

Critically Discussing the Social Model of Disability as a Theory Underpinning Person-Centred Carer

Introduction

In this written assignment I will discuss Person-centred care which is a principle of contemporary health and social care that places individuals at the centre of decisions about their care, recognising their values, preferences, rights, and lived experiences. Rather than treating people as passive recipients of services, person-centred care promotes collaboration, dignity, respect, and shared decision-making between professionals, individuals, and their families. A number of theories underpin this approach, including the Social Model of Disability, Ethics of Care, the Recovery Model, and strengths-based practice.

Also in this essay I will, and critically discusses the **Social Model of Disability** as a theoretical framework underpinning person-centred care. It also begins by explaining the origins and principles of the model before examining its relationship with person-centred care. The discussion then critically evaluates its strengths and limitations and explores how it has influenced health and social care policy and professional practice within the UK. Finally, the essay considers ongoing challenges in implementing the model and concludes by evaluating its continuing relevance to person-centred care.

Social Model of Disability

The Social Model of Disability was developed during the disability rights movement in the 1970s by the Union of the Physically Impaired Against Segregation (UPIAS). It was later explained in more detail by Michael Oliver (1990), who argued that disability is mainly caused by the barriers people face in society rather than by their medical condition or impairment.

The model makes a clear distinction between **impairment** and **disability**. An impairment is a person's physical, sensory, intellectual, or mental condition. Disability, however, is created when society fails to meet the needs of people with impairments through physical, social, or organisational barriers (Oliver, 1990). This is different from the medical model, which focuses on the person's condition and often sees disability as something that needs to be treated or fixed.

For example, a wheelchair user is not disabled because they cannot walk. They become disabled when buildings do not have ramps or lifts, public transport is inaccessible, or employers do not make reasonable adjustments. In the same way, a person with a hearing impairment may face barriers if healthcare information is not available in British Sign Language (BSL) or other accessible formats.

Overall, the Social Model of Disability encourages society to remove barriers so that disabled people can take part fully in everyday life. It promotes equality, inclusion, independence, and equal opportunities by recognising that many of the challenges disabled people face are caused by society rather than by their impairment (Oliver, 1990).

Relationship Between the Social Model and Person-Centred Care

The **principles** of the Social Model of Disability closely match those of person-centred care because both focus on respect, choice, independence, and working in partnership with individuals. Instead of focusing only on a person's impairment, both approaches encourage professionals to understand the barriers that affect a person's ability to take part in everyday life.

Person-centred care recognises that people are experts in their own lives and should be involved in decisions about their care and support (NICE, 2021). Rather than asking, **"What is wrong with this person?"**, the Social Model encourages professionals to ask, **"What barriers are preventing this person from fully participating?"** (Oliver, 1990). This change in thinking helps professionals focus on removing barriers instead of expecting individuals to adapt to them.

As a result, the role of health and social care professionals changes from making decisions for people to supporting them in making their own choices and achieving their personal goals. This reflects the key principles of person-centred care, including:

- Respect for individual values and preferences
- Shared decision-making
- Independence and autonomy
- Dignity and human rights
- Social inclusion
- Empowerment and participation

For example, an older person with mobility difficulties may struggle to access community services because of poor transport or inaccessible buildings. Instead of expecting the person to cope with these difficulties, health and social care professionals can work with local authorities and other services to improve transport, provide accessible facilities, or arrange support that meets the person's individual needs and preferences. This shows how both the Social Model of Disability and person-centred care aim to remove barriers and help people live as independently as possible (NICE, 2021; Oliver, 1990).

Strengths of the Social Model of Disability

Promotes Human Rights and Equality

One strength of the Social Model of Disability is that its focus on human rights and equality. The model argues that disabled people should have the same opportunities as everyone else to take part in education, employment, healthcare, and community life. Instead of seeing disability as an individual's problem, it highlights the responsibility of society to remove barriers that prevent equal participation (Oliver, 1990).

The Social Model has also influenced important laws and policies, including the **Equality Act 2010** and the **United Nations Convention on the Rights of Persons with Disabilities**

(UNCRPD). These frameworks require organisations to make reasonable adjustments so that disabled people can access services fairly and equally (Equality Act 2010; United Nations, 2006). By promoting dignity, respect, and equal opportunities, the Social Model strongly supports the principles of person-centred care.

Encourages Empowerment and Independence

Another important strength of the Social Model is that it encourages empowerment and independence. Rather than treating disabled people as passive recipients of care, it supports their right to make decisions about their own lives and to be actively involved in planning their care. This reflects the principles of person-centred care, where professionals work in partnership with individuals instead of making decisions for them (NICE, 2021).

For example, personalised care planning within the NHS allows people with long-term health conditions to set goals that are important to them. This approach helps individuals become more involved in managing their health and often leads to better experiences and outcomes (NHS England, 2019).

Challenges Discrimination and Barriers

The Social Model has also helped to highlight discrimination and barriers that many disabled people experience in health and social care. These barriers may include inaccessible buildings, poor communication for people with sensory impairments, inflexible appointment systems, negative attitudes from professionals, and limited access to information or technology. Recognising these challenges encourages organisations to improve services so they are more accessible and inclusive. As a result, care becomes more responsive to the needs of each individual, which is a key aim of person-centred care (Oliver, 1990).

