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Disability Models and Inclusive Education: A Critical Review

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ABSTRACT

Purpose – This paper critically examines major theoretical models of disability and their implications for inclusive education, highlighting the historical evolution of how disability has been conceptualized and applied in educational contexts.

Methodology – A systematic review design was employed. Relevant scholarly literature was identified, synthesized, and critically analysed to extract key themes, debates, and comparative insights on disability models. The review focused on four dominant frameworks: the medical, social, biopsychosocial, and human rights models. Thematic synthesis was used to interpret patterns across the selected sources and evaluate each model's relevance to inclusive education.

Findings – The review found that each disability model provides valuable perspectives but also contains significant limitations. These frameworks strongly influence inclusive education policies and practices, shaping curriculum design, assessment approaches, teacher training, and accessibility standards. No single model was found to be fully sufficient for addressing the complexity of disability in educational settings. The study concludes that inclusive education requires a more integrated and nuanced understanding of disability, combining strengths across models to better inform policy and practice.

Novelty – This study offers a critical and comparative synthesis of disability models specifically in relation to inclusive education, advocating for an integrated approach rather than reliance on a single theoretical framework.

Significance – The study benefits policymakers, educators, researchers, and disability advocates by clarifying how disability models shape educational outcomes and by providing guidance for building more effective, truly inclusive educational environments.

Keywords: Biopsychosocial model; Disability models; Human rights model; Medical model; Social model.

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1. Introduction

The discourse surrounding disability has undergone a significant transformation, moving from exclusionary practices to inclusive education advocacy, yet the theoretical models underpinning these shifts require critical examination (Hornby & Kauffman, 2021; Teschers, 2020). These influential models shape perceptions, policies, and practices regarding individuals with disabilities, influencing how societies understand and respond to their needs (Llewellyn & Hogan, 2000; Retief & Letšosa, 2018). The model has been adapted for decades in the development of national and international inclusive education frameworks and policies that continue to be followed today. It has evolved from viewing disability as an individual deficit to recognizing it as a socially constructed phenomenon (Retief & Letšosa, 2018).

The medical model, which historically dominated the field, conceptualized disability as an individual pathology requiring medical intervention to "cure" or "normalize" (Petasis, 2023). Meanwhile, the social model emerged as a counter-narrative, asserting that disability is not inherent in an individual's impairment but rather is a consequence of societal barriers and attitudes (Joshi & Pappageorge, 2023; Thorneycroft, 2024). Newly emerged models, such as the biopsychosocial model and the human rights model, portray a different picture of how we should view disability. The models did not emerge at the same time, creating competing perspectives that have far-reaching implications for inclusive education, influencing everything from curriculum design and assessment practices to teacher training and accessibility standards. Often, the emergence of one model is influenced by the failures and limitations of another, creating gaps in how we understand disability. Understanding the historical evolution and contemporary implications of various disability models is paramount to fostering truly inclusive educational environments (Waldschmidt, 2018).

The conceptualization of disability has evolved significantly over time, reflecting broader societal shifts in attitudes, values, and scientific understanding; therefore, examining the historical context in which different disability models emerged is essential for understanding their underlying assumptions and biases. Historically, disability was often viewed through a moral or religious lens, with individuals with disabilities seen as objects of pity, charity, or even divine punishment (Forstner, 2022). This perspective led to practices of segregation, institutionalization, and exclusion, with limited opportunities for education, employment, or social participation. The medical model emerged as a dominant framework, framing disability as an individual medical problem requiring diagnosis, treatment, and rehabilitation (Llewellyn & Hogan, 2000).

As individuals who were born with defects are perceived to be different from what is normal, the medical field attempts to make them normal (Zaks, 2023). However, this view has been abused over time due to failure to address the social and environmental factors that contribute to the experience of disability (Llewellyn & Hogan, 2000). Hence, the emergence of the social model. This model offers a paradigm shift by locating the problem not within the individual but within society, which fails to accommodate and include individuals with impairments. The model holds that the problem lies not in the individual but in their social and physical environment (Young, 2020). Later, scholars introduced the biopsychosocial model as a paradigm that integrates the medical and social models in response to criticisms both models faced. In the height of the enactment of the rights of persons with disabilities, a new model emerges from such movements. The human rights model of disability emphasizes the inherent dignity, equality, and rights of all individuals, including those with disabilities (Oliver, 2013). The aforementioned models have been adapted and followed by many disability studies scholars, policy-makers, and practitioners, which has contributed to the development of inclusive education.

