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The Social Model of Disability as a Foundation for Person-Centred Care in Health and Social Care Policy and Practice

Introduction

Person-centred care has become a central ideal in contemporary health and social care, emphasising respect for individuals' preferences, needs, and values, and ensuring that these guide all clinical and care decisions. Among the conceptual frameworks that underpin person-centred care, the social model of disability stands out as particularly influential. Emerging from the disabled people's movement in the late twentieth century, the social model reframes disability not as an individual medical problem but as the result of social, environmental, and attitudinal barriers. This essay critically discusses the social model of disability, tracing its emergence, development, and key critiques, before examining its application to health and social care policy and practice. It concludes with recommendations for strengthening the alignment between the social model and person-centred care in policy and frontline practice.

Emergence and Development of the Social Model of Disability

The social model of disability emerged in the 1970s and 1980s, primarily in the United Kingdom, as part of a broader disabled people's movement challenging dominant medical and individualistic understandings of disability. Prior to this, the "medical model" prevailed, locating disability within the individual's body or mind as a deficit requiring diagnosis, treatment, and, where possible, cure. Disability was thus framed as a personal tragedy, with interventions focused on rehabilitation or care rather than rights or social change.

In contrast, the social model distinguishes between "impairment" (the physical, sensory, or cognitive difference) and "disability" (the disadvantage and exclusion produced by social organisation). As articulated by key thinkers and activists such as Mike Oliver and the Union of the Physically Impaired Against Segregation (UPIAS), disability is understood as "the disadvantage or restriction of activity caused by a contemporary social organisation which takes no or little account of people who have impairments and thus excludes them from participation in the mainstream of social activities" (Oliver, 1990; UPIAS, 1976).

This distinction was revolutionary. It shifted the focus from fixing individuals to transforming environments, policies, and attitudes. It provided a powerful tool for disabled people to articulate their experiences of discrimination and to demand civil rights, accessible infrastructure, inclusive education, and anti-discriminatory legislation. The model's influence is evident in landmark policy developments such as the Disability Discrimination Act 1995 and later the Equality Act 2010 in the UK, which embed duties to remove barriers and promote equality (Shakespeare, 2014; Goodley, 2014).

Over time, the social model has been refined and expanded. Early formulations were sometimes criticised for appearing to downplay the lived reality of impairment, pain, and fatigue. In response, scholars and activists have emphasised that the social model does not deny impairment effects but insists that social barriers are the primary cause of disablement. This nuanced position maintains the political clarity of the original model while acknowledging the complexity of embodied experience (Shakespeare, 2014; Morris, 2001).

Critiques of the Social Model and Responses

Despite its transformative impact, the social model has faced several critiques. One prominent criticism is that it creates a sharp dichotomy between impairment and disability, potentially marginalising the significance of bodily experiences such as chronic pain, fatigue, or progressive conditions. Critics argue that by focusing almost exclusively on external barriers, the model risks silencing discussions about the personal and medical dimensions of living with impairment (Shakespeare, 2014; Goodley, 2014).

Another critique concerns the model's applicability across different types of impairment. Some scholars suggest that the social model is most readily applied to physical and sensory impairments, where environmental modifications (e.g., ramps, Braille, sign language interpreters) can clearly remove barriers. For people with learning disabilities, mental health conditions, or complex needs, the relationship between impairment and social exclusion may be less straightforward, requiring more integrated approaches that consider both social and individual factors (Shakespeare, 2014; Goodley, 2014).

A further critique is that the social model, in its strong form, can appear to underplay the role of health and social care services. If disability is entirely socially produced, what is the role of medical intervention, therapy, or personal care? Some argue that this risks positioning care as inherently oppressive or paternalistic, rather than potentially enabling and supportive (Tronto, 1993; Kittay, 2001).

In response to these critiques, proponents of the social model have developed more relational and inclusive interpretations. Rather than abandoning the core insight that social barriers are central, they advocate for a "social relational" understanding of disability that recognises the interplay between impairment effects and social structures. This approach acknowledges that while barriers are socially created, individuals experience impairment in embodied ways that matter for policy and practice (Shakespeare, 2014; Morris, 2001).

Additionally, dialogue between the social model and other frameworks, such as the ethics of care and the human rights model, has enriched its application. The ethics of care, for example, highlights the moral significance of interdependence, relationships, and responsiveness to need, complementing the social model's focus on structural change with attention to the quality of care interactions (Tronto, 1993; Kittay, 2001). Similarly, the human rights model builds on the social model by explicitly framing disability as a matter of rights, dignity, and equality, reinforcing the imperative for legal and policy reform (Shakespeare, 2014; Morris, 2001).

These developments demonstrate the social model's adaptability and ongoing relevance. Rather than being static, it has evolved through critical engagement, maintaining its radical edge while incorporating insights from lived experience and complementary theoretical perspectives.

Application to Health and Social Care Policy and Practice

The social model of disability has significantly influenced health and social care policy and practice, particularly in promoting person-centred, rights-based approaches. Its core principle, that disability arises from barriers rather than deficits, aligns closely with the values of person-centred care, which prioritise individuals' autonomy, preferences, and participation in decision-making (World Health Organization, 2015; Department of Health, 2014).

In policy terms, the social model underpins key legislative and strategic frameworks. The Equality Act 2010, for instance, requires service providers to make reasonable adjustments to avoid disadvantage to disabled people, reflecting the social model's emphasis on removing barriers (Shakespeare, 2014). Similarly, the Care Act 2014 in England embeds principles of wellbeing, prevention, and personalisation, encouraging local authorities to support individuals in ways that promote independence and social inclusion rather than dependency (Department of Health, 2014; World Health Organization, 2015).

