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1. Introduction:

The evolution of the traditional, paternalistic paradigms of health care into person-centred care is a relevant modern change in the sphere of health and social care provision. At the heart of this change is a radical shift or redirection; people are no longer considered passive beneficiaries of care determined only by their diagnoses, but as active participants, whose values, stories, and life backgrounds inform the care plan and care provision. One of the theoretical frameworks that lay the groundwork of this approach is the social model of disability, as one of the most powerful and radical ones. This model was formulated by disabled individuals in the disability rights movement, and not by an individual scholar or practitioner, and provides a deep critique of the traditional practice. (Frontiers in Health Services, 2025). It assumes that the main problems that disabled people face are not associated with personal limitations, rather than with societal ones, which are attitudinal, physical, and organisational, and limit participation and marginalise persons. This essay is going to critically look at the social model of disability as an underlying concept of person-centred care. It will initially follow the historic rise of the model and its main theoretical principles in contrast to the prevailing medical model and discuss the major criticisms. This theory will then be translated into health and social care policy and practice, including finding structural barriers and unresolved gaps in implementation. (Grimes and Namboya, 2015). Lastly, with reference to the current implementation science and best-practice rules, the essay will include specific recommendations to be offered to policymakers, organisational leaders, and practitioners to significantly incorporate the principles of the social model. These recommendations are meant to result in a fairer, responsive, and truly person-centred system that is true to the ethical requirement of partnership and justice to all. (Sermo, 2025).

2. General Emergence and Theory Development:

2.1 Historical and Philosophical Bases:

The social model of disability did not grow out of scholarly conjecture, but rather out of the popular political movement. It is deep-rooted in the disability rights movements of the 1960s and 1970s in the United Kingdom and the United States, as well as in similar movements of civil rights movements. The disabled activists started to critically examine why their systemic exclusion was happening in terms of education, employment, and in the general life of people. They criticized the existing discourse that defined disability as a personal medical tragedy, but they found the issue of social oppression and discrimination (Santana, 2022). One of the important events in the crystallisation of this concept was the establishment of the Union of the

Physically Impaired Against Segregation (UPIAS) in the United Kingdom in the 1970s (UPIAS, 1970). UPIAS proposed a revolutionary definition that broke the deterministic relationship between impairment and disability and defined impairment as a physical state and disability as the disadvantage or limitation of action of a contemporary social organisation that does not account for or care about physically impaired people. This difference was the backbone of the social model to change the center of the problem and, by extension, solutions to the problem to be upon the society instead of the individual.

2.2 These Elementary Theoretical Principles:

The strength of the social model is its radical and classy redefinition of disability. It separates impairment and disability in the following way:

- **Impairment:** This is the physical, sensory, or cognitive difference in an individual (e.g., blindness, use of a wheelchair, autism).
- **Disability:** This is a social phenomenon of exclusion, discrimination, and disadvantage, or the experience of a person with impairment interacting with a world that has not been constructed to include them.

This paradigm is contextual and relational in nature. Although the impairment of a person might be in terms of certain functionality, it is environmental and social obstacles that make them disabled. (Frontiers in Digital Health, 2021). The model divides the disabling barriers into three major areas, therefore giving a clear road map for society to change:

- **Attitudinal Barriers:** Prejudicial social and cultural beliefs that degrade disabled individuals.
- **Physical/Environmental Barriers:** These elements of the physical setting hinder access.
- **Organisational/Communication Barriers:** Organisation policies, systems, and formats that exclude.

These differences are in sharp contrast to the medical model of disability that places the issue in the body of the individual, with disability being viewed as a loss to be cured, treated, or managed by medical means. (Center, 2025).

2.3 Pillars of Independent Living:

The social model offers a change strategy besides criticism. It is operationalised by the pillars of independent living, which are a set of requirements that have been identified by disabled persons as being considered vital in the pursuit of equality and participation. These pillars are

the right and accessible information, sufficient income, the availability of transport and housing, the availability of personal assistance, equal employment opportunities, and access to peer support and advocacy (Scandinavian Journal of Disability Research, 2024). The pillars turn the abstract principles of the model into specific requirements on the policy and service design, which directly lead to the person-centred practice by putting in place the conditions of authentic choice and control in his or her life.

3. Theory Responses and Critiques:

3.1 Critical Concerns of the Social Model:

Nevertheless, the social model, despite its transformative effect, has been subject to serious and detailed criticism, and the development of theoretical material continues:

Omission of the Experience of the Impairment: The website on the persistent criticism of the model is that the high emphasis on social barriers may minimize or overlook the personal, usually painful, reality of chronic pain or fatigue, or illness. In this regard, critics and, in many cases, belonging to the disability community itself, hold that the model establishes a false dichotomy to the extent that it becomes hard to talk about the effects of impairment without being accused of returning to a medicalist worldview. The physicality of impairment can be one of the primary and unavoidable aspects of life for people with progressive or fluctuating conditions. (Goering, 2015).

Lack of Intersectionality attention: Early definitions of the social model have been accused of making the experience of disability homogeneous, thereby ignoring the issue of the intersection of disability with other forms of social stratification, including race, gender, class, and sexuality. This is because the experience of a disabled woman of colour, for example, is influenced by several overlapping systems of oppression rather than disability. (Tuqiri et al., 2025).

Practical Application Problems: There is a group of people who believe that the model is not complex enough to deal with complex policy and practice problems. Indicatively, in resource-deprived health systems, the issue of priorities in treatment or support may be challenging to determine when all restrictions are perceived to be discriminatory obstacles.

3.2 Theoretical Development and Reactions:

The social model has evolved rather than being abandoned. Activists and researchers have developed superior iterations:

- The Affirmative Model and Embodiment: Newer concepts, such as the affirmative model, celebrate disability identity and culture, as well as acknowledge the actual body limitations. This is the method of learning impairment without considering it as a disease and acknowledges that disability is a social construct and a fact of embodiment (von Humboldt, 2024).
- The Human Rights Model: This model is an extension of the social model and is founded on international human-rights laws, like the UN Convention on the Rights of Persons with Disabilities. It states that people have a right to access, inclusion, and support, and not charity. This provides solid ground for advocacy and policy change.
- Enhancing Intersectional Analysis: Intersectional perspectives are employed in contemporary disability studies to understand the interaction of disability with other identities. This has resulted in more diversity and inclusive activism and policies that are more representative of the diversity of the community (Owen et al., 2024).

These alterations demonstrate that the model is not dead yet. It has changed to a more mature, yes/no approach to one that is more complex and can deal with complexity without losing its primary point, which is that the main cause of disablement is society and not the individual.

4. Policy and Practice Implications:

4.1 Policy Translation: From Theory to Framework:

The social model is the obvious influence on current health and social care policies. The Framework on Integrated People-Centred Health Services (IPCHS) provided by WHO is a good illustration. It states that we need to shift systems that revolve around diseases and institutions to people-designed systems. (Almgren and G, 2017). The five broad objectives engage and empower people, change care models, coordinate services, strengthen governance, and create conducive environments is an outline of how to dismantle organisational and attitude obstacles. Similarly, the Care Act 2014 of the UK has a principle of well-being which emphasizes personal choice and control and dictates that local councils make information accessible through simple formats. That is simply a direct response to communication issues.

The social model also provides national regulations that assist in the support of personal decisions, such as personal budgets and direct payments. These enable the disabled individuals to decide on the assistance they require, and hence they have power rather than service providers. This addresses the concept of offering adequate personal support. But there

is still a big problem with the gap between these good rules and what is really happening on the ground.

4.2 Persistent Problems in Practical Implementation:

Converting the social model into everyday practice encounters inertial challenges of demonstrating the incompatibility of new ideas with old systems.

- **Cultural and Attitudinal Inertia:** The old medical way, which many health workers still have imbibed in their academic years, words, and unspoken prejudices. A physician who has been trained to diagnose and treat may struggle to become a partner who helps a patient recount his story and collaborates to build a health plan, as the person-centred models such as the Gothenburg model suggest. The old-fashioned style of compliance and knowing what is best can retain an old-fashioned style (Goering, 2015).
- **Structural and Resource Barriers:** Health systems typically strive to achieve efficiency, rather than personal flexibility. Short-term appointments, clinical outcome-oriented targets, and division of services between health and social care cause the organisation to stumble over hurdles mentioned by the social model. Lack of money implies that, although one may wish to change, he or she may not find full accessibility, time-consuming joint planning, or non-medical assistance.
- **Tokenistic Participation:** A major criticism of person-centred care is that it can just be superficial. The patients may be listened to and not provided with real choices, or only a fraction of a small care plan, not as part of service creation, rules, and training. That is not what the social model desires, which is the disabled people to be the leaders of the change (von Humboldt, 2024).
- **Terminological Confusion and Conceptual Dilution:** There are numerous similar words in the area, such as patient-centred, person-centred, and people-centred, each with a different meaning used interchangeably. Without a generally accepted definition, it is difficult to speak precisely, gauge progress, and maintain changes at a constant level. This allows systems to claim they are person-centred and only do superficial alterations.

5. Conclusion:

The social model of disability is not just a theory. It is an effective analysis and a call to action, providing the most appropriate grounds for person-centred care. Shifting the focus to the failures of society instead of the individual, it provides a much-needed means of locating the problems in the system and determining the way the process can be corrected. Nevertheless,

this article demonstrates that its radical transformations are curtailed by the criticism of studies, the ongoing reign of the medical paradigm practice, and the reversibility of fast progressive policies by politics (Sermo, 2025). Creating a system that adheres to the social model requires a consistent, multi-party strategy: powerful, collaboratively shared regulations; workplaces based on cooperation; and employees who are educated to assist in getting rid of the obstacles. However, after all, this is not a mere technical problem, but a profound ethical project. It entails never giving up on getting rid of attitudes, material impediments, and barriers in the workplace that handicapped individuals, to ensure that all people can get equal treatment and engagement in society.

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