Influences Health and Social Care Policy

The Social Model has had a significant influence on health and social care policy in the UK. Policies such as the Care Act 2014, the Equality Act 2010, the **NHS Long Term Plan (2019)**, and the **Universal Personalised Care Model** all promote approaches that put people at the centre of their care. These policies encourage professionals to work in partnership with individuals through personalised care planning, strengths-based assessments, independent living, community participation, and co-production (Department of Health and Social Care, 2014; NHS England, 2019). Together, they show how the Social Model continues to shape person-centred care and improve the way health and social care services are delivered.

Critical Evaluation of the Social Model

Although the Social Model of Disability has made an important contribution to health and social care, it also has some limitations. One of the main criticisms is that it can oversimplify disability by focusing mainly on social barriers and not giving enough attention to the personal effects of an individual's impairment.

Underestimates the Impact of Impairment

A common criticism of the Social Model is that it does not fully recognise the physical and emotional impact of living with an impairment. Shakespeare (2018) argues that although removing barriers in society is important, many people still experience pain, fatigue, or progressive health conditions that cannot be solved by making the environment more accessible.

For example, people living with conditions such as multiple sclerosis, Parkinson's disease, or motor neurone disease may continue to face significant physical challenges even when they receive good support and have access to accessible services. This suggests that disability is often caused by a combination of both a person's impairment and the barriers they face in society, rather than by social barriers alone (Shakespeare, 2018).

Oversimplifies Complex Health Conditions

Another limitation of the Social Model is that it may not fully meet the needs of people with complex or changing health conditions. For individuals living with dementia, chronic fatigue syndrome, severe mental illness, advanced neurological conditions, or terminal illnesses, medical treatment and ongoing healthcare support are often just as important as removing social barriers.

Because of this, some researchers argue that relying only on the Social Model may overlook the medical, psychological, and therapeutic support that many people need. A balanced approach that combines person-centred care with both social and medical support may therefore provide better outcomes for individuals with complex health needs (Shakespeare, 2018).

Application of Health and Social Care to Practice

The Social Model of Disability has influenced health and social care practice by encouraging professionals to focus on individuals' abilities, strengths, and personal goals rather than only focusing on their limitations. It supports a person-centred approach where individuals are involved in decisions about their own care and support. This includes involving people in care planning, promoting shared decision-making, providing information in accessible formats, supporting independence, and working in partnership with families and carers when appropriate (NICE, 2021).

For example, the **Care Act 2014** encourages professionals to focus on what individuals want to achieve in their lives rather than only identifying their care needs or problems. This strengths-based approach allows people to have greater choice and control over their support. Similarly, NHS personalised care planning encourages individuals to set goals that are meaningful to them, including goals related to employment, relationships, housing, and wellbeing, rather than focusing only on medical treatment (Department of Health and Social Care, 2014; NHS England, 2019).

However, applying the principles of the Social Model in practice is not always consistent. Challenges such as staff shortages, high workloads, limited resources, and organisational

pressures can sometimes result in professionals making decisions for individuals instead of working together with them. This can reduce people's involvement and affect the delivery of truly person-centred care.

Policy Implications

The Social Model has had a strong influence on health and social care policies in the UK by promoting equality, independence, and individual choice. The **Equality Act 2010** protects disabled people from discrimination and requires organisations to make reasonable adjustments, such as providing accessible communication, improving physical access, and adapting services to meet individual needs (Equality Act, 2010).

The **Care Act 2014** also reflects the principles of the Social Model by placing wellbeing, independence, choice, and control at the centre of adult social care. It encourages professionals to work collaboratively with individuals and use strengths-based assessments that recognise people's abilities and aspirations rather than focusing only on their difficulties (Department of Health and Social Care, 2014).

The **NHS Long Term Plan (2019)** further supports personalised care through approaches such as shared decision-making, personalised care planning, social prescribing, and integrated care. These policies demonstrate how the Social Model continues to shape the way health and social care services aim to support individuals as active participants in their own care (NHS England, 2019).

Ongoing Challenges

Although legislation and policies support person-centred care, several challenges continue to affect its implementation. These include limited funding, workforce shortages, differences in service availability between areas, digital exclusion, and inconsistent delivery of reasonable adjustments. Some disabled people still experience difficulties accessing healthcare appointments, communication support, and appropriate social care services.

These challenges show that having policies in place is not enough on its own. Effective person-centred care also requires sufficient resources, strong leadership, staff training, and a commitment from organisations to remove barriers and involve individuals in decisions about their lives (Shakespeare, 2018).

Conclusion

In my perspective the Social Model of Disability provides a strong theoretical foundation for person-centred care by shifting attention from individual impairment to the social, environmental, and organisational barriers that restrict participation. Its emphasis on equality, empowerment, autonomy, inclusion, and human rights has significantly influenced modern health and social care policy, including the Equality Act 2010, the Care Act 2014, and the NHS Long Term Plan. However, **the model is not without limitations**. Critics argue that it underestimates the impact of impairment, overlooks the complexity of many health conditions, and can be difficult to implement within resource-constrained healthcare systems. Additionally, many contemporary scholars advocate a more integrated approach

that combines the strengths of the Social Model with appropriate medical care. Overall, the Social Model remains highly relevant in promoting person-centred care, but its successful application depends on sufficient resources, effective leadership, and professionals who balance clinical expertise with genuine **partnership, respect, and empowerment**.

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