

BSc Health and Social Care

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Person-Centred Care and the Social Model of Disability

in UK Health and Social Care

Introduction:

Within the contemporary landscape of health and social care in the United Kingdom, person-centred care is recognized as a fundamental principle. This approach signifies a departure from traditional paternalistic paradigms, which typically vested primary decision-making authority in professionals, towards a framework prioritizing individual autonomy in the planning and delivery of care. Fundamentally, this model is predicated upon principles of dignity, respect, and compassion, asserting the imperative of active individual engagement in decisions pertaining to their health and well-being (The Health Foundation, 2016). Rather than conceptualizing individuals solely through the lens of illness, dependency, or diagnostic categories, person-centred care acknowledges their inherent uniqueness, encompassing their distinct values, preferences, lived experiences, and aspirations.

The genesis of person-centred care can be traced to humanistic psychology, notably through the contributions of Carl Rogers. Rogers posited that efficacious therapeutic relationships are contingent upon the presence of empathy, genuineness, and unconditional positive regard (Rogers, 1951). These conceptual frameworks continue to inform health and social care practice, fostering the development of supportive relationships grounded in trust and reciprocal respect. Operationally, person-centred care advocates for individual choice, collaborative partnership, personal empowerment, and enhanced independence. Its objective is to ensure that care provisions are co-produced with individuals, rather than merely dispensed to them. This imperative is particularly salient within the United Kingdom, where demographic shifts towards an aging population, a rising prevalence of long-term conditions, and intensified pressures on service provision collectively underscore the critical need for personalized and integrated support mechanisms (NHS England, 2019).

Among the foundational theoretical frameworks informing person-centred care, the Social Model of Disability holds significant prominence. This model fundamentally contested conventional conceptualizations of disability, asserting that individuals are disabled not solely by their impairments, but by an array of social, environmental, and attitudinal barriers that constrain their full participation (Oliver, 1990). Its influence on UK health and social care policy has been substantial, particularly concerning the advancement of equality, inclusion,

independence, and the provision of rights-based support. The present essay undertakes a critical examination of the Social Model of Disability, exploring its historical development, inherent strengths, and recognized limitations. Furthermore, it evaluates the model's impact on health and social care policy and practice within the UK context, concluding with recommendations aimed at enhancing the implementation of person-centred care.

The Social Model of Disability: Development, Strengths and Limitations

The Social Model of Disability emerged in the United Kingdom during the 1970s, alongside the disability rights movement. Before this, disability was mainly understood through the medical model, which viewed disability as a problem within the individual. Under this model, impairment was seen as something that needed treatment, rehabilitation, or cure. Although the medical model remains useful in understanding health conditions, it often reduced disabled people to their impairments and encouraged dependency by focusing mainly on limitations rather than rights or opportunities (Oliver, 1996).

Disabled activists contested this paradigm, positing that exclusion frequently originated from societal barriers rather than from the impairment per se. Such barriers encompassed inaccessible infrastructure, discriminatory practices, inadequate transportation, rigid services, and pervasive negative perceptions. Mike Oliver played a pivotal role in formalizing the Social Model, establishing a clear differentiation between impairment and disability (Oliver, 1996). Within this framework, impairment denotes a physical, sensory, intellectual, or mental condition, whereas disability is understood as the disadvantage imposed by societal structures. This conceptual separation held considerable importance, as it redirected focus from an individual's perceived deficits to the imperative for societal transformation.

Table 1: Comparison of the Medical Model and Social Model of Disability:
Source: Adapted from Oliver (1990; 1996)

Aspect	Medical Model of Disability	Social Model of Disability
View of disability	A problem within the individual	A result of social and environmental barriers

Aspect	Medical Model of Disability	Social Model of Disability
Main focus	Treatment, cure, rehabilitation	Inclusion, accessibility, equality
Role of the individual	Often passive and dependent	Active participant with rights and choice
Role of professionals	Main decision-makers	Partners in support and planning
Aim of care	Manage impairment	Remove barriers and promote independence
Link to person-centred care	Limited	Strong

As shown in Table 1, the Social Model is more closely linked to person-centred care because it promotes autonomy, choice, and inclusion. One of its greatest strengths is that it is empowering. Rather than defining people by their limitations, it highlights the responsibility of society to remove barriers and ensure equal participation. It also supports a rights-based approach to care by encouraging professionals and policymakers to focus on equality, access, and social justice (Shakespeare, 2013).

