Accessible Tourism in Denmark

A Pragmatic Perspective

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Introduction

In the beginning, this was thought to be a report on *handicap-tourism* as it is and could be practised in Denmark, hoping to reach findings which are applicable beyond. Rather, the appropriate term is *accessible tourism*, although the intended customer segment to be discussed is people with disabilities, not people with access needs.

The motivation for writing this thesis was sparked in 2008 when I started working as part of a young team of helpers at Sct. Knudsborg in North Fyn which then offered two-week vacation stays for people with disabilities. Here, guests would experience a unique and very personal customer service where all physical needs – from personal hygiene to holding playing cards – were covered by the ever-present team of helpers. After years of successful practice in this niche market, all disability-related activities came to an end as the ageing facility (built 1928) did not meet the criteria for being certified as `accessible´, and there was insufficient funding for the necessary renovation. Sadly, Sct. Knudsborg is now a 26-bedroom pool house for rent[1]. With this experience, and never since having heard of a similar place, the choice to investigate the role of disability in tourism seemed given in advance – especially as the subject had never been mentioned in textbooks and lectures while studying for the MA in Tourism and therefore seemed to deserve some attention.

In earliest phase of inquiry it became apparent, as teased by the opening of this introduction, that an unsettling tone of political correctness had manifested in the academic discourse on disability and thereby embedded itself into that on accessible tourism. While one hand was praising a fully diverse and inclusive society, the often often seemed accompanied with a peculiar, highly biased and sometimes even militaristic style of underlining argumentation – attention to which had been awakened while undertaking a BA in Applied Philosophy. In the initial reading phase it became apparent that the moralising approach to disability and accessibility tended to come with an adherence to the so-called *social model of disability*, treating these issues in relation to structural oppression, discrimination and human rights, rather than as a `problem´ of the individual – as characterised by the opposed *medical model of disability.*

Tying up this origin story, it was then clear that an in-depth review of the conceptual history of disability/handicap and theoretical foundation of disability studies could provide an opportunity to merge the competencies of the two study programs into a new perspective on accessible tourism.

Personal anecdotes and wondering aside, there are three introductory reasons for drawing attention to accessible tourism in Denmark. First, the worldwide population of disabled people is estimated at

1 At: https://www.feriepartner.dk/sommerhus/nordvestfyn-lille-brog%C3%A5rdsvej-m64310-3/?pets=0&duration=7

about 15% (WHO, 2011), roughly equivalent to 1 billion people who are all potential customers for the accessible market. With accessible tourism also including elderly people, families with small children and all other groups or individuals with special access needs, no exaggeration is needed to emphasise the colossal scale of the customer segment at hand.
Not only is the market size and potential already huge, it is prospected to grow continuously in the foreseeable future, as populations are getting older, human rights are enforced, and the medical sciences reaches new breakthroughs. Assessments on the economic impact of accessible tourism, now and in the coming decades, are therefore extremely positive, despite great variation in the measurements used (Bowtell, 2015; Buhalis, Michopoulou, Eichhorn, & Miller, 2005; Darcy & Dickson, 2009; European Commission, 2013).

Second, accessible tourism is a relatively new concept, developed in this millennia and still having a long way to go in terms of raising awareness and convincing stakeholders of the promising market potential (European Commission, 2014). Also, given its infancy as a field of study, many research questions remain unanswered or only partially covered in the tourism literature (Blichfeldt & Nicolaisen, 2011; Bowtell, 2015; Lyu, 2017; Michopoulou & Buhalis, 2013). This opens the door, not only to the contribution of new findings, but also to the possibility of establishing a comprehensive (although not exhaustive) overview existing research as method for identifying gaps of knowledge – or, as will partially be case here, areas with excessive attention on knowledge creation.

Third, while not leading the European competition (UK and Spain being ahead), Denmark is already a front runner on ensuring an access to the public domain, major tourism attractions and accommodation (European Commission, 2015). Furthermore, thanks primarily to the highly developed health care system, the relative population of disabled people is among the highest in the world (Darcy & Dickson, 2009). Perhaps most importantly, the Danish welfare state ensures that even severely disabled people without the opportunity to participate in the labour market, can enjoy public benefits (*førtidspension*; early retirement) equivalent to a €2500/month (DKK 18.642[2]) income, before tax. This figure may vary individually and the requirements for eligibility can result in some being categorised as unemployed (with a lower rate of public benefits) rather than disabled; a political dilemma not to be unfolded in detail. Regardless, €2500/month is a decent approximation of the financial reality for many of the `worst off´ (i.e., unmarried, uneducated, unemployed) people

2 Standard rate of *førtidspension* for 2018, according to the government website https://borger.dk. In 2015 (more recent data was not available), this accounted for 79% of Danish citizens on disability allowance (Danmarks Statistik, 2015).

with disabilities in Denmark. Thus, the disabled customer segment in Denmark is less inflated by low-income individuals who cannot afford to participate in tourism activities than is seen internationally (Pagán, 2012). Combining these factors; a large population of disabled people where even the worst off can save up to the occasional trip, situated in a highly developed country already well on the way of improving accessibility, makes Denmark particularly suited for a strong position on the accessible tourism market.

The central problem to be investigated in this thesis is as follows:

Problem formulation

> The supply of products targeting disabled consumers does not match the market potential for accessible tourism. This can be correlated to a lacking emphasis on the individual tourist with a disability, caused by the discoursive consensus on the social model of disability in which the needs of society as a whole overshadows the practical needs of the individual.

Above problem formulation is essentially two claims that first will be supported theoretically by secondary research, after which it will be approached as a practical issue with practical solutions.

The investigation of the problem will consist of three parts:

1) **What is disability?**
   Chronological review of major disability models and definitions
2) **Accessibility: Legislation, principles and strategy**
   Review of current strategies, policies and regulations on disability and accessibility relevant to Danish stakeholders (UN, EU, Danish Government)
3) **Accessible tourism research**
   Review of major findings in tourism literature

Based on a combined understanding of these elements the thesis will culminate in:

4) **A refreshing conclusion**
   Discussion of new opportunities and recommendations for business and research in accessible tourism.

Methodology

It is here assumed that what is *real* precedes what is or can be *known*. By extension, this study positions itself within a generic realist ontology, contending that objective reality exists independently of the belief, language, etc. of any knowing subject (Miller, 2016). Meanwhile, a scepticist approach is taken to epistemology, acknowledging the nigh impossible philosophical challenge of providing sufficient justification for the *truth* component of knowledge as `justified true belief´ (Steup, 2005; 2017).

Given the methodological difficulty in providing truth, the aim when analysing accessible tourism is to identify the practical effects of how disability and accessibility is characterised in academic literature and legislation relevant to the Danish context. For this purpose, pragmatism is selected as the best suited research paradigm.

Pragmatism was developed as a principle for clarifying contested concepts and hypotheses by tracing `practical consequences´ in disputes where the opposing were unable to find common ground for a meaningful discussion (Hookway, 2016). Although intended for a reintroduction of metaphysical debate in the predominantly empiricist discourse of the late 19th century, where the division of science and religion was fully underway, it is here applied to the similarly zealous debate between medical and social perspectives on disability, and its implications for accessible tourism. At the core of classical pragmatism is the *pragmatist maxim* of Charles Sanders Peirce (originally from 1878), urging researchers and thinkers to;

> "Consider what effects, which might conceivably have practical bearings, we conceive the object of our conception to have. Then, our conception of those effects is the whole of our conception of the object" (Houser & Kloesel, 1992, p. 132).

In simple terms, rather than the impossible identification of what is *true*, which often results in idle discussions, the pragmatic approach concentrates on finding theories which are practically useful to believe in the long-run (Putnam, 1995). Doing so naturally requires a predetermined assumption of the practical bearings we seek to gain from the discussion – in this case a statement which encapsulates the nature of a practical model of disability.

Here, the assumption of practicality is related to the problem that, despite political efforts, campaigns and legislation focusing on accessibility, relatively few tourism businesses takes independent steps towards specialising in accessible tourism. Hence, a strong model of disability ought to emphasise the independent agency of tourism stakeholders, as this is where the practical heart of the problem currently appears to be located. Thus, the guiding statement of a practicality oriented model of disability is as follows:

A strong model of disability must be effectively applicable for individual tourism stakeholders seeking to approach people with disabilities as their target customers.

Being *effectively applicable* is here associated with independent agency, meaning that the route from intension to action should not be overly complicated by factors outside the influence of individual stakeholders. Furthermore, a strong theoretical model ought to carry practical bearings, or implied areas of reasonable action, to guide the direction of its users when applied to a business context.While this characterisation of a practical model of disability is considered valid for its intended purpose by being conceived in close correspondence with the stated problem, it is inherently rooted in the subjective assumptions of this author. This is an unavoidable consequence of the pragmatist maxim, and likely its most substantial weakness, as the notion of *our conception* of practical effects cannot be determined objectively and will always vary according to the discourse of the problem. In this way, pragmatism is essentially reinvented each time it is applied as a methodological principle. Although generally relying on empirical evidence and compatibility with the scientific method, none of the classical pragmatists (C.S. Peirce, William James and John Dewey) provided a fully developed analysis to explain exactly what `practical consequences´ are (Hookway, 2016).
The assessment of above defined practicality will be supported by a comprehensive reading of secondary research, corresponding with part 1 (disability), 2 (accessibility) and 3 (accessible tourism research), as presented in the introduction.

Treating the selected literature as a single organic discourse, the principles of semiotics are used as a guideline for interpreting the structure of meaning in the reviewed texts. As with pragmatism, the field of semiotics was pioneered by C.S. Peirce in the late 19th century, making it compatible with his pragmatic paradigm (Peirce, 1991). To Peirce, “meaning is derived through a triadic relationship between the designatum (the object signified), the sign (the signifier used to represent the object) and the interpretant (the person who interprets the sign)” (Hannam & Knox, 2005, p. 25). This will allow for a closer, more systematic approach to the literature, serving to identify and compile elements for the SWOT analysis that will unfold in the fourth and final part of the thesis (a refreshing conclusion). SWOT analysis (Renault, 2016; Tribe, 2010) is chosen to recap, structuralise and evaluate the internal (strength & weakness) and external aspects (opportunities & threats) revealed in the review of secondary research and legislative documents – thereby tying together the arguments behind the concluding recommendations for future business and research in the accessible tourism market.

What is disability?

In order to define people with disabilities (PWD[3]) as a market segment in tourism, we must be first have a clear definition of disability. Naturally, there have always been people with limited ability to walk, see, hear, learn, think, speak, etc., but such conditions have traditionally (i.e., Christian Litany) been seen as part of "life's hardships or evils", not as defining a social group or subject worthy of scientific or philosophical[4] inquiry – disability was simply treated synonymously with `inability´, or "as a reference to legally imposed limitations on rights and powers" (Wasserman, Asch, Blustein & Putnam, 2016, p. 1).
Legally imposed limitations may, for example in the case of the UK *Idiots Act, 1886*, refer to the historic "care, education, and training" (i.e., segregation in certified asylums and hospitals) of lunatics, idiots, imbeciles and other patient groups (Idiots Act, 1886), a tradition much older than the concept of disability.

During the 19th century, the medical sciences developed more sophisticated terminology of human function and form, resulting in methods to identify and treat certain abnormalities and deviances (Wasserman et al., 2016). This laid the conceptual foundation for academic discussions about `the disabled´ which had a dramatic increase in interest and relevance in the aftermath of World War II, particularly from the 1960s and onwards (Masala & Petretto, 2008).
Since then, the discourse regarding disability has become, and remained, a contested subject, resulting in an evolution of continuously changing and often contradicting definitions and research approaches. As Jette (2009, p. 1165) puts it; "This confusion of languages has created a veritable Babylonian Tower of Babel with its resulting weakening of the foundation for our research".

To navigate on such ground, we must deconstruct, or at least understand the structural components of the `Tower of Babel´. Again; only with a clarified definition of disability can we fully grasp the idea, practice and implications of accessible tourism.

3 The PWD abbreviation was introduced as an example of a socially appropriate `person-first´ language, as opposed to the alleged discrimination embedded in the term `disabled people´ (Dunn & Andrews, 2015).. Here, the abbreviation is used for practical resons (widely used and recocnised) and does not signify an ideological stance. PWD is used in both plural (people/persons with disabilities) and singular form (person with a disability). Discrimination and person-first language will be discussed in more detail under the social model of disability.

4 "Molyneux's Problem", first described by William Molyneux in 1688 in a letter to John Locke, may be the only notable excetption. Molyneux asked if a blind man, taught to distinguish between a sphere and a cube by touch, could identify these objects by sight if his blindness was cured (Degenaar, 2017). Despite medical technology lifting the issue beyond mere thought experiment, Molyneux's Problem remains epistemologically relevant today.

The evolution of disability models

In recent literature, the development of disability models is generally reduced to a dichotomy between the *medical model*, describing disability as a problem or disadvantage for the individual person and something to be fixed, treated or healed, and the *social model*, which shifts the ownership, responsibility and means of treatment of the problem to the sociopolitical environment (e.g., Blichfeldt & Nicolaisen, 2011; Dunn & Andrews, 2015; Masala & Petretto, 2008; Pfeiffer, 2002, WHO, 2001). The outcome of this debate, where the social model emerged as the academic victor, is of critical importance to the current conceptualisation of accessible tourism. In this section, the following disability models and UN conventions will be covered:

Medical Model
Nagi's model: Nagi (1965)
Harris' model: Harris (1971)
ICIDH model: WHO (1980)
IOM model: Nagi (1991)
NCMRR model: NCMRR (1993)
IOM revised: Brandt & Pope (1997)

Social Model
Social model: UPIAS (1976)
Later development of the social model – the disability studies paradigm (1980s → present day)

Biopsychosocial Model
ICF: WHO (2001)

UN Conventions
Standard Rules on the Equalization of Opportunities for Persons with Disabilities: UN (1993)
Convention on the Rights of Persons with Disabilities: UN (2006)

The sources listed above will be briefly covered in chronological order (see Appendix 1 for a far more detailed review), thereby providing a foundation for the following SWOT analysis of the two primary models. WHO's ICF model, being a synthesis of medical and social perspectives, is included along with the UN conventions because of the influence of these organisations at an international level of politics and human rights.

The medical model

Identifying models as `medical´ is here governed by the assumption that *defining disability as being caused by an interference or abnormality in the bodily system (including mental health) of an individual qualifies as a medical perspective*. Disability is thus a physical phenomenon, as opposed to being social by nature. This initial distinction was necessary as none of the reviewed models carried the medical label by themselves, despite being developed in a medical context for the purpose of health care, rehabilitation and insurance.

Note that defining disability as a physical phenomenon does not exclude attention to the social aspects of living with a disability. This is clearly exemplified by Egyptian sociologist Saad Nagi (1965; 1991), who was amongst the early pioneers studying the `disability experience´ and introduced the first dynamic and socially focused model on disability (Altman, 2016; Masala & Petretto, 2008).

Nagi (1965, p. 101) considered disability to be an "expression of a physical or a mental limitation in a social context" and presented a model consisting of four dimensions, which have since been characterising the structure of the medical model:

1) *Active pathology* – "a state of the body's defences and coping mechanisms" (e.g., infection, trauma, disease)
2) *Impairment* – "a loss or abnormality at the tissue, organ, and body system level"
3) *Functional limitation* – "in 'the individual's ability to perform the tasks and obligations of his usual roles and normal daily activities" (e.g., seeing, walking, listening)
4) *Disability* – "limitations in performing socially defined roles" (e.g., employment or self-care)

These four dimensions are causally associated but not statically linked. An active pathology *may* result in an impairment, which *may* result in functional limitation and/or disability. Despite several revisions of Nagi's model, some of which includes slight variations in terminology (e.g., *handicap* instead of *disability* – Harris, 1971; WHO, 1980), the core elements have remained intact throughout the years. In short, the medical model conceptualises disability as "a gap between the individual's capabilities and the demands created by the physical and social environment" (Masala & Petretto, 2008, p. 1234).

