

The Social Model of Disability in Health and Social Care Practice

Introduction

Disability theory has long been shaped by a tension between two competing frameworks: the medical model and the social model. The social model of disability was developed by disabled people and disability rights organisations from the 1970s onwards, most notably through the work of the Union of the Physically Impaired Against Segregation, and has since become a cornerstone of disability rights thinking in the United Kingdom (Disability Rights UK, no date). Unlike the traditional medical model, which locates the problem of disability within the individual's body or mind, the social model argues that people are not disabled by their impairment or health condition but by the physical, organisational, communication and attitudinal barriers created by society (Scope, no date). The focus therefore shifts from "fixing" the individual towards removing the barriers that prevent equal participation in everyday life.

This distinction is not merely academic. In health and social care, adopting the social model has practical implications for how services are planned, delivered and evaluated. It promotes person-centred care, inclusion, equality and independence, while ensuring that services are designed around the individual's needs rather than expecting the individual to adapt to a service that was not built with them in mind (The University of Edinburgh, 2024). This report examines the principles of the social model, contrasts it with the medical model, considers how it can be applied in everyday health and social care practice, and reviews the UK legislative and policy framework that underpins its implementation.

The Social Model of Disability

At the heart of the social model is a distinction between two related but separate concepts. Impairment refers to the physical, sensory, intellectual or mental health condition experienced by the individual, while disability refers to the barriers created by society that restrict participation and inclusion (Scope, no date). This distinction allows practitioners to separate the clinical reality of a health condition from the social and environmental factors that determine whether a person can participate fully in society.

According to the social model, these barriers typically fall into four broad categories (Disability Rights UK, no date; The University of Edinburgh, 2024):

- Physical barriers – for example, inaccessible buildings, steps without ramps, or equipment that cannot be adjusted for different users.
- Communication barriers – for example, information that is not available in accessible formats such as easy read, large print or British Sign Language.

- Organisational barriers – for example, inflexible appointment systems, rigid opening hours, or processes that assume a level of digital literacy that not everyone has.
- Attitudinal barriers – for example, stereotypes, discrimination, low expectations, or a tendency to speak to a carer rather than the disabled person themselves.

Taken together, these barriers demonstrate that disability, as understood through the social model, is a consequence of an inaccessible environment rather than an inevitable result of a person's condition. This reframing has significant consequences for practice: rather than asking "what is wrong with this person?", the social model encourages professionals to ask "what is preventing this person from participating, and how can it be removed?"

Language plays an important part in putting the social model into practice. Guidance from the Government Digital Service (2026) encourages the use of terminology that reflects the social model, such as referring to a "disabled person" rather than a "person suffering from" a condition, since the former reflects the idea that disability is something imposed by society rather than an inherent deficit. Careful use of language of this kind reduces attitudinal barriers and signals respect for the individual's autonomy and identity.

Difference Between the Medical and Social Models

The medical and social models differ fundamentally in where they locate the "problem" of disability and, consequently, in what they consider to be an appropriate response. The table below summarises the key differences (Scope, no date; The University of Edinburgh, 2024).

Medical Model	Social Model
Focuses on the individual's illness or impairment.	Focuses on removing barriers within society.
Seeks to diagnose and treat the condition.	Seeks to improve accessibility and inclusion.
Professionals are viewed as the experts making decisions.	Individuals are partners in decisions about their care.
Disability is seen as a personal problem.	Disability is viewed as a social issue created by barriers.
Success is measured by improvement in the medical condition.	Success is measured by participation, independence and equal opportunities.

Although healthcare inevitably requires medical treatment, many organisations now combine medical care with the principles of the social model in order to deliver holistic, person-centred care. In practice, this means diagnosing and treating a condition where appropriate, while

simultaneously working to remove the environmental and attitudinal barriers that would otherwise prevent the individual from living independently and participating in society on an equal footing with others.

Applying the Social Model in Practice

Health and social care professionals can apply the social model by systematically identifying and removing the barriers that prevent people from accessing services. The following examples illustrate how the model translates into day-to-day practice.

Example 1: Physical Accessibility

Consider a patient who uses a wheelchair and attends an outpatient clinic. A medical model approach would focus primarily on the patient's mobility impairment as the source of any difficulty they experience. A social model approach instead focuses on adapting the environment, for example by providing step-free access, ensuring accessible toilets are available, using adjustable examination couches, and offering accessible parking close to the entrance. The emphasis throughout is on adapting the environment rather than expecting the patient to overcome physical barriers unaided.