While these perennial models of disability remain appealing in today's inclusive education landscape, they require critical examination. Especially when considering the ongoing challenges and implementation of inclusive practices. The need for effective, truthful, inclusive education environments requires a comprehensive understanding of how these models both facilitate and hinder genuine inclusivity in educational settings. Moreover, providing an explicit discussion and analysis of these models will expand on current perspectives and identify areas where educational policies and practices can be refined to better serve the diverse needs of students with disabilities. This paper will critically review the predominant disability models—medical, social, biopsychosocial, and human rights—to elucidate their historical development, core tenets, and, more importantly, their profound implications for the theory and practice of inclusive education.

2. Methodology

This review paper critically examines the evolution and implications of disability models, with a particular focus on their relevance to inclusive education. It will review four major models of disability: the medical, social, biopsychosocial, and human rights models. By synthesizing and analyzing the scholarly literature, this paper aims to provide insights into how these models shape our understanding of disability and inform educational policies and practices. This paper will adopt a systematic review of related literature as its methodology to identify key themes, debates, and research gaps in the existing literature on disability models and inclusive education.

To ensure comprehensive coverage, the search strategy will encompass prominent academic databases, including but not limited to ERIC, EBSCOHost, Web of Science, and Scopus, utilizing keywords such as "disability models," "inclusive education," "medical model," "social model," "biopsychosocial model," and "human rights model." The search will be limited to peer-reviewed articles, books, and reputable reports published primarily in English to capture contemporary discourse while acknowledging foundational texts. The selection process will prioritize studies that offer theoretical insights, empirical evidence, or critical analyses directly relevant to the interplay between disability conceptualizations and inclusive pedagogical approaches. Exclusion criteria were applied to studies that did not directly engage with disability models or their ramifications, thereby ensuring a focused and rigorous examination of the selected topic.

