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Critically Discuss the Social Model of Disability and its Contribution to Person-Centred Health and Social Care Policy and Practice

Introduction

The person-centred approach to care has become a central tenet of contemporary policy and practice in health and social care. It emphasises respect for the rights, preferences, dignity, and individuality of service users, while promoting independence, autonomy, and participation in decision-making. One of the most influential theories underpinning the person-centred approach to care is the social model of disability. The social model challenged traditional understandings of disability, arguing that people are disabled not so much because of their impairments but because of social, environmental, and institutional barriers. This represented a significant departure from the medical model, which viewed disability as an individual problem requiring treatment or correction. The social model emerged from the work of disability rights activists in the 1970s and has had a significant impact on policy, social care, education, and healthcare. It encouraged professionals and organisations to recognise discrimination, inaccessible environments, and unequal social structures as underlying causes of disadvantage. Consequently, it has made a significant contribution to the development of rights-based and person-centred approaches to care. However, despite its influence, this model has also been criticised for ignoring the lived experiences of people with disabilities, underestimating health needs, and failing to fully consider the interrelationships and complex health conditions. This essay critically discusses the social model of disability and its contribution to person-centred health and social care policy and practice. First, the essay examines the emergence and development of the model, including its core principles and theoretical underpinnings. Second, it considers key criticisms and responses to them. Third, it analyses the application of the social model in health and social care policy and practice, as well as the challenges associated with its implementation. Finally, the essay presents recommendations for improving policy and practice, followed by an overall conclusion.

The Emergence and Development of the Social Model of Disability

The social model of disability emerged in the United Kingdom in the 1970s as a response to dissatisfaction with traditional medical approaches to disability. Prior to this, disability was primarily understood through the lens of the medical model, which focused on impairments, illnesses, or physical limitations as the source of distress. According to the medical model, people with disabilities were viewed as dependent individuals requiring treatment, rehabilitation, or institutional care to function effectively in society (Shakespeare, 2018). This approach often positions health care professionals as experts, while limiting the voice and autonomy of people with disabilities themselves. The social model developed from the disability rights movement and organisations such as the Union of Physically Disabled People Against Segregation (UPIAS). Activists argue that society itself created discrimination through inaccessible buildings, discriminatory attitudes, exclusionary policies, and social inequality. Mike Oliver, one of the key theorists associated with this model, challenged the assertion that discrimination should be understood as social oppression rather than as an individual tragedy (Oliver, 1996). According to the social model, impairment refers to a physical, sensory, or mental condition, whereas disability refers to barriers created by society. This distinction between impairment and disability became a central element of the model. For example, a person using a wheelchair is not disabled by their disability, but by the lack of ramps, elevators, accessible transportation, and inclusive social attitudes. Consequently, the social model shifted the emphasis from changing the individual to changing society. This was of paramount importance because it promoted empowerment, inclusion, equality, and human rights. The social model gained increasing influence in the 1980s and 1990s, particularly in the area of social policy and disability legislation. It contributed to campaigns for equal opportunities, anti-discrimination laws, independent living, and accessible public services. In the United Kingdom, the Disability Discrimination Act of 1995, and later the Equality Act of 2010, reflected many principles associated with the social model, requiring organisations to make reasonable adjustments and reduce barriers faced by people with disabilities. In health and social care, the social model influenced the development of person-centred approaches, encouraging professionals to involve patients in decisions about their treatment and support. Instead of focusing solely on medical treatment, practitioners were encouraged to consider social participation, independence, and quality of life. This represented a significant cultural shift in services that traditionally adhered to paternalistic approaches. However, the social model has evolved over time. Early versions of the model focused heavily on structural barriers and social oppression, but more recent theorists have recognised the need to consider the interaction between impairments and social experiences. Contemporary approaches often incorporate bio-psychosocial perspectives that consider both medical realities and social inequalities. This demonstrates that the social model continues to evolve in response to changing social, political, and medical conditions.

Critiques of the Social Model and Responses

Despite the social model of disability's enormous influence, it has also faced a number of significant criticisms. One of the most common criticisms is that the model undervalues or ignores the lived experiences of people with disabilities. Critics argue that pain, fatigue, chronic illness, and physical limitations can have a significant impact on people regardless of social barriers (Shakespeare, 2018). For example, a person with severe arthritis may experience pain even in an accessible and inclusive environment. Consequently, some scholars argue that disability cannot be understood solely as a product of social oppression. Tom Shakespeare, a prominent disability scholar, argues that the distinction between disability and handicap is often oversimplified because disabilities and social barriers interact (Shakespeare, 2018). According to this critique, discrimination is shaped by both biological and social factors, not just social barriers. This critique is important because it emphasises the need for medical interventions, treatment, and rehabilitation alongside social change. Another criticism is that the social model does not fully account for the experiences of people with learning disabilities, mental disorders, or illnesses with variable progression. Some conditions involve cognitive or psychological difficulties that cannot always be explained solely by social oppression. For example, people with severe mental illnesses, in addition to social integration, may require therapeutic support, medication, and clinical intervention. Therefore, critics argue that the social model can oversimplify complex aspects of health. Feminist scholars also criticise the social model for ignoring the emotional and personal aspects of care. Morris (1991) argued that people with disabilities may require support and assistance even in an inclusive society. Ignoring dependency and care needs can create unrealistic expectations of independence while undervaluing the role of caregivers and interpersonal relationships. This criticism is particularly relevant in health and social care, where support and interdependence are central aspects of everyday life. Furthermore, intersectional critiques suggest that the social model does not always consider how discrimination interacts with gender, race, age, sexual orientation, and socioeconomic status. For example, women with disabilities and members of ethnic minorities may simultaneously face multiple forms of discrimination. Without considering intersectionality, policy and practice may fail to recognise the diverse experiences of people with disabilities. Despite these criticisms, proponents of the social model argue that it was never intended to deny the reality of disability or health needs. Instead, its purpose was to challenge oppressive social structures and shift attention to equality and inclusion. Oliver (1996) noted that the model should be understood as a policy tool designed to empower people with disabilities and promote social change. In response to these criticisms, many scholars now support more flexible and integrated approaches. The bio-psychosocial model, for example, combines biological, psychological, and social perspectives to provide a more holistic understanding of disability. Similarly, the social-relational model recognises that the consequences of disability and social barriers can interact in complex ways. These developments demonstrate that, while the social model may have limitations, it continues to influence contemporary discussions and remains highly relevant within a patient-centred approach.