The model also played an important role in wider social and political change. Historically, many disabled people were placed in institutional settings and had little control over their own lives. As demands for equality and independent living grew, policy began to move towards community-based care. This shift influenced legislation such as the National Health Service and Community Care Act 1990 and later the Care Act 2014, both of which promoted independence, choice, and personalisation (UK Parliament, 1990; HM Government, 2014). Despite its strengths, the Social Model has been criticised. One criticism is that it may place too much emphasis on barriers in society while giving less attention to the lived reality of impairment. Even in an inclusive environment, some people still experience pain, fatigue, distress, or reduced functioning because of chronic or progressive conditions (Shakespeare, 2013). This means that disability cannot always be explained purely in social terms. Some scholars therefore prefer broader approaches, such as the biopsychosocial model, which recognises the interaction between health conditions, personal factors, and social barriers (World Health Organization, 2001).

Another limitation is that the Social Model does not always fully capture the diversity of disabled people's experiences. Factors such as age, class, gender, ethnicity, and culture can shape how disability is experienced. In addition, while the model offers a strong theoretical and political framework, its full implementation can be difficult in systems facing workforce shortages, limited funding, and organisational pressures. Nevertheless, despite these criticisms, the Social Model remains highly influential and continues to provide a strong basis for person-centred and rights-based care.

Application in UK Health and Social Care Policy and Practice:

The Social Model of Disability has substantially shaped health and social care policy and its implementation within the United Kingdom. Its impact is notably evidenced in legislative frameworks like the Equality Act 2010, which seeks to safeguard disabled individuals from discrimination and foster equitable access to services and opportunities (HM Government, 2010). Correspondingly, the Care Act 2014 mandates local authorities to integrate principles of wellbeing, dignity, participation, and independence into their care planning and support provisions (HM Government, 2014). These legal instruments collectively underscore the Social Model's core tenet: the systematic removal of societal barriers to facilitate greater individual independence.

Operationally, the Social Model informs the implementation of person-centred care, a paradigm that advocates for services to adapt to an individual's specific requirements rather than prescribing adherence to pre-existing rigid structures. This approach necessitates the customisation of support to align with each person's unique needs, values, and preferences. Furthermore, it acknowledges individuals as primary authorities on their own lived experiences, thereby empowering their active involvement in care-related decision-making. As articulated by The Health Foundation (2016), person-centred care prioritises the individual's perspectives and aims to structure services responsively to their expressed needs.

The Mental Capacity Act 2005 serves as an additional pertinent illustration of these principles. This legislation stipulates that individuals are to be facilitated in exercising their autonomy in decision-making to the greatest extent feasible. In instances where an individual is determined to lack capacity, decisions are nonetheless mandated to incorporate their expressed wishes, underlying values, and objectively assessed best interests (HM Government, 2005). Such

provisions underscore the imperative that individuals retain a central position in the decision-making process, even when requiring supplementary support.

Figure 1: How the Social Model of Disability Supports Person-Centred Care

Source: Adapted from Oliver (1996) and The Health Foundation (2016)