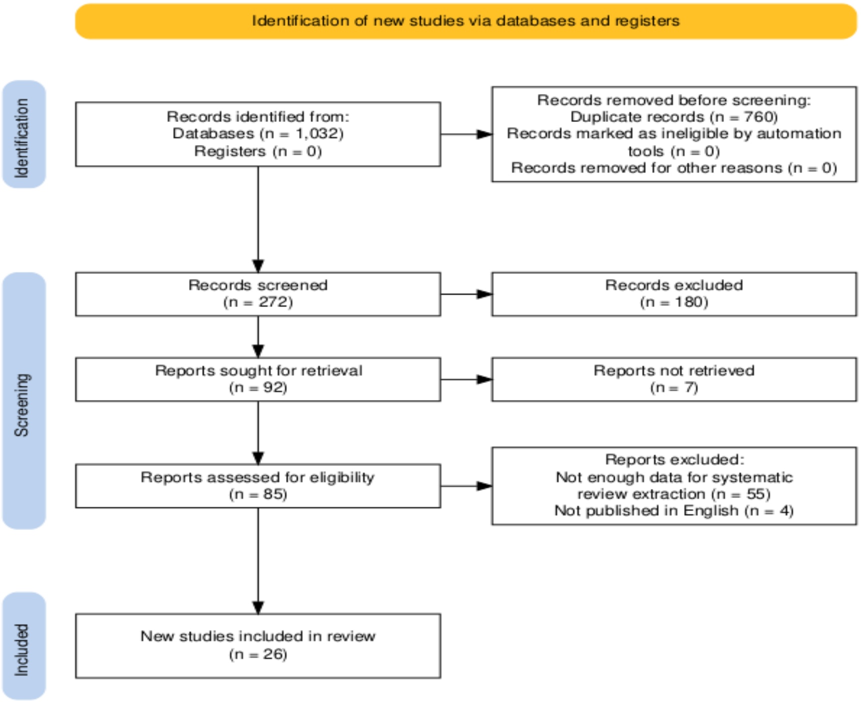

Figure 1. PRISMA Flow Diagram

3. Results and Discussion

3.1 The Medical Model of Disability

The medical model of disability, rooted in a biomedical understanding of impairment, views disability as a deficit or abnormality residing within the individual (Retief & Letšosa, 2018). It posits that disabilities are primarily medical problems that can be diagnosed, treated, and potentially cured by medical professionals (Petasis, 2023). The medical model emphasizes the importance of medical interventions, such as medication, surgery, and therapy, to alleviate symptoms, correct impairments, and restore individuals to a state of "normal" functioning. It considers disability inherently abnormal and pathological, residing within the individual rather than being a societal construct (Retief & Letšosa, 2018). The primary goals of intervention within this framework are cure, amelioration of the physical condition to the greatest extent possible, and rehabilitation (i.e., the adjustment of the person with the disability to their condition and environment) (Retief & Letšosa, 2018). Individuals with disabilities are expected to avail themselves of various services offered by trained professionals, assuming the role of a patient or learner being "helped" (Retief & Letšosa, 2018) (Llewellyn & Hogan, 2000).

This model is sometimes referred to as the "personal tragedy" model because it fundamentally defines disability in a negative light (Retief & Letšosa, 2018). Disability is regarded as objectively bad, a pitiable condition, and "a personal tragedy for both the individual and her family, something to be prevented and, if possible, cured". This negative conception has historically contributed to questionable medical treatments, including involuntary sterilization and euthanasia (Reinders et al., 2019). This model assigns significant power to medical professionals who diagnose individuals based on criteria developed from a perspective of what is considered "normal" in society (Retief & Letšosa, 2018). In contexts where the medical model prevails, individuals with disabilities are often expected to play a "sick role," which includes exemption from normal social responsibilities and an obligation to seek technical competence (Retief & Letšosa, 2018). Medical professionals adhering to this model may even regard persons with disabilities as "failures" if a cure is not achieved. When individuals with impairments are unable to function as "normal" people, they are considered disabled (Petasis, 2023).

The focus on "fixing" the individual has historically led to segregated educational settings, such as special schools or separate classes, where specialized professionals aim to remediate the student's "deficiencies." The goal is often to prepare the student to "fit into" the mainstream, rather than to have the mainstream adapt to the student. This model perpetuates segregation, thereby increasing individuals' isolation from mainstream society (Joshi & Pappageorge, 2023).

3.2 The Social Model of Disability

Arising from the growing discontent and recognized inadequacies of the medical model, the social model of disability presents a fundamentally contrasting and influential perspective. This model challenges the notion that disability is an inherent attribute of an individual, instead asserting that it is a socially constructed phenomenon resulting from barriers and discriminatory practices within society (Stephens, 2011). The social model makes a clear distinction between impairment, defined as the functional limitations of the individual, and disability, defined as the restriction of activity caused by a society that does not account for them (Adam & Koutsoklenis, 2023). This differentiation between *impairment* (a long-term condition of the body or mind) and *disability* (the disadvantage or restriction of activity caused by societal structures) (Adam & Koutsoklenis, 2023; Anastasiou & Kauffman, 2013; Walker, 1993). The social model argues that impairment and disability are both discursively constituted, emphasizing that impairment was always already disability in a social context (Thorneycroft, 2024). It asserts that people are disabled by the environment's limitations, not by their physical conditions (Stephens, 2011).

At its core, the social model posits that disability is something imposed on top of impairments by the way society unnecessarily isolates and excludes individuals, making it a form of social oppression (Forstner, 2022). It argues that the problem lies not in the individual but in society's social and physical environment, which unfairly stigmatizes certain bodily traits as disabilities (Joshi & Pappageorge, 2023; Stephens, 2011). This framework illuminates the societal barriers that explain one's disability, compelling systems to change to accommodate and empower people with disabilities (Joshi & Pappageorge, 2023). Advocates of the social model emphasize that individuals are more disadvantaged by societal attitudes than by functional losses (Llewellyn & Hogan, 2000).

