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Introduction

Person-centred care has become an important part of health and social care, moving away from traditional approaches where professionals were often the main decision-makers. Instead, it recognises that individuals have valuable knowledge about their own lives and should be involved in decisions about their care and support. This approach focuses on treating people with dignity and respect while considering their personal values, relationships, identity, and wider circumstances alongside their health needs (McCormack and McCance, 2021).

The social model of disability has significantly influenced person-centred approaches by challenging traditional medical views of disability. Developed through the disability rights movement during the 1970s, the model argues that disability is not caused only by impairment but is created through social, environmental, and attitudinal barriers that limit participation (Oliver, 1990). This shifted attention away from changing individuals and towards addressing inequalities within society.

Although the social model of disability has contributed to more inclusive and rights-based approaches within health and social care, it has also been criticised for not fully addressing the personal experiences associated with impairment, such as pain and illness (Shakespeare, 2014). This essay will critically explore the social model of disability as a framework underpinning person-centred care by examining its development, key criticisms, influence on policy and practice, and recommendations for strengthening its application.

Development of the Social Model of Disability

Historically, disability was often viewed through the medical model, which focused on a person's impairment as the main cause of their difficulties. This approach placed emphasis on diagnosis, treatment, and rehabilitation to help manage the effects of a condition (Barnes and Mercer, 2010). Although medical care remains an important source of support for many disabled people, the model has been criticised for sometimes focusing on what people cannot do rather than recognising their strengths, rights, and individual goals (Oliver, 1990).

The social model of disability developed during the 1970s as disabled people began challenging traditional views of disability. Rather than seeing disability as being caused only by an individual's impairment, the model highlighted how barriers within society, such as inaccessible environments and negative attitudes, can limit people's opportunities (UPIAS, 1976). The work of the Union of the Physically Impaired Against Segregation (UPIAS) helped

to change the focus from individual limitations to the wider social factors that can prevent inclusion.

A key idea within the social model of disability is the difference between impairment and disability. Impairment relates to a person's physical, sensory, or cognitive condition, while disability occurs when barriers in society prevent people from taking part fully (Oliver, 1990). For example, someone who uses a wheelchair may have a mobility impairment, but they experience disability when buildings, transport, or services are not accessible. The social model of disability therefore suggests that improving equality involves removing these barriers rather than trying to change the individual.

The social model of disability challenged the idea that disabled people needed to be "fixed" before they could fully participate in society. Oliver (1996) argued that disability is also influenced by the way society operates, as attitudes, systems, and environments can create barriers for disabled people. This way of thinking has influenced person-centred care by highlighting the importance of choice, independence, and involvement in decisions. Instead of focusing only on a person's diagnosis or impairment, person-centred approaches consider their wider experiences, relationships, values, and goals (McCormack and McCance, 2021).

However, the social model of disability does not fully explain every aspect of disability. Barnes and Mercer (2010) argue that while it successfully highlights the impact of social barriers, it may not fully recognise the personal experiences associated with impairment. More recent approaches therefore emphasise the need to consider both individual health needs and the social factors that influence participation. Shakespeare (2018) suggests that disability is best understood through the interaction between impairment, personal experiences, and wider social environments.

Debates surrounding the Social Model of Disability

Although the social model of disability has had a significant influence on disability rights and person-centred care, it has also been subject to considerable debate. Its contribution lies in challenging assumptions that disability is solely an individual problem, while its limitations relate to how fully it explains the varied experiences of disabled people.

One of the main strengths of the social model of disability is that it changed the focus from what individuals cannot do to the barriers within society that limit participation. Oliver (1990) argued that disability can be seen as a form of social oppression because inaccessible

environments, negative attitudes, and organisational practices can prevent disabled people from having equal opportunities. This perspective has influenced person-centred care by encouraging greater choice, control, and involvement in decisions about care and support.

The model has also encouraged health and social care services to consider how their own systems may create barriers. Rather than focusing only on what a person cannot do, services are encouraged to examine whether their practices, communication methods, or environments prevent equal access. For example, if healthcare information is only available in written formats, a person with a visual impairment may be excluded because of the way information is provided rather than their impairment itself. This approach has contributed to greater awareness of accessibility and reasonable adjustments.

However, a significant criticism of the social model of disability is that it may underestimate the impact of impairment. Shakespeare (2014) argues that while social barriers contribute to disability, some experiences associated with impairment cannot be removed through environmental changes alone. Conditions involving chronic pain, fatigue, or progressive illness may continue to affect a person's daily life even when society becomes more inclusive.

For example, a person living with Parkinson's disease may benefit from accessible environments and supportive services, but these changes will not remove the physical symptoms of the condition. This demonstrates the need for a balanced approach within health and social care, where professionals address social barriers while also recognising individual health needs and support requirements.

A further criticism is that disabled people do not experience disability in the same way. Shakespeare (2018) highlights that disability is shaped by factors such as age, gender, ethnicity, economic circumstances, and access to support. Therefore, person-centred practice must consider individual experiences rather than assuming that removing environmental barriers alone will resolve all difficulties.

The relationship between the social model of disability and medical approaches has also been debated. Although some interpretations suggest that medical approaches focus too heavily on impairment, healthcare interventions can remain essential to improving quality of life. Oliver (1996) emphasised that the social model of disability was not intended to reject healthcare but to challenge the assumption that medical treatment alone can address disability-related inequality. A more effective approach therefore recognises the value of both medical support and social inclusion.