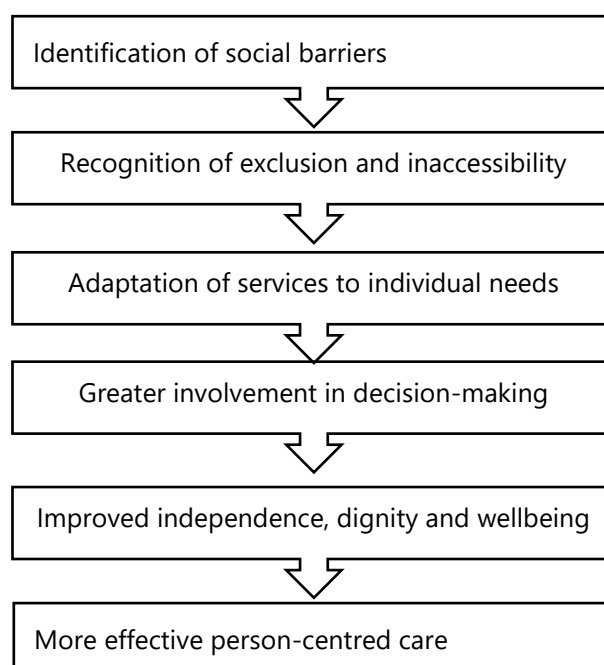


Figure 1 shows that person-centred care becomes more effective when services identify and reduce barriers. This approach moves beyond routine, task-focused care and supports participation, autonomy, and better outcomes.

Partnership working is also central to applying the Social Model in practice. Effective person-centred care depends on collaboration between nurses, doctors, social workers, occupational therapists, support workers, carers, and community organisations. This multidisciplinary approach makes care more coordinated and holistic. NHS England (2019) also supports this through its personalised care agenda, which promotes shared decision-making and joined-up support around the individual.

Dementia care provides a useful example of person-centred practice. Traditional approaches to dementia often focused mainly on symptoms and decline. In contrast, person-centred dementia care emphasises understanding the individual's life history, identity, relationships, and preferences. Kitwood (1997) argued that the personhood of individuals with dementia must remain central to care, while Brooker (2007) showed how this can be translated into practice. Examples include maintaining routines, offering choices, adapting communication, and involving family members appropriately. These actions can improve quality of life because they treat the person as more than a diagnosis.

However, the practical implementation of the Social Model and person-centred care remains inconsistent. A major challenge is pressure on services. Staff shortages, high workloads, and growing demand reduce the time professionals have to listen, build relationships, and tailor care. As a result, services may become more task-oriented and less personalised. The King's Fund (2024) continues to highlight workforce pressures in adult social care, showing that staffing shortages remain a serious issue.

Funding constraints are another barrier. As more people live with long-term and complex conditions, demand for support continues to rise. Yet financial pressure often limits service availability and reduces opportunities for truly personalised care. Organisational culture can also be a problem. In some settings, traditional hierarchical attitudes still make it difficult to involve service users as equal partners. Communication barriers may further restrict participation, especially for people with dementia, learning disabilities, sensory impairments, or mental health needs. Overall, while the Social Model has shaped policy and encouraged more inclusive thinking, its full implementation in practice remains limited by structural and organisational challenges.

Recommendations for Policy and Practice:

Several recommendations can be made to improve the implementation of the Social Model of Disability and strengthen person-centred care in the UK. First, greater investment in health and social care is essential. Person-centred care requires time, continuity, and skilled staff, yet many services are under severe pressure. Increased funding would support staff recruitment and retention, reduce workloads, and allow more time for meaningful engagement with service users.

Second, training and professional development should be strengthened. Staff need practical skills in communication, shared decision-making, cultural competence, and partnership working, alongside a clear understanding of the Social Model and its relevance to practice. This would help ensure that person-centred care is applied more consistently in day-to-day settings.

Third, policy implementation should be monitored more effectively. Although legislation provides a strong framework, practice is often uneven. More regular inspection, evaluation, and accountability would help ensure that person-centred principles are not only written into policy but also embedded in real practice.

Finally, services should place greater emphasis on partnership working and the involvement of service users and families. Shared decision-making and personalised care planning should be routine rather than optional. When individuals are supported to shape their own care, services are more likely to be respectful, relevant, and effective.

