



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

A Critical Discussion of the Social Model of Disability as a Concept Underpinning Person-Centred Care in Health and Social Care Practice

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Student Name: Olga Maculska-Migovska

Student ID: 2242936

Lecturer: Dr Itse Olaoye

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Introduction

Person-centred care, which emphasises the individual needs, preferences and values of service users, is widely recognised as a key principle in health and social care practice. It promotes autonomy, dignity and active involvement in decision-making, rather than viewing individuals as passive recipients of care (Mackreth, 2021; Glasby, 2012; WHO, n.d.). In the UK, this approach is increasingly reflected in policy and practice through personalised care and shared decision-making.

The social model of disability is a key framework underpinning person-centred care. It challenges traditional medical perspectives by suggesting that disability is shaped not only by impairment but also by social and environmental barriers that limit participation (Genova et al., 2023).

This essay critically examines the social model of disability, including its development, key critiques and application within health and social care policy and practice, before providing recommendations for improvement.

Emergence and development of the social model of disability

The social model of disability developed as a response to the limitations of the traditional medical model. The medical model views disability primarily as an individual problem caused by impairment, illness or physical limitation (Oliver, 1990). From this perspective, health and social care focuses on diagnosis, treatment and professional intervention. Although medical support is essential, this approach has been criticised for placing too much emphasis on the individual and not enough on the social barriers that restrict people's lives.

In contrast, the social model of disability argues that people are disabled not only by their impairments, but by the way society is organised (Oliver, 1990). Barriers such as inaccessible buildings, limited transport, discrimination and negative attitudes can prevent individuals from participating fully in society (Oliver, 1990; Cropper, 2007). Therefore, disability is understood as a social issue rather than solely a medical condition. This perspective is closely linked to person-centred care, as it requires practitioners to consider the individual's environment, rights and lived experience, rather than focusing only on diagnosis.

The development of the social model has influenced health and social care practice by encouraging a shift from dependency towards empowerment, inclusion and participation. It

supports the idea that service users should be actively involved in decisions about their care, which reflects the principles of person-centred practice (Mackreth, 2021; Glasby, 2012).

However, the social model has limitations. It may underestimate the impact of impairment, particularly in relation to pain or complex health conditions. As a result, a balanced approach is needed that recognises both individual needs and wider social barriers (Genova et al., 2023).

Critiques of the social model of disability

While the social model of disability has made a significant contribution to understanding disability in a more inclusive and rights-based way, it has also been subject to a number of important critiques (Goodley, 2014). One of the main criticisms is that the model tends to overlook the lived experience of impairment, particularly in relation to pain, illness and physical or mental limitations.

Critics argue that by focusing primarily on social and environmental barriers, the social model may underestimate the impact that impairment itself can have on an individual's daily life. For example, even in an accessible and inclusive environment, some individuals may still experience chronic pain, fatigue or complex health conditions that require ongoing medical support. This suggests that the model may be incomplete, as it does not fully account for the biological and psychological dimensions of disability.

Another limitation is that the social model may oversimplify the relationship between disability and society. While it effectively highlights issues such as discrimination and social exclusion, it does not always provide clear guidance for addressing individual care needs in practice. Health and social care professionals must therefore balance both perspectives, ensuring that service users receive appropriate medical care while also promoting independence and inclusion. Goodley (2014) suggests that the model can become overly simplified and may not fully reflect the complexity of disability experiences.

Furthermore, the strict separation between the medical and social models has been criticised as unrealistic in contemporary health and social care systems. In practice, care often requires an integrated approach that combines medical treatment with social support and person-centred planning. Reamer (2018) highlights that ethical issues in integrated care require professionals to consider both individual needs and wider social factors, rather than relying on a single theoretical perspective.

Despite these limitations, the social model remains highly influential. It has played a key role in shifting attitudes towards disability and promoting equality. However, a more balanced and holistic approach is required, recognising both the impact of impairment and the importance of removing social barriers in order to achieve effective and realistic practice.

Application to health and social care policy and practice

The social model of disability has had a significant impact on health and social care policy and practice, particularly in the UK. It has contributed to a shift towards more inclusive, rights-based and person-centred approaches, where individuals are supported to live independently and participate fully in society. This is reflected in key legislation such as the Care Act 2014 (UK Government, 2014), which places a legal duty on local authorities to promote individual wellbeing, personal choice and independence.

Within health and social care practice, the social model encourages professionals to focus not only on medical needs, but also on removing barriers that may prevent individuals from accessing services or participating in daily life. For example, accessibility of services, communication support and inclusive environments are essential elements of care. This aligns closely with person-centred care, where service users are actively involved in decisions about their own care and support (Mackreth, 2021). This demonstrates how the model supports more holistic and individualised approaches to care.