Applying the Social Model of Disability within Health and Social Care Policy and Practice

The influence of the social model of disability can be seen within health and social care policy through increased emphasis on equality, accessibility, and disabled people's rights. In the United Kingdom, these principles have contributed to legislation and policies designed to reduce discrimination and promote participation.

The Equality Act 2010 is a key example of this influence. The Act requires organisations, including health and social care providers, to prevent discrimination and make reasonable adjustments to ensure disabled people can access services equally (Equality Act, 2010). This reflects the social model of disability because it recognises that disadvantage is often created by barriers within society rather than impairment alone.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) also supports a rights-based approach by recognising disabled people's rights to equality, independence, participation, and inclusion (United Nations, 2006). These principles align closely with person-centred care by emphasising autonomy and recognising individuals as active participants in decisions about their lives.

In practice, the social model of disability has influenced areas such as care planning, communication, and shared decision-making. Person-centred assessments should look beyond a person's medical needs and consider the social and environmental factors that affect their daily lives (McCormack and McCance, 2021). For example, someone with a learning disability may need accessible communication and additional support to understand information and share their preferences about care. This approach focuses not only on managing a condition but also on supporting independence, involvement, and choice (World Health Organization, 2022).

The model has also contributed to the development of co-production, where professionals and service users work together to design and improve services. Beresford (2002) argues that people with lived experience have valuable knowledge that should inform service development. This reflects the social model of disability's emphasis on disabled people having influence over decisions that affect their lives.

Despite these improvements, there are still challenges in applying the social model of disability consistently in health and social care. Although laws and policies support equality, many disabled people continue to experience barriers, including inaccessible environments, communication difficulties, and limited access to reasonable adjustments (World Health Organization, 2022). Services can also face pressures such as staff shortages, limited resources, and increasing demand, which can make personalised support more difficult to provide (Care Quality Commission, 2023). In addition, attitudes towards disability remain an issue, as assumptions about people's abilities and independence can affect their experiences of care. Therefore, applying the social model of disability requires not only removing physical barriers but also improving professional attitudes and creating more inclusive services (Shakespeare, 2018).

Recommendations for Health and Social Care Policy and Practice

To strengthen the use of the social model of disability within person-centred care, disability equality and rights-based approaches should be embedded more consistently within health and social care education and professional development. Professionals require a broader understanding of disability that recognises the impact of social, environmental, and attitudinal barriers alongside individual health needs. The inclusion of disabled people's lived experiences within education and training is particularly important, as it supports more inclusive practice and challenges assumptions about disability (World Health Organization, 2022). This approach is consistent with the social model of disability's emphasis on recognising disabled people as experts in their own experiences (Oliver, 1996).

Disabled people should also have greater involvement in the design, delivery, and evaluation of health and social care services. Although co-production is increasingly promoted within policy, meaningful involvement is not always consistently achieved. The involvement of people with lived experience can improve the relevance, accessibility, and quality of services by ensuring that decisions are informed by those who use them (Needham and Carr, 2022). This reflects the principles of person-centred care, where partnership and shared decision-making are central to effective support (McCormack and McCance, 2021).

Accessibility should remain a key priority across health and social care environments. This includes accessible buildings, inclusive communication methods, and information provided in formats that meet individual needs. The World Health Organization (2021) highlights that inaccessible environments remain a significant contributor to disability-related inequalities globally. Therefore, accessibility should be understood not only as a legal requirement under

legislation such as the Equality Act 2010, but as an essential element of safe, equitable, and high-quality care.

Finally, health and social care services should measure outcomes that reflect what matters to individuals rather than focusing only on clinical indicators or organisational targets. Person-centred approaches require attention to outcomes such as independence, participation, wellbeing, and quality of life (McCormack and McCance, 2021). Gathering feedback from disabled people should be central to evaluating services, as this supports continuous improvement and ensures that care remains responsive to individual priorities and circumstances (Care Quality Commission, 2023).

Conclusion

The social model of disability of Disability has significantly influenced contemporary understandings of disability and has contributed to the development of person-centred approaches within health and social care. By challenging the dominance of the medical model, it shifted attention towards the role of social barriers, accessibility, and disabled people's rights (Oliver, 1990). This change in perspective has supported more inclusive approaches to care by encouraging professionals to consider how environments, systems, and attitudes can contribute to exclusion.

However, the social model of disability also has limitations. While it effectively highlights the impact of social barriers, disability cannot be fully explained through social factors alone, as impairment and personal experiences remain important aspects of many disabled people's lives (Shakespeare, 2014). A balanced approach is therefore required, recognising both the need to remove disabling barriers and the importance of providing appropriate healthcare, treatment, and support (Shakespeare, 2018).

The lasting contribution of the social model of disability is the way it has challenged traditional views of disabled people as passive recipients of care. Instead, it has encouraged professionals to recognise disabled people as individuals with their own rights, knowledge, experiences, and personal goals. When combined with the principles of person-centred care, which promote autonomy, partnership, and involvement in decision-making (McCormack and McCance, 2021), the social model of disability supports the development of more inclusive, respectful, and responsive approaches to health and social care practice.

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