As a model that views social barriers as the primary cause of disability, the social model seeks to emphasize identifying and dismantling societal barriers, which can include inaccessible environments, discriminatory attitudes, and inflexible policies (Joshi & Pappageorge, 2023). It promotes systemic changes to remove these barriers, thereby enabling full participation and inclusion for individuals with impairments (Joshi & Pappageorge, 2023). The focus is on transforming society rather than on "fixing" the individual. The theoretical foundation of this model redefines disability, positioning its foundation within the socioeconomic environment instead of the individual, which fails to recognize and meet the needs and rights of people with disabilities (Petasis, 2023).

3.3 The Biopsychosocial Model of Disability

The biopsychosocial model of disability, conceptualized by George Engel in 1977, provides an integrative framework for understanding health, illness, and disability. It moves beyond a singular focus on biological factors, asserting that these are inextricably linked with psychological and social dimensions in shaping an individual's experience of disability (Bhartiya, 2021; Carrió et al., 2004; Williamson, 2022). The BPS model emerged as a critique of the prevailing biomedical model, which often reduced health and disease to purely biological phenomena (Bhartiya, 2021; Klazura & Fogaça, 2020). Engel advocated for a new medical model that recognized the broader influences on patient health (Benning, 2015). It seeks to resolve the historical polarization between problem-centered "medical" models and social "disability as construction" models by integrating elements from both (Rothman, 2010). This framework acknowledges the biological realities of impairment while also recognizing the significant role of psychological and social dimensions (Anastasiou & Kauffman, 2013).

This model recognizes the complex interplay among these components, offering a more holistic perspective than its predecessors. Within the Biopsychosocial Model, the biological dimension encompasses an individual's genetic predispositions, physiological functioning, and physical impairments or chronic conditions. The psychological dimension incorporates an individual's thoughts, feelings, behaviors, and coping mechanisms, which can significantly influence how they perceive and manage their disability. The social dimension considers the broader societal context, including cultural norms, social support systems, economic factors, and environmental barriers or facilitators. The model highlights that these factors are not isolated but continuously interact, shaping the individual's subjective experience and health outcomes (Carrió et al., 2004).

The biopsychosocial model offers a comprehensive approach to understanding disability by considering the biological, psychological, and social factors that contribute to an individual's experience (Bhartiya, 2021; Bolton, 2023). It posits that disability arises from a complex interplay among biological factors (such as impairments or health conditions), psychological factors (such as coping mechanisms and emotional responses), and social factors (such as societal attitudes and environmental barriers) (Petasis, 2023). Unlike the medical model, which primarily focuses on the biological aspects of disability, the biopsychosocial model recognizes the importance of psychological and social factors in shaping the lived experience of disability (Carrió et al., 2004). Similarly, it moves beyond the social model by acknowledging the role of biological factors alongside societal barriers (Petasis, 2023).

In recent years, extensions of the biopsychosocial model have emerged, such as the biopsychosociotechnical model (Card, 2022). This expanded model integrates sociotechnical systems theory, offering a more practical framework for assessing determinants of health and designing interventions. The biopsychosocial model promotes a patient-centered approach to healthcare, emphasizing the importance of understanding the individual's unique circumstances and tailoring interventions accordingly (Alitabar, 2025).

3.4 The Human Rights Model of Disability

The human rights model of disability represents a significant shift in understanding disability, viewing it not as an individual deficit or a consequence of societal barriers alone, but as an issue of human rights. This model emerged from critiques of the medical and social models of disability, advocating a framework that directly addresses disability as a human rights concern (Oliver, 2013). A pivotal development in its rise was the adoption of the United Nations Convention on the Rights of Persons with Disabilities in 2006 (Degener, 2016). The CRPD signifies a paradigm shift in disability policy, moving away from viewing disabled persons as objects of charity, medical treatment, or social protection to recognizing them as rights-holders (Degener, 2016; Harpur, 2011). The social model of disability, grounded in the lived realities and activism of disabled people, significantly facilitated the transition to this rights-based approach, which is central to the CRPD (Russo & Wooley, 2020).

The human rights model is rooted in the principles of equality, dignity, and non-discrimination, asserting that persons with disabilities are entitled to the same rights and opportunities as all other members of society. It emphasizes the importance of accessibility, inclusion, and participation in all aspects of life, including education, employment, healthcare, and political participation. And that denying accessibility to an individual with disability should not be tolerated and is a violation of their human rights. This model aims to improve international human rights law by promoting inclusive autonomy and inclusive equality (Degener, 2024). It recognizes that persons with disabilities are subjects of human rights and possess inherent dignity, advocating for their full and equal enjoyment of all human rights and fundamental freedoms (Degener, 2016)

The Human Rights Model has profoundly influenced disability law and human rights law globally, primarily through the CRPD (Degener, 2016). The CRPD, with widespread ratification, has led many State Parties to review and revise their domestic disability laws and establish national monitoring mechanisms (Degener, 2016). This framework guides the development of inclusive policies, advocating for the removal of legislative and systemic barriers that prevent persons with disabilities from fully participating in society and exercising their rights (Menezes et al., 2016; Twardowski, 2020). The focus is on promoting social inclusion and ensuring equal treatment, self-determination, and access to essential services, such as education, employment, and recreation, for individuals with disabilities (Nia, 2022).

The human rights model acknowledges that disability is a natural part of the human experience and that persons with disabilities have the right to live independently and be included in the community. It also acknowledges that impairment may not be used as a justification for denying or restricting human rights (Degener, 2016). It calls for removing barriers that prevent persons with disabilities from exercising their rights and participating fully in society. Furthermore, the human rights model underscores the importance of empowering individuals with disabilities to advocate for their own rights and participate in decision-making processes that affect their lives (Degener & Castro, 2022).

3.5 Critical Analysis of Disability Models

3.5.1 The Medical Model

The medical model has faced considerable criticism for its individualistic approach to disability, which often overlooks the broader social and environmental factors that contribute to the experience of disability (Petasis, 2023). The medical model places the problem of disability squarely within the individual's impaired body or mind, seeing it as a personal tragedy or deficit (Oliver, 2013). This perspective can lead to a focus on "fixing" the individual through medical interventions, rehabilitation, or therapy, rather than addressing societal barriers or promoting inclusion (Joshi & Pappageorge, 2023). It views disability as a deviation from the norm, implying that the individual's body is the issue, not the environment or societal structures (Forstner, 2022). It creates a value of able-bodied people over disabled-bodied people, and it often puts people with disabilities in the hands of doctors, experts, and specialists.

By defining disability solely as a medical condition, the model can pathologize individuals, leading to a sense of brokenness or abnormality (Stephens, 2011). This perspective can disempower people with disabilities, making them passive recipients of care rather than active agents in their own lives (Joshi & Pappageorge, 2023). It can reinforce a perception of dependency and often overlooks the strengths, capabilities, and unique experiences of disabled individuals (Stephens, 2011). People may perceive individuals with disabilities as helpless, weak, and unable to make decisions for themselves, propagating the idea that they are not capable of doing daily things such as making decisions for themselves, holding jobs, or being in relationships. In addition, the approach may disregard or minimize the impact of external factors on a person's functional abilities and overall quality of life.

A major limitation of the medical model is its almost exclusive focus on the biological or individual aspects of disability, largely ignoring the profound impact of social, environmental, and attitudinal barriers (Anastasiou & Kauffman, 2013). It fails to account for how inaccessible environments, discriminatory practices, and societal prejudices create or exacerbate disability (Joshi & Pappageorge, 2023). The model does not acknowledge that a person's physical or mental condition only becomes a "disability" when society fails to accommodate their needs (Oliver, 2013). This oversight can result in interventions that are misdirected, ineffective, or even harmful, as they do not address the root causes of disability-related exclusion and marginalization.

The medical model often overlooks the subjective experiences of people with disabilities, reducing their complex lives to a set of symptoms or diagnoses. It can disregard the psychological, emotional, and social consequences of living in a disabling society (Thorneycroft, 2024). This reductionist approach can lead to a lack of empathy and understanding, as well as the development of interventions that are insensitive to the individual's unique needs and preferences. Disregarding other aspects of development could lead to a misinformed society that believes that the only issue individuals with disabilities face is their medical condition.

Another criticism of the model is that it often promotes a "cure" mentality, prioritizing the elimination or reduction of impairment. While medical advancements are vital, this exclusive focus can imply that life with a disability is inherently undesirable and that a disabled person's life cannot be fulfilling unless their impairment is removed (Thorneycroft, 2024). This can lead to unrealistic expectations and a devaluation of adaptive strategies and the unique identities that can emerge from living with an impairment (Joshi & Pappageorge, 2023). The "cure" mentality can overshadow the importance of promoting independence, inclusion, and self-determination for individuals with disabilities, and it can ignore the value of disability as a source of diversity and innovation.

3.5.2 The Social Model

While the social model of disability offers a transformative perspective by shifting the focus from individual impairment to societal barriers, it is not without its limitations. A significant critique of the social model is its tendency to downplay or "background the body of the disabled person" and the lived experience of impairment (Stephens, 2011). Critics argue that by rigidly separating impairment from disability, the model can overlook the pain, discomfort, and personal challenges directly associated with a physical or mental condition (Anastasiou & Kauffman, 2013; Thorneycroft, 2024). This can lead to an incomplete understanding of an individual's reality and needs (Stephens, 2011). Some argue that while politically successful, this strict dichotomy might not always align with the complex interplay between a person's body and their environment (Thorneycroft, 2024).

The social model has also been criticized for its perceived lack of inclusivity for all types of impairments, particularly those that are not easily attributable to external societal barriers, such as chronic illness or mental health conditions (Adam & Koutsoklenis, 2023; Nabbali, 2009). Critics suggest that the model may inadvertently exclude individuals whose experiences of disability are more closely tied to their internal states or fluctuating health conditions. For example, people with mental health conditions or chronic pain may find that the social model does not fully capture the complexities of their disabilities, which may involve both internal and external barriers. While effective for physical disabilities caused by inaccessible environments, some argue it struggles to adequately address disabilities where the internal experience of impairment plays a more dominant role in limiting participation.

By focusing heavily on social construction, critics contend that the social model might risk downplaying the biological realities of certain impairments (Anastasiou & Kauffman, 2013). This can lead to a neglect of medical and rehabilitative needs that, while not solely defining disability, are crucial for an individual's well-being and functioning (Anastasiou & Kauffman, 2013). While the model aims to shift focus from individual deficit, it can inadvertently create a perception that the impairment itself is irrelevant (Edwards, 2007). It is essential to acknowledge that medical interventions and therapies can significantly improve the quality of life for many people with disabilities, even within a socially inclusive framework.

Another limitation is that, like other disability models, the social model has been criticized for failing to consistently acknowledge intersectionality (Brinkman et al., 2022). It may not fully account for how disability intersects with other marginalized identities, such as race, gender, or socioeconomic status, to create unique experiences of oppression and health inequities (Brinkman et al., 2022; Wickenden, 2023). This oversight can lead to a less nuanced understanding of the diverse challenges faced by individuals with multiple marginalized identities (Barnartt & Altman, 2013). Consequently, the experiences of individuals navigating disability alongside other forms of marginalization, such as racism, sexism, or classism, can be particularly complex and multifaceted, often resulting in compounded discrimination that stems from the intersection of systemic barriers and societal attitudes (Retief & Letšosa, 2018).

Some scholars suggest that the social model, in its effort to distinguish disability from impairment, may inadvertently create new divisions or reinforce a "us vs. them" mentality between disabled and non-disabled individuals. It has been labeled an outdated ideology by some, generating conflict and tensions within disability studies (Dewsbury et al., 2004; Owens, 2014).

3.5.3 The Biopsychosocial Model

The biopsychosocial model, while aiming to provide a holistic view of disability, has also faced criticisms regarding its practical application and theoretical underpinnings. A primary criticism of the BPS model is its perceived vagueness and lack of clear operationalization. Critics argue that while the model emphasizes the interconnectedness of biological, psychological, and social factors, