



Student Name: Sami Pattvean

Student Number: 2414789

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1. Introduction: A Paradigm in Justice in Care

The modern change toward person-centred care (PCC) is a significant shift in the health and social service delivery that supports the idea that the systems in the health sector must be designed with an emphasis on individual autonomy, respect, and partnership. (Santana et al., 2022). The social model of disability is the theoretical basis of this philosophical transition, as this paradigm redefines the concept of disability as a social phenomenon and not a medical one. (Oliver and Barnes, 2012). The model was developed out of the joint efforts of the disability-advocacy movements, and it questions the superiority of the medical model by reevaluating disability as a human-rights and social-justice challenge and removing barriers. (Shakespeare, 2014). The current essay will claim that not only is the social model not incompatible with PCC but its key precondition; it provides the necessary structural analysis to take PCC beyond a model of individualised consumer choice within a system that has not changed, but to a transformative programme of systemic equity. Based on an analysis of its historical inception, its main principles, and a critique of it in modern times, this discussion will assess the problematic utilisation of it in policy and practice and will conclude with some strategic suggestions on how to realise its potentially transformative potential in the establishment of genuinely inclusive care systems.

2. Theoretical Genesis, Evolution, and Critical Debate:

The social model was not based on clinical theory but was created because of the radical politics of the disability movement of the second half of the twentieth century. Disorderly of charitable and medicalised views, including Disabled People's International (DPI), the so-called Nothing About Us Without Us, organisations in the disabled sector claimed that disabled people should write the policies on how their lives and destinies should be controlled. (Disability Rights Fund, 2023). The main axiom of the model was formalised by British sociologist Colin Barnes and other influential theorists, who held that it was not their impairments that disabled people, but rather it was the barriers and exclusionary attitudes in society that are the disabling elements. (Barnes, 2012). This and the construction make a central difference between impairment (the functional limitation) and disability (the disadvantage of an inaccessible society) (Union of the Physically Impaired Against Segregation, 1976). This way, the issue is no longer on the individual body but in the social environment; this issue requires not only medical or rehabilitative solutions.

This theoretical change was radical and saw disability no longer as a personal, tragic story of either a cure or care, but as a collective experience of oppression that needed civil rights and social transformation. It directly took on the power of medical professionals as the only determining factor of the lives of disabled people, shifting disabled individuals to the role of specialists in their experiences and creators of solutions. (Goodley, 2017). The practical barriers framework of the model describes the barriers in various spheres, such as environmental (inaccessible buildings and transport), attitudinal (prejudice, pity, and low expectations), and institutional (discriminatory laws, policies, and system designs) (World Health Organization, 2011). In this analysis, it has clearly been shown that the independent living agenda should be supported, with the necessary support integrated to support self-determination, including, but not limited to, accessible housing, personal assistance, and inclusive education. (Zola, 1989). The model facilitates the principles of universal design by defining the needs as rights to access and participation, which positively affect a broader range of society, including pram-carrying parents and older people.

The social model has, however, experienced a lot of scholarly criticism, provoking its development. Other academics say that this intense structural emphasis can unwittingly push to the sidelines the personal experience of chronic illness, pain, and body realities of impairment, and establish an artificial distinction between the social and the medical. (Hughes and Paterson, 1997). This was pointed out by feminist disability scholar Jenny Morris, who argued that impairment should be seen through a lens that does not imply medical paternalism. (Morris, 1991). The affirmative model, which attempts to glorify disability identity and culture and recognize bodily difference, and the human rights model, which bases the demand to eliminate barriers on the legally binding requirements of the UN CRPD, were prompted by this critique. (Shakespeare, 2014). Moreover, as critics point out, early conceptualizations usually had a monolithic notion of disability, which did not adequately consider the intersection of disability with other identities, including race, gender, and socioeconomic status, which further complicate the exclusionary experiences (Thomas, 2004). The model is also challenged by the postmodern criticisms that it can be quite categorical, and both impairment and disability are dynamic and subject to cultural and discursive practices. (Goodley, 2017). The model in turn has become more varied, leading to more subtle strategies that combine social criticism with an appreciative recognition of embodied difference and overlapping oppressions.

3. Turning Theory into Practice: Policy Landscapes and Long-term Contradictions

The social model influences key global policy tools. This can be best expressed in the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which has been ratified by more than 180 countries and requires states to make full participation, accessibility, and non-discrimination a reality. (United Nations, 2006). The principles of the model are directly addressed in Articles 19 (living independently and being included in the community) and 26 (habilitation and rehabilitation), which require the move towards institutional care towards community-based support. Equally, national policies that espouse self-managed care and personal budgets, such as those in the United Kingdom and Australia, strive to realise the model by deriving financial authority on service users, thus overturning conventional paternalistic service arrangements. (Watson, 2012).