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

The social model of disability has had a significant impact on policy and practice in health and social care, particularly in promoting person-centred approaches. One of the most important contributions of this model is its emphasis on empowerment and participation. A person-centred approach recognises service users as active participants in decisions about their treatment, rather than passive recipients of treatment. The social model supports this by challenging paternalistic attitudes and encouraging professionals to respect individual autonomy and choice. In the social sector, the social model has influenced the development of personalisation policies and independent living initiatives. Personal budgets and direct payments allow people with disabilities greater control over the services and support they receive. This reflects the social model's emphasis on choice, independence, and self-determination. Service users are encouraged to set their own goals and actively participate in care planning. The social model has also influenced equality legislation and policy. The Equality Act 2010 requires employers, educational institutions, health care providers, and public services to make reasonable adjustments for people with disabilities. This includes the provision of accessible spaces, communication support, and non-discriminatory practices. Such policies aim to reduce social barriers and promote equal participation. In healthcare, the social model encourages professionals to consider the environmental, social, and psychological factors that influence well-being. For example, healthcare professionals can focus on improving accessibility, communication, and inclusivity, rather than solely treating medical symptoms. This is particularly important for people with chronic conditions, who may face barriers to employment, education, housing, and social participation. The model has also facilitated the development of co-production in healthcare and social services. Co-production involves service users working together with professionals to develop and evaluate services. This approach recognises the value of personal experience and aims to ensure that services reflect the needs and preferences of individuals. Consequently, the social model has strengthened democratic participation and accountability in healthcare systems. However, despite these positive changes, significant challenges remain in applying the social model in practice. One of the main challenges is the continued dominance of the medical model in healthcare systems. Hospitals and clinical settings often prioritise diagnosis, treatment, and risk management over social inclusion and empowerment. As a result, people with disabilities may continue to face paternalistic attitudes and limited participation in

decision-making. Another challenge is the lack of funding and resources in health and social care. Austerity measures and budget cuts have reduced the availability of community-based support services, affordable housing, and social care. Even when policies promote people-oriented care, limited resources can hinder its effective implementation. This creates a gap between policy ideals and everyday practice. Problems also arise from staff shortages. Insufficient staff, high workloads, and limited training can reduce the ability of professionals to provide truly people-oriented support. In some cases, care becomes task-oriented rather than relationship-oriented. This can undermine the principles of dignity, autonomy, and empowerment associated with the social model. Moreover, some critics argue that person-centred care policies can become mere formalities if organisations fail to meaningfully engage people with disabilities in decision-making. Consultation processes can be superficial, while structural inequalities remain entrenched. Therefore, simply adopting person-centred terminology is insufficient without broader social and organisational transformations.

Recommendations for Policy and Practice

Several recommendations can improve the application of the social model within health and social care policy and practice. Firstly, organisations should strengthen co-production by involving disabled people directly in the design, delivery, and evaluation of services. This would promote more inclusive and responsive care systems while ensuring that policies reflect lived experiences.

Secondly, greater investment in social care and community support services is necessary. Accessible housing, transport, education, and employment opportunities are essential for reducing social barriers and promoting independence. Without adequate funding, person-centred care cannot be effectively achieved.

Thirdly, health and social care professionals should receive training on disability equality, anti-discriminatory practice, and person-centred communication. Training can help challenge stereotypes and improve understanding of the social barriers faced by disabled people.

Fourthly, policymakers should adopt more intersectional approaches that recognise the diversity of disabled people's experiences. Services should consider how disability interacts with gender, ethnicity, poverty, and other social inequalities.

Finally, integrated models of care should combine medical support with social inclusion approaches. Rather than viewing medical and social perspectives as oppositional, professionals should adopt holistic approaches that address both impairment-related needs and social barriers.

Conclusion

In conclusion, the social model of disability has made significant contributions to people-centred health and social care policy and practice. By shifting the focus from individual impairments to social barriers, the model has challenged traditional medical understandings of disability and promoted equality, empowerment, and inclusion. It has influenced important changes in legislation, personalisation, independent living, and rights-based approaches to care. However, the model has also faced significant criticism. Critics argue that it can underestimate the lived experiences of people with disabilities, ignore medical needs, and fail to fully consider the interrelationships and complex health conditions. However, responses to these criticisms have led to the development of more integrated and holistic approaches that combine social, psychological, and medical perspectives. Despite persistent challenges such as underfunding, staff shortages, and the continued dominance of medical approaches, the social model remains highly relevant in contemporary health and social care. Its emphasis on dignity, participation, and social inclusion remains at the core of person-centred care and provides an important foundation for reducing discrimination and promoting human rights. Ultimately, effective personalised care requires both the removal of social barriers and the recognition of individual support needs to ensure that people with disabilities can participate fully and equally in society.

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