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Introduction

Person-centred care is a key principle of modern health and social care, placing individuals at the centre of decisions about their care while recognising their unique values, preferences and experiences. Rather than focusing only on illness or impairment, it promotes dignity, autonomy, choice and independence by ensuring care is tailored to individual needs (NHS England, 2024). To support this approach, health and social care professionals use various theories and models, including the Social Model of Disability, which has significantly influenced disability rights and inclusive practice.

Before the Social Model emerged, disability was mainly understood through the Medical Model, which viewed impairment as an individual's problem requiring treatment or rehabilitation (Oliver, 1990). In contrast, the Social Model argues that disability results largely from physical, social and attitudinal barriers within society rather than impairment itself. This shift in thinking has had a major impact on UK legislation, policy and professional practice.

Despite its influence, the Social Model has been widely debated. While it has strengthened disability rights and person-centred care, critics argue that it pays insufficient attention to the lived experience of impairment and the ongoing need for medical care. These differing perspectives highlight the importance of critically evaluating the model.

This essay critically examines the emergence and development of the Social Model of Disability, explores its main criticisms and responses, evaluates its application to health and social care policy and practice in the United Kingdom, and presents recommendations for improving person-centred care.

The Emergence and Development of the Social Model of Disability

Understanding the Social Model of Disability begins with the Medical Model, which dominated healthcare for much of the twentieth century. The Medical Model views disability as the result of an individual's physical, sensory, intellectual or mental impairment, with professionals focusing on diagnosis, treatment and rehabilitation (Shakespeare, 2018).

Consequently, disabled people were often viewed as passive recipients of care, while healthcare professionals made most decisions.

Although the Medical Model contributed to advances in treatment and rehabilitation, it has been criticised for focusing on impairment while overlooking the environmental and social barriers that restrict participation (Barnes, 2012).

The Social Model of Disability emerged during the 1970s through the UK disability rights movement. The Union of the Physically Impaired Against Segregation (UPIAS) argued that disability results from barriers created by society rather than impairment itself, distinguishing between *impairment* (a person's condition) and *disability* (social barriers that restrict participation) (UPIAS, 1976).

Michael Oliver later developed these ideas by introducing the term *Social Model of Disability* (Oliver, 1990). He argued that inaccessible environments, discrimination and organisational barriers disable people, shifting responsibility from changing the individual to creating a more inclusive society. This approach promoted equality, empowerment and greater involvement of disabled people in decisions about their own care.

The Social Model has significantly influenced disability legislation, public policy and person-centred practice by promoting accessibility, reasonable adjustments and shared decision-making. However, critics argue that it places too much emphasis on social barriers while giving insufficient attention to the lived experience of impairment and chronic illness. These criticisms have led to the development of more balanced approaches to disability, discussed in the following section.

Critical Evaluation of the Social Model of Disability: Critiques and Responses

Although the Social Model of Disability has transformed disability studies and influenced person-centred health and social care, it has also attracted criticism. While praised for challenging discrimination and promoting equal rights, many academics argue that it places greater emphasis on societal barriers than on the realities of impairment. These debates have encouraged the development of more balanced approaches to disability.

One of the main criticisms is that the Social Model separates disability from impairment too rigidly. Oliver (1990) argued that disability results mainly from environmental, social and attitudinal barriers rather than an individual's condition. Although this challenged the belief that disabled people were responsible for their exclusion, critics argue that it oversimplifies the lived experience of disability.

Shakespeare (2018) argues that many impairments involve chronic pain, fatigue and progressive conditions that cannot be removed simply by eliminating social barriers. For example, people living with multiple sclerosis or receiving chemotherapy may continue to experience pain and exhaustion despite accessible environments. These examples demonstrate that healthcare interventions remain essential alongside social inclusion. Consequently, person-centred care requires professionals to recognise both social barriers

and the individual's experience of impairment, particularly when supporting people with complex or long-term conditions.

A further criticism is that the Social Model does not fully reflect the diversity of disabled people's experiences. Thomas (2007) argues that disability is also shaped by factors such as age, gender, ethnicity, socioeconomic status and culture. Consequently, two people with the same impairment may experience very different levels of disadvantage depending on their circumstances and access to support. This highlights the importance of holistic assessments that consider social, psychological, cultural and economic factors alongside physical needs.

Another criticism is that the Social Model may underestimate the importance of healthcare professionals and medical interventions. While it successfully challenged the dominance of the Medical Model, some scholars argue that it creates an unnecessary divide between medical care and social inclusion. Medical treatment, rehabilitation and psychological support often improve quality of life, and many disabled people actively choose these interventions. Therefore, person-centred care should combine appropriate healthcare with efforts to remove environmental and social barriers rather than viewing them as competing approaches.

Supporters argue that these criticisms misunderstand the model's original purpose. Oliver (1996) stated that the Social Model was never intended to deny impairment or the value of healthcare, but to challenge discrimination by shifting responsibility from the individual to society.

In response to these debates, more comprehensive frameworks have emerged. The biopsychosocial model recognises that disability results from the interaction of biological, psychological and social factors, while the human rights model, reinforced by the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006), emphasises equality, dignity and participation.