At the practice level, the social model informs approaches such as personalisation, self-directed support, and co-production. Personalisation shifts control from services to individuals, enabling disabled people to design their own care packages and employ personal assistants, thereby challenging traditional paternalistic models of care (Shakespeare, 2014). Co-production goes further, involving disabled people as equal partners in designing, delivering, and evaluating services. This reflects the social model's insistence that disabled people are experts in their own lives and should lead efforts to remove barriers (World Health Organization, 2015; Department of Health, 2014).

However, the application of the social model in health and social care is not without problems. One major issue is the persistent dominance of the medical model within clinical settings. Despite policy commitments to person-centred care, many health professionals continue to view disability primarily through a diagnostic and treatment lens, focusing on impairment management rather than barrier removal. This can result in care plans that

prioritise medical outcomes over social participation, undermining the social model's core message (Goodley, 2014).

Another challenge is the gap between policy rhetoric and implementation. While legislation and strategy documents endorse the social model, resource constraints, bureaucratic processes, and risk-averse cultures often limit its realisation in practice. For example, personalisation policies may be undermined by eligibility criteria, funding cuts, or lack of support for individuals to navigate complex systems (Department of Health, 2014). Similarly, co-production initiatives may become tokenistic, with disabled people invited to participate but lacking genuine influence over decisions (World Health Organization, 2015).

A further problem concerns the intersection of the social model with other forms of inequality. Disabled people are not a homogeneous group; experiences of disability are shaped by gender, race, class, sexuality, and migration status. The social model, in its original formulation, has been critiqued for not adequately addressing these intersections. For instance, disabled women, particularly those from minority ethnic backgrounds, may face compounded barriers in accessing care, employment, and social participation (Hochschild, 2000; Yeates, 2004).

Moreover, the globalisation of care labour introduces additional complexities. The concept of "global care chains" highlights how care work is increasingly transferred from the Global South to the Global North, often relying on migrant women to fill care gaps in affluent households and care systems (Hochschild, 2000; Yeates, 2004). This raises ethical questions about the sustainability and equity of care arrangements that enable disabled people in high-income countries to live independently while potentially exploiting migrant care workers. Aligning the social model with an ethics of care requires attention to these transnational dynamics and the rights of all involved in care relationships (Tronto, 1993; Kittay, 2001).

Recommendations for Health and Social Care Policy and Practice

To strengthen the alignment between the social model of disability and person-centred care, several recommendations can be made for policy and practice.

1. Embed the Social Model in Professional Education and Training

Health and social care professionals require robust training on the social model of disability, moving beyond awareness-raising to critical engagement with its implications for practice. Curricula should integrate disabled people's voices, emphasise barrier removal over individual deficit, and explore the intersection of disability with other forms of inequality (Shakespeare, 2014; Goodley, 2014). This includes challenging ableist assumptions and promoting reflective practice that centres disabled people's expertise.

2. Strengthen Implementation of Personalisation and Co-Production

Policy commitments to personalisation and co-production must be backed by adequate resources, simplified processes, and genuine power-sharing. Local authorities and service providers should invest in advocacy support, peer networks, and accessible information to enable disabled people to exercise choice and control (World Health Organization, 2015; Department of Health, 2014). Co-production should be embedded at all stages, from commissioning to evaluation, with clear mechanisms for accountability and feedback.

3. Integrate the Social Model with Clinical Practice

While the social model challenges the medical model, it does not negate the importance of health interventions. Instead, clinical practice should adopt a biopsychosocial approach that addresses impairment-related needs while actively working to remove social barriers (Goodley, 2014). This might involve multidisciplinary teams that include social workers, occupational therapists, and peer supporters, ensuring that care plans promote both health and social participation.

4. Address Intersectionality and Global Care Dynamics

Policy and practice must recognise the diverse experiences of disabled people, particularly those facing multiple forms of marginalisation. This requires targeted strategies to address barriers related to gender, race, class, and migration status (Hochschild, 2000; Yeates, 2004). Additionally, ethical care frameworks should consider the rights and conditions of migrant care workers, promoting fair wages, safe working conditions, and pathways to citizenship where appropriate (Tronto, 1993; Kittay, 2001).

5. Monitor and Evaluate Progress Using Disabled People's Indicators

Finally, progress towards person-centred, socially modelled care should be measured using indicators developed with disabled people. These might include measures of social participation, satisfaction with care, access to employment and education, and experiences of discrimination (World Health Organization, 2015; Department of Health, 2014). Regular audits and feedback loops can ensure that policies and practices remain aligned with the social model's principles.

Conclusion

The social model of disability has profoundly reshaped the understanding of disability, shifting the focus from individual deficit to social barriers. Its emergence from the disabled people's movement provided a powerful framework for challenging discrimination and advocating for rights, accessibility, and inclusion. While critiques have highlighted limitations (particularly regarding impairment effects, intersectionality, and care relationships) these have been met with thoughtful responses that enrich rather than undermine the model's core insights.

In health and social care, the social model underpins person-centred approaches that prioritise autonomy, participation, and barrier removal. However, gaps between policy and practice, the persistence of medical model thinking, and the complexities of global care chains present ongoing challenges. By embedding the social model in education, strengthening personalisation and co-production, integrating it with clinical practice, addressing intersectionality, and centring disabled people's indicators, health and social care can move closer to realising the vision of person-centred care.

Ultimately, the social model reminds us that disability is not a problem to be fixed but a dimension of human diversity that calls for social transformation. Person-centred care, informed by this model, is not merely about tailoring services to individuals but about reshaping systems, cultures, and relationships to enable all people to live with dignity, choice, and full participation in society.

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