Figure 2: Key Principles Linking the Social Model of Disability and Person-Centred Care
Source: Adapted from Oliver (1990), Rogers (1951) and The Health Foundation (2016)

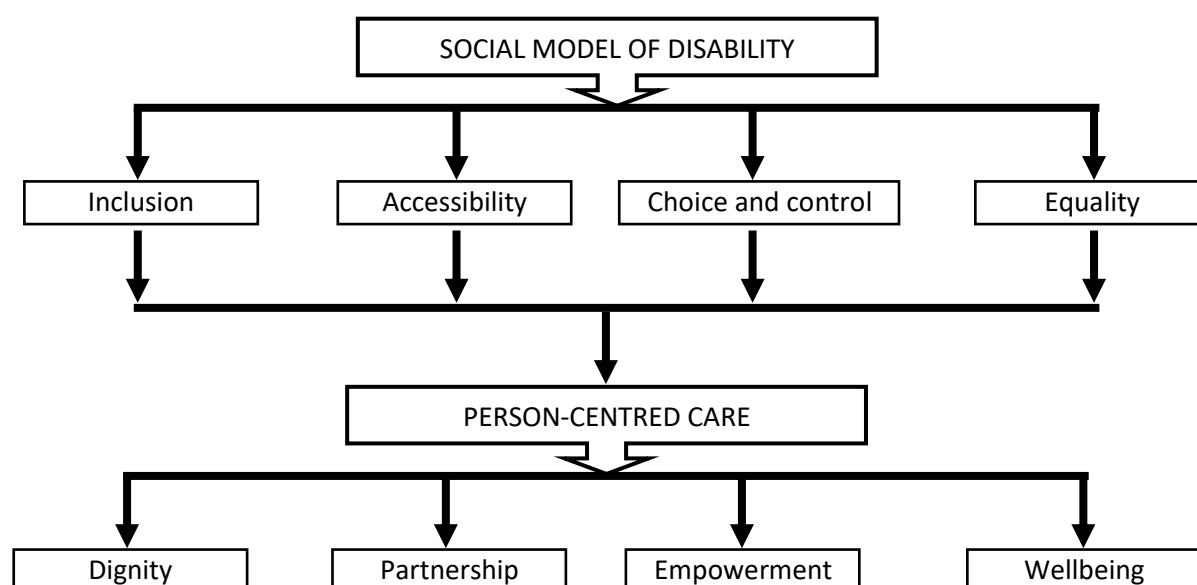


Figure 2 shows that the Social Model provides a strong foundation for person-centred care by linking inclusion, accessibility, equality, and choice to key care outcomes such as dignity, empowerment, partnership, and wellbeing.

The recommendations presented here are not without inherent limitations. The successful execution of such changes invariably necessitates substantial allocations of time and resources, alongside decisive leadership and a sustained organizational commitment. Securing these elements, however, may pose considerable challenges given prevailing financial constraints and workforce pressures. Nevertheless, these recommendations offer actionable pathways for advancing the quality and consistency of person-centred care.

Conclusion:

In conclusion, the principle of person-centred care is recognized as an indispensable tenet inside contemporary healthcare and social care settings in the United Kingdom, primarily due to its emphasis on upholding individual dignity, fostering respect, enabling personal choice,

and supporting autonomy. A significant theoretical underpinning for this approach has been provided by the Social Model of Disability. This model critically re-evaluates restrictive medical perspectives on disability, simultaneously highlighting the systemic barriers that originate within societal structures rather than inherent individual deficits. The impact of this model is discernible across legislative frameworks, policy formulation, and professional practice, which increasingly prioritize the assertion of rights, the integration of individuals, and their active engagement within communities.

This essay has shown that the Social Model provides a strong foundation for person-centred care because it supports empowerment, equality, and active involvement in decision-making. However, it also has limitations, particularly in relation to the lived reality of impairment and the practical difficulties of implementation. Workforce shortages, funding pressures, and organisational barriers continue to affect how far person-centred care can be fully achieved in practice. Nevertheless, the Social Model remains highly relevant. With greater investment, stronger training, better partnership working, and more consistent implementation, UK health and social care services can move closer to providing care that is genuinely inclusive, respectful, and responsive to individual needs.

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