Example 2: Communication

A patient with a hearing impairment may face significant barriers to participating in their own care if communication support is not provided. Professionals can arrange a British Sign Language interpreter where required, provide written information in accessible formats, use hearing loop systems, and allow additional consultation time so that the patient is not rushed. Adjustments of this kind, recommended in inclusive communication guidance (Government Digital Service, 2026), enable the patient to participate fully in decisions about their own care rather than relying solely on a companion to communicate on their behalf.

Example 3: Long-Term Health Condition

A person receiving chemotherapy may experience fatigue and reduced mobility that affect their ability to attend appointments and maintain their usual routines. Rather than focusing exclusively on treating the underlying cancer, professionals applying the social model could also offer flexible appointment times, arrange community or home-based support, coordinate transport services, involve occupational therapists in adapting the home environment, provide psychological support, and encourage shared decision-making about treatment options. The aim is to reduce the barriers that prevent the individual from maintaining independence and quality of life throughout their treatment, not simply to treat the disease in isolation.

Example 4: Learning Disability or Autism

People with a learning disability or autistic people often encounter barriers that are rooted in how services are organised rather than in their underlying condition. Healthcare providers can make reasonable adjustments by offering longer appointments, using easy read information, reducing sensory overload in waiting areas, involving carers where appropriate, and ensuring staff understand each individual's communication needs. Adjustments of this kind improve access to healthcare and are recognised as an important means of reducing the health inequalities experienced by people with a learning disability or autistic people (Government Digital Service, 2026).

Benefits of the Social Model

Implementing the social model across health and social care settings brings a wide range of benefits, both for individuals and for services as a whole. These include the following (Disability Rights UK, no date; Scope, no date):

- Promoting independence, by focusing on what a person can achieve when barriers are removed.
- Improving equality of access to services, facilities and information.
- Reducing discrimination, by challenging stereotypes and low expectations.
- Supporting person-centred care that responds to individual needs and preferences.
- Encouraging participation in decision-making about one's own care and treatment.
- Improving health outcomes, as barrier-free services are more likely to be accessed and used effectively.
- Enhancing dignity and respect in interactions between professionals and service users.
- Empowering individuals to have greater control over their own lives.

These benefits extend beyond the individual service user. Organisations that embed the social model into their culture and practice are better placed to meet their legal obligations, reduce complaints and litigation arising from discrimination, and build trust with the communities they serve.

Relevant UK Legislation

The social model is not simply a theoretical framework; it is embedded, directly or indirectly, in a range of UK legislation and policy that governs how health and social care services must be delivered.

Equality Act 2010

The Equality Act 2010 protects disabled people from discrimination in employment, education and the provision of goods and services (Equality Act 2010). It places a legal duty on organisations,

including health and social care providers, to make reasonable adjustments to remove barriers experienced by disabled people. These adjustments may include accessible facilities, communication support, adapted equipment or changes to policies and procedures, and the duty applies proactively rather than only when a specific individual requests support.

Human Rights Act 1998

The Human Rights Act 1998 protects fundamental rights including dignity, respect for private life, autonomy and non-discrimination (HM Government, 1998). Within health and social care, this means that professionals must ensure that individuals are treated fairly and respectfully while maintaining their independence and choice, and that decisions affecting a disabled person's care take proper account of their own wishes and views.

Care Act 2014 (England)

The Care Act 2014 sets out a legal framework for adult social care in England and promotes wellbeing, independence, prevention, personalised care and the involvement of individuals in decisions affecting their own care (HM Government, 2014). These principles closely reflect the social model, in that they focus on what people can achieve with appropriate support rather than concentrating solely on their impairments or limitations.

NHS Constitution for England

The NHS Constitution sets out the rights and pledges that patients can expect from the NHS, including equitable access to healthcare, dignity and respect, involvement in decisions about their care, and personalised care based on individual needs. These principles reinforce the social model by promoting inclusive and accessible healthcare that is designed around the person rather than around institutional convenience.

Conclusion

The social model of disability has transformed contemporary health and social care by shifting attention away from an individual's impairment and towards the barriers that restrict their participation in society. While the medical model remains essential for diagnosing and treating illness, the social model complements it by promoting accessibility, equality, independence and person-centred care (Scope, no date; The University of Edinburgh, 2024). Through reasonable adjustments, inclusive communication and collaborative decision-making, health and social care professionals can help to ensure that disabled people are able to participate fully in society and access healthcare on an equal basis with others.

This approach is underpinned by a robust UK legislative framework, particularly the Equality Act 2010, which places a clear legal duty on organisations to remove barriers and provide equitable access to services (Equality Act 2010), alongside the Human Rights Act 1998, the Care Act 2014

and the principles set out in the NHS Constitution. Together, these legal and policy foundations, combined with the practical application of the social model in everyday practice, provide a strong basis for delivering health and social care that respects the dignity, autonomy and independence of every individual.

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