Overall, the criticisms of the Social Model do not diminish its importance but demonstrate the need for a balanced understanding of disability. Combining the Social Model's focus on equality with holistic assessment and evidence-based healthcare enables professionals to provide more effective person-centred care that respects both individuals lived experiences and their right to participate fully in society.

Application of the Social Model of Disability to Health and Social Care Policy and Practice

The Social Model of Disability has had a major influence on UK health and social care policy by shifting attention from impairment to the barriers that restrict participation and independence. This has shaped legislation and guidance that promote equality, accessibility and person-centred care. However, applying these principles consistently in practice remains challenging.

One of the most significant examples is the Equality Act 2010, which protects disabled people from discrimination and requires organisations to make reasonable adjustments to ensure equal access to services (Equality Act, 2010). In health and social care, this includes accessible facilities, information in alternative formats and communication support. The Act reflects the Social Model by placing responsibility on organisations to remove barriers rather than expecting individuals to adapt. However, reasonable adjustments are not always implemented consistently, and many disabled people continue to experience inaccessible services and communication barriers (Care Quality Commission, 2023). This demonstrates that legislation alone cannot eliminate inequality without adequate funding, staff training and organisational commitment.

The Social Model also influenced the Care Act 2014, which places wellbeing, independence and choice at the centre of care planning (Department of Health and Social Care, 2014). Professionals are encouraged to consider wider aspects of a person's life, including housing, employment and community participation, rather than focusing solely on medical needs. Although this strengths-based approach supports person-centred care, increasing demand, workforce shortages and financial pressures often limit professionals' ability to deliver comprehensive assessments and long-term support.

Its influence is also evident within NHS England's personalised care agenda. The NHS Long Term Plan (2019) promotes shared decision-making, personalised care planning and initiatives such as Personal Health Budgets and social prescribing, encouraging individuals to play a greater role in managing their health. Likewise, NICE guidance emphasises collaborative care planning, accessible communication and informed decision-making, reinforcing the principles of the Social Model and person-centred care.

Despite these developments, significant barriers remain. The continued influence of the Medical Model means that healthcare often prioritises diagnosis and treatment over wider social factors affecting wellbeing. Workforce shortages, increasing demand and limited resources can also reduce opportunities for holistic, person-centred care. In addition, disabled people continue to experience health inequalities, poor access to services and barriers related to housing, employment and transport. Professional attitudes and unconscious bias may further limit participation in care planning, highlighting the need for ongoing education and organisational commitment.

Overall, the Social Model has made a substantial contribution to UK health and social care policy by promoting equality, accessibility and empowerment. However, its successful implementation depends not only on legislation but also on sufficient resources, effective multidisciplinary working and a continued commitment to removing barriers that prevent disabled people from receiving genuinely person-centred care.

Recommendations for Health and Social Care Policy and Practice

Although the Social Model of Disability has significantly influenced UK health and social care policy, challenges remain in translating its principles into consistent practice. Addressing

these issues requires coordinated action from policymakers, healthcare organisations and professionals to strengthen person-centred care.

A key recommendation is to improve education and continuing professional development on disability equality and person-centred practice. Training should encourage professionals to recognise environmental and attitudinal barriers, reflect on unconscious bias and involve disabled people as equal partners in decision-making. Greater use of reflective practice and service-user involvement in staff training could further enhance understanding of the lived experience of disability.

A second recommendation is to increase investment in accessible services and environments. Although the Equality Act 2010 requires reasonable adjustments, implementation remains inconsistent because of financial pressures and organisational differences. Greater investment should improve accessible facilities, information in alternative formats and inclusive digital healthcare. These improvements would benefit not only disabled people but also older adults, carers and individuals with temporary accessibility needs.

Strengthening multidisciplinary collaboration is another priority. Effective communication between healthcare professionals, social workers and voluntary organisations enables more coordinated, holistic care by addressing medical, psychological and social needs. This collaborative approach also helps identify wider barriers relating to housing, education, employment and community participation.

Greater involvement of disabled people in policy development and service design should also be promoted. Co-production reflects the principles of both the Social Model and person-centred care by recognising individuals as experts in their own experiences. Involving service users in planning and evaluating services can improve accessibility, increase accountability and ensure services better meet people's needs.

Finally, policymakers should continue addressing the wider social determinants of health, including housing, education, employment, transport and community support. Reducing inequalities and promoting social inclusion are essential alongside high-quality healthcare. A holistic approach that addresses both health and social factors is more consistent with the principles of the Social Model and person-centred care.

Conclusion

The Social Model of Disability has transformed the understanding of disability by shifting the focus from individual impairment to the barriers created by society. It has influenced UK legislation and policy, particularly the Equality Act 2010, the Care Act 2014 and the development of person-centred care within the NHS.

However, the model has limitations. While it highlights the importance of removing social and environmental barriers, critics argue that it gives insufficient attention to the lived experience of impairment and the ongoing need for healthcare interventions. Consequently,

contemporary approaches increasingly recognise that disability is shaped by biological, psychological and social factors.

Overall, the Social Model remains a key framework underpinning person-centred health and social care. When combined with holistic assessment, evidence-based healthcare and partnership working, it supports more inclusive, equitable and person-centred services that respect individuals' rights, preferences and lived experiences.

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