes a sub-program where disability issues could be addressed (CRC Sustainable Tourism 2003). One project proposal was rejected on three separate occasions for different reasons (Darcy and Daruwalla 1998-2000), although support for the project had been received from state tourism commissions and the ATC. This suggests that the CRC did not believe that disability was worthy of inclusion within the tourism research agenda. After the third application rejection, an offer was made from the CRC Board to convene a meeting to seek external funding with other TI partners rather than to fund it internally (Pritchard 1999). Negotiations for this offer are to be further investigated in 2004.

9.3 The Accommodation Sector

Chapter 8 indicated that accommodation is a crucial component in the decision-making process involved in undertaking any tourism experience for people with disabilities. This section documents the accommodation sector's perceptions of providing goods and services for people with disabilities, based on the insights provided by interviews with industry representatives interviewed and the comments of those attending a focus group. As identified in the Chapter 6, the respondents represented hotels and motels established from 1961 to 1999, ranging from three to five stars. All were identified as having accessible accommodation stock and the researcher verified this.

The predominant finding from the interviews and the focus group were that, regardless of legislation and policy, there was a desire by those involved to provide a high quality experience for customers with disabilities. All managers recognised that providing high quality customer service for people required an understanding of their individual needs and that there should be no difference in servicing people with disabilities and the non-disabled.

Three issues were identified by respondents themselves, in discussion, namely: safety; the need for people with a disability to communicate their needs to the hotel; and assistive equipment. Other issues were raised by the interviewer/focus group convenor and participants were asked for their reactions. Two of these were related to basic rationales for providing for people with disabilities, namely: legislation, policy and building codes; and consideration of people with disabilities as a market segment. Other issues were ostensibly more technical, although reactions to them often revealed underlying attitudes and values. They were: staff awareness/training; perceptions of accessible rooms; and language, marketing, promotion information. These issues are discussed in turn below.

A. Industry- identified issues

Safety

The focus group members identified the importance of being aware of people with mobility disabilities and communicating evacuation procedures and routes from their rooms in cases of emergency. One member of the focus group identified the planning issues related to hosting conferences attended by people with vision disabilities, including safety and wayfinding issues. The hotel had undertaken a staff training day facilitated by the Royal Blind Society. The day was invaluable in ensuring the successful hosting of a conference and consequently the organisation now holds its annual conference at the hotel. These issues did not arise in the interviews.

Individuals to identifying their needs to the hotel

Linked to safety, was the issue of self-identification of people with *invisible* disabilities, or those travelling with partners or attendants, and who therefore did not have direct contact with hotel staff. The example was given of a person with a hearing disability staying independently but who does not indicate to staff that they have a disability. If a fire alarm was to be activated and the person was not aware of it, how would staff know that this person would not respond to the alarm or know to knock on the door? This issue also concerns people with disabilities taking responsibility for their own safety. These findings are contrary to Drabek's (2000) US survey of manager and customer attitudes towards disaster evacuations, which found that managers queried whether there is an obligation to provide assistance to people with disabilities. Interestingly, there were major gaps between the expectation of customers and the policy of managers for disaster evacuations (Drabek 2000: 55).

Assistive equipment

A small number of managers interviewed and members of the focus group indicated that assistive equipment was required at some establishments where some areas of the premises were not AS1428 compliant. The equipment included ramps, stair climbers, inclinators and porch lifts. Staff were trained in the use of the equipment during their induction program at the hotel and customers were told upon check-in of the areas of the hotel that required assistive equipment and how to contact staff to deploy it. These procedures were put in place to provide people with disabilities with a comparable level of service to other customers.

B. Legislation, policy and building codes

Unlike the findings of O'Neill and Ali Knight (2000) most managers involved in this study recognised that building regulations dictated that hotels should have what they referred to as 'disabled rooms'. The understanding of what constituted *accessible* rooms varied greatly among those interviewed and those at the focus group and was dependent on the role of the manager, with building/maintenance managers being more aware than sales, marketing and reception managers. Yet there was a lack of recognition that access extended beyond the guest rooms to all areas of the hotel. Many managers recognised the inherent inaccessibility of their general facilities but only a few had a strategy in place to address these issues. There was also less awareness of how the legislation and policy impacted on all areas of service provision. The *disabled rooms* were the focus of access provision but did not extend to understanding the totality of the tourism experience.

A number of managers (particularly general, building and maintenance managers) had detailed experience and understanding of the BCA. One general manager was directly involved with the WADSC (1997a) *Think Tanks*. This manager recognised the importance of the age of the premise, the degree of interaction of staff with people with disabilities, and the approach taken by management to incorporate disability issues into staff training. The hotel had a decade-long involvement with a major disability sporting event and this on-going experience had helped develop a greater staff understanding about their responsibilities under the legislation. For example, the manager recognised that the premises had a number of substantial access-related constraints (only two accessible rooms and some inaccessible public areas). He recognised the hotel had extra responsibility to

accurately inform people with disabilities as to the establishment's level of provision and to make whatever 'modifications or adjustments' were necessary to facilitate a more satisfying experience. Many of these adaptations were relatively simple (e.g. raising the height of beds or removing bathroom doors to increase circulation space). It was also recognised that these adaptations were possible because of the physical abilities of elite athletes. These same adaptations might not assist the average person with a disability. As the manager noted, his level of understanding and responsibility would not have been possible without his involvement in an educative program and on-going experiences with people with disabilities through the hotel's activities.

As with O'Neill and Ali Knight's (2000) study, managers were generally unaware of relevant disability legislation at the federal or state level and, hence, the implications of this for their operations. In particular, reception, sales and marketing staff had no understanding of the provisions of the DDA and their responsibilities. A number of the customer service-related HREOC complaint cases reviewed in Chapter 8 may have been avoided with a greater awareness and understanding of the DDA.

C. People with disabilities as a market segment

It became evident that managers' understanding people with disabilities as a market segment began and finished with the provision of 'disabled rooms'. The most common response was that if there were an expressed demand by people with disabilities for facilities and services then they would see if this could be accommodated within the hotel. Yet, when probed further about what constituted accommodating this group the responses were vague. None of the hotels had actively pursued disability as a market segment. Of the four managers who had experience with people with disabilities, two involved wheelchair sporting events, including pre-Paralympic and Paralympic involvement, and one had experience in hosting a conference for people who were blind. However, this involvement was reactive rather than strategic - they had responded to approaches by disability organisations. Apart from the previously discussed physical adaptations for people with mobility disabilities and specific training for people with vision disabilities, no other strategies had been implemented to meet the needs of this market segment.

The different dimensions of disability were unequally recognised by the managers. The focus of access issues was on access for wheelchair users. There was some recognition of

the needs of people with vision impairment or who are blind and to a lesser extent people with hearing impairments or are deaf, but no recognition of people with cognitive or psychiatric disabilities. Literature provided by the government and non-government sector reinforces this limited view of disability by focussing primarily on mobility access (ONT 1998b; ACROD 1999).

A number of managers recognised the link between ageing and disability, and the substantial market that seniors offer. This was based on the demand from some seniors for accessible accommodation. One manager saw adapted rooms as having extra features to market in a very positive way. The features that older people liked in accessible rooms were the handrails for mobility support, the hobless shower as a safety feature and the extra circulation space in rooms.

The industry awareness strategies promoted by the Commonwealth and discussed earlier in the chapter (ONT 1998b; CDFACS 1999c) appeared to have had little impact on the managers interviewed. These findings are supported by the observation of the CEO of the Tourism Task Force, a tourism industry lobby group, who, in 1999, stated: 'To date, the tourism industry has not been smart enough to tap into the potential of the market or not good enough in meeting its moral responsibility in providing access for people with disabilities' (C. Brown 1999). This statement juxtaposes the approaches and values of the market ideology and human rights approach.

D. Staff awareness and training

One manager stated, 'Staff training is crucial to the way people with disabilities are treated'. He went on to explain that if staff have not had experience of people with disabilities then it they were unsure of how to approach people or act in an appropriate manner. Having accessible premises was the starting point for providing services for people with disabilities but if staff are ill-prepared to provide appropriate customer service then a customer's needs cannot be adequately addressed, as experiences recounted in Chapter 8 indicate.

The CEO of the Tourism Task Force has argued that staff awareness and training is the one element that all organisations can undertake regardless of the general accessibility of their premises. In relation to the need for all organisations to improve customer service for

people with disabilities, he stated,

Training your staff in disability awareness is probably the cheapest and best option. The greatest fear in the community is fear of offending people with disabilities and we need to remove this ignorance (C. Brown 1999).

Three hotels represented among the interviewees and focus group members had undertaken, or were undertaking, disability awareness training. Two of these hotels had had experience with athletes with disabilities and were to be involved with the Paralympics. The third hotel had a number of access constraints that required the use of assistive equipment. Another manager noted that any training must be undertaken at all levels of the hotel to ensure a 'quality management' approach to servicing people with disabilities. This was particularly important for managers of front line staff who were the ones in most contact with guests but are also the positions that had the highest rate of turnover. It was observed that, unless managers discuss disability issues with new staff or have an orientation program that includes disability awareness, these issues could become lost with staff turnover. Staff turnover was a major issue for establishments that used high levels of casuals in customer service provision and is a noted industry-wide issue (Weaver and Opperman 2000). Yet, even with this recognition, most managers had not planned any disability awareness training.

Another manager was a recent graduate of a private tourism college but nowhere in the curriculum had disability issues been addressed. He had undergone disability awareness training as part of customer service training for Stadium Australia's Olympic involvement and he was impressed with what he had learnt and how it could be applied in his current position. It was an area that he thought should be part of the tourism curriculum. Training issues have been discussed in the Australian context in the literature (Weiler and Muloin 1990; Daruwalla 1999), but the extent to which disability issues are included in tourism training curricula is unknown.

E. Perception of accessible rooms by the non-disabled

When guests with disabilities do not require accessible rooms they may be allocated to non-disabled guests, often on a 'last sale' basis. However, managers indicated that this can cause problems. They acknowledged that many accessible rooms had historically been located in the parts of hotels with poorer vistas and were not offered across all classes of accommodation. All managers in this study reported that the non-disabled had made

negative comments or complained about having to use a ‘disabled room’. When probed further, the managers offered examples of the non-disabled perceptions of these rooms. They included the following.

- Due to the rooms being ‘last sale’ rooms for the non-disabled, and the way that they were sold (see below), there was a perception among staff and guests that they were of an inferior standard.
- The inclusion of a hobless roll-in shower within the accessible bathroom is the feature that most non-disabled people negatively comment on when staying in an accessible room. Reasons given include: the lack of a fixed shower screen, creating a space that lacks the ‘privacy’; and, if the bathroom floor has not been designed with an adequate gradient, flooding of the bathroom and the room itself. As one manager stated: ‘It can make guests feel like they are idiots!’
- The provision of a hobless, accessible shower is generally made at the expense of the loss of a bathtub.
- Guests felt that they were being ‘ripped off’ or disadvantaged by being given the ‘disabled room’ that did not have the same facilities as a standard room.
- Older designed bathrooms have fittings, particularly hand rails, that are clinical/ medical to look at and create a sense of the room being ‘different’ or aesthetically unpleasing.

The above comments varied according to the classification and age of establishment, in that the size of rooms increases with classification, as do the bathrooms. In the more spacious and better-designed 5-star accommodation a bathtub and roll-in shower are provided while in most 3-4-star establishments the bath and shower are combined.

Apart from the belief that the rooms were of an inferior standard, a number of managers described an unexplained *fear* associated with the rooms. For whatever reason, these rooms were confronting to the non-disabled, this perception reflecting a particular status associated with disability in society. The perceived inferior nature, belief of a ‘rip-off’, difference or the ‘fear’ expressed can be seen as being associated with the stigma or *otherness* attached to disability in Australia (Goffman 1963; Young 1990; Meekosha and Dowse 1997a; Goggin and Newell 2001).

One manager made the comment that the problem arose from the way the ‘adapted rooms’ were sold and the language that was used. The manager argued the word *disabled* still carries with it a negative connotation and that using *adapted* focuses on the features of the room rather than people’s varying perception of *the disabled*. The policy of his hotel was to hold adapted rooms for people that required them and only to use the rooms for other guests when occupancy approached capacity. The staff were trained to indicate to customers that the rooms being offered were adapted rooms with extra features and that the

only difference was that these rooms did not have a bathtub. Rarely did any customer refuse the adapted room, the manager interpreting this as being due to the overall room quality, and the fact that the customers were just happy to have a room. He felt the language used and staff training were essential to the creation of a positive perception of adapted rooms.

F. Language, marketing, promotion and information distribution

As argued in Chapter 1, language and terminology is an important aspect of disability. The discourse of language has been identified as a priority area in disability studies in the quest to claim and create an appropriate disability discourse (Corbett 1996; Linton 1998; Corker and French 1999). This issue was explored in the interviews and focus group in regard to managers' own use of terminology and the language and terminology used in their marketing and promotion.

Generally, most of the managers interviewed referred to *the disabled*, *the handicapped* or to their *disabled rooms or facilities* thus creating a sense of *otherness*. Some used person-first language and referred to their facilities as being *accessible* or *our accessible rooms*. Some sought to avoid direct reference to people with disabilities at all. Contrasting discourses in the interviews existed where one manager referred to the hotel's *adapted* rooms as being a positive marketing label to explain to guests the extra features the rooms had, while another tells the non-disabled guest that 'all that's left is the *disabled room*' and they are sorry for not having a 'normal' room available.

An extension of the role of language and the discourse in relation to disability was the absence of documentation of the accessible establishment features among the establishments represented. None had developed a system of access audit and information collation. Consequently, none undertook marketing, promotion or distribution of information relating to the accessible features of the establishments to people with disabilities, even though some managers had a sound understanding that their facilities were well suited to people with disabilities. For example, one manager, whose hotel has nine accessible rooms, was unaware that a hotel with this number of accessible room was unusual, given that most hotels have only three accessible rooms. When it was brought to this manager's attention that the hotel could be considered to be at a competitive advantage in attracting the business of groups of people with disabilities, the response was: 'I hadn't

thought about it that way before'. Most managers had no idea that specialist information collection exercises existed to establish databases on accessible rooms. They were surprised to hear of the TA initiatives for listing accessible accommodation and were unaware of commercially available access guides. The process for dealing with an inquiry from a people with disabilities was to respond to see if they could cater for the group within their own establishment.

To most managers interviewed the issue of 'accessible accommodation' meant accessibility of hotel rooms. Most recognised some key components of such rooms: for example, width of doorways, circulation space in the rooms, hobless shower and bed height were commonly mentioned. It was only after further probing that other accessible features and amenities of hotels were discussed. Sometimes this was because there was recognition that the hotel had some access-related problems in regard to certain of these other amenities. For example, many of the hotels did not provide access to recreation facilities such as gymnasia. A number of managers knew something of the accessibility of the surrounding environment and the location of accessible public transport. Yet, when asked what information they provided when they received an inquiry for an accessible room, they all stated that they simply confirmed that the hotel had 'disabled rooms'. No other information was provided on the accessible features of the establishments. Some reported that people would ask very specific information from them (e.g. measurements) and they would try and provide that information to the customer if they could.

The room-related focus could be attributed to the questions that may be asked by people with disabilities when making an inquiry about the hotels. This is not surprising given the experiences documented in Chapter 8 regarding the primary constraint of finding accessible rooms. Given the urban focus of the research this may not fully reflect experiences of staff in non-metropolitan resort settings where these recreational features and surrounding tourist attractions are far more prominent in marketing their other facilities and services.

A further demonstration of the problem of terminology is demonstrated in the Australian Hotels Association's own 1998 survey of its members (AHA 1998). Frequently in the qualitative comments quoted in the report, hoteliers referred to 'all rooms having wheelchair access', 'rooms are on the ground floor' and 'doorways wide enough' as an indicator of wheelchair access. This signified a lack of understanding of the concept of

physical room access, let alone issues of other dimensions of access. It should be noted that these types of comments flow through into self-reported information databases as discussed earlier in the chapter, reinforce the problematical accommodation-seeking experiences that people with disabilities identified in Chapter 8.

With respect to information networks used by the accommodation sector, these extend beyond the consumer and the accommodation provider to the communication chain between the consumer, wholesale and retail intermediary. While accommodation providers expressed a trust in their intermediaries to showcase their properties, they were uncertain as to how the intermediaries represented their accessible product. This situation arguably arose because of their own lack of information provision about their accessible product and what the intermediaries understood accessibility and the needs of people with disabilities to be. An example was given of a three-week period from the time of receiving a booking from a wholesaler about a group's access needs and those needs being fully articulated to the accommodation provider. As another manager asked: 'What do retailers say about our accommodation to potential guests who make an inquiry?' As found in Chapter 8, retail travel agents often tell people with disabilities that they would be best advised to organise the trip and accommodation themselves. Clearly, as Chapter 8 demonstrates, the problem of lack of awareness and information is not confined to the accommodation sector and its personnel – it encompasses the whole of the tourism system. The discussion here merely demonstrates its nature in one sector.

Lastly, it was recognised by those managers involved in this study that networking was an important part of sharing disability-related information. Yet, this research was the first opportunity that most had had to discuss disability-related issues.

9.4 Regulatory Processes and Industry Responses

Many of the issues noted in Section 9.3 relate to the built environment. The regulatory processes covering disability and tourism are described in Chapter 2 and, at national level, arise primarily from the provisions of the DDA. Examination of these processes and their outcomes provides documentation of TA and TI behaviour and insights into the motivations of the organisations involved. The outcomes of this section contribute towards research questions 1d, 3b, 3c, 4c and 4d.

Hundreds of complaint cases are referred to the HREOC each year in regard to the inaccessible environment – for example, 267 cases were referred in 2001 (HREOC 2001a). As indicated in Chapter 2, most are settled through the conciliation process where a compromise outcome is reached between the two parties. Where conciliation cannot be reached, complainants either act no further or pursue their case to a HREOC inquiry (pre 13 April 2000) or a Federal Court action where a legally binding decision is made. It was not until the enactment of the DDA that people with disabilities were able to counter discriminatory practices of the TA and TI in any formal way. The enactment of the DDA, subsequent complaint cases, inquiries and Federal court actions effected the public discourse of what was required to be provided as *reasonable access*. Non-disabled stakeholders could no longer ignore the provision of reasonable access for the group.

Under this system, the power for directing the agenda was shifted towards people with disabilities through the provision of a transparent process where their voices could be heard. Each conciliation case where discrimination was recognised and a remedy provided was a victory for the individual involved. The TI organisations involved also gained a greater understanding of what constitutes discriminatory and non-discriminatory practice. However, each complaint case dealt with by HREOC did not contribute to a body of precedents as each complaint case was regarded as a confidential arrangement between the parties. This did little to promote industry understanding of disability and access issues. The Federal Court actions have had a far greater impact through the case-law precedent that they set. This is particularly so in regard to the transport (Corcoran 2001) and built environment sectors (Ozdowski 2001) where the rights to accessible public transport, the built environment and responsibilities of local government have been clearly established.

The new-found power of people with disabilities provided by the DDA was, however, short-lived. The other stakeholders involved in the transport and built environment sectors sought to bring about certainty to system. They investigated other strategies of the DDA as a means of asserting their sectoral influences within this decision-making framework.

Below, the processes used to change for this agenda are examined under four headings: a. HREOC inquiries, Federal Court cases and HREOC complaint cases; b. Disability Action Plans; c. the development of transport access standards; d. development of disability Standards for access to premises; e. development of environmental planning process; and f. management of accommodation rooms; and g. implementation of citizenship rights..

A. HREOC inquiries, Federal Court determinations and HREOC complaint cases

In Chapter 8, reference was made to a number of Federal Court determinations, HREOC inquiries and complaint cases to illustrate issues raised by individual respondents with impairments – the demand side of the system. Here the emphasis is on the supply-side response to cases where the practice of the TA and TI is summarised in Table 27. The first part of the table identifies the major HREOC inquiries and Federal Court cases that have significant implications for TA and TI. The second part of Table 27 identifies specific complaint cases of TI discrimination against people with impairments. While Table 27 presents a representative sample of complaint cases, the full data set identifies ongoing disability discrimination by the TI against people with impairments. This discrimination involves all dimensions of disability, all sectors of the TI and through all stages of the tourism system.

Table 27: HREOC, Federal Court, other Court and Complaint Cases

Case	Year	Court	Topic	Dimension	Discriminatory Practice
Kitt v Tourism Commissioner and Ors	1987	NSW EOC	Employment practice	Cognitive	Tourism authority refusal to promote on the ground of disability
Cocks v the State of Queensland	1994	QldEOC	Segregated access	Mobility	Public buildings must have an universal entrance for all people including those with mobility impairments
Magro v NSW State Transit	1995	HREOC	Public transport	Mobility	Established the principle that public transport providers need to purchase accessible fleets.
White v Crown Casinos Ltd.	1995	HREOC	Refusal of service on grounds of appearance	Cognitive	While White was not discriminated against, businesses should be aware of behavioural difference based on impairment.
Adams v Arizona Bay Pty. Ltd., Charlie Habib and Bunge Pty. Ltd.	1996	Fed. Court	Para-transit systems	Mobility	A case of discriminatory customer service because of the persons disability
Jennings v Lee	1996	HREOC	Access for assistance animals	Vision	Refusal to allow an assistance animal to accompany a blind woman
McLean v. Airlines of Tasmania Pty Ltd	1996	HREOC	Independent travel	Mobility	Found in favor of airline requiring a wheelchair user with high support needs to travel with an attendant
Scott v Telstra Corporation	1997	HREOC	Telecommunications	Hearing	Organisations must provide an equality of access to telecommunication technology
Francey and Meeuwissen v Hilton Hotels of Australia Pty Ltd.	1997	HREOC	Environmental tobacco smoke	Medical	Hotels should provide a smoke free environment. However, a reasonable solution was not found.
Brown v Birss Nominees Pty Ltd	1997	HREOC	Access for assistance animals	Hearing	Refusal of allowing an assistance animal to accompany a hearing impaired man.
Cooper & Others v Holiday Coast Cinema Centres Pty Ltd [1997]	1997	HREOC	Access to premises	Mobility	Attractions must have access provisions.
W v P Pty Ltd	1997	HREOC	Employment practice	Mobility	Tourism providers cannot discriminate against people with disabilities as employees
Maguire v SOCOG (Ticket book)	1999	HREOC	Access to ticketbook	Vision	Organisations need to provide access to information in alternative formats
Maguire v SOCOG (Internet)	2000	HREOC	Internet access	Vision	Organisations need to provide Internet access for people with vision impairment or print disabilities
Cooper, President North Coast D.I.A.L. Inc. v Coffs Harbour City Council	2000	HREOC	Environmental planning procedures	Mobility/all	Local government authorities must incorporate spirit and intent of the DDA within DA approval process
Pruszinski Architects v. the City of Adelaide	2001	EnvRes&Dev SA	Access to swimming pool in Hotel	Mobility	Developers must include access all recreational facilities in a hotel

Complaint Case Name	Year	Dimension	Discriminatory Practice
Access in country trains	1994	Mobility	<ul style="list-style-type: none"> Segregated provision in a guard's carriage
Toilet access & wheelchair seating on coaches	1994	Mobility	<ul style="list-style-type: none"> Long distance coach service offered no accessible toilet or seating options
Access to interurban trains and main terminal station	1995	Mobility	<ul style="list-style-type: none"> Lack of physical access to stations and ingress and egress from carriages
Air travel with own oxygen	1996	Medical	<ul style="list-style-type: none"> Pilot refused access to man with oxygen even though airline had approved
Guide dog on tour	1996	Vision	<ul style="list-style-type: none"> A tour guide operator refused to allow a blind man to be accompanied by his guide dog
Hand controls for hire car	1996	Mobility	<ul style="list-style-type: none"> A hire car firm did not provide an option for hand controls
Less favourable treatment in a hotel	1996	Cognitive	<ul style="list-style-type: none"> Hotelier required a party with a person with cerebral palsy to relocate to a less visible section
Shop apologises to man	1996	Disfigurement	<ul style="list-style-type: none"> A shop asked a man to leave his shop because of the way he looked due burns scars
Sleeping carriage access	1996	Mobility	<ul style="list-style-type: none"> A new rail service provided no access to sleeping carriages
Travel insurance for mental disorder	1996	Cognitive	<ul style="list-style-type: none"> Travel insurer refused to honor an insurance agreement
Hotel disability access improved	1997	Mobility	<ul style="list-style-type: none"> A hotel that advertised access proved not to be accessible to wheelchair users
Travel accompanied with medical condition	1997	Cognitive	<ul style="list-style-type: none"> Requirement that a woman with epilepsy needed to travel with an attendant was upheld
Blind access to information kiosks	1998	Vision	<ul style="list-style-type: none"> Government authority information kiosk was inaccessible
Restaurant access/heritage and planning concerns	1998	Mobility	<ul style="list-style-type: none"> Planning processes did not include physical access to a heritage listed restaurant
Hotel design causes wheelchair accident	1999	Mobility	<ul style="list-style-type: none"> Hotel design and lack of signage resulted in a wheelchair user having an accident
Regional Airlines Association	1999	Mobility	<ul style="list-style-type: none"> application for an exemption to carry wheelchair users was refused
Access to consumer information	2000	Vision	<ul style="list-style-type: none"> Government authority did not consumer information in alternative formats
Beach access restored	2000	Mobility	<ul style="list-style-type: none"> Change to beach access restored for mobility impairment
Deaf access to tourist experience	2000	Hearing	<ul style="list-style-type: none"> No provision of alternative formats for guided tourism experience
Failure to ensure access conditions fulfilled	2000	Mobility	<ul style="list-style-type: none"> Council approved hotel development that was inaccessible
Oxygen on plane	2000	Medical	<ul style="list-style-type: none"> Airline had discriminatory pricing for use of onboard oxygen
Refused attendance at conference	2000	Cognitive	<ul style="list-style-type: none"> Conference organiser refused person registration because of their intellectual disability
That's a guide dog mate...	2000	Vision	<ul style="list-style-type: none"> A hotelier required a parking to leave a hotel because they were accompanied by a guide dog
Toilet access only in 1 st class carriages	2000	Mobility	<ul style="list-style-type: none"> Toilet provision was only in first class carriages
Accessibility of existing long distance rail carriages	2001	Mobility	<ul style="list-style-type: none"> A rail carrier provided no access to existing a long distance route
Airline lounge access	2001	Mobility	<ul style="list-style-type: none"> Airline club lounge facilities did not provide access
Airline terminal access	2001	Mobility	<ul style="list-style-type: none"> New budget airline did not provide mobility access to terminal
Carer attendance at camp	2001	Medical	<ul style="list-style-type: none"> Camp organizer charged for a carer who attended with a girl
Conference registration fee for carer	2001	Mobility	<ul style="list-style-type: none"> A conference organizer insisted on the carer of an attendee paying full registration fees
Deaf access to conference	2001	Hearing	<ul style="list-style-type: none"> Conference organizer refused to provide a sign interpreter for an organisation member
Higher price for accessible cruise cabin	2001	Mobility	<ul style="list-style-type: none"> A cruise ship operator charged a higher price for an accessible cabin
Making inaccessibility a museum piece	2001	Mobility	<ul style="list-style-type: none"> A refurbished museum did not provide adequate access to facilities
On plane wheelchair access	2001	Mobility	<ul style="list-style-type: none"> Travel arrangements for on board access to toilet not provided
Transit procedures reviewed	2001	Mobility	<ul style="list-style-type: none"> Airport transit arrangements fail to fulfil travel planning contract
Caravan park facilities	2002	Mobility	<ul style="list-style-type: none"> A caravan park did not provide a toilet with mobility access even though they said they did
Hotels provide television captioning	2002	Hearing	<ul style="list-style-type: none"> No access to Hotel TV captioning and TTY systems

Source: Selection from 150 HREOC complaint cases http://www.HREOC.gov.au/disability_rights/decisions/ (HREOC 2002a)

B. Disability Action Plans

Under the DDA, Disability Action Plans (DAP) are used to strategically address systemic organisational disability issues. As at 30 June 2001, some 211 DAPs had been registered with HREOC, comprising 24 by business enterprises, 20 by non-government organisations, 30 by Commonwealth government agencies, 28 by State government agencies, 76 by local councils, and 33 by education providers (HREOC 2002b). Among these there was only one TA, Tourism NSW (2000a), and no private sector tourism organisation (HREOC 2002b). As discussed in Chapter 2, DAPs seek to provide a strategic approach to identifying disabling practices and environments within organisations and provide enabling outcomes through a strategic approach. They are voluntary for Commonwealth and state government, although they were strongly recommended by HREOC and the CAGD.

The government transport sector has been the most active government agencies in this area, with twelve Commonwealth and state government transport agencies lodging DAPs. This may be explained by the *Disability Standards for Accessible Public Transport* creating a high priority for dealing with these issues and other transport organisations seeking temporary exemptions. The exemptions included air, rail and bus transport with direct implications for tourism (HREOC 2001e). DAPs have an added advantage in that, if a complaint is made against an organisation with a lodged DAP, HREOC considers the DAP to be part of the defence against the complaint. An example of this occurred when a complaint lodged against a local authority in relation to access to premises was denied because the authority had a DAP in place that had a strategy for dealing with this issue in the future (HREOCCC Oct 1999).

As indicated in Section 9.1 above, only one TA, Tourism NSW, has lodged a DAP and no TI organisation has done so. It is also noted above that the NSW plan resulted from a government-wide edict, rather than from its own initiative, and resulted in no discernible impact on service development for people with disabilities. As a Tourism NSW spokesperson stated: ‘I suppose the approach is skeptical ... the organisation has not embraced the concept, it has been more a couple of people within the organisation who have had an interest and who carried the banner’ (Anderson 2002, pers. comm.).

This in itself is an important point to note as organisational change often starts with

enthusiastic individuals within the organisation who embrace disability and access issues. They become *disability product champions* and bring the organisation along with them. Further, these individuals need to be sufficiently highly placed in the organisation to be able to influence organisation practice (Meekosha and Jakubowicz 1987). As with attitude change, this takes time. Anderson goes on to suggest that the situation was changing by 2002 when Tourism NSW had implemented disability awareness training across the organisation for 90% of staff.

I think in the last six months since the disability awareness training has been undertaken that more people in the organisation have an understanding and may now be able to see that the implementation comes under their responsibility (Anderson 2002, pers. comm.).

The Tourism NSW example demonstrates that a DAP alone does not signify a change in organisation culture towards disability tourism. It suggests, the change in culture did not start to occur until disability awareness training had occurred at all levels of the organisation. This created a sense of ownership of the issues within each business unit. In particular, Anderson linked the disability awareness training sessions with the review of the DAPs that was organised on a business unit level (Anderson 2002 pers. comm.).

C. Disability Standards for Accessible Public Transport

Lack of access to transport, particularly public transport, has long been a constraint on people with disabilities wishing to enjoy the rights of citizenship, as outlined in Chapter 4. Chapter 8 identified particular concerns about transport within the tourism context. From the earliest calls for accessible public transport, government and the transport industry sought to thwart the rights of people with disabilities to participate due to ableist discourses. These discourses are evident in the earliest struggles of people with disabilities to gain access to public transport.

An example an ableist discourse was provided by a spokesperson for the NSW Urban Transit Authority delivered an address that suggested that, 'it could be a case that a significant proportion lack the desire or the ability to achieve mobility' (NSW Dept. of Tourism 1981: np). His presentation then went on to support the introduction of a paratransit system that would provide a subsidised alternative to the 'costly' imposition of providing accessible public transport. Twenty-two years on this provides insights into the experiences documented in Chapters 7 and 8.

The complaint cases identified in Chapter 8 and Section B above highlighted tourism-specific public transport issues. These complaint cases brought about industry interest in developing a Disability Standard for accessible public transport, largely to bring certainty to the transport sector in its operations. People with disabilities and groups representing them viewed the idea of a standard in two lights. First, it would provide an opportunity to obtain a uniform approach to accessible public transport across the states of Australia. Second, however, there was concern that a standard that might not be as effective as complaint cases because it was felt that they would probably reflect the view of industry at the expense of people with disabilities (Corcoran 2001).

A signifier of industry resistance to the standards was the prolonged process for their establishment. The *Disability Standards for Accessible Public Transport* (CAGD 2001a; 2001b) were formulated after six years of negotiation. This process involved a heated debate amongst stakeholders, which revealed that many industry bodies and state government transport departments did not want to see their implementation. The draft standards were first endorsed by the Australian Transport Council in May 1996 before transport industry pressure brought about their delay through the Regulatory Impact Statement (RIS) process (Price Waterhouse 1997; Todd 1999 - see Chapter 2).

There was great concern within the disability community that the industry peak body, the Australian Transport Council, would not endorse the draft standards due to transport industry pressure. A coalition of disability organisations organised the *We Shall Ride* campaign that culminated in an overnight vigil of people with disabilities outside the venue for the April 1999 meeting of the Australian Transport Council (Disability Action Inc. 1999a). The meeting subsequently endorsed the draft standards (Disability Action Inc. 1999b), but renewed pressure by industry and some government transport authorities yet again slowed the process of approval.

These actions by industry and some government transport authorities led HREOC to issue a *DDA Advisory Note on Public Transport* (HREOC 1999), which endorsed the draft standards by indicating that HREOC would consider them in complaint handling and exemption applications. HREOC took this action, as there was a perception amongst the disability community that again the delay was caused by undue influence by the transport industry (Corcoran 2002a). This was based on the over-estimation of the cost and an underestimation of the community benefits of accessible public transport expressed in the

RIS by transport industry bodies (Australian Bus and Coach Association 1995; Deloitte Touche Tohmatsu 1996; Australian Bus and Coach Association 1997; Price Waterhouse 1997; Todd 1999). These ableist and market discourses have also been documented in overseas studies of mass transit operators (Almon-Hamm 1997).

The cost issue was exemplified by the *Regulatory Impact Statement on Draft Disability Standards for Accessible Public Transport* (CAGD 1998; 1999) misrepresentation of the true costs of providing accessible public transport (Physical Disability Council of NSW 1997; Hodge, Corcoran and Murfitt 1998; Physical Disability Council of Australia 1999). Firstly, this involved the over-estimation of costs of implementation, particularly the \$1200 million estimate to implement accessible rural and school bus services (these were excluded from compliance). Secondly, the RIS under-estimated the benefits based on a narrowly defined conceptualisation of disability, poor understanding of the economics of inclusion, and a lack of understanding of the replacement cycle of transport modes (Vintila 1996; Frisch 1998). Even with these weaknesses, the revised RIS showed that the costs of implementation to be \$3737 million and the benefits derived to be \$2655 million (CAGD 2002a).

In the RIS cases, the cost evidence presented is more polemic than detailed higher costs of providing accessible facilities. The estimates presented rarely include an assessment of the benefits of improved disability citizenship and the substantial extra costs of providing segregated facilities and services. As Bagshaw (2003) suggests, an inaccessible community costs the Australian government US\$29bn annually in continuing welfare payments and the cost of lost social opportunity. A great deal of industry scare mongering involves the cost of making existing infrastructure accessible through retrofitting. Yet, the logic used in this ableist and market ideology shows a lack of understanding of the DDA, which does not require retrofitting. This was most recently borne out in cost estimates for the Disability Education Standards where estimates for state education departments varied from \$2.2m to \$1.8bn (The Allen Consulting Group 2003). The Federal Minister for Education showed his contempt for the methodologically questionable RIS estimates by immediately adopting the *Disability Standards for Education* against the wishes of all but two State governments.

A final amendment to the *Disability Standard for Accessible Public Transport* extended the implementation period to 30 years instead of 20 years for trains and trams and excluded

charter services (CAGD 2002b). The exclusion of charter services was a major blow for tourists with disabilities. The Commonwealth ratified the Standard on 23 October 2002 after the *Disability Discrimination Amendment Bill 2002* was passed to allow temporary exemptions to the standards (CAGD 2002b). However, the disability sector was critical of this mechanism for exemption as it provides the transport sector with a provision to avoid short-term compliance (Corcoran 2002a).

The implications for the tourism experiences of people with disabilities in the short term are bleak for those relying on public transport and day tour services. This is because the public transport system will remain largely inaccessible to people with disabilities and, hence, they will remain reliant on paratransit systems, which were noted for their inefficiencies (Folino 1999; HREOC 2002b). In particular, people with disabilities are at a distinct disadvantage with day tour and coach transport operators. People with disabilities will remain segregated from the general tourist population for the foreseeable future. This is due to the history of public transport development in Australia, the pluralist actions of the transport sector and sections of the government transport authorities in resisting the transport Standard for charter services.

D. Disability Standard for Access to Premises

Support for a specific Disability Standard for access to premises arose in the 1990s as a result of the perceived uncertainty of existing access requirements under the Building Code of Australia (BCA), relevant Australian Standards and the spirit and intent of the DDA (Ozdowski 2001). What was regarded as *reasonable access* was contested by the stakeholders (ABCB 1996a; 1997b; 1997a; 2001a).

In 2001 the Australian Building Codes Board (ABCB) released a discussion paper on the proposed Standard, the BCA review, AS1428 and other issues about harmonising the BCA and the DDA requirements (ABCB 2001b) and established a Built Access Policy Committee (BAPC) to oversee the project. The membership of the BAPC was constituted by representatives from:

- Attorney-General's Department;
- ABCB;
- Australian Construction Industry Forum;
- Australian Procurement and Construction Council;
- Australian Local Government Association;
- DDA Standards Project – disability sector representatives;

- Department of Industry, Tourism and Resources;
- HREOC;
- Property Council of Australia; and
- The design professions.

The membership of the BAPC is a signifier of the unequal power relations within the DDA process, reflected in the fact that, while HREOC would provide disability legal advocacy, people with disabilities themselves had one voice on the committee. The BAPC was made up of industry/government representatives who viewed the issue predominantly from a market perspective. As part of the consultation process workshops were held in major cities around Australia. The Sydney workshop was held in March 2002 and provided an insight into the various stakeholders' positions (see Appendix 7). At the time of writing, it was intended that the proposed DDA Standard would proceed after the ABCB stakeholder consultation processes were finalised in 2003. This is still to be concluded.

Three values underpin the proposed Australian Building Codes Board standards on access to premises (ABCB 2001b): certainty; cost-effectiveness; and equitable access:

- Certainty relates to the desire of industry and of government regulators to provide a system, which provides legal protection against complaint cases if building owners/managers, adhere to the proposed standard.
- Industry will only countenance a standard if they believe it is cost-effective from their perspective.
- HREOC and people with disabilities want equitable access and a greater inclusion of the benefits of providing an accessible environment (PDCN 1997; Frisch 1998).

The major issues under consideration are presented in Appendix 7. Most of the broad issues dealt with the provision of a continuous pathway for the different dimensions of access, wayfinding and safety. However, a number of inclusions have direct relevance to the findings of Chapter 8 and for tourism generally. These include:

- Access to guest houses, hostels, B&Bs or the like (Class 1b Buildings);
- Number of accessible rooms in hotels/motels (Class 3 Buildings);
- Access to common areas within hotels/motels (Class 3 Buildings); and
- Access to swimming pools and other recreational facilities.

In general, industry representatives, on the ostensible grounds of cost-effectiveness, are resistant to the imposition of standards considered necessary and adequate by disability representatives. The nature of the process undertaken to manage the stakeholders' positions suggests that compromise may occur, but, given the weight of membership of the committee, this process may well disadvantage people with disabilities. While the outcome

of this process should not be pre-judged, the process itself provides an insight into the position and the relative power of people with disabilities within a pluralist public policy environment.

E. Disability and access in the development of environmental planning processes - accommodation provision

While the above section considers the important issue of specific standards for disability access in regard to accommodation, such matters are embedded in a wider range of issues concerning the planning of the built environment which are central to the tourism experiences of people with disabilities from an accommodation and destination perspective. Chapter 8 documented the tourism-specific barriers to the built environment encountered in the tourism experiences of people with disabilities. Further, Appendix 9, drawing on the interviews and qualitative responses to Tourism NSW (Darcy 1998), documents the components of the built environment that people with disabilities regarded as essential to their experience of any environment. As L.J. Davis (2002) suggests, the non-disabled take the provision of these essential components of access for granted whereas people with disabilities can never take them for granted.

The structural-historical forces that forge the production of the built environment are comprised of government legislation, regulation and market forces. The government regulated environmental planning process involves assessing diverse stakeholder positions within the regulatory framework. Yet much of what is documented in Chapter 8 involved examples of discrimination in which people with disabilities were not treated equally before the law. While the government regulates the market environment, it is the market environment that dominates the discourse of the planning, design, construction and operation of the built environment. This section reviews aspects of the environment planning process to provide a structural-historical explanation for the accommodation experiences of people with disabilities. This involves: the development of disability and access considerations; equality of provision; accessible room provision; and the role of professionals and professional values in regulation.

The development of disability and access considerations

Many of the accommodation issues identified in Chapter 8 can be understood through the development of environmental planning processes. There were no Australia Standards for access and mobility until 1977 (Fox 1994) and it was not until the early 1980s that access

requirements for people with disabilities became part of state building regulations (Murray 1994). However, these varied for each state (e.g. in NSW: NSW Dept. of Local Government 1981a; 1981b; NSW Dept. of Environment and Planning 1985) and were far less inclusive than the later BCA inclusions (BCA 1990; 1996). The BCA brought a uniformity to building regulations across Australia, identified situations where access for people with disabilities must be provided and outlined the provisions through reference to the Australian Standards (Standards Australia 1992c; 1993; 1999; 2001). The provisions of access for people with disabilities to hotels and motels (Class 3 Buildings) were first stipulated through *Ordinance 70* (NSW Dept. of Local Government 1981a) and consequently Part D3 of the BCA (1990; 1996).

Due to the development of Part D3, most budget and 2-3 star accommodation stock was built during the 1960s and 1970s (ABS 2000b) when there were no access requirements under the state building regulations. The next major tourism building boom occurred in the second half of the 1980s and involved mainly 4-5 star hotels and resorts (Griffin 1989; Darcy 1991; ABS 2000b). These developments were subject only to the provisions of state-based building legislation (ABCB 1996a) which included comparatively low standards for access requirements, as shown in Table 28. Similar Australia-wide standards were introduced by the BCA in 1990 but in 1996 the BCA (1996) reviewed the numerical requirement and doubled the previous provisions. This became known as the 5% rule, which specified that one in twenty rooms in new establishments were required to be accessible (see Table 28).

Table 28: Hotels/motels – accessible room requirements, 1981-1996

Size of Establishment	Number of Accessible Rooms		
	New South Wales Ord 70 1981	Australia BCA 1990	Australia BCA 1996*
10-49 Units	1	1	2
50-99 Units	2	2	5
100+ Units	3	3	6

Source: NSWDLG 1981a; BCA 1990; 1996 * 1 sole occupancy unit for every 20 units - the 5% rule.

Equality of provision

The development of the BCA led to a range of anomalies experienced by people with disabilities, as documented in Chapter 8. The 1996 changes to the BCA for the number of sole occupancy units was recognition of supply restrictions in accessible accommodation stock (ABCB 1996a). While the numeric standard was changed, there was little

recognition of the other dimensions that were identified in Chapter 8 and, which collectively make up the *equality of provision* of accessible rooms. These include the location of rooms in the establishment and the range of classes of room available.

The early state-based provisions (NSW Dept. of Local Government 1981a) referred only to the number of rooms and not to their location or class. The language used in the advisory note recognised that the:

...design requirements are innovatory but untested. At every stage of their development adjustments have to be made to cope with previously unforeseen problems... the important thing to keep in mind is the aim of the overall exercise to make buildings as accessible as practicable (NSW Dept. of Local Government 1981b: 550/33).

From the government perspective, the disability and access inclusions were seen as a problem and that there was a loophole of making buildings as *accessible as practicable*. The 1990 BCA recognised these omissions and included the phrase, ‘accessible rooms must be distributed as equitably as is practical to be representative of the range of amenity available’ (BCA 1990:37) including rooms with self-catering features. Further to this, the BCA (1996) introduced performance-based criteria and this provided further leeway for developers to try to avoid compliance.

While the intent was evident, the qualification ‘as equitably as is practical’ and the performance based criteria has meant, in practice, that most hotels were constructed without providing what might be termed ‘equality of location’, as evidenced in Chapter 8, where people with disabilities are relegated to the second class accommodation vistas. For example, a letter to Tourism NSW from a wheelchair using international visitor to Sydney queried the lack of wheelchair accessible rooms with a view of Sydney Harbour or Darling Harbour (Anderson 2001, pers. comm.). Only one hotel was found to have an accessible room with a view of the harbour, and even that was a limited one. No rooms facing Darling Harbour are accessible¹⁰. All the accessible rooms have a view of the poorer vistas and not of the environmental ‘jewels’ that Sydney is marketed on.

The inadequacy of the environmental planning processes let many of these issues pass into development without being adequately addressed. It was not until *Cooper v Coffs Harbour Council [2000]*, and *Pruszinski Architects v. the City of Adelaide (2001)* and the subsequent clarification by the acting Disability Discrimination Commissioner (Ozdowski

2001), that the environmental planning processes were brought to account. Not only did the accommodation sector have to provide access to all classes of accommodation and an equality of amenity but also they must provide access to all social and recreational areas of the accommodations. The anomalies identified in Chapter 8 could be redressed through developing a third-party system of access verification. Apart from the ABCB (2001), these issues had previously been discussed at a national level (NAWG 1999).

Professional roles and values

A number of professions and quasi-professions are involved in the development of tourism infrastructure, including planners, architects, engineers, and designers. Each profession has its own set of values and discourses engendered through education and practicing within a professional culture. These may or may not include access requirements within their curriculums. The lack of accessibility of tourism infrastructure has arguably been caused by breakdown in the environmental planning processes as regards what practically constitutes accessibility, among:

- the architects, planners and builders at the design, planning and construction stages through the lack of understanding of access, disability or compliance to the BCA, the Australian Standards and the DDA; or
- management, staff and consumers in the operations or supply chain (wholesale and retail) stages through what constitutes accessibility, whether rooms are accessible, consumer needs and information communication processes.

At any of the five development stages the integrity of access and access information can be compromised, producing the experiences documented in Chapter 8. However, it is not only people with disabilities that are the losers but also the owners, leaseholders and managers who think they have accessible product. Poorly constructed accommodation stock and inaccurate access information is inefficient from an individual's perspective (time, money, lost opportunity and impact on future behaviour) and from the provider's perspective (reduced functionality of accommodation stock and wasted outlays).

The previously mentioned court determinations and complaint cases, as summarised by Ozdowski (2001), exposed a lack of understanding of disability and access issues by developers, architects, planners, owners and managers. They did not ensure an equality of access and service provision for people with disabilities. At any point in the environmental

¹⁰ The researcher is a member the Planning Institute of Australia and an Accredited Access Auditor.

planning process disability and access issues should have been flagged. However, they were not, and these and a multitude of similar developments proceeded. The actions or non-actions by these groups were a signifier of the Australian construct of an inclusive community and people with disabilities' right to citizenship – simply to provide as little access as possible.

These determinations exposed the ableist discourses of those professionals charged with implementing disability and access in the development processes (Chouinard 1997; Gleeson 1999b). Goldsmith (1997) refers to this as *architectural disablement*, where a person is subjected to disabling constraints in buildings that should not have been there if the architect had designed the building with disability and access considerations. Holland (1999) and Imrie (2000a) argue that disability and access issues have been absent from the curriculum and, hence, the professional values of architects where the discourse of the aesthetic predominates. This in turn leads to the creation of disabling environments, and in a broader context, disabling cities (Imrie 1996). Yet, the complaint cases and Federal court determinations suggest that this professional failing is much broader than just the role of architects. In effect, all groups of professionals involved from *design* ➔ *planning* ➔ *construction* ➔ *operations* ➔ *wholesale/retail* discounted the importance of disability and access. By doing so people with disabilities were excluded from tourism opportunities and, hence, their rights of citizenship.

F. Management of accommodation

One of the outcomes of E, is that the BCA mandates that a certain number of accessible rooms must be provided in accommodation establishments. However, the tourism experience of the user is mediated by the subsequent management of this stock and is part of the social relations of the accommodation sector. Further, industry attitudes are shaped by their experiences in managing the stock and this feeds back, via lobby groups, into the policy formulation process.

In particular, the industry is concerned with costs and returns. The industry is aware that accessible rooms cost more to provide than standard rooms, but the DDA is clear that a person cannot be charged extra for an accessible room. This situation is exacerbated by the assertion of some owners and managers that their accessible rooms are under-utilised. Therefore, the provision of the required number of accessible rooms is portrayed as a

costly imposition. Consequently these same stakeholders have been seeking to reduce the number of accessible rooms required under the BCA, as noted above.

Chapter 8 suggests that people with disabilities make the decision not to stay at establishments where rooms do not provide the features required. This would also explain why some owners and managers are critical that their accessible rooms were under utilised. Research of the use of accessible rooms by the non-disabled has not received any attention in the literature. While there have been no published reports, these anecdotal reports by managers indicate that their *disabled rooms* have lower occupancies and are not liked by the non-disabled. These same stakeholders had been seeking to reduce the number of accessible rooms required under the BCA (AHA 1998; Mirvac Hotels 1998; B. Thomas 2001). This resistance to the provision of accessible rooms continued through to the consultations for the proposal for a DDA Standard for Access to Premises (ABCB 2001b). The CDITR had encouraged members of the sector to make submissions to the ABCB relating to accommodation and the number of accessible rooms (Newhouse 2002).

These views seem to be firmly entrenched in parts of the industry, but its validity is challenged by three key issues: sale policies related to the rooms; quality issues; and marketing.

Sale policies

If accessible rooms are available for use by the non-disabled as well as people with disabilities then, *prima facie*, there should be no issue of under-occupancy of these rooms. As indicated earlier in the chapter, many managers interviewed said their establishments had a policy of keeping the accessible rooms available as long as possible for people who had a need for them. The accessible rooms therefore became their 'last sale' rooms. Occupancy rates for the majority of hotels range between 30 and 70%, so this practice has no impact on occupancy rates until they approach 95%. Only when occupancy is near capacity or where the accessible rooms are in the parts of the hotel with better vistas, are they heavily used by the non-disabled. The policy of using accessible rooms as last sale therefore leads to biased occupancy statistics and management perceptions of the rooms.

Quality

Whether rooms in particular hotels are utilised may be related to their quality. A generally low level of quality could result in a generally low level of utilisation, from both people

with disabilities and the non-disabled. Establishing this would require each room be audited to determine the level of access, class, price, location, outlook, aesthetic quality and availability of alternative local and accessible competitors. Generally, it would seem, the accommodation sector does not apply the same quality management principles to disability product as they do to the non-disabled product – a ‘disabled room’ is a ‘disabled room’, regardless of quality. The evidence presented in Chapter 8 suggested that many rooms regarded as accessible by the TI were not accessible or did not provide an equality of access to people with disabilities. In effect, this is a market argument about room selection from a disability perspective – people with disabilities do not necessarily choose to use a room just because a hotel regards the room as accessible. The ONT (1998b) identified Australian examples of best practice of high quality accessible rooms where occupancy is well above the TI average. Yet, these establishments are never used in TI arguments to improve benchmarks for accessible rooms and establishments.

Marketing

As earlier sections of this chapter have documented, accommodation establishments rarely provide information about access or market accessible rooms generically or specifically to people with disabilities and information collated by the TA is often incomplete and/or inaccurate. It would not therefore be surprising if these rooms were under-used. An organisation that does not market their facilities cannot expect them to be used. In such circumstances it would seem that people with disabilities would be being blamed for non-use although their information and marketing needs have not been met (Reedy 1993; Burnett 1996; Burnett and Bender-Baker 2001).

G. Implementation of Citizenship Rights

The human rights agenda promote the citizenship rights of people with disabilities. Citizenship rights (see Section 2.3) involve the relationship between the individual, the social system and the state. Importantly, the state through policy or legislative frameworks must provide supportive mechanisms to protect and ensure those rights. The development of disability and access considerations in the environmental planning process demonstrates that legislation requires a political will to implement. While there were disability and access considerations in the environmental planning process before the DDA, these were implemented on an ad hoc basis by state and local government authorities without bringing a uniformity to the process (Ozdowski 2001).

The weaknesses of complaints based legislation (M. Jones and Basser Marks 1999; Thornton 2000; Handley 2001) have been compounded through the political implementation of the DDA over 1990s. The supportive mechanisms of the State in Australia eroded the powers of the DDA through three actions. The first was to significantly cut the funding of HREOC, effectively hampering its ability to hear complaint cases and carry out its functions in a timely manner (Banks 1997; Pengelly 1997). Second, the removal of HREOC's powers to undertake hearings of complaint cases that could not be conciliated through the *Human Rights Legislation Amendment Act, 1999* meant that the Federal Court of Australia was the only body that could make binding decisions (D.J. Boniface 1997). This amendment changed the inquiry process of HREOC to the cost jurisdiction of the Federal Court. This meant that individuals bringing Federal Court actions faced the likelihood of having the other party's cost awarded against them whether they won or lost the case. This fundamentally changed the power of the DDA by reducing the likelihood of an individual taking a Federal Court action. In effect, this has sent a signal to industry interests that conciliation can be dispensed with, as people with disabilities will not have the economic resources to mount Federal Court actions (Handley 2001).

Third, the abolition of the position of the Disability Discrimination Commissioner was a powerful signifier that disability rights were no longer viewed as a priority issue by the Commonwealth government (D.J. Boniface 1997). This action, together with the funding cuts and structural changes to HREOC marginalised its disability powers (Lagan 1998). This limited HREOC's powers to administer the DDA and resulted in the dilution of citizenship rights for people with disabilities in Australia. This dilution may have eventuated through pressure brought by industry, based on the market ideology that perceives access as equalling substantial extra costs. Section C and D above argue that there was a change in power in the implementation of the DDA, from people with disabilities to other stakeholders, following the initial success of the complaint cases. It has also been argued that the changes were a product of the liberalist ideology of the Howard government (Thornton 2000; Handley 2001). Liberalist ideology believes firstly in less government regulation of the market and, secondly, in individuals determining their own destiny where inequality is a motivation rather the use of equity programs (Leach 1993).

These three changes have brought about an environment where citizenship rights of people

with disabilities are being eroded in Australia. An example of the attack on the citizenship rights was highlighted by the comments of Stuart St Clair, Federal MP for New England. At the 2001 NSW National Party Conference he claimed that ‘building facilities for people with a disability is killing country towns...he attacked the provision of toilets for the aged and disabled, claiming that they were examples of excessive government regulations’ (Silmalis 2001). In making this statement, St Clair challenges a basic human rights provision of the DDA – that people with disabilities have a right to use accessible toilets away from their homes. In a rebuke of this position, Heath (2001) made the connection between tourism, universal design and inclusive communities ‘where people are welcome, not places where the aged and disabled need to look for a bush to relieve themselves’ (Heath 2001). This example is similar to the arguments put forward in the RIS process for the Standards examples discussed earlier in this Chapter (CAGD 1998; ABCB 2001b).

The arguments are typical of a market ideology and ableist discourse where disability is framed as a dichotomy between costs verse citizenship. This dichotomy is used to stifle the provision of accessible facilities. The assumption is that people with disabilities do not have the same rights of citizenship as the non-disabled if those in power perceive the costs to be too high. These assumptions prioritise disability and access after all other social considerations and reinforce the medical model worldview of disability as *other*. This *otherness* is regarded as less than the non-disabled and allows discrimination on assumptions that access is a substantial extra cost on top of social infrastructure expenditure. This discourse does not recognise the inefficiency of a poorly conceived planning framework that does not incorporate the benefits of including disability and access from the outset.

9.5 Ending

The chapter has reviewed TA initiatives and, as an example of the TI, accommodation sector practices in regard to tourism and disability. In so doing, it provides partial answers to a number of the research questions posed in Chapter 5. These are discussed in turn below. Research question 3 concerns the policies and practices of both the TA and TI and the summary is divided into two groups.

Identifying the practices of TA in regard to service provision for people with impairments (RQ 3)

In regard to the activities of Commonwealth and state tourism marketing authorities (TA),

it was found that:

- Tourism authorities in Australia have been involved in a range of disability-related initiatives over the 15 years, including:
- *Preparation of strategic plans* - confined to two states (SA and NSW), but in neither case was there evidence of follow through and implementation.
- *Industry awareness campaigns* – two initiatives by the federal government, but no goals or evaluation of outcomes were built into the project, and interviews with accommodation managers for this research suggests minimal impact on the industry.
- *Collection, processing and dissemination of access information* in regard to transport, accommodation and attractions – the most common type of activity involving all TA, however, the results were invariably far from comprehensive in coverage of establishments or in consideration of types of access, relied on self-reporting on the part of tourism establishments, and generally failed to provide precise information which would be of practical use to people with specific impairments.
- *Research* – only two TA-sponsored research projects on tourism and disability are known to have been conducted in Australia with one publicly available, and the major national tourism research vehicle, CRC Tourism, supported financially by all TA, includes no disability-related research.
- In general, therefore, it can be seen that each of these groups of initiatives has been limited in scope or flawed in execution, or both.
- Invisibility, inaction, omission or an *ad hoc* approach has marked TA approaches to disability and tourism over the last 15 years.
- The various activities undertaken by the TA have lacked a strategic approach to address the issues identified in the early 1990s to transform the rhetoric of the concept of people with disabilities as an emerging market segment into a reality. The most notable initiative was the development of a tourism strategy for people with disabilities by the South Australian Tourism Commission. However, its implementation was hampered by a lack of resources.
- Apart from limited Commonwealth efforts to raise TI awareness nothing has been done to address the underlying reasons for the dissatisfaction which people with disabilities experience in seeking to participate in tourism.
- The ATC, the most well-funded TA in Australia and the lead TA for information provision, marketing and promoting Australian tourism product overseas, has undertaken no disability-specific projects beyond basic fact sheets, listing self-reported information and the promotion of the Paralympics as an event (Pembroke 2002 pers. comm.). Analysis of these sources suggest that the ATC does not understand the issues surrounding disability and access but has not sought expertise to improve its information provision responsibilities.

Identifying the practices of the tourism industry (accommodation sector) in regard to service provision for people with impairments (Research Question 3)

The accommodation sector managers in this case study responses to disability are complicated by many interrelated factors.

- *Lack of awareness.* Accommodation sector seem largely unaware of the disability legislation, and their related responsibilities or of any initiatives taken by the TA in this area.
- *Limited focus.* The main focus of accommodation managers in discussing disability is on designated ‘disabled rooms’ but these were not regarded as a valuable part of their accommodation stock.
- *Limited market orientation.* The accommodation sector managers do not treat disability as a market segment, although there is some recognition of, and experience with, disabled athletes.
- *Lack of information and promotion.* As a result of lack of knowledge and understanding of disability needs and lack of recognition of disability as a market segment, managers have generally not collated and utilised access information to market and promote their facilities generically or specifically to people with disabilities.
- *Limited premises awareness.* A precursor for adopting a market segment approach requires managers to understand the accessible features of their premises. None had undertaken this fundamental work.

The role of TA and TI practices in producing the constraints on tourism opportunities and experience identified in Chapter 8 (RQ 3a)

The effects of the practices identified above on the tourism opportunities and experiences of people with disabilities can be summarised as follows:

- TA1. Lack of strategic planning
- TA2. Lack of industry awareness raising
- TA3. Poor information provision
- TA4. Lack of research
- TI1. Lack of awareness
- TI2. Limited focus
- TI3. Limited market awareness
- TI4. Lack of information and promotion
- TI5. Limited premises awareness.

Table 29 cross-references these practices with the summary of constraints presented in Chapter 8 and further constraints identified in this chapter to indicate those constraints unduly affected by TA and TI practices (represented by ✓). The constraints left blank indicate that they were not predominantly the responsibility of the TA or accommodation sector. Some of these constraints are investigated further in Chapter 10.

Table 29: Summary of Constraints in Relation to TA and TI Practices

CATEGORY (Intrinsic) (Smith 1987)	CONSTRAINTS EVIDENCE FROM THIS THESIS INTRAPERSONAL	Practices of TA & TI that contribute to each constraint									
		TA1	TA2	TA3	TA4	TI1	TI2	TA3	TA4	TA5	
Lack of knowledge	• Significant constraint for non-travellers or with recently acquired disabilities	✓	✓	✓	✓	✓				✓	
	• Similarly, for associates or service providers who organise trips	✓	✓	✓	✓	✓				✓	
Health related problems	• The TA/TI doesn't recognise the difference between disability and illness	✓	✓		✓	✓	✓			✓	
	• Inflexible booking arrangements to minimise pain and discomfort	✓	✓	✓		✓	✓			✓	
	• Lack of temperature controlled environments	✓	✓		✓	✓				✓	
Physical and psychological dependency	• Reliance on full time carers or attendants (see also of attendant care programs)				✓						
	• Dependency on family members as carers				✓						
	• Dependency on monopolised personal care and paratransit services				✓						
(Communication)	INTERPERSONAL										
Skill-challenge incongruities	• TA/TI assumptions of ability limited pwd choices of what was offered.		✓	✓	✓	✓	✓	✓			
	• Risk involved in participating due to lack of access to environments		✓	✓	✓	✓	✓			✓	
Communication	• Non-disabled aversion to communicating with people with disabilities		✓	✓	✓	✓					
	• Attendants as communication facilitators		✓		✓	✓					
	• Disability as an <i>appropriate other</i> to be gazed upon		✓		✓	✓					
(Environmental)	STRUCTURAL										
Lack of information	• Availability, relevance and distribution channels	✓	✓	✓	✓	✓		✓	✓		
	• All dimensions of access, accuracy, detail, presentation and format	✓	✓	✓	✓	✓		✓	✓		
	• Complexity of operationalising the above	✓	✓	✓	✓	✓			✓		
	• Discourses of access creates a different meanings for individuals, TA & TI	✓	✓	✓	✓	✓			✓	✓	
	• Conscious decision by TA & TI not to provide equality of information;	✓	✓	✓	✓	✓			✓		
Organisation communication of access	• Communication of tourism access information to staff at all levels of org	✓	✓	✓	✓	✓	✓	✓	✓		
	• Communication of tourism access information to intermediaries		✓	✓	✓	✓	✓	✓	✓		
	• Inclusion of tourism access information in generic marketing/target marketing	✓	✓	✓	✓	✓	✓	✓	✓		
	• Dimension of access, particularly vision, hearing, cognitive or psychiatric	✓	✓	✓	✓	✓	✓	✓	✓		
	• Provision of alternative communication technology and formats	✓	✓	✓	✓	✓	✓	✓	✓		
Economic circumstance	• Economic constraints disadvantaged a disproportionate number of people				✓						
	• Affects ability to travel but also the frequency, duration and choice of trip.				✓						
Cost	• Double cost for those travelling with an attendant		✓		✓	✓					
	• Accommodation due to accessible rooms only available in higher class	✓	✓		✓	✓				✓	
	• Paratransit systems are more expensive than public transport				✓						
	• Equipment hire (commode, hoist etc.)				✓						

(Environmental)	STRUCTURAL (continued)	TA1	TA2	TA3	TA4	TI1	TI2	TA3	TA4	TA5
Attendant care	<ul style="list-style-type: none"> Resources and flexibility of HACC programs away from residence Availability of attendants Suitability of attendants for the individual 				✓					
Socio-spatial =	<ul style="list-style-type: none"> Destination = architecture + ecological + transport + attitudinal + rules & regs 									
<i>Attitudinal</i> +	<ul style="list-style-type: none"> Customer service exclusion through non-provision Customer service exclusion through inappropriate language use Assumptions about abilities of travellers with disabilities; Attitudinal exclusion = segregated tourism experience; 	✓	✓		✓	✓	✓	✓	✓	✓
<i>Ecological</i> +	<ul style="list-style-type: none"> Destination accessibility (see Architectural & Appendix 9) Access to area attractions/activities/services/natural areas Independent and dignified spatial use Linkages between transport, the natural and built environments. 	✓		✓	✓	✓				
<i>Architectural</i> +	<ul style="list-style-type: none"> Basics of parking, toilets and a continuous pathway were absent (Appendix 9) Linkages between transport/accomm/common domain/attractions. Finding appropriate accommodation Bedroom and bathroom requirements as foundation components to tourism Discourses of access of accommodation – equality of provision 	✓		✓	✓	✓		✓	✓	✓
<i>Transport</i> +	<ul style="list-style-type: none"> Lack of accessible public transport provision Available class of transport provision Heavier reliance on private motor vehicles & paratransit as mode of transport Lack of day tour operations (coach, rail & watercraft)/segregated experiences 		✓		✓	✓		✓		
<i>Rules and regulations</i>	<ul style="list-style-type: none"> Government, TA and TI perception of disability as <i>special provisions</i> The complaints case implementation of the DDA Relevant environmental planning legislation not implemented correctly Results in the <i>nuisance or fire hazard</i> interaction of pwd and the non-disabled Aircraft access regulated through international agreements 	✓	✓	✓	✓	✓	✓	✓	✓	✓
Air transport	<ul style="list-style-type: none"> Airline information management of the needs of people with disabilities; Loss of travel independence and dignity through boarding procedures; Seating location and retractable arms; Personal care issues and lack of accessible toilets; Equipment handling and damage on flights; and Ground staff awareness and OH&S training. 		✓	✓	✓	✓				

Source: thesis findings

Rationales Given for the Particular Pattern of Service Provision (RQ 3b)

As discussed in Chapters 4 and 5, it might be expected that, as *government bodies*, TAs might act in the area of disability as a result of the obligations arising from human rights-based legislation, notably the DDA. As *marketing bodies*, they might be expected to act as a result of identifying people with disabilities as a market segment. The review suggests that both types of motivation were at work (ONT 1998b), but in neither case was there full commitment. People with disabilities are mentioned in tourism policy documents as a market segment but the evidence indicates that the rhetoric is not followed-up with action. Despite the publicly available empirical evidence, as summarised in this thesis, the general view is that, in fact, the disability is a small, low yield market and the ‘substantial extra cost’ required to meet its needs would not produce an adequate return. This is, arguably, a view in fact influenced by the TI – it would certainly not appear to be based on the TA’s own research. Thus, again arguably, the market ideology of the TI influences the TA response in regard to its legislative human rights obligations. However, with the possible exception of the Commonwealth awareness information, there has been no concerted action to provide leadership in the tourism industry concerning its obligations.

The overriding influence of the market ideology and equating disability with extra costs was reinforced through the contestation of the Disability Standards’ RIS process. With respect to the accommodation managers, the rationale for their practices is firmly based in the context of the commercial management criteria of the market. Disability issues – notably the management of ‘disabled rooms’ – are seen almost entirely in operational terms. In general, the disabled rooms are regarded as an imposition that they would rather not have with the exception of two managers who had a specialist disability sports market segment. Yet, even these managers did not understand the basic access features of their establishments or provide any specific information/marketing. In the absence of information from the TA or training courses, there is no awareness of a wider agenda and therefore they offered no rationale for failing to address it. Further discussion on the explanation for this behaviour is examined in Chapter 10.

The evidence that the human rights-based regulatory process and its operation offers in relation to the tourism experiences of people with disabilities (RQ 4)

Following from RQ3b, the human rights-based regulatory environment provided evidence of the tourism experiences of people with disabilities through complaint cases, HREOC

and Federal Court actions, the Disability Standards processes and the DAP strategic planning mechanisms. Table 27 provides a summary of the complaint cases, HREOC inquiries and Federal Court actions that relate to tourism generally and, disability discrimination practices of the TI specifically. The outcomes of these actions reinforce many of the tourism constraints faced by people with disabilities identified in Chapter 8 and, summarised in Table 22, but also add further constraints through the practices of the TA and TI. This provides another layer of understanding to the tourism constraints faced by people with disabilities and how TA and TI practices contribute to this situation. Each of the mechanisms is summarised in relation to the subsidiary questions.

Discriminatory practices and omissions revealed by the implementation of the regulatory processes (RQ 4a and 4b)

Individually the complaint cases, HREOC inquiries and Federal Court actions documented wide ranging practices that were regarded as disability discrimination under the DDA. These involved a series of structural constraints across all sectors of the industry and across the geographic spectrum of the tourism system that reinforced the experiences documented in Chapter 8. Further, the practices involved all dimensions of disability, albeit that people with mobility disabilities were most frequently represented in the complaint cases. However, the most disturbing finding from this chapter was that the cumulative experiences of the Commonwealth and state based TA (Douglas 1999) recognized the major issues that were highlighted by the regulatory processes and still no action was taken collectively by this group to improve service provision for people with disabilities. The outcome of this omission was that the discriminatory practices and omissions will be perpetuated into the foreseeable future.

The influence of the DDA on the practices and discourses of the TA and TI (RQ 4c)

Quite simply, the DDA has had no or limited influence on the practices and discourses of the TA and TI. There was little understanding of the requirements of the DDA by TA or the TI. The complaint cases have had the largest impact on individual operators where operators have changed behaviour after the conciliation or Court processes. However, from a broader industry perspective there has been no systemic change to the way the industry operates. This was signified in this chapter by the approaches by the TA who traditionally lead the TI in areas of industry education and coordination. The only TA who focuses on improving service provision for people with disabilities did so out of a market response rather than through understanding the legislative responsibilities of the DDA. The reasons

for this situation are explored further in RQ 4d, 4e and Chapter 10.

The influences of ‘other mechanisms’ of the DDA (RQ 4d)

The strategic and educative strategies of the DDA appeared to have had little impact on the discourse of TA and TI. For the TA, this is due to the market ideology of the industry, and the accommodation sector, this is the result of a lack of awareness of their responsibilities under the DDA. The two industry awareness initiatives (ONT 1998a; DFACS 1999c) appear to have been largely ineffectual and lacked the resources to be implemented in any systematic way. Only one TA or TI undertook a strategic approach to disability through developing a DAP (TNSW 2000a) and this was because their state government required this action to be taken. As reported, the DAP has provided a greater understanding of business unit responsibilities for disability and access, and has the potential for future cultural change. However, there has been no material improvement to the products and services on offer for people with disabilities wanting to travel.

The extent to which the evidence of the implementation of regulatory processes offers an explanation for the tourism experiences of people with impairments (RQ 4e).

The complaint cases gave people with disabilities and disability advocacy organisations a voice to redress disability discrimination. Yet, the complaint cases in tourism highlight substantial and ongoing discrimination against people with disabilities. The complaint cases have been duplicated many times without an ongoing resolution. The evidence presented in this thesis reinforces findings by other researchers that suggest the weaknesses of the DDA complaints based legislation involves:

- the onus is on the individual to make a complaint;
- the subsequent power relations of the complaints process is disempowering for many people with disabilities;
- the confidential nature of the complaints process provides no common law precedent to act as an incentive for future industry practice;
- there are no industry compliance timeframes or responsibilities;
- the cost disincentive after 13 April 2000 to take a Federal Court action (M. Jones and Bassar Marks 1999; Thornton 2000; Handley 2001).

This was different to the ADA, which has case law precedent and is compliance-based legislation with timeframes and performance based standards. There has been a far greater level of compliance by accommodation sector in the US (Davies and Beasley 1994; Seal 1994; Peniston 1996; Salomon 1996; Andorka 1999; Worcester 2000). Many of the accommodation issues documented in Chapter 8 and 9 have become part of the US accommodation sector’s disability discourse.

Where human rights changes have been sought they have been characterised by heated contestation by non-disabled stakeholders. An explanation of this is examined in Chapter 10, but the evidence presented in this chapter suggests that the TA and TI discourse is based on a belief that disability and access considerations are not their responsibility. Further, the market-based ideology of the TI equates disability and access considerations to substantial extra costs and that access provisions should be regarded as an unjustifiable hardship (e.g. *Cooper v Coffs Harbour Cinemas [2000]*). However, subsequent Court determinations did not support industry assertions of unjustifiable hardship.

The early success of the complaint cases gave rise to other stakeholders using the DDA Standards process to shift power away from the human rights perspective of the DDA. The complaint cases and the DDA Standards revealed an unequal power relationship existed between people with disabilities and the non-disabled stakeholders. This was based on clash of values between people with disabilities' desire for citizenship (human rights and social model approaches) and a market ideology that equates access to extra cost. This was evident through the discourse of industry professionals of the design, planning, construction, accommodation and transport sectors. Within the implementation of the DDA and the environmental planning processes, people with disabilities were at a demonstrated disadvantage as they were only one voice amongst many industry stakeholders. Hence, equality of provision in tourism is inter-related to the economic, social and political interests that construct the legal and policy contexts that shape the tourism environment. Inaccessibility is multi-faceted and inextricably bound with this social and economic power.

In particular, the problems of accessible facilities and services are a product of the structural-historical development of *design* ➔ *planning* ➔ *construction* ➔ *operations* ➔ *wholesale/retail* sectors, which together with government regulators, shape the tourism environment. As disability and access were absent from the broader environmental planning processes until reasonably recently, the professional discourse of those working in the areas may not have the background, expertise or education to understand the nature of the issue and the need for change. Whether TA, TI or other bodies responsible in the broader environmental planning processes, they lack an understanding of the spirit and intent of the human rights-based DDA. Chapter 10 investigates likely explanations for this situation.

10 DEVELOPING AN EXPLANATION FOR INDUSTRY PRACTICES

10.1 Introduction

Chapters 7, 8 and 9 presented empirical evidence on the demand, supply and regulatory aspects of tourism by and for people with disabilities and confirmed that tourism opportunities and the quality of tourism experiences for this group were constrained, compared with those of the non-disabled, and that such constraints arose primarily as a result of the policies and practices of the TA and TI sectors. Thus we have an explanation of why people with disabilities seeking tourism experiences face more constraints than the non-disabled – Chapters 7-9 establish that it is due in large part to the disabling practices of the TA and TI. However, we do not have an explanation of why the TA and TI behave the way they do. While some indications of motivations and rationales have been given in the earlier chapters, the question of explanation is considered more fully in this chapter. Further, if the rationales for the disabling TA and TI practices can be shown to be questionable, the main research question can be addressed: that is, the additional constraints faced by people with disability can be said to be undue.

In each of the four groups of research questions, concerned respectively with constraints, impairments, industry practice and the regulatory environment, the explanatory questions remain to be fully addressed. Thus, in regard to constraints, research question 1c seeks to identify the social relations that produce the social constraints faced by people with impairments when travelling. Research question 3c asks what discourses offer an explanation for the practices, rationales and behaviour of tourism organisations and managers. In addressing these questions we turn to the various theoretical frameworks considered in Chapters 3 and 4, and indicated as Component D, ‘Theories and discourses’, in the theoretical framework (Figure 6).

This chapter seeks to provide an explanation for the existence of these constraining practices. This is done by first classifying TA and TI responses to disability into four organisational approaches. Each of these approaches is then analysed drawing on the theoretical perspectives discussed in Chapter 5, namely: the market ideology; the medical model and its associated ableist discourses; human rights principles; and the social model. Each of these provides

insights into the relative positions of power held by the various stakeholders. However, in the course of analysing the material in Chapters 7-9, an additional theme emerged which seemed to merit particular attention and to stand alongside the more generic theoretical perspectives identified from the literature in Chapter 5. This theme has been termed *discourses of access* and described first. Subsequently it plays a role in the analysis of TA/TI practices.

10.2 Discourses of Access

The behaviour of TA/TI organisations in relation to disability issues is partly explained by the complexities of the various *discourses of access*. Access exclusion is a product of the differing understandings of the concept of access by the stakeholders: people with disabilities; tourism authorities; the tourism industry, including the accommodation sector; and the regulatory sector. Chapter 8 established that many of the experiences that people with disabilities had were unexpected as they thought they had negotiated accessible facilities and experiences. However, their expectation was not met due to the other stakeholders having different understandings of the term access.

People with disabilities use the word *access* in a multiplicity of ways. They negotiate tourism citizenship rights upon this basis. Yet, their highly individual understandings of *access* were found substantially different to those of the TA and TI with whom they were negotiating. As discussed in Chapter 2 and documented in Chapter 8, one person's meaning of access could be dependent upon the:

- dimension of their impairment (vision, hearing, mobility or cognitive);
- access needs;
- level of support needs;
- past experiences; and
- disabling environment and social attitudes that they were encountering.

The highly individualised understanding of access by people with disabilities leads to erroneous assumptions being made about the accessibility of tourism products and services because of poor market information systems. Hence, a construct of access for a person with vision disability is substantially different to a person with a mobility disability who uses a scooter for long distances but is able to walk for short distances. These two individuals' construct of access is different to that of a wheelchair user with high support needs who was travelling with an attendant.

Nevertheless, it can be said that there is an identifiable discourse of access among people with disabilities. In this context, it begins with the individual's desire to travel and then to anticipate, avoid and negotiate constraints in doing so. This is imbued with the broader discourse of human rights – that is, the assumption that the individual with an impairment has a right to travel like everyone else.

This individual and collective understanding of the concept of access is juxtaposed against the technical prescriptions for access set down in the BCA and relevant Australian Standards. Few of the developers, owners and managers who operate with the outcomes of these standards are familiar with the detail of the standards and their rationales, let alone the broad human rights principles which are enshrined in the 'parent' legislation on which they are based. They deal with a limited range of facilities, concepts and terms, such as 'disabled room' and 'ramp', in a largely market-driven, profit-orientated environment. People with disabilities themselves are, as we have seen, considered to be *other – the disabled* – who, for the most part, are viewed by the TA and TI as presenting particular problems. This, then is a different *discourses of access* from that used by people with disabilities themselves – in fact it might be termed the *discourse of inaccessibility*. It is partly a reflection of limited knowledge and understanding, partly of the desire to limit the scope of responsibility in line with perceived market imperatives, and partly a product of underlying attitudes towards people with disabilities as a social group. The consequences are that TA/TI measures ostensibly designed to respond to the needs of people with disabilities often fail to do so.

This can be illustrated by consideration of one dimension, which permeates the whole tourism experience. Chapter 8 identified the critical stages in the tourism system as travel planning, transport, accommodation and other destination experiences. The common theme linking these stages was tourism access information provision. From an access information perspective, all the TA and TI sources had the same inherent weaknesses, which often reflected the clash of access discourses. Examples which illustrate this are: a. the lack of understanding of tourism access information needs demonstrated in some information gathering and dissemination exercises; and b. the frequent failure to consider all dimensions of access. These are discussed in turn below. Finally, the part played by professional roles and values in access discourse is considered.

A. *Understanding tourism access information needs*

The confusion and discontent with the provision of accommodation information was articulated in Sections 8.3 and 8.5. Further, Sections 9.2 and 9.3 documented TA and TI responses to providing market information to people with disabilities. An explanation for the low level of response to requests for information from tourism operators and the poor quality of information provided, lie partly in the task of understanding the complexities of access and the difficulty of conveying this in basic checklists. Many of the sources reviewed (CTEC 1999a; WATC 2001; SATC 2000) were based on an interpretation of the AS1428.1. These Australian Standards are highly technical and would require anyone in an organisation responding to the request for information to have a sound understanding of AS1428. Many managers lack the expertise and/or may find the task too onerous and may put it task aside. As identified in the interviews with managers, the responsibility for disability and access issues varies for each hotel or does not exist at all. This would also explain the low level of response from the TA and TI in Australian and overseas studies (Muloin and Weiler 1991; Touche Ross 1993; Gallagher and Hull 1996; Upchurch and Seo 1996; O'Neill and Ali Knight 2000; Tourism New South Wales 2000b).

The issues can be illustrated in relation to the source of accommodation information most frequently criticised in Chapter 8, the independent 'wheelchair access' and 'wheelchair access with assistance' symbols shown in Figure 14. Most access information media, including the NRMA and other states AAA accommodation guides, were based on this or a similar system.

Figure 14: Wheelchair access symbols



Source: NRMA 1999.

The processes to determine whether a room is *independently accessible* or *accessible with assistance* was based on a checklist for accommodation access originally developed by ACROD (1994). The checklist was derived from the provisions of AS1428.1 which were applicable for BCA Class 3 hotel/motel accommodation. The development involved reducing hundreds of measurements in AS1428.1 to 28 'Yes/No' statements (Appendix 11). The statements were then assessed to determine whether they should be given an *independent wheelchair access* symbol or a *wheelchair access with assistance* symbol. The criterion for

the determination of *independent access* was that all statements had to be answered *Yes*. For *access with assistance*, six essential statements had to be answered *Yes*, such that, ‘this means a person can get in, use the toilet and have a shower but they may need assistance. One step is tolerable, more than one step is not’, although this latter explanation was not provided in the NRMA guide only in the NRMA assessment sheet (ACROD 1994).

This assessment process provides part of the explanation for the level of dissatisfaction with the accessibility of rooms on the part of people with disabilities, since it resulted in the provision of inadequate or misleading information to customers. There was a misunderstanding concerning access between the stakeholder groups: individuals with disabilities, service providers and the agencies administering accommodation assessment.

The dissatisfaction stemmed from the simplification of the concept of access based on the complexities of AS1428. These complexities were reduced through the process described above to just two symbols. Thus, the meaning of access for individuals was lost. The level of detail presented in the accommodation guides did not provide an adequate level of information for individuals with disabilities to make informed decisions about their needs. People with disabilities assumed that the access symbols were a guarantee of accessibility. Yet, the icons could not represent the type and detail of information needed to make informed individual decisions about the actual accessibility of establishments. The discontent with the ratings system was supported by a number of TA who had received complaints from people with disabilities (Douglas 1999; Miller 2002 pers. comm.), which supported the documented complaint cases brought under the DDA (HREOC 2002a).

In particular, the process was inadequate in regard to conveying spatial information about rooms. There was no spatial dimension to this assessment to provide the consumer with an understanding of the dimensions of the room. It is possible to collect information on the spatial dimensions and layouts of rooms from operators, as demonstrated by Cameron (1995; 2000 Appendix 10). Conveying this information to the user also requires thought, since many people with disabilities only understand their needs from a personal viewpoint, rather than based on technical measurements. Spatial representation creates a common understanding of access through presenting information in the way that people use the rooms – spatially (Cameron, 1995; 2000). This reinforces calls to incorporate socio-spatial elements in assessing access whether on a room, building, local area or destination basis (Imrie 1996;

Gleeson 1999b; Wilton 1999).

B. Failure to consider all dimensions of access

The most notable omission in relation to virtually all understandings of access was the tendency of TI/TA organisations to confine their considerations to *mobility* access. No government research or information has been provided on the other dimensions of access - vision, hearing, cognitive, ambulatory mobility or manipulative mobility. The travel needs of people with sensory and communication dimensions of access are seemingly invisible among the Commonwealth and state level TA, and among the TI. (Yet, the HREOC complaint cases demonstrate that TA and the TI treat these dimensions of access in the same discriminatory fashion as mobility requirements although the issues differ significantly).

Thus, the discourses of access among TI and TA organisations is simplified and limited to one type of perceived problem with one type of solution. Conceivably, awareness and consideration of a broader range of impairments would lead to consideration of disability in the context of a broader range of customers, including the elderly, and links with a discourses more familiar to business managers, such as ‘customer service’. The Australian industry could take direction from a number of overseas initiatives that have included these other dimensions of access within their tourism access planning processes (English Tourism Council 2000a; Hasselt and Brussels 2001) and information media (Fodor’s 1996).

10.3 Organisational Approaches to Tourism and Disability

Four organisational approaches to disability emerge from the Chapter 9 documentation of TA and TI/accommodation sector practices. The approaches are:

- Do nothing
- Be seen to be doing something
- React to legislative requirements
- Disability as a market segment.

Table 30 identifies the primary and, in some cases, secondary approach adopted by each of the Australia TAs. The Commonwealth departments responsible for disability tourism initiatives were judged to represent three approaches. As regards the TI/accommodation sector organisations represented in the interviews and focus groups: the majority appeared to be most closely aligned with the ‘do nothing’ approach, while three had adopted a market

segment or partial market segment approach. This observation cannot be generalised to the whole of the TI because of the single sector involved and the small, and not necessarily representative, number of respondents and organisations involved in the study.

Table 30: Relative Position of TA and TI (accommodation) re. Policy Approaches

TA/TI (Accommodation)	1. Do nothing	2. Be seen to be doing something	3. Legislative requirements	4. Market segment
TA				
Commonwealth Departments §	○	●	○	
Australian Tourist Commission	●			
Canberra Tourism & Events		●		○
Northern Territory Tourist	●			
South Australian Tourism		●		○
Tasmania Tourism		●		
Tourism NSW		○	●	
Tourism Queensland				●
Tourism Victoria	●			
Western Australian Tourist		●		
TI (Accommodation sector)*	●			○

● Primary emphasis ○ Secondary emphasis * Based on those involved in interviews and focus groups only
 § Commonwealth Department of Tourism and Office of National Tourism

Table 31 outlines each of the theoretical perspectives in relation to the four organisational approaches. As indicated in Table 27, in Chapter 9, some of the TA were involved in only a limited number of initiatives that were easily judged to be wholly within one of the policy approaches. Other TA were involved in a number of initiatives and, hence, could be judged to have adopted more than one organisational approach, although one was usually dominant.

Table 31: Policy approaches to disability tourism

	APPROACH 1 Do Nothing	APPROACH 2 Be Seen to be Doing Something	APPROACH 3 React to Legislation	APPROACH 4 Disability as a Market Segment
Features:	<ul style="list-style-type: none"> No initiatives undertaken or a single superficial initiative. No concealment of lack of interest in pwd. General lack of information on policy/practices. Motivations unclear. 	<ul style="list-style-type: none"> Initiatives undertaken are token and provide no substantive improvement in the situation of pwd wishing to travel. Motivation: to deflect criticism of neglected from political masters & disability sector (TA). 	<ul style="list-style-type: none"> Initiatives include staff training, DAPs, product audits Primary motivation fulfil legal obligations under DDA or other legislation. 	<ul style="list-style-type: none"> Initiatives involve development, marketing & promotion of tourism products & services for pwd. Motivation: to gain a competitive market advantage & service pwd as a market segment.
Market ideology	<ul style="list-style-type: none"> If disability considered at all: not rational to allocate resources. Perceived as a ‘low yield’ group Access for people with disabilities equated to substantial ‘extra’ cost. 	<ul style="list-style-type: none"> As for approach 1. 	<ul style="list-style-type: none"> Use of Disability Standards mechanisms to misrepresent costs & benefits of compliance. Benefits of compliance not articulated due to lack of understanding of access. Economic and political power used to influence the decision-making. 	<ul style="list-style-type: none"> Assessment that disability market segment can deliver returns equal to other sectors. Promote & market disability access information in the same way that other market segments are targeted.
Medical Model /Ableist Discourses	<ul style="list-style-type: none"> If disability considered at all: believed that: access is ‘someone else’s problem, not ours’. 	<ul style="list-style-type: none"> People with disabilities regarded as different to the non-disabled. Could not understand pwd militancy/ anger and seeking redress through the DDA. Believed someone else - e.g. Government - responsible. 	<ul style="list-style-type: none"> Reacted to legislation with no understanding of responsibility. As in approaches 1 & 2 but required to act. Short-term attitude change/ awareness may provide longer-term improvements. 	<ul style="list-style-type: none"> Recognised historical/welfare/ paternalistic treatment of pwd. Sought to challenge stereotypes through market, image & product development.
Human rights approach	<ul style="list-style-type: none"> The TA & TI did not recognise or believe that their charter required a systematic approach to ensuring that disability discrimination did not occur within the tourism environment. Virtually no recognition of the DDA & its responsibilities. 	<ul style="list-style-type: none"> As for approach 1. 	<ul style="list-style-type: none"> Addressed letter of the law but not the spirit and intent of DDA. No equality of provision. TA & TI used Standards & RIS for their ends to bring about greater certainty to the process. Legislation used to compromise the disability perspective. 	<ul style="list-style-type: none"> Little understanding of the impact of the human rights responsibilities of DDA.

	APPROACH 1 Do Nothing	APPROACH 2 Be Seen to be Doing Something	APPROACH 3 React to Legislation	APPROACH 4 Disability as a Market Segment
Social Model	<ul style="list-style-type: none"> No awareness of a social approach to disability. Pwd seen as a problem that was not their responsibility. Up to individuals to solve their own problems. 	<ul style="list-style-type: none"> Deliberately obstructed pwd from obtaining rights of citizenship by ignoring systemic issues Understood disabling constraints yet did not redress them. 	<ul style="list-style-type: none"> Underlying philosophy based on a social approach to disability that recognised an equality of service provision required an enabling environment. 	<ul style="list-style-type: none"> Motivation based on the market ideology Did recognise tourism as part of citizenship rights.
Discourses of Access	<ul style="list-style-type: none"> Limited to the ‘disabled room/facility’ without understanding the basis of what pwd wanted. 	<ul style="list-style-type: none"> Greater understanding of the needs of the group but not the details of access. Did not want to allocate resources access needs. No product development. 	<ul style="list-style-type: none"> Greater understanding of the organisational strategic issues but not the details of access. No focus on developing accessible tourism product. Resources not allocated to address the strategic issues. 	<ul style="list-style-type: none"> Product development undertaken. Operationalization of access still problematic. Recognized that access was problematic to operationalise. Unsure of solutions.
Outcomes of the discourses.	<ul style="list-style-type: none"> Did not engage with pwd or representative organisations. Inaction perpetuated marginalised existence of pwd in tourism. Pwd had to struggle with a hostile tourism environment to construct tourism experiences. 	<ul style="list-style-type: none"> Token action could be regarded as more serious than the inaction. While one group were ignorant, this group deliberately obstructed pwd. Recognised issues requiring action & made a decision not to address them Pwd marginalised - left to construct and negotiate their own tourism experiences. 	<ul style="list-style-type: none"> Engaged with disability through the legislative requirements. Pwd able to affect the agenda through complaint cases. Overall power shifted when DS become a site of contestation. Pwd placed in a position of powerlessness due to the greater influence of other stakeholders. Legislative responses did not improve pwd tourism choices. 	<ul style="list-style-type: none"> Viewed disability as equal to other market segments. Pwd had improved chances for tourism experiences. TA & TI gained market advantage. Recognition of issues to be addressed to create an equality of provisions. Due to lack of resources responses not fully developed
Conclusion: Why are these chosen by organisations?	<ul style="list-style-type: none"> Believed disability was beyond their brief & other arms of government should address these issues. TI believed responsibilities ended with provision of disabled rooms. 	<ul style="list-style-type: none"> Recognised responsibility to address disability issues but deliberate chose not to because of ableist discourses. Compounded by the market ideology that pwd were not a market segment, & access = cost. Lacked understanding of discourses of access & responsibilities under the DDA. 	<ul style="list-style-type: none"> Legislative requirements acted as a punitive ‘stick’ - TA & TI not given choice. Responded in a minimalist fashion to these directives. May have longer-term benefits for pwd if DAP lodged + disability awareness training instituted. 	<ul style="list-style-type: none"> Largely ‘championed’ by an individual with personal experience or contact with disability. Belief in market opportunities & the competitive advantage of accessible tourism product. Subscribed to market ideology rather than a human rights or social model discourse.

The four approaches are discussed in turn below. Each is discussed under three headings: a. the nature of the approach; b. the approach in action; and c. explanations.

A. Approach 1: Do Nothing

a. The nature of the approach

This approach involves taking no initiatives at all to meet the tourism needs of people with disabilities or taking a single superficial initiative. It is generally associated with no attempt to conceal the organisation's lack of interest in people with disabilities and a general lack of information on policy/practices.

b. The approach in action – TA - Tourism Marketing Authorities

The most frequent approach of TA and TI has been to do nothing. Disability was largely absent from tourism policy development at both Commonwealth and state levels.

At the Federal level the ATC epitomised this approach and did little to disguise its lack of interest in disability and access issues. Tourism Victoria was noticeable for its silence on disability and tourism. Apart from the provision of basic fact sheets, these TA did not attempt to engage with people with disabilities. Similarly, the NTTC did little to engage with the group except to provide the universal symbol in their generic brochure. This action demonstrated a lack of any understanding of access from a disability perspective and provided no information on which a person could plan a trip.

These organisations provided market information for people with disabilities that was so deficient compared with that available to the non-disabled, that their actions can be classified as, in effect, 'doing nothing'. Among the TA, the 'do nothing' approach is closely aligned to approach 2, 'be seen to be doing something', so the explanation for both these approaches among TAs is considered below in relation to approach 2.

b. The approach in action - TI – Accommodation Sector

The majority of accommodation managers had little understanding of disability and access beyond recognition of the *disabled rooms*. They had done little to recognise what constituted accessible rooms or the market requirements for understanding the accessibility of the rooms. They were also generally not aware of the DDA and its implications for their industry. Further, their understanding did not extend to access to the wider facilities of the

hotel or an understanding that disability could constitute a market segment. Accessible rooms and other access features exist in hotels largely as a result of regulatory impacts on another sector of the industry, owners and developers, who are required by the BCA to incorporate disability access provisions into motels and hotels - that sector, in effect, adopts organisational approach 3, responding to legislation. However, most of the accommodation management sector, which generally leases the establishments from building owners, does little more than hire out these rooms on demand and can therefore be classified as adopting a 'do nothing' approach.

Chapter 9 also documents the collective resistance of the transport and developer sectors to the introduction of access standards.

c. Explanations for the TI/accommodation sector

Historically, the first clear evidence of the accommodation sector's perspective on providing services for people with disabilities was demonstrated in the NSW government event for IYDP, a one-day seminar on tourism organised in 1981 by the NSW Department of Tourism. The seminar was held at the Cinema Hall of the Sydney Opera House (a notoriously exclusionary building). The General Manager of the Menzies Hotel, Sydney and Chair of the Executive Committee of the AHA summarised the attitude of the accommodation sector towards people with disabilities as follows:

We are told of the enormous market potential in catering for the handicapped and of the financial benefits that will ensue. We are not convinced and believe that the estimates are grossly over-stated. As a representative of private enterprise which is historically profit orientated, I cannot imagine our industry spending large sums of money without the firm belief that a reasonable return is forthcoming. Until that happens, however, we offer our sincere goodwill and understanding (Stefan Kaye in NSW Dept. of Tourism 1981: np)

Kaye's presentation presented anecdotal evidence about the lower occupancy rates of 'disabled rooms' and attacked NSW government legislation that had introduced mandatory provisions for these rooms. These comments provide an insight into the discourse that, while perhaps not so directly expressed, is still evident across the accommodation sector. This was evidenced in Chapter 9 and is further demonstrated by the fact that some in the sector have actively sought to reduce the number of accessible rooms required under the building codes in recent years (AHA 1998; Mirvac Hotels 1998; B. Thomas 2001).

The position as expressed by Kaye is ostensibly market-orientated – it declares that a profit-orientated industry cannot be expected to invest in an unprofitable market sector. In

1981 this was based on anecdotal evidence. Twenty years later there is research evidence, as shown in this study, to indicate that the potential market is substantial. The costs of necessary investment have not been explored in detail in this study but it is known that, when building new facilities - the additional costs of making facilities accessible is minimal. The economic arguments of universal design expose the fallacy that disability access equates to substantial extra costs (Frisch 1998; 2001). As overseas research by Steven Winter and Associates Inc., Tourbier and Wamsley Inc., and Building Technology Inc. (1993) for the US government identified, incorporating universal design principles involved an average 0.34% cost differential (cited in Steinfeld and Shea 2001:35.8). In the Australian context the cost differential of including AS4299 principles of adaptable and accessible housing was between 0.3-1.0% depending on the class of building (Hill 1999). It is arguable therefore that, in the last 20 years, a fully rational, market-orientated industry would have researched the market and the costs of provision and reached a different conclusion from that of Mr Kaye in 1981. However, this has not happened, suggesting that other factors must be at work to explain the industry's stance.

It is possible that the industry position is based on less rational grounds related to the ableist discourses implicit in the medical model of disability. The most evident expression of such an ableist discourse to arise in the interviews and documented industry positions (AHA 1998; Mirvac Hotels 1998; B. Thomas 2001) was the belief that the 'disabled rooms' were not required because people with disabilities do not travel, because of their impairments. As discussed in Chapter 2, beliefs and attitudes may be conveyed by the use of language. The language used by accommodation sector managers in this study was indicative of the 'discourse of inaccessibility'. While some sections of TI used person first language, most used language that is not considered appropriate by today's standards (e.g. the disabled, handicapped, disabled rooms). In essence, their language signified an exclusion of people with disabilities as *other*, thus placing people with disabilities apart from the responses that the industry gives to other market segments.

As a consequence, the principles of the social model of disability, despite the fact that it conceivably has certain parallels with a traditional 'customer focus' ethos of service industries, played no apparent part in the thinking of accommodation managers. Generally access difficulties were seen as someone else's problem and there was no conception that the industry might be contributing in any way to such difficulties by its practices.

The discourse of human rights had not generally reached the accommodation sector representatives involved in this study. There was little awareness of the DDA and its implications and official communications on legislative obligations had not reached them or, if they had, the message had not been retained. Accessible facilities and particular expressed needs of people with disabilities were seen as an imposition on the organisation rather than something which, the guest had a right to. The tradition of ‘the customer is always right’ often did not appear to extend to people with disabilities.

Thus, on a number of grounds, the rationale for the TI ‘do nothing’ approach can be questioned. In terms of the main research question, the constraints on people with disabilities which arise from this inaction can therefore be said to be undue.

B. Approach 2: Be Seen to be Doing Something

a. The nature of the approach

The approach is typified by high profile initiatives designed to attract attention when announced, but with inadequate resources and little if any follow-up. The approach that was restricted to TA and was closely aligned to the *do nothing* approach.

b. The approach in action

The Commonwealth departments with responsibilities for tourism (CDOT and ONT), Tourism Tasmania and the WA Tourism Commission can be classified as having adopted this approach. The ONT market information kit is an example of this approach in action: it sought to encourage the TI to improve provision for people with disabilities, but resources were not allocated to take the initiative to the TI through workshops or seminars; it remained a static and limited information provision initiative. The Office of National Tourism, together with the ATC, undertook the only cooperative effort in disability tourism in convening the 1999 meeting of TAs, which could be seen as being motivated by a desire to be seen to be doing something at the time where the international spotlight was focused on Australia through the Sydney 2000 Games. Yet, there was no follow up to this meeting. Similarly, the *Gold Medal Disability Access Strategy*, outlined in Chapter 9, was also motivated by the Sydney 2000 Games with funding for just one year. The strategy had little to do with improving the tourism experiences of people with disabilities but focused on encouraging and rewarding business for carrying out their responsibilities

under the DDA.

The above initiatives were directed at state TAs as well as TI organisations, but the existence of ‘do nothing’ states and Tourism Tasmania and WATC in the ‘be seen to be doing something’ category would suggest that they were of very limited success in this regard. Whether a more committed campaign on the part of the federal government would have produced actual changes in attitudes and practice is a matter for conjecture, but it is clear that the above initiatives had no such effect, thus justifying their classification as ‘be seen to be doing something’ practices. While Tourism Tasmania and WATC did more than providing a fact sheet, the outcomes of their initiatives made no material improvement for people with disabilities travel planning or experiences.

c. Explanations

The reasons why organisations adopted the *do nothing* approach and the *be seen to be doing something* approach were difficult to determine because the TA organisations which adopted these approaches provided only limited documentation and did not wish to be interviewed about disability and tourism. However, one person within the TA was willing to discuss the underlying reasons for their approach. The following extract provides several insights into the role and status of disability within the organisational priorities.

It was perceived that the size of the available disability market and the potential returns could not justify the expenditure required to attract it...a limited marketing budget and larger, more accessible markets were seen as a higher priority. Added to this was the low level of suitable products and facilities providing an unrealistic opportunity to market successfully. A high level of development and attitude change across various industry and community organisations was seen as a prerequisite to marketing ... [the organisation] does not have the charter or resources to tackle these various ‘whole of Government’ issues on its own. ... There are currently no plans to develop the industry’s ability to cater for the disability market nor plans to especially market these products to people with disabilities. (Anonymous source 1)

A number of separate arguments are contained in this statement:

- The ‘size of market’ and ‘investment cost/returns’ argument is identical to that advanced by the accommodation sector, as discussed above, prompting similar questions as to the current factual basis of these assertions.
- The investment cost/returns argument in this case appears to apply to TA marketing activity rather than investment in facilities, so a further impediment is also put forward, namely the limited budget of the TAs, suggesting that meeting the needs of this group would be particularly expensive, again raising questions as to the factual basis for the statement.
- The claimed current lack of accessible products/facilities suggests a ‘Catch 22’ situation.
- It is admitted that attitude change is required across the TA, government in

general and the industry, raising immediate questions as to what existing attitudes to people with disabilities are and why they are resistant to activity in the disability area.

- The idea that a TA organisation does not have a 'charter' to address disability issues flies in the face of government and industry obligations under the DDA and the federal government rhetoric in the industry awareness initiatives discussed above.

Thus, despite the TAs statutory position as an arm of government, with, it might be thought, particular awareness of responsibilities to uphold the human rights agenda implicit in the DDA, this discourse includes elements which are identical to the 1981 Australian Hotels Association perspective outlined above. It was evident that industry awareness campaigns promoted by Commonwealth TA had failed to change the culture of state TA and TI attitudes towards disability. Disability remains on the fringes because:

Let me say this, it's not that it's not a market, it is just not one of our priority markets. What are often priority markets are the young, white, Anglo-Saxon, blond-haired and blue eyed. They're 25-35, and we have acknowledged the over-50s in terms of touring by car, but we are still predominantly thinking pretty young. Disability markets: we're not saying there isn't a market its just not considered perhaps viable (Anonymous source 2).

The resultant omission, in-action and lower prioritisation resulted in TA and TI not strategically planning to resource strategies in the disability area. One source commented: 'there are no specific resources allocated to this area...Unfortunately the work I do in this area is constrained by lack of funds as it is not seen as a high priority in an organisation that is generally marketing focused' (Anonymous source 3). Thus the publicly funded TA are seen to align themselves quite closely with the market ideology of the private sector in its assessment of this market segment and its likely costs and returns.

It was noted above that the assessment of the disability market by the accommodation sector appeared to be anecdotal, despite the availability of contrary research data. TA organisations generally have better access to broad market information but appear to adopt the same stance. Yet, the perceptions of other tourism market segments have changed over time as research has been undertaken. For example, the late 1980s saw a concentration by Australian TA on all Asian inbound markets but it was not until the early 1990s that there was a differentiation made between high yield (Japan) and low yield (e.g. Korea) Asian markets (Griffin and Darcy 1997). Similarly, it was not until two significant studies of the backpacker market in the early 1990s (Pearce 1990; Loker 1993) that the perception of the value of that market was recognised and TA responded (Commonwealth Department of Tourism 1995a; 1995c; 1995d; Haigh 1995). However, the evidence of the market

potential, as evidenced in Chapter 7 of this study, has not brought about a similar reappraisal in relation to people with disabilities.

The lack of engagement with disability explains a great deal about the position and status of TA response to disability. The CDOT (1992) summary of the issues identified some of the basic concerns expressed in Chapter 8. Ten years later a great deal more was understood about the tourism patterns and experiences of people with disabilities through baseline data, but the TA had not responded to address these issues as they had for other segments. The minutes of the 1999 TA meeting (Douglas 1999; Wells 2002 pers. comm.) and the anonymous sources quoted above provide a greater understanding of the underlying reasons for adoption of the *do nothing* and *be seen to be doing something* approaches. It involves a complexity of social relations including:

- An understanding of what constitutes accessible tourism products and public facilities;
- The role that TA should take given the scope of access for tourism involving agencies across the whole of government (e.g. local government, public works and transport);
- Determining what information to gather, the scope of its collection (city, region etc.) how best to present and distribute the information;
- Establishing the process for information collection (self reported/independent inspection/assessment), format of presentation and how costs are to be recovered;
- Creating TI awareness and ownership of the issues;
- Risk management issues of the potential for legal claims based on inaccurate information; and
- Developing a consultation process with people with disabilities and disability advocacy organisations.

Market-based rationales for TA behaviour are to the fore, reflecting the proposition put forward in Chapter 4, that TA organisations, although arms of government, typically behave like private sector organisations. However, as with the private sector, evidence to back up the market-based stance is not put forward and available evidence leads to a questioning of the rationale. Thus it would seem that the real explanation for inaction lies elsewhere.

The ableist indicators of the medical model are less to the fore in this instance, at least in regard to TA use of language, which is undoubtedly influenced by the government status of the organisations concerned. However, the ‘discourse of inaccessibility’ was prevalent, if not as overt as among TI organisations. Further, the remark of one of the sources, that widespread attitude change in government and industry would be needed before action

could be taken in this area, allied with the lack of objective support for the market-based rationale, suggests, by default, that innate negative attitudes toward people with disabilities as a group may be a factor in explaining the TA *do nothing* and *be seen to do something* approaches.

While it is arguable that the existence of the DDA gave rise to the token *be seen to be doing something* TA activities, there is no evidence of TA embracing human rights principles in regard to the tourism needs of people with disabilities. Indeed, one comment suggested that a certain amount of hostility may exist, when reference was made to, ‘the number of disability groups, a chip on the shoulder attitude, and a degree of militancy to use the DDA as a threat rather than tools for guidance/education. This tends to dent the enthusiasm of those trying to learn and help’ (Anonymous source 1).

Again, the principles of the social model of disability do not play a strong role in the thinking of TA organisations, which adopt the *do nothing* or *be seen to do something* approach. As hybrid organisations with private sector and public sector allegiances, TA organisations might be expected to adopt both a ‘customer orientated’ approach, based on market research to understand customer needs, and a ‘community orientated’ approach, based on consultation to ascertain community needs, but neither of these approaches was in strong evidence.

C. Approach 3: React to Legislative Requirements

a. The nature of the approach

Reactions to legislative requirements can range along a spectrum from outright opposition to enthusiastic adoption, with resistance and compliance being somewhere in the middle. Opposition and resistance can take the form of political/lobby-group opposition to legislative measures at the time of their formulation and challenges in the courts, as in the HREOC and Federal Court cases documented in Chapter 9. Resistance can be less overt, involving failure to comply with the law or regulations in the hope that this can be done with impunity, or failing to allocate required resources. Compliance can be ‘full’ compliance or ‘minimalist’ compliance. Enthusiastic adoption involves embracing the principles behind legislation and using its provisions to achieve desired outcomes.

b. The approach in action

The activities of TA and TI in this area are documented in Chapter 9. The reaction of the TI to the DDA has, in the main, ranged from opposition to minimalist compliance. The oppositional activity has been largely the work of lobby groups in regard to access standards for buildings and transport. A number of HREOC and Federal Courts reveal individual providers' acts of resistance to access requirements. Compliance activity has been largely in the hands of the developers and owners in the form of provision of required numbers of accessible rooms and building access. Apart from hiring out accessible rooms on demand, accommodation sector managers have little involvement with the relevant legislation requirements and, indeed, as shown in Chapter 9, remain largely ignorant of its requirements. Only one accommodation manager adequately understood the implications of the DDA for their establishment. The evidence presented suggests that the DDA has had little impact on the culture of the TI.

As government bodies, there is little evidence of opposition or resistance by TA organisations to the letter of the relevant legislation, but equally, there is little evidence of TA organisations endorsing the spirit of the legislation and embracing their human rights responsibilities in this area. As we have seen, only one TA had implemented a DAP and then only because of a government-wide edict.

Under the DDA, both the TA and TI have a responsibility not to discriminate on grounds of disability and to provide an equal treatment before the law (Chapter 2). However, this was clearly not the case in the experiences and practices presented in Chapters 8 and 9. The experiences and HREOC complaint cases provided evidence of an inequality of service provision in comparison to the non-disabled. Quite simply, TA and TI have not provided an equality of service provision with respect to marketing, information provision, accommodation and customer service, and hence, discriminate against the group.

c. Explanations

The explanations for TI reaction to legislative requirements must be seen as identical to the rationale for the *do nothing* approach. Doing nothing can be seen simply as the fallback position when opposition and resistance has failed.

The TA situation is similar. While outright opposition and resistance is not involved, the response to legislation has often been of the *be seen to be doing something* kind. The

reasons why it was necessary to be seen to be doing something was that, as governmental bodies, they should be seen to be promoting the relevant legislation. Thus the explanations for the *be seen to be doing something* approach apply here also.

D. Approach 4: Disability as a Market Segment

a. The nature of the approach

This approach was identified in Chapter 4 as a seemingly logical framework for the TI and TA to adopt to address the tourism demands of people with disabilities. Market segmentation involves identifying groups with common needs or tastes and developing product development and marketing accordingly. This organisational approach and approach 3 are clearly the two with the potential to address the tourism demands of people with disabilities but, given the private sector, profit-orientated nature of the industry, this is arguably the one with most potential.

b. The approach in action

In Chapter 9, it was noted that none of the accommodation establishments represented among interviewees and focus-group participants recognising disability as a market segment. Indeed, one manager noted that he had never thought of disability as a market segment. Three establishments had accidentally become involved in hosting disability-sporting teams, but did not deploy the other features that might be expected from a segmented approach, such as production of access-related tourism information, market research or target marketing to people with disabilities.

The Commonwealth government's approach to disability tourism changed from issues to that of developing a market segment by the mid-1990s and beyond (ONT 1998b; CDITR 2002). The policies sought to entice the business community to seize a hidden market opportunity. Hence, the Commonwealth undertook two initiatives to promote disability as a market segment to the TI but, as noted in Chapter 9, both these initiatives were poorly conceived and had little apparent impact on the accommodation sector.

Tourism Queensland was the only organisation to adopt a market segment approach to disability with product development initiatives. To a lesser extent, the SATC and CTEC began initiatives but the momentum was lost. These initiatives were prompted partly by

market statistics which provided quantitative evidence of the potential the group as a market, but also by, in each organisation, an individual with an interest in the market that was willing to *champion the cause*. Without the initiative of these individuals, no such disability tourism initiatives would have been undertaken.

Because of the potential importance of this approach, the experience of one TA, Tourism Queensland, in developing the approach merits detailed attention. The key individual involved was the Manager of Special Interest Tourism, who acknowledged that his involvement was through a chance meeting with a person with a disability while he was holidaying at Wilson's Lodge, Cape York. As he explained:

It was just a discussion over dinner sitting there talking to ****. I have to be honest there was nothing altruistic that happened, I realised that there was a market there that we were ignoring. Primarily our interest is in making Queensland Australia's most accessible Holiday destination. To promote it to people with disabilities as the great place to come and have a holiday (Miller 2002, pers. comm.).

Miller said that one of the outcomes of Tourism Queensland involvement was an increased level of awareness of the needs of people with disabilities within the organisation, which contrasts with the view referred to above, that attitude change was required before an initiative could be undertaken. However, the involvement was strictly a market decision where accessible tourism provides Tourism Queensland with a competitive advantage over the other states. He wanted Queensland to be Australia's 'number one tourist destination' for people with disabilities. Miller felt that the difference between Tourism Queensland and others was that 'we see people with disabilities as an opportunity, not as a pain in the bum'. Miller attended the *National Workshop on Tourism for People with Disabilities* (Douglas 1999) where he was perplexed that none of the other organisations was represented by marketing people. He felt the attitude of the other attendees was that they were trying 'to find some other body we can flick-pass this to'. Tourism Queensland's approach was customer-centred and this came as a shock to many of the other attendees:

I suppose I pissed them off a bit...we have gone out and talked to the customer first and found out what they wanted...we see people with disabilities as potential customers not as people who need welfare services (Miller 2002 pers. comm.).

From Miller's perspective people with disabilities are just like any other market segment in that there is a need to understand their basic needs and desires. Firstly, they need high quality information about the sectors of the TI. Tourism Queensland started by firstly collating information on what was regarded accessible product and documenting this information into market-specific brochures. It was found that people with disabilities are a

relatively easy group to contact through a range of disability-specific organisations and through Internet distribution. Tourism Queensland recognised that the next step was to integrate disability information into their mainstream *Sun Lover* brochures. This required access audits of the products presented in the brochures and development of a system for presenting disability information. This has required consideration of such issues as: essential information required in an access audit; determining where the responsibility for access auditing lay; provision of resources; and formatting and presenting of information.

These issues had been discussed at the 1999 *National Workshop* (Douglas 1999) but a resolution was not reached. Other areas targeted in the Queensland approach were media promotion of best practice and regional/local liaison to promote access at the destination level and to mainstream tourism operators. It is recognised that, unless there is support by local government authorities for infrastructure, and tourism operators for development of product, then people with disabilities will not find destination regions attractive – again a contrast to the earlier ‘Catch 22’ view that marketing was not worthwhile because of the lack of accessible product.

Yet, even in an organisation pursuing the market, the legislative responsibilities have passed unnoticed and have had little impact on operations. Tourism Queensland has not lodged a DAP, undertaken disability awareness training or promoted employment opportunities for people with disabilities. Tourism Queensland do have a number of people with disabilities working for the organisation (vision, hearing and mobility) and their presence in the organisation had raised awareness of disability issues. Yet, Miller’s philosophy encompasses the best intentions of the DDA, ‘...the days of putting people out under the trees with a blanket on their lap is long gone and you’ve got to give every body the opportunity to get out and experience life’.

c. Explanations

The Qld market segmenting initiative, while it is entirely consistent with a market-based approach, can be seen as espousing the central tenet of the social model, namely the assumption of equality of access to service provision, which can only be achieved through actively seeking to reduce tourism constraints for people with disabilities. It is also notable that, once an organisation has adopted people with disabilities as a recognised market segment, internal consistency requires that other attitudes and discourses fall into place. Thus ableist attitudes and marginalising language are avoided because they would

undermine the policy, while promotion of a human rights approach can be used to reinforce the policy.

Ideally, such initiatives should arise through the normal process of strategic market appraisal within the organisation. Yet, it would appear that the Tourism Queensland example, and those of SATC and the CTEC, arose in an ad hoc manner, because of a professional within the organisation becoming associated with disability by chance. While SATC (1999b) had integrated the disability agenda within their policy framework their initiatives failed due to a lack of resources. Conversely, Tourism Queensland allocated appropriate resources to product development. Whether the resources were allocated based on a strategically sound understanding of disability tourism needs could be questioned.

10.4 Ending

This chapter has considered the practices of TI and TA organisations, which were established as disabling in Chapters 8-9, and explored the reasons for their existence. In doing so, a number of research questions were addressed, and these are discussed in turn below.

What are the social relations that produce the social constraints faced by people with impairments when travelling? (RQ 1c)

A great deal of people with disabilities' dissatisfaction was due to the discourses of access between the stakeholders. While people with disabilities' understanding of access were highly individualised, an underlying discourse was substantially different to TA and TI. TA and TI understanding of access was non-existent or overly simplified and did not provide the level or detail of information for people with disabilities to make informed decisions about the accessibility. The reasons for this situation was a combination of:

- The development and history of the development of the built environment (accommodation sector);
- ineffective inclusion of disability and access in environmental planning processes;
- a lack of understanding of access by the architectural, planning, building and management professionals;
- a lack of understanding of access of their premises by managers of accommodations;
- no accurate documentation of the access of premises;
- the self reported nature of TA collection of access information; and
- a lack of ownership by government, TA and the TI of the need to establish third party access information assessment system for people with disabilities.

The discourses of access were understood very differently by each stakeholder. As Table 32 demonstrates, whether from a demand or the supply side there were a multiplicity of meanings ascribed to access and access information. TA had done little to ensure a common language or discourse of access was promoted to achieve understanding between these groups based on the needs of people with disabilities, the technical considerations of the BCA and the referenced AS1428 and the operationalization by the TI. This possible action of TA would have promoted sound human rights and market outcomes for firstly, people with disabilities and, secondly, the tourism industry sectors.

Table 32: Access stakeholders

Demand	Supply
<ul style="list-style-type: none"> • Personalised understanding of access for their needs (non-technical) • impairment groups (single dimension) • service providers (organisational) • advocacy groups (collective) 	<ul style="list-style-type: none"> • design, planning and construction professionals (technical) • tourism providers (operational) • intermediaries (retail) • tourism authorities (coordination)
Government Regulatory Processes	

The meeting of Commonwealth and state TA recognised many of the issues identified in this research (Douglas 1999), including a coordinated information strategy. Yet, since that meeting no further work on a coordinated approach has been undertaken despite the initiative to establish the Australian Tourism Data Warehouse (Australian Tourism Data Warehouse 2001). This further act of omission supports an explanation that TA is dominated by a combination of market and ableist ideologies.

This was further compounded by the TA and TI as they had little understanding of the requirements of the DDA. The strategic and educative strategies of the DDA appeared to have had little impact on the ableist discourse of TA and TI. For the TA, this is due to the market ideology of the sector, and the accommodation sector, this is the result of a lack of awareness of their responsibilities under the DDA. Where a TA developed a DAPs (TNSW 2000a), it has provided a greater understanding of business unit responsibilities for disability and access, and the potential for future cultural change. However, there has been no material improvement to the products and services on offer for people with disabilities wanting to travel.

What discourses offer an explanation for the practices, rationales and behaviour of tourism organisations and managers? (RQ 3c).

In this chapter, the four theoretical frameworks derived from the literature – market ideology, the medical model, human rights, the social model – together with the ‘discourses of access’ derived from the research, have been used to examine the four organisational approaches to disability. All have a part to play in explaining the disabling practices of TI and TA organisations.

Market ideology

Market ideology dominates tourism, including the public sector TA organisations. People with disabilities are generally viewed as a small, high cost, low yield group, which is therefore, a low priority for managers and marketers. This stance is used to justify the *do nothing* approach in the case of TI and the *be seen to do something* approach in the case of the TA. Yet, the hard evidence for this perception of people with disabilities as a market is not produced – indeed, the evidence of this thesis suggests that it does not exist. This suggests that the hard market-based criteria ostensible used to justify the stance must be supported by other, less obvious, motives.

However, organisational approach 4, considering people with disabilities as a market segment, is also a perspective that is market-based. Limited examples were found where this approach had been adopted, partly as a result of ad hoc events and partly as a result of considering actual data on the market. It was found that, where this approach had been adopted, other negative perspectives which, as discussed below, can be used to reinforce the *do nothing* and the *be seen to do something* approaches, begin to fade away.

Discourses of access

The discourses of access involve the multiplicity of meanings ascribed to access by people with disabilities, TA, TI and government regulatory processes. The underlying commonality of access experience of people with disabilities is substantially different to the industrial responses of the TA and TI. If TA and TI see a group as unimportant, it follows that it is not important to become well informed about their needs. This in turn maintains limited, stereotyped conception of the group and its characteristics and requirements – the *discourse of inaccessibility*. However, this then becomes reinforcing – the discourse itself suggests that the group is unimportant, difficult to service, requires extra high cost infrastructure and are low yield. Further, they *cause trouble* by threatening

legal action. Due to the ongoing discursive structural misunderstandings, TA and TI have disregarded people with disabilities as a market segment.

Medical model – ableist views

The views implicit in the medical model of disability were found prevalent among TI and TA personnel and in corporate documentation. The idea that this is a group with particular problems, who do not travel should be dealt with by other arms of government, generally welfare and/or medically based, rather than being placed at the door of tourism organisations. This in itself becomes part of the discourse of inaccessibility and further underpins the market-based rationale for marginalising the group.

Human rights

While the human rights framework underpins the legislation and regulations on access, it was found that human rights principles played little part in the thinking of TI and even of the TA, which might have been expected to be upholding such principles on behalf of the government sector. Overall, there was found a culture of resistance, and at best reluctant compliance, in the tourism industry. Despite the value of the associated regulatory system in ‘drawing a line in the sand’, it appears that this is not the mechanism which will succeed in changing industry culture to achieve significant improvements in access. The human rights discourse is further complicated by the changes to its implementation in Australia and the implications this has for disability citizenship.

Social model

Given the generally negative culture in the TI and TA, and broader cultures that construct the tourism environment, it is not surprising to find that the principles of the social model play little part in the thinking of the industry. However, the paradox is that, as a service industry, tourism subscribes to the principles of customer service – which involves putting the customer’s needs at the centre of the picture. The limited examples of organisations adopting a market segmentation approach in relation to people with disabilities suggests that the two models are, in fact, not far apart, but the other constraining ideologies and discourses discussed above prevent this from being recognised and adopted by TA and TI.

11 CONCLUSIONS

11.1 Introduction

The central argument that develops from the evidence presented in this thesis is that disability is a social relationship, or rather a complex set of social relationships, between people with disabilities and those organisations that control and deliver the environments, both institutional and social, in which they live. Leisure – and in particular tourism as a sub-sector of the field – represents an important arena for social and cultural participation. Given the commitment by governments to ‘reduce disability’ and to promote tourism, it is thus critical to consider whether the relationships in the area of tourism are disabling or enabling. This concluding chapter summarises the major findings of the research questions raised in Chapter 5. Based on the findings of the research and the critiques of other models for explaining disability experiences in tourism, an explanation is offered that foregrounds the social model of disability in the form of the Comprehensive Tourism Access Model (CoTAM), which is presented and explained through a reconceptualisation of tourism constraints from the research findings and the application of the social model of disability. Further research opportunities that focus on enabling people with disabilities to participate in tourism are then proposed. Finally the chapter reflects on the research process and the implications of the process for future work in the field.

11.2 Conclusions About the Detailed Research Questions

The initial motivation for this thesis was a recognition of the lack of available knowledge about the tourism experiences of people with disabilities and in particular, of the failure by TA, TI and the academic community to systematically consider and respond to the disabling social relations of tourism in Australia. What was available lacked an understanding of the experiences of people with disabilities. Quite simply, tourism had never been considered from the disability perspective. The social model offered an approach that placed the lived experience of people with disabilities at the centre of the research paradigm. It allowed questions to be asked about the situation for people with disabilities in the tourism sector – and established the initial framework for amassing the data and considering the parameters of the issues to be explored. Once these parameters were identified, the thesis was increasingly oriented towards explanation – if this situation existed, why had this happened and what could be done to modify its disabling

consequences? A series of questions were developed to explore the experiences of people with disabilities in the tourism environment. They reflect macro-institutional, local and personal levels of interaction. They include examinations of individual experiences, national and regional surveys, policy, and management practices and are informed by consideration of the theory and discourses of the medical and the social models of disability, the tourism systems model, leisure constraints theory, the human rights perspective and market ideology. The major findings for four groups of research questions, as presented in the conclusions to Chapters 7-10 are brought together below.

1: Are people with impairments constrained in their tourism patterns and experiences in comparison to the non-disabled?

The analysis of national survey data in Chapter 7 shows unequivocally that the level of tourism participation of people with disabilities is substantially lower than for the non-disabled. Further, the national survey data and qualitative data in Chapter 8 show not only that people with disabilities have lower levels of participation but that the tourism patterns differ substantially in respect of the availability of and access to information sources, transport and accommodation. Qualitatively, the tourism patterns differ substantially in terms of destination choice, experience, activities undertaken and attractions visited.

a. Identifying Constraints

Quantitative findings in Chapter 7 and qualitative findings in Chapter 8 indicate that people with disabilities identify a range of constraints that affect their ability to participate at each stage of the tourism system. Yet, these are complex relationships with some constraints relating to all stages of the tourism system, while others are unique to a particular stage of the tourism system. The specifics of the constraints at each stage of the tourism system are extensively detailed in, and summarised at, the end of Chapter 8 (Table 22).

b. Classification of constraints

The constraints identified have been classified using two systems: the three-fold system used in the leisure constraints literature – intrapersonal, interpersonal and structural; and the more detailed, system developed by Smith. These findings are presented in Table 33 as a foreground to reconceptualising tourism constraints for people with disabilities as part of CoTAM (Section 11.4). The evidence from people with impairments in Chapters 7 and 8, suggests that the overwhelming majority of constraints are structural – that is, they are seen

to arise largely from the policies and practices of the TI and TA and related institutions. The Chapter 7 finding, that 99% of people with disabilities stated they did not perceive their impairment as the reason for their non-participation in tourism, is supported by the quantitative and qualitative data examined in Chapter 8. Detailed documentation of the tourism experiences of people with disabilities confirms that they faced a host of constraints that were not generally experienced by non-disabled tourists.

c. Negotiation of constraints

That people with impairments travel at all indicates that many do negotiate the constraints faced, with varying degrees of success. However, unlike non-disabled tourists, people with disabilities tourism experiences involved an ongoing constraint negotiation, possibly everyday of their trip as new structural constraints are encountered. Analysis of these processes resulted in a five-category typology of tourists with impairments:

1. Those who have never considered undertaking a tourism trip because they perceive their impairment as too great an intrapersonal constraint to travel;
2. Those who have never considered undertaking a tourism trip because they perceive the intrapersonal and structural constraints as too great a barrier;
3. Those who have undertaken tourism trips but no longer do so because of the intrapersonal and structural constraints that they encountered in the past;
4. Those who continue to undertake tourism trips but no longer seek new tourism experiences because of the structural constraints that they encountered in the past; and
5. Those who continue to seek new tourism experiences and negotiate the constraints as they arise.

d. Social relations that produce tourism constraints

A great deal of people with disabilities' dissatisfaction was due to the discourses of access between the stakeholders. While people with disabilities' understanding of access were highly individualised, there was an underlying discourse that was substantially different to TA and TI. TA and TI understanding of access was non-existent or overly simplified and did not provide the level or detail of information for people with disabilities to make informed decisions about the accessibility. The reasons for this situation was a combination of:

- the history of the development of the built environment (accommodation sector);
- ineffective inclusion of disability and access in environmental planning processes;
- a lack of understanding of access by the architectural, planning, building and management professionals;
- a lack of understanding of access of their premises by managers of accommodations;
- no accurate documentation of the access of premises;
- the self reported nature of TA collection of access information; and

- a lack of ownership by government, TA and the TI of the need to establish third party access information assessment system for people with disabilities.

The discourses of access were understood very differently by each stakeholder. As Table 32 demonstrated, whether from a demand or the supply side there was a multiplicity of meanings ascribed to access and access information. TA had done little to ensure a common language of access was promoted to achieve understanding between these groups based on the needs of people with disabilities, the technical considerations of the BCA and the referenced AS1428 and the operationalisation by the TI. This possible action of TA would have promoted sound human rights and market outcomes for firstly, people with disabilities and, secondly, the tourism industry sectors.

The meeting of Commonwealth and state TA recognised many of the issues identified in this research (Douglas 1999), including a coordinated information strategy. Yet, since that meeting no further work on a coordinated approach has been undertaken despite the initiative to establish the Australian Tourism Data Warehouse (Australian Tourism Data Warehouse 2001). An explanation for the practices and omissions are put forward through an examination of medical model world views, market ideologies, human rights and social model discourses in RQ 3 and 4.

e. Functionality of the tourism systems model

The tourism systems model was used as a framework for examining the tourism experiences of people with disabilities, as indicated in the theoretical framework outlined in Chapter 5 (Figure 6). While this framework was useful in a broad sense, its limitations immediately became apparent, in that, as presented in the literature, the model appears to assume a smooth running system and fails to foreground the various actors in the system. The development of the theoretical framework, as presented in Figure 6 and in more developed form in this chapter below, while it has a wider purpose, goes some way to overcoming the limitations of the tourism system as it exists for people with disabilities.

2: Within the disability tourism experience, to what extent do impairment and socio-demographic characteristics influence an individual's tourism patterns and experiences?

The quantitative and qualitative data in Chapters 7 and 8 demonstrate that people with disabilities have many commonalities in relation to their structural, socio-economic and geographic experiences of tourism. Yet, the impairments they carry intensify the negative

elements of these experiences, and disarm them in their attempts to negotiate the tourism environment. The national BTR survey and Tourism NSW data in Chapter 7 show that there is a relationship between both the disability type and the degree of disability, and the level of tourism opportunities, participation and patterns. The most marginalised travellers are people with mental health, vision, speech, mobility and hearing impairments who have high support needs. The HREOC complaint cases and Federal Court actions suggest that people with mobility disabilities are most frequently discriminated against in a formal sense. Yet, this data shows that the ‘problem’ is not the nature of the impaired body or the degree of disability that affects the experience as people with impairments did not regard their impairment as a reason for non-travel. Rather the ‘problem’ involved multi-dimensional structural factors that create their negative tourism experiences.

Further analysis of the Tourism NSW data in Chapter 7 confirmed that impairment-related and socio-demographic considerations are determinants of likelihood of tourism and the number of trips taken. The distinguishing characteristic of the social relations of tourism is lifestyle situation (employment status) and, hence, income. If people with disabilities are employed, they have a much higher likelihood of participating in tourism. Further, if they travel for work, this involves travelling more and solutions are found to ensure that these trips can be made but if they travel for pleasure, the constraints are at times insurmountable. While gender was not found a statistically significant predictor in this thesis, a further exploration of the power hierarchy of tourism, examining the social relations between resources and gender, may provide an area of further investigation.

a. Implications for the social model of disability

The quantitative findings in Chapter 7 and qualitative results in Chapter 8 provide empirical evidence that suggests that an *embodied ontology* of tourism exist based on impairment-related and other socio-demographic characteristics. What becomes apparent is that the relationships between the impairment, socio-demographic characteristics and tourism participation are complex and dynamic for each individual, with no simple interpretation or uniform effect. This suggests that, while people with impairments as a group have common needs and face common constraints to tourism, individual agency does intertwine with structural factors to affect the tourism experiences of the individual. The evidence suggests the need to incorporate agency in social model theory development.

3: What are the practices of the TA and TI towards service provision for people

with disabilities?

The secondary data analysis, content analysis of disability tourism initiatives, in-depth interviews of the accommodation sector and analyses of the outcomes of regulatory processes presented in Chapter 9 identify and analyse a range of TA and TI policies, practices and discourses which influence the tourism patterns, opportunities and experiences of people with disabilities. In regard to TA, these included strategic planning, awareness raising and access information collection and dissemination activities. In regard to TI, these included access information provision, facility management practices and, collective, lobbying activity in relation to the development of building and transport access standards.

a. Effects of TA/TI policies, practices and discourses

The evidence presented in Chapter 9 confirms that the policies, practices and discourses of the TA and TI actively produced the constraints identified by people with disabilities. While the accommodation sector largely ignored people with disabilities as a market sector, the TA had made deliberate decisions not to address the most *disabling practices* involving market research, information provision and marketing constraints identified by people with disabilities.

It was found that a large proportion of TA and TI do not have disability on the tourism agenda. This has led to organisations either omitting disability, undertaking token initiatives or setting a lower prioritisation that avoids addressing the recognised issues - even by the TA and TI in some official pronouncements - as essential to delivering an equality of provision for the group. The few TA and TI that serviced people with disabilities had done so through an historic accident, championed by individuals in organisations, rather than as part of strategic market segment policy and product development.

b. Rationales for TA/TI disabling policies, practices and discourses

Chapter 10 proposes a typology of four TA/TI organisational approaches to frame analysis of the situations uncovered by the research. These were: 1. do nothing; 2. be seen to be doing something; 3. react to legislative requirements; and 4. identify tourism as a market segment. The primary rationale offered by both TA and TI organisations for their generally negative attitudes towards disability in the tourism context is the market ideology – that people with disabilities constitute a high cost, low yield group. The TI response simply

ignores disability, as they do not consider it to constitute a viable market. In one case, however, a TA appear to adopt a totally contradictory, but still market-based, rationale, of identifying and pursuing people with disabilities as a viable market segment to gain a competitive advantage over other TA. These examples, and the quantified data presented in this thesis, suggest that the basis for the ostensible market view is questionable. This, in turn, suggests that other, less overt, motivations underlie the publicly expressed viewpoint.

c. Discourses that explain TA/TI collective and individual behaviour

Chapter 10 examines the four organisational approaches from the point of view of four discourses or frameworks: the medical model of disability and associated ableist discourses; the social model; human rights principles and *discourses of access*. The first three of these arose from the literature and shaped the research design. The last, *discourses of access*, arose as a theme from the empirical research. It suggests that the discourse of access used by people with disabilities is very different from the discourse used by TI organisations and personnel and significantly different from that used by TA organisations and personnel. It is so different to the extent that the discourse used by the TI/TA might be termed a *discourse of inaccessibility*.

TA and TI generally hold a medical model worldview of disability that leads to a series of ableist preconceptions about people with disabilities and their tourism patterns. The most fundamental of these assumptions is that they do not travel due to their impairment. This flawed assumption disregards national and regional tourism data collected by TA. The accommodation sector anecdotally supports this assumption through the selected use of occupancy rates of *disabled rooms*. The flawed assumptions of their arguments negate the very market considerations that would be provided for other market segments. However, the inaction, with noted exceptions, of the managers in the TA was a deliberate decision not to address the identified issues that would provide an equality of service provision to people with disabilities. This deliberate omission should be considered far more serious than the ignorance of the TI as the TA had evidence of the needs of the group, considered their position and avoided their responsibility under the DDA.

Regarding discourses of access, people with disabilities have highly individualised understandings of access that are substantially different to TA and TI. TA and TI understandings of access were non-existent or overly simplified. Consequently, when asked for access information, they generally failed to provide the level or detail of

information for people with disabilities to make an informed decision about the accessibility of tourism product. Closely connected to this was values of the professionals involved in the environmental planning processes that regulate the development of the built environment, including design, planning, construction and facility operation, which generally do not include an understanding of disability and access. This results in widespread non-compliant access arrangements within developments, not only in relation to tourism, but also in relation to the considerations of the impact of wider government legislation and policy on TA and TI practice and discourse. The discourses of access are further compound through the implementation of disability citizenship rights in Australia.

Generally, there was a lack of a human rights considerations/recognition/knowledge by TA and TI. The evidence demonstrates that the DDA has had little impact on the practice and discourse of TA and TI, who have no or limited understanding of their responsibilities under the legislation. This is despite the development of two disability information initiatives by the Commonwealth (ONT 1998b; DFACS 1999c). It must be stated that these initiatives involved information packages, and a limited symposia program that was only half completed. Neither initiative was designed or resourced to involve a program of TI education. While the Australian and overseas literature suggested that TI would have a low recognition of a human rights agenda, the finding that the Commonwealth and state government TA seemed surprised that the legislation applied to their operations was disturbing.

Given the generally negative culture in the TI and TA, and broader cultures that construct the tourism environment, it is not surprising to find that the principles of the social model play little part in the thinking of the industry. However, the paradox is that, as a service industry, tourism subscribes to the principles of customer service – which involves putting the customer's needs at the centre of the picture. The limited examples of organisations adopting a market segmentation approach suggests that the two models are, in fact, not far apart, but the other constraining ideologies and discourses prevent this from being recognised and adopted by TA and TI.

4. What evidence does the government regulatory environment of the DDA provide on the tourism experiences of people with impairments?

Chapters 8 and 9 present evidence on the regulatory environment using individual complaint cases and a brief history of development of Disability Standards for accessible

public transport and access to premises.

a & b. Discriminatory practices or omissions which give rise to complaint cases

The discriminatory practices identified affected all dimensions of disability, across all sectors of the TI and involved other contributory sectors of government and commercial organisations. Chapter 8 and Table 27 from Chapter 9 provide an extensive understanding of the discriminatory practices. A summary of these discriminatory practices includes:

- non provision of facilities and services;
- frequently incomplete and misleading information provision;
- information not provided in alternate formats;
- inaccessible transport and day tours;
- attractions with segregated entrances;
- segregated pricing practice;
- inaccessible attractions, conferences and common domain areas;
- interpretive services that are not inclusive of people with sensory impairments;
- inaccessible accommodation or accommodation of non compliant standard;
- inattention and lack of information on access to other hotel amenities;
- general lack of consideration of impairments other than mobility;
- segregated, ostracized or exclusionary customer service practice;
- lack of staff training and consequent poor customer service; and
- general lack of equality of access provision compared with non-disabled.

c. Effects of the DDA

The tourism complaint cases documented in Chapters 8 and 9 involved both direct and indirect discrimination with new complaint cases in tourism being lodged every week. However, the DDA has had no or limited influence on the practices and discourses of the TA and TI. There was little understanding of the requirements of the DDA by TA or the TI. The complaint cases have had the largest impact on individual operators where operators have changed behaviour after the conciliation or Court processes. However, from a broader industry perspective there has been no systemic change to the way the industry operates. This was signified by the approaches to disability by the TA who traditionally lead the TI in areas of industry education and coordination. The only TA who focused on improving service provision for people with disabilities did so out of a market response rather than through understanding the legislative responsibilities of the DDA. The reasons for this situation are explored further in RQ 4d and 4e.

d. Other mechanisms of the DDA

The development of a DAP to systematically address systemic disability issues within TA or TI was only undertaken by one organisation because it was made compulsory by its

State government. While providing a greater understanding of business unit responsibilities for disability and access there has been no subsequent material improvement to the products and services on offer for people with disabilities. This inaction has a flow on effect for the TI, as the TA has provided neither direction for, nor coordination of, disability initiatives for the TI. Another organisation develop a disability tourism policy but this was not implemented. Yet, even where TA had developed tourism products and services there still was no recognition of their responsibilities under the DDA.

e. Explanations for tourism experiences of people with disabilities

The complaint cases under the DDA gave people with disabilities and disability advocacy organisations a voice to redress disability discrimination. The complaint cases highlighted ongoing discrimination against people with disabilities in a tourism context and had the largest impact on individual operators involved in cases. However, the unfair treatment identified in the complaint cases is duplicated many times without having broader strategic outcomes. Chapter 8 reinforces the findings of other research, which identifies the weakness of complaints based legislation as being that the onus is on the individual to make a complaint, the lack of common law precedent and lack of compliance timeframes. This is different to the ADA, which is compliance based and has led to strategic outcomes in the accommodation sector in the US. Many of the accommodation sector's constraints discussed in Chapter 8 with respect to the discourses of access (marketing, information provision and hotel disability design inclusions) have become part of the US accommodation chain's disability practice and discourse.

Moreover, Australian TA and TI regarded the use of the DDA as a sign of *disability militancy*. They found this perplexing as they believed disability was not their responsibility and that any efforts on their part should be well received by the group. This was partly due to an overt paternalism of their limited action, lack of understanding of the group's market needs and a decision to omit disability from their tourism agendas.

Some sectors of the TI, such as operators in the transport and accommodation sectors, have used the Disability Standards process as a means to limit the advancement of a disability human rights agenda. With their greater resources, the transport operators were able to significantly stifle the Standards process for seven years, dilute the level of access requirements, gain a further 10 year extension in implementation to 30 years, and still have scope for exemptions. The Standards process exemplifies the limitations that the current

legislative environment creates. It reflects a bureaucratic and professional system of decision-making, where ‘the disabled’ are seen as just one other interest group rather than the human rights agenda being recognised as a prioritising of equity considerations because of documented social disadvantage. This in itself demonstrates a lack of political will to implement the human rights agenda of the DDA and, hence, disability citizenship.

Many of the complaint cases involve a failure of the environmental planning system to incorporate, regulate and enforce disability and access considerations that form the basis of tourism environment. This contributes to the discourses of access that the evidence in Chapters 7, 8, 9 and 10 presents. This supports an argument that the disabling tourism environment is partly a product of the structural-historical development of design, planning, construction and operations sectors. These sectors, together with government regulators, shape the legal, policy and market contexts. Powerful market interests play an important role in framing the parameters of government decisions and undermines the human rights framework that seeks to provide an equality of provision through access for people with disabilities. Disability citizenship is compromised through the sustained market agendas of these interests that actively seek to dilute the human rights agenda of government legislation and, hence, the rights of the Australian disability community.

11.3 The Central Research Question

Having addressed the detailed research questions, it is now possible to address the central research question:

To what extent are the tourism patterns and experiences of people with impairments in Australia unduly constrained by tourism authorities and tourism industry practice and discourse?

The research has established that the tourism patterns and experiences of people with disabilities are constrained compared with those of the non-disabled. Quantitative and qualitative evidence from people with disabilities themselves indicate that, from their point of view, numerous significant constraints are experienced in all stages of the tourism system and trip negotiation process. The constraints are seen as largely resulting from the policies and practices of the TA and TI. Interviews with TA and TI representatives, examination of policy documents and initiatives, and examination of cases arising from the regulatory process confirm that many TA and TI policies and practices do indeed produce the constraints identified and can therefore be described as *disabling*. Further, examination

of the rationales offered by the TA and TI and an examination of organisational approaches to disability from a number of discourses, reveal a number of inconsistencies which lead to the conclusion that the *disabling policies and practices* are unjustified. Therefore, the proposition that the policies, practices and discourses of the TA and TI place *undue* constraint on the tourism patterns and experiences of people with impairments is supported.

11.4 Comprehensive Tourism Access Model (CoTAM)

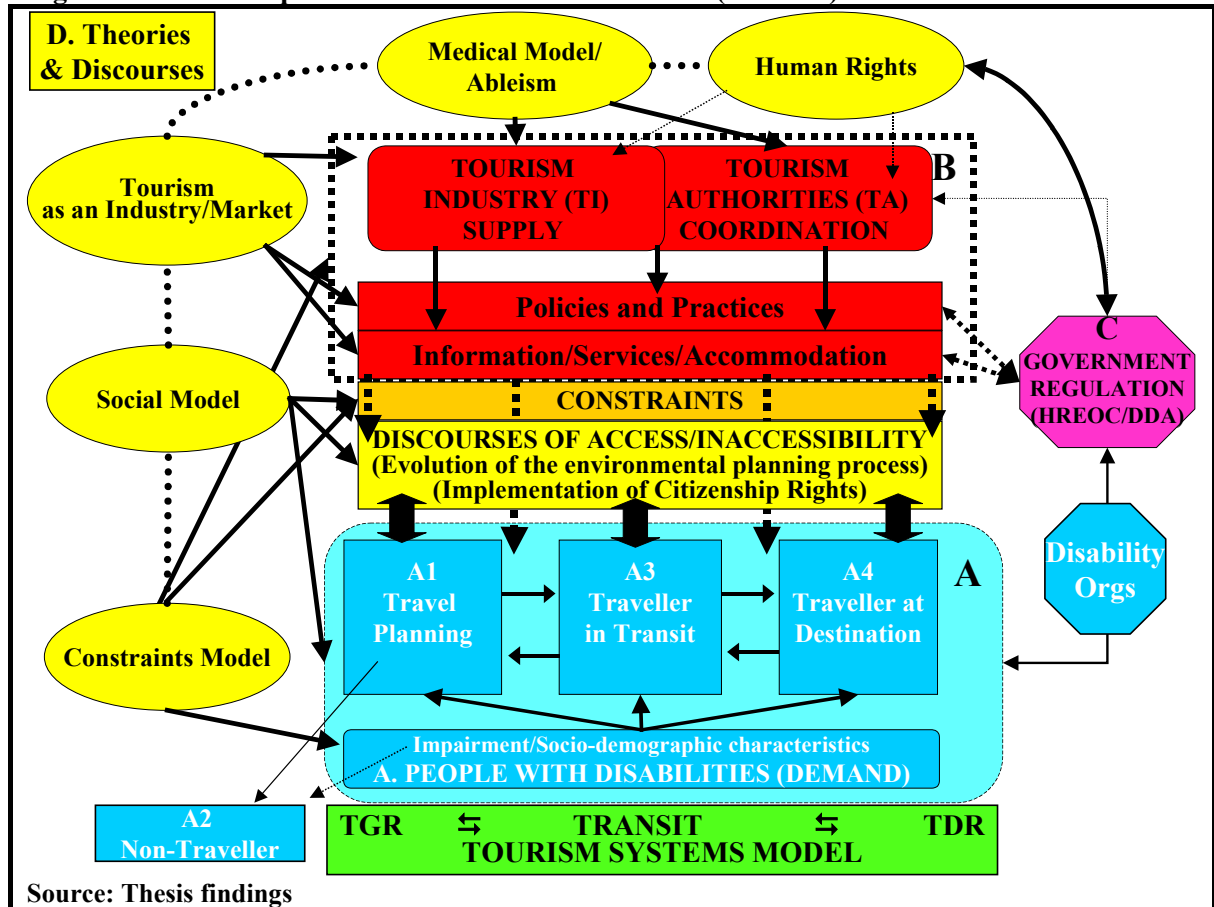
The thesis draws together divergent areas of study and seeks to address disability tourism from the three positions of demand, supply and regulation/coordination. As previous studies have done, this thesis could have studied one of these positions from only one of the areas of study. However, doing so would not have addressed the complexity that is required to understand the social relations of disability tourism in Australia. CoTAM represents the outcome of this research process and offers an explanation for the tourism experiences of people with disabilities. The drawing together of these three positions is in itself a distinct contribution of this thesis to the body of knowledge. Drawing on this distinct contribution, Figure 16 presents a general model of disability tourism experiences in Australia. The Comprehensive Tourism Access Model (CoTAM) largely reflects the theoretical framework proposed in Chapter 5 (Figure 6) but has been modified and extended through the findings of the thesis. The model consists of four interrelated components:

- A. People with disabilities and their tourism experiences (demand);
- B. Tourism industry (supply) and tourism authorities (coordination) practice;
- C. Government human rights framework of the DDA (regulation);
- D. An explanation for the experiences of people with disabilities through theoretical perspectives and discourses and the social relations of access.

CoTAM is framed within the geographic tourism system (TGR \rightleftharpoons TRANSIT \rightleftharpoons TDR) and draws upon the tourism definitions presented in Chapter 1 (e.g. tourist, tourism etc.). It includes constraint and social model theory within the tourism system framework to incorporate a disability perspective. The model is inclusive of all stakeholder positions of demand, supply and coordination/regulation. The line width and continuity (patterns) represent the strength of interaction between each of the components. For example, the strongest relationships of the model exist for the individual decision-making process and the individual's interaction with the tourism environment. The relationships the individual has with disability organisations, government, TA and TI, are dependent upon the

individual and their experiences. Each component is briefly summarised based on Section 11.2 before a broader discussion incorporates constraint and social model theory within this framework.

Figure 16: The Comprehensive Tourism Access Model (CoTAM)



Source: Thesis findings

A. People with disabilities and disability organisations/advocates

Component A involves the individual with a disability who is contemplating tourism. The research develops an understanding of the influence of impairment and socio-demographic characteristics on the likelihood and frequency of trips. These characteristics, together with the constraints they encounter (see Table 33 for a full list of constraints) affect whether an individual becomes a traveller (A1 ⇌ A3 ⇌ A4) or non-traveller (A2) within the tourism system. The findings confirm that a major pre-trip constraint involves the marketing responses of the TA, TI and retail travel agents to the provision of tourism access information (from Component B ↓ to Component A). People with disabilities were also assisted by disability organisations and/or their advocates who provided an avenue for telling/sharing their tourism experiences, provided information and were available for consultation or advice on running complaint cases (↑ to Component C). Their tourism

experiences are examined in context to the responses of TA and TI (Component B), as are those who take DDA complaint cases (\uparrow Component A to Component C \leftarrow to Component B). A five-category typology of tourists with disabilities emerges from the findings, as outlined in Section 11.2. The five categories are a product of the individual's impairment, socio-demographic characteristics and pre-trip constraints (Component B \downarrow to Component A), the responses of TA and TI (Component B) and the on-trip constraints (A3 \rightleftharpoons A4). The constraints are reviewed and reconceptualised below in F. The resultant experiences become part of the individual's tourism history and affect their future tourism choices.

B. TA (coordination) and TI (supply)

The findings of the thesis identify a multitude of structural constraints perpetuated by the TA, TI and other bodies responsible for equality of service provision to people with disabilities (\downarrow to A1, A2, A3 and A4). In particular, the tourism access information constraints were compounded by lack of organisational communication of access. A host of other structural constraints attributable to TA and TI were identified that unduly constrained the tourism opportunities, patterns and experiences of people with disabilities (see Table 33 for a full list of structural constraints). Four approaches to disability tourism by TA and TI were identified that explained the behaviour of the organisations (\downarrow to Component A). They were to do nothing, to be seen to be doing something, to react to legislative responsibilities and to identify as a market segment. An explanation for these behaviours is examined in D.

C. Government regulation processes regarding citizenship rights of people with disabilities

The findings suggest that the educative aspects of the DDA (\leftarrow Component C to Component B) had little impact on the practices and discourses of TA or TI. This is also supported through the review of the complaint cases brought by people with disabilities against the TA and TI (\uparrow from Component A to Component C \curvearrowright to Component B). The only TA to undertake a DAP did so because it was made compulsory by its State government. Yet, the practices of this TA have not changed. The only TA to develop a market segment approach did so through a chance meeting by a key member of management who *championed* disability tourism in the organisation. Outside of the recognition of BCA requirements for accessible rooms, the TI had little understanding of their responsibilities under the DDA. Disability organisations (\uparrow Component A to Component C) also played a role by attempting to influence the practices and discourses of government, TA and TI through lobbying, consultation and the complaints cases.

D. Discourse analysis – explaining the behaviour of TA and TI and the resultant tourism experiences of people with disabilities

The experiences of people with disabilities are explained through the combination of the TA and TI approaches to disability (see Component B) and the discourses of access that produced the constraints encountered. The TA and TI behaviour is a combination of the medical model worldview of disability, resultant ableist practices and the market ideology that dominates tourism. An area for further research involves the relative position of power that the TA and TI exert over people with disabilities. The social model of disability placed the lived experience of people with disabilities at the centre of the research paradigm. In doing so it focused attention on the tourism constraints facing the group and that offered an approach to research tourism from a disability perspective and, hence, offer an explanation for their experiences.

Apart from the behaviour of TA and TI towards people with disabilities, their experiences are attributable to the discourses of access. The discourses of access involve the multiplicity of meanings ascribed to access by people with disabilities, TA, TI and government regulatory processes. The underlying commonality of access experience of people with disabilities is substantially different to the industrial responses of the TA and TI. If TA and TI see a group as unimportant, it follows that it is not important to become well informed about their needs. This in turn maintains limited, stereotyped conception of the group and its characteristics and requirements – the *discourse of inaccessibility*. This then becomes reinforcing – the discourse itself suggests that the group is unimportant, difficult to service, requires extra high cost infrastructure and are low yield. Further, *they cause trouble* by threatening legal action. Due to these ongoing discursive structural misunderstandings, TA and TI disregarded people with disabilities as a market segment.

E. Understanding CoTAM through constraints and social model theory

CoTAM is further explained through the summary of tourism constraints identified in Chapters 7, 8, 9 and 10 and summarised in Table 33. It uses Smith's (1987) categorisations of barriers to leisure travel (left column) as a foundation to review the tourism constraints that emerged from this thesis (right column). The next three sub sections review and reconceptualise the intrapersonal, interpersonal and structural constraints in light of the findings of the thesis and through foregrounding the social model of disability as a way of understanding the disability tourism experience.

Table 33: Summary of tourism constraints

CATEGORY (SMITH 1987)	CONSTRAINTS EVIDENCE FROM THIS THESIS
(Intrinsic)	Intrapersonal
Lack of knowledge	<ul style="list-style-type: none"> • Significant constraint for non-travellers or with recently acquired disabilities • Similarly, for associates or service providers who organise trips
Health related problems	<ul style="list-style-type: none"> • The industry doesn't recognise the difference between disability and illness • Inflexible booking arrangements to minimise pain and discomfort (structural) • Lack of temperature controlled environments (structural)
Social ineffectiveness	<ul style="list-style-type: none"> • Not a consideration of this sample
Physical and psychological dependency	<ul style="list-style-type: none"> • Reliance on full time carers or attendants (see also of attendant care programs) • Dependency on family members as carers • Dependency on monopolised personal care and paratransit services (structural)
(Communication)	Interpersonal
Skill-challenge incongruities	<ul style="list-style-type: none"> • TI assumptions of ability limited pwd choices of what was offered. (structural) • Risk involved in participating due to lack of access to environments (structural)
Communication	<ul style="list-style-type: none"> • Language difficulties when travelling to non-English/non-Auslan speaking countries; • Non-disabled aversion to communicating with people with disabilities (structural) • Attendants as communication facilitators • Disability as an <i>appropriate other</i> to be gazed upon (structural)
(Environmental)	Structural
Lack of information	<ul style="list-style-type: none"> • Availability, relevance and distribution channels • All dimensions of access, accuracy, detail, presentation and format • Complexity of operationalising the above • Discourses of access creates a different meanings for individuals, TA & TI • Conscious decision by TA & TI not to provide equality of information;
Organisation communication of access	<ul style="list-style-type: none"> • Communication of tourism access information to staff at all levels of organisations • Communication of tourism access information to intermediaries • Inclusion of tourism access information in generic marketing/target marketing • Dimension of access, particularly vision, hearing, cognitive or psychiatric • Provision of alternative communication technology and formats
Economic circumstance	<ul style="list-style-type: none"> • Economic constraints disadvantaged a disproportionate number of people • Affects ability to travel but also the frequency, duration and choice of trip.
Cost (extra costs of disability)	<ul style="list-style-type: none"> • Double cost for those travelling with an attendant • Accommodation due to accessible rooms only available in higher class • Paratransit systems are more expensive than public transport • Equipment hire (commode, hoist etc.) • Excluded from economic advantages of discounted packaged product
Attendant care	<ul style="list-style-type: none"> • Resources and flexibility of HACC programs away from residence • Availability of attendants • Suitability of attendants for the individual
Socio-spatial =	• Destination – culmination of architectural, ecological, transport, attitudinal and rules & regulations
Attitudinal +	<ul style="list-style-type: none"> • Customer service exclusion through non-provision, inappropriate language use and unfair treatment • Assumptions about abilities of travellers with disabilities; • Attitudinal exclusion = segregated tourism experience;
Ecological +	<ul style="list-style-type: none"> • Destination accessibility (see Architectural & Appendix 9) • Access to area attractions/activities/services/natural areas • Independent and dignified spatial use
Architectural +	<ul style="list-style-type: none"> • Linkages between transport, the natural and built environments. • Basics of parking, toilets and a continuous pathway were absent (Appendix 9) • Linkages between transport, accommodation, common domain, attractions and sites of interest. • Finding appropriate accommodation • Bedroom and bathroom requirements as foundation components to tourism
Transport +	<ul style="list-style-type: none"> • Discourses of access of accommodation – equality of provision • Lack of accessible public transport provision • Available class of transport provision • Heavier reliance on private motor vehicles & paratransit as mode of transport • Lack of day tour operations (coach, rail & watercraft) result in segregated experiences
Rules and regulations	<ul style="list-style-type: none"> • Government, TA and TI perception of disability as <i>special provisions</i> • The complaints case implementation of the DDA • Relevant environmental planning legislation not implemented correctly • Results in the <i>nuisance or fire hazard</i> interaction of pwd and the non-disabled • Aircraft access regulated through international agreements
Air transport	<ul style="list-style-type: none"> • Airline information management of the needs of people with disabilities; • Loss of travel independence and dignity through boarding procedures; • Seating location and retractable arms; • Personal care issues and lack of accessible toilets; • Equipment handling and damage on flights; and • Ground staff awareness and OH&S training.

This thesis contributes to the empirical testing of tourism constraints categorisations for people with disabilities and suggests that they need to be reconceptualised in light of the evidence presented in this research. The evidence presented in this thesis suggests that a great deal of what was assumed intrinsic to a person's impairment was wrongly attributed. The reason for these assumptions is an area for further research and beyond the scope of the thesis. Whatever the reasons, this thesis argues that many of these constraints were structural rather than intrapersonal or interpersonal and were the product of the *disabling tourism environment and hostile attitudes*, and not the *fault and problem of the individual*.

Intrapersonal

Lack of knowledge

This study reinforces that the lack of knowledge about tourism was a constraint for some people with disabilities. This was most evidenced by those people who had recently acquired their disability and those who had not previously travelled. However, contrary to the ableist assumption that a lack of knowledge is intrinsic to the person, this thesis shows that for the majority of people, lack of knowledge was a structural factor. It is attributable to the inaction of the TA and TI in providing relevant market research and marketing needs for the group. In particular, it is the failure to provide relevant access information as part of tourism information systems. This was partly attributable to the discourses of access where the TI did not understand the access provisions of their premises/services or the requirements of the group. The lack of tourism access information was compounded by the deliberate omission of the TA to provide the group with an equality of information in their role as market research and, hence, information and marketing coordinators of the sector. The result was that the TA and TI did not provide any of the level of detailed tourism access information that people with disabilities required to make informed tourism decisions. Therefore, lack of knowledge is discussed as a new category of structural constraint together with organisation communication of access (see structural).

Impairment and health-related conditions

The thesis documents that some people perceived their impairment or its health-related effects as an intrinsic constraint to tourism. For some, this involved the decision not to travel or to constrain their tourism choices. The quantitative results in Chapter 7 suggest that a person's level of tourism participation and patterns were significantly influenced by the type of impairment. Quite simply, participation varied by impairment. While Barnes and Mercer (1996) argue that in the social model, disability experience is different to

illness or health-related conditions, Shakespeare and Watson (2001) counter that the social model needs to intertwine agency and structure. The results of this research may offer empirical evidence to develop the social model as a theory through suggesting that the social relations of tourism may be better understood through incorporating agency with structure. However, while impairment was an influence on whether a person travelled, the frequency of travel was influenced by general socio-demographic considerations, most notably lifestyle situation (employment status) and income.

The above findings of the research involve complex social relations with the national tourism data in Chapter 7 identifying that 99% of people with disabilities did not regard their impairment as an intrinsic constraint to tourism. Rather, the quantitative data in Chapter 7 and qualitative data in Chapter 8 identify a series of structural constraints that created disabling organisational procedures, environments and attitudes. This thesis reinforces that for most people with disabilities, while impairment may influence tourism participation and patterns, structural changes to TA and TI practices would remove many of the constraints identified in Table 33. Quite simply, their non-participation is due to a series of interrelated structural constraints and not their impairments.

Social ineffectiveness

There is little evidence of social ineffectiveness of people from which the sample was drawn. While a small proportion of responses was provided by carers or guardians of people with disabilities, neither of the secondary data sources identified the proportion of responses provided by these people. Social ineffectiveness was identified by Smith (1987) as an issue for some people with cognitive, mental health and other communication disabilities. It is recognised that there is an under representation of these people in all facets of citizenship in Australia (Clear 2000b). Only a few HREOC complaint cases involved people from these groups. Further research with these groups could investigate the relevance of this constraint. Social changes may explain why social ineffectiveness may not be regarded as the constraint that it once was. In the Australian context, this may involve deinstitutionalisation (Meekosha and Dowse 2001), developments in adaptive communication technologies (Clear 2000a) and the role of the self-advocacy movement (Ippoliti, Peppey and Depoy 1994; Dowse 2001). These changes have assisted independent communication of people with disabilities and, hence, what were regarded as issues of social ineffectiveness can now be regarded as structural communication constraints.

Dependency

Physical and psychological dependency was a major constraint. Most of this dependency involved the personal assistance needs of people with disabilities, which was provided by family members, carers and attendants. While others have identified psychological and physical components to dependency, the interviews also identify structural constraints to dependency. Dependency in this case was not the fault of the individual but attributable to the policy environment of HACC programs (see PDCN 2002a). People are made reliant on a system orientated towards dependency through a lack of resources and an inflexible policy environment (McClure 2000). Therefore, attendant care policies are discussed as a new category of structural constraint.

Interpersonal

Skill challenge incongruities

No skill challenge incongruities emerged through the tourism experiences of the sample. Where incongruities did arise, it was through the anxiety created when trying to participate in activities where structural constraints required the individual to negotiate physical risk to participate. A number of dangerous examples were given of trying to board boats without access ramps or floating pontoons. However, the literature on disability and recreation in Australia suggests that skill challenge incongruities may continue where non-inclusive structural practices of leisure providers inhibit opportunities for development of activity skill (Section 4.3 and Lockwood and Lockwood 1999; Patterson and Taylor 2001).

Communication

Communication is an interactive process and people with disabilities, like the non-disabled, reported language as an issue when travelling to non-English speaking countries. The communication aspects of disability involve more than the perceived sensory or cognitive *deficits* of the individual. The DDA has changed the onus for communication from that the *fault of the individual* to an organisational responsibility. The experiences documented in Chapter 8, including complaint cases and Federal Court actions, draw attention to organisational responsibility for communicating with people who have vision, hearing, speech or print disabilities and require information in alternative formats. Therefore, these issues are addressed as a new structural constraint of organisation communication of access.

Structural

The previous two sections have shown that some intrapersonal and interpersonal constraints to tourism thought to be the *fault or the problem of the individual* are largely a product of the social relations of tourism. The insights that the social model provides, and which emerge from the findings of the research, suggest that a number of new structural categories would contribute towards a better understanding of the tourism constraints encountered by people with disabilities. These include destination as a socio-spatial construct, marketing and tourism access information, organisational communication of access, air transport (separate to transport), economic circumstance, extra cost of disability and attendant care policy.

Destination as a socio-spatial construct

As Table 33 identifies, the understanding of the structural categorisations of attitude, ecological, architecture, transport, and rules and regulations have been significantly extended by the constraints identified in this thesis. Yet, the qualitative data presented in Chapter 8 shows that destination experience is a product of the interrelationship between these categories. Taking direction from Gleeson (1999b) and other geographers (see Chapter 3), the interrelationships can be described as socio-spatial constructs. Chapter 10 outlines an explanation for the socio-spatial constructs through the discourses of access, development of the environmental planning system, the values of professionals involved and the implementation of citizenship rights in Australia. The interrelationships involve complex social relations that will differ for each country, region, destination and precincts within destinations. Within precincts, the unique socio-spatial disability and access considerations converge to produce *enabling or disabling destination experiences*.

Marketing, research and tourism access information

While lack of knowledge was an intrapersonal constraint for some people, the lack of provision of relevant tourism access information as shown in Chapters 7 and 8 affected a large proportion of people with disabilities. The usual market research responses of the TA and TI for market segments did not exist for people with disabilities. An extensive discussion of knowledge as a structural issue is undertaken through the discourses of access in Chapter 10. The outcomes were less than satisfying experiences for a significant proportion, some people abandoned tourism planning, while others relied on word of mouth and family/networks to negotiate this constraint rather than the TA and TI responses. The importance of this for people with disabilities is best understood as Jenkins

(1999) states that destination image is the sum of all ‘knowledge, impressions, prejudice, imaginations and emotional thoughts an individual or group might have of a particular place’. Yet, the TA or TI did not understand this from a disability perspective and, hence, had not considered the inclusion of tourism access information as being an important part of developing destination image for people with disabilities.

Organisational communication of access

An extension of market research, marketing and provision of information on tourism access was the lack of organisational communication of access by TA and TI. Most organisations did not have a sound understanding of the access features of the facility or service they offered (see OCA 2002). Those organisations that did understand disability and access needs did not transform this understanding into meaningful tourism access information (see Ashton 2000; Cameron 2000b). Most organisations recognised mobility access but did not understand the other dimensions of disability (see Fodor’s 1996; English Tourism Council 2000a; Hasselt and Brussels 2001) or the need for alternative communication technologies and formats (see CDFACS 1999a; HREOC 2002d). Even if these constraints had been addressed, organisations did not internally communicate access information to all levels of staff to ensure successful operational implementation. Disability and access were frequently the domain of one individual within an organisation. Further, tourism access information was rarely marketed externally to intermediaries or to people with disabilities. Only one TA recognised disability as a market segment and marketed directly to people with disabilities and the organisations that represent them.

Transport

The constraints to public transport in Australia have been well documented (Downie 1994b; DDA Standards Project 2000) and reinforced in a tourism context by this research. This thesis shows that the lack of accessible public transport and day tour charter operations were major constraints to people with disabilities. This constrained not only the mode of transport to a destination but constrained involvement in recreational tourism activities at destinations. These constraints significantly added to the costs of tourism, affected interaction with the natural and built environment and excluded people with disabilities from social interaction with other tourists. Transport constraints need to be separated into transport to/from destinations and transport at the destinations, where transport at the destinations becomes part of the destination socio-spatial constructs. However, air travel constraints caused the greatest distress and are treated separately.

Air transport

The research shows that the disabling air transport environment created a loss of independence and dignity due to the embarking and disembarking procedures that were dictated by aircraft design regulation and international air safety legislation. This led to people expressing a sense of helplessness until they were reinstated to their independent embodiments (wheelchair, assistance animals etc.). For a proportion of people, this did not occur as their equipment was damaged or lost in transit. The loss of dignity, independence and sense of helplessness continued until the situation could be rectified. In the worst case, their tourism experience could not continue and they returned home. The outcome of this constraint was that some people would only travel by their private vehicles to avoid these situations. While the air transport is governed by international regulations that Australia must adhere to, many identified issues involved disabling organisational practices.

Economic circumstance

Most studies recognise economic circumstance as a constraint to tourism for all people. However, it can not be ignored that proportionally, people with disabilities live in poverty at higher rates than do the non-disabled. This reality for people with disabilities is part of complex equity issues relating to citizenship. The patterns and experiences examined in Chapters 7 and 8 show the complex interactions between economic circumstance, extra costs of disability, impairment and lifestyle situation on the likelihood, frequency, duration and choice of trip. These structural inequities require a whole of government approach. Many parties have called for a disability participation allowance to redress these wider structural issues (PDCA 1997; McClure 2000; Frisch 2001). Yet, government has resisted a policy that would better enable people with disabilities to access all their rights of citizenship including tourism.

Extra costs of disability

On top of economic circumstance, the thesis shows that in a tourism context people with disabilities face extra costs to tourism that must be negotiated before tourism can occur. This supports other research into the extra costs of disability. The costs are highest where a person needs to travel with an attendant, and requires wheelchair accessible accommodation and transport. The cost issues are further compounded by the practices of TA and TI that exclude people with disabilities from the economic and organisational advantages of discounted packaged tourism products. Due to the exclusionary practices of

the TA and retail agents, people must negotiate their own trips to ensure the accessibility of each component. The estimation of the extra costs of tourism for people with disabilities warrants further research.

Attendant care policy

Under resourcing and the inflexibility of HACC attendant care programs were significant constraints to tourism opportunities. People who are reliant on family members, carers or attendants want the opportunity to holiday where they want, when they want and with whom they want. This requires an extension to, and improved flexibility in HACC programs to facilitate independent and dignified tourism experiences for people with disabilities. Most State disability frameworks stress the importance of addressing *individual need* (NSW Government 1998; NSW DADHC 2002) but little is done to achieve this (PDCN 2002a). The reality for people with high support needs is that what is offered is *home care* in its strictest sense, rather than the flexibility to attend to personal care needs at home, work or in tourism.

F. Hierarchical model and negotiating tourism constraints

People with disabilities face these constraints to tourism that not only affect whether a person travels or not but also the frequency and duration of their trips. Yet, most people with disabilities negotiate these constraints to experience tourism to some degree. Even the most marginalised of people with disabilities still desire tourism experiences. While the basic intrapersonal and interpersonal hierarchy of constraints may be similar for people with disabilities and the non-disabled, as the preceding discussion identifies the constraints differ dramatically for people with disabilities in specific interpersonal and intrapersonal constraints, a series of structural constraints and the constraint negotiation process. Unlike the non-disabled, for people with disabilities constraint negotiation, during each of the stages of travel within the tourism system, involves a series of iterations rather than a linear hierarchy.

The undue constraints experienced by people with disabilities are a result of TA and TI practices and discourses that result in a greater level of planning having to be undertaken by the individual. People with disabilities could not begin their trip planning without tourism access information for accommodation, transport and destination sectors. While Dellaert, Ettema and Lindh (1998:19) suggested the packaging of destination and

accommodation information together is important for the non-disabled, what emerges from this research is the overriding priority that accommodation has for people with disabilities. Without accessible accommodation, people with disabilities can not stay away from their residence. What becomes apparent from the experiences is that some people negotiate a destination based on their knowledge of the availability of accessible accommodation. This is very different to the non-disabled experience of choosing a destination and then deciding upon accommodation. For others, transport constraints are negotiated before accommodation and destination decisions. This was predominantly where people had decided to travel by car due to the inaccessibility of public transport and the constraints associated with air travel. Hence, the destination was dependent car access, excluded overseas travel and was constrained by their knowledge of accessible accommodation.

Once satisfied with the tourism access information, then the individual must go back in the hierarchy and negotiate the interpersonal and intrapersonal policy dimensions of attendant care, equipment organisation and the associated extra costs. Only after these are organised, can a person book their trip. Unlike the non-disabled, people with disabilities are unable to rely on travel agents and must undertake this process themselves. The cost issues are then compounded through their exclusion from the discounted packages that travel agents have available. This constrains their tourism choices, adds to the time taken, adds to the costs of tourism and reduces people's enjoyment of their tourism experiences.

Yet, the booking of the trip is only the beginning of their constraint negotiation. At every stage of their tourism experiences, further constraints may need to be renegotiated. The most notable reason given for this was the high degree of inaccuracy in the tourism access information that they received for transport, accommodation and destination, leading to further constraints. People spoke of their continual state of anxiety as they went from one stage of their trip to the next. At each stage, a series of constraint iterations may need to be negotiated for the tourism experience to continue. At any stage of their tourism experience, they may encounter a constraint that can not be negotiated, where they may have to modify their expectation or discontinue their trip.

The constraint negotiation strategies identified through their experiences exemplify the way that people with disabilities are made to feel when constraints are encountered – that their marginalisation from tourism is their fault and their problem. The TA and TI did not perceive that their practices and discourses produced the *disabling constraints and hostile*

attitudes and were the cause of the person's marginalisation. If the TA and TI practices had been *enabling*, then people with impairments would not have been transformed into people with disabilities through the experiences of their *disabling journeys*.

11.5 Contribution to the Body of Knowledge

The contribution to knowledge of this thesis is seen as sixfold.

1. The thesis contributes to the knowledge and understanding of the tourism patterns and experiences of a much neglected market segment in the Australian context. The thesis provides the first comparison of the tourism patterns of people with disabilities and the non-disabled at a national level to have been conducted not only in Australia but, as far as can be ascertained, anywhere in the world. The data establishes that people with disabilities have lower levels of tourism participation than the non-disabled. While impairment type is identified as a significant influence on tourism participation, people with disabilities do not regard their impairment as a reason for non-participation in tourism.

2. The thesis applies the social model of disability to a new area of study, tourism. This provides a new cultural lens through which to view tourism. In adopting the social model approach to tourism, attention is focused on the disabling tourism constraints of the group. This approach suggests that an understanding of the social model and constraints theory should be incorporated within tourism systems. This would offer an opportunity to develop enabling tourism environments within the tourism system that, in the past, has proved largely dysfunctional in its dealing with people with disabilities.

3. The thesis provides an opportunity to reconceptualise previous understandings of tourism constraints for people with disabilities. It is concluded that the constraints encountered by people with disabilities are a product of the social relations of tourism in Australia rather than arising from the individual's embodiment. Based on the findings of the thesis, a number of new structural categories of constraints are proposed. Further, it is shown that, while substantial tourism constraints exist for the group, these constraints are largely negotiated by the majority of people with disabilities in order to participate in tourism. However, while the constraints to participation may be successfully negotiated, the resultant phenomenology (discussed below) suggests that they are less satisfied with

their experiences than the non-disabled.

4. The thesis provides a greater understanding of the resultant phenomenology of the tourism experiences of people with disabilities. They are invariably frustrated by the travel planning process and disempowered by the by the lack of understanding of their needs by the TA and TI. It was found that the transit experience, in particular, left them in a state of helplessness through the loss of independence and dignity. While wanting the benefits of tourism, those who continued tourism experiences are left in state of on-going anxiety as to the likely constraints that they are to encounter at each stage of the journey.

5. The social relations that produce the undue constraints are explained through an examination of TA and TI practices and discourses. In particular, the thesis includes the first detailed analysis of government disability tourism initiatives and seeks to provide an understanding of the perceptions of the accommodation sector in servicing the group. It is concluded that the reasons for TA and TI behaviour is the fact that it is based ostensibly on market principles, underpinned by a largely medical model worldview and resultant ableist practices and discourses. Further explanation for the resultant tourism experiences of people with disabilities are found in the discourses of access, the environmental planning process and the problems of implementation of the notion of citizenship rights through the Australian human rights legislation. The explanation is operationalised in the Comprehensive Tourism Access Model (CoTAM) in which constraints and social model theory is incorporated to address the dysfunctional nature of the tourism system for people with disabilities.

6. The thesis presents evidence for an *embodied ontology* of tourism for people with disabilities. It does so through the exploration of the significant influences that impairment, mobility aid, support needs and socio-demographic variables have on the tourism patterns and experiences of the group. This understanding of individual circumstance further contributes to the understanding of the complexities of the disability tourism experience. The findings of the thesis suggest there is statistical support for incorporating the notion of agency within social model theory development.

11.6 Directions for future policy and practice

Two key implications for future policy and practice arise from this research, relating to: the

development tourism access information provision; and the development of tourism access precincts.

Until every sector of the tourism industry systematically addresses the challenge of providing fully accessible tourism facilities and attractions and the TA effectively coordinates an independent, systematic third party access assessment and information collection and dissemination system, people with disabilities will continue to be disadvantaged in a significant area of their rights of citizenship. The outcomes of the processes documented in this research were that tourists with disabilities did not experience the essence of place that constitutes the *destination image* (Jenkins 1999). All of the considerations discussed in this thesis could be incorporated into a systematic approach to developing *tourism access information systems*. Ashton (2000) and Cameron (2000b), together with a number of other overseas publications (Fodor's 1996; English Tourism Council 2000a; Hasselt and Brussels 2001) provide a direction for strategically addressing tourism access information. The Australian Tourism Data Warehouse (ATDW 2001) offers an opportunity to provide a framework for an Australia-wide system of tourism access information provision but to date it has not been utilised. A necessary condition for the successful implementation of such a system would be the addressing of a broader industry education issues with all sectors and providers, but starting with TA, retail travel agents and the accommodation sector in particular. Daruwalla's (1999) work provides a strategic approach to structuring disability awareness education.

The development of *tourism access precincts* could alleviate many of the socio-spatial constraints experienced by people with disabilities. The requirements for tourism access information systems need to be operationalised in conjunction with national, regional and local environmental planning initiatives, and universal design principles (Aslaksen et al. 1997; Preiser and Ostroff 2001). The concepts of: continuous pathways (Standards Australia 2001), mobility maps (Krause and Reynolds 1996), pedestrian access and mobility plans (NSW Roads and Traffic Authority 2002) and regional tourism initiatives (Toowoomba & Golden West Regional Tourist Association 1999; Blue Mountains Tourist Authority 2000; Illawarra Tourism 2001) could be developed strategically through *tourism access precincts*. Access has already been defined in the thesis. There is a substantial literature on leisure/tourism precincts (see Getz 1993:583). A *precinct* in this context is defined as a place or space for recreational and tourism purposes. *Tourism access precincts* could incorporate all of the previous tourism access information and spatial considerations

discussed in the thesis and would become the subject of operationalisation. The outcome of developing tourism access precincts would allow people with disabilities to use the precinct in an equitable, independent and dignified manner. Access precincts would address the socio-spatial needs of people with disabilities by recognising the importance of the social organisation of space. These precincts would meet their needs by developing resources that provide tourism access information based on how people with disabilities use and occupy these environments.

11.7 Reflections on the Research Process and Further Research

Generally, in this thesis it is recognised that people with disabilities are a diverse group. The data presented in the thesis demonstrates the unequal citizenship status of people with disabilities in Australia. The findings and discussion reflect the bias of these sources and, hence, the social relations of tourism for these groups. The TA and TI are virtually silent on all but people with mobility disabilities. Future research could be undertaken specifically on the other dimensions of disability and access. The literature also suggests that there are cultural differences to understanding disability and access (Miles 1996; 2000). Further research could review these understandings to recognise the differences and promote an operational universalism (Zola 1989; Bickenbach et al. 1999). In a tourism context, this is particularly important because of Australia's position as an international tourism destination. This work in itself would develop the sophistication of disability and market segmentation theory as begun by Burnett and Bender-Baker (2001).

The research into the perceptions of the TI drew its sample from 4-5 star hotels in Sydney and Parramatta, NSW. These hotels were identified as having accessible accommodation and were members of the AHA. It is recognised the research was exploratory in nature and is only a beginning to understanding the accommodation sector's perceptions. People with disabilities expressed a desire to access lower cost accommodation including motels, backpacker hostels, caravan parks and camping grounds. Further work should be pursued with these accommodation classes and other sectors of the TI.

In taking direction both from Daruwalla's (1999) work on attitudes towards disability and the HREOC actions reviewed in this thesis, further research could investigate the attitudes of the Australian tourism industry towards disability. This would provide a basis for developing continuing professional development opportunities for the TI on disability

customer service provisions. These professional development interventions need to be formulated in collaboration with the TI sectors and to view disability as part of universal diversity management practices (Aslaksen et al. 1997; Allison 1999; Carr-Ruffino 1999; Patterson and Taylor 2001). Disability needs to be incorporated as an essential social dimension to the triple bottom line for sustainable tourism (Goeldner et al. 1999; Weaver and Opperman 2000). This thesis also suggests further research is required on how market segmentation decisions are made by TA and TI.

The policy analysis in the thesis draws on the Australian human rights legislation, frameworks that regulate the environmental planning processes and the Commonwealth and State TA. As identified in the literature review, some interesting initiatives are occurring at the regional and local levels. However, it was beyond the scope of this thesis to investigate these initiatives. The regional and local initiatives may provide fertile material for further research.

One of the issues facing tourism is its ability to engage with the challenges that an ageing Western society presents. The nexus of disability and ageing issues is one of these challenges. To date, tourism research on disability and ageing in Australia has remained separate. Further research should seek to bring these two areas together to capture the synergies that exist. Overseas research on air travel regulations provides some direction to achieve this (Abeyratne 1995). Yet, this thesis suggests that the tourism system has been dysfunctional in respect to non-participation by marginalised groups. Social model and constraints theory could be incorporated into the tourism systems approach to provide a greater understanding of non-participation of these groups and to develop a universal tourism systems approach. The Australian TA and TI could also take direction from the overseas social tourism movement.

Apart from these areas a number of specific opportunities for further research in the field of disability and tourism, and broader areas have been identified, including:

- developing a greater understanding of tourism constraints: common to people with disabilities and the non-disabled; those common to all people with disabilities; and those common to specific disability groups.
- investigation of the intersection of gender, employment/unemployment, lower income and the extra costs of disability on the recreational and tourism opportunities, choices and experiences of people with disabilities;
- refinement of holiday and destination choice models and considerations for destination image from a disability perspective;
- disability as *appropriate other* in the social consumption of tourism;

- a sophisticated examination of disability and market segmentation;
- the discourse of power that became evident through the examination of the implementation of the DDA complaint cases, Federal Court actions and disability Standards processes; and
- a historical analysis of the development of disability and access considerations within the environmental planning processes in Australia.

11.8 Final Thoughts

The social model of disability has provided a new paradigm through which to view tourism. This thesis shows that the tourism patterns and experiences of people with disabilities are unduly constrained by the TA and TI practices and discourses. These practices and discourses contribute towards a series of interrelated structural constraints that are not the fault of the individual. Tourism for people with disabilities cannot be reduced to a question of bad or good practice, for the constraints involve conscious considerations of environment, attitude, language, knowledge and power. Understanding the social relations that bring about this situation is complex, due to the dimensions of time, space, ideology and the relative power of the different stakeholders. The explanations for the disability tourism experience involve the discourses of access, development of the environmental planning process and the implementation of citizenship rights in Australia. In particular, people with disabilities are in a position of relative powerlessness against many non-disabled stakeholders. The result has been that people with disabilities are marginalised by the TA and TI because of a medical model worldview and resultant ableist practices and the market ideology of the sector. These powerful worldviews and the market-based interests of the private sector are dominant over the human rights and social model agendas designed to improve the citizenship rights of people with disabilities.

From this foundation, people with disabilities, government, TA and TI are better able to initiate a process for change. Strategies for change must provide a basis for improving the material position of the tourism experiences of people with disabilities. Changes to the identified structural constraints will contribute to tourism becoming enabling and improving disability citizenship. The social model of disability provides a paradigm to extend current knowledge about the social relations that produce *disabling journeys*. Understandings of these social relations are the contribution of this thesis to the field of tourism studies.

REFERENCES

Legislation

Americans with Disabilities Act, 1990 (United States of America)
Handicapped Persons Assistance Act, 1974 (Commonwealth)
Disability Services Act, 1986 (Commonwealth)
Equal Opportunity Act (Disability Provision), 1988 (Commonwealth)
Disability Discrimination Act, 1992 (Commonwealth)
Disability Discrimination Act Amendment Bill, 2002 (Commonwealth)
Human Rights Legislation Amendment Act, 1999 (Commonwealth)
Anti-Discrimination Act, 1977 (NSW)
Environmental Planning and Assessment Act, 1979 (NSW)
Local Government Act, 1919 (NSW)
Local Government Act, 1993 (NSW)
Disability Services Act, 1993 (NSW)

Case Law

Adams v Arizona Bay Pty. Ltd., Charlie Habib and Bunge Pty. Ltd. [1996], Unreported (HREOC No. H.96/128).
Brandy v HREOC [1995], PLPR 19 (High Court of Australia).
Brown v Birss Nominees Pty Ltd [1997], Unreported (HREOC No. H.97/6).
Cocks v the State of Queensland [1994], Unreported (Queensland Equal Opportunity Commission 92-612).
Cooper & Others v Holiday Coast Cinema Centres Pty Ltd [1997], Unreported (HREOC No. 96/157).
Cooper v Human Rights & Equal Opportunity Commission [1999], Unreported (Federal Court of Australia 180).
Cooper, President North Coast D.I.A.L. Inc. v Coffs Harbour City Council [2000], Unreported (HREOC No. H.97/232).
Francey & Meeuwissen v Hilton Hotels of Australia Pty Ltd [1997], Unreported (HREOC H97/50 & H97/51).4
Francey & Meeuwissen v Hilton Hotels of Australia Pty Ltd (Outcome) [2000], Unreported (HREOC H97/50 & H97/51).
Jennings v Lee [1996], Unreported (HREOC No. H.96/3).
Magro v NSW State Transit [1995], Unreported (HREOC No. H.95/?).
Maguire v Sydney Organising Committee for the Olympic Games (Internet) [2000], Unreported (HREOC No H 99/115).
Maguire v Sydney Organising Committee for the Olympic Games (Ticket Book) [1999], Unreported (HREOC No H 99/115).
McLean v. Airlines of Tasmania Pty Ltd [1996], Unreported (HREOC No. H.96/77)
Pruszinski Architects v. the City of Adelaide (2001), Unreported (Environment Resources and Development Court - SA No. 84).
Scott v Telstra Corporation; DPI(A) and Australian Association of the Deaf v Telstra Corporation [1997], Unreported (HREOC H95/34, H95/51).
W v P Pty Ltd [1997], Unreported (HREOC No H95/133).
White v Crown Casinos Ltd. [1995], Unreported (HREOC No. H.95/7).

Books, Journals & Other Sources

Abberley, P. 1987, *The Concept of Oppression and the Development of a Social Theory of Disability. Disability, Handicap & Society*, 2(1), 5-19.
Abberley, P. 1999, *The Significance of Work for the Citizenship of Disabled People*. Unpublished paper presented at University College Dublin April 15th 1999: Dublin.
Abello, D., and Parkinson, A. 2001, *Queer and Disabled - Lessons from the Melting Pot*, Social Relations of Disability Research Network (SRDRN) (Eds.), In the proceedings of *Disability with Attitude: Critical Issues 20 Years After the International Year of Disabled Persons*, Parramatta Campus, University of Western Sydney, Sydney, Australia, 16-17 February, Additional paper to conference proceedings.
Abeyratne, R. I. R. 1995, *Proposals and Guidelines for the Carriage of Elderly and Disabled Persons by Air. Journal of Travel Research*, 33(3), 52-59.

- Accessible Arts, and Australia Council. 1999, *Access All Areas: Guidelines for Marketing the Arts to People with Disabilities*. Australia Council: Redfern, N.S.W.
- Adams, P. 2000, High Hurdles for Able-Bodied. *The Weekend Australian*, Sat 21 October, 31.
- Agresti, A. 1996, *An Introduction to Categorical Data Analysis*. Wiley: New York.
- Aitchison, C. 1999, Poststructural Feminist Theories of Representing Others: A Response to the 'Crisis' in Leisure Studies' Discourse. *Leisure Studies*, 19(3), 127-144.
- Aitchison, C., MacLeod, N. E., and Shaw, S. J. 2000, *Leisure and Tourism Landscapes: Social and Cultural Geographies*. Routledge: London.
- Albert, W. 1995, *The Social Model*, [Electronic discussion list]. Disability-Research List Last [1998, 20 June].
- Allison, M. T. 1999, Organizational Barriers to Diversity in the Workplace. *Journal of Leisure Research*, 31(1), 78-101.
- Almon-Hamm, P. A. 1997, *Mass Transportation Operators' Beliefs About Visual Impairment*. Unpublished Ph.D Thesis, The University of Texas, Austin.
- Anderson, J. 2001, *Letter Re Lack of Accessible Rooms with a View of Sydney Harbour*, Policy and Planning Division, Tourism New South Wales, Sydney, pers. comm. to S. Darcy, Email, 11 April
- Anderson, J. 2002, *Interview on Tourism NSW Disability Processes*, Policy and Planning Division, Tourism New South Wales, Sydney, pers. comm. to S. Darcy, Interview, 11 April
- Andorka, F. H., Jr. 1999, Bass Settles Disputes over ADA Compliance. *Hotel & Motel Management*, 214(2), 1,30.
- Antonak, R. F., and Livneh, H. 2000, Measurement of Attitudes Towards Persons with Disabilities. *Disability and Rehabilitation*, 22(5), 211-224.
- Ariotti, L. 1999, Social Construction of Anangu Disability. *Australian Journal of Rural Health*, 7, 216-222.
- Armstrong, D. 2001, Discrimination at Airlines Remains a Problem for Disabled Travelers. *The Wall Street Journal*, May 9. www.msnbc.com/news/570730.asp?cp1=1
- Ashton, M. 2000, *Access Audit of Tourism Products in South Australia for People with a Disability - Auditors Report*. September. MASHROB - EQUITABLE ACCESS CONSULTANCY for South Australian Tourism Commission: Adelaide.
- Aslaksen, F., Bergh, S., Bringa, O. R., and Heggem, E. K. 1997, *Universal Design: Planning and Design for All*. The Norwegian State Council on Disability: Oslo.
- Australian Building Codes Board. 1996a, *Building Code Australia Access Provisions Review*. Australian Building Codes Board: Canberra.
- Australian Building Codes Board. 1996b, *Building Code of Australia*. CCH Australia: Canberra.
- Australian Building Codes Board. 1997a, *Draft Regulatory Impact Statement for the Amendment of the Building Code of Australia (Bca96) Provisions for Access and Facilities for People with a Disability*. Australian Building Codes Board: Canberra.
- Australian Building Codes Board. 1997b, *Provisions for People with Disabilities (Rd97/01)*. Australian Building Codes Board: Canberra.
- Australian Building Codes Board. 2001a, *Building Community Access*. December. Australian Building Codes Board: Canberra. www.abcb.gov.au/content/whatsnew/main.cfm#Access
- Australian Building Codes Board. 2001b, *Disability Discrimination Act (DDA) - Disability Standard on Access to Premises Directions Report*. December. Australian Building Codes Board: Canberra. www.abcb.gov.au/content/whatsnew/main.cfm#Access
- ABS. 1981, *Handicapped Persons, Australia 1981 (Cat No. 4343.0)*. ABS: Canberra.
- ABS. 1988, *Disability and Handicap, Australia 1988 (Cat No. 4120.0)*. ABS: Canberra.
- ABS. 1993, *Disability, Ageing and Carers, Australia. - Summary of Findings (Cat No. 4430.0)*. ABS: Canberra.
- ABS. 1996, *Projections of the Populations of Australia States and Territories (Cat No. 3220.0)*. ABS: Canberra.
- ABS. 1998, *Disability Ageing and Carers Summary of Findings (Cat No. 4430.0)*. ABS: Canberra.
- ABS. 2000a, *Short Term Overseas Arrivals and Departures (Cat No. 3401.0)*. ABS: Canberra.
- ABS. 2000b, *Tourism Accommodation in NSW (Cat No. 8636.1)*. ABS: Canberra.
- Australian Bus and Coach Association. 1995, *Response to Draft Accessible Public Transport Standards, Disability Discrimination Act 1992 - Submission to Australian Transport Council Taskforce*. Dec. Australian Bus and Coach Association: Sydney.
- Australian Bus and Coach Association. 1997, *Submission Regarding the Impact of the Accessible Transport Standards on the Private Bus Industry - Submission to Australian Transport Council Taskforce*. Australian Bus and Coach Association: Sydney.
- Australian Council for Rehabilitation of Disabled (ACROD). 1994, *Building Access - AAA Accommodation Checklist*. ACROD: Canberra.
- Australian Council for Rehabilitation of Disabled (NSW Div Ltd). 1994, *Accessing Sydney - a Handbook for People with Disabilities and Those Who Have Trouble Getting Around*. ACROD Ltd: Sydney.
- Australian Government Committee of Inquiry into Tourism. 1987a, *Report of the Australian Government*

- Inquiry into Tourism - Volume 1 (Kennedy Report)*. AGPS: Canberra.
- Australian Government Committee of Inquiry into Tourism. 1987b, *Report of the Australian Government Inquiry into Tourism - Volume 2 (the Consultants Reports)*. AGPS: Canberra.
- Australian Hotels Association. 1998, *Catering for Guests with Disabilities: Survey of AHA Members*. 15 September. AHA: Canberra.
- Australian Quadriplegic Association. 1999, A Survey of the Unavoidable: Cost of Disability among 200 People with Quadriplegia. *Quad Wrangle*, Winter, 3-5.
- Australian Quadriplegic Association. 2001, *Accessing Sydney - a Visitors Guide to Sydney*. AQA: Sydney.
- Australian Quadriplegic Association. 2002, *Access Sydney: The Easy Guide to Easy Access* (1st edn.). Australian Quadriplegic Association: Sydney.
- Australian Tourism Data Warehouse. 2001, *One Small Step - One Joint Leap: Intelligent Tourism Distribution*. Australian Tourism Data Warehouse. Available: www.tourism.nsw.gov.au/corporate/getconnected/atdw.asp Last [2001, 12 November].
- Australian Tourist Commission. 1993, *Fact Sheet - Travel in Australia for People with Disabilities*. Australian Tourist Commission: Canberra.
- Australian Tourist Commission. 1995a, *Backpacking, Its a State of Mind: Opportunities in the Australian Independent Travel Market*. Australian Tourist Commission: Sydney.
- Australian Tourist Commission. 1995b, *Fact Sheet - Travel in Australia for People with Disabilities*. Australian Tourist Commission: Canberra.
- Australian Tourist Commission. 1995c, *Marketing Advice on Developing the Rural Tourism Market: Rural Travellers to Australia: Summary*. Australian Tourism Commission: Woolloomooloo, NSW.
- Australian Tourist Commission. 1999, *Facts for the Visitor: Disabled Visitors*. Australian Tourist Commission: Canberra.
- Australian Tourist Commission. 2001, *Image Library*. Australian Tourist Commission. Available: www.atc.gov.au Last [2001, 21 May].
- Barnes, C. 1991, *Disabled People in Britain and Discrimination: A Case for Anti-Discrimination Legislation*. Hurst in association with the British Council of Organizations of Disabled people: London.
- Barnes, C. 1996a, Disability, Discrimination and Equal Opportunities - a Comparative Study of the Employment Rights of Disabled People. *Disability & Society*, 11(2), 291-293.
- Barnes, C. 1996b, Theories of Disability and the Origins of the Oppression of Disabled People in Western Society. In L. Barton (Ed.), *Disability and Society: Emerging Issues and Insights*. Longman: New York
- Barnes, C. 1998, The Social Model of Disability: A Sociological Phenomenon Ignored by Sociologists? In T. Shakespeare (Ed.), *The Disability Reader: Social Science Perspectives*. Cassell: London. 66-78
- Barnes, C., and Mercer, G. 1996, *Exploring the Divide: Illness and Disability*. The Disability Press: Leeds.
- Barnes, C., and Mercer, G. 1997, *Doing Disability Research*. The Disability Press: Leeds.
- Barnes, C., Mercer, G., and Shakespeare, T. 1999a, Culture, Leisure and the Media. In C. Barnes, G. Mercer and T. Shakespeare (Eds.), *Exploring Disability: A Sociological Introduction*. Polity Press: Malden, Mass. 182-210
- Barnes, C., Mercer, G., and Shakespeare, T. 1999b, *Exploring Disability: A Sociological Introduction*. Polity Press: Malden, Mass.
- Barton, L. 1989, *Disability and Dependence*. Falmer Press: Lewes.
- Barton, L. 1994, Disability, Difference and the Politics of Definition. *Australian Disability Review*, 3, 8-22.
- Barton, L. 1998, Sociology, Disability and Education. In T. Shakespeare (Ed.), *The Disability Reader: Social Science Perspectives*. Cassell: London. 53-64
- Bas, D. 1992, Social and Cultural Tourism. *World Leisure & Recreation*, 34(3), 7.
- Baum, T. 1994, The Development and Implementation of National Tourism Policies. *Tourism Management*, 15(3), 185-192.
- Baumann, M. A. 2001, Form Meets Function in ADA Compliance. *Hotel & Motel Management*, 216(10), 56-58.
- Beale, A. 1999, [Ozadv] Gold Medal Awards, Ozadvocacy, pers. comm. to Ozadvocacy Discussion List, Email, Thursday 16 September
- Bedini, L. A. 2000, "Just Sit Down So We Can Talk": Perceived Stigma and Community Recreation Pursuits of People with Disabilities. *Therapeutic Recreation Journal*, 34(1), 55-68.
- Bedini, L. A., and Henderson, K. A. 1994, Women with Disabilities and the Challenge to Leisure Service Providers. *Journal of Parks and Recreation Administration*, 12(1), 17-34.
- Begum, N. 1994, Mirror, Mirror on the Wall. In N. Begum, M. Hill and A. Stevens (Eds.), *Reflections: The Views of Black Disabled People on Their Lives and Community Care*. CCETSW: London
- Bickenbach, J. E. 1993, *Physical Disability and Social Policy*. University of Toronto Press: Toronto.
- Bickenbach, J. E., Chatterji, S., Badley, E. M., and Ustun, T. B. 1999, Models of Disablement, Universalism and the International Classification of Impairments, Disabilities and Handicaps. *Social Science & Medicine*, 48(9), 1173-1187.

- Blamey, R. K. 1995, *The Nature of Ecotourism*. Bureau of Tourism Research: Canberra, A.C.T.
- Blue Mountains Tourist Authority. 2000, *Access the Best - Blue Mountains*. Blue Mountains Tourist Authority: Katoomba, NSW.
- Boniface, B. G., and Cooper, C. 2001, *Worldwide Destinations: Geography of Travel and Tourism* (3rd edn.). Butterworth-Heinemann: Oxford.
- Boniface, D. J. 1997, Does Anyone Really Know Where We're Going? Changes to the HREOC. *Australian Journal of Human Rights*, 4(3), 205-212.
- Brandenburg, J., Greiner, W., Hamilton-Smith, E., Senior, R., and Webb, J. 1982, A Conceptual Model of How People Adopt Recreation Activities. *Leisure Studies*, 1(3), 263-276.
- Bray, G. W., and Allison, M. 2001, *Disability, NSW (Cat No. 4443.1)*. ABS: Canberra.
- Brjesson, M. 1989, *Public Transport for Everyone - a Summary of the Results of Research and Development Projects Concerning Disabled People in Sweden*. Swedish Transport Research Board: Stockholm.
- Brokensha, P., and Guldberg, H. 1992, *Cultural Tourism in Australia: A Report on Cultural Tourism*. Department of the Arts, Sport, the Environment and Territories/AGPS: Canberra.
- Brown, C. 1999, *Address to Gold Medal Disability Access Strategy Hobart Symposium*. Dept. Family and Community Services, Canberra. Available: www.goldmedal.gov.au/symphobart.html Last [2000, 10 March].
- Brown, F. 1991, Tourism for All. *Tourism Management*, 12(3), 258-260.
- Buchanan, I. 1998, *International Backpackers and Australian Tourism Regions*. Bureau of Tourism Research: Canberra.
- Buchanan, I. 1999, *Cultural Tourism in Australia: Visual Art & Craft Shopping by International Visitors, 1997*. Dept. of Tourism: Canberra.
- Bureau of Tourism Research. 1988-1998, *Domestic Tourism Monitor*. Bureau of Tourism Research: Canberra.
- Bureau of Tourism Research. 1998, *National Visitor Survey: Travel by Australians*. Bureau of Tourism Research: Canberra.
- Bureau of Tourism Research. 2001, *National Visitor Survey: Travel by Australians*. Bureau of Tourism Research. Available: www.btr.gov.au Last [2001, 10 September].
- Burnett, J. J. 1996, What Services Marketers Need to Know About the Mobility-Disabled Consumer. *Journal of Services Marketing*, 10(3), 3-20.
- Burnett, J. J., and Bender-Baker, H. 2001, Assessing the Travel-Related Behaviors of the Mobility-Disabled Consumer. *Journal of Travel Research*, 40(1), 4-11.
- Calantone, R. J., and Mazanec, J. 1991, Marketing Management and Tourism. *Annals of Tourism Research*, 18(1), 101-119.
- Cameron, B. 2000a, *ATC Website Inclusions*, Sydney, pers. comm. to S. Darcy, Email and phone conversations, 15 January
- Cameron, B. 2000b, *Easy Access Australia* (2nd edn.). Kew Publishing: Kew, Vic.
- Canadian Transport Agency. 1997a, *Air Travel Accessibility Regulations*. Canadian Transport Agency: Canada.
- Canadian Transport Agency. 1997b, *Code of Practice: Aircraft Accessibility for People with Disabilities*. Canadian Transport Agency: Canada.
- Canadian Transport Agency. 1997c, *Taking Charge of the Air Travel Experience - a Guide for Persons with Disabilities*. Canadian Transport Agency: Canada.
- Canberra Tourism and Events Corporation. 1999a, *Access Info Website*. Canberra Tourism and Events Corporation ACROD & NICAN. Available: www.canberratourism.com Last [2001, 12 Jan].
- Canberra Tourism and Events Corporation. 1999b, *Access to ACT Venues Project - Checklist*. Canberra Tourism and Events Corporation, ACROD & NICAN: Canberra.
- Canberra Tourism and Events Corporation. 1999c, *Discover*. Canberra Tourism and Events Corporation: Canberra.
- Capella, L. M., and Greco, A. J. 1987, Information Sources of Elderly for Vacation Decisions. *Annals of Tourism Research*, 14, 148-151.
- Carberry, F. 2002, General Overview of Current Disability Policy in Australia and Specifically Future Directions and Initiatives in the Field of Disability Policy, Social Relations of Disability Research Network (SRDRN) (Eds.), In the proceedings of *SRDRN Seminar Series*, Sydney, 15 February, 1-10. www.srdn.unsw.edu.au
- Carr-Ruffino, N. 1999, *Diversity Success Strategies*. Butterworth-Heinemann: Boston.
- Cavinato, J. L., and Cuckovich, M. L. 1992, Transportation and Tourism for the Disabled: An Assessment. *Transportation Journal*, 31(3), 46-53.
- Chadwick, A. 1994, For Disabled People the Body Is the Principal Site of Oppression, Both in Form and What Is Done to It. *Australian Disability Review*, 4(1), 36-44.
- Chamie, M. 1995, What Does Morbidity Have to Do with Disability? *Disability and Rehabilitation*, 17(7), 323-337.
- Champeaux, J.-P. 1987, *Le Marche Du Tourisme Social En Europe: To Be or Not to Be (French) the*

- European Social Tourism Market: To Be or Not to Be *Espaces*, 86(1), 17-20.
- Charlton, J. I. 1998, *Nothing About Us without Us: Disability Oppression and Empowerment*. University of California Press: Berkeley.
- Chouinard, V. 1997, Making Space for Disabling Differences - Challenging Ableist Geographies - Introduction - Situating Disabling Differences. *Environment & Planning D Society & Space*, 15(4), 379-387.
- Chouinard, V., and Grant, A. 1995, On Being Not Even Anyway near "the Project": Ways of Putting Ourselves in the Picture. *Antipode*, 27(2), 137-166.
- CityRail. 2001, *Accessing Cityrail: An Easy Guide to Accessible Services*. City Rail: Sydney.
- Clark, A. K. 2002, *Show Me the Money: A Market Segment Approach to Spending by International Travellers*. Bureau of Tourism Research: Canberra.
- Clarke, J., and Critcher, C. 1985, *The Devil Makes Work: Leisure in Capitalist Britain*. Macmillan: Basingstoke, Hampshire.
- Clawson, M., and Knetsch, J. L. 1966, *The Economics of Outdoor Recreation*. Johns Hopkins Press: Baltimore.
- Clear, M. 2000a, Personal Lives in Unaccommodating Systems. In M. Clear (Ed.), *Promises Promises: Disability and Terms of Inclusion*. Federation Press: Sydney. 109-125
- Clear, M. 2000b, *Promises Promises: Disability and Terms of Inclusion*. Federation Press: Sydney.
- Clegg, S. 1989, *Frameworks of Power*. Sage: London.
- Commonwealth Attorney General's Dept. 1998, *Regulation Impact Statement on Draft Disability Standards for Accessible Public Transport*. AGPS: Canberra.
- Commonwealth Attorney General's Dept. 1999, *Regulation Impact Statement on Draft Disability Standards for Accessible Public Transport*. AGPS: Canberra.
- Commonwealth Attorney General's Dept. 2001a, *Disability Standards for Accessible Public Transport*. AGPS: Canberra.
- Commonwealth Attorney General's Dept. 2001b, *Disability Standards for Accessible Public Transport Guidelines*. AGPS: Canberra.
- Commonwealth Attorney General's Dept. 2002a, *Press Release: Accessible Public Transport*. 14 Feb. AGPS: Canberra.
- Commonwealth Attorney General's Dept. 2002b, *Press Release: Back on Track for Accessible Public Transport*. 23 October. AGPS: Canberra.
- Commonwealth Department of Family and Community Services. 1999a, *Better Information and Communication Practices*. DFACS: Canberra.
- Commonwealth Department of Family and Community Services. 1999b, *Better Physical Access*. DFACS: Canberra.
- Commonwealth Department of Family and Community Services. 1999c, *Gold Medal Disability Access Strategy - Information Kit (Program/Policy Document)*. 16 August. DFACS: Canberra. www.goldmedal.gov.au/
- Commonwealth Department of Family and Community Services. 2000, *Gold Medal Disability Access Strategy - Website*, [Program/Policy Document]. DFACS. Available: www.goldmedal.gov.au/ Last [2000, 19 July].
- Commonwealth Department of Tourism. 1992, *Tourism: Australia's Passport to Growth - a National Tourism Strategy*. Department of Tourism: Canberra.
- Commonwealth Department of Tourism. 1993a, *Forest Ecotourism Program Grants Scheme 1993-94 (2nd edn.)*. AGPS: Canberra.
- Commonwealth Department of Tourism. 1993b, *National Ecotourism Strategy*. Dept. of Tourism: Canberra.
- Commonwealth Department of Tourism. 1993c, *Rural Tourism*. AGPS: Canberra.
- Commonwealth Department of Tourism. 1994a, *National Ecotourism Strategy*. Department of Tourism: Canberra.
- Commonwealth Department of Tourism. 1994b, *National Rural Tourism Strategy*. AGPS: Canberra.
- Commonwealth Department of Tourism. 1994c, *A Talent for Tourism: Stories About Indigenous People in Tourism*. Department of Tourism: Canberra.
- Commonwealth Department of Tourism. 1995a, *Backpacker Accommodation Ratings Guide*. AGPS: Canberra.
- Commonwealth Department of Tourism. 1995b, *Best Practice Ecotourism: A Guide to Energy and Waste Minimisation*. Department of Tourism,: Canberra.
- Commonwealth Department of Tourism. 1995c, *Building for Backpackers: Guidelines for Backpacker Accommodation*. Department of Tourism: Canberra.
- Commonwealth Department of Tourism. 1995d, *National Backpacker Tourism Strategy*. Department of Tourism: Canberra.
- Commonwealth Department of Tourism. 1995e, *National Cruise Shipping Strategy*. Department of Tourism: Canberra.
- Commonwealth Department of Tourism. 1995f, *The Yield from Inbound Tourism*. Department of Tourism:

- Canberra.
- Commonwealth Dept. of Education Science and Training. 2001, *Consultation for Disability Standard on Education*, [Website]. Dept. of Education Science and Training. Available: www.dest.gov.au/archive/iae/analysis/ddacnslt.htm Last [2001, 23 December].
- Commonwealth Dept. of Industry Science & Resources. 2000, Tourism - the Indigenous Opportunity, Dept. of Industry Science & Resources (Eds.), In the proceedings of *The National Indigenous Tourism Forum proceedings report*, Sydney, 3-4 June,
- Commonwealth Dept. of Industry Tourism and Resources. 2002, *The 10 Year Plan for Tourism - a Discussion Paper*. Dept. of Industry, Tourism and Resources: Canberra.
- Commonwealth of Australia. 2002, *Intergenerational Report 2002-03, Budget Paper No. 5*. AGPS: Canberra. <http://www.budget.com.au/2002-03/bp5/html/index.htm>
- Compart, A. 1999, Report Is Critical of Dot and Airlines in Treatment of Disabled. *Travel Weekly*, 58(25), 12.
- Cook, A., and Szirom, T. 1980, The Municipal Recreation Officer in Victoria. In D. Mercer and E. Hamilton-Smith (Eds.), *Recreation Planning and Social Change in Urban Australia*. Sorrett: Malvern, Vic. 153-166
- Coombes, P., and Millar, J. 1998, *Cultural Tourism in Australia: International Conventions and Luxury Cruise Ships*. Dept. of Communications, Information Technology and the Arts: Canberra.
- Cooper, I. 1994, *A Guide to Sydney for Travellers with Disabilities*. Barrier Free Travel: North Bellingen.
- Corbett, J. 1996, *Bad-Mouthing: The Language of Special Needs*. Falmer Press: London; Washington, D.C.
- Corcoran, M. 2001, Disability Discrimination Act Standards - What's the Delay?, SRDRN (Eds.), In the proceedings of *Disability with Attitude: Critical Issues 20 years after International Year of Disabled Persons*, Parramatta Campus, University of Western Sydney, 16 & 17 February 2001, 57-66.
- Corcoran, M. 2002a, *Accessibility for All: The Australian Experience in Accessible Public Transport*, [Web based report]. Disability Standards Project. Available: <http://members.ozemail.com.au/~ddasp/DDAStandards1.htm> Last [2003, 2 December].
- Corcoran, M. 2002b, *Disability Support Pension Changes*, [Web based media release]. ACOSS and PDCA Last [2002, 10 May].
- Corker, M., and French, S. 1999, *Disability Discourse*. Open University Press: Buckingham.
- Cormode, L. 1997, Emerging Geographies of Impairment and Disability - an Introduction. *Environment & Planning D Society & Space*, 15(4), 387-390.
- Council of Disabled Motorists. 1986, *Disabled Travellers Guide to Australia: Accessible Motels and Hotels*. Council of Disabled Motorists.
- Cox, E. 1995, *A Truly Civil Society*. ABC Books: Sydney.
- Craik, J. 1991, *Resorting to Tourism: Cultural Policies for Tourist Development in Australia*. Allen & Unwin: Sydney.
- Crawford, D. W., and Godbey, G. 1987, Reconceptualizing Barriers to Family Leisure. *Leisure Sciences*, 9(2), 119-128.
- Crawford, D. W., Jackson, E. L., and Godbey, G. 1991, A Hierarchical Model of Leisure Constraints. *Leisure Sciences*, 13, 309-320.
- Crawshaw, G. 1994, Is There an Urgent Need for the Development of a Social Model of Impairment? *Australian Disability Review*, 4(1), 27-35.
- CRC Sustainable Tourism. 2003, *CRC Sustainable Tourism Website*. CRC. Available: www.crctourism.com.au Last [2003, 20 December].
- Creswell, J. W. 1998, *Qualitative Inquiry and Research Design: Choosing among Five Traditions*. Sage: Thousand Oaks, CA.
- Crouch, D. 2000a, Places around Us: Embodied Lay Geographies in Leisure and Tourism. *Leisure Studies*, 19(2), 63-76.
- Crouch, G. 2000b, *Access in Israel & the Palestinian Authority: A Guide for People Who Have Problems Getting Around* (3rd edn.). Pauline Hephastios Survey Projects & Quiller Press: London.
- Crow, L. 1992, Renewing the Social Model of Disability. *Coalition*, July, 5-9.
- Culyer, B. 1996, *Phone Conversation About ATC Fact Sheet for Disabled Travellers*, NICAN, Sydney, pers. comm. to S. Darcy, Phone, 26 November
- Cushman, G., Purvis, A., and Rickards, D. 1991, *Liberal Ideology and Its Relationship to Leisure Theory and Policy: The Case for Australia*. Dept of Parks Recreation and Tourism, Lincoln University: Canterbury NZ.
- Darcy, S. 1991, *Environmental Planning Control of NSW Coastal Resort Developments*. Unpublished Masters Thesis, Macquarie University, Graduate School of Environment, Sydney.
- Darcy, S. 1995, *Satisfaction and Experiences of Sydney as an Accessible Destination: 1994 World Assembly of Disabled Peoples International*. Centre for Leisure and Tourism Studies and People with Disabilities (NSW) Inc: Sydney.
- Darcy, S. 1996, Estimating the Size of the Market of Tourism for People with a Physical Disability, B. Culyer (Eds.), In the proceedings of *Citizenship...Beyond Disability - NICAN 1996*, Brisbane

- Novotel, 10-12 October 1996, 1996, 112-119.
- Darcy, S. 1998, *Anxiety to Access: The Tourism Patterns and Experiences of New South Wales People with a Physical Disability*. Tourism New South Wales: Sydney.
- Darcy, S. 2000, *Tourism Industry Supply Side Perceptions of Providing Goods and Services for People with Disabilities*. report to New South Wales Ageing and Disability Department: Sydney.
- Darcy, S. 2002a, Marginalised Participation: Physical Disability, High Support Needs and Tourism. *Journal of Hospitality and Tourism Management*, 9(1), 61-72.
- Darcy, S. 2002b, People with Disabilities and Tourism in Australia: A Human Rights Analysis, E. Arola, J. Karkkainen and M.-L. Siitari (Eds.), In the proceedings of *Tourism and Well Being - 2nd Tourism Industry and Education Symposium*, Jyväskylä, Finland, 16-18 May, 137-166. www.tei2002.net
- Darcy, S. 2003a, Disability, Community and Citizenship, NSW Premier's Department (Eds.), In the proceedings of *Making Connections: NSW Premier's Forum on Spinal Cord Injury and Conditions*, Sydney Exhibition & Convention Centre, Sydney, 27-28 February, http://www.spinalforum.com/Transcripts/2H_SimonDarcy.pdf
- Darcy, S. 2003b, Disabling Journeys: The Tourism Patterns of People with Impairments in Australia, R. W. Braithwaite and R. L. Braithwaite (Eds.), In the proceedings of *Riding the Wave of Tourism and Hospitality Research*, CAUTHE - Southern Cross University, Lismore, 5-8 February, CD-ROM.
- Darcy, S., and Daruwalla, P. S. 1998-2000, *CRC in Sustainable Tourism Research Application - Understanding Tourism Industry Perceptions of Providing Accessible Facilities and Services for People with Disabilities*. unpublished University of Technology, Sydney: Sydney.
- Darcy, S., and Daruwalla, P. S. 1999, The Trouble with Travel: People with Disabilities and Tourism. *Social Alternatives*, 18(1), 41-46.
- Daruwalla, P. S. 1999, *Attitudes, Disability and the Hospitality and Tourism Industry*. Unpublished Ph.D. Thesis, University of Newcastle, Dept. of Leisure and Tourism Studies, Newcastle, NSW.
- Dattilo, J., Caldwell, L., Lee, Y., and Kleiber, D. A. 1998, Returning to the Community with a Spinal Cord Injury: Implications for Therapeutic Recreation Specialists. *Therapeutic Recreation Journal*, 32(1), 13-27.
- Davenport, K. 1991, Wheel in Change. *Leisure Management*, June, 36-40.
- Davidoff, P. G., and Davidoff, d. 1988, *Financial Management for Travel Agencies*. Delmar Publishers: Albany, N.Y.
- Davies, T. D., Jr., and Beasley, K. A. 1994, *Accessible Design for Hospitality: ADA Guidelines for Planning Accessible Hotels, Motels and Other Recreational Facilities*. McGraw-Hill: New York.
- Davis, E., Beer, J., Gligora, C., and Thorn, A. 2001, *Accounting for Change in Disability and Severe Restriction, 1981-1998*. ABS: Canberra.
- Davis, G., Wanna, J., Warhurst, J., and Weller, P. 1993, *Public Policy in Australia*. Allen & Unwin: Sydney.
- Davis, L. 1999, Riding with the Man on the Escalator: Citizenship and Disability. In M. Jones and L. A. Basser Marks (Eds.), *Disability, Divers-Ability and Legal Change*. Kluwer Law International: London. 3-24
- Davis, L. J. 2002, *Disability, Dismodernism & Other Difficult Positions*. Routledge: New York.
- DDA Standards Project. 2000, *DDASP Transport Survey*. DDA Standards Project - Commonwealth Attorney General's Dept. Available: <http://members.ozemail.com.au/~ddasp/DDAStandards1.htm> Last [2002, 12 Dec].
- de Vaus, D. 2002, *Surveys in social research* (5th edn.). London: Routledge.
- Dellaert, B. G. C., Ettema, D. F., and Lindh, C. 1998, Multi-Faceted Tourist Travel Decisions: A Constraint-Based Conceptual Framework to Describe Tourists' Sequential Choices of Travel Components. *Tourism Management*, 19(4), 313-320.
- Deloitte Touche Tohmatsu. 1996, *Review of Financial Estimates Used by the DDA Taskforce to Generate Cost Projections on Accessible Transport*. Deloitte Touche Tohmatsu: Sydney.
- Dempsey, I., and Simmons, A. 1995, National Profile of Away from Home Leisure Activities of People with a Disability. *Leisure Options: Australian Journal of Leisure and Recreation*, 6(4), 22-25.
- Denzin, N. K. 1989, *The Research Act: A Theoretical Introduction to Sociological Method*. Prentice Hall: New York.
- Denzin, N. K., and Lincoln, Y. S. (Eds.). 1994, *Handbook of Qualitative Research*. Sage: Thousand Oaks, CA.
- Department of Aviation. 1987, *Australian Airport Facilities for People with Disabilities*. AGPS: Canberra.
- Department of Industry and Commerce. 1982, *Accommodation for Disabled Travellers in Australia*. 1982. Department of Industry and Commerce: Canberra.
- Department of Sport, R. a. T. 1986, *Accessibility Guide for Disabled Travellers to Tourist Attractions in Australia*. Department of Sport, Recreation and Tourism: Canberra.
- Destefano, D., and Boon, K. 1999, A Trip of a Lifetime. *Journal of Leisurability*, 26(1), 31-33.
- Dickman, S. 1997, *Tourism: An Introductory Text* (3rd edn.). Hodder Headline: Sydney.
- Dickman, S. 1999, *Tourism and Hospitality Marketing*. Oxford University Press: Melbourne.
- Disability Action Inc. 1999a, *Media Release: Disability History to Be Made Tomorrow*, [Email]. Disability

- Action Inc. Available: OZADVOCACY-- Disability rights in Australia <OZADVOCACY@MAELSTROM.STJOHNS.EDU> Last [1999, Thursday 29 April].
- Disability Action Inc. 1999b, *Media Release: Rights, Equality and Empowerment for People with Disabilities - People with Disabilities Praise Transport Ministers*. Disability Action Inc. Available: OZADVOCACY-- Disability rights in Australia <OZADVOCACY@MAELSTROM.STJOHNS.EDU> Last [1999, Friday April 30].
- Disability Services Commission (WA). 1997a, *Accessing New Markets: Customers with Disabilities Information Kit*. Western Australia Disability Services Commission: West Perth.
- Disability Services Commission (WA). 1997b, *Accessing New Markets: Tourism Industry Think Tank Report*. Western Australia Disability Services Commission: West Perth.
- Disability Services Commission (WA). 2000, *Training Resource Kit: Accessing New Markets - You Can Make a Difference to Customer Service for People with Disabilities [Kit]: Hospitality, Tourism, Retail & Entertainment Industries*. Western Australia Disability Services Commission: West Perth.
- Disability Task Force. 1991, *Discussion Paper on the Additional Costs Faced by People with Disabilities* (Discussion Paper). December. Disability Task Force: Canberra.
- Donaldson, B., and Pickford, P. 1994, *Providing Accessible Visitor Attractions*. National Tourist Boards of England, Scotland, Wales and Northern Ireland, and Glaxo Holdings: London.
- Donnelly, J. 1989, *Universal Human Rights in Theory and Practice*. Cornell University Press: Ithaca.
- Douglas, N. 1999, *Minutes - National Workshop on Tourism for People with Disabilities*. Tuesday 3 August. South Australian Tourism Commission: Adelaide.
- Downie, A. 1994a, Chapter 22.0: Australia's Travel Industry - "an Appraisal". In A. Downie (Ed.), *Target 2015: A Vision for the Future - Access to Transport in Australia for All Australians*. Disability Advisory Council of Australia: Canberra. 321-360
- Downie, A. 1994b, *Target 2015: A Vision for the Future - Access to Transport in Australia for All Australians*. August. Disability Advisory Council of Australia.
- Dowse, L. 2001, Contesting Practices, Challenging Codes: Self Advocacy, Disability Politics and the Social Model. *Disability & Society*, 16(1), 123-141.
- Drabek, T. E. 2000, Disaster Evacuations: Tourist-Business Managers Rarely Act as Customers Expect. *The Cornell Hotel and Restaurant Administration Quarterly*, 41(4), 48-57.
- Driedger, D. 1987, Disabled People and International Air Travel. *Journal of Leisurability*, 14(1), 13-19.
- Durgin, R. W., Lindsay, N., and Hamilton, F. 1985, *A Guide to Recreation, Leisure and Travel for the Handicapped Volume 2: Travel and Transportation*. Resource Directories: Toledo, Ohio.
- Dye, T. R. 1975, *Understanding Public Policy*. Prentice-Hall: Englewood-Cliffs, New Jersey.
- Elliott, J. 1997, *Tourism: Politics and Public Sector Management*. Routledge: London.
- Elton, B. 1991, *Gridlock*. MacDonald: London.
- English Tourism Council. 1999, *Tomorrow's Tourism*. English Tourism Council: London.
- English Tourism Council. 2000a, *National Accessible Scheme: For a Quality Service You Can Trust - Consultation Document*. English Tourism Council: London.
- English Tourism Council. 2000b, *People with Disabilities and Holiday Taking*. November 2000. English Tourist Council: London. www.englishtourism.org.uk
- English Tourist Board, and Holiday Care Service. 1990, *Tourism for All - a Report of the Working Party Chaired by Mary Barker*. English Tourist Board: London.
- Ervin, M. 1989, Unfriendly Skies: The Disabled Are Often Left at the Gate. *The Progressive*, June(6), 28-31.
- European Civil Aviation Conference, and European Conference of Ministers of Transport. 1995, *Access to Air Travel for People with Reduced Mobility*. Organization for Economic Cooperation and Development (OECD): Paris.
- European Commission. 1996, *Making Europe Accessible for Tourists with Disabilities: Handbook for the Tourism Industry*. Office for Official Publications of the European Communities, Directorate General XXIII -Tourism Unit: Luxembourg.
- Faulkner, H. W., and French, S. 1982, *Occasionally Paper 54: Transport for the Disabled in the ACT*. Bureau of Transport Economics/AGPS: Canberra.
- Fayos-Solá, E. 1996, Tourism Policy: A Midsummer Night's Dream? *Tourism Management*, 17(6), 405-412.
- Fine, M., and Asch, A. 1988, Disability Beyond Stigma: Social Interaction, Discrimination, and Activism. *Journal of Social Issues*, 44(1), 3-21.
- Finkelstein, V. 1980, *Monograph No.5 - Attitudes and Disabled People: Issues for Discussion*. World Rehabilitation Fund: New York.
- Finkelstein, V. 1993, Disability: A Social Challenge or an Administrative Responsibility? In V. Finkelstein, S. French and M. Oliver (Eds.), *Disabling Barriers - Enabling Environments*. Open University Press/Sage: London
- Finkelstein, V. 1995, *Definitions of the Social Model*. Disability-Research List. Available: www. Last [1998, 20 June].
- Finlon Dajani, K. 2001, What's in a Name? Terms Used to Refer to People with Disabilities. *Disability Studies Quarterly*, 21(3), 196-209.

- Fishbein, M., and Ajzen, I. 1975, *Belief, Attitude, Intention and Behavior: An Introduction to Theory and Research*. Addison-Wesley: Reading, Massachusetts.
- Flavigny, C., and Pascal, M. 1995, Tourism among the Disabled: Dissatisfied Clients (French). *Espaces (Paris)*(134), 36-42.
- Fleischer, A., and Pizam, A. 2002, Tourism Constraints among Israeli Seniors. *Annals of Tourism Research*, 29(1), 106-123.
- Fodor's. 1996, *Fodor's Great American Vacations for Travelers with Disabilities* (2nd edn.). Fodor's Travel Publications Inc.: New York.
- Foggin, S. E. A. 2000, *The Experience of Leisure Tourism of People with Disabilities*. Unpublished Ph.D. Thesis, Universite de Montreal, Faculte des Erudes Superieures, Montreal.
- Folino, B. 1999, *Taxis and People with a Disability: Issues for Government and Industry*. Disability Council of NSW: Sydney.
- Fontana, A., and Frey, J. H. 1994, Interviewing - the Art of Science. In N. K. Denzin and Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*. Sage: Thousand Oaks, CA. 361-376
- Foo, L. M. 1998, *Cultural Tourism in Australia: Characteristics and Motivations*. Bureau of Tourism Research: Canberra.
- Fotos, C. P. 1992, Right-to-Fly Law Spurs Operators to Provide Access for Disabled. *Aviation Week and Space Technology*, June 8, 58-60.
- Foucault, M. 1988, *Selections. English. Politics, Philosophy, Culture: Interviews and Other Writings, 1977-1984* (A. S. a. others, Trans.). Routledge: New York.
- Fox, M. 1994, Access Standards and Legislation in Australia. *Quad Wrangle - the Journal of the Australian quadriplegic Association*, 12(3), 10-12.
- Fraser, L. 1987, *Park Access: Report Series No. 10*. Australian National Parks and Wildlife Service: Canberra.
- French, S. 1993, Disability, Impairment or Something in Between? In J. Swain, V. Finkelstein, S. French and M. Oliver (Eds.), *Disabling Barriers, Enabling Environments*. Open University: Sage: London
- Frisch, D. J. 1998, *The Benefits of Accessible Buildings and Transport - an Economist's Approach*. Physical Disability Council of Australia: Brisbane.
- Frisch, D. J. 2001, *Towards a Disability Allowance: Offsetting the Costs of Disability - an Analysis*. June. Physical Disability Council of Australia: Brisbane.
- Frohman, C. 1999, *Violence against Women with Disabilities*. Women with Disabilities Australia: Dickson, ACT.
- Fullagar, S., and Owler, K. 1998, Narratives of Leisure - Recreating the Self. *Disability & Society*, 13(3), 441-450.
- Gagneux, M., Ducher, I., Troubat, J. P., Herberg, E., Hervez, V., Dequidt, S., Gilbert, C., Pigeassou, C., Ruffie, S., BuiXuan, G., Gleyse, J., and Lopez, D. 1999, Tourism for Handicapped Persons (French). *Espaces (Paris)*(161), 15-36.
- Gallagher, J. M., and Hull, A. H. 1996, Cruise Ship Accommodations for Passengers with Physical Limitations Due to Disability or Age. *American Journal of Occupational Therapy*, 50(8), 685-687.
- Gee, C. Y. 1990, *Professional Travel Agency Management*. Prentice Hall: Englewood Cliffs, N.J.
- Gee, C. Y. 1996, *Resort Development and Management* (2nd edn.). Educational Institute of the American Hotel & Motel Association: East Lansing, MI.
- George, C. 2001, *Disability Tourism Initiatives of the NTTC*, Northern Territory Tourist Commission, Darwin, pers. comm. to S. Darcy, Email & Fax, 21 September 2001
- Gething, L. 1999, *We're Getting Older Too: Quality of Life and Service Provision Issues for People with Long Standing Disabilities Who Are Ageing*. (Research Report). June 1999. University of Sydney/Nursing Research Centre for Adaptation in Health and Illness/Community Disability and Ageing Program: Sydney.
- Giddens, A. 1989, *Sociology*. Polity Press: Cambridge.
- Gilbert, D., and Hudson, S. 2000, Tourism Demand Constraints: A Skiing Participation. *Annals of Tourism Research*, 27(4), 906-925.
- Gleeson, B. 1997, Disability Studies: A Historical Materialist View. *Disability and Society*, 12(2), 179-202.
- Gleeson, B. 1998, Disability and Poverty. In R. Fincher and J. Nieuwenhuysen (Eds.), *Australian Poverty: Then and Now*. Melbourne University Press: Melbourne. 314-333
- Gleeson, B. 1999a, Beyond Goodwill: The Materialist View of Disability. *Social Alternatives*, 18(1), 11-17.
- Gleeson, B. 1999b, *Geographies of Disability*. Routledge: London.
- Goeldner, C. R., Ritchie, B., and McIntosh, R. W. 1999, *Tourism: Principles, Practices, Philosophies* (8th edn.). Wiley: New York.
- Goffman, E. 1963, Selections from Stigma. In L. J. Davis (Ed.), *The Disability Studies Reader*. Routledge: London. 205-215
- Goggin, G., and Newell, C. 2001, Crippling Paralympics? Media, Disability and Olympism. *Media International Australia*, 97(Nov), 71-83.
- Goldlust, J. 1996, *Understanding Citizenship in Australia*. AGPS: Canberra.

- Goldsmith, S. 1997, *Designing for the Disabled: The New Paradigm*. Architectural Press: Boston.
- Golledge, R. G. 1996, Ableist Geographies, Disablist Spaces - Towards a Reconstruction of Golledge's Geography and the Disabled - Response. *Transactions of the Institute of British Geographers*, 21(2), 404-411.
- Goodale, T. L., and Witt, P. A. 1989, Recreation Non-Participation and Barriers to Leisure. In E. L. Jackson and T. L. Burton (Eds.), *Understanding Leisure and Recreation: Mapping the Past, Charting the Future*. Venture Publishing: State College, PA
- Goossens, R. 2001, Freewheeling Florence. *Sydney Morning Herald*, 13 January, T3.
- Gotting, P. 1999, Airline Says Sorry to Disabled Man. *The Sydney Morning Herald*, October 1, 10.
- Graham, I. 2001, *Special Report: Service for All Is the Bottom Line*. November. Andersen - Hospitality and Leisure: London.
- Graham, J. 2000, *A Guide to Accessible Caravan Parks in Queensland*. Tourism Queensland: Brisbane.
- Gregory, P. 1999, Games Ticket Win to Quadriplegic. *The Age*, 4 August, np.
- Griffin Dolon, J. 2000, Accessibility, the Americans with Disabilities Act, and the Natural Environment as a Tourist Resource. *anatolia: International Journal of Tourism and Hospitality Research*, 11(2), 101-110.
- Griffin, T. 1989, Hotel Development: The Downtown Sydney Case. In J. Blackwell and L. Stear (Eds.), *Case Histories of Tourism & Hospitality*. Australian-International Magazine Services: Sydney. 317-333
- Griffin, T., and Darcy, S. 1997, Australia: Consequences of the Newly Adopted Pro-Asia Orientation. In F. M. Go and C. L. Jenkins (Eds.), *Tourism and Economic Development in Asia and Australasia*. Cassell: London; Washington. 67-90
- Hahn, H. 1986, Disability and the Urban Environment: A Perspective on Los Angeles. *Environment and Planning D: Society and Space*, 4, 273-288.
- Haigh, R. 1994, *Holidays in Store: Shopping Patterns of International Tourists*. Bureau of Tourism Research: Canberra.
- Haigh, R. 1995, *Backpackers in Australia*. Bureau of Tourism Research: Canberra.
- Hall, C. M. 1995, *Introduction to Tourism in Australia: Impacts, Planning and Development* (2nd edn.). Longman: Melbourne.
- Hall, C. M. 1998, *Introduction to Tourism: Development, Dimensions and Issues* (3rd edn.). Longman: Melbourne.
- Hall, C. M., and Jenkins, J. 1995, *Tourism and Public Policy*. Routledge: London.
- Handley, P. 2001, 'Caught between a Rock and a Hard Place': Anti-Discrimination Legislation in the Liberal State and the Fate of the Australian Disability Discrimination Act. *Australian Journal of Political Science*, 36(3), 515-528.
- Hanley, E. 1996, Hearing the Voice of People with Disabilities: Benefits of Leisure and Constraints to Participation in Inclusive Leisure Options Experienced by Women with Disabilities, NICAN (Eds.), In the proceedings of *Citizenship - Beyond Disability*, Brisbane, Oct 10-12, 85-93.
- Hansard. 1999, *Senator Joselyn Newman's Launch Speech for the Gold Medal Disability Strategy*. Commonwealth of Australia, Canberra. Available: Online Text: 430644 Last [2000, 10 October].
- Hansard. 2000, *Gold Medal Disability Strategy: Funding Allocation*. Commonwealth of Australia Last [2000, 10 October].
- Hansard. 2003, *Graham Edwards (Cowan MP) - Qantas and Wheelchair Damage*. Commonwealth of Australia Last [2003, Monday 16 June].
- Haralambos, M., van Krieken, R., Smith, P., and Holborn, M. 1996, Power, Politics and the State, *Sociology Themes and Perspectives (Australian Edition)*. Longman: Melbourne. 97-153
- Harper, M. 1999, *A Wheely Good Access Guide to Sydney Australia*. Megan Harper: Sydney.
- Harris, J. 2000, Is There a Coherent Social Conception of Disability? *Journal of Medical Ethics*, 26(2), 95-100.
- Harvey, D. 2000, *Spaces of Hope*. Edinburgh University Press: Edinburgh.
- Hasselt, T. v. z. w., and Brussels, L. R. a. D. s. p. r. l. 2001, *Tourism for All in the European Union: Status Report on Tourist Accommodation Accessibility Schemes in Europe*. September. Toerisme Vlaanderen - Meeting of EU Ministers of Tourism.
- Hastings, E. 1995, *Clarification of High Court Decision About the Enforcement of HREOC Determinations*. 13 March 1995. HREOC: Sydney.
- Hastings, E. 1997, *Foundations: Reflections on the First Five Years of the Disability Discrimination Act in Australia*. HREOC: Sydney.
- Hearn, K. 1991, Disabled Lesbians and Gays Are Here to Stay. In T. Kaufmann and Lincoln P (Eds.), *High Risk Lives: Lesbian and Gay Politics after the Cause*. Prism Press: Bridport
- Heath, J. 2002, *South Australian Tourism Access Forum Process*, Jeff Heath, Link Publications, Adelaide, pers. comm. to S. Darcy, Meeting, phone and email regarding meeting with Hon Joe Hockey, Minister for Tourism, 10 September
- Henderson, K. A. 1991, *Dimensions of Choice: A Qualitative Approach to Recreation, Parks, and Leisure Research*. Venture Publishing: State College, PA.

- Henderson, K. A., and Bedini, L. A. 1997, Women, Leisure, and "Double Whammies": Empowerment and Constraint. *Journal of Leisurability*, 24(1), 36-46.
- Henderson, K. A., Bedini, L. A., Hecht, L., and Schuler, R. 1995, Women with Physical Disabilities and the Negotiation of Leisure Constraints. *Leisure Studies*, 14(1), 17-31.
- Henry, I. 1993, *The Politics of Leisure Policy*. Macmillan: London.
- Herbert, J. T. 2000, Therapeutic Adventure Staff Attitudes and Preferences for Working with Persons with Disabilities. *Therapeutic Recreation Journal*, 34(3), 211-226.
- Hill, M. 1999, Breaking into Adaptable Housing: A Cost Benefit Analysis of Adaptable Homes, ACT Housing (Eds.), In the proceedings of *Housing for Life: the ACT Adaptable and Accessible Housing Conference*, National Convention Centre, 26-27 May, www.act.gov.au/urbanservices/docs/biah.doc
- Hinch, T. D., and Jackson, E. L. 2000, Leisure Constraints Research: Its Value as a Framework for Understanding Tourism Seasonality. *Current Issues in Tourism*, 3(2), 87-107.
- Hine, J., and Mitchell, F. 2001, Better for Everyone? Travel Experiences and Transport Exclusion. *Urban Studies*, 38(2), 319-332.
- Hing, N., Breen, H., and Weeks, P. 1998, *Club Management in Australia: Administration, Operations and Gaming*. Hospitality Press: Melbourne.
- Hodge, M., Corcoran, M., and Murfitt, K. 1998, *Response to Regulation Impact Statement on Draft Disability Standards for Accessible Public Transport - Community Representatives' Responses*, [Website]. DDA Standards Project. Available: <http://members.ozemail.com.au/~ddasp/DDAStandards1doc4.htm> Last [2002, 12 Dec].
- Holland, Z. 1999, *Exploring Disability in the Context of Architecture: Towards an Enabling Built Environment*. Unpublished Dissertation, University of Sheffield, School of Architecture, Sheffield.
- Holloway, J. C., and Robinson, C. 1995, *Marketing for Tourism* (3rd edn.). Longman: Harlow, Essex.
- Holstein, J. A., and Gubrium, J. F. 1994, Phenomenology, Ethnomethodology, and Interpretive Practice. In N. K. Denzin and Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*. Sage: Thousand Oaks, CA. 262-272
- Honneth, A. 1995, *The Struggle for Recognition: The Moral Grammar of Social Conflicts*. Polity: Cambridge.
- Hudson, S., and Gilbert, D. 1999, Tourism Constraints: The Neglected Dimension in Consumer Behaviour Research. *Journal of travel and tourism marketing*, 8(4), 69-78.
- HREOC. 1993, *Issues Paper: Disability Standards under the Disability Discrimination Act*, [Website]. Prepared by the Disability Discrimination Commissioner for the DDA Disability Standards Working Group HREOC. Available: www.hreoc.gov.au/disability_rights/standards/issues93.htm Last [2001, 23 December].
- HREOC. 1994, *Disability Discrimination Act - Information Kit*. HREOC: Canberra.
- HREOC. 1995a, *Disability Discrimination Act - Action Plans: A Guide for Business*. HREOC: Canberra.
- HREOC. 1995b, *Disability Discrimination Act - Action Plans: A Guide for Commonwealth Government Departments and Authorities*. HREOC: Canberra.
- HREOC. 1995c, *Disability Discrimination Act - Action Plans: A Guide for Local Government*. HREOC and the Australian Local Government Association: Canberra.
- HREOC. 1995d, *Disability Discrimination Act - Action Plans: A Guide for State and Territory Government Departments and Agencies*. HREOC: Canberra.
- HREOC. 1998, *Advisory Notes on Access to Premises* (1st 1997 2nd 1998 edn.). HREOC: Sydney.
- HREOC. 1999, *Advisory Notes on Transport*, [Website]. HREOC. Available: www.hreoc.gov.au/disability_rights/standards/transport_note/transport_note.html Last [2000, 6 June].
- HREOC. 2000, *Disability Discrimination Act Complaints Cases*. HREOC: Sydney. www.hreoc.gov.au
- HREOC. 2001a, *Disability Discrimination Act Complaints Register Jan 1998 - Jun 2001*, [Website]. HREOC. Available: www.hreoc.gov.au/complaints_information/register/index.html Last [2001, 2 December].
- HREOC. 2001b, *Frequently Asked Questions: Employment*, [Website]. HREOC. Available: www.hreoc.gov.au/disability_rights/faq/Employment/employment_contents.html Last [2001, 2 December].
- HREOC. 2001c, *HREOC Annual Report 2000 - 2001*, [Website]. HREOC. Available: www.hreoc.gov.au/annrep00_01/index.html Last [2002, 1 April].
- HREOC. 2001d, *Revised Draft DDA Disability Standards: Employment*, [Website]. HREOC. Available: www.hreoc.gov.au/disability_rights/standards/Employment_draft/employment_draft.html Last [2001, 23 December].
- HREOC. 2001e, *Website - Disability Rights*, [Website]. HREOC. Available: www.hreoc.gov.au/disability_rights/ Last [2001, 23 December].
- HREOC. 2002a, *Disability Discrimination Act Complaints Cases*. HREOC. Available: http://www.hreoc.gov.au/disability_rights/decisions/ Last [2002, January].
- HREOC. 2002b, *Register of Disability Discrimination Act Action Plans*, [Website]. HREOC. Available:

- www.hreoc.gov.au/disability_rights/action_plans/Register/register.html#business Last [2002, 26 Dec].
- HREOC. 2002c, *Report: Inquiry into the NSW Wheelchair Accessible Taxi Service*, [Website]. HREOC. Available: www.hreoc.gov.au/disability_rights/inquiries/taxi/direction.htm Last [2002].
- HREOC. 2002d, *Storm or Sea-Change: Meeting the Challenges of Providing Tertiary Materials in Accessible Formats for People with Print Disabilities*, [Website]. HREOC. Available: www.hreoc.gov.au/disability_rights/ Last [2002, 29 May].
- Hume, J. 1994, *Media Guidelines*. Disability Council of NSW: Sydney.
- Hunter, D. W. 1984, Social Constraints on the Play Behavior of the Disabled Person. *Journal of Leisureability*, 11(4), 8-12.
- Hutchison, P. 1997, Citizenship - Setting the Scene (Keynote Address), NICAN (Eds.), In the proceedings of *Citizenship...beyond Disability Conference*, Brisbane, 10-12 October, 3-17.
- Illawarra Tourism. 2001, *Illawarra Easy Access: A Visitors' Guide for People with Limited Mobility*. Wollongong City Council: Wollongong.
- Illum, S., Lillard, B., and Thompson, G. 2000, *Disability Express: Travel and Disability Resource Directory* (5th edn.). Office of Leisure Research Southwest Missouri State University: Springfield, Mo.
- Imrie, R. 1996, *Disability and the City: International Perspectives*. Paul Chapman: London.
- Imrie, R. 2000a, Disability and Discourses of Mobility and Movement. *Environment & Planning A*, 32(9), 1641-1656.
- Imrie, R. 2000b, Disabling Environments and the Geography of Access Policies and Practices. *Disability & Society*, 15(1), 5-24.
- International Bureau of Social Tourism. 1997, *Montreal Declaration: Towards a Human and Social Vision of Tourism*. 4/7/97. International Bureau of Social Tourism (BITS): Montreal.
- Ippoliti, C., Peppy, B., and Depoy, E. 1994, Promoting Self Determination for Persons with Developmental Disabilities. *Disability & Society*, 9(4), 453-460.
- Israel, J. 2000, It Might Not Be Plane Sailing but It Is Better Than Before. *Sydney Morning Herald*, 18 April, 27.
- Jackson, E. L. 1988, Leisure Constraints: A Survey of Past Research. *Leisure Sciences*, 10, 203-215.
- Jackson, E. L. 1991, Leisure Constraints/Constrained Leisure: Special Issue Introduction. *Journal of Leisure Research*, 23, 279-285.
- Jackson, E. L., Godbey, G., and Crawford, D. W. 1993, Negotiation of Leisure Constraints. *Leisure Sciences*, 15(1), 1-11.
- Jackson, E. L., and Scott, D. 1999, Constraints to Leisure. In E. L. Jackson and T. L. Burton (Eds.), *Leisure Studies: Prospects for the Twenty-First Century*. Venture Publishing, Inc: State College, PA. 299-332
- James, C., and James, D. 2000, *A Wheelie's Handbook of Australia*. Program Print: Hamilton, Victoria.
- Jenkins, O. H. 1999, Understanding and Measuring Tourist Destination Images. *International Journal of Tourism Research*, 1(1), 1-15.
- Jensen, M. 1999, *CTEC Initiatives*, CTEC, Canberra, pers. comm. to S. Darcy, 7 July
- Johnson, G. 1999, Airline Fined for Moving Passenger. *The Associated Press*.
- Johnson, T. J. 1972, *Professions and Power*. Macmillan: London.
- Jones, M., and Basser Marks, L. A. 1999, Disability Rights and Law in Australia. In M. Jones and L. A. Basser Marks (Eds.), *Disability, Divers-Ability and Legal Change*. Kluwer Law International: Great Britain. 189-208
- Jones, P. 2002, *Introduction to Hospitality Operations: An Indispensable Guide to the Industry* (2nd edn.). Continuum: New York.
- Kazel, R. 1996, Days Inn Disputes Liability for Franchisees' ADA Duties. *Business Insurance*, 30(11), 21.
- Kennedy, D. W., Smith, R., and Austin, D. R. 1991, *Special Recreation: Opportunities for Persons with Disabilities* (2nd edn.). Wm. C. Brown Pub.: Dubuque, Iowa.
- Keppie, G. 1997, *Cooperative Research Centre for Sustainable Tourism Proposal*. Dept. of Industry, Science and Resources: Brisbane.
- Kèroul. 1995, *Tourism for People with Restricted Physical Ability*. Kèroul: Quebec.
- Kerstetter, D., and Holdnak, A. 1990, *Comparison of Perceived Travel Constraints to Travel Behaviour - Characteristics of College-Educated Mature Adults: An Exploratory Study*.: Paper presented at the Resort and Commercial Recreation Association Research Symposium. Amelia Island, Florida.
- King, B., and Hyde, G. 1989, *Tourism Marketing in Australia*. Hospitality Press: Melbourne.
- Kitchin, R. 1998, Out of Place, Knowing Ones Place - Space, Power and the Exclusion of Disabled People. *Disability & Society*, 13(3), 343-356.
- Kitchin, R. 2000a, Mind and Body Spaces: Geographies of Illness, Impairment and Disability. *Transactions of the Institute of British Geographers*, 25(2), 263-264.
- Kitchin, R. 2000b, The Researched Opinions on Research: Disabled People and Disability Research. *Disability & Society*, 15(1), 25-47.
- Knorr-Cetina, K., and Cicourel, A. V. (Eds.). 1981, *Advances in Social Theory and Methodology: Toward an*

- Integration of Micro- and Macro-Sociologies*. Routledge and Kegan Paul: Boston.
- Kotler, P., Bowen, J., and Makens, J. 1998, *Marketing for Hospitality and Tourism* (2nd edn.). Prentice Hall: Upper Saddle River, NJ.
- Krause, D., and Reynolds, F. 1996, *A Guide for Making a Mobility Map*. Local Government and Shires Association of NSW: Sydney.
- Lagan, B. 1998, Changes 'a Real Threat' to Rights Watchdog. *Sydney Morning Herald*, 10 Aug, 5.
- Law, G. 1994, Public Policy and Social Constructions of Disability. *Australian Disability Review*, 2, 16-22.
- Laws, E. 2002, *Tourism Marketing: Quality and Service Management Perspectives*. Continuum: London.
- Lawton, M. 1993, From Startrac to Leisure Choice: The First Slow Steps Towards Change. In J. Swain, V. Finkelstein, S. French and M. Oliver (Eds.), *Disabling Barriers - Enabling Environments*. Open University/Sage: London;
- Leach, R. 1993, *Political Ideologies: An Australian Introduction* (2nd edn.). Macmillan: Melbourne.
- Legg, R. 1997, *National Visitors Survey - Disability Identifier*, National Office of Tourism, Canberra, pers. comm. to S. Darcy, Email and phone, 20 August
- Leiper, N. 1995, *Tourism Management*. TAFE Publications: Collingwood, Vic.
- Linton, S. 1998, *Claiming Disability: Knowledge and Identity*. New York University Press: New York.
- Lloyd, M. 1992, Does She Boil Eggs? Towards a Feminist Model of Disability. *Disability*, 7(3), 207-221.
- Lockwood, R., and Lockwood, A. 1996, Physical Activity for People with Disabilities: Considerations for Community Service Providers Based on Recent Research in Western Australia. *Leisure Options: Australian Journal of Leisure and Recreation*, 7(3), 42-45.
- Lockwood, R., and Lockwood, A. (Eds.). 1999, *Recreation and Disability in Australia* (1st edn.). DUIT Multimedia: Perth, WA.
- Lockwood, R., and O'Meara, W. 1999, Politics of Disability. In R. Lockwood and A. Lockwood (Eds.), *Recreation and Disability in Australia* (1st edn.). DUIT Multimedia: Perth, WA. 44-59
- Loker, L. 1993, *The Backpacker Phenomenon II: More Answers to Further Questions*. James Cook University of North Queensland: Townsville, Queensland.
- London Transport. 1993, *Access to the Underground: A Step by Step Guide to Each Station for Elderly and Disabled People*. London Transport: London.
- Longmore, P., and Umansky, L. (Eds.). 2001, *The New Disability History*. New York University Press: New York.
- Lumsdon, L. 1997, *Tourism Marketing*. International Thomson Business Press: London.
- MacLennan, S. 2003, Disabled Insult (Accommodation Discrimination). *Sydney Morning Herald*, October 18-19, 8.
- Manidis Roberts Consultants. 1994, *An Investigation into a National Ecotourism Accreditation Scheme*. Commonwealth Dept. of Tourism: Canberra.
- Mason, D. 2002, *Gaining Access to HREOC Complaint Cases for Academic Purposes*, HREOC, Sydney, pers. comm. to S. Darcy, Email, 18 January
- Massey, P. 1999, *South Sydney Council, Oxford Street Strip and the Gay and Lesbian Mardi Gras*, South Sydney Council, South Sydney, pers. comm. to S. Darcy, Phone conversation, 5 April 1999
- Maxa, R. 2001, *A Guide to Travel for the Disabled*, [www]. MSNBC. Available: www.msnbn.com/news/274109.asp?cp1=1 Last [2001, 24 August].
- McAuley, H. 1993, *Paper 1 - Background to the Development of Access Standards*. ACROD: Canberra.
- McClure, P. 2000, *Participation Support for a More Equitable Society: Final Report of the Reference Group on Welfare Reform*. Reference Group on Welfare Reform, Commonwealth Dept. of Family and Community Services: Canberra.
- McGuire, F. 1984, A Factor Analytic Study of Leisure Constraints in Advanced Adulthood. *Leisure Sciences*, 6, 313-326.
- Medlik, S., and Ingram, H. 2000, *The Business of Hotels* (4th edn.). Butterworth-Heinemann: Oxford.
- Meekosha, H. 1998, Body Battles: Bodies, Gender and Disability. In T. Shakespeare (Ed.), *The Disability Reader: Social Science Perspectives*. Casell: London. 163-180
- Meekosha, H. 1999, *Disability and Human Rights in Australia*. March 11. Paper presented to the Attorney General's NGO Forum on Domestic Human Rights: Canberra.
- Meekosha, H., and Dowse, L. 1997a, Distorting Images, Invisible Images: Gender, Disability and the Media. *Media International Australia*, 84(May), 91-101.
- Meekosha, H., and Dowse, L. 1997b, Enabling Citizenship: Gender, Disability and Citizenship in Australia. *Feminist Review*, 57(Autumn), 49-72.
- Meekosha, H., and Dowse, L. 2001, Disability Policies and Programs in Australia, Japan College of Social Work (Eds.), In the proceedings of *International Seminar on Social Welfare in Asia and The Pacific*, Tokyo, November 13-16, 70.
- Meekosha, H., and Jakubowicz, A. 1987, *Equal Disappointment Opportunity? A Report to the Department of Community Services on Programs for Immigrants and Their Children*. Commonwealth Department of Community Services and Health: Canberra.
- Meekosha, H., and Jakubowicz, A. 1999, *Disability, Political Activism, and Identity Making: A Critical*

- Feminist Perspective on the Rise of Disability Movements in Australia, the USA and the UK. *Disability Studies Quarterly*, 19(4), 393-404.
- Middleton, V. T. C., and Clarke, J. 2001, *Marketing in Travel and Tourism* (3rd edn.). Butterworth-Heinemann: Oxford.
- Miles, M. B., and Huberman, A. M. 1994, *Qualitative Data Analysis: An Expanded Sourcebook* (2nd edn.). Sage: Thousand Oaks, Calif.
- Miles, M. 1982, Why Asia Rejects Western Disability Advice. *International Rehabilitation Review*, 4th Quarter, www.pcs.mb.ca/~ccd/disbook1.html.
- Miles, M. 1996, Community, Individual or Information Development - Dilemmas of Concept and Culture in South Asian Disability Planning. *Disability & Society*, 11(4), 485-500.
- Miles, M. 2000, Disability on a Different Model: Glimpses of an Asian Heritage. *Disability & Society*, 15(4), 603-618.
- Miles, M. 2001, ICIDH Meets Postmodernism, or Incredulity toward Meta-Terminology. *Disability World E-Zine (March/April)*, 2001(7), www.disabilityworld.org/03-04_01/resources/icidh.shtml.
- Mill, R. C., and Morrison, A. M. 1985, *The Tourism System: An Introductory Text*. Prentice-Hall International: Englewood Cliffs, NJ.
- Miller, G. 1999, *Tourism Queensland Focus Groups on Disability Product*, Queensland Tourism's Manager of Special Interest Tourism, Brisbane, pers. comm. to S. Darcy, Interview, 8 March
- Miller, G. 2002, *Interview on Queensland Tourism Disability Processes*, Queensland Tourism's Manager of Special Interest Tourism, Brisbane, pers. comm. to S. Darcy, Interview, 10 April
- Mills, E. D. 1983, *Design for Holidays and Tourism*. Butterworths: London.
- Mirvac Hotels. 1998, *Occupancy Review of Mirvac Properties*. 26 July. Mirvac Hotels: Sydney.
- Mitchell, D. T., and Snyder, S. L. 1997, *The Body and Physical Difference: Discourses of Disability*. University of Michigan Press: Ann Arbor, MI.
- Morgan, M. 1996, *Marketing for Leisure and Tourism*. Prentice Hall: London.
- Morris, J. 1991, *Pride against Prejudice*. The Women's Press: London.
- Morris, J. 1993, *Pride against Prejudice: A Personal Politics of Disability*. The Women's Press Ltd: London.
- Morrison, A. M. 2001, *Hospitality and Travel Marketing* (3rd edn.). Delmar Thomson Learning: Albany.
- Muloin, S. 1999, Social Psychology. In R. Lockwood and A. Lockwood (Eds.), *Recreation and Disability in Australia* (1st edn.). DUIT Multimedia: Perth, WA. 15-32
- Muloin, S., and Weiler, B. 1991, Provision of Travel Information for Persons with Specific Needs, A. J. Veal, P. Johnson and G. Cushman (Eds.), In the proceedings of *Leisure and Tourism: Social and Environmental Change: World Leisure and Recreation Association Congress*, Sydney, July, UTS/WLRA, 631-635.
- Muloin, S., Zeppel, H., and Higginbottom, K. 2001, *Indigenous Wildlife Tourism in Australia: Wildlife Attractions, Cultural Interpretation and Indigenous Involvement*. Co-operative Research Centre for Sustainable Tourism: Gold Coast, Qld.
- Murphy, P. E. 1985, *Tourism: A Community Approach*. Methuen: New York.
- Murray, M. 1994, Wheelchair Access: The Impossible Dream. *Australian Journal of Leisure & Recreation*, 4(1), 57-61.
- Murray, M., and Sproats, J. 1990, The Disabled Traveller: Tourism and Disability in Australia. *Journal of tourism studies*, 1(1), 9-14.
- National Access Working Group. 1999, *National Discussion Paper on Access*. National Access Working Group: Sydney.
- National Roads and Motorists Association (NRMA). 1999, *Accommodation Guide May 1999 - May 2000*. National Roads and Motorists Association: Sydney.
- National Tourist Boards, and Holiday Care Service. 2001, *Accessible Accommodation Accreditation Scheme*. National Tourist Boards: London.
- Neumayer, R. J. 1993, *How Leisure Beliefs Relate to Attitudes toward the Normalization Principle as Perceived by Service Providers for People with Mental Retardation*. Unpublished Ph.D Thesis, Pennsylvania State University.
- New South Wales Government. 1997, *NSW Government Disability Policy Framework: A Five Year Strategy for Action: A Green Paper for Public Comment*. Ageing and Disability Department NSW Health New South Wales Government: Sydney.
- New South Wales Government. 1998, *Disability Policy Framework*. Ageing and Disability Department NSW/Health New South Wales Government: Sydney.
- NICAN. 2000, *National Information Communication Awareness Network Website*. NICAN. Available: www.nican.com.au/NICAN.html Last [2000, 9 Nov].
- Noble, C. 1979, Increasing Opportunities Available for Disabled Travellers. *Journal of Leisurability*, 6(3), 20-26.
- Northern Cartographic, I. 1988, *Access America: An Atlas and Guide to the National Parks for Visitors with Disabilities* (1st edn.). Northern Cartographic: Burlington, VT.
- Northern Territory Tourist Commission. 2001, *Exploring the Territory: A Guide for Self-Drive Travellers*

- 2001/02. Northern Territory Tourist Commission: Darwin.
- NSW Anti-Discrimination Board. 2001a, Deaf Access to Conference. *EQUALtime*, November 50, 11.
- NSW Anti-Discrimination Board. 2001b, Therapy Dog and Public Transport. *EQUALtime*, November 50, 11.
- NSW Dept. of Ageing Disability and Home Care. 2002, *Strategic Directions 2002-2005*. DADHC: Sydney.
www.dadhc.nsw.gov.au
- NSW Dept. of Environment and Planning. 1985, *Access to Public Spaces for Disabled People*. Dept. of Environment and Planning: Sydney.
- NSW Dept. of Local Government. 1981a, *Access Facilities for Disabled People (Ordinance No. 70 under the Local Government Act, 1919)*. Government Printer: Sydney.
- NSW Dept. of Local Government. 1981b, *New South Wales Building Regulation Advisory Note No. 29*. Government Printer: Sydney.
- NSW Dept. of Tourism. 1981, *1981 International Year of the Disabled Persons - Tourism Seminar*. 10 February. NSW Dept. of Tourism: Sydney.
- NSW Roads and Traffic Authority. 2002, *How to Prepare a Pedestrian Access and Mobility Plan*. NSW Roads and Traffic Authority: Sydney.
- Office of National Tourism. 1997, *Towards a National Tourism Plan: A Discussion Report*. Office of National Tourism: Canberra.
- Office of National Tourism. 1998a, *Tourism - a Ticket to the 21st Century - National Action Plan for a Competitive Australia*. Office of National Tourism: Canberra.
- Office of National Tourism. 1998b, *Tourism Challenge: Access for All*. Office of National Tourism: Canberra.
- O'Halloran, M. 2000, *Rural Tourism in Australia: The Visitor's Perspective*. Bureau of Tourism Research: Canberra.
- O'Halloran, M. 2002, *National Visitors Survey - Unit Record Data Clarifications*, Division of Tourism - DISR, Canberra, pers. comm. to S. Darcy, Email and phone conversations, 26 April & 18 October
- Oliva, G. A., and Simonsen, A. 2000, Re-Thinking Leisure Services for Deaf and Heard of Hearing Persons: A New Paradigm. *Parks & Recreation*, 35(5), 78-85.
- Oliver, M. 1990, *The Politics of Disablement*. Macmillan: Basingstoke, Houndmills.
- Oliver, M. 1996, *Understanding Disability: From Theory to Practice*. Macmillan: Basingstoke, Houndmills.
- Oliver, M. 1999, Final Accounts and the Parasite People. In M. Corker and S. French (Eds.), *Disability Discourse*. Open University Press: Buckingham. 183-191
- Oliver, M., and Barnes, C. (Eds.). 1998, *Disabled People and Social Policy*. Addison Wesley Longman: New York.
- Olympic Co-ordination Authority. 1998, *Access Guidelines* (2nd edn.). Olympic Co-ordination Authority: Sydney.
- Olympic Co-ordination Authority. 1999, *Access Guidelines* (3rd edn.). Olympic Co-ordination Authority: Sydney.
- Olympic Co-ordination Authority. 2002, *OCA Achieving Access Website*, [Website]. Olympic Co-ordination Authority. Available: www.oca.nsw.gov.au/access/html/default.cfm Last [2002, 20 December].
- O'Neill, M., and Ali Knight, J. 2000, Disability Tourism Dollars in Western Australia Hotels. *FUI Hospitality Review*, 18(2), 72-88.
- Ozdowski, S. D. 2001, *Local Government Liability for Permitting Inaccessible Development*. HREOC: Sydney. Available: www.HumanRights.gov.au/disability_rights/buildings/permit.htm Last [2001, 18 July].
- Ozdowski, S. D. 2002, *Disability Discrimination Legislation in Australia from an International Human Rights Perspective: History, Achievements and Prospects*. April. HREOC: Sydney.
www.hreoc.gov.au/disability_rights/
- Page, S. 1999, *Transport and Tourism*. Longman: Harlow, Essex.
- Palmer, I. 1998, Arts Managers and Managerialism: A Cross-Sector Analysis of CEO's Orientations and Skills. *Public Productivity & Management Review*, 21(4), 433.
- Parsons, T. 1951, *The Social System*. Free Press: New York.
- Parsons, W. 1995, *Public Policy*. Edward Elgar: Cheltenham, Sussex.
- Patterson, I., Hanley, E., and Auld, C. 1996, Constraints to Participation in Sport and Recreation Activities for People with Disabilities - a Study. *Australian Disability Review*, 2, 38-44.
- Patterson, I., and Taylor, T. (Eds.). 2001, *Celebrating Inclusion and Diversity in Leisure*. HM Leisure Planning Pty Ltd: Melbourne.
- Patton, M. Q. 1990, *Qualitative Evaluation and Research Methods*. Sage: Newbury Park, CA.
- Pearce, P. L. 1990, *The Backpacker Phenomenon: Preliminary Answers to Basic Questions*. James Cook University of North Queensland: Townsville, Qld.
- Pembroke, K. 2002, *A Response to Australian Tourist Commission Initiatives for People with Disabilities for the CEO of the ATC Ken Boundy*, ATC, Sydney, pers. comm. to S. Darcy, Email and phone, 3 February
- Pengelly, K. 1997, HREOC Funding Cuts - Howard's Lack of Commitment to Human Rights? *On the*

- Record*, April/June, 6-7.
- Peniston, L. C. 1996, Hotel Accessibility and Accommodations for People with Disabilities. *Parks & Recreation*, 31(12), 24-29.
- Pennington-Gray, L. A., and Gray, D. L. 2002, Testing a Constraints Model within the Context of Nature-Based Tourism. *Journal of Travel Research*, 40(4), 416-423.
- Perry, T. L. 1994, *The Experience of Leisure Constraints by Families Who Have Children with Physical Disabilities*. Unpublished Ph.D Thesis, Pennsylvania State University.
- Pfieffer, D. 2001, The Conceptualization of Disability. In S. N. Barnartt and B. Mandell Altman (Eds.), *Exploring Theories and Expanding Methodologies* (Vol. 2). JAI Press Inc.: Stamford. 29-52
- Pfieffer, D. 2002, *Comparative National Impairment/Disability Rates*, DISABILITY-RESEARCH@JISMAIL.AC.UK, Sydney, pers. comm. to S. Darcy, 19 April
- Physical Disability Council of Australia. 1997, *Cost of Disability - Submission to Dept. Of Social Security* (Research Report). April. Physical Disability Council of Australia: Brisbane.
- Physical Disability Council of Australia. 1999, *We Will Ride Campaign - the Argument for DDA Accessible Public Transport Standards*. Physical Disability Council of Australia. Available: www.pdc.org.au Last [1999, 20 November 1999].
- Physical Disability Council of NSW. 1997, *Response to the Australian Building Codes Board Regulatory Impact Statement* (Research Report). September 1997. Physical Disability Council of NSW: Sydney.
- Physical Disability Council of NSW. 1999, *Position Papers '99 - Citizenship and Physical Disability*. Physical Disability Council of NSW: Sydney.
- Physical Disability Council of NSW. 2002, *Living on Our Own Terms: Personal Assistance Services for Participatory Living by People with Physical Disability in NSW - a Discussion Paper*. Physical Disability Council of NSW: Sydney.
- Porter, A. 2002, Compromise & Constraint: Examining the Nature of Transport Disability in the Context of Local Travel. *World Transport Policy & Practice*, 8(2), 9-16.
- Porter, G. 2001, *Access Audit of South Australian Accommodation and Attractions*, SATC, Adelaide, pers. comm. to S. Darcy, Email, 21 July and 17 Oct
- Preiser, W. F. E., and Ostroff, E. 2001, *Universal Design Handbook*. McGraw-Hill: New York.
- Price Waterhouse. 1997, *Financial Impact Study of the Accessible Transport Standards on the Private Bus Industry*. February. Price Waterhouse prepared for the Australian Bus & Coach Association: Sydney.
- Priestley, M. 1998, Constructions and Creations: Idealism, Materialism and Disability Theory. *Disability & Society*, 13(1), 75-94.
- Pritchard, I. 1999, *Project Application for CRC in Sustainable Tourism - Supply Side Perceptions of People with Disabilities*, Cooperative Research Centre for Sustainable Tourism, Griffith University, Brisbane, pers. comm. to S. Darcy, 4 October
- Public Works and Government Services Canada. 1994, *Design Guidelines for Accessible Outdoor Recreation Facilities*. Canadian Heritage Parks Canada: Ontario.
- Qantas. 1996, *NICAN Carer Concession Card - Press Release*. Qantas Last [1996, Oct].
- Queensland Office of Ageing. 1998, *Not over the Hill - Just Enjoying the View: A Close-up Look at the Seniors Market for Tourism in Australia*. Seniors Card Tourism Scheme - Office of Ageing, Department of Families, Youth and Community Care: Brisbane.
- Queensland Tourism. 2000a, *Accessible Queensland Images* [CD ROM], Tourism Queensland: Brisbane.
- Queensland Tourism. 2000b, *Accessible Queensland Website*, [Website]. Tourism Queensland, Brisbane. Available: www.tq.webcentral.com.au/accessqld/conditions.html Last [2000, 21 November].
- Queensland Tourism. 2000c, *A Schedule of Providers of Services and Accessible Public Infrastructure for Use by People with Disabilities When Visiting Queensland*. Tourism Queensland: Brisbane.
- Queensland Tourism. 2002, *Disability Tourism*. Tourism Queensland, Brisbane. Available: www.qttc.com.au/research/pdf/free/spec_interest/tq_Disability.pdf Last [2003, 11 Feb].
- Queensland Tourist and Travel Corporation. 1998, *Accessible Queensland*. Queensland Tourist and Travel Corporation: Brisbane.
- Quicksilver. 2000, *Quicksilver Offers New Wheelchair Access to the Great Barrier Reef*, [Internet - press release]. Quicksilver. Available: www.quicksilver-cruises.com/ Last [2001, 7 May].
- Raleigh, L. E., and Roginsky, R. J. 1999, *Hotel Investments: Issues & Perspectives* (2nd edn.). Educational Institute of the American Hotel & Motel Association: Lansing, Mich.
- Ransley, J., and Ingram, H. 2000, *Developing Hospitality Properties and Facilities*. Butterworth-Heinemann: Oxford.
- Reedy, J. 1993, *Marketing to Consumers with Disabilities: How to Identify and Meet the Growing Market Needs of 43 Million Americans*. Probus Pub Co: Chicago, Ill.
- Revis, J. S., and Revis, B. D. 1978, Transportation and Disability: An Overview of Problems and Prospects. *Rehabilitation Literature*, 39(6-7), 170-179.
- Rimmer, J. H., Rubin, S. S., and Braddock, D. 2000, Barriers to Exercise in African American Women with

- Physical Disabilities. *Archives of Physical Medicine and Rehabilitation*, 81(2), 182-188.
- Rojek, C. 1985, *Capitalism and Leisure Theory*. Tavistock: London.
- Rosen, F. 1997, *How to Travel: A Guidebook for Persons with a Disability*. Science & Humanities Press, Chesterfield, MO.
- Ross, G. A. 1994, *Attitudes Towards the Disabled in Destination Marketing Organizations (Marketing Organizations)*. Unpublished Ph.D. Thesis, Virginia Polytechnic Institute and State University.
- Rous, M., and Ward, E. 1997, *Anyone Can Travel - the Essential Travel Guide for Seniors, the Disabled, People with Health Problems and the Regular Traveller*. Health Ideas: Montreal Quebec.
- Rushton, P. 1998, Globe-Trotting with Wheels. *The Sun-Herald*, January 25.
- Ruys, H., and Wei, S. 1998, Accommodation Needs of Mature Australian Travellers. *Australian Journal of Hospitality Management*, 5(1), 51-59.
- Salomon, A. 1992, Hotels, Holiday Set Example for ADA Compliance. *Hotel & Motel Management*, 207(19), 56.
- Salomon, A. 1996, Days Sued over Alleged ADA Non-Compliance. *Hotel & Motel Management*, 211(4), 1,23.
- Samdahl, D. M., and Jekubovich, N. J. 1997a, A Critique of Leisure Constraints: Comparative Analyses and Understandings. *Journal of Leisure Research*, 29(4), 430-452.
- Samdahl, D. M., and Jekubovich, N. J. 1997b, A Rejoinder to Henderson's and Jackson's Commentaries on "a Critique of Leisure Constraints". *Journal of Leisure Research*, 29(4), 469-471.
- Seal, K. 1994, Feds Cracking Down on ADA Compliance. *Hotel & Motel Management*, 209(17), 1,5+.
- Shakespeare, T. 1993, Disabled People's Self-Organisation: A New Social Movement? *Disability, Handicap & Society*, 8(3), 249-264.
- Shakespeare, T. 1994, Cultural Representation of Disabled People - Dustbins for Disavowal. *Disability & Society*, 9(3), 283-299.
- Shakespeare, T., and Watson, N. 2001, The Social Model of Disability: An Outdated Ideology? In S. N. Barnartt and B. Mandell Altman (Eds.), *Exploring Theories and Expanding Methodologies* (Vol. 2). JAI Press: Stamford. 9-28
- Sherry, M. 2000, Exploring the Social and Political Dimensions of Access. In M. Clear (Ed.), *Promises Promises: Disability and Terms of Inclusion*. Federation Press: Sydney. 126-137
- Simpson, P., and Simpson, A. 1999, *Wheelchair Down Under*. Pentland, Press Inc: Raleigh, North Carolina.
- Skyrail Pty Ltd. 2002, *Facts About Skyrail*, [website]. Skyrail Pty Ltd. Available: www.skyrail.com.au/facts.htm Last [2002, 10 December].
- Slade, C. 2001, *With the Sea on Our Right: An Epic Australian Journey*. Carolyn Slade Copyright: Unknown.
- Smears, L. 1996, Researching Disability: A Response to Karla Henderson, Leandra Bedini, Lynn Hecht and Rosemary Schuler. *Leisure Studies*, 15(1), 79-81.
- Smith, J. H. J. 1992, A Study of Handicapped Employment in the Hospitality Industry. *Hospitality & Tourism Educator*, 4(3), 16-25.
- Smith, R. 1987, Leisure of Disabled Tourists: Barriers to Participation. *Annals of Tourism Research*, 14(3), 376-389.
- Smith, S. 1988, Defining Tourism: A Supply-Side View. *Annals of Tourism Research*, 15(2), 179-190.
- South Australian Tourism Commission. 1999a, *Accessible: Making It Easier to Discover South Australia*. South Australian Tourism Commission: Adelaide.
- South Australian Tourism Commission. 1999b, *Tourism Strategy for People with Disabilities*. South Australian Tourism Commission: Adelaide.
- South Australian Tourism Commission. 2000, *Disability Access Audits Results - SATC* (CD-ROM). South Australian Tourism Commission: Adelaide.
- Sport and Recreation Victoria. 1997, *Access for All: A Guide to the Design of Accessible Indoor and Outdoor Recreation and Sporting Facilities*. Sport and Recreation Victoria: Melbourne.
- SPSS. 2002, *Help File: Statistical Package for the Social Sciences (V11 Windows Edition)* (v11 edn.). Statistical Package for the Social Sciences: Chicago, IL.
- Stainburn, S. 1997, On a Wing and a Crutch. *Government Executive*, 29(7), 76-77.
- Stake, R. E. 1994, Case Studies. In N. K. Denzin and Y. S. Lincoln (Eds.), *Handbook of Qualitative Research*. Sage: Thousand Oaks, CA. 236-245
- Standards Australia. 1992a, *As 1428.2 - 1992 Design for Access and Mobility. Enhanced and Additional Requirements - Buildings and Facilities*. ([Rev.] edn.). Standards Australia: North Sydney, NSW.
- Standards Australia. 1992b, *As 1428.3 - 1992 Design for Access and Mobility. Requirements for Children and Adolescents with Physical Disabilities*. Standards Australia: North Sydney, NSW.
- Standards Australia. 1992c, *As 1428.4 - 1993 Design for Access and Mobility. Tactile Ground Surface Indicators for the Orientation of People with Vision Impairment*. Standards Australia: North Sydney, NSW.
- Standards Australia. 1993, *As 2890.1 - Parking Facilities: Off Street Parking*. Standards Australia: Homebush, NSW.

- Standards Australia. 1995, *As 4299 - 1995 Adaptable Housing*. Standards Australia: Homebush, NSW.
- Standards Australia. 1998, *As 1428.1 - 1998 Design for Access and Mobility. General Requirements for Access - New Buildings*. (3rd edn.). Standards Australia: Homebush, NSW.
- Standards Australia. 1999, *As 1735.12 - Lifts, Escalators and Moving Walkways: Facilities for Persons with Disabilities*. Standards Australia: Homebush, NSW.
- Standards Australia. 2001, *As 1428.1 - 2001 Design for Access and Mobility - General Requirements for Access - New Building Work*. Standards Australia: Homebush, NSW.
- Stanford, J. 1999, *Accessible Holidays in the British Isles, 1999: A Guide for Disabled People*. Radar Promotions for RADAR: London.
- Steinfeld, E., and Shea, S. M. 2001, Fair Housing: Toward Universal Design in Multifamily Housing. In W. F. E. Preiser and E. Ostroff (Eds.), *Universal Design Handbook*. McGraw-Hill: New York. 35.31-35.13
- Steven Winter and Associates Inc., Tourbier and Wamsley Inc., and Building Technology Inc. 1993, *The Cost of Accessible Housing*. U.S. Dept. of Housing and Urban Development: Washington, DC.
- Stone, E., and Priestley, M. 1996, Parasites, Pawns and Partners: Disability Research and the Role of Non-Disabled Researchers. *British Journal of Sociology*, 47(4), 699-716.
- Stutts, A. T., and Wortman, J. F. 2001, *Hotel and Lodging Management: An Introduction*. J. Wiley: New York.
- Swain, J., Finkelstein, V., French, S., and Oliver, M. (Eds.). 1993, *Disabling Barriers - Enabling Environments*. Open University: Sage: London.
- Swarbrooke, J. 2002, *Development and Management of Visitor Attractions* (2nd edn.). Butterworth-Heinemann: Oxford.
- Takamine, Y. 2001, *The Situation of Disabled Persons in the Asia and Pacific Region*. Economic and Social Commission for Asia and the Pacific (ESCAP): Tokyo.
- Thomas, B. 2001, *BCA Requirements for the Number of Accessible Rooms in Hotels/Motels*, Bruce Thomas and Associates: Fire Safety and Risk Engineers, Melbourne, pers. comm. to S. Darcy, Email and fax, 5 December
- Thomas, C. 1999, *Female Forms: Experiencing and Understanding Disability*. Open University Press: Buckingham.
- Thomson, R. G. 1997, *Extraordinary Bodies: Figuring Physical Disability in American Culture and Literature*. Columbia University Press: New York.
- Thornton, M. 2000, Neo-Liberalism, Discrimination and the Politics of Resentment. In M. Jones and L. A. B. Marks (Eds.), *Explorations on Law and Disability in Australia*. Federation Press: Leichhardt, NSW. 8-27
- Tiddy, J. 2001a, *It's Just Not Fair: Overcoming Discrimination in Australia*. ABC Books: Sydney.
- Tiddy, J. 2001b, Seeing Ability in Disability, *It's Just Not Fair: Overcoming Discrimination in Australia*. ABC Books: Sydney
- Tisato, P. 1997, Travel Affordability for People with Disabilities. *Urban Policy and Research*, 15(3), 175-187.
- Todd, K. 1999, *The Impact of the Disability Discrimination Act*. 16 March. Australian Bus and Coach Association Conference: Hobart.
- Toowoomba & Golden West Regional Tourist Association. 1999, *Access the Best - Toowoomba*. TGWRTA: Toowoomba.
- Touche Ross. 1993, *Profiting from Opportunities - a New Market for Tourism*. Touche Ross & Co: London.
- Tourism Forecasting Council. 2003, *Forecasts Full Analysis Including External Shocks*. May. Dept. Industry, Tourism and Resources: Canberra.
http://www.industry.gov.au/content/controlfiles/display_details.cfm?ObjectID=80E72BA6-3584-4DAD-B55780EF35713968
- Tourism New South Wales. 2000a, *Disability Action Plan: 1 January 2000 to 31 December 2002*. Tourism New South Wales: Sydney.
- Tourism New South Wales. 2000b, *Visnet Database*. Tourism New South Wales: Sydney.
- Tourism Tasmania. 1997, *Tasmania - Tourism Information for People with Disabilities*. Tourism Tasmania: Hobart.
- Tourism Tasmania. 2001, *Images of People with Disabilities*. Tourism Tasmania: Hobart.
- Tourism Victoria. 2000, *Disability Fast Facts*. Tourism Victoria: Melbourne.
- Turco, D. M., Stumbo, N., and Garnarcz, J. 1998, Tourism Constraints - People with Disabilities. *Parks and Recreation Journal*, 33(9), 78-84.
- Uelmen, J. 1998, G'day Australia. *Quad Wrangle*, Autumn 8.
- Union of Physically Impaired Against Segregation. 1975, *Fundamental Principles of Disability*. Union of Physically Impaired Against Segregation and The Disability Alliance: London.
- United Nations. 1948, *Universal Declaration of Human Rights*. United Nations: Geneva.
www.un.org/Overview/rights.html
- United Nations. 1975, *Declaration on the Rights of Disabled Persons*. United Nations: Geneva.

- www.unhchr.ch/html/menu3/b/72.htm.
- United Nations. 1976, *The International Year of Disabled Persons 1981 (General Assembly Resolution 31/123)*. United Nations: Geneva. www.un.org/esa/socdev/enable/disidydp.htm.
- United Nations. 1993, *Standard Rules on the Equalization of Opportunities for Persons with Disabilities (General Assembly Resolution 48/96)*. United Nations: Geneva.
- United Nations. 1996, *Government Action on Disability Policy: A Global Survey - Industrialized Countries Australia*. United Nations: Geneva.
www.independentliving.org/standardrules/UN_answers/Australia.html.
- United Nations Committee on Transport, C., Tourism and Infrastructure Development. 2000, *Major Issues in Transport, Communication, Transport and Infrastructure Development: Promotion of Barrier-Free Tourism for People with Disabilities in the Asian Pacific Region*. United Nations: Geneva.
www.unescap.org/tctd/water/committee/e5f.htm.
- Upchurch, R. S., and Seo, J. W. 1996, Civic Responsibility and Market Positioning: Complying with the Americans with Disabilities Act. *Facilities*, 14(5/6).
- Uriely, N. 1997, Theories of Modern and Postmodern Tourism. *Annals of Tourism Research*, 24(4), 982-985.
- Urry, J. 1990, *The Tourist Gaze: Leisure and Travel in Contemporary Societies*. Sage: London.
- van Lin, M., Prins, R., and Zwinkels, W. 2001, *The Employment Situation of Disabled Persons in the Eu* (Working Paper). Commissioned by: DG Employment and Social Affairs: © EIM Zoetermeer.
www.eim.nl
- Veal, A. J. 1997, *Research Methods for Leisure and Tourism: A Practical Guide* (2nd edn.). Pitman Publishing: London.
- Veal, A. J. 2002, *Leisure and Tourism Policy and Planning*. CABI Publishing: Wallingford, Oxon, UK.
- Verwegen, J. 1989, The Handicapped Tourism of Leisure (Dutch). *Recreatie en Toerisme*, 21(9), 299-303.
- Vignuda, J.-L. 2001, *Promotion of Barrier-Free Tourism for People with Disabilities in the Asian and Pacific Region*. Economic and Social Commission for Asia and the Pacific (ESCAP): Tokyo.
- Villamanta Publishing. 1997, *Right of Access - a Guide to Developing Action Plans and Improving Access for People with Disabilities*. Villamanta Publishing: Melbourne.
- Vintila, P. 1996, *Transport for People with Disabilities* (0869054740). Institute for Science and Policy, Murdoch University: Perth, WA.
- Virginia Travel Corporation. 1997, *The Virginia Travel Guide for People with Disabilities* (3rd edn.). Opening Door Inc: Virginia.
- Wade, M. G., and Hoover, J. H. 1984, Mental Retardation as a Constraint on Leisure. In M. G. Wade and M. Ellis (Eds.), *Constraints on Leisure*. C.C. Thomas: Springfield, Ill. 83-110
- Walsh, A. 1991, *Nothing Ventured: Disabled People Travel the World*. Harrap Columbus: Kent.
- Walsh, D., and London, J. 1995, *Arts and Disability*. Australia Council for the Arts: Sydney.
- Way, R. 2002, *Contestation in the Disability Sector*. 11 October. Social Relations of Disability Research Network: University of NSW, Sydney. www.srdn.unsw.edu.au
- Wearing, B. 1998, *Leisure and Feminist Theory*. Sage: London.
- Weaver, D., and Opperman, M. 2000, *Tourism Management*. John Wiley and Sons Australia Pty Ltd: Milton Park, Queensland.
- Weiler, B., and Muloin, S. 1989, The Disabled Traveller: An Untapped Market Segment, B. Patching (Eds.), In the proceedings of *National Conference on Leisure for People with a Disability*, Townsville, Queensland, 21-23 September, 19-34.
- Weiler, B., and Muloin, S. 1990, Introducing Specific Populations into Curricula in Tertiary Tourism Education in Australia, Bureau of Tourism Research (Eds.), In the proceedings of *Australian National Tourism and Education Conference*, Canberra,, 101-105.
- Wells, M. 2002, *Response to Request for Information on Tourism Tasmania's Tourism and Disability Initiatives*, Tourism Tasmania, Hobart, pers. comm. to S. Darcy, Letter, 4 March
- Wen, X., and Fortune, N. 1999, *The Definition and Prevalence of Physical Disability in Australia*. Australian Institute of Health and Welfare: Canberra.
- Wendell, S. 1996, *The Rejected Body: Feminist Philosophical Reflections on Disability*. Routledge: New York.
- Western Australian Tourism Commission. 2001, *Western Australia - Search and Plan*. Perth, WATC. Available: www.westernaustralia.net/search_plan/ Last [2001, 1 November].
- Wilhelm, U. 2000, Handicapped People and Holiday Sports - an Opportunity for Social Integration (German). *Rehabilitation*, 39(5), 283-288.
- Wilken, U. 1997, Tourism and Disability - Advances in Travel and Holiday Mainstreaming (German). *Rehabilitation*, 36, 121-125.
- Williams, P., and Fidgeon, P. R. 2000, Addressing Participation Constraint: A Case Study of Potential Skiers. *Tourism Management*, 21(4), 379-393.
- Wilson, J. 1988, *Politics and Leisure*. Unwin Hyman: Boston.
- Wilton, R. D. 1999, *The Social and Spatial Construction of Disability (Community Opposition, Attitudes toward Disability)*. Unpublished Ph.D. Thesis, University of Southern California, Dept. of

- Geography, Los Angeles.
- Winter, I. 2000, *Social Capital and Public Policy in Australia*. Australian Institute of Family Studies: Melbourne.
- Witt, C. A., and Wright, P. L. 1992, Tourist Motivation: Life after Maslow. In P. Johnston and B. Thomas (Eds.), *Choice and Demand in Tourism*. Mansell: London. 33-55
- Wolfensberger, W. 1983, Social Role Valorization: A Proposed New Term for Normalization. *Mental Retardation*, 21(6), 234-239.
- Wolfensberger, W., and Nerje, B. 1972, *The Principle of Normalization in Human Services*. National Institute on Mental Retardation: Toronto.
- Woodside, A. G., and Etzel, M. J. 1980, Impact of Physical and Mental Handicaps on Vacation Travel Behaviour. *Journal of Travel Research*, 18(3), 9-11.
- Woodside, A. G., and Lysonski, S. 1989, A General Model of Traveller Destination Choice. *Journal of Travel Research*, 27(4), 8-14.
- Worcester, B. A. 2000, Day Inns Settles: Helps Simplify ADA. *Hotel & Motel Management*, 215(1), 1,78.
- World Health Organization. 1980, *International Classification of Impairments, Disabilities and Handicaps (Icidh)*. World Health Organization: Geneva.
- World Health Organization. 1997, *International Classification of Impairments, Disabilities and Handicaps (ICIDH)*. World Health Organization: Geneva.
- World Health Organization. 2001, *International Classification of Functioning, Disability and Health (Icidh-2)*. World Health Organization: Geneva.
- World Tourism Organization. 1985, *Tourism Bill of Rights and Tourist Code* (WTO/034 General Assembly Sixth Ordinary Session Held at Sofia (People's Republic of Bulgaria)). 17-26 September 1985. World Tourism Organization: Madrid, Spain.
- World Tourism Organization. 1991, *Creating Tourism Opportunities for Handicapped People in the Nineties* (Resolution A/res/284(IX) of the General Assembly held at Buenos Aires, Argentina). 30 September-4 October 1991. World Tourism Organization: Madrid, Spain.
- Worthington, F. 1993, *Barriers to Recreation Participation in People with Physical Disabilities*. Unpublished Bachelor of Social Science (Honours) Thesis, University of Newcastle, School of Recreation and Tourism, Newcastle, NSW.
- Yeatman, A. 1996, *Getting Real: The Final Report of the Review of the Commonwealth/State Disability Agreement. The Executive Summary*. AGPS: Canberra, A.C.T.
- Yeend, M. 1993, *Travels with My Wheelchair*. Pagemasters Pty Ltd: Richmond, Victoria.
- Young, I. 1990, *Justice and the Politics of Difference*. Princeton University Press: Princeton, New Jersey.
- Zola, I. K. 1989, Toward the Necessary Universalizing of a Disability Policy. *The Milbank Quarterly*, 67(401), 8.

APPENDIX 1: CHAPTER 7 STATISTICAL TABLES

Table A1: Respondent/someone else in household has disability by Travellers/non travellers

n= 78312	Traveller	Trav %	Non traveller	Non Trav %	Total	% of all Travellers
PWD	607	39.2%	943	60.8%	1550.39	9.4%
Non-disabled	5846	44.1%	7415	55.9%	13261.4	90.4%
Refused	16		54		70	0.2%
Total	6469		8412		14881.8	

Table A2: Travel affected by respondent disability or long-term health condition by Travellers/non travellers

n=78312	Traveller	Trav %	Non traveller	Non Trav %	Total	% of all Travellers
PWD	358	36.3%	629	63.7%	987	5.5%
Non-disabled	6095	44.1%	7725	55.9%	13820	94.2%
Refused	16		59			0.2%
Total	6469		8413		14807	

Table A3: Needs assistance when travelling by Travellers/non travellers

N=78312	Traveller	Trav %	Non traveller	Non Trav %	Total
PWD need assist	121	32.1%	256	67.8%	377
PWD no assist	236	38.7%	373	61.2%	609
Non-Disabled	6111	44.0%	7784	56.0%	13895
Total	6468		8413		14881

Table A4: Impairment conditions by traveller/non-traveller

ABS Condition n=2544	Trav '000	Trav %	Non trav '000	Non Trav %	Total '000
A mental illness which requires help or supervision	4	24%	13	76%	17
Sight problems not corrected by glasses or contact lenses	14	25%	43	75%	57
Speech problems	2	29%	5	71%	7
Limited use of arms or fingers, legs or feet	46	30%	107	70%	153
Hearing problems	11	31%	24	69%	35
A restriction on physical activity or physical work	105	35%	198	65%	303
Long term effects as a result of head injury, stroke or other brain damage	15	35%	28	65%	43
Other additional	15	35%	28	65%	43
Treatment or medication for a long term condition or ailment	116	36%	202	64%	318
Arthritis, Asthma, Heart Disease, Alzheimers Disease, Dementia or any other long-term condition	183	36%	328	64%	511
Nerves or emotional conditions	14	37%	24	63%	38
Other	3	38%	5	63%	8
Not applicable	6111	44%	7784	56%	13895

Figure A1: Binary Logistic Regression Model

$$\mu(\text{age})_i + (\text{sex})_j + (\text{disability})_k + (\text{sex} * \text{age})_{ij} + (\text{sex} * \text{disability})_{jk} + (\text{age} * \text{disability})_{ik} + (\text{sex} * \text{age} * \text{disability})_{ijk}$$

where p_{ijk} = is the probability of going on holiday for a disabled person of age i , sex j and disability k .

ABS 1993

Table A5a: Binary Logistic Regression Analysis – Domestic Travel (last 12 months)

Variables	Coding	Frequency	Parameter Coding								
			(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Q6DIS type	Disability1 Paraplegia	307	1.000	.000	.000	.000	.000	.000	.000	.000	.000
	2 Quadraplegia	246	.000	1.000	.000	.000	.000	.000	.000	.000	.000
	3 Spina bifida	82	.000	.000	1.000	.000	.000	.000	.000	.000	.000
	4 Multiple sclerosis	515	.000	.000	.000	1.000	.000	.000	.000	.000	.000
	5 Polio/post polio	130	.000	.000	.000	.000	1.000	.000	.000	.000	.000
	6 Muscular Dis/atrophy	108	.000	.000	.000	.000	.000	1.000	.000	.000	.000
	7 Cerebral palsy	211	.000	.000	.000	.000	.000	.000	1.000	.000	.000
	8 Brain injury/Stroke	58	.000	.000	.000	.000	.000	.000	.000	1.000	.000
	9 Bone related disease	38	.000	.000	.000	.000	.000	.000	.000	.000	1.000
	10 Other	111	.000	.000	.000	.000	.000	.000	.000	.000	.000
LIFESIT situation grouped	Lifel1 home duties	234	1.000	.000	.000						
	2 education FT,PT	193	.000	1.000	.000						
	3 work FT,PT,vol	476	.000	.000	1.000						
	4 Unemp/retired/ pension/other	903	.000	.000	.000						
Q1IND dependence	Travel1 Independent	596	1.000								
	2 With attendant	1210	.000								
MOBWC Wheelchair & Others	1 Wheelchair users	1094	1.000								
	2 Other mobility problems	712	.000								
GEOGR region	Geographic1 Sydney City	1027	1.000								
	2 NSW country, ACT, Other	779	.000								
Q6GEN Gender	1 Female	894	1.000								
	2 Male	912	.000								

		B	S.E.	Wald	df	Sig.	Exp(B)
Step 1	AGE5YR	-.092	.024	14.414	1	.000	.913
	Q6INC	.147	.052	7.879	1	.005	1.158
	Q6EDU	.049	.049	.979	1	.322	1.050
	Q6GEN(1)	.042	.140	.091	1	.763	1.043
	Q1IND(1)	.369	.151	5.952	1	.015	1.447
	MOBWC(1)	-.457	.152	9.014	1	.003	.633
	GEOGR(1)	-.795	.132	36.275	1	.000	.452
	LIFESIT			22.107	3	.000	
	LIFESIT(1)	.401	.204	3.862	1	.049	1.493
	LIFESIT(2)	.935	.300	9.732	1	.002	2.548
	LIFESIT(3)	.743	.188	15.594	1	.000	2.103
	Q6DIS			22.911	9	.006	
	Q6DIS(1)	.088	.284	.096	1	.757	1.092
	Q6DIS(2)	.067	.289	.054	1	.816	1.069
	Q6DIS(3)	.092	.394	.054	1	.816	1.096
	Q6DIS(4)	.171	.254	.452	1	.501	1.186
	Q6DIS(5)	.923	.367	6.315	1	.012	2.517
	Q6DIS(6)	.044	.346	.016	1	.900	1.044
	Q6DIS(7)	.943	.349	7.308	1	.007	2.567
	Q6DIS(8)	-.122	.372	.107	1	.744	.886
	Q6DIS(9)	-.561	.426	1.738	1	.187	.571
	Constant	1.685	.371	20.563	1	.000	5.390

a Variable(s) entered on step 1: AGE5YR, Q6INC, Q6EDU, Q6GEN, Q1IND, MOBWC, GEOGR, LIFESIT, Q6DIS.

Table A5b: PLUM – Ordinal Regression Analysis – No. domestic trips (last 12 months)

Variable	Coding	N	Marginal Percentage
NDOMTR Number of domestic trips recoded	1 1-3 trips	704	62.2%
	2 4-9 trips	318	28.1%
	3 10+ trips	109	9.6%
Q6GEN Gender	1 Female	580	51.3%
	2 Male	551	48.7%
Q1IND Travel dependence	1 Independent	382	33.8%
	2 With attendant	749	66.2%
MOBWC Wheelchair & Others	1 Wheelchair users	651	57.6%
	2 Other mobility problems	480	42.4%
GEOGR Geographic region	1 Sydney City	606	53.6%
	2 NSW country, ACT, Other	525	46.4%
Q6DIS Disability type	1 Paraplegia	173	15.3%
	2 Quadraplegia	139	12.3%
	3 Spina bifida	53	4.7%
	4 Multiple sclerosis	318	28.1%
	5 Polio/post polio	96	8.5%
	6 Muscular Dis/atrophy	72	6.4%
	7 Cerebral palsy	162	14.3%
	8 Brain injury/Stroke	34	3.0%
	9 Bone related disease	21	1.9%
	10 Other	63	5.6%
REASON Reason for domestic trip	1 conference, business	65	5.7%
	2 sport, recreation	38	3.4%
	3 medical, disab, other	93	8.2%
	4 holiday, family, personal	935	82.7%
Valid		1131	100.0%
Missing		864	
Total		1995	

		Estimate	Std. Error	Wald	df	Sig.	95% ConI	
							Lower Bound	Upper Bound
Threshold	[NDOMTR = 1]	.426	.369	1.333	1	.248	-.297	1.148
	[NDOMTR = 2]	2.311	.378	37.335	1	.000	1.570	3.052
Location	AGE5YR	-9.516E-02	.024	15.584	1	.000	-.142	-4.792E-02
	Q6INC	.105	.045	5.345	1	.021	1.594E-02	.194
	Q6EDU	.134	.050	7.203	1	.007	3.608E-02	.231
	[Q6GEN=1]	.105	.137	.583	1	.445	-.164	.373
	[Q6GEN=2]	0	.	.	0	.	.	.
	[Q1IND=1]	9.162E-02	.146	.392	1	.531	-.195	.378
	[Q1IND=2]	0	.	.	0	.	.	.
	[MOBWC=1]	-4.053E-02	.149	.074	1	.786	-.333	.252
	[MOBWC=2]	0	.	.	0	.	.	.
	[GEOGR=1]	-.756	.130	33.996	1	.000	-1.010	-.502
	[GEOGR=2]	0	.	.	0	.	.	.
	[Q6DIS=1]	.370	.322	1.319	1	.251	-.262	1.002
	[Q6DIS=2]	-7.480E-02	.336	.049	1	.824	-.734	.585
	[Q6DIS=3]	-.104	.408	.065	1	.798	-.903	.695
	[Q6DIS=4]	1.038E-02	.297	.001	1	.972	-.572	.593
	[Q6DIS=5]	.163	.352	.214	1	.643	-.528	.854
	[Q6DIS=6]	-1.288E-02	.369	.001	1	.972	-.736	.710
	[Q6DIS=7]	.120	.325	.136	1	.713	-.517	.756
	[Q6DIS=8]	.589	.439	1.797	1	.180	-.272	1.450
	[Q6DIS=9]	-.587	.612	.920	1	.337	-1.786	.612
[Q6DIS=10]	0	.	.	0	.	.	.	
[REASON=1]	1.237	.256	23.401	1	.000	.736	1.738	
[REASON=2]	.907	.321	7.981	1	.005	.278	1.537	
[REASON=3]	3.840E-02	.228	.028	1	.866	-.409	.485	
[REASON=4]	0	.	.	0	.	.	.	

Table A6: Impairment type * Domestic travel in the last year Crosstab & Chi-square

		Domestic travel in the last year		Total	
		No	Yes		
Disability type	Paraplegia	Count	89	302	391
		Expected Count	90.6	300.4	391.0
		% within Disability type	22.8%	77.2%	100.0%
	Quadriplegia	Count	90	243	333
		Expected Count	77.2	255.8	333.0
		% within Disability type	27.0%	73.0%	100.0%
	Spina bifida	Count	28	100	128
		Expected Count	29.7	98.3	128.0
		% within Disability type	21.9%	78.1%	100.0%
	Multiple sclerosis	Count	158	508	666
		Expected Count	154.3	511.7	666.0
		% within Disability type	23.7%	76.3%	100.0%
	Polio/post polio	Count	27	139	166
		Expected Count	38.5	127.5	166.0
		% within Disability type	16.3%	83.7%	100.0%
	Muscular Dis/atrophy	Count	31	113	144
		Expected Count	33.4	110.6	144.0
		% within Disability type	21.5%	78.5%	100.0%
	Cerebral palsy	Count	55	350	405
		Expected Count	93.9	311.1	405.0
		% within Disability type	13.6%	86.4%	100.0%
	Brain injury/Stroke	Count	36	53	89
		Expected Count	20.6	68.4	89.0
		% within Disability type	40.4%	59.6%	100.0%
	Bone related disease	Count	15	35	50
		Expected Count	11.6	38.4	50.0
		% within Disability type	30.0%	70.0%	100.0%
	Other	Count	61	113	174
		Expected Count	40.3	133.7	174.0
		% within Disability type	35.1%	64.9%	100.0%
Total		Count	590	1956	2546
		Expected Count	590.0	1956.0	2546.0
		% within Disability type	23.2%	76.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	58.685	9	.000
Likelihood Ratio	58.446	9	.000
Linear-by-Linear Association	.820	1	.365
N of Valid Cases	2546		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 11.59.

Table A7: Domestic travel in the last year by Gender (Chi-Square Tests)

		Gender		Total		
		Female	Male			
Domestic travel in the last year	No	Count	269	301	570	
		Expected Count	285.0	285.0	570.0	
	% within Domestic travel in the last year		47.2%	52.8%	100.0%	
	% within Gender		21.6%	24.2%	22.9%	
Yes	Count	Count	975	943	1918	
		Expected Count	959.0	959.0	1918.0	
	% within Domestic travel in the last year		50.8%	49.2%	100.0%	
	% within Gender		78.4%	75.8%	77.1%	
Total	Count	Count	1244	1244	2488	
		Expected Count	1244.0	1244.0	2488.0	
	% within Domestic travel in the last year		50.0%	50.0%	100.0%	
	% within Gender		100.0%	100.0%	100.0%	
		Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square		2.330	1		.127	
Continuity Correction		2.187	1		.139	
Likelihood Ratio		2.331	1		.127	
Fisher's Exact Test					.139	.070
Linear-by-Linear Association		2.329	1		.127	
N of Valid Cases		2488				

a Computed only for a 2x2 table

b 0 cells (.0%) have expected count less than 5. The minimum expected count is 285.00.

Table A8: Gender by No. Domestic Trips Independent Samples t-Test

	Gender		N	Mean	Std. Deviation	Std. Error Mean			
	Female	Male							
Number of Domestic trips in the last year	Female	777	3.97	5.15	.18				
	Male	712	4.64	6.79	.25				
	Levene's Test for Equality of Var	t-test for Equality of Means							
	F	Sig.	T	Df	Sig. (2-tailed)	(2-Mean Difference	Std. Error Difference	95% CI Lower Difference	Upper Difference
Number of Domestic trips last yr	11.181	.001	-2.168	1487	.030	-.67	.31	-1.28	-6.42E-02
	Equal var assumed		-2.143	1322.068	.032	-.67	.31	-1.29	-5.69E-02
	not assumed								

As Levene's test for equality of variance was low (Sig. .001), the equal variances not assumed test was used to determine whether this difference in number of trips taken was significant. The 2-tailed significance coefficient was 0.032 and, hence, there was a significant gender based difference for the number of domestic trips taken each year. This was further supported as the confidence interval does not contain a zero.

Table A9: No. Domestic Trips and Age - ANOVA

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
0-24 years	330	4.23	5.60	.31	3.62	4.84	1	53
25-39 years	347	4.55	5.60	.30	3.96	5.14	1	40
40-49 years	301	5.12	8.08	.47	4.20	6.04	1	70
50-59 years	252	4.15	5.67	.36	3.45	4.85	1	50
60 and older	250	3.14	4.01	.25	2.64	3.64	1	52
Total	1480	4.29	6.01	.16	3.98	4.59	1	70

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	564.562	4	141.141	3.942	.003
Within Groups	52811.243	1475	35.804		
Total	53375.805	1479			

Table A10: Multiple Comparisons - Dependent Variable: Number of Domestic trips in the last year - Tamhane Post-hoc

(I) Age Recoded	(J) Age Recoded	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
0-24 years	25-39 years	-.32	.46	.998	-1.53	.89
	40-49 years	-.89	.48	.694	-2.46	.68
	50-59 years	7.95E-02	.50	1.000	-1.25	1.41
	60 and older	1.09	.50	.065	-3.52E-02	2.21
25-39 years	0-24 years	.32	.46	.998	-.89	1.53
	40-49 years	-.57	.47	.973	-2.13	.99
	50-59 years	.40	.50	.994	-.92	1.71
	60 and older	1.40*	.50	.004	.30	2.51
40-49 years	0-24 years	.89	.48	.694	-.68	2.46
	25-39 years	.57	.47	.973	-.99	2.13
	50-59 years	.97	.51	.649	-.68	2.62
	60 and older	1.98*	.51	.002	.48	3.47
50-59 years	0-24 years	-7.95E-02	.50	1.000	-1.41	1.25
	25-39 years	-.40	.50	.994	-1.71	.92
	40-49 years	-.97	.51	.649	-2.62	.68
	60 and older	71.01	.53	.199	-.23	2.24
60 and older	0-24 years	-1.09	.50	.065	-2.21	3.52E-02
	25-39 years	-1.40*	.50	.004	-2.51	-.30
	40-49 years	-1.98*	.51	.002	-3.47	-.48
	50-59 years	-1.01	.53	.199	-2.24	.23

* The mean difference is significant at the .05 level.

Table A11: Main Mobility Aid by Travel Dependence

			Travel dependence		Total
			Independent	With attendant	
Main mobility aid	Wheelchair use	Count	335	1240	1575
		Expected Count	468.4	1106.6	1575.0
		% within Main mobility aid	21.3%	78.7%	100.0%
	Walking frame/sticks	Count	170	287	457
		Expected Count	135.9	321.1	457.0
		% within Main mobility aid	37.2%	62.8%	100.0%
	Braces/belts etc.	Count	50	57	107
		Expected Count	31.8	75.2	107.0
		% within Main mobility aid	46.7%	53.3%	100.0%
	Mobility limitation	Count	207	216	423
		Expected Count	125.8	297.2	423.0
		% within Main mobility aid	48.9%	51.1%	100.0%
Total	Count	762	1800	2562	
	Expected Count	762.0	1800.0	2562.0	
	% within Main mobility aid	29.7%	70.3%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	155.615	3	.000
Likelihood Ratio	151.314	3	.000
Linear-by-Linear Association	146.337	1	.000
N of Valid Cases	2562		

a 0 cells (.0%) have expected count less than 5. The minimum expected count is 31.82.

Table A12: Accommodation (main dest) by travel affected by disability/health condition (Chi-square)

Accomm used at main dest – derived		Travel affected by dis or health condition		Total
		Yes	No	
Hotel, Resort, Motel, Motor Inn	Count	360	7430	7790
	Expected Count	449.7	7340.3	7790.0
	Row %	4.6%	95.4%	100.0%
	Col %	22.6%	28.6%	28.2%
Guest house/B&B	Count	27	502	529
	Expected Count	30.5	498.5	529.0
	Row %	5.1%	94.9%	100.0%
	Col %	1.7%	1.9%	1.9%
Self-catering cottage/apartment	Count	73	1688	1761
	Expected Count	101.7	1659.3	1761.0
	Row %	4.1%	95.9%	100.0%
	Col %	4.6%	6.5%	6.4%
Caravan park or commercial camping ground	Count	87	1818	1905
	Expected Count	110.0	1795.0	1905.0
	Row %	4.6%	95.4%	100.0%
	Col %	5.5%	7.0%	6.9%
Backpacker/hostel	Count	13	131	144
	Expected Count	8.3	135.7	144.0
	Row %	9.0%	91.0%	100.0%
	Col %	.8%	.5%	.5%
University/school dormitory/college	Count	3	113	116
	Expected Count	6.7	109.3	116.0
	Row %	2.6%	97.4%	100.0%
	Col %	.2%	.4%	.4%
Friends or relatives property	Count	828	11441	12269
	Expected Count	708.3	11560.7	12269.0
	Row %	6.7%	93.3%	100.0%
	Col %	52.0%	44.0%	44.5%
Own property (e.g. holiday house)	Count	86	1121	1207
	Expected Count	69.7	1137.3	1207.0
	Row %	7.1%	92.9%	100.0%
	Col %	5.4%	4.3%	4.4%
Privately owned boat/yacht etc	Count	5	86	91
	Expected Count	5.3	85.7	91.0
	Row %	5.5%	94.5%	100.0%
	Col %	.3%	.3%	.3%
Caravan or camping near road/privatep	Count	58	1026	1084
	Expected Count	62.6	1021.4	1084.0
	Row %	5.4%	94.6%	100.0%
	Col %	3.6%	3.9%	3.9%
Cruise ship/commercial houseboat	Count	3	76	79
	Expected Count	4.6	74.4	79.0
	Row %	3.8%	96.2%	100.0%
	Col %	.2%	.3%	.3%
Slept in bus/coach/train/plane	Count	2	46	48
	Expected Count	2.8	45.2	48.0
	Row %	4.2%	95.8%	100.0%
	Col %	.1%	.2%	.2%
Other non-commercial property	Count	15	184	199
	Expected Count	11.5	187.5	199.0
	Row %	7.5%	92.5%	100.0%
	Col %	.9%	.7%	.7%
Hospital or hospital related accommodation	Count	21	81	102
	Expected Count	5.9	96.1	102.0
	Row %	20.6%	79.4%	100.0%
	Col %	1.3%	.3%	.4%
Other	Count	11	209	220
	Expected Count	12.7	207.3	220.0
	Row %	5.0%	95.0%	100.0%
	Col %	.7%	.8%	.8%
Accommodation not asked	Count	1	47	48
	Expected Count	2.8	45.2	48.0
	Row %	2.1%	97.9%	100.0%
	Col %	.1%	.2%	.2%
Total	Count	1593	25999	27592
	Expected Count	1593.0	25999.0	27592.0
	Row %	5.8%	94.2%	100.0%
	Col %	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	108.494	15	.000
Likelihood Ratio	94.855	15	.000
Linear-by-Linear Association	2.057	1	.151
N of Valid Cases	27592		

a 3 cells (9.4%) have expected count less than 5. The minimum expected count is 2.77.

Table A13: Accommodation Choice by Mobility Aid (Chi-square)

Accommodation Recoded		Wheelchair User	Others	Total
Hot/motel 4-5 star	Count	249	120	369
	Expected Count	215.8	153.2	369.0
	Row %	67.5%	32.5%	100.0%
	Col %	21.5%	14.6%	18.6%
Hot/motel 2-3 star	Count	218	130	348
	Expected Count	203.5	144.5	348.0
	Row %	62.6%	37.4%	100.0%
	Col %	18.8%	15.8%	17.6%
Priv hotel/gst.hse	Count	33	32	65
	Expected Count	38.0	27.0	65.0
	Row %	50.8%	49.2%	100.0%
	Col %	2.8%	3.9%	3.3%
Rented house/flat	Count	84	45	129
	Expected Count	75.4	53.6	129.0
	Row %	65.1%	34.9%	100.0%
	Col %	7.2%	5.5%	6.5%
Own hol/house/flat	Count	29	17	46
	Expected Count	26.9	19.1	46.0
	Row %	63.0%	37.0%	100.0%
	Col %	2.5%	2.1%	2.3%
Friends/rels house/flat	Count	327	345	672
	Expected Count	393.0	279.0	672.0
	Row %	48.7%	51.3%	100.0%
	Col %	28.2%	41.9%	33.9%
Farm	Count	19	10	29
	Expected Count	17.0	12.0	29.0
	Row %	65.5%	34.5%	100.0%
	Col %	1.6%	1.2%	1.5%
Cpark/Camping	Count	74	68	142
	Expected Count	83.0	59.0	142.0
	Row %	52.1%	47.9%	100.0%
	Col %	6.4%	8.3%	7.2%
Boat/cabin cruiser	Count	3	4	7
	Expected Count	4.1	2.9	7.0
	Row %	42.9%	57.1%	100.0%
	Col %	.3%	.5%	.4%
Hostel/ b.packer/YHA	Count	8	11	19
	Expected Count	11.1	7.9	19.0
	Row %	42.1%	57.9%	100.0%
	Col %	.7%	1.3%	1.0%
Other	Count	115	41	156
	Expected Count	91.2	64.8	156.0
	Row %	73.7%	26.3%	100.0%
	Col %	9.9%	5.0%	7.9%
Total	Count	1159	823	1982
	Expected Count	1159.0	823.0	1982.0
	Row %	58.5%	41.5%	100.0%
	Col %	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	66.485	10	.000
Likelihood Ratio	67.232	10	.000
Linear-by-Linear Association	1.894	1	.169
N of Valid Cases	1982		

a 2 cells (9.1%) have expected count less than 5. The minimum expected count is 2.91.

Table A14: Transport used to arrive at main destination - derived * Travel affected by disability Crosstabulation

		Travel affected by disability or long term health condition		Total
		Yes	No	
Transport used to arrive at main destination - derived	Count	132	3819	3951
	Expected Count	228.4	3722.6	3951.0
	Row %	3.3%	96.7%	100.0%
	Col %	8.3%	14.7%	14.3%
All water	Count	7	167	174
	Expected Count	10.1	163.9	174.0
	Row %	4.0%	96.0%	100.0%
	Col %	.4%	.6%	.6%
Railway	Count	108	771	879
	Expected Count	50.8	828.2	879.0
	Row %	12.3%	87.7%	100.0%
	Col %	6.8%	3.0%	3.2%
Bus/coach	Count	94	936	1030
	Expected Count	59.5	970.5	1030.0
	Row %	9.1%	90.9%	100.0%
	Col %	5.9%	3.6%	3.7%
Private veh	Count	1233	19924	21157
	Expected Count	1222.8	19934.2	21157.0
	Row %	5.8%	94.2%	100.0%
	Col %	77.4%	76.8%	76.8%
Rented/hire vehicle	Count	9	214	223
	Expected Count	12.9	210.1	223.0
	Row %	4.0%	96.0%	100.0%
	Col %	.6%	.8%	.8%
Comb of air and long road	Count	3	59	62
	Expected Count	3.6	58.4	62.0
	Row %	4.8%	95.2%	100.0%
	Col %	.2%	.2%	.2%
Other	Count	6	62	68
	Expected Count	3.9	64.1	68.0
	Row %	8.8%	91.2%	100.0%
	Col %	.4%	.2%	.2%
Total	Count	1592	25952	27544
	Expected Count	1592.0	25952.0	27544.0
	Row %	5.8%	94.2%	100.0%
	Col %	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	136.254	7	.000
Likelihood Ratio	124.899	7	.000
Linear-by-Linear Association	10.332	1	.001
N of Valid Cases	27544		

a 2 cells (12.5%) have expected count less than 5. The minimum expected count is 3.58.

Table A15: Transport Recoded * Mobility Impairments Crosstabulation

		Wheelchair & Others		Total	
Transport Recoded		Wheelchair users	Other mobility problems		
Transport Recoded	Plane	Count	199	119	318
		Expected Count	186.2	131.8	318.0
		Row %	62.6%	37.4%	100.0%
		Col %	17.0%	14.4%	15.9%
	Bus/coach	Count	30	51	81
		Expected Count	47.4	33.6	81.0
		Row %	37.0%	63.0%	100.0%
		Col %	2.6%	6.2%	4.1%
	Private veh/mod	Count	835	579	1414
		Expected Count	828.1	585.9	1414.0
		Row %	59.1%	40.9%	100.0%
		Col %	71.4%	70.0%	70.8%
	Hired veh/mod	Count	9	6	15
		Expected Count	8.8	6.2	15.0
		Row %	60.0%	40.0%	100.0%
		Col %	.8%	.7%	.8%
	Train	Count	40	62	102
		Expected Count	59.7	42.3	102.0
		Row %	39.2%	60.8%	100.0%
	Col %	3.4%	7.5%	5.1%	
Ship/boat ferry	Count	4	2	6	
	Expected Count	3.5	2.5	6.0	
	Row %	66.7%	33.3%	100.0%	
	Col %	.3%	.2%	.3%	
Taxi/mod	Count	11	0	11	
	Expected Count	6.4	4.6	11.0	
	Row %	100.0%	.0%	100.0%	
	Col %	.9%	.0%	.6%	
Community	Count	26	5	31	
	Expected Count	18.2	12.8	31.0	
	Row %	83.9%	16.1%	100.0%	
	Col %	2.2%	.6%	1.6%	
Other	Count	15	3	18	
	Expected Count	10.5	7.5	18.0	
	Row %	83.3%	16.7%	100.0%	
	Col %	1.3%	.4%	.9%	
Total	Count	1169	827	1996	
	Expected Count	1169.0	827.0	1996.0	
	Row %	58.6%	41.4%	100.0%	
	Col %	100.0%	100.0%	100.0%	

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	54.146	8	.000
Likelihood Ratio	59.198	8	.000
Linear-by-Linear Association	.751	1	.386
N of Valid Cases	1996		

a 3 cells (16.7%) have expected count less than 5. The minimum expected count is 2.49.

APPENDIX 2: ANXIETY TO ACCESS METHODOLOGY

The population for the study was all people with physical impairments in Australia. The study drew its sample from those people with physical impairments who were members of organisations representing people with physical impairments. The method used was a questionnaire-based, self completed, postal survey of all members of organisations representing people with a physical impairments in NSW. This was felt to be the only viable method to reach a cross section of the population of people with physical impairments in sufficient numbers. NSW was chosen as the focus because it is the most populous state in Australia and Tourism NSW funded the project.

No census list of NSW people with a physical impairment was available other than through the organisational mailing lists. The study was carried out with the co-operation of the key organisations representing people with physical impairments. Confidentiality and anonymity were assured as the organisations were responsible for all the postal administration, with the cover letter explaining that the questionnaire was self completed and voluntary. Privacy of individuals was protected by the member organisations controlling all aspects of the postal survey and hence, their members' confidential information. No link could be drawn between the mailing list and the returned questionnaires. The University of Technology, Sydney Ethics Committee, approved the study.

The sample frame utilised the 7 major physical impairment based groups and the one cross disability group based in NSW. Table A16 presents the organisations, their respective database size and the number of people identified as having disabilities on these databases:

Table A16: Sampling Frame

Organisation	Database	PWD
AQA	3000	1100
ParaQuad	6500	3300
MS Society	3000	1500
The Spastic Centre	4000	1500
Muscular Dystrophy	700	300
NSW Society	580	400
PWD (NSW)	300	300
Polio/Post Polio	700	300
TOTAL	18780	8700

Employing total population sampling of membership of the organisations ensured representativeness by providing all members of the sample frame with an equal chance of inclusion in the sample. However, this method does not provide all people with physical impairments with an equal chance of being included. This is because all people with physical impairments might not be members of the key organisations representing people with physical impairments and does not include like members in other states. Secondly, the respondents to a postal survey are not randomly selected but self selected e.g., some choose to answer, others do not. Hence, this introduces bias with little that can be done except to employ mechanisms to encourage a high response rate. In the case of this research four mechanisms were used to illicit a higher response rate (de Vaus 1991; Veal 1997):

- A detail cover letter outlining the research background, aims and outcomes;
- A reply paid envelope was included with the questionnaire;
- The budget included a contingency for two reminder notices (only one was required except for ParaQuad); and
- An incentive for a chance to win a prize related to the purpose of the questionnaire (\$500 worth of Tourism NSW travel services).

The other factor affecting response rate is the respondent's interest in the survey topic. Given that access affected each of the respondent's daily life the respondent's interest could thought to be high. The researcher also received many comments during the questionnaire development phase about the need for the survey and it was long overdue (See Appendix # for other aspects of the sample).

Discussions with key organisations and individuals were held during the development of the questionnaire and to obtain access to organisational mailing lists. The initial proposal suggested a questionnaire instrument of no more than five pages. However, after the initial literature review and liaison with organisations and

individuals, it was recognised that the study would be a first in Australia and internationally. Given that there was no other substantial baseline data, the questionnaire content was substantially expanded through replication of the major components of the BTR *Domestic Tourism Monitor* and *Day Trip Monitor*, and the ABS *Short Term Departures*. These were supplemented with impairment specific inclusions based on an understanding of the ACROD (1992), ABS (1993), Cameron (1995) and extensive liaison with people with disabilities, organisations representing people with disabilities, service organisations and relevant government departments. The questionnaire was sent for discussion to more than 30 organisations and individuals over a three-month period during the different stages of preparation. A final pilot questionnaire was sent back to these organisations and individuals. The questionnaire was piloted through 10 people with disabilities known to the researcher. Comments from the groups involved in the liaison and through the experience gained in piloting the questionnaire were incorporated into the final questionnaire. The final questionnaire instrument was a substantially changed instrument to the original drafts. In addition to organisations representing people with a physical disability involved in the development of the questionnaire, the following were also involved throughout the process.

- ACROD;
- Australian Local Government Association;
- IDEAS - Information on Disabilities, Equipment, Access and Services;
- NSW Local Government and Shires Association;
- NICAN (National Information Communication and Awareness Network for arts, sport, recreation and tourism);
- Sydney City Council; and
- Sydney Paralympic Organising Committee.

Each organisation was able to target only those members with a physical impairment. The questionnaire was sent to 8700 people between May and October 1995. More than 2600 questionnaires were returned completed and a further 500 were either returned uncompleted or phone calls were received (change in circumstance or inappropriate to their circumstance etc.). This represented a return rate of 32% for completed questionnaires excluding the questionnaires returned uncompleted or the phone calls received (de Vaus 1991). However, this does not take account cross organisation membership that was estimated at between 500 - 1000 members of all organisations. This was largely because ParaQuad administer the Continence Aids Assistance Scheme (CAAS) in NSW which is Commonwealth Dept. of Family and Community Services program for people with disabilities with continence conditions.

There were a number of limitations to the study:

- People with a physical disability who are not members of organisations representing people with a physical disability;
- NSW people with a physical disability who were not present in NSW during the survey period;
- People with a newly acquired physical disability;
- People with a physical disability who do not speak or read the English language;
- People with a physical disability who are unable to write;
- People with other communication or multiple disabilities; and
- Other unrecognised limitations.

While these limitations are noted, the study more than adequately addressed the sampling problems for the majority of the specified population. A number of these limitations were overcome through the provision of a phone questionnaire answer service. Information about this service was provided in the cover letter accompanying the questionnaire (Appendix #).

The thorough methodology for the development of the questionnaire instrument ensured that it was both valid and reliable. Firstly, the tourism content of the instrument replicated the provisions of the relevant BTR and ABS surveys, both of which are highly regarded instruments. The disability content had no reference point as this had not been attempted anywhere else in the world. However, it drew on the best available expertise available in Australia through disability advocacy organisations, disability service organisations, relevant government bodies and most importantly the personal experiences of people with disabilities in drafting the instrument. The reliability of the data has been widely acknowledged by the disability community, government and the industry. The published report was widely distributed through 1500 hard copies prior to the report being made available for download from the Tourism NSW website. Some 4,000 copies have been downloaded to date. The validity and reliability of the research has also been verified through its citing in academic, disability, government and industry publications

The questionnaire instrument used filter questions to exclude those people without physical impairments or

those completing the questionnaire on their behalf (e.g. attendants, carers and family members). A summary of the key data items is provided in Table A17.

Table A17: Key data items for *Anxiety to Access*

Frequency	One-off	
Description	Postal based survey of people with impairments who were members of the 8 major disability organisations. It is the primary source of information on the characteristics and travel patterns of people with physical impairments The survey collected information on: <ul style="list-style-type: none"> • Domestic trips • Day trips • Overseas trips • Travel needs, constraints and barriers • Demographic details 	
Key data items	Characteristics of travellers and non-travellers:	<ul style="list-style-type: none"> • Age • Gender • Lifestyle situation • Respondent income • Place of residence • Impairment type • Independence level • Mobility aid used
	Travel behaviour for overnight trips	<ul style="list-style-type: none"> • No. of trips • Last destination visited • Nights away • Reasons for trip • Accommodation used • Accessible accommodation/Info about • Transport used to arrive at destinations • Transport used at destinations • Activities undertaken at destinations • Seasonality of visit • Travel party description/size/others with disability
	Travel behaviour for day trips	<ul style="list-style-type: none"> • No. of trips • Transport used • Activities undertaken at destination • Travel party description/size/others with disability
	Travel behaviour for overseas trips	<ul style="list-style-type: none"> • No. of trips • Destination country visited • Reasons for trip • Duration of visit • Seasonality of visit
	Needs, constraints and barriers	<ul style="list-style-type: none"> • Travel needs • Information sources/formats/needs • Overall satisfaction with level of travel • Constraints • Barriers encountered • Suggestions for improvement
Source	Darcy 1998 http://www.tourism.nsw.gov.au/corporate/information/3060.asp	

APPENDIX 3: NATIONAL VISITOR SURVEY

The disability module contains nine questions about a person's health condition or impairment or those living with the person in their household (BTR 1998). The opening question of the module specifically asks,

G1. Do you have any long term health conditions or impairment which means you need to make special travel plans, or have special facilities when you travel, or which otherwise limits your ability to travel? DO NOT INCLUDE TEMPORARY CONDITIONS SUCH AS A BROKEN LEG

If answering 'Yes' to this question, the conditions identified in Table A18 are read out to the person.

Table A18: G2 Modified ABS disability module

ABS Condition	
• Sight problems not corrected by glasses or contact lenses	• Long term effects as a result of head injury, stroke or other brain damage
• Hearing problems	• Treatment or medication for a long term condition or ailment
• Speech problems	• Arthritis, Asthma, Heart Disease, Alzheimers Disease, Dementia or any other long-term condition
• Limited use of arms or fingers, legs or feet	• If one so far, any other additional restriction or difficulty?
• Nerves or emotional conditions	• If none so far, any other restriction or difficulty? Specify
• A restriction on physical activity or physical work	• Not applicable
• A mental illness which requires help or supervision	

Source: BTR 1998

No explanatory notes were provided for the person beyond the reading of the conditions by the person. It was then up to the person to correctly identify the condition. This is problematic given a person who may not understand the definition of impairment, disability and/or what constitutes a core activity restriction as used in determining disability for the ABS (1998). This may have led to over identification of disability. Secondly, while the question was listed as multi response in nature this module does not take into account *multiple disabilities*. For example, a person who has multiple sclerosis could identify of the 10 first conditions on the list depending on the affect that multiple sclerosis currently has on the embodiment.

This biased the data collection reporting. This question was followed by,

G3 Does this (condition/restriction) mean you need help from another person or a technical aid (such as a wheelchair, nebulizer, hearing aid) in your everyday activities?

The yes/no response provides a comparison to the ABS core activity restriction category. The next question sought to identify what the likely impacts of these levels of assistance would mean in a tourism context. It used the term 'special arrangements' and included,

G4 What sort of special arrangements do you need to make when you travel? PROBE FOR SPECIAL TRAVEL PLANS, SPECIAL FACILITIES REQUIRED. IF THEY SAY THEY CAN'T TRAVEL PROBE what kind of arrangements or assistance might make it possible to travel? MULTI RESPONSE

- 1.Nebulizer/ventilator/other equipment or medication needs to be taken on a trip
- 2.Comfortable seating/difficulty sitting for long periods
- 3.Wheelchair access or other ease of access to allow for walking frames, walking sticks, difficulty with stairs
- 4.Support/assistance of other person required/need to travel with other persons (PROBE TO SEE IF OTHER CATEGORIES ALSO APPROPRIATE)
- 5.Special dietary arrangements
- 6.Opportunity to stop frequently/easy access to toilets
- 7.Do not know - nothing in particular
- 8.Unable/unwilling to travel, and no arrangements or assistance would make travel possible
- 9.Other (SPECIFY) _____

The fifth question in the module (G5) checked the number of people in the household. If it was greater than one then G1-G4 were repeated for G6-G9 based on whether there was another member of the household with a health condition or impairment.

G6. Does anyone in your household have any long term health conditions or impairment, which affects your ability to travel? DO NOT INCLUDE TEMPORARY CONDITIONS SUCH AS A BROKEN LEG

This question compounds the validity issues of G1 by asking the person to make a judgment as to whether another member of their household has a long term health condition or impairment. This is because the person may have no understanding of health condition or impairment and the module provides no explanatory notes. Therefore, a judgment could be made based on a flawed assumption as to what constitutes disability. For this reason only the person questions G1-G4 are used in this research. Table A19 presents the key data items for the NVS.

Another methodological issue to consider is the recall period for day trips (last 7 days) and overnight domestic trips (last month). This was a considerably shorter recall period than for the ABS (1993) and Darcy (1998). These shorter recall periods may provide an overall lower estimation of travel by people with disabilities. However, for purposes of comparison between people with disabilities and the non-disabled this is not of a concern. It is with this understanding that this data were used to present comparative rates of travel between people with disabilities and the non-disabled, and to provide further profiling of the group.

Table A19: Key data items for *National Visitor Survey*

Frequency	Ongoing Results reported quarterly and annually	
Description	Household, origin-based survey of domestic travel, that is, travel by Australian residents aged 15 years and over. It is the major source of information on the characteristics and travel patterns of domestic tourists The survey collects information on: <ul style="list-style-type: none"> • Overnight visitors • Visitor nights • Expenditure by overnight visitors • Day visitors • Expenditure by day visitors • Outbound (international) visitors • Outbound visitor nights 	
Key data items	Characteristics of travellers and non-travellers:	<ul style="list-style-type: none"> • Age and sex • Lifecycle group • Country of birth and years in Australia • Employment status • Annual household income • Place of residence • Information on physical impairments and the effect of these on travel
	Travel behaviour for overnight visitors	<ul style="list-style-type: none"> • Destinations visited (region and state level) • Reasons for visiting each destination • Accommodation used • Transport used to arrive at destinations • Activities undertaken at destinations • Duration of visit • Seasonality of visit • Travel party description and size • Itemised trip expenditure
	Travel behaviour for day visitors	<ul style="list-style-type: none"> • Destinations visited (region and state level) • Reasons for visiting each destination • Transport used • Activities undertaken at destination • Seasonality of visit • Travel party description and size • Itemised trip expenditure
	Travel behaviour for outbound visitors	<ul style="list-style-type: none"> • Destination countries visited • Reasons for visiting each destination country • Duration of visit • Seasonality of visit • Port of departure and airline used • Itemised trip expenditure
	Market shares	<ul style="list-style-type: none"> • Share of visitors by State/Territory received • Share of visitor nights by State/Territory received • Share of interstate visitors/visitor nights by State/Territory received • Share of holiday/leisure visitors/visitor nights by State/Territory received • Accommodation/transport shares
Source	BTR http://www.btr.gov.au/statistics/sos/sos_nvs.html	

APPENDIX 4: PEOPLE WITH DISABILITIES UNSCHEDULED INTERVIEW CHECKLIST

TOURISM PATTERNS and EXPERIENCES OF PEOPLE WITH DISABILITIES

Hello,

My name is Simon Darcy and I am a Ph.D. student in the School of Leisure, Sport & Tourism, UTS. As part of ongoing research into the tourism patterns and experiences of people with physical disabilities, I would like to interview people with disabilities about their tourism experiences or reasons for non-travel.

The interview is taped and transcribed. All information collected is confidential and any published information will not use anyone's names. The information will not only contribute towards the Ph.D. but is used to actively seek to improve tourism for people with disabilities. If you like I can provide copies of the transcription when completed and any completed publications that use the interviews.

Yes/No

If yes, obtain address or email details.

REASONS/MOTIVATIONS

- Want do tourism/holidays/trips away mean to you?
- Tell me something about your previous tourism experiences...
- What is the best tourism experience you have had?
- Motivations: What are your main reasons for traveling?
- **Probe, what are your motivations for taking a holiday?**
- Probe, what are the benefits/outcomes received from traveling?

GENERAL TRAVEL PATTERNS

- As a person with a disability do you regard yourself as an experienced traveler?
If yes, probe for details about frequency, duration, domestic/overseas, short break/long trip etc.
If no, why not? Probe, meaning of regular, reasons for not traveling etc.
- How you develop these patterns?

OVERSEAS TRAVEL

- For overseas travellers, what were your reasons for the choice of destination? Were the expectations met for the reasons for choice of the destination? Why/why not? From your experiences, what are the things that the overseas destinations do well and that the Australian providers can learn from? What can overseas destinations learn from the Australian situation?
- What are the essential planning differences between domestic and overseas travel? Elaborate.

ACCOMMODATION

- What do you regard as being accessible accommodation for your needs? Probe, detail specific accessibility needs. How well are these needs met by the Tourism industry? What are the strengths/weaknesses?
- What was the main type/class of accommodation used? Probe, why do you choose this type of accommodation? Are there constraints to the types of accommodation you choose? Why? Probe, provide examples.
- Do you find the information supplied about the accessibility of the accommodation accurate? If yes, what sources do you use? If no, what are the major problems encountered?

TRANSPORT

- What are the main modes of transport used to reach the destination on domestic/overseas/day trip? Why did you use these?
- What are the access considerations in using this type of transport? Specifics, probe and get detail.
- Once at the main destination what types of transport did you use to explore the area? What are the strengths/weaknesses of these forms of transport?
- Can you give examples of success stories or difficulties with mobility at destination areas?

GROUP DYNAMICS

- Who do you normally travel with? Age/gender breakdown. Does this create any issues surrounding your disability and travel?
- Do you require an attendant/attendant services when you travel? If yes, how does this simplify/complicate travel?
- Do you travel with other people with disabilities? Does this simplify/complicate travel plans? Why? Types of disability?

TRAVEL REQUIREMENTS & OTHER INFORMATION

- When you undertake travel away from home (in Australia or Overseas) what are your disability specific travel needs
- What do you regard as the major constraints to travel? By constraints I refer to pre travel perceptions of likely problems. See below for a guide
- What do you regard as the major barriers to travel? By barriers I refer to any problems encountered whilst traveling. See below for a guide

COSTS

- Attendants: travel
- Equipment: commode/shower check, hoist/patient lifter
- Higher charges for accommodation
- Transport: Special purpose taxis, hire cars with hand controls, accessible vans

RECREATIONAL TRAVEL ACTIVITIES

- Main purpose of your holidays
- Activities engaged in
- Activities desired
- Activities unable to be engaged in

INFORMATION

- What are the main ways you obtain information about accommodation & attractions? Are these adequate? Have you had specific problems obtaining information? What makes good access related information?
- In what formats would you prefer access information about tourism related facilities and services? Brochures (i.e. on individual establishments); Directories (i.e. NRMA); Electronic directories (i.e. NICAN); Guide Books for areas (i.e. Holidaying in Coffs Harbour); Phone services (with specialist knowledge of disability needs); Others...
- Does the internet have the potential to be a good info source for people with disabilities?
- What other information is required to better meet the travel planning needs of people with a physical disability?

BOOKINGS

- Do or have you used a Travel Agent?
- What have your experiences being with travel agents?
- Have you been satisfied with the services they have provided? If yes or no, probe as to why.

TOURISM INDUSTRY

- Issues that need to be addressed when catering for PWD in the tourism industry?
- Attitude of the Tourism Industry toward PWD
- Any changes?
- Comments about how the tourism industry approaches people with disabilities?

GOVERNMENT

- Main contribution the government could do to help PWD in tourism?
- Legislation
- Funding
- Programs
- Information
- Action plans

PEOPLE WITH DISABILITIES/ORGANIZATIONS REPRESENTING THEM

- Are there things people with disabilities/organisations could be doing to contribute to improving current provision? If yes, probe, seek examples etc.

Are there any further comments you would like to make about your travel, holiday or day trip experiences, or the interview.

That completes the interview. Thankyou for your time and cooperation! Further comments or inquiries can be directed to Simon Darcy on Ph: (02) 9514-5100 Fax: (02) 9514-5195 Email: simon.darcy@uts.edu.au

☺ THANKYOU ☺

APPENDIX 5: ACCOMMODATION SECTOR INTERVIEW AND FOCUS GROUP CHECKLIST

INTRODUCTION

This paper has been prepared to identify some issues to be discussed by participants of the accommodation provision and people with disabilities seminar.

ISSUES

1. Responsibilities
 - What do organisations regard as their responsibilities to customers generally?
 - What do organisations regard as their responsibilities to customers with disabilities?
 - Is there a difference?
 - If so, what is that difference?
 - Recognition of legislation/policy?
2. People with disabilities -
 - What are the needs, wants and desires of people with disabilities?
 - Why would people with disabilities stay at your establishment?
 - Transport/parking/amenities etc.
3. Promotion and Distribution
 - How do organisations promote and distribute information to people with disabilities?
4. Product/Experience - All Encompassing
 - What do organisations perceive as the product tourists with disabilities were purchasing?
 - Components?
5. Staff Experiences/Training
 - What training/information are staff provided with about people with disabilities?
 - Is there a need for specific training for understanding the customer requirements of people with disabilities? If yes, what in particular?
6. Rooms
 - Perceptions of attitude of general public towards the use of accessible rooms
 - Location and vista
 - Price differentiation
 - Occupancy - accessible vs. other rooms
7. The Market
 - Who
 - Size
 - Where

Simon Darcy
School of Leisure and Tourism Studies
Faculty of Business
University of Technology, Sydney
Tel: 61 2 9514-5100; fax: 61 2 9514-5195; email: Simon.Darcy@uts.edu.au

**This research seminar is made possible by a research grant from the Ageing and Disability
Dept. of New South Wales**

APPENDIX 6: TOURISM AUTHORITY CHECKLIST

1. Organisation Responsibilities

- What do organisations regard as their responsibilities to customers generally?
- What do organisations regard as their responsibilities to customers with disabilities?
- Is there a difference? If so, what is that difference?
- Which section/sections of the authority are responsible for disability issues and services?
- What do you believe is the organizational priority of providing tourism services for this group in comparison to other market segments?
- Recognition of legislation/policy?
- Disability action plans?
- What training/information are staff provided with about people with disabilities?
- Does the organisation have specific employment opportunities for people with disabilities?

2. People with disabilities

- What are the needs, wants and desires of people with disabilities?
- Why would people with disabilities stay in your state?
- Services – generic and specific
- What do organisations perceive as the product tourists with disabilities were purchasing?
- Components?

3. Promotion and Distribution

- How do organisations promote and distribute information to people with disabilities?
- Generic and specific

4. Tourism industry perceptions

- Is there a recognition by industry that people with disabilities are a legitimate market segment? Why, why not?
- In discussions with the industry what are the major issues that they cite in servicing this group?
- Which sectors are servicing this group well/neglecting this group?
- Do you know industry associations who have been active in assisting operators to understand this market? If so, who are they and what are they doing?
- Opportunities to cooperatively market accessible tourism product?
- Are there differences between metropolitan/regional areas?
- Are there opportunities for specific industry training/information that needs to be provided or isn't currently being provided?

APPENDIX 7: ACCESS STANDARD'S STAKEHOLDERS AND ISSUES UNDER CONSIDERATION

Stakeholder	Perspective
BAPC	
People with disabilities?	Officially represented by the DDA Standards project
Attorney-General's Department;	Government's legal Dept. – open to pluralist influences
ABCB;	The regulator
Australian Construction Industry Forum;	Construction industry
Australian Procurement and Construction Council	Construction industry
Australian Local Government Association;	Local government authorities
DDA Standards Project;	Disability sector
Department of Industry, Tourism and Resources;	Business, small business and tourism
HREOC	Human rights
Property Council of Australia	Property owners and managers
The design professions.	Architects and other allied professionals

Issues Under Consideration

Following is a brief list of some of the issues being considered by the BAPC in relation to the DDA Standard on Access to Premises:

- Types of buildings to be accessible and extent of access within those buildings including:
 - Access to guest houses, hostels, bed and breakfast accommodation or the like (Class 1b Buildings);
 - Access to common areas within residential flat buildings (Class 2 Buildings);
 - Number of accessible units in hotels/motels (Class 3 Buildings);
 - Access to common areas within hotels/motels (Class 3 Buildings);
 - Access to and within offices, shops, restaurants, factories, warehouses, carparks, schools, theatres and places of public assembly; and
- Review of parts of buildings that are currently not required to be accessible;
- The number and location of entrances that must be accessible;
- Handrail type and location;
- Way finding information in buildings, e.g Braille and tactile signs;
- Emergency warning systems;
- Emergency egress provisions;
- Extent and location of hearing augmentation systems;
- Number, location and layout of accessible sanitary facilities;
- Access to swimming pools;
- Number, location and size of accessible carparking spaces;
- The extent and location of tactile ground surface indicators;
- Vertical access within buildings; lift and lifting devices, ramps and stairways

The BAPC has recognised that the dimensions of wheelchairs and scooters are an integral factor in determining the requirements for access to premises. Accordingly, a research project is currently being undertaken to determine the 90th percentile wheelchair and scooter envelope. This research provides information for the discussion by the BAPC of circulation spaces required by people who use wheelchairs and scooters within buildings.

APPENDIX 8: COMPARATIVE DISABILITY RATES

The table was compiled as part of the Ph.D from the sources denoted below.

Country	Year of Survey	Population (Million)	Percent of Population	People with Disabilities (Million)
Australia *	1998	18.6	19.6	3.6
New Zealand *	1996	3.6	19.1	0.7
Canada *	1991	30.6	15.5	4.7
China **	1987	1265.5	4.9	62.0
Pakistan **	1984/85	135.1	4.9	6.6
India **	1991a	983.3	4.8	47.2
Thailand **	Unknown	60.0	0.8	0.5
Sri Lanka **	Unknown	18.9	0.4	0.1
Peru **	Unknown	26.1	0.2	0.1
USA	2000	270.3	19.5	52.7
Japan		125.9		
European ***				
Austria	1995	8.1	12.5	1.0
Belgium	1997	10.2	12.9	1.3
Denmark	1995	5.3	17.4	0.9
Germany	1998	82.0	17.3	14.2
Greece	1991	10.6	8.2	0.9
Spain	1999	39.1	9.9	3.9
France	1999	58.8	15.3	9.0
Finland	2000	5.1	22.9	1.2
Ireland	None Avail	3.6	10.9	0.4
Italy	1994	56.8	7.8	4.4
Luxembourg	Exp Est.	0.4	16.5	0.1
Netherlands	1999	15.7	18.6	2.9
Portugal	None Avail	9.9	18.4	1.8
Sweden	1999	8.9	17.1	1.5
UK	2000	57.7	18.8	10.8
Total				232.6

* denotes definition by activity limitation Takamine (2001); ** denotes definition by impairment (van Lin, Prins and Zwinkels 2001); *** based on European Community Household Panel estimates (van Lin et al. 2001)

Sources: Takamine (2001), van Lin et al. (2001), Pfeffer (2002) and Chamie (1995) cited in Wen and Fortune (1999:12). Population estimates from <http://www.census.gov/ipc/www/wp98.html>

APPENDIX 9: THE FOUNDATIONS OF THE BUILT ENVIRONMENT

This appendix outlines what people with disabilities identified in the in-depth interviews and HREOC complaint cases as the foundations of access for the built environment. This involved a continuous accessible path of travel, parking and toilets. As L. Davis (1999) suggests, the non-disabled reading of these inclusions may be regarded as trivial but to people with disabilities, these are essential to any experience. The provisions identified for each of these from the research are now discussed.

Continuous accessible path of travel

A key concept to the accessibility of destination regions and the lived experience is that of a continuous accessible path of travel (or accessway). A continuous accessible path of travel was defined under the AS1428 as:

an uninterrupted path of travel to or within a building providing access to all required facilities.

NOTE: For non-ambulatory people, this accessible path shall not incorporate any step, stairwell or turnstile, revolving door, escalator or other impediment which would prevent it being negotiated by people with a disability (Standards Australia 1992a; 1992c; 1992b; 1995; 2001):8).

This was inclusive of all dimensions of access and the Standards recognise the impact of the DDA and specifically identify people with vision, hearing, mobility, cognitive and respiratory impairments (Standards Australia 2001:4). It is these basic access requirements that still make up the bulk of DDA complaint cases and the specifics of the lived experiences described in the qualitative data sources. While the public focus of access has been on access to individual buildings this is only the starting point for an accessible tourism experience. People with disabilities require a continuous pathway to offer them the best possible chance to have an equitable, dignified and independent tourism experience. The lack of a continuous pathway means that people with disabilities are often excluded from full participation in community life, and in these cases tourism. Some key issues related to developing continuous pathways that were raised by the study are identified below. It is essential that there are no impediments to the continuous pathway.

- A general lack of access routes.
- Pathways without kerb ramps (known as pram ramps in many local government areas) and steps are insurmountable constraints to wheelchair users and people with other mobility impairments. The use of kerb ramps, pathways and ramps could overcome many of the simpler access barriers and provide continuous pathways.
- Lack of lifts. While access provisions have been made to ground floor areas, in many older buildings, other floors are not accessible. This should be made known to people with disabilities when an inquiry is made.
- Handrails. Similarly for people with other mobility disabilities the lack of handrails impedes their mobility.
- Tactile tiles and audible signals. For people with vision impairment, the lack of tactile warning, directional tiles and audible signals impede independent wayfinding.
- Signage. When accessible kerb ramps, pathways, ramps and lifts are provided they are often not adequately sign posted or their whereabouts made known on maps or information sheets.
- Signage is also an important issue for people with cognitive impairments to aid wayfinding.

The outcome of a discontinuous pathway may have serious repercussions for the tourism experiences of people with disabilities. In Beth's example this has led to physical injury and loss of confidence to participate in the community through an accident where:

I have fallen out of this chair twice...on a wet ramp...I am just not game. It's a special family dinner we go to and it is just a dangerous ramp. And that really dwarfed me. **I wouldn't even go out of here (home) for a while** (Beth Pg 605).

For a full list of access requirements see the AS1428 (Standards Australia 1992a; 1992c; 1992b; 1995; 2001). As highlighted in Table A20, access under the Standards includes a range of other provisions (e.g. telephones, vending machines, furniture etc.).

Table A20: Standards Australia AS1428.1 and AS1428.2 requirements

Standards Australia AS1428.1*	Standards Australia AS1428.2 **
*Compulsory minimum requirements	**Items not covered under Pt.1. Offers enhanced but not compulsory requirements.
Continuous accessible path of travel	Lighting and sound levels
Walkways, ramps, landings, handrails & grabrails	Reach and viewing ranges
Doors, doorways and circulation space	Furniture and fitments
Lifts and stairways	Auditoriums
Toilets and showers	Street furniture
Controls and floor surfaces	Gateways and checkouts
Parking	Vending machines
Entertainment venue seating	Telephones and Postboxes
Signs	Time delays at lights and pedestrian crossings
Hearing augmentation-listening systems	Kitchens and laundries

If people with disabilities are to have independent experiences in destination areas, these provisions need to be co-ordinated across the industry sectors that form the core providers. These include accommodation, associated hospitality, carrier (transport), attractions, tour operator, marketing, coordination and miscellaneous sectors (Leiper 1995:28-29). As described in Chapter 8, any break in this continuity disadvantages people with disabilities far more than the non-disabled. Many people with disabilities are frustrated by the lack of accessibility of much of the built environment. The experiences and complaint cases identified shops, restaurants, attractions, leisure facilities, natural areas, theatres, cinemas and other places of interest to residents and tourists alike. Apart from the specific tourism related exclusion discussed in Chapter 8, the two most common omissions of access are parking and toilets.

Parking

Parking was a critical issue for people with disabilities. There are a number of reasons for this but the principal one was the general inaccessible nature of public transport, and in the case of tourism, transport related tours. Many people with disabilities are reliant on private motor vehicles or will only use private vehicles for tourism trips and, hence, require parking. The major parking issues that frustrated people with disabilities were:

- the limited number of accessible parking spaces;
- inappropriate size of parking spaces as extra space was required to transfer from car to wheelchair or to ingress or egress from side or rear loading vehicles;
- the location of accessible parking and pick up/drop off bays which should be provided near the main entrance or near the accessible entrance;
- lack of shelter from the weather as it takes time for some people to transfer from car to wheelchair, walk to buildings or to disembark from accessible transport;
- enforcement of parking authority schemes where people without the appropriate parking authorities use the spaces. This was a concern at attractions such entertainment centres and shopping centre;
- the cost of private parking in metropolitan areas was prohibitive where free council parking was not provided;
- accessible parking was often not adequately sign-posted or its whereabouts made known on maps or information sheets.

If accessible parking was not available and clearly signposted near a facility, the likelihood was people with disabilities would not participate. The role of parking promotes independence and without adequate accessible parking people found participation impossible. The outcome of a lack of accessible parking may mean:

Independent day trips, even to suburban parks, are thwarted due to lack of suitable parking, lack of zebra crossings and barriers to vehicle access to recreational areas (off roadside) in order to unload wheelchair and disabled passengers. Often when wheelchair parking is provided, the space is too narrow to get chair alongside car to get disabled passengers from car (Qn 470 Pg 368).

Toilets

No building, facility, accommodation or area can be considered accessible to people with disabilities unless

accessible toilets are provided for their use. This impacts on people with mobility disabilities to a greater extent than other groups. The issue was compounded when people were assisted by attendants. The major issues about toilets raised in the study are:

- a general lack of accessible toilets;
- while this problem was noted generally, it was acute when people were travelling by car on domestic or day trips and needed to make convenience stops on major road routes. This is fully detailed in Section 8.4.3;
- lack of unisex toilet provision to allow attendants, carers and friends of the opposite sex to assist the person with a disability if required rather than either party having to enter a gender specific toilet;
- locked or obstructed access to accessible toilets. Authorities explained this as a way to prevent vandalism or illicit drug use. In restaurants and hotels these toilets were frequently inoperable because they were used as storage areas. People with disabilities referred to this as the 'locked toilet syndrome';
- where accessible toilets were provided, they were not adequately signposted nor was their whereabouts made known on maps or information sheets.

The issue of the availability of accessible toilets can not be overstated. Toilet provision becomes an issue on the route to the destination by all modes of transport. In particular, air travel as documented in Section 8.4.5 was most problematic. Without the confidence to visit a destination in the knowledge that accessible toilets are available, then visitation may be curtailed. Experienced travellers note that this was not a problem isolated to Australia:

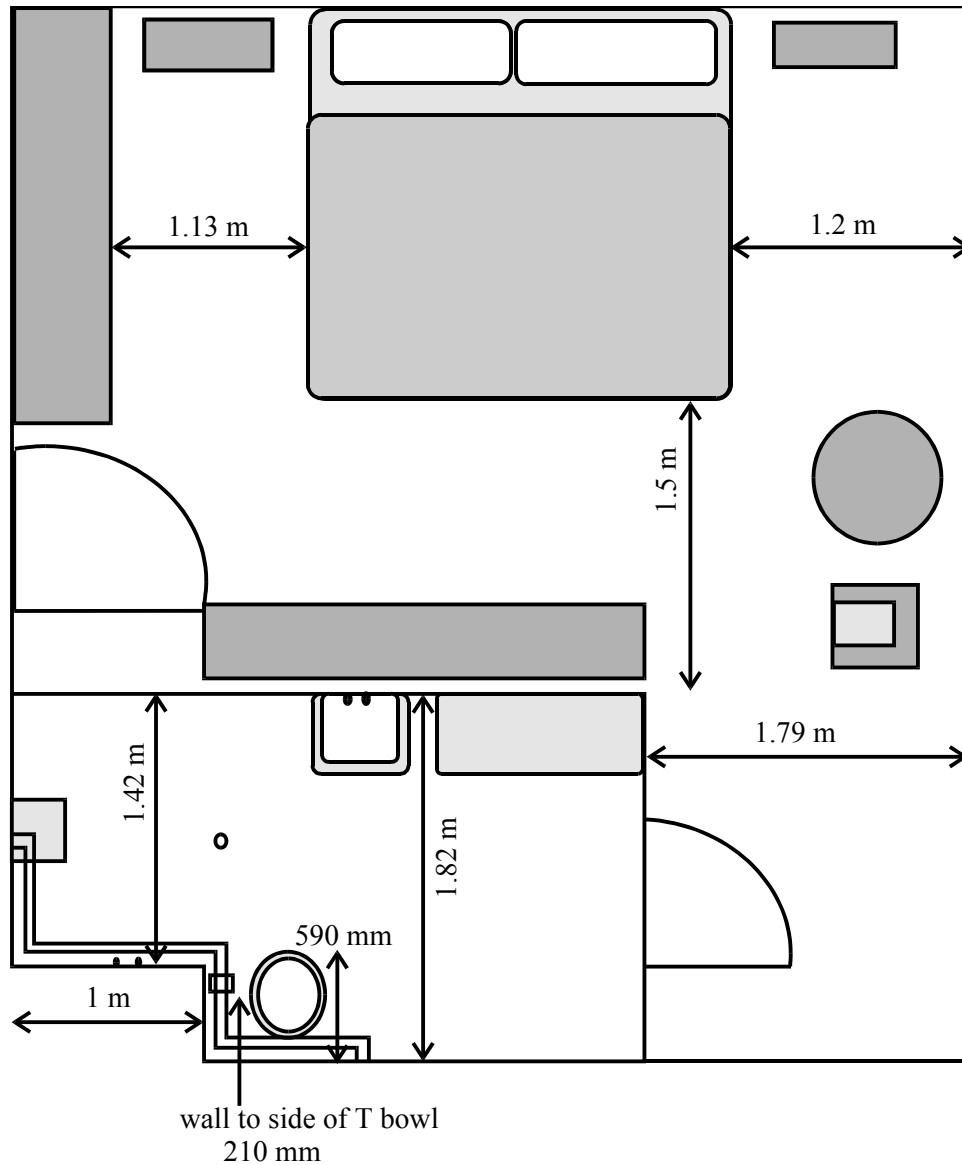
Accessible wheelchair toilets are a major problem in any destination anywhere we have travelled.
Thank God for MacDonalds! (Qn 1029 Pg 819).

Lastly, accessible toilets should be located on an unimpeded continuous pathway to facilitate their use. Experiences such as the following hamper the use of the accessible toilet and draw attention to the person with a disability by needing other tourists to move out of their way. This behaviour may reinforce their sense of otherness or differentness:

Also the toilet facilities are often inadequate or non-existent or the toilet is usually at the back of the room and you have to struggle through a crowded restaurant to get there and back (Qn 2304 Pg 1916).

APPENDIX 10: DIAGRAMATIC REPRESENTATION OF AS1428.1 FOR ACCOMMODATION ACCESS

Hotel X Floorplan
02 9999-9999/fax 02 9888-8888
email@address.com.au



Access into Hotel:

Taxi drop off at main entrance. Short but steep ramped crossover to gently sloping tiled area to automatic glass doors. Complimentary valet parking.

Foyer:

Large open foyer with Porter desk just on the right inside the entry. Reception desk straight ahead. Both counters are high.

Access to restaurants:

From reception there is sign (international wheelchair symbol) indicating a lift which is located towards the bar. The turning area into the lift is sufficient. Take the lift down one level. Restaurants are on this level. Table heights are to Australian Standards. Accessible

toilet is just near the lift and while it appears limited to male/female, it would be no problem to be accompanied by an attendant.

Access to Room:

There are four accessible rooms.

From reception there is sign (international wheelchair symbol) indicating a lift which is located towards the bar. The turning area into the lift is sufficient. You take the lift up one level, turn left through a short and reasonably narrow (approx 1m) passage way, turn right towards the main lifts. Both lifts are sufficiently large and call buttons about shoulder height (1100mm).

Room door lock is magnetic card inserted from top and lever handle, shoulder height 1.1m. Door into room is 760 mm wide, there is no door return (good) but there is a polished metal ball knob on the inside. Entry into the room is governed by cabinets on the left and a writing desk/chair on the right.

There is a double bed at 650 mm high (can be lowered if needed). Reading lights are located on bedside tables and can be operated from the table by the cabinet. The round table and lounge chair clutter circulation space

Bathroom:

There is plenty of turning space to enter the bathroom, the door is 760 mm with lever handle inside and out at 1.1 m. Circulation space is good. The shower seat is very small (350 mm * 270 mm, 500 mm high, useless) and there is a hand held shower nozzle. The shower and basin taps are both circular capstan and very difficult to grip.

The grab rails run from the shower around and behind the toilet, the top measurement is 940 mm. There should be no difficulty getting a shower chair over the toilet except (490mm), possibly for the toilet roll located just under the grab rail. This would be very easily unscrewed.

**APPENDIX 11: AAA CHECKLIST FOR WHEELCHAIR
ACCESSIBILITY IN HOTELS/MOTELS**

APPENDIX 12: MILES & HUBERMAN (1994) TACTICS FOR VALIDITY & RELIABILITY OF QUALITATIVE DATA

Miles and Huberman <i>Tactics</i>:		Data sources				
		A. Quantitative survey Qualitative survey data from pwd	B. Qualitative interviews from pwd	C. HREOC/High Court cases	D. Interviews with Tourism Authorities	E. Interviews with Hotel Managers
1.	Checking for representativeness	Large-scale, representative survey data used	Qualitative data drawn from the same sample as A.	All relevant cases available for analysis.	All TAs available for interview, subject to limited non-response	Limited by geography and industry sector.
2a	Researcher > subject effects	Scale of the sample and postal method limits this effect	Checklists constructed after pilot with disability orgs	Limited by nature of the data	Some possibility of interviewees giving 'politically correct' responses.	
2b	Subject > researcher effects	Researcher already involved with disability issues				
3.	Triangulation	Two types of data from the same source complement each other	Used to cross check A & C	Used to cross-check partly on responses of pwd (A, B) and partly on industry (E)	Interview material cross-checked with published/ web-site material	Interview material cross-checked with published material and HREOC etc. cases
4.	Weighting evidence	Extra weight given to survey evidence because of its scale and depth		High weight given because of legal status	High weight given because of cross check to policy.	Less weight given because of limited sample (see 1.)
5.	Checking the meaning of outliers	All outliers checked				
6.	Using extreme cases	Not pursued				
7.	Following up surprises	Not pursued				
8.	Checking for negative evidence	Followed up for all sources				
9.	Making 'if-then' tests	Not pursued				
10.	Ruling out spurious relationships	Multiple data sources and methodologies to guard against this				
11.	Replicating a finding	Not possible due to resource constraints				
12.	Checking out rival explanations	Theoretical/conceptual framework draws on a variety of theoretical traditions				
13.	Getting feedback from informants	NA	Undertaken	NA	Undertaken	Undertaken