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Introduction

An approach that treats patients as equal partners by tailoring healthcare to their unique preferences, values and goals instead of solely focusing on the medical condition is person-centred care (Glasby, 2026). It is important for improving health outcomes of the people with better agreement on care plans that result in higher satisfaction of people with utmost effectiveness. This essay will focus on discussing the social model of disability as the chosen model that underpins the person-centred care of a patient named Alex, who suffers from challenges in daily routine activities. It will also cover the issues raised in the application of the social model of disability to health and social care (HSC) policy and practice in detail.

Main body

As per the views of Bansal *et.al* (2022), the performance of any person depends on their capability to function normally in their daily tasks. The model that explains that people are disabled by attitudinal, systemic and environmental barriers in society instead of their own impairments is the social model of disability (SMD) (Oliver, 2023). This approach shifts the focus away from seeing disability as an individual medical problem to highlighting ways in which society creates barriers that limit the participation of people. It fits the person-centred care of Alex, age 21, with autism disability, as it offers empowerment by emphasising listening to the person's own experiences, voice, and choices instead of imposing professional assumptions. In this model, equality is also considered, as care is designed to remove barriers so that people with disabilities can live with dignity and independently in the community. This provides a holistic approach by considering different factors of the individual and not only the medical needs of the person specifically.

Jurgens, (2023), have argued that the growth of society depends on the well-being of people living in it for creating a better living environment. The **emergence** of the SMD model as the chosen model began in the UK during the 1970s and 1980s, which was developed by disabled activists and scholars who were determined to challenge the prevailing medical model. A social model states that disability is particularly created by societal barriers like exclusionary practices, discriminatory attitudes and inaccessible environment instead of impairments (Zaks, 2024). In this, the UPIAS played the main role in articulating this perspective as their 1976 policy statement distinguished between impairment and disability. It contributes to radical reframing that shifted the debate from personal tragedy to social injustice by creating the foundation for disability rights movements and influencing UK policy as well.

On the other hand, the care outcomes of the patient can be enhanced by addressing their needs and requirements properly (Dwyer *et.al* 2025). The **development** of the SMD model started with its becoming central to UK disability disclosure as well as legislation. This informed campaigns for accessibility, inclusive education and anti-discrimination laws, such as the disability discrimination act (DDA) 1995 and later the Equality Act 2010, which showcased the principles of the SMD model by requiring organisations to make reasonable adjustments to remove barriers. In HSC, the model is united with person-centred care that emphasises autonomy, choice and dignity instead of solely focusing on clinical interventions. The services began to prioritise by allowing participation in the everyday life of the individual. The Care Act 2014 embedded duties for promoting well-being and independence, aligning with the ethos of the social model. It also influenced the disability studies and inspired the international frameworks for social exclusion, empowerment and rights as well.

According to Andrews *et.al* (2022), the effectiveness of any activities is measured by the responses of people towards their use. The SMD model has been subject to several **critiques**, and one of them is the neglect of impairment experience, as they state that the chosen model downplays the lived reality of pain; mental distress of fatigue by exclusively focusing on social barriers that risk ignoring the effects of impairments on their daily life (Amundson, 2022). Oversimplification is also a major critique of this model, as the binary distinction between disability and impairment has been criticised for being too rigid. The major reason behind this is that people suggest that disability arises from the interaction of social, psychological and biological factors, not only from external barriers. Policy challenges and limited applicability to the invisibility of fluctuating conditions are also criticised in the SMD model by people. In this, the major focus is on people's mental health conditions or those with chronic illness who sometimes feel that the model does not adequately capture the experiences and barriers, which are not always external but extrinsic to the condition.

Groth *et.al* (2025), have argued that coordination is primary in HSC to improve the outcomes of care for the patient. The responses of the above-mentioned critiques of the SMD model include integration of the approach with other models for the bio-psycho-social approach that combines the emphasis of the social model on barriers to recognition of personal and medical experience, which views disability as an interaction between contextual factors and health conditions. Expansion to diverse conditions is also a response of the model as its adaptation is effective for including fluctuating and visible health conditions by focusing on the fact that barriers can be physical and attitudinal as well (Collins *et.al* 2022). Policy refinement is also a major response to SMD model critiques, as UK HSC policy combines person-centred care with recognition of

health needs. Continued activism as a response makes it vital for challenging discrimination and promoting equality by offering a clear political message regarding the change of society, and not only the individual.

It is identified by Giri *et.al* (2022) that the accomplishment of ideal care outcomes demonstrates the use of the right practices in HSC. SMD model as the concept has been applied to practice and policy of health and social care in the UK in different ways, and legislation and rights are a significant way. It focuses on the DDA 1995 and also the Equality Act 2010 in the UK, which were significantly influenced by the chosen model. In this, the organisations are required to make the proper adjustments that are reasonable for removing any kind of barriers in person-centred care of people like Alex with disability in society (Sutton *et.al* 2023). SMD model is also applied through the Care Act 2014 in UK HSC policy and practices by embedding duties for promoting choice, independence and well-being of people with ideal alignment with the model through autonomy emphasis. This is essential for promoting the rights of people living with disabilities in an ideal manner to prevent any kind of uncertainty.

