Tourism Management Perspectives 26 (2018) 59–66

Contents lists available at ScienceDirect

Tourism Management Perspectives

journal homepage: www.elsevier.com/locate/tmp

Re-conceptualizing barriers to travel by people with disabilities

Bob McKercher[a,*], Simon Darcy[b]

[a] School of Hotel and Tourism Management, The Hong Kong Polytechnci Unveirsity, Hong Kong
[b] UTS Business School, Sydney, Australia

ARTICLE INFO

Keywords:
Disability
Constraints
Barriers
Disability studies
Tourist experience

ABSTRACTS

This paper proposes a four-tiered hierarchy to understand better the nature and effects of barriers, constraints and obstacles to travel faced by people with disabilities. Previous studies tended to aggregate barriers into a single group and further, some research associated barriers faced by all tourists as being unique to people with disabilities. The failure to recognise the complex, yet subtle interplay between tourism and different types of barriers results in the tendency to see people with disabilities as a homogeneous group where a one size fits all solution applies. In reality, they are a heterogeneous cohort who face the same types of barriers as everyone, some barriers that are common to all people with disabilities, those that are unique to each disability dimension and specific impairment effects that are individualistic.

1. Introduction

The World Health Organization (WHO) estimates that more than one billion people worldwide can be classified as having a disability, with up to 190 million experiencing significant difficulties in functioning (WHO, 2015). This figure is expected to increase as a causal link exists between aging and the onset of disabilities (Patterson & Pegg, 2011). The WHO recognizes further that a range of obstacles, barriers and/or constraints hinder their full and effective participation in society. Within a tourism context, a large number of studies has also identified barriers as one of the many reasons why participation rates in and qualities of experience of tourism are lower than that of the general population (see Buhalis & Darcy, 2011 and UNWTO, 2016 for a summary of these studies).

Much of this research tends to regard people with disabilities as a largely homogeneous group "as if every person with a disability possessed the same constraints and has to overcome the same barriers (Figueiredo, Eusebio, & Kastenholz, 2012: 534)." Yet, Darcy and Buhalis (2011) remind us first that disabilities can be classified into a wide array of categories and second, that within each category, the degree of ability exists along a continuum based on the individual's level of support needs. Much of this research also identifies the types of barriers noted in the general tourism and leisure constraints literature as being unique to people with disabilities (PWD), when in fact they are issues all tourists must resolve. As a result, there is a tendency in the literature to adopt a one-size fits all approach to constraints research, which as Eichhorn and Buhalis (2011) observe has hindered the systematic understanding, analysis and resolution of issues faced by people with different types of disabilities.

This paper proposes that we should adopt a more holistic perspective by disaggregating constraints and, instead, grouping them hierarchically into a four-tiered framework (Fig. 1). Each tier represents an increasing level of specificity beginning with constraints faced by all and ending with the consideration of specific impairment effects (Thomas, 1999, 2004) that are highly individualistic. The model is conceptual in nature based on a critical review of the literature, the authors' own research, the lived experience of one author and the other author's experience of travelling with PWD. The paper begins by examining the many contextual challenges involved in the development of such a framework. Each of the tiers is then discussed and the paper concludes with an overview of the model's implications for future research.

2. Contextual challenges

A number of contextual challenges arise when discussing barriers to travel by people with disabilities. To begin, the paper adopts a social model of disability whereby the types of constraints identified are imposed on those with impairments by society, more so than 'disability' being a function of a medical condition (Barnes, Mercer, & Shakespeare, 2010; Oliver, 1990). It acknowledges that social approaches of environments (physical, economic, social, cultural etc.) are disabling by their nature and that people with disabilities are exposed to hostile social attitudes that overtly and covertly constrain participation. Together the disabling environments and hostile attitudes are imposed on top of an individual's impairment creating 'disabled people' (Barnes

* Corresponding author.
E-mail addresses: bob.mckercher@polyu.edu.hk (B. McKercher), Simon.Darcy@uts.edu.au (S. Darcy).

https://doi.org/10.1016/j.tmp.2018.01.003
Received 26 June 2017; Received in revised form 20 January 2018; Accepted 22 January 2018

