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A Critical Evaluation of the Social Model of Disability and Its Application to Person-centred Health and Social Care Policy and Practice in the UK

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1.0 Introduction

Person-centred care has become the focal point of health and social care practice in the United Kingdom since it regards each person as unique with specific needs, preferences and goals. This approach is based on the Social Model of Disability, which grounds disability in societal obstacles instead of personal inadequacy, and is gaining strength through modern scholarship on embodiment (Rivas et al., 2025). The current report critically assesses the Social Model, its emergence, development and criticisms and is based on the latest peer-reviewed literature uploaded on 2022-2026. It subsequently examines its implementation in UK policy and practice, and offers evidence-based suggestions on how to enhance future health and social care services.

2.0 Emergence, Development and Critical Evaluation of the Social Model of Disability

2.1 Emergence of the Social Model of Disability

The medical model of disability interpreted disability as a personal loss that needs to be treated or healed as a disability (Sociability, 2026). In the 1970s, the Union of the Physically Impaired Against Segregation, UPIAS, disputed such an opinion, claiming that society is the source of disability through exclusion and segregation (NADP, 2024). These ideas were further formalised by Oliver (1983) into the Social Model of Disability and the difference between impairment and disability. An impairment is the physical, sensory or cognitive state of a person, whereas disability is the limitation of accessible environments and discriminating attitudes (Karagianni and Koutsoklenis, 2023). This difference became mainstream in the broader disability rights movement and serves to shape modern researchers in their conceptualisation of structural barriers to health equity (Gréaux et al., 2023).

2.2 Development of the Social Model of Disability

Following this emergence, the Social Model became a rights-based norm of equality, independent living and empowerment of disabled individuals (NADP, 2024). The model was employed by campaigners who held that the elimination of physical, attitudinal and organisational obstacles would provide disabled people with a real choice and control in living their lives. This transformation promoted a change in services away from paternalistic service towards services based on preference and dignity. According to Rivas et al. (2025), a Social Model plus the ideas of embodiment and strengths-based approaches creates more effective person-centred solutions to under-represented and intersectional groups. The model is thus quite aligned with person-centred care, which equally prioritises the voice of individuals, their autonomy and lived experience in health and social context (Morris et al., 2022).

2.3 Criticisms of the Social Model

Social Model has undergone long-term criticism by academics and practitioners. Conversely, it down-emphasises lived experience of impairment, especially pain, exhaustion and chronic illness that cannot be addressed only through removing barriers (Adam and Koutsoklenis, 2023). According to Karagianni and Koutsoklenis (2023), the model simplifies disability by assuming that it is a uniform category, instead of a diverse set of conditions. Mental health disorders and switching or bipolar disabilities are especially hard to provide with an exclusively social model. Molnar et al. (2024) noted that patients with intellectual disability tend to need co-designed and prescribed-specific healthcare support, which cannot be completely codified in a generalised social framework.

2.4 Responses to the Criticisms

To address such criticisms, the Biopsychosocial Model came out, which integrates biological, psychological and social aspects of disability into a single model (Adam and Koutsoklenis, 2023). The methodology maintains the Social Model focus on elimination of societal barriers with the added discovery of clinical realities of impairment and illness. According to Shakespeare (2006), this type of integration was not necessary to eliminate the fundamental aim of the Social Model: social change (NADP, 2024). Similarly, Morris et al. (2025) argue that at present, person-centred rehabilitation research combines the social, relational, and biomedical perspectives instead of viewing them as antithetically opposed.

3.0 Application of the Social Model to UK Health and Social Care Policy and Practice

3.1 Application in Health and Social Care Practice

In the UK health and social care setting, the Social Model favours person-centred care through the promotion of services, putting more focus on individual choice, dignity and independence. Shared decision-making has grown in popularity, whereby practitioners and service users collaboratively create care based on their personal objectives instead of institutional utility (Molnar et al., 2024). NHS and social care providers are also becoming more attentive to the aspect of access in designing services, such as the provision of accessible forms of information and physical environments. Nieuwenhuis et al. (2025) discovered that meaningful engagement between jointly disabled individuals was enhanced greatly by the use of person-centred approaches when relationships and communication were put at the forefront. Inclusive practice also entails training employees to be able to identify attitudinal impediments, also known as disablism, which may otherwise inhibit the possibilities of people with disabilities.

3.2 Influence on UK Legislation, Policies and Guidelines

The Social Model has been influential in the legislation and other broader policy frameworks in the UK. The Equality Act 2010 forbids discrimination against disabled individuals and calls on reasonable changes done to eliminate barriers in services and employment. According to Christiaens and Brittain (2023), introducing such inclusion responsibilities is truly complicated even in organisations with sufficient resources, as the legal demands do not necessarily lead to any cultural shift. The Care Act 2014 encourages the wellbeing of individuals, independence and choice, which the model is based on autonomy and not paternalism. The Human Rights Act 1998 ensures equal treatment and dignity of disabled individuals in the public services. Health and Social Care Act 2012 brought responsibilities to decrease health disparities, and the NHS Long Term Plan promises to offer more client-focused and obtainable signposting (NHS England, 2023). Person-centred principles are gradually being incorporated into the NICE guidelines to create clinical guidelines (NICE, 2024). This role of the Social Model in regulating expectations on the national level is supported by the Fundamental Standards of the Care Quality Commission that base their expectations on dignity, respect and real choice. The International Journal for Equity in Health (2023) conducted a global scanning review and found the same, stating that legal frameworks are needed but have not been adequately supported through long-term implementation.

3.3 Challenges in Applying the Social Model

Nevertheless, the practical implementation of the Social Model is really challenging. Lack of workforce in health and social care constrains time to provide genuinely personalised help, a stress which has been affirmed by recent economic research of NHS and social care staffing (Oxford Review of Economic Policy, 2025). Local government financial strains have limited funding, and a significant portion of disabled individuals are now in arrears to social care and awaiting reduced service delivery (The Big Issue, 2025). Recruitment issues have become even worse after recent amendments to overseas care worker visa paths, where the labour supply to the providers has been decreased (Hamid et al., 2026). The majority of settings have both physical and influence barriers to communication despite the legislative provisions of accessibility. The intentions of personnel can also be sabotaged by the organisational culture and attitude of the staff, especially where efficiency is considered more than personal preferences of services. According to Watermeyer et al. (2025), UK policy documents have increasingly become person-centred, with major discrepancies in translating the language to regular everyday practice, especially in relation to people with learning disabilities and dementia.

4.0 Critical Recommendations for Future Health and Social Care Policy and Practice

4.1 Critical Evaluation of the Social Model in Contemporary Practice

The Social Model has authentic merits of advancing equality, inclusion and empowerment in the UK health and social care. It was able to rebrand disability as a social problem, leading policymakers to concentrate on eliminating obstacles instead of labelling people as having disabilities. This change has facilitated self-sufficiency and strengthened rights-based strategies in laws like the Equality Act 2010. Genuine person-centred care is based on the model as it requires services to be tailored to the individual instead of demanding a person conform (Morris et al., 2022).

Nonetheless, the limitations of the model are evident in the context of complex medical conditions that need to be under ongoing clinical care. Social factors alone are not sufficient in explaining chronic pain, progressive illness or mental health that changes. One of the concerns raised by Karagianni and Koutsoklenis (2023) during a review of competing disability frameworks. Implementation is also complicated by resource constraints, as barriers frequently need significant investment, which services may not be able to make (Oxford Review of Economic Policy, 2025). The practical implementation is also quite different in regions and providers, which makes the way truly person-centred the ensuing care is, inconsistent. The Biopsychosocial-informed combined approach enables services to target both the societal impediments and individual medical requirements at the same time (Adam and Koutsoklenis, 2023).

4.2 Recommendations for Improving Health and Social Care Practice

There are a few practical guidelines that would enhance the use of the Social Model in daily care. Such training should involve organised disability awareness, which will assist staff to identify attitudinal and environmental barriers to their own services. Training can mitigate disablist attitudes and improve confidence in providing person-centred support (Adam and Koutsoklenis, 2023). Co-production needs to be integrated, as service users must be involved in designing the support that they desire, where Rivas et al. (2025) believe that this idea is necessary in their work with under-represented and intersectional groups. Autonomy is reinforced with true co-production, which has the historical focus of the Social Model on the voice of disabled people. Molnar et al. (2024) suggest that co-educators who experienced having a disability introduced would be more effective at training healthcare staff than generic training.

There should also be an increase in multidisciplinary working to enable health and social care offices to merge clinical skills with a social perspective of barriers. Access to

communication should be made regular and in formats like easy-read documents, British Sign Language interpretation and plain English summaries. Service design should be inclusive, and not an addition that is implemented in the later stages of the plan. Digital access is a topic that should be given special consideration, as otherwise, disabled service users can be excluded by online appointment systems and digital records. These principles should be embedded in continuous professional development during the career of a practitioner, and not perceived as a one-time training on disability awareness.

4.3 Recommendations for Health and Social Care Policy

At the policy level, more effective action is needed to ensure the Equality Act 2010 and Care Act 2014 do the same, as Christiaens and Brittain (2023) suggest implementation assistance but legal obligations. Social care would improve due to increased funding that will lead to fewer limits on personalised support and social care debt (The Big Issue, 2025). Better accountability practices must also see the providers show tangible improvements in person-centred outcomes as opposed to general statements of intent. Accessibility and actual involvement of service users should be scrutinised more stringently by monitoring systems, which may be headed by the Care Quality Commission. Accessibility criteria must be reinforced and regularly implemented throughout health and social care environments throughout the country, as evidenced by the Gréaux et al. of disability-inclusive healthcare (International Journal for Equity in Health, 2023).

4.4 Future Directions for Person-Centred Care

In the future, multiple trends have the potential to enhance the practical use of the Social Model and person-centred care. Integrated care systems provide the possibilities to integrate health, social care and community services around the individual needs instead of institutional boundaries. Individual care planning, such as personal budgets, enables the disabled to have more control in the way they receive their support. Digital-based health technologies can enhance access to those with mobility or geographical constraints, but digital exclusion must be tackled (Makhado and Makhado, 2025).

Artificial intelligence can be utilised one day utilized to offer more responsive, predictive care, but it is necessary to carefully regulate it to avoid emerging types of exclusion. The concept of universal design (to make environments practical for all initially) is particularly compatible with the principles of the Social Model that focus on eliminating the barriers instead of accommodating individuals. Independent living can also be aided by community-based services that ensure that people are attached to familiar surroundings and peace of mind. Technologies including assistive communication devices continue to open possibilities of real participation, and new research in rehabilitation tends toward the idea that person-centred

adoption of technology is best done by co-designing it with disabled people themselves (Morris et al., 2025).

5.0 Conclusion

Social Model of Disability underlies the concept of person-centred care as it disputes the social obstacles instead of personal inability. It has significantly influenced the practice and UK legislation, but implementation issues still remain. Realising its potential requires stronger policy implementation, increased funding and real co-production with disabled individuals.

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