It is contradicted by Masterson *et.al* (2022) that the effective theory, evaluation of legislation, guidelines, policy and theory in HSC is vital for a person's well-being in society. The application of the SMD model is also done through the NHS, and person-centred care in the UK is done properly through the policies and practices of the HSC. In this NHS framework, there is an increasing emphasis on personalised care planning, shared decision making and co-production, which demonstrates the principles of the SMD model that shapes the support specifically (Defar *et.al* 2023). The policies of HSC encourage accessible services, recognition of social determinants of health and inclusive communication. Education and social services are also major ways of SMD model application in HSC, as inclusive education policies are the Special Educational Needs and Disability (SEND) code of practice, which is mainly rooted in the social model. It focuses on adapting the schools and curricula instead of children's segregation.

Workplace and community are also significant ways of application of the SDM model in HSC policy and practice of the UK, as employment policies help in promoting workplace adjustments and anti-discrimination measures, and community initiatives concentrate on accessibility in public spaces, housing and transport by minimising participation barriers. There are several **problems** that are involved in the application of the SDM model in the policy and practice of HSC, such as implementation gaps, as raised issues (Glasby, 2026). The legislation reflects the social model, but practice lags behind it, as accessibility improvements can be consistent, but enforcement is uneven. Resource constraints are also involved in the problem as local

authorities and NHS services face funding pressures that limit their ability to completely implement person-centred barrier-removing approaches.

The neglect of impairment experience is also involved in a problem or raised issue in the application of the chosen model, as policies inspired by the model sometimes underplay the reality of the situation, as this can leave individuals like Alex feeling unsupported when their impairment creates challenges. This reduces the effectiveness of the approach in the changing environment of the patient's needs and requirements (Bansal *et.al* 2022). Complex needs also create problems in the model, as people with invisible or fluctuating conditions can find it less applicable. Fragmentations of services along with cultural and attitudinal barriers are also involved in the problem in HSC, as integration between health and social care remains a challenge.

Relevant recommendations

Strengthening accessibility standards across all services is a relevant recommendation for HSC policy and practice in the UK. The healthcare businesses should use this for enforcing stricter accessibility requirements in digital services, transport, housing and healthcare facilities. It is useful for ensuring that disabled people can access a range of services independently by minimising the reliance on intermediaries (Oliver, 2023). This can effectively examine the theory of the SMD model, its implementation and evaluation of partnership working in HSC as well. Accessibility standards strengthening will boost the effectiveness of the SMD model by acting as the foundation of the approach, as without it, equality and participation remain limited in society. This also ideally aligns with legal obligations under the Equality Act 2010 in a proper way.

Expansion of personalised budgets and direct payments is also recommended to the UK government. The government should utilise this to increase the funding and simplify the procedures for personal budgets that can allow individuals to control and choose in their care arrangements. This is practical for people with disabilities by promoting flexibility and autonomy, allowing people to tailor support to their unique needs and preferences (Jurgens, 2023). It can embody person-centred care by shifting the power from institutions to individuals by fostering dignity and independence.

Investment in disability awareness and professional training can also be a relevant recommendation for HSC policy and practice. In this HSC should use this by providing mandatory training for staff of HSC on the SMD model, anti-discrimination practices and inclusive communication. It is vital for building empathy, equipping professionals and reducing stigma among the workers for delivering the genuine care that is centred on the person mainly (Zaks, 2024). This will be important as changing attitudinal barriers can be significant to physical

barriers, and changing the professional culture may ensure policies by translating into empowering and respectful practice.

Enhancing data collection and monitoring can also be recommended for the practice and policy of HSC. The government should utilise this for establishing robust systems to publish, monitor, and collect data on accessibility, experiences and service outcomes across health and social care services. It is effective as it provides the evidence for identifying gaps in provision and highlights persisting barriers as well (Dwyer *et.al* 2025). This can enable accountability by showing that policies are genuinely improving inclusion in the practices or not. It will be important in HSC, as without reliable data, progress towards the SMD model cannot be measured, and transparent monitoring can ensure that disabled people's voices will be reflected in policy. In this, better resource allocation will be supported by targeting the areas with the greatest needs.

Conclusion

From this essay, it is concluded that the HSC is a very complex sector that requires expertise and knowledge on the needs and requirements of people with disabilities. SMD model, as chosen one, highlighted its development in the UK by informing different campaigns for anti-discrimination laws, accessibility and inclusive education. Legislation and rights, along with education and social services, are illustrated as ways of applying the SMD model properly by emphasising independent living and personal budgets for disabled people. Resource constraints and implementation gaps are addressed as the raised issues and major problems involved in the application of the selected model in HSC due to funding pressures.

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