Despite these normative achievements, there is a deep implementation gap. The main barrier is the established biomedical culture in health and social care systems, when professionalism usually dominates patient knowledge and efficiency goals prevail over a time-consuming co-production process. (Mladenov, 2015). As an example, a clinician who has 15 minutes or fewer appointment time blocks is structurally unincentivized to participate in the narrative and partnership-building practice demanded by PCC and the social model. The institutional structures are siloed and are focused on controlling pathologies as opposed to empowering lives and thus, again, recreate exactly the organisational barriers that are identified by the model. This often leads to performative inclusion wherein consultation takes place, but real power-sharing in service design, governance, and evaluation is always out of reach. (Waldschmidt, 2017).

There are also conceptual ambiguities in the field. The spread of the related terms, such as client-centered, relationship-based, and personalised, tends to create an inconsistency in application and measurement, which undermines accountability and enables a system to rebrand an existing practice without any substantial change (French and Swain, 2012). Furthermore, the continuation of the rights-based agenda is predisposed to political and economic changes. The declines in the social care budgets through austerity measures are explicitly in opposition to the demands of the social model, forcing disabled individuals to return to their dependency and crisis management practices. This is a clear illustration of the incompatibility between rights-based rhetoric and resource-starved realities. The tensest section is the contrast between the CRPD promoting deinstitutionalisation and the chronic under-

investment in community-based options, thus robbing many of the opportunity to choose the first place and creating new isolation in the already compromised community processes.

4. Strategic Recommendation to an Inclusive Future

To truly incorporate the social model into person-centred systems, action on the various levels is needed.

- **Legislative and Systemic Level:** Governments need to implement more than simple anti-discrimination laws and implement proactive legislation regarding accessibility with specific enforcement mechanisms that use universal design principles in the digital, physical, and social landscape. The European Accessibility Act offers an example, and it establishes binding specifications of significant products and services. More effective funding must be reorganized to respond to the outcomes of the CRPD, including social participation and community inclusion, instead of funding so-called segregated points of service or per-procedure medical activity (Waldschmidt, 2017). Most importantly, co-production must be institutionalised, which means disabled individuals and their organisations must be provided with a formal, resourceful voice in the decision-making process at all levels of policy and service provision, both in planning and performance evaluation.
- **Service Delivery Level and Organisational Level:** Healthcare providers should develop cultures that proactively break ableism. This requires the introduction of compulsory disability equality training; co-coach and trainer training, which is designed and delivered by disabled people to all levels of staff. This training needs to go beyond awareness-raising and look critically at and ask questions about power dynamics, implicit bias, and the history of medical institutions in disability oppression. Facilitative, graphic planning models used in service models should include Making Action Plans (MAPs) or Planning Alternative Tomorrows with Hope (PATH) models that place the voice and aspirations of the individual at the centre (Sanderson, 2000). In addition, strong investment in user-led organisations (ULOs) and independent peer advocacy must be undertaken to give the collective voice and personal support necessary to negotiate existing systems and confront them.
- **Level of Education and Evaluation:** Medical, nursing, and social work educational and assessment methods should also be revamped to incorporate and instill the social as well as the human rights model as basic background knowledge, as opposed to side-

whiskers. This entails the incorporation of disability studies standpoints that preempt the scholarship and lived experience of disabled people during their first year of training. Evaluation must change to focus more on measures of capability and well-being that indicate person-centred success and leave clinical biomarkers in favor of experiences of choice, control, and dignity. Auditing system performance should be done based on barrier-removal measures, like the percentage of public health information in accessible formats or waiting time savings on available housing.

5. Conclusion:

The social model of disability forms a monumental and invaluable model in the realisation of authentic person-centred care. By assertively projecting the deprivation of exclusionary social organization, as opposed to personal pathology, it provides a strictly analytical approach to institutionalizing systemic failure and states a clear requirement of inclusive redesign.

However, as will be seen below, the model is usually undermined by theoretical complication, the continued prevalence of medical paradigms in practice, and a lack of alignment between progressive policy and its financing and implementation. The translation of the model into lived reality requires addressing embarrassing facts about power relations, resource distribution, and professional identity. The transfer of person-centred care to being based on structural justice necessitates the transformation of that philosophy of a philosophy of individualized benevolence.

It takes a ruthless, multi-strategic effort that includes enforceable rights-based laws, cultural and procedural change of services, and centralisation of expertise and leadership of the disabled. In the end analysis, social model implementation is not just a technical or clinical change, but a highly political and ethical project; a long-term project to break the boundaries and build a society where equity, autonomy, and full participation are a reality and are undisputed among all.

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