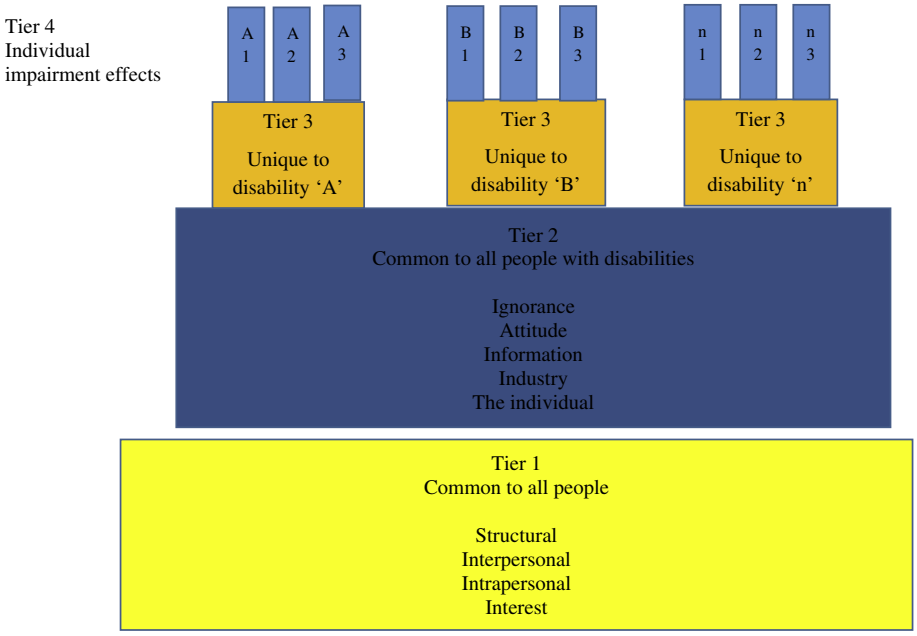

Fig. 1. Hierarchy of barriers to travel by people with disabilities.

et al., 2010; Oliver, 1990), rather than people who happen to have a disability. The materialist or critical theory underpinnings of the social model focus on the way that organisations, structures, processes and practices exclude, omit, overlook or deliberately discriminate against people with disability (see Shakespeare, 2017 for a deeper discussion of this issue).

The social model further highlights a number of linguistic, subjective and emotive challenges that arise when trying to develop a framework to assess barriers. Very little is absolute in this issue, and as with much foundation work in other tourism topic areas, early works have laid the foundation for future studies up to the current time, even if they have been proven to be conceptually deficient (McKercher & Prideaux, 2014). One example is Smith's (1987) original work which built on leisure studies research with little discussion of the conceptualisations of disability. Here, the focus along with other early studies by Muloin (1992) and Murray and Sproats (1990) was disproportionately on people with mobility disabilities with high or very high support needs.

Likewise, there seems to be an enduring belief in the homogeneity of disabilities and therefore the provision of a one-size-fits-all solution (Figueiredo et al., 2012). This situation has been noticed in works by Bergier and Kubińska (2010), Richards, Pritchard, and Morgan (2010), Lee, Agarwal, and Kim (2012) and Ray and Ryder (2003) which involved studies of people with different types of disabilities, but resulted in the proposition of a homogenized conclusion. Yet, Darcy, Ambrose, Schweinsberg & Buhalis (2011:304) note that "within the seemingly narrow World Health Organization's categories, literally thousands of conditions can be diagnosed for an individual's lack of ability." For example, the Australian Human Rights Commission that administers the *Disability Discrimination Act*, 1992 states the definition of disability in the Act includes those with physical (mobility); intellectual; psychiatric (mental health); sensory (vision and hearing); neurological; and learning disabilities, plus; physical disfigurement; and those with the presence in the body of disease-causing organisms. These categories are based on data collected from the WHO biopsychosocial approach, which is predominantly impairment based and then aggregated into 'body functions/structures' (WHO, 2001, 2002).

'Disability' also exists along a continuum from those with all types of disability who need no support needs to those with profound restrictions who may need 24 h support (CSD, 2015; Darcy & Buhalis, 2011; Dwyer & Darcy, 2011). The Australian Bureau of Statistics identifies five categories of 'severity of disability' including none, mild, moderate, severe, or profound (ABS, 2015). Dwyer and Darcy (2011), for example, report Australian Bureau of Statistics figures identified that 20% of the Australian population has a disability but 50% of that figure are people who have no or only mild support needs, while about 15% have profound needs or 3% of the overall population. The Hong Kong Census and Statistics Department (CSD, 2015) states about one-quarter of people with restrictions in body movements always require a wheelchair, while half do not require any type of specialist tool or need one occasionally. Likewise, less than 5% of people with vision difficulties are unable to see at all and fewer than 3% of people with hearing difficulties are completely deaf. And so, while the numbers of PWD may seem high, in reality, only the relatively small share of those with moderate, high or very high support needs may require specialist tourism products and services (Darcy et al., 2011; Darcy & Buhalis, 2011).

Finally, barriers and constraints are not absolute. Thirty years ago, McGuire, Dottavio, and O'Leary (1986) noted the impact of any constraint is dependent on how people react to it. In some cases, the same constraint may prohibit participation; in other cases it may limit the range of activities; and in other cases still, it may be a non-issue. The key difference between a prohibiting and a limiting factor is that one may stop travel in whole or preclude people from visiting certain places, while the other may affect the frequency, type of activities engaged in, or satisfaction (Small, Darcy, & Packer, 2012; UNWTO, 2016). Each may or may not be successfully negotiated either by choosing strategies or by making personal compromises to enable participation (Daniels, Drogin Rodgers, & Wiggins, 2005; Mactavish, Mackay, Iwasaki, & Betteridge, 2007; Yau, McKercher, & Packer, 2004). Moreover, a person who might have low ability in one area (e.g. mobility) might have exceptionally high ability in another (e.g. intelligence or seeing) (Buhalis, Eichhorn, Michopoulou, & Miller, 2005).

And yet, an apparent belief held by many in industry is that resolving mobility access issues represents a universal template to resolve all other issues. The O'Neill and Knight (2000) study of hotels in Western Australia, for example, found 96% of properties surveyed had a clear and accessible route to the reception desk, but only 29% had any facilities for people with sight or hearing impairments. In an extreme example, Richards et al. (2010) reported a visually impaired couple