The NHS has also adopted principles that reflect the social model, particularly through personalised care and shared decision-making. These approaches aim to empower individuals, giving them greater control over their treatment and care planning. According to the Nuffield Trust (2022), ongoing reforms in the NHS emphasise integration between health and social care services, highlighting the importance of coordinated and holistic support. However, the extent to which these principles are implemented in practice can vary across different services.

Partnership working is another key area influenced by the social model (Baggott, 2013; Leathard, 2003). Effective collaboration between professionals, organisations and service users is essential in addressing complex needs. Baggott (2013) argues that partnership working can improve outcomes by bringing together different services to address both medical and social aspects of care. Similarly, Miers, Thomas and Pollard (2010) highlight the importance of interprofessional working in delivering coordinated and effective support.

However, despite these developments, challenges remain in applying the social model in practice. Limited funding, staff shortages and organisational constraints can restrict the ability of services to fully implement person-centred approaches. In addition, some systems remain influenced by the medical model, focusing more on treatment rather than empowerment and inclusion. This suggests that there is often a gap between policy intentions and practical implementation.

Overall, while the social model has significantly shaped policy and practice, its application is not always consistent. A balance between medical and social approaches is often required to ensure that individuals receive both appropriate healthcare and support to overcome social barriers.

Benefits and limitations in practice

The application of the social model of disability within health and social care practice offers several important benefits. One of the key advantages is the promotion of empowerment, as individuals are encouraged to take an active role in decisions about their care. This supports autonomy and helps service users to maintain greater control over their lives. In addition, the model promotes inclusion by addressing barriers that may prevent individuals from accessing services or participating in society. This aligns with person-centred care, which focuses on dignity, independence and respect for individual preferences (Mackreth, 2021).

Furthermore, the social model supports the development of more holistic and integrated services. By recognising both social and environmental factors, health and social care professionals are better able to provide coordinated and personalised support. This can improve outcomes for service users and enhance overall quality of care (Stone, 2019). However, the effectiveness of these approaches often depends on the availability of resources and the capacity of services to deliver personalised support.

Despite these benefits, there are also significant limitations in practice. One of the main challenges is limited funding, which can restrict the availability of resources and support services. Additionally, staff shortages and high workloads can make it difficult for professionals to fully implement person-centred approaches. Bureaucratic processes and organisational constraints may also limit flexibility, reducing the ability to tailor care to individual needs. As highlighted by Baggott (2013), organisational and policy constraints can affect the effectiveness of partnership working and service delivery.

Overall, while the social model provides a valuable framework for promoting empowerment and inclusion, its practical implementation remains uneven. This highlights the need for continued investment and organisational support to ensure that person-centred care can be delivered effectively in practice.

Recommendations

Health and social care practice can be strengthened by adopting a more balanced approach that combines the strengths of both the social and medical models of disability. Firstly, there should be increased investment in workforce training to improve understanding of person-centred care, communication skills and the impact of social barriers. This would enable practitioners to involve service users more effectively in decision-making and care planning, in line with person-centred principles (Mackreth, 2021).

Secondly, services should prioritise accessibility in all forms, including physical environments, communication formats and digital access. Improving accessibility is essential to reducing inequalities and ensuring that all individuals can engage fully with services (WHO, n.d.). This also supports the aims of policies such as the Care Act 2014 (UK Government, 2014), which emphasises wellbeing and independence.

Advocacy should also be strengthened, particularly for individuals who may struggle to express their needs or navigate complex systems. Effective advocacy can support autonomy, protect rights and ensure that individuals' voices are heard in care decisions (Bateman, 2000).

In addition, stronger partnership working between health, social care and community organisations is essential. Integrated services can provide more coordinated and holistic support, addressing both medical and social needs. This reflects current policy directions that promote joined-up care and collaboration across services (Baggott, 2013).

Finally, greater emphasis should be placed on co-production, where service users are actively involved in the design, delivery and evaluation of services. While these recommendations have the potential to improve outcomes, their implementation may be limited by funding constraints, workforce pressures and organisational barriers. Therefore, sustained investment and policy support are required to achieve meaningful and long-term improvements.

Conclusion

In conclusion, the social model of disability provides an important framework for understanding disability in a more inclusive and rights-based way. It has contributed significantly to the development of person-centred care by shifting the focus from individual impairment to the removal of social and environmental barriers (Genova et al., 2023). However, the model is not without limitations, particularly in its tendency to underrepresent the impact of impairment and the practical challenges faced in service delivery.

This essay has critically demonstrated that while the social model has strongly influenced health and social care policy and practice, its implementation is often constrained by factors such as funding, workforce capacity and organisational structures. Therefore, a more balanced approach, which recognises both individual needs and wider social barriers, is essential.

Overall, integrating both social and medical perspectives can support the delivery of more effective, responsive and person-centred services, ensuring that care is both inclusive and realistic within contemporary health and social care systems.

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