While early examples of the medical model are characterised by simplicity and ease of application, later editions have become increasingly complex and ambiguous as a response to the growing critique from adherents of the social model. For example, the US National Center for Medical

Rehabilitation Research (NCMRR, 1993) introduced s*ocietal limitations* as a fifth dimension of the model, defined as "Restrictions attributable to social policy or barriers (structural or attitudinal) which limit fulfilment of roles or deny access to services and opportunities associated with full participation in society" (NCMRR, 1993, p. 25). This theoretical manoeuvre adds a new layer of arguably impenetrable complexity – undesirable from a pragmatic perspective.
Similarly, Brandt & Pope (1997, p. 68) excluded disability from the *enabling-disabling process* (emphasising that the process from pathology to functional limitation may be reversed by means of rehabilitation), with the reason that disability is "not inherent in the individual". This begs the question; what are the practical bearings of conceptually excluding disability from a process aiming at the rehabilitation of PWD? The only identifiable logic here is found in the social constructivist assumption that changing the terminology, or simply silencing the discourse and meaning of a problem, somehow transforms its nature or makes it disappear. Again, this is related to, and intended as a response towards socially oriented critique – bringing us to the review of the social model.

Revisiting the problem: From a pragmatic perspective, Nagi's version of the medical model has proven to be consistently useful over a significant time span, to the point where some scholars (Masala & Petretto, 2008; Verbrugge & Jette, 1994) have argued for its reintroduction in favour of more recent contributions, such as ICIDH and ICF. Regarding tourism, the medical notion of an individually based process of rehabilitation is highly compatible with businesses providing specialised, accessible travel experiences.
From a critical viewpoint, the health care industry tends to act semiotically as both the messenger and the interpretant of the medical model, which may enforce the signification of PWD as the objectified `Other´. Furthermore, the notion of functional limitation can be seen as denoting PWD as limited and abnormal, signifying PWD as less valuable to society than non-disabled people[5]. As will be further unfolded later, these are crucial elements of the antagonism towards the medical model, qualifying the trivialisation of *normal* (i.e., not treating it as a value laden term) as an external threat associated with its use.

5 Paradoxically, if accepting the historical materialism underlining significant parts of the social sciences, including disability studies, PWD *are* inherently less valuable than non-disabled, given their lowered contribution to the means of production.
In light of this, it is worth revisiting one of the classical pragmatic findings that a seemingly irrational, religious view on human value may be defended in reference to its practical bearings (Hookway, 2016). Characterising human beings as of equal value requires metaphysical assumptions of which there are no empirical evidence (rather the contrary), but lots of practical reasons to uphold.

The social model

In the 1970s, disability rights movements were starting to form and grow in England – a trend which soon spread to the United States. These groups campaigned against the institutionalisation and marginalisation of people with functional limitations who "were the recipients of paternalist interventions and of actions that limited their freedom and their human and social rights" (Masala & Petretto, 2008, p. 1236). Among the early UK movements were UPIAS, the *Union of the Physically Impaired Against Segregation*, and The Disability Alliance, the collaboration of whom led to the formulation of the social model of disability (UPIAS, 1976). The social model was based on "the objective fact that society causes our disablement by the way it is organised" (UPIAS, 1976, p. 19). Disability was now seen as "something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society", and thus "a particular form of social oppression" (UPIAS, 1976, p. 3-4). Any limitation to full and egalitarian participation in society constitutes discrimination in the social model.

UPIAS aimed to overcome oppression, discrimination and segregation by identifying and removing social and physical barriers (UPIAS, 1976). As society imposes disablement upon people with impairments, it is also responsible for integrating these people. Doing so to its full extent would prevent disability from being an issue (UPIAS, 1976).

Because of discriminatory associations[6], the social model excluded *handicap* from its terminology. Also, given the social focus, individual causes of impairment (i.e., *active pathology*) was not considered relevant to the model, which then only contained the dimensions of impairment and disability (UPIAS, 1976, p. 14):

1) Impairment; "lacking part of or all of a limb, or having a defective limb, organ or mechanism of the body."[7]
2) Disability; "disadvantage or restriction of an 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."

6 The literature does not disclose where or when this value ladden interpretation of handicap emerged. However, as will be discussed later, it is clearly culturally dependent and mostly associated with English speaking countries, such as UK, US, Australia and Canada.

7 The model was soon widened to include all impairments, rather than just physical ones (Masala & Petretto, 2008).

Furthermore, the social model comes with the embedded notion that medical authorities and practitioners are exerting too much power over PWD, hindering independent living. Sociologists (excluding Saad Nagi and others who disagree on the premises of the social model) should therefore replace the medical profession as dominant in the field of disability research (UPIAS, 1976).
In semiotic terms, the social model uses concepts of power, oppression, segregation and control as signs to convey an ominous social reality (*designatum*) where PWD (*interpretant*), in partnership with sociologists and other socially responsible allies, should rebel against the immoral elite to reclaim their rightful agency and construct their own meaningful experience of life. This pattern becomes increasingly clear with the later development of the social model, later to be covered in greater detail. First, returning to the chronology of events, WHO's *International Classification of Functioning, Disability and Health* (ICF) will be discussed, as critique hereof is a featured element of later contributions to the social model.

Revisiting the problem: Already clear at this point is that the extensive socio-political focus of the social model represents a pragmatic problem for independent tourism stakeholders, as their sphere of influence rarely allows for a structural change of society to be realistically treated as a practical task.

As seen above, the social model has a semiotic structure similar to that of the medical model, with PWD acting as both the messenger and the interpretant, with concepts of *our* [impairments] and *we* [are isolated] as clear signs of a unified community of PWD.
This is in some ways a strength of the social model, as the sense of belonging to a community is assumedly beneficial to the quality of life. However, it is here identified as a threat to the development of accessible tourism, given how such a community quickly transfers to a feeling of *us* and *them*, contributing to a discourse where it is difficult for *them* to prove that they are not part of an oppressive agenda.

Contrary to PWD, medical professionals have a well defined role in society and is implicitly included in the wider sense of *us* as citizens. Therefore, even a closed discourse between medical scientists is not seen as a division between *us* and *them*, and thus not a threat to accessible tourism development.

The International Classification of Functioning, Disability and Health (ICF)

WHO (2001, p. 20) acknowledged the "dialectic of "medical model" versus "social model"" and hence, "ICF is based on an integration of these two opposing models [where] a "biopsychosocial" approach" is used to synthesise the different perspectives. This consensus-seeking approach resulted in a rather complex model, illustrated below by the "overview of ICF" (Fig. 1):

<table>
<tr><td></td><td colspan="2">Part 1: Functioning and Disability</td><td colspan="2">Part 2: Contextual Factors</td></tr>
<tr><td>Components</td><td>Body Functions and Structures</td><td>Activities and Participation</td><td>Environmental Factors</td><td>Personal Factors</td></tr>
<tr><td>Domains</td><td>Body functions
Body structures</td><td>Life areas
(tasks, actions)</td><td>External influences on functioning and disability</td><td>Internal influences on functioning and disability</td></tr>
<tr><td>Constructs</td><td>Change in body functions (physiological)

Change in body structures (anatomical)</td><td>Capacity
Executing tasks in a standard environment

Performance
Executing tasks in the current environment</td><td>Facilitating or hindering impact of features of the physical, social, and attitudinal world</td><td>Impact of attributes of the person</td></tr>
<tr><td rowspan="2">Positive aspect</td><td>Functional and structural integrity</td><td>Activities
Participation</td><td rowspan="2">Facilitators</td><td rowspan="2">not applicable</td></tr>
<tr><td colspan="2">Functioning</td></tr>
<tr><td rowspan="2">Negative aspect</td><td>Impairment</td><td>Activity limitation
Participation restriction</td><td rowspan="2">Barriers / hindrances</td><td rowspan="2">not applicable</td></tr>
<tr><td colspan="2">Disability</td></tr>
</table>

Fig. 1 – *An overview of ICF* (WHO, 2001, p. 11).

In the definitions given to navigate the model, ""Activity limitation" replaces the term "disability" used in the 1980 version of ICIDH" (see Appendix 1), while "Participation restriction" replaces the term "handicap"". (WHO, 2001, p. 213).

Other key concepts used in ICF includes:

> "***Personal factors*** are contextual factors that relate to the individual such as age, gender, social status, life experiences and so on, which are not currently classified in ICF but which users may incorporate in their applications of the classification." (WHO, 2001, p. 214).

"***Health condition*** is an umbrella term for disease (acute or chronic), disorder, injury or trauma. A health condition may also include other circumstances such as pregnancy, ageing, stress, congenital anomaly, or genetic predisposition. Health conditions are coded using ICD-10." (WHO, 2001, p. 212).

"***Functioning*** is an umbrella term for body functions, body structures, activities and participation. It denotes the positive aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)." (WHO, 2001, p. 212).

"***Disability*** is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)." (WHO, 2001, p. 213).

Figure 2 (below) describes the interaction between the components of ICF. Functioning is the positive aspect of this interaction, with disability being the negative (WHO, 2001, p. 11). This model is often used to summarise the ICF framework (e.g., Jette, 2009; Hyldgaard & Nielsen 2008).

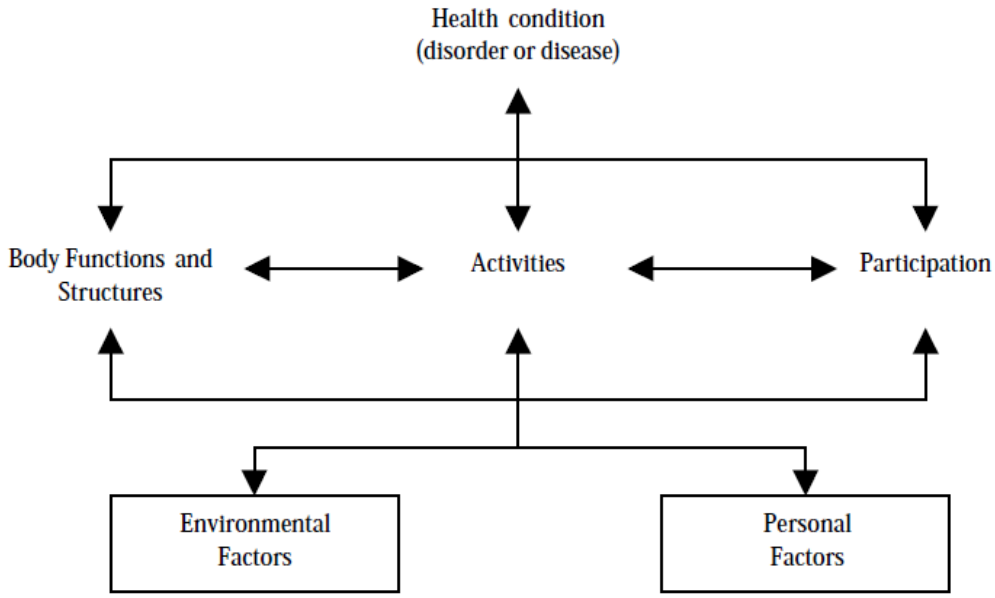


Fig. 2 – *Interactions between the components of ICF* (WHO, 2001, p. 18).

Contributing to the outcome of this interaction (Fig. 2) are *facilitators* and *barriers*:

"***Facilitators*** are factors in a person's environment that, through their absence or presence, improve functioning and reduce disability." (WHO, 2001, p. 214).
– e.g., accessible environment, relevant assistive technology, services, systems and policy, absence of stigma (WHO, 2001, p. 214).

> "***Barriers*** are factors in a person's environment that, through their absence or presence, limit functioning and create disability." (WHO, 2001, p. 214).
> – e.g., inaccessible environment, negative attitudes, lack of relevant assistive technology, "as well as services, systems and policies that are either nonexistent or that hinder the involvement of all people with a health condition in all areas of life" (WHO, 2001, p. 214).

The multilayered framework of ICF has, since its publication and widespread use, been criticised for its ambiguity in lacking clear terminology and distinctions (Altman, 2016; Jette, 2009; Masala & Petretto, 2008). To some extent, WHO is itself admitting the weak terminology of ICF, stating for example that "It is difficult to distinguish between "Activities" and "Participation" on the basis of the domains in the Activities and Participation component" (WHO, 2001, p. 16). In short, ICF is an attempt at consensus at the cost of clarity.

Revisiting the problem: ICF serves as an example of the difficulty in attempting to bridge the gap between mutually exclusive opposites. The compromises needed to do so comes at a price which is often too high for functional practicality, let alone logical validity. On the positive side, ICF introduces the concept of *facilitators* into the mainstream academic discourse on disability, which is highly useful in relation to accessible tourism. Tourism stakeholders are often powerless when it comes to removing barriers, which is generally the sole focus regarding the facilitator/barrier dichotomy in other literature, whereas they are always free to act (and brand themselves) as facilitators of accessible experiences. As such, the concept of facilitators can be applied beneficially in the tourism industry as a tool for product development and marketing, without having to consider the rest of the ICF framework.

Later development of the social model – disability studies

Pfeiffer (2002, pp. 3-4), highly useful in this context for providing a philosophical overview of the underlining reasoning behind the evolution of the social model, identifies the medical model as a *deficit model*, with the health condition or pathology being the deficit associated with the disabled individual.
Claiming that "a person with a disability does not have a deficit", Pfeiffer (2002, p. 3) immediately states his opposition to the medical model. Also, the medically associated terms of normal/abnormal are characterised as value judgements used to justify the disadvantages of living with a disability (i.e., being eternally abnormal).

As a result of this gap in perspectives disability studies emerged as a separate field of research in the 1980s, quickly adopting the social model as a universally accepted theory (Bickenbach, Chatterji, Badley, & Üstün, 1999). This soon led to a discourse of animosity towards researchers studying disability outside the field of disability studies. Stone and Priestley (1996, p. 701) describes these researchers, who "have perpetuated the marginalization of disabled people, justifying segregationist policies, eugenics, and the systematic denial of human rights" as *the parasite people* – criticised for working "within an oppressive theoretical paradigm and within an oppressive set of social relations" (Stone & Priestley, 1996, p. 699).
In a similar tone, Pfeiffer (2002, p. 4) acknowledges that the deficit models still "infects many people doing disability research outside of the field of disability studies".

The oppressive paradigm

Being the academic representative of a group of people's experiences of oppression, disability studies often draw upon theoretical issues found in thematically similar study programs, such as ethnic-, feminist-, and queer/LGBT studies (this list continues to grow), which emerged during the same period, also mainly in UK and US universities, and sharing the objective of highlighting the oppression of a particular social group (Oliver 1992; Pfeiffer, 2002; Stone & Priestley, 1996).

According to Stone and Priestley (1996, p. 699) the cultural representation of PWD in Western societies "is underpinned by a conceptualization of disablement in terms of tragedy, the impaired body and Otherness". This is a result of the historical dominance of the positivist, and later the interpretive, research paradigms which alienates PWD either as objects to be studied, or subjects to be interpreted (Oliver 1992; Stone & Priestley, 1996).

Pfeiffer (2002, p. 7) takes the argument a step further by stating that "identifying as a person with a disability is an ideological act, the term disability is an ideological term, and there is no commonly accepted way to identify or define disability and to measure it". This critique has heavy implications on the view of WHO and other powerful institutions related to disability:

> "Not only does the World Bank in DALYs [*Disability Adjusted Life Years*] and the World Health Organization in the ICF try to measure an undefined concept (disability), they further the agenda of eugenics which will eliminate (kill off) people with disabilities. (Pfeiffer, 1992, 1994, 1998, 2000)" (Pfeiffer, 2002, p. 8).

Pfeiffer's (2002) following philosophical analysis uncovers how the oppressive paradigm has become universally dominant in Western societies.

The philosophy of oppression

Three major ontologies have dominated Western culture throughout its existence, each with an accompanying epistemology; one of Ancient Greece, one of Christianity, and one of modern philosophy and science.

Summing up the three main ontologies of Western thinking (see Appendix 1 for more details), Logos is the shared element that sustained the dichotomy between those with knowledge, true speech, reason and moral character, and those who have not been educated in the ways of the Logos. In other words, a gap of power between political/religious/intellectual leaders and their followers.

To Pfeiffer (2002, p. 13), it is clear that people "follow the political leader because of the Logos" and that all three Western ontologies "says that the populace must follow their leaders". Alignment with Logos have been a sign of authority in Western culture for more than two millennia, and as a consequence; following the leaders have become second nature to its population (Pfeiffer, 2002). In the ideal society of Western ontology, "The peasant must become pious (as defined by the religious leaders) and obey the law (as defined by the political leaders)" (Pfeiffer, 2002, p. 18).

The discrimination and oppression of PWD is, however, not merely a question of political power and authority. Logos is socially embedded in our thought and language, resulting in "the blanket acceptance of a series of dichotomies", which in turn creates stereotypes and the assumption of "a true value system" in modern ontology (Pfeiffer, 2002, p. 13). Such dichotomies includes objective reality/subjective illusion, body/mind, hard data/soft impressions, right/wrong, true/false, evil/good,

worthy/unworthy, beautiful/ugly – “And guess what? People with disabilities are wrong, false, evil, unworthy, and ugly” (Pfeiffer, 2002, p. 13). Such untested hypotheses, usually called stereotypes, constitutes important steps on the road towards discrimination and oppression, and unites the field of disability studies with other stereotyped minorities, including women, and people of colour, which are all characterised in opposition to the infamous `white males´ and their monopoly on power (Pfeiffer, 2002):

> “the stereotype of white males are that they are virile, manly, intelligent, smart, strong, able, are problem solvers, are natural leaders, run the world, are heterosexual, healthy, and good looking and in their lives they embody truth, goodness, value, justice, and beauty” (Pfeiffer, 2002, p. 14).

Making matters worse, ignorant stereotypes are often accompanied by inappropriate language:

> “To speak of grief, guilt, and bitterness in relation to people with disabilities is not appropriate. Nor should people with disabilities be described as courageous, noble, and brave because of what they have accomplished any more than any one else. Unlike the common stereotypes, people with disabilities can be sexual, sensual, and very good parents. They are not poor unless they are unemployed. They are not ignorant unless they were excluded from mainstream education and only provided special education. Many people with disabilities are quite brilliant in fact.”
> (Pfeiffer, 2002, p. 8).

The critique of Westen ontology becomes even more sinister, as “accepting the Greek, Christian, or modern ontology, as here outlined, leads to a fanaticism in which the "other" should be, needs to be, must be destroyed [because] giving one's life in the destruction of the lives of the "other" is the highest moral, ethical, and religious act possible” (Pfeiffer, 2002, p. 17). Such fanaticism is then used to explain the 9/11 attack on World Trade Center, American imperialism, German and Japanese military campaigns in the 1930s and 40s, as well as various genocides committed by the English, Russians, French, Spanish, Italian, Japanese, Chinese and Balkan nations (Pfeiffer, 2002).

Finally, the critique is directed towards ICIDH and ICF, which “uncritically embodies the modern ontology and its epistemology”, through which it “objectifies disability as a deficit and conveys stereotypes (the untested hypotheses) of the worst type”, thereby representing a mismatch “between the way people with disabilities experience disability and the way "outsiders" say disability ought to be experienced” (Pfeiffer, 2002, p. 15). Such a perspective on the history of ideas naturally warrants a replacement with an entirely new research paradigm – the nature of which will be covered in the following section.

The disability paradigm – emancipatory research

When critically reconstructing Western ontology into a more suitable paradigm of disability research, "only an experientially based epistemology will be sufficient" (Pfeiffer, 2002, p. 3).
In broad terms, disability is "created by a disabling environment and disabling attitudes (UPIAS, 1976), which are "socially constructed and culturally produced" (Oliver, 1990), and a form of structural oppression" (Abberley, 1987). The focus of researchers should therefore be on "the identification and removal of disabling physical and social barriers" (Stone & Priestley, 1996).
A subjective epistemology with emphasis on how disability is experienced is necessary, as any "claims to 'detachment' and 'objectivity' - where the context is one of oppression - are inherently flawed" (Stone & Priestley, 1996, p. 702). As the independent researcher is a myth (Barnes, 1996), one should engage "in processes of emancipation, rather than merely monitoring them from sympathetic sidelines" (Stone & Priestley, 1996, p. 703) – hence the proposed *emancipatory research paradigm* (Oliver, 1992; Stone & Priestley, 1996).
Researchers should engage in emancipation by "laying her/his research skills 'at the disposal of disabled people" (Barnes 1992, p. 122), thereby having the nature of the engagement determined by disabled people (Oliver 1992; Stone & Priestley, 1996**)**, In this way, researchers should be political activists, personally committed to the cause of improving the lives of PWD – thus becoming a *partner* rather than a *parasite* (Stone & Priestley, 1996**).**

Stone and Priestley (1996, p. 706)) sums up the emancipatory research paradigm by listing six central principles for its intended practice:

1) the adoption of a social model of disablement as the epistemological basis for research production
2) the surrender of claims to objectivity through overt political commitment to the struggles of disabled people for self-emancipation
3) the willingness only to undertake research where it will be of practical benefit to the self-empowerment of disabled people and/or the removal of disabling barriers
4) The evolution of control over research production to ensure full accountability to disabled people and their organizations
5) giving voice to the personal as political whilst endeavouring to collectivize the political commonality of individual experiences
6) the willingness to adopt a plurality of methods for data collection and analysis in response to the changing needs of disabled people

The emancipatory research paradigm remains open to a variety of interpretations, practices and theoretical foundations. This is neatly illustrated by Pfeiffer's (2002) review of the `nine versions of the disability paradigm´, which here is treated synonymously with the emancipatory paradigm:

Version	Description	Core idea	Weakness	Strength
(1) The social constructionist version as found in the United States (Pfeiffer, 2002, p. 5; 7)	Disability is socially constructed in interactions where "unexpected differentness [in function, appearance, or behaviour] is seen as a stigma by the so-called normal people"	"carrying out social roles and tasks produces discrimination"	Does not challenge existing social roles or value judgements. Similar to the deficit model in blaming the PWD for not fulfilling a social role.	"makes sense to many people for why a person is described as having a disability"
(2) The social model version as found in the United Kingdom (Pfeiffer, 2002, p. 5; 7)	A class perspective of disablity where society prevents PWD from participation in terms of employment and access. Agency of PWD is replaced by an empowerment of physicians and other health authorities.	"the organization of society also produces discrimination"	Explains why there is PWD but "is not a social theory which would lead to understanding and change". Alienates PWD who makes their own life decisions and have a job.	"its adherents are vociferous in its defense"
(3) The impairment version (Pfeiffer, 2002, pp. 5-7)	The impairment(s) differentiates PWD from non-disabled (and other PWD) and is the important variable	"an impairment in no way signifies tragedy and a low quality of life and to assume so is discriminatory"	Seen as a deficit model, and not fully developed. Furthermore, "impairments and disabilities are both socially constructed so that it is nothing new".	Drives a lot of research and is good for raising awareness of particular organisations (e.g. Cancer Society)
(4) The oppressed minority (political) version (Pfeiffer, 2002, p. 6; 7)	PWD as as second class citizens, barriers, dicrimination, leading many PWD to "see a correspondence of their experiences with those experienced by an oppressed minority group"	"people with disabilities are an oppressed minority"	Inadequate theoretical basis, too much emphasis on structure and too little on discourse, while using "dichotomies (disabled, non-disabled; rich, poor) which are limiting and not real". Also, "its militancy turns off non-disabled people"	"Its insights, however, are useful in research and it is very useful for organizing and advocacy"
(5) The independent living version (Pfeiffer, 2002, p. 6; 7)	Independent living as a fundamental right; disability as socially created barriers (no deficit) against this (i.e., poor support services, professionals trying to control)	"all people need various services in order to live independently"	None, although its use is limited to "investigating certain topics"	Good for advocacy and organising
(6) The post-modern (poststructuralist, humanist, experiential, existential) version (Pfeiffer, 2002, p. 6; 7)	"Disability is a cultural and political construct which needs to be decoded and deconstructed in order to set forth the basic orientations and unstated assumptions about disability and people with disabilities. Everyone has an agenda and this agenda must be set forth."	"all people have agendas most of which result in discrimination, but especially discrimination based on disability"	"not understandable by most academics much less the general public", and "of no use in organizing and in advocacy"	None ("But it certainly has its adherents who use it as a basis for their work")
(7) The continuum version (Pfeiffer, 2002, p. 6; 7)	There is a continuum from non-disabled to disabled and everyone will eventually become disabled (old and dead)	"everyone will eventually become disabled"	None	Explains "why everyone should be concerned about discrimination" of PWD
(8) The human variation version (Pfeiffer, 2002, p. 7)	PWD "suffer discrimination because the disability community is so varied, not just different. Society simply is not able to deal with the wide variation in the complex disability community and standardization will not work."	"there is no "normal" human behavior which can be the basis of social policy"	"It relies too much on the concept of normal and it views policy outcomes (such as the ADA) as an attempt to remedy discrimination when it actually is a statement of rights"	None
(9) The discrimination version (Pfeiffer, 2002, p. 7)	Discrimination is the issue, not disability. "Disability rights are civil rights", "a person with a disability only feels she is disabled when confronted with discrimination", "We must not be seen as being in a protected class with special prerogatives because that destroys all ideas of equality"	"discrimination against persons with disabilities is found everywhere at all times"	None (this version was developed by the Pfeiffer himself)	Discrimination unites the 9 versions and "opens up a vast area of research". Good for organising, very good for advocacy

Fig. 3 – *Nine versions of the disability paradigm* (Pfeiffer, 2002, pp. 5-7).

The disability/emancipatory research paradigm holds two major implications (Pfeiffer, 2002). First, PWD must have free agency where their life decisions is now dominated by professionals and service providers. Second, society (being the disabling/discriminating/oppressing factor) must change – not PWD.

In conclusion, researching disability, or identifying yourself as a PWD, is an ideological act which cannot be separated from the political arena (Pfeiffer, 2002). Furthermore, uncritically conforming to traditional Western ontology signifies the doom, death and destruction of PWD, and the current paradigm (modern/scientific) is therefore in urgent need of replacement:

> "Any ontology which presents a world of experience as inferior to a world of divine law will lead to the oppression of people with disabilities. Any ontology which emphasizes ablism and normality dooms people with disabilities to destruction. Any ontology which presents an epistemology based on authority and conformity results in the death of people with disabilities" (Pfeiffer, 2002, p. 18).

Responding to this horrifying situation requires the adoption of a sceptical, experience based social epistemology in the attempt to "cleanse the intellect of people who disagree with that position" (Pfeiffer, 2002, p. 18). After having cleansed the intellect, worked out a new epistemology and applied it to reconstruct a "personal ontology" (Pfeiffer, 2002, p. 14), realising emancipatory research is still not without its challenges. First of all, critical thinking and discussion is difficult in English, as is deeply connected to the history of philosophy, and "fundamentally Platonic in its ontology and epistemology" (Pfeiffer, 2002, p. 15).

Secondly, the proposed research paradigm relies heavily on social constructivism to conceptualise the experience of disability, thus relying on the assumed existence of "social groups, social organization, social oppression, and social ways to deal with differences usually by creating social barriers", while on the other hand; "only the individual self exists with its perceptions" (Pfeiffer, 2002, p. 16). These two statements are mutually contradicting. As admitted by Pfeiffer, testing a hypothesis about social forces within a constructionist framework is like testing for "extraterrestrial aliens or demons or ghosts or gods" (Pfeiffer, 2002, p. 16). This issue becomes a practical problem when relating the definition of disability to the experience of oppression, as not all PWD shares this experience (Shakespeare, 2008; Stone & Priestley, 1996).

Revisiting the problem: If the socio-political focus of the original social model was problematic for a pragmatic approach on disability and accessible tourism, the shift towards extreme ideology, militant argumentation and emancipatory research further reinforces this standpoint. Disability studies have become a self-sufficient echo-chamber, not suited for the multidisciplinary focus embedded in tourism research – particularly when concerned with practical products and solutions.

The Convention on the Rights of Persons with Disabilities (CRPD)

In order to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities", UN (2006, p. 4) presented the *Convention on the Rights of Persons with Disabilities* (CRPD). This convention follows up on the earlier *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* (UN, 1993), criticised for conceptually distinguishing between "disability" as a lack of function, and "handicap" as a lack of participation – highly similar to the evolution from ICIDH to ICF (see Appendix 1).

CRPD recognises that "disability is an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (UN, 2006, p. 1). In other words:

> "Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (UN, 2006, p. 4).

This definition summarises the ICF framework in a simplified sentence, and thus, CRPD does not contribute to a new perspective or model of disability. Instead, it focuses on how policy makers in UN member states can unite in facilitating human rights and fundamental freedoms for persons with disabilities. This goal is to be achieved by means of non-discrimination, full participation, inclusion, accessibility, and equalisation of opportunities. With this purpose in mind, the concept of *universal design* is introduced to the UN context:

> ""Universal design" means the design of products, environments, programmes and services to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design" (UN, 2006, p. 4).

CRPD has direct implications on tourism, as described in Article 30; *Participation in cultural life, recreation, leisure and sport*, which ensures the right to:

> *1. (c)* "Enjoy access to places for cultural performances or services, such as theatres, museums, cinemas, libraries and tourism services, and, as far as possible, enjoy access to monuments and sites of national cultural importance" (UN, 2006, p. 22).

This obligation involves;

> *5. (c)* "To ensure that persons with disabilities have access to sporting, recreational and tourism venues" (UN, 2006, p. 23).

And: *5. (e)* “To ensure that persons with disabilities have access to services from those involved in the organization of recreational, tourism, leisure and sporting activities” (UN, 2006, p. 23).

Including access to such venues and activities as an obligation of human rights invites questions on how this should be financially realised. Improving accessibility requires resources that can be provided by either the government, the individual business owner or the visitor in form of higher prices. In practice, this question is left in the hands of legislators in each country or region (i.e., the European Union), which will be the focus in the following section of the thesis.

Revisiting the problem: CRPD brings the framework of ICF, thus including crucial elements of the social model, into an international context of human rights and policy. Accepting the premise of the social model being unfit for multidisciplinary research and development, further emphasised by the ambiguity of a biopsychosocial compromise, this is a practical step back from previous, medically oriented distinctions between disability as a physical phenomenon and handicap as a social issue (Harris, 1971; UN, 1993). Physical/functional issues demands particular types of treatment, be it theoretically or in the practice of health care and rehabilitation, whereas social issues belong to a different domain, generally regulated politically. Merging these domains requires a holistic methodology suited for approaching biopsychosocial issues – something which remains to be fully developed by either WHO or the United Nations.
Again, this reinforces the standpoint of the medical model discourse being associated with one domain research and practice, and the social model with another. These domains each have more or less legitimate methodologies and theoretical foundations which crumbles in the attempt of synthesis.

Accessibility: Legislation, principles and strategy

UNWTO's *Recommendations on Accessible Tourism*

The raised awareness of discrimination against PWD, which grew with the introduction of disability studies programs and publications, was quickly gaining influence on international policy makers. The UN (2006) *Convention on the Rights of Persons with Disabilities* (CRPD) thus became the fastest negotiated human rights treaty, receiving the highest number of signatories in the history of UN Conventions during its opening day[8].

The political responsibilities prescribed by CRPD naturally applied to UNWTO, the United Nations World Tourism Organization, resulting in an an increased focus on the "tourism sector's obligations to ensure that people with disabilities can exercise their right to enjoy leisure, sport and tourism under the same conditions as other people" (UNWTO, 2013, p. 2).

Based on CRPD, and maintaining a clear parallel to the social model of disability, UNWTO (2013, p. 4) defines the disabled tourist as "any person whose full and effective participation in society on an equal basis with others in travel, accommodation and other tourism services is hindered by the barriers in the environment they are in and by attitudinal barriers".

It is further clarified that "Understanding disability as an interaction [between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others] means that disability is a social construct, not an attribute of the person" (UNWTO, 2013, p. 4).

Facilitating travel opportunities for PWD is therefore described as an essential part of a responsible and sustainable development that will give rise to "equitable and accessible tourism for all", which in turn will create jobs and tax revenue, and hence (despite the extensive emphasis on human rights and social responsibility), "seen as an opportunity rather than an obligation" (UNWTO, 2013, p. 2).

With this in mind, `Accessible Tourism for All´ is defined as "a form of tourism that involves a collaborative process among stakeholders that enables people with access requirements, including mobility, vision, hearing and cognitive dimensions of access, to function independently and with equity and dignity through the delivery of universally designed tourism products, services and environments" (UNWTO, 2013, p. 4). This definition is based on Darcy (2006, p. 3) who first conceptualised accessible tourism as "a process of enabling people with disabilities and seniors to function independently and with equity and dignity through the delivery of universal tourism products, services and environments (adapted from Olympic Co-ordination Authority 1999[9])".

8 According to the UN website; https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

9 Government agengy involved in planning the Sydney 2000 Olympic and Paralympic Games.

With the definition targeting all people with access requirements (tourists with mental, intellectual or sensory impairments, the elderly, temporarily disabled people, people carrying heavy luggage, and people of every size) are grouped together in a highly diverse market segment.

To facilitate accessible tourism, UNWTO is recommending `reasonable accommodation´ and accessibility of the built environment based on *The Seven Principles of Universal Design* (see text box). Reasonable accommodation refers to the requirement of "necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden" on the business owner (UNWTO, 2013, p. 5) – in other words, balancing the cost of investment against the actual access demands. For example, in Danish building legislation, a hotel with 200 rooms is deemed `accessible´ if only ten of them follow the criteria for wheelchair access (Hansen, 2017).

The Seven Principles of Universal Design
(Connell et al., 1997):

Principle 1. Equitable use
The design is useful and marketable to people with diverse abilities.

Principle 2. Flexibility in use
The design accommodates a wide range of individual preferences and abilities.

Principle 3. Simple and intuitive use
Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.

Principle 4. Perceptible Information
The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.

Principle 5. Tolerance for error
The design minimizes hazards and the adverse consequences of accidental or unintended actions.

Principle 6. Low physical effort
The design can be used efficiently and comfortably and with a minimum of fatigue.

Principle 7. Size and space for approach and use
Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.

As with the concepts of disability and the disabled traveller, the definition of reasonable accommodation is adopted directly from CRPD (UN, 2006, Article 2) which is also the source of defining "Discrimination on the basis of disability" as;

> "any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others, of all human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field. It includes all forms of discrimination, including denial of reasonable accommodation" (UN, 2006, Article 2; UNWTO, 2013, p. 5).

Using the example of a 200-room hotel under Danish legislation, failing to provide ten rooms with wheelchair access is to discriminate on the basis of disability, thus breaking the law throughout the

United Nations[10]. Tourism businesses may choose to see accessibility as an opportunity but may not ignore it as an obligation.

The principles of universal design should be applied to entire destinations and regions, rather than at the level of individual stakeholders such as a hotels and restaurants. To succeed in this involves a wide improvement of tourism-related infrastructure from a holistic perspective throughout the tourism chain, including (UNWTO, 2013, p. 6):

A. Tourism destination management
B. Tourism information and advertising (Preparation, information and booking)
C. Urban and architectural environments
D. Modes of transport and stations
E. Accommodation, food service and conventions
F. Cultural activities (museums, theatres, cinemas, and other)
G. Other tourism activities and events

Aside from the built environment and infrastructure being designed to facilitate special access needs in each element of the chain, staff training – another key point in CRPD – plays a very important role in achieving full accessibility of the tourism industry (UN, 2006; UNWTO, 2013).

Although remaining severely under-researched due to the academic infancy of the subject, the importance of staff training and education in relation to PWD needs is stressed throughout the literature on accessible tourism – other examples including Bizjak, Kneževic & Cvetrežnik (2011), Burnett & Bender-Baker (2001), Darcy & Pegg (2011), Daruwalla & Darcy (2005), European Commission (2013; 2014), Kim, Stonesifer & Han (2012), Navarro, Garzón & Roig-Tierno (2015) and UNWTO (2016).

10 CRPD is ratified in 177 countries, including all EU member states.

Accessibility in Europe

While the United Nations sets a global tone on human rights, disability, discrimination and accessibility, the specific legislation and status on achieving accessible environments varies between its sovereign members. Notable policies with an international impact on accessible tourism includes the United States' ADA; *The Americans with Disabilities Act of 1990* (Burnett & Bender-Baker, 2001; Darcy & Pegg, 2011; Kim, Stonesifer & Han, 2012), Australia's DDA; the *Disability Discrimination Act, 1992* (Darcy & Dickson, 2009) and the European Union's ECA; the *European Concept for Accessibility* of 1996 (EuCAN, 2003). Note that the ECA itself does not bind by law, but is rather a *Technical Assistance Manual* which, along with the *European disability strategy 2010–2020* (European Commission, 2010), is guiding the individual policies of EU member states. A binding *European Accessibility Act*, based on CRPD and aimed at standardising and improving the accessibility of specific products and services is currently being negotiated but has not yet been adopted (EU, 2017; FRA, 2018). Given the Danish/European focus of this thesis, further focus will be directed at the EU legislation and principles before delving into the specifics of Danish law.

With reference to *The Universal Declaration of Human Rights* (UN, 1948) and later the *Standard Rules on the Equalisation of Opportunities for Persons with Disabilities* (UN, 1993), accessibility has been part of EU policy since 1985, making the current version of ECA (EuCAN, 2003) firmly based within the framework of the United Nations, despite predating the CRPD.

The fundamental basis of the European philosophy for accessibility is “human rights at all levels of society” in a “context of high human health, safety, comfort and environmental protection”, where accessibility is “an essential attribute of a "person-centred", sustainable built environment” (EuCAN, 2003, p. 1).
In this person-centred environment, human diversity is described as an undeniable resource for society:

> “It is unfortunate that even today many people still believe that decisions regarding an individual's welfare and his/her integration into society can be based upon personal differences (race, gender, beliefs, age, abilities, circumstances, etc.).
> For to deny that human diversity enriches culture and, consequently, each individual who develops within it, is to deny the innate ability which all of us have to learn and benefit from new situations” (EuCAN, 2003, p. 28).

With Europe becoming increasingly diverse due to its high quality of life, immigration, birth rate

and civil rights, integration and the right to independent living is fundamental in ensuring equal opportunities and accessible environments.

Universal design is "the cornerstone of a fully inclusive society" that enables human diversity to thrive as required by human rights (EuCAN, 2003, p. 7). Three principles of universal design are stated (EuCAN, 2003, p. 14), contrary to the seven known from Connell et al. (1997):

1. The objective is the provision of environments which are convenient, safe and enjoyable to use by everyone, including people with disabilities.
2. The universal design principles reject the division of the human population into able-bodied and disabled people.
3. Universal design includes supplementary provisions where appropriate.

Living in an accessible environment (EuCAN, 2003, p. 41):

- We have no problems putting our rubbish bags into street containers.
- The bus we take to work has a low floor.
- We do not come across obstacles on the pavement when we go for a walk.
- We receive both visual and audible information.
- The instructions for use of a domestic appliance are clear.
- We can use the various services available in our area without problems.
- Children can play in the park without being exposed to risk.

In order to "eliminate the segregation of disabled people from society" (EuCAN, 2003, p. 8), everyone must have equal access to services, goods and the built environment, which may include modified natural environments such as recreational forests and paved beaches.

An accessible environment based on universal design must to be (1) *Respectful* of human diversity, (2) *Safe*, (3) *Healthy*, (4) *Functional* "in such a way that it can carry out the function for which it was intended without any problems or difficulties", (5) *Comprehensible* in providing easy orientation, clear information and coherent spatial distribution, and (6) *Aesthetic* with the purpose of being "likely to be accepted by everybody" (EuCAN, 2003, p. 20-21).

To achieve these goals, the European Union should be committed to support with complementary measures (e.g., EU funding), legislative initiatives, training of relevant stakeholders and facilitation of dialogue and information exchange between relevant partners, all within a context of sustainable development to benefit future generations (EuCAN, 2003). As the United Nations CRPD was published in 2006, the EU strategy on disability and accessibility was adapted to support its full implementation throughout Europe (European Commission, 2010).

In addition to revisiting their disability strategy, the EU (2012; 2012a) agreed on a series of legislative principles, compiled in the *Charter of Fundamental Rights of the European Union* (CFR) and the *Treaty on the Functioning of the European Union* (TFEU), concerning the collective commitment to human dignity, non-discrimination and integration of PWD (see Appendix 2 for a collection of relevant CRPD, CFR and TFEU articles). CFR and TFEU are largely inspired by CRPD, and together, these three documents form the foundation of the current European disability strategy.

Along with CRPD, CFR and TFEU, the EU disability strategy continues applying the social constructivist argument of PWD being prevented from participation in society (and thereby being imposed with disability) "because of environmental and attitudinal barriers" and pointing out poverty and unemployment rates as evidence of discrimination (European Commission, 2010, p. 3). The strategy is therefore focused on eliminating such barriers, with eight areas identified as primary targets for action (see textbox[11]).

The overarching goal is to create smart, sustainable and inclusive growth by ensuring "Full economic and social participation of people with disabilities" (European Commission, 2010, p. 4), requiring;

1) Awareness-raising
2) Financial support
3) Statistics and data collection and monitoring
4) Mechanisms required by the UN Convention (referring to CRPD, Article 33)

Eight main areas for action (European Commission, 2010, p. 5-9):

1 – Accessibility
Ensure accessibility to goods, services including public services and assistive devices for people with disabilities.

2 – Participation
Achieve full participation of people with disabilities in society by:

- enabling them to enjoy all the benefits of EU citizenship;
- removing administrative and attitudinal barriers to full and equal participation;
- providing quality community-based services, including access to personal assistance.

3 – Equality
Eradicate discrimination on grounds of disability in the EU.

4 – Employment
Enable many more people with disabilities to earn their living on the open labour market.

5 – Education and training
Promote inclusive education and lifelong learning for pupils and students with disabilities.

6 – Social protection
Promote decent living conditions for people with disabilities.

7 – Health
Foster equal access to health services and related facilities for people with disabilities.

8 – External Action
Promote the rights of people with disabilities within the EU external action.

11 EU external action (area 8) = *The European External Action Service* (EEAS).

Following up on the *European disability strategy 2010–2020*, The European Commission (2013) later published a study on the *Economic Impact and Travel Patterns of Accessible Tourism in Europe* estimating that "by 2020 the demand by people within the EU will grow to about 862 million trips per year whilst the demand by the key international inbound markets will reach 21 million trips per year" (European Commission, 2013, p. 466). Taking all effects into account, people with special access needs may then generate up to 1133 billion Euros of total output, along with 13 million jobs, supporting the argument of accessible tourism being a valuable business opportunity and not just a legal obligations. Naturally, these numbers may rise and fall depending on the accessibility of the future environment. With one in six in the EU being counted as having a disability (European Commission, 2010), it is not surprising that a massive economic impact is expected from this costumer segment.

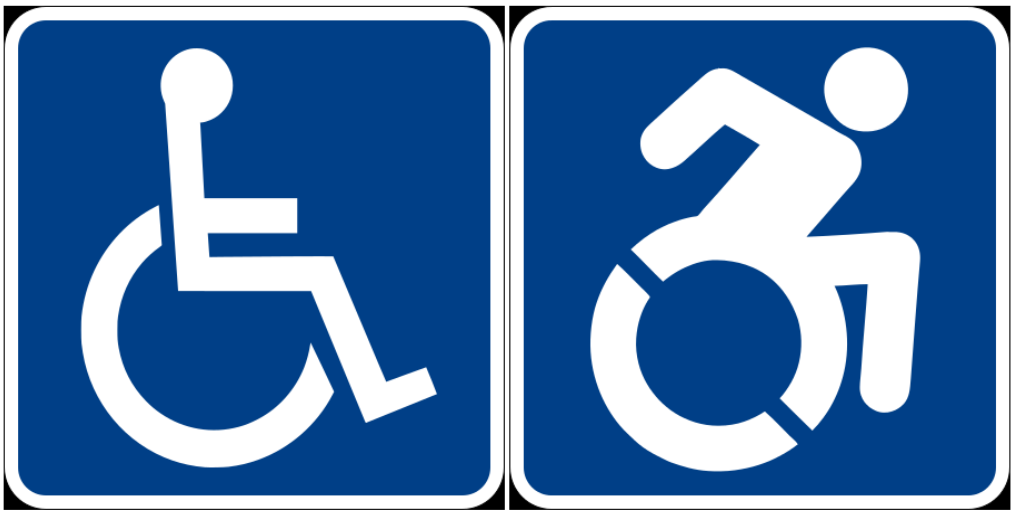
Several factors are needed if the estimated growth is to prove correct. The effort must be highly coordinated between public and private stakeholders with long-term planning and investments (including direct financial support from EU), standards and legislation should be harmonised across EU members, marketing and advertising strategies needs improvements, and sufficient accessibility information must be included in mainstream platforms to provide accessible offers across all categories of services and prices, particularly in airports, aircraft, public transport, pathways, parking and nature-based activities where barriers are most often encountered (European Commission, 2013). Furthermore, tourism service providers should always listen to the different needs and expectations of guests and, with EU support, continuously improve the education and training of staff and management to better cater to PWD (European Commission, 2013).

In relation to the latter point, another follow up study was conducted; *Mapping skills and training needs to improve accessibility in tourism services* (European Commission, 2014). Acknowledging that "the level of awareness and qualifications of tourism services providers is inadequate to address the needs of people with disabilities", seven essential training types and skills are identified to solve the issue (European Commission, 2014, p. 24):

1) Knowledge of disabilities / types of disability and access requirements
2) Barriers to accessibility & Design for All
3) Strategic development of accessibility in business
4) Principles of effective customer service
5) Proper etiquette for dealing with PwD
6) Recognising and responding appropriately to people using personal supports
7) Service animals and assistive technology

To effectively manage financial and human resources, training provision must reflect the occupational role of each staff member (e.g., managers with/without customer contact) in order for everyone to be best suited to their particular task in the tourism operation.
Based on expert interviews and review of case studies, The European Commission (2014, p. 6) found "lack of awareness of accessibility and the lack of a convincing business case for accessibility training" to be the greatest barriers to accessibility training provision, with many respondents still viewing accessibility a matter of legal compliance rather than business opportunity.

The core argument for a business case has already been presented; there are millions of PWD with billions of Euro and willingness to travel, thereby generating the demand for accessible tourism. Convincing stakeholders of this argument is therefore seen as largely a matter of awareness-raising. To this end, there is "a strong case for a European certificate" which may help standardise and professionalise training provision, raise awareness of accessibility and serve as a marketing tool and added-value for businesses (European Commission, 2014, p. 71). Such certificates exist in certain countries but they do not give academic credit and are generally not recognised in the wider tourism sector. Similarly, there are no internationally recognised certificates for accessible tourism facilities, public areas, transportation, etc. A partial exception is the International Symbol of Access (ISA), which is recognised globally despite its meaning not being fully defined. The ISA has been subject so severe criticism for further marginalising PWD by representing the entire group as passive, helpless and machine-like wheelchair-users (Ben-Moshe & Powell, 2007), why several redesigns have been proposed in recent years. Below is an illustration[12] of the official ISA (left), along with the more dynamic posture presented by *The Accessible Icon Project*[13] (right), based in the United States and currently among the most influential alternatives:



12 From *Wikimedia Commons, the free media repository* (2018) https://commons.wikimedia.org
13 From http://accessibleicon.org/

Accessibility in Denmark

With the strategy being clear, another follow-up study was soon published by the European Commission (2015) with the self-explanatory title; *Mapping and Performance Check of the Supply of Accessible Tourism Services*.

A total of 313,286 accessible tourism suppliers was identified throughout the European Union. 224,036 of these are listed in *Accessibility Information Schemes* (AIS) of each member state (with the exception of Bulgaria, Lithuania, Hungary and Slovakia), while the remaining 89,250 were located by *Pantou* (ENAT, 2014), an online directory of Accessible Tourism facilities in Europe, created with support of the Commission for the purpose of said study and, since 2017, managed independently while being maintained by ENAT (*the European Network for Accessible Tourism*). With roots in these datasets (AIS and Pantou) all EU member states are ranked from `front-runners´ to `low achievers´ based on their "effectiveness of the supply of accessible services" (European Commission, 2015, p. 57) and "provision of accessible tourism services and facilities" (European Commission, 2015, p. 88) – or, roughly speaking, quality and quantity of their accessible offers:

Effectiveness of the supply of accessible services (European Commission, 2015, p. 57)

Front-runners:	Finland, **Denmark**, Spain, Ireland, Luxembourg, Cyprus, Malta, Lithuania, France, Poland, Austria, UK
Improvers:	Latvia, Netherlands, Portugal, Greece, Sweden, Czech Republic, Germany, Slovenia
Late-starters:	Hungary, Estonia, Belgium, Italy
Low achievers:	Bulgaria, Croatia, Slovakia, Romania

Provision of accessible tourism services and facilities (European Commission, 2015, p. 88):

Front-runners:	Spain, Belgium, UK, Italy
Improvers:	Germany, Portugal, France, **Denmark**, Finland, Sweden, Czech Republic, Slovenia, Luxembourg, Croatia
Late-starters:	Malta, Cyprus, Ireland, Poland, Latvia, Austria, Netherlands, Greece
Low achievers:	Bulgaria, Romania, Estonia, Lithuania, Hungary, Slovakia (naturally including the four states without AIS given their lack of data)

In addition to the overall EU-wide analysis, where lack of information on accessibility was found to be the most frequently encountered barrier, individual country reports were developed for each member as part of evaluating the availability and quality of accessible offers.

When the country reports were published in 2015, there were no “market studies or reports which describe the numbers and types of tourists/visitors who make up the accessible tourism segment” in Denmark (European Commission, 2015a, p. 8; 39) – a gap of knowledge which VisitDenmark has since worked to fill (VisitDenmark, 2017).
Accessible facilities in Denmark are registered by FTA; Foreningen Tilgængelighed for Alle [*Association of Access for All*] who manages the official AIS and accessibility certification system, God Adgang [*Good Access*], at godadgang.dk (FTA, 2003). God Adgang was founded with representatives from the tourism industry and national disability organisations and was the main provider of data for the European Commission (2015a) study. Pantou, which currently lists 24 accessible suppliers in Denmark, 22 Scandic Hotels and two travel agencies (ChrisTravel and HandiTours & Profil Rejser A/S), was of minor importance in analysing the Danish market.

According to VisitDenmark (2017, p. 6), “Accessible tourism - also known as tourism for all - is based on the concept of `universal design´, which is focused on (re-)designing facilities, products and services, so that everyone has the opportunity of participating”, meaning that “everyone - physical functional impairment or not - must have the opportunity to travel to any area, attraction or event, as they wish”. This definition is drawn from ECA (2003) and The Nordic Council on Disability Policy [*Nordiska Handikappolitiska Rådet*] (NHR, 2004), embedding Danish disability and accessibility policies in the international context. By extension to the conceptual framework, Danish building legislation on accessibility is principally aiming at `accessibility for all´ [*tilgængelighed for alle*] (Hansen, 2017). To qualify as an accessible tourism provider in Denmark is a matter of compliance with the *Building Regulations 2018* [*Bygningsreglementet*] (BR18) issued by The Danish Transport, Construction and Housing Authority under the Ministry of Transport, Building, and Housing (TBST, 2018). The Danish Building Research Institute [*SBi; Statens Byggeforskningsinstitut*] is then responsible for developing detailed instructions [*SBi-anvisninger*] on how to follow the regulations. BR18 is structured differently than its predecessor, BR15, but is otherwise identical regarding the regulations on building accessible accommodation (TBST, 2017; 2018). For this reason, and since the instructions on BR18 are still under development, *SBi-anvisning 258* on BR15 (Hansen, 2017) served as the primary source for understanding the relevant specifics of Danish building legislation.

Although targeting everyone in principle, the Building Regulations refers exclusively to wheelchair accessibility. For hotels, inns and similar accommodation it is stated that one fifth of beds must be wheelchair accessible and established with en suite facilities (Hansen, 2017, 3.6. STK 1).

The actual requirements are however significantly lower and only applies to accommodation facilities with 10 beds or more (see *Fig. 9* to the right).

Total beds	Accessible beds
10-20	2
21-59	4
60-79	5
80-99	6
100-119	7
120-139	8
140-159	9
160-	10

Fig. 9: SBi on accessible beds (Hansen, 2017, 3.6, STK. 3)

As seen in *Fig. 9*, having ten wheelchair accessible beds with en suite facilities is sufficient, regardless of the size of the hotel. To qualify as an accessible beds, the room (particularly the toilet and bath) must be constructed after a specific layout and dimensional characteristics to ensure manoeuvrability and safety for wheelchair users. Similar rules apply to balconies is such are part of the rooms.

Several other aspects of buildings (doors, pathways, elevators, etc.) are graded as quality-level A, B or C based on specific measurements (Hansen, 2017). For legal compliance, all elements in the building must meet the `C´ standard while `B´ is required to be included as an accessible facility by God Adgang (European Commission, 2015a).

Despite the strategic importance and legal obligations towards universal design, accessibility does not influence the stars accreditation of Danish hotels (European Commission, 2015a).

Providers of accessible accommodation are dependent on the accessibility of the supporting tourism infrastructure. Without accessible transportation and attractions, tourists with access needs will likely look for another destination – hence the need for public-private partnerships, planned investment and a widely scoped strategy.

From a holistic perspective, Denmark is a highly accessible tourist destination with only Spain and UK being significantly ahead in the EU market (European Commission, 2015). Accessible accommodation can be found throughout the country, most of the major attractions and museums are accessible, public buses and trains are generally accessible (*good access*), with the more recently built Copenhagen Metro being fully accessible (*excellent access*) for wheelchair users and visually impaired (European Commission, 2015a). Of the included factors in the Commission country report, only the availability of accessible taxis/vans is somewhat lacklustre as they are a public service for Danish PWD but not for tourists, although they may be available for private hire in major cities (European Commission, 2015a).

Looking at the case of accessibility in Denmark also reveals the culture-dependency of language. As discussed earlier, `handicap´ is now considered to be derogatory term in most English-speaking countries and has therefore been replaced by `disability´ or other more appropriate terms, such as

`handicapable´ or `diverse ability´. There is no clear logic behind the quickly changing tides of political correctness, especially when considering the discourse on social media and television. For example, almost as quickly as handicapable emerged as a polite alternative to handicap/disability, it was deemed inappropriate and ridiculous – all it took was an episode of South Park, a widely popular satirical cartoon.

With this in mind, it is less surprising that handicap is still being used to describe PWD in non-English speaking countries such as Denmark, Sweden (*handicap* for sports, *handikapp* for people), Netherlands and France. For example, the UN CRPD (ratified in Denmark in 2009) is known in Danish as *FN's Handicapkonvention*, disability organisations are known as *handicaporganisationer* and PWD is translated as *personer med handicap* (VisitDenmark, 2017).

One exception is found in a Danish guide to ICF (Melchiorsen, Østergaard & Nielsen, 2011), translating disability to *funktionsevnenedsættelse* [lowering of functional ability] as opposed to impairment simply being a *funktionsnedsættelse* [lowering of function]. As the original ICF text (WHO, 2001), the Danish translation uses a commonly recognised definition of impairment (*funktionsnedsættelse* is widely used in the Danish health sector, including the translation of CRPD) while *funktionsevnenedsættelse* is a term made up for the the occasion and not encountered outside the context of ICF.

Revisiting the problem: In the European Union, including Denmark, the obligation of ensuring access to private tourism venues and activities is the responsibility of the individual business owner, whereas an accessible public domain and infrastructure is in the hands of national governments, guided by the principles of universal design. The primary problem here is that the legislative demands are rather one-dimensional in solely focusing on the mobility of wheelchair uses. Full accessibility, as required by CRPD, is thus not achieved by legal compliance alone.

However, one must start somewhere when undertaking such an enormous task and Denmark is currently in a good position of enforcing such legislation compared to its immediate competitors, including Sweden, Germany and the Netherlands.

In short, stakeholders must take steps go beyond legal compliance if the Danish tourism industry is to achieve the full potential of the accessible market. Thankfully, such steps are not out of reach, given the current status on accessibility, a highly developed welfare system, a mostly effective public infrastructure, as well as a population with high average income, travel frequency and quality of life.

Accessible tourism research

Since the inception of accessible tourism as a field of research, the majority of studies have been focused on various barriers encountered by PWD and hindering their participation in tourism activities (Blichfeldt & Nicolaisen, 2011; Lyu, 2017; Michopoulou & Buhalis, 2013). Research findings relating to such barriers will be reviewed under three categories; environment, attitude and discrimination.

Following this section, less prevalent research topics will be covered, including accessible information provision, economic impact of accessible tourism, PWD motivation and decision-making, as well as accessible destination competitiveness and value co-creation.

Nearly all research in accessible tourism fall under the categories outlined above. As a consequence, we have severe gaps of knowledge in other areas, such as marketing and branding of accessible products and return on investments (RoI) when improving accessibility (Bowtell, 2015), a discussion of which will conclude this chapter.

Lack of accessible environments

Being frequently referenced in other publications, most notably UNWTO (2013), Australian Professor Simon Darcy is amongst the most influential researchers and advocates of accessible tourism. His works are based on a *Whole-of-Life Approach* to tourism where disability is understood as a natural and unavoidable part of human lifespan, including the temporary disability of families with young children, seniors with access considerations and people with physical injuries (Darcy & Dickson, 2009). Describing disabled travellers in terms of access requirements is useful for arguing that accessible tourism is a benefit for all, as in this perspective, everyone is disabled at some point in life (Darcy & Dickson, 2009; EuCAN, 2003; Pfeiffer, 2001). Using the Australian population as example, the Whole-of-Life Approach to tourism expands the customer segment of the the `Easy Access Market´ from 20% living with a disability to 31% having access requirements (Darcy & Dickson, 2009, p. 33).

Darcy adheres strongly to the social model of disability by characterising the cause of access requirements as “a product of the disabling tourism environment [where] it is not the person’s impairment that is disabling but the social exclusion that they are subjected to by environmental design or service attitude” – serving to argue that society is obligated to “improve the lives of PwD, giving them the same opportunities as others” (Darcy & Pegg, 2011, p. 470). This obligation should be realised through universal design of the built environment to provide accessible facilities connected by a system of uninterrupted pathways, with independence, equity and dignity being the

core values to strive for (Darcy & Dickson, 2009). Accessible accommodation and universally designed environments should be accompanied by detailed, accessible and up-to-date information in order for guests to locate their destination and trust that it complies to the given access standards (Darcy, 2010).

By **failing to to provide necessary information** and accessible services, some travel agencies acts as inhibitors rather than facilitators of accessible tourism (McKercher, Packer, Yau & Lam, 2003). A major reason for this is the financial reality of the tourism industry leaning towards standardised package products (mass tourism), which in effect is a structural barrier, making accessibility a peripheral priority involving extra cost and effort for everyone involved (McKercher et al., 2003). Even if when the accessible environment and information is properly designed, **affordability** remains as "the most important barrier to participation", given that disabled people are more likely to live with low employment and income (Pagán, 2012, p. 1518).

Negative attitudes towards PWD

With the increased focus on disability rights and experiences, societal attitudes have become more positive towards PWD. However, this positive development does not always match personal attitudes where human rights and integration of minorities are generally lesser prioritised issues (Bizjak, Kneževic & Cvetrežnik, 2011). A similar result is found by distinguishing between verbal and unverbal attitudes where "the public verbalizes favorable attitudes towards people with disabilities but actually possesses deeper unverbalized feelings which are frequently rejecting" (Daruwalla & Darcy, 2005, p. 549). As a society, we can all agree on the necessity of civil rights, equity and equality for PWD, but in reality, few are personally interested and engaged in the issue. Despite laws and regulations ensuring the rights of PWD, people in tourism management positions often lack fundamental knowledge about disabilities while showing little willingness to include PWD as target customers or employees. As is often the case with issues of corporate social responsibility (CSR), "marketing organizations are very clever at providing politically correct responses" (Bizjak, Kneževic & Cvetrežnik, 2011, p. 842). Corresponding with the trend of **political correctness**, one can easily find tourism businesses with positive and inclusive attitudes towards PWD and a desire to provide quality experiences, even when there is "no pro active approach to developing disability as a market segment; low levels of disability awareness/training; and no specific marketing and promotion information central to inform decision making for their access needs" (Darcy & Pegg, 2011, p. 475).

For the vast majority of tourism businesses, accessibility is **entirely a matter of legal compliance** – "satisfying a set of costly rules for a customer group that is often not even desired" (Burnett &

Bender-Baker, 2001, p. 4). Similar statements results from interviewing European business owners and managers, reporting that the biggest reason (89%) for improving accessibility was “To be seen as socially responsible”, with only 11% of respondents attributing it to a “Fight for market share” (Bowtell, 2015, p. 215). The same study concluded that **cost of investment** was a major hindrance to improving accessibility – as one respondent stated; “[…] to deliver the right product, you are going to have to invest, in something that your core customer doesn’t require and you are not going to be able to charge a premium for it” (Bowtell, 2015, p. 211).

A practical aspect of negative personal attitudes towards PWD has been found by interviewing Australian accommodation managers who reports “low occupancy of the accessible rooms and that non-disabled customers do not like using accessible rooms” (Darcy, 2010, p. 816). More research is needed to know if the **negative perception of accessible rooms by the non-disabled** is an isolated issue or a general problem in the industry (Darcy & Pegg, 2011).

Tourism education rarely (if ever) includes accessible tourism, and hence, changing educational priorities is considered an effective method for bringing about more positive personal attitudes towards disabled guests (Bizjak, Kneževic & Cvetrežnik, 2011; Darcy & Pegg, 2011). Although harder to change than societal attitudes, efficacious and long-lasting change in personal attitudes has been demonstrated by intervention programs which socially exposes non-disabled students to PWD (Daruwalla & Darcy, 2005).

According to Kim, Stonesifer & Han (2012), **insufficiently trained staff** is generally a bigger issue than insufficient facilities in guest rooms, public spaces and reservation systems. Staff must have knowledge of disabled people's needs and equipment, be flexible in communication, smiling, helpful, and unafraid to deal with disabled people. Evaluating and expanding sensitivity training programs should therefore be top priority for business owners (Kim, Stonesifer & Han, 2012).

Discrimination against PWD

When negative attitudes are allowed to flourish, discrimination may emerge as a result. To face this issue, more than a hundred nations have implemented disability discrimination legislation, starting in 1990 with the United States' *Americans with Disabilities Act* (ADA) (Darcy & Pegg, 2011). Two years later, in 1992, Australia introduced the *Australian Disability Discrimination Act* (DDA), followed by UK *Disability Discrimination Act* (DDA) in 1995 (later repealed by the *Equality Act 2010* which unified the laws against discrimination based on gender, sexual orientation, race, religion or belief, age and disability). Reflecting the prevalence of disability studies, English-

speaking countries have acted as the forefront of disability discrimination acts.

Despite the international consensus on adopting anti-discrimination laws, there is little empirical evidence that such legislation produces the intended outcome. On the contrary, the ADA, which given its long track record and continuous evaluation will form the basis for this assessment, has been widely criticised for *increasing* discrimination of PWD and producing negative attitudes amongst employers living in constant fear of lawsuits from professional plaintiffs of the PWD emancipation movement (Schwochau, 2000). One such lawsuit with relevance to accessible tourism was the case against major accommodation marketers Hotels.com and Expedia.com, who were forced to incorporate accessibility information in their search engines (Disability Rights Advocates, 2009). Perhaps not pleasing the owners of these businesses, it nonetheless is an example of ADA bringing accessible services into mainstream platforms.

(In)conclusively, Schwochau (2000) was not able to determine if the ADA was beneficial or harmful piece of legislation. A corresponding US study found that "the ADA appears to be adequate as a vehicle for educating society about prejudice" although we cannot expect it to change the attitudes of employers and other individuals, making it doubtful that the intended effects of increasing PWD participation will be achieved (Schall, 1998, p. 201).

Similar inconsistencies are found in the EU context where legislation based on vague concepts like "reasonableness", "disproportionate burden" and "accommodation which is not *unduly difficult* or *troublesome*", results in different interpretations across member states (European Commission, 2009).

Denmark, despite being known as a European front-runner of accessibility, is one of the EU countries with the least protective laws against PWD discrimination (European Commission, 2017). Until recently, discrimination on the basis of disability was covered in the 1996 *Act against discrimination in the labour market* which prohibits "any direct or indirect discrimination due to race, skin colour, religion or belief, political opinion, sexual orientation, age, disability or national, social or ethnic origin", but only in the labour market – not the private sphere (Beskæftigelsesministeriet, 2017, § 1, translated from Danish).

This naturally sparked the attention of Danish human rights activists and disability organisations who long campaigned for an expansion of the anti-discrimination laws (DHF, 2017). To this end, The Danish Institute for Human Rights (Pedersen, Andersen & Jørgensen, 2016) developed a report accounting eight examples of discrimination against PWD in the private sphere, thereby demonstrating the need for protective legislation. These examples are briefly recounted in the following (Pedersen, Andersen & Jørgensen, 2016, p. 27-34):

1) A private kindergarten refusing to be responsible for the medication of a diabetic child, thus

forcing the parents to choose a public kindergarten in another municipality.
2) A public school without accessible playground and only partially accessible classrooms, despite offering special classes for challenged children.
3) Private clinics refusing to treat the chalazion (cyst in eyelid) of a man with cognitive impairment and severe epilepsy, thus denying him to skip the 1-year waiting list at the public hospital.
4) A blind man not allowed to bring his guide dog into a restaurant.
5) Waiter telling PWD customer that wheelchairs are not wanted at the restaurant.
6) Life insurance denied to man with OCD due to an unfounded claim of suicidal tendencies.
7) Director of a museum describing wheelchair accessibility as practically impossible.
8) School refusing to provide a mother with mental impairment from a brain injury with a more accessible alternative to the digital intranet where all school-parent communication is conducted.

Another, morbidly humorous example of PWD discrimination is found in the bar-street of Aalborg, Jomfru Ane Gade, where a man with impaired speech and walking balance from a brain tumour was denied access to a bar for being "too drunk" (Mortensen, 2004).
If this is the showcase of private PWD discrimination produced from 22+ years of technical legality (assuming that there are many more examples but these are amongst the worst), one may argue that the problem is somewhat blown out of proportion. This is of course not to deny that discrimination of PWD is a problem to be taken seriously.
Striking a compromise to satisfy the human rights and disability organisations (and possibly because Denmark was the only Scandinavian country without such legislation), a unanimous Danish Parliament adopted the *Act against discrimination due to disability* in June, 1, 2018. "The purpose of the law is to prevent discrimination due to disability and to promote equal treatment of persons with disabilities" (Folketinget, 2017, § 1, translated from Danish). However, "The law does not imply an obligation of reasonable adjustment or accessibility" (Folketinget, 2017, § 3, translated from Danish), making the Act appear more as symbolic politics than effective policy. Consequently, it would be naive to expect it having any practical outcome. Unsurprisingly, the lobbying effort of removing § 3 began even before the Act was adopted (DHF, 2017).
What exactly constitutes discrimination on the basis of disability is largely an open question. The CRPD defines it as "any distinction, exclusion or restriction on the basis of disability which has the purpose or effect of impairing or nullifying the recognition, enjoyment or exercise, on an equal basis with others" (UN, 2006, Article 2). Countless situations may have the effect of nullifying equal enjoyment, but it is difficult to distinguish when this happens on the basis of disability or for other reasons, coincidently affecting PWD.

Playing the devil's advocate, one may revisit a few examples of PWD discrimination:

1) Blind person not allowed to bring guide dog into a restaurant.
   Rebuttal: This is a case of discrimination against dogs, not PWD.
2) Company not employing PWD due to concerns of cost and efficiency.
   Rebuttal: This is discrimination based on economics and competence, not disability.
3) School refusing to provide special treatment for disabled children or parents.
   Rebuttal: Equality is present (the child is attending school) despite equity being absent. Although equity (i.e., equality of outcome) is a central aspect of the social model, CRPD is solely based on equality (i.e., equalisation of opportunities).

The debate between striving for equity or equality is key to assessing the extent of discrimination. If measurements are based on equity, PWD are indeed discriminated against at a structural level which validates the argument of oppression – clearly evident when looking at employment and income rates. However, it is important to stress that such methodology only applies to analysing equity. Other aspects are in play when equality is the measured factor, such as access to health care, suffrage, education and accommodation – areas where differences between disabled and non-disabled citizens are less evident.

Depending on interpretation, accessible tourism may be inherently discriminatory in being defined as something different to normal tourism (Bowtell, 2015). Also, it should be added that “not all barriers are discriminatory” (Shakespeare, 2008, p. 12), nor are they always external to the disabled individual, in which case they will not be found in the three presented categories (and thereby not in many research papers). For example, Rowinski et al. (2017) found that `**health**´ was reported as the most frequently encountered barrier towards tourism participation amongst elderly Poles (age 65+) for both disabled (68.6%) and non-disabled (44.8%) respondents. The same study (Rowinski et al., 2017) found `**lack of interest**´ ("I feel no need") to be the second most common barrier (44.2% for non-disabled, 26.5% for PWD), with `**lack of money**´ being third (23.6% for non-disabled, 28.0% for PWD).
Another barrier to be considered is “lack of social skills caused by the barriers that exist within society and exclusion from involvement and participation in society” (Kim & Lehto. 2013, p. 19). In other words a PWD's **lack of social skills** is an internal barrier created by external circumstances. Fortunately, far from all PWD are faced with this issue but it is particularly relevant when catering for individuals who were born with a disability and have been institutionalised and dependent on

professional care for much of their lives. Despite many of the `very severely handicapped´, as Harris (1971) would call them, technically not having intellectual impairments or mental health problems, some will develop such issues by not being exposed to the same experiences as non-disabled or more functional PWD of the same age. Social skills takes time and experience to develop, which is not always an option for people who, for example, are permanently bedfast. Lack of social skills may also develop from a speech impairment, cosmetic disfigurement or psychological disorder preventing the person from seeking social experiences. The issue is far from isolated to the PWD segment and may in time prove to be a niche market in its own right. Tourism activities can become increasingly accessible by carefully nudging people with social insecurities to participate (Kim & Lehto. 2013).

Finally, many PWD are faced with the **need to travel with caregivers** which can hinder the sense of personal freedom on a trip for both parties, while also imposing an additional cost of travelling (Lehto, Luo, Miao, & Ghiselli, 2018). Caregivers may come as friends or family (informal caregivers) or hired personnel (formal caregivers) and their needs and experiences are highly "underappreciated and under-researched" (Lehto et al., 2018, p. 1). Being a caregiver is often a full-time and relatively stressful job, reflected by `respite´ being identified as their greatest need when accompanying PWD (Lehto et al., 2018). On the other end of the relationship, PWD may self-identify as a burden to their caring companion(s) which may also ruin the enjoyability of the trip. The solution presented by (Lehto et al. (2018, p. 2) involves the removal of "psychological and physical barriers" to establish an inclusive environment of "social justice and equity" within the accessible tourism sector in order to offer a "resistance site [which] can protect individuals from oppression and lead to self-discovery" - thus employing tourism as "a counter-mechanism to overcome unequal power structures affecting minorities".

Interestingly, it is also concluded that overcoming obstacles can be a positive experience for both PWD and their caregivers, to a degree where the positive experiences of capability, autonomy, novelty and social bonding overrides the more temporary negative sentiments associated with various obstacles and adversities encountered while travelling (Lehto et al., 2018). By the logic of this conclusion, enabling the overcoming of barriers (e.g., climbing a mountain) may provide a better tourism experiences than is offered by the removal of barriers (e.g., driving up said mountain on smooth pavement). The images[14] below (next page) are intended to illustrate the conceptual difference between overcoming and removing barriers in tourism.

14 *Left*: Woman on beach (from: Wikimedia Commons). *Right*: Accessible beach (from: EuCAN, 2003, p. 19).

Economic impact of accessible tourism

Even without considering available financial and organisational resources for necessary investments, developed countries generally have a higher potential for accessible tourism as they have a higher percentage of disabled citizens. Using the relative population of PWD to quantify the potential for accessible tourism, Finland, Australia, USA, New Zealand, UK, Netherlands, Portugal, Denmark, Sweden and Germany ranks (from high to low) as the most promising markets (Darcy & Dickson, 2009). Given the forecasted ageing of Western and Asian populations, this potential will only continue to spread and grow in the future.

Considering the European Union as a single destination, this is projected as by far the most lucrative region for accessible tourism with market estimates varying between 80 and 1100 billion Euro depending on methodology and accounted economic effects (Bowtell, 2015; Buhalis, Michopoulou, Eichhorn, & Miller, 2005; Darcy & Dickson, 2009; European Commission, 2013).

Providing accessible information

According to Michopoulou & Buhalis (2013) there are three fundamental requirements of the disability market; `Accessibility of the physical/built environment´, `Information regarding the accessibility of tourism facilities´, and `Online information accessibility´, meaning that the information itself should also be designed for accessibility which includes availability via mainstream channels. Of these three requirements, only the first is sufficiently researched.

Central to facilitating positive experiences for disabled tourists is "a profound understanding of the requirements of people with disabilities and the provision of adequate support services tailored towards their specific needs" (Eichhorn, Miller, Michopoulou & Buhalis, 2008, p. 190). Moreover, communication this understanding by providing detailed information on accessible products and services is critically important for PWD planning a trip. Unfortunately, such information schemes are rarely fully developed, even for businesses who are otherwise well aware of the needs resulting from various disabilities, with especially the lack of rich details being a widely prevailing shortcoming (Darcy, 2010; Eichhorn et al., 2008; Michopoulou & Buhalis, 2013).

To be fully inclusive of PWD needs, information on access must be oriented after the individual customer, reflecting the vastly different requirements of people with disabilities, rather than only those of the generic wheelchair user (Eichhorn et al., 2008; Michopoulou & Buhalis, 2013). In particular, information on bed- and bathroom facilities must be as detailed as possible, ideally with the aid of digital photography and architectural floor plans (Darcy, 2010).

Michopoulou & Buhalis (2013) found the so-called `veto principle´ to be highly useful when designing and providing access information. "The 'Veto' is regarded as the absolutely minimal prerequisite that allows a person to enter a building or make use of a service" (Michopoulou & Buhalis, 2013. p. 235). Minimal prerequisites varies individually and should be incorporated in the early planning phase of a trip, for example by booking websites having a disability search function with filters such as `no stairs/steps´, `sign language proficiency´, `written communication in braille´, `soundproof bedrooms´, `availability of disability hoists´, `wheelchairs for rent/loan´ etc. Following the court case against Hotels.com and Expedia.com (Disability Rights Advocates, 2009), these websites now includes filterable Accessibility Features[15]; Accessible bathroom, In-room accessibility, Roll-in shower, and Wheelchair accessible rooms. The latter feature, Wheelchair accessible rooms, is not found at Expedia.com, but may be said to overlap with In-room accessibility. These tree or four features are all related to mobility impairments and far from being embracive of all PWD needs.

Aside from knowing about the accessibility features of tourism venues, the user must also be

15 Found via the hotel search function at www.hotels.com and www.expedia.com.

informed about the accessibility of the route between these venues (Michopoulou & Buhalis, 2013). To meet this demand, “comprehensive, customizable, dynamic, and interactive accessibility path plans” should be provided in order for PWD to plan their trip “from the moment they leave their house until they reach their destination and the individual tourism facilities that they would like to visit” (Michopoulou & Buhalis, 2013. p. 235). Given the importance of reliable information and accessibility features, the choice of hotel often precedes that of the destination (Blichfeldt & Nicolaisen, 2011).

Following up on their Recommendations on Accessible Tourism, UNWTO (2016) published a report on *Recommendations on Accessible information in Tourism*. Acknowledging that the tourism market continues to display a “persistent lack of information” regarding accessibility (UNWTO, 2016, p. 5), the report sums up some of the major research findings on providing access information and applies them to a set of tangible recommendations for tourism stakeholders. Thus, information on accessibility must be available, accurate, reliable, and designed to maximise ease of use for as many people as possible (i.e., universal design), as a way of increasing autonomy and independent living of PWD (UNWTO, 2016). Four steps of information provision are identified in the report, each of which should be considered when producing informative content (UNWTO, 2016, p. 7):
Step A - Perception: Customers use their eyes, ears or sense of touch to perceive content.
Step B - Discoverability: Customers find the information they want.
Step C - Understanding: Customers interpret and understand how to use the content.
Step D - Use: Customers decide how to use and act on the content that is presented.

Furthermore, “five elements are key to providing accessible information” (UNWTO, 2016, p. 8):
1) Include information regarding accessibility of the infrastructures and services
2) When providing material or information about services or procedures, provide a point of contact in order to enable the reader to obtain more information, including personalized messages
3) Make sure the information is consistent across all media and channels of communication
4) It is highly advisable to train information managers in the specific techniques that are indicated in these recommendations
5) Make sure the content is up-to-date

More specific recommendations relates to the layout, design and placement of written material (printed and digital), audio-visual content, websites, apps, self-service terminals and mobile/smart devices, and signage (UNWTO, 2016).

A major problem here is that the many national schemes, standards, labels and laws on access and disability mostly operates independently, making it difficult to harmonize information provision at a European (and worldwide) level (Eichhorn et al., 2008).

Motivation and decision-making of disabled tourists

One of the earliest studies on disabled tourists, before the term accessible tourism had been coined, was done by Burnett and Bender-Baker (2001), *Assessing the Travel-Related Behaviors of the Mobility-Disabled Consumer*, which has later been credited for introducing the disabled market segment to the hospitality industry (Kim, Stonesifer & Han, 2012).

Burnett & Bender-Baker (2001, p. 5) defined the *disabled consumer* as "an individual with physical or mental impairments that substantially limit one or more of the major activities of life at a given point in time", leaning at the time on the framework of ICIDH and the ADA. This allowed for a slightly more `medical´ perspective than is prevalent today, given that disability was seen to be caused by impairments rather than a disabling society or environment. As a result, based on a survey of mobility-disabled consumers, one of the primary findings was that "segmenting the disabled by level of severity is a valuable process and that those with more severe disabilities travel differently and for different reasons" (Burnett & Bender-Baker, 2001, p. 4). Providers of hospitality should be aware that distinguishing between mild, moderate and severe disability results in three significantly different segments.

Other major findings are listed below, all of which remains relevant to this day (paraphrased from Burnett & Bender-Baker, 2001, p. 10):

1) Mobility-disabled consumers are not wealthy, but have adequate resources to travel and may be considered a profitable segment.
2) Environmental factors (quiet and peaceful) and accessibility are increasingly important the more severe the disability is.
3) Many disabled people have someone else making reservations. These facilitators (e.g., family members, attendants) may also be targeted for marketing.
4) Disabled consumers are very loyal customers when their needs are satisfied. Staff training is important to achieve satisfaction and legal compliance is not enough to meet this end.
5) Cruise and package-tour operators may not be able to target the mobility-disabled segment due to the cost of modifying ships and buses.
6) Communication strategies should be designed with the criteria of the disabled segment in mind.

7) The majority of the segment are economy minded, which should be reflected by fair pricing (not low quality).
8) Despite their unique challenges, disabled travellers share many needs with the non-disabled and both groups can be provided for simultaneously.

An important sub-segment of PWD, with its own set of motivations, is families with disabled children. Given than roughly 10% of the world's youth population possesses a disability (corresponding with the 10-15% estimated for the world population as a whole) and that most children travel in family groups, it is a segment counting hundreds of millions potential customers (Kim & Lehto. 2013). Recreational leisure activities with their families is a benefit for all children, and when provided the right services, it can help "enhance long-term physical and mental well-being" for those with disabilities (Kim & Lehto. 2013, p. 13).
To better understand the needs of such families with disabled children, Kim & Lehto (2013, p. 18) conducted a series of in-depth interviews in South Korea, revealing five levels motivations which are listed below in order of importance:

1) Physical competence (mastery) of disabled children	Need of child(ren) with disabilities
2) Family closeness	Need of family
3) Children's intellectual competence	Need of all children
4) Relaxation and escape	Need of parents themselves
5) Socializing	Need for social support

The top priority for parents with disabled children is to utilize tourism as a way of developing the physical ability and self-confidence of their children, ideally in an out-door environment where wildlife and natural beauty can be enjoyed without requiring too much physical energy (Kim & Lehto. 2013). In conclusion to these findings, "providing activities and programs that facilitate physical and intellectual development of children with disabilities" is the most important aspect of tourism experience design when catering to families with disabled children (Kim & Lehto, 2013, p. 21). In a wider context, this clearly illustrates the complexity of PWD needs and that physical accessibility is merely the tip of the iceberg when considering optimal provision of services and experiences. Furthermore, it reinforces Burnett & Bender-Baker's (2001) argument of of a more fragmented segmentation of disabled customers. Adding to this is the inconclusiveness of studies trying to assess the allocation of leisure time for PWD (Pagán, 2012, 2014; Rowinski et al., 2017), indicating the difficulty of characterising disabled customers as *one* group.

Worth mentioning here is the result of a more recent Korean study, addressing the question *Which accessible travel products are people with disabilities willing to pay more?* (Lyu, 2017). The study revealed that Korean PWD on average were willing to pay an additional US$125.6 to upgrade from low to high accessibility of accommodation, $101.5 to upgrade from low to high accessibility of tour bus, $41.2 for rental of electrical wheelchairs, and $34.3 to have a social worker included on a trip in addition to a tour guide (Lyu, 2017). These finding indicates a profitable potential for specialised accessible offers which goes beyond common access legislation and certification eligibility. The study also showed that medium accessibility is only slightly more interesting than low accessibility, and that the presence of social workers was preferred to that of nurses (Lyu, 2017).
Although the study is confined to Korea, one may assume that similar patterns can be found elsewhere. If the findings are transferable to an international context, it may be worth to reconsider the concept of `tourism for all´ (which, if merely legally compliant, will generally count as medium accessibility) in favour of tourism offers that specialises in, and specifically targets, PWD or sub-segments hereof. More research is called for to assess such assumption.

Returning to the national context, Blichfeldt & Nicolaisen (2011) conducted a series of interviews and focus group discussions with Danish PWD and disability associations. Here, it was found that the daily life of PWD is often highly structured, particularly due to the schedule of caregivers, and that this dependency on other people would give extra motivation to escape from the routines of everyday life (Blichfeldt & Nicolaisen, 2011). Respondents acknowledged that non-disabled would always have easier access to tourist activities due to the extra needs of PWD making it difficult to take spontaneous decisions without detailed planning. No amount of universally designed features can totally equalise the ease of access for disabled and non-disabled tourists (Blichfeldt & Nicolaisen, 2011). Despite disabled travel not being easy, it certainly is doable, and increasingly so as PWD accumulates travel experience to contribute to their practical knowledge and reduce the dependency on pre-planning and up-front decision making (Blichfeldt & Nicolaisen, 2011; Pagán, 2012). With this in mind, it is no wonder that PWD are often very loyal customers if a venue has already proven itself as a provider of satisfactory experiences (Burnett & Bender-Baker, 2001). Disabled people often engage in leisure activities with other disabled people and, at least in Denmark, these activities are often hosted by disability associations practically acting as travel agencies for PWD (Blichfeldt & Nicolaisen, 2011). Furthermore, disability associations crucially serve as “highly trustworthy experts” on accessible tourism, as platforms for sharing travel experiences, and, most importantly, as “‘ambassadors’, i.e. forums that ensure the individual that

disabled people can, and should, take on the role as tourist" (Blichfeldt & Nicolaisen, 2011, p. 91).

The roles of disability associations are mostly unexplored in international tourism research, this may also be due to the infancy of accessible tourism and the focus on barriers rather than facilitators, or perhaps simply because they are less crucial outside the Danish context. Again, this calls for further investigation in future research (Blichfeldt & Nicolaisen, 2011).

Destination competitiveness and value co-creation

In the Spanish-Australian study, *Competing for the disability tourism market*, Vila, Darcy & González (2015) set out to measure which destination attributes statistically exerted the strongest influence on the competitiveness of accessible destinations. The measured factors was based on Crouch's model (Crouch, 2011), distinguishing between `important´ and `determinant´ destination attributes. Importance is linked to attitudes and preference (what is important for you when visiting X?) while determinance is linked to actual purchasing decisions (what makes tourists buy a product) (Crouch, 2011; Vila, Darcy & González, 2015). In terms of competitiveness, determinant factors are the ones in focus. The study showed that compared to Crouch's findings (see textbox), `Cost/Value´, `Safety/Security´, `Infrastructure´, `Accessibility´ and `Political will´ ranked significantly higher in the list of determinant factors, while `Quality of services/experience´ and `Positioning and branding´ ranked higher in importance. As Crouch's model is based on non-disabled tourists, this comparison holds noteworthy implications for stakeholders in accessible tourism. Furthermore it adds empirical confirmation to notion of PWD being economy-minded (Burnett & Bender-Baker, 2001; Pagán, 2012) and concerned with safety (Darcy & Pegg, 2011; EuCAN, 2003; UNWTO, 2013) and, of course, accessibility and infrastructure. Actualising such attributes requires political will while raising awareness hereof requires positioning and branding, hence the high rankings of these factors.

Determinant destination attributes (Crouch, 2011):

1) Physiography and Climate
2) Culture and History
3) Tourism Superstructure
4) Mix of Activities
5) Awareness/Image
6) Special Events
7) Entertainment
8) Infrastructure
9) Accessibility
10) Positioning/Branding

The factors included in Crouch's model are primarily physical/material in nature, meaning that the social dimension is, uncharacteristically, lacking from the assessment of competitiveness in the

disability market. Adding nuance to this observation, is the work of Navarro, Andreu & Cervera (2014) and Navarro, Garzón & Roig-Tierno (2015), isolating the factors influencing co-creation of valuable hotel stays for disabled customers. Based on expert interviews of decision-makers from disability associations in Spain, it was found that four criteria makes up nearly 80% of the value perceived in this context (Navarro, Garzón & Roig-Tierno, 2015, p. 1634):

1. (23.5%) - relationships with staff, when employees provide useful information and answer disabled customers' questions, and when customers offer the hotel information about their needs. (booking)
2. (20.6%) - specialist training in customer service for disabled people (stay)
3. (20.3%) - good accessibility of the environment and interaction between disabled customer and hotel staff (stay)
4. (14.4%) - disabled customers' collaboration to inform or suggest service improvements (stay)

Categorising the factors by the booking, stay and post-stay phases of a trip, it was determined that the hotel stay generates 60,6% the experienced value, booking 30% and the post-stay phase (recommendations and feedback) a mere 9,4% (Navarro, Garzón & Roig-Tierno, 2015). These findings confirms the importance of reliable information (including photos and/or videos - Navarro, Andreu & Cervera, 2014) and physical accessibility, while adding a highly noteworthy emphasis on the equally important role of a good customer-staff relationship. Thus, working towards a more competent troupe of staff may be more worthwhile than improving the accessible environment, marketing strategy, etc.

Involving disabled guests in the continuous improvement of accessible hotel services is a rewarding experience for both parties, and a useful mechanism of fostering loyal customers (Navarro, Andreu & Cervera, 2014). Many hotel managers are already aware of this, but customers generally needs more confirmation that their feedback is genuinely valued and not just a facade of attempted politeness (Navarro, Andreu & Cervera, 2014).

Further contributing to the knowledge satisfying disabled guests, Tutuncu (2017, p. 35) found, based on a US survey, that people with physical disabilities (PwPD) are “very sensible to all services offered by hotels” and that particularly “accessibility factors, disability types and forms of assistive devices are closely linked to the hotel satisfaction of PwPD”. Additionally, people with acquired disabilities showed lower levels of satisfaction than those with congenital disabilities (Tutuncu, 2017). Aside from adding assistive devices to the list of important accessibility features, these briefly stated findings further reaffirms the early notion of Burnett & Bender-Baker (2001), calling for a narrower segmentation of disabled customers.

The most recent addition to UNWTO's collection of accessible tourism recommendations is concerned with *Good Practices in the Accessible Tourism Supply Chain* (UNWTO, 2016a), compiling a series of successful accessible offers to inspire tourism developers across the world. For example, in the *Exhibition of 3-D copies of Works of Art from the Prado Museum´s Collection, Spain*, visitors with visual impairments are able to experience famous works of art, such as the Mona Lisa, via highly detailed tactile recreations (UNWTO, 2016a). By contrast, the *Push to Open Nature* programme in Alberta, Canada is a widely scoped plan to open the outdoors to people with reduced mobility and learning difficulties, featuring accessible campsites, lodges, comfort camping, barrier-free interpretive trails and a specially designed adaptive wheelchair to manoeuvrer in rough terrain (UNWTO, 2016a). As a shared factor, these examples offer a specific type of tourism to a specific segment of PWD. A similarly focused approach is found in the self-explanatory vocational training course *T-GUIDE: Guiding Visitors with Learning Difficulties*, which is EU funded and based in London but available online via e-Learning (UNWTO, 2016a). Countering this observation is the *Accessible Heritage Tourism* in India which deliberately aims at tourism for all (UNWTO, 2016a). However, this project is limited to a few major attractions, such as Taj Mahal and the Red Fort, which already attracts an extremely diverse and numerous audience.

The most generally applicable recommendation is to promote the use of *Lonely Planet's Accessible Travel Online Resources Guide* (Heng, 2017) to ensure that relevant, detailed information on accessibility is available through mainstream channels and at a global scale (UNWTO, 2016a). The guide contains hyperlinks to resources on accessibility in each region or country, particularly the national Accessibility Information Schemes although other services (apps, guidebooks, websites, etc.) are included if possible, as well as blogs and travel tips to advise and encourage PWD travel. Danish travel resources in the Lonely Planet Guide are, besides the Pantou database (see European Commission, 2015), limited to the national AIS, God Adgang and *Aarhus Pilot* – a city guide of Aarhus for wheelchair users (Heng, 2017).
Although not always taken into account, it always raises ethical concerns when public offices and DMOs are actively promoting a particular private enterprise. Despite the *Accessible Travel Online Resources Guide* being available `for free´ (requires sign-up and thereby the relinquishment of user data) Lonely Planet is far from being a non-profit organisation. Although expensive and time consuming, it may, in the long run, be better for EU or UNWTO to set up an independent equivalent to Lonely Planet.

Alternatively, community-based platforms such as Wikitravel[16] and the lesser known Wikivoyage[17] may be worth considering. As Lonely Planet, Wikitravel is a private enterprise, earning its profit from advertisement. This contradiction of the classical `wiki-model´ eventually led to frustration amongst its voluntary contributors, leading to the creation of Wikivoyage which is hosted by the non-profit Wikimedia Foundation. Unfortunately, neither Wikitravel nor Wikivoyage contains information on accessibility, making the ethical discussion of who to support entirely academic for the moment. Nonetheless, it may be argued that a UN or EU collaboration with Wikivoyage to develop a community-based platform for accessible travel is a reasonable step for the future.

From a more practical perspective, Burnett & Bender-Baker (2001, p. 8) concluded their survey with a series of tangible suggestions for accessible rooms, some of which are now part of the concept of universal design (the percentage indicating how many respondents recognised each suggestion as a relevant issue); “put a lower shag carpet on the floor (30%), extend or motorize drape pulls (27.2%), widen hall- ways in and out of room (41%), change the direction doors swing open (30.1%), light switch too far from bed (37.8%), too much furniture (46.8%), and phone too far from bed (23.7%)”.

Based on interviews with PWD (with hearing, visual and mobility impairments) and hoteliers in the United States, Kim, Stonesifer & Han (2012) produced a similar list of five easily implemented recommendations for hotel managers (paraphrased from pp. 1315-1316):

1) *Evaluate and expand sensitivity training programs*; staff must be adequately trained to interact with disabled guests.
2) *Communication*; guests should not have to repeatedly explain their needs to different staff members and departments, or when returning for later visits. A digital tracking system that remembers individual guest needs and accommodations could be a valuable investment.
3) *Provide an escort and in-room orientation*; done at check-in to “cater to the specific needs and disability of each guest while simultaneously providing guest engagement with little cost to the property” (Kim, Stonesifer & Han, 2012, p. 1316).
4) *Utilize cut-in room keys*; cutting one corner of the key card makes it easier to use for guests with visual impairment.
5) *Flexible adaptability needed to meet different types of disabilities*; specific procedures should be prepared for specific needs (e.g., how to identify and communicate with someone who is blind and/or deaf).

16 https://wikitravel.org
17 https://wikivoyage.org

Relating to these recommendations, it was found that, generally, "guests who are deaf or hard of hearing require the least amount of special accommodation, followed by guests with vision impairments, then guests with mobility impairments" (Kim, Stonesifer & Han, 2012, p. 1313). Echoing Burnett & Bender-Baker (2001), it is once again stated that legal compliance (in this case the ADA) is not sufficient to fully accommodate the needs of disabled tourists (Kim, Stonesifer & Han, 2012).

As a final remark, it is worth including the plea of Polat & Hermans (2016) who argues that rethinking tourism offers in relation to universal design, there is no excuse not to include environmental, economic and social sustainability as guiding principles in the process – hence their proposed model for sustainable accessible tourism (SAT). Most prominently, the SAT model holds that accessible services should to be available for tourists with a restricted budget, supported by public funding and that legislation should be internationally harmonised in order to standardise the implementation of accessibility and the information available to customers (Polat & Hermans, 2016).

Revisiting the problem: The social model is theoretically dominating accessible tourism research, partially due to the highly influential work of Simon Darcy. As a result, most research is focused on identifying barriers hindering the participation of disabled tourists, with emphasis on the problem rather than the solution. Given the pragmatic approach to the literature, as much practical, solution-driven research as possible was included in the review, resulting in several useful findings:

First, the claim of accessible tourism having the potential for significant economic impact is widely supported by research, with all forecasts being optimistic despite large variations in the suggested prognoses. However, such research rarely includes data on how much investment is needed to reach the financial goal, nor the potential return on such investments. A fully developed business model of accessible tourism remains to be seen in the literature.

Second, highly detailed accessible information is crucial for disabled customers and should be designed with the individual in mind, as PWD needs are very diverse, even for people with the same type of disability. Providing such information is not covered by any legislation, but is included in the Danish ASI, GodAdgang.dk, which unfortunately is far from covering the entire Danish market – in part due to businesses having to apply for the label themselves, which comes with a heavy initial price tag[18], plus an annual membership fee (Sabroe, 2016).

18 See prices at: http://www.godadgang.dk/dk/a-maerket/bliv%20medlem/priser.asp (Danish only).

Third, the claim that PWD can and will travel if provided the opportunity is widely supported. Perhaps equally important, they are generally willing to pay extra for accessible products and services, meaning that the equalisation of opportunity does not have to be accompanied by an equalisation of price.

Fourth, PWD rarely travels alone, either being accompanied by friends, family, hired caregivers or a larger group of disabled tourists. The role of caregivers in tourism, which is often filled by friends and family, is severely under-researched, with only one relevant study (Lehto et al., 2018) identified for review. The need of *respite* for both caregiver and PWD is extremely important, given the stressful experience of either carrying or self-identifying as a practical burden. The quality of the tourism experience can therefore be greatly improved for both parties if some, or all, of the responsibility and tasks of the accompanying caregivers are shifted to the already present staff. This aspect of staff responsibility is almost entirely overlooked in the otherwise hugely emphasised role of tourism staff training, which tends to focus on fostering positive attitudes, communication skills and appropriate conduct. Researchers agree that tourism staff must posses knowledge of various disabilities, but rarely touches upon the *hands-on* needs that follows as a consequence, such as preparing and serving food, assisting with personal hygiene, etc. Expanding the practical role of staff in accessible tourism may also contribute positively to the much important customer/staff relationship.

Fifth, and final, there is a wealth of knowledge on how to design the interior of accessible venues, down to the placement of light switches and single pieces of furniture, much of which is also covered in the Danish building regulations. This enables thorough planning of how to best facilitate an accessible physical environment, highly necessary as correcting mistakes at a later phase can prove a costly affair, potentially ruining the sustainability of a business (as illustrated by the example of Sct. Knudsborg).

Note that these key findings do not include the role of discrimination and oppression. Research on these issues was reviewed, but is here deemed inconsequential to stakeholders in accessible tourism. Simply participating in the accessible market is sufficient to make such socio-political factors non-issues for the individual business owner.

A refreshing conclusion

Based on the reviewed literature, the notion that "Most disability research is founded on either the medical or social model perspectives" (Blichfeldt & Nicolaisen, 2011, p. 80) appears outdated, as the social model (especially since the publication of ICF and CRPD) has clearly won the position as the dominant discourse. Regardless, as Blichfeldt & Nicolaisen (2011, p. 80) continues, "both of these models (or dominant discourses) fail to see 'ability' and 'disability' as dynamic *processes* [where] disability is subject to change as disabled people build competencies and reconstruct their connections with both their environment and other people". Thanks to the provided overview of disability models, we now know this conclusion to be falsely based on the misrepresentation of the medical model in disability studies and tourism research. Older models, in particular the revised IOM model of Brandt & Pope (1997), do indeed describe disability as a dynamic *enabling-disabling process*, just as requested above.

Two of the primary alleged weaknesses of the medical have now been drawn into question. First the lack of a social dimension proved to be a gross overstatement, as all versions of the medical model agrees that the social environment is where the disadvantage of being disabled becomes a reality – the problem (from a social model standpoint) rather being that it is conceptualised with reference to a lack of capability in the individual, relative to the demands of society. Second, as outlined above, the medical model is dynamic, not static – a point which have been emphasised since ICIDH (WHO, 1980 – see Appendix 1).

These findings are significant for the assessment of SWAT factors (strengths, weaknesses, opportunities, threats) as it leaves few valid weaknesses associated with the medical model:

SWOT – The Medical Model	
Strengths • Simplicity and ease of use. • Tangible focus on physical needs of the person with a disability. • Individual problems are treated by individual solutions with measurable outcome and means of rehabilitation. • Can be applied at the level of individual stakeholders.	**Weaknesses** • Overlooks the analysis of stigmatisation, negative attitudes and other complex social phenomena. • Does not include a moral obligation to strengthen the accessible tourism market.

Opportunities	Threats
• Specialised product development. • Branding and marketing. • Facilitation of rehabilitating activities.	• Contradicts the dominant discourse, making relevant contributions rare and without much impact. • Trivialises the concept of *normal* (i.e., statistically average), which may result in political backlash.

The last identified threat warrants a brief elaboration. As of now, the threat of political backlash (from so-called `social justice warriors´ and members of the disability community) is still of little relevance to the Danish context – simply because such cases remains relatively rare. However, the power of social media and internet trolls is something to be monitored in the future, especially if seeking to enter the US, Canadian or UK markets where `PC culture´ is far more developed that in Denmark and holds serious practical implications for both public and private stakeholders. Alignment with the trending political correctness is therefore identified as a possible threat to the medical model and a strength of the social model.

SWOT – The Social Model	
Strengths	**Weaknesses**
• Rich on empathy in highlighting the complexity of experiencing life with a disability. • Strongly argues that society is instrumental for quality of life. • Emphasises the social responsibility for everyone to participate in the equalisation of opportunities. • Fits the current scheme of political correctness.	• Overlooks the importance of individual agency and responsibility. • Ignores much of the physical aspect of disability. • Fails to include the severely disabled who cannot be treated by means of participation alone. • Denies the mechanical notion that a person can be `fixed´. • Applies social constructivism to something which cannot be reduced to a social construct. • Difficult to apply for individual stakeholders.

Opportunities	**Threats**
• Political activism. • Awareness raising. • Legislation. • Stenghthens the argument for public funding of accessible tourism.	• Signifies a community of PWD that may result in *us and them* discourses (e.g., *partners* and *parasites*). • Conceptualising disability and access as social/societal issues takes focus away from individual effort and innovation. • Contributes to the illusion of legal compliance being sufficient when dealing with disabled customers. • Feeds and gives meaning to a high-pitched feud on words and symbols (e.g., *The Accessible Icon Project*), with little practical implication besides shifting focus away from more important issues.

In conclusion, it is clear that we are dealing with different models for different domains, one dealing with the physical aspects of disability and one dealing with the role of the socio-political environment.

Considering the SWOT of each model in relation to the context-determined assumption of a strong model being *effectively applicable for individual tourism stakeholders seeking to approach people with disabilities as their target customers*, it is here contended that in a pragmatic consideration of its practical bearings, the medical model of disability emerges as the more reasonable approach to accessible tourism development. As stated, this is a context-dependent conclusion which mainly applies in relation to individual stakeholders in accessible tourism. In a holistic perspective, both models contains significant strengths and opportunities in different contexts. Thus, the concluding argument is therefore not a critique of the social model *per se*, as policy makers, DMOs and NGOs may have much to gain from it. However, in terms of what travel agent *X*, hotel owner *Y* and tour guide *Z* can do independently to improve the accessibility of their products, the medical model is by far the most practically oriented theory – making it the `best practice´ in a pragmatic paradigm.

Despite the social model dominating the academic discourse, certain supporting elements for above conclusion can be extracted from the literature. Kim & Lehto (2013, p. 21) found that despite the medical model not presenting “as comprehensive of a view of disability as the social model” and

placing disability as the result of a physical condition inherent to the individual (thus possibly reducing the individual's quality of life), “it does provide a foundation for advocacy for specialized services and facilities in the tourism context”. This statement captures part of the essence of what is here contended to be a key aspect of a functional accessible tourism sector; *specialized services and facilities*.

To Kim & Lehto (2013, p. 22), disability is a social *and* a medical/physical problem, why they call for an integration of the too models to ensure the development of “incorporated services and dynamic multilevel interventions”, suggesting that while the medical model provides practical insights to the special needs of individuals, the social model fosters “a heightened sense of social obligations” towards accommodating such needs.

Joining the argument that it is “possible to combine the positive elements of the two models” is Polat & Hermans (2016, p. 127) who emphasises that both environmental manipulation and health care policy may serve as positive elements in the improvement of quality of life, while stressing the fact that “personal adjustment and individual adaptation” is an unavoidable part of any interaction with an environment. Pointing towards personal adjustment and adaptation as inherent factors in life is not equivalent to the radical claim that throughout Western societies, “the person with the disability is blamed for not being able to fulfill the social role” (Pfeiffer, 2002, p. 5).

As such, a holistic view on accessible tourism ought to encompass both medical and social perspectives. Nonetheless, this thesis aims at a pragmatic perspective for individual stakeholders – not a holistic one – and in this case, there is little remaining doubt that the medical model has the most to offer.

Also worth considering is that a heightened sense of social obligations is worth little without tangible knowledge on individual needs and accordingly specialized services and facilities. One can only use a moral compass in relation to its markers and waypoints in the physical world. Specialized services and facilities are not likely to be developed in a context limited by it own over-extension into the political domain of removing societal barriers, emancipating people from oppression, and putting an end to discrimination. Also, the socially meaningful idea of facilitating accessible tourism for *all*, is here seen as a hindrance towards specialised services. As an illustrating example, blind people should enjoy music without offending the deaf while the deaf should enjoy visual art without offending the blind. Tourism developers ought to be able to design products with a target customer in mind, without risking criticism and legal consequence on the basis of ill-considered principles of social justice. Simply put, specialized services and facilities, in tourism and beyond, can never be designed to satisfy the entire world population.

To define disabled tourists as *one* segment is not only a simplification (disabled tourists are as diverse the non-disabled), as we have learned from Blichfeldt & Nicolaisen (2011) and Burnett & Bender-Baker (2001) , but a dangerous distraction from high quality product development. Rather than pondering the administration of human rights and social justice for all, the accessible tourism industry should focus on how to facilitate a positive recreational experience which;

a) takes mobility, sensory perception and stimuli, social skills and communication, cognitive capability and physical needs of the target customer into account, and
b) is affordable and available to the target customer, and
c) is financially, environmentally and socially sustainable.

The consideration outlined above ought to apply to all branches of the tourism and is, with the widely embracing scope, leaning on the essence of Tourism for All – the difference being the vastly important inclusion of a *target customer*. If one is targeting a segment of disabled people, such as the blind or deaf, chances are high that mere compliance with the laws and certification criteria on accessibility is setting the bar too low for a truly specialised product, given that access requirements, both in Denmark and Europe as a whole, are primarily concerned with wheelchair mobility. Rather than having legal compliance or the `Good Access´ label as an end goal, these should be seen as the minimum level to transcend for tourism venues seeking to satisfy a particular type of disabled customers. Again; specialisation is key, not standardisation.

Summing up the implications of said findings is the following recommendations for businesses and researchers.

Recommendations for businesses

With specialisation as the guiding theme for establishing brand differentiation and visibility in a standardised market. In catering to disabled tourists, there are several options for positively transcending the currents of the established discourse on disability and accessibility:

- **Go beyond legal compliance:** Neither the legal requirements of the Danish Building Regulations, nor the standards set for being officially certified as having `Good Access´, fully grasps the depth and diversity of PWD needs.
- **Tourism for some – not all:** Given their diversity of needs, PWD (or people with special access needs) is too large a customer segment to be properly targeted by marketing and product development. Instead, business owners should specialise in one or a few groups with access needs (e.g., young people with physical impairments, families with cognitively impaired children, the elderly, people with autism, disabled veterans, people with sensory impairments, PWD with a specific martial status, etc.). The target group in mind for the recommendation presented hire is the severely disabled who are permanently bedfast or dependent on the care of others – people for whom accessible tourism often remains inaccessible if the chosen facility does not specialise in their needs. This group includes people with pathologies such as cerebral palsy, muscular dystrophy, spina bifida and multiple sclerosis, which are all fairly common and can leave the person much less capable and independent than the generic wheelchair user.
- **Medical model specialisation:** The social model neglects PWD needs which a specialised tourism facility could include when considering product development and design of the environment.

  In addition to modifying buildings and redesigning websites, medically specialised hotels and resorts could hire medical personnel or social workers to obsolete the need of personal caregivers – making a world of difference in improving the independence of guests.

  A medical model specialisation could also be reflected on the in-house menu being inclusive of people with allergies or diabetes and those needing food to be fine-cut or blended for safe consumption. A specialised facility should also contain an array of assistive devices, from diapers to disability hoists, according to guest needs and the experiences offered. Part of this is to enable necessary activities, such as getting out of bed and into the shower, another part is the element of recreation. The typical example of recreational assistive devices are wheelchairs designed for sport, beaches, off-road hiking or even mountaineering, but may also include tactile artwork, digitally recorded guides, communication devices to contact

staff, or other, more imaginative initiatives – being creative here may help building market visibility.

- **Untrained staff:** If above objective of abolishing the need for personal caregivers is to be realised, lots of staff is needed. With detailed planning and briefing, most PWD needs (changing clothes, personal hygiene, eating, etc.) can be served without additional staff training. Assisting in such daily tasks requires motivation and flexibility, but is something every adult human knows how to do. This means that a small core of trained staff (e.g., social and healthcare helpers/assistants) will often be sufficient to manage and instruct a larger team of untrained helpers. Certain tasks, such as administering medicine, requires medical training which should be reflected in the composition of staff. This model was used at Sct. Knudsborg (see the introduction of this thesis) where it worked to perfection, adding practical experience to feasibility of this suggestion.
  Having untrained staff may even increase guest satisfaction by providing a change from the highly professionalised environments many PWD are used to. Tourism is, after all, generally characterised as an alternative and contrast to everyday life. Furthermore, it reduces the cost of investing in accessibility and makes the organisation less vulnerable to seasonal changes and regular change of staff.
- **Sustainability:** With the demand for specialised equipment and numerous staff members on one hand and a target customer who is likely to be unemployed on the other, a fine balancing act is needed when determining the pace and scale of investment. With €2500/month as the guiding figure for the customer's income and a documented willingness to pay for heightened quality, a profitable business ought to be possible. Of course, public funding could help tremendously to launch Denmark as a best practice example of specialised accessible tourism, but this is not considered strictly necessary here (nor should it for any healthy business), especially when considering the potential for very loyal customers who are likely to return at an annual basis. Again, practical experience from the one facility attempting this particular type of tourism in Denmark (accessible with in-house caregivers) supports this conclusion, as guests at Sct. Knudsborg would gladly save up the entire year to enjoy 2 weeks of `luxury´ and repeat the cycle for next summer – or in some cases both summer and Christmas (although celebrating Christmas and New Year at a tourism facility is of course more a question of social factors than of economics). Even without offering low prices (or a wage above the legal minimum), guests, owners and staff displayed a consistent level of high satisfaction.

Recommendations for researchers

- Marketing of accessible products is severely under-researched. The same is true for branding of such products. We need to know how PWD can be targeted as consumers without crossing the line of political correctness or alerting the wrath of PWD emancipation groups.
- Return on investment (RoI) is anothoer significant gap of knowledge throughout the literature on accessible tourism. This could, for example, be part of best practice analysis and serve to kindle the interest of the private sector.
- Relating to above stated gaps of knowledge, the economic aspects of accessible tourism (profitable competitiveness) has largely been neglected, apparently in the name of social responsibility. Seeking profit from the most vulnerable in society is, understandably, not the most popular angle when investigating the market. Thus, we have a decent understanding of PWD needs, but not how to cater for them in a financially sustainable manner. It is therefore argued that most of the focus on social obligations, human rights, equity and equality should be left in the political domain rather than brought into the tourism research context.
- In extension to the call for a more practical perspective on accessibility, tourism researchers should distance themselves from the militant tone of disability studies. Pointing out oppressors, ablists and parasites is counterproductive to increasing cooperation, shared language and political goals.
- Most research is on PWD needs is focused on physical accessibility. As a consequence, we have very little knowledge on catering to the needs of mentally ill and cognitively impaired tourists. The demand for “research that goes beyond the study of accessibility” (Blichfeldt & Nicolaisen, 2011, p. 83) remains highly relevant.
- Lots of research is based on data from national surveys or interviews, resulting in a constant uncertainty when applying findings to an international context. A study on the cultural and economic differences between PWD in various countries and regions could help clarify when the `disabled tourist´ can be regarded as a global entity and when it cannot.
- Less relating to tourism and more to the conceptualisation of disability itself; if quality of life is measured by income, employment rates and average life expectancy, PWD will always be second-class citizens. We must either change the measurement or accept the statistical inequality between PWD and the non-disabled. Social equity and equality of outcome is not only impossible but also undesired in a society that thrives on individual competence and competition.
- We need practical knowledge and change, not ideological slogans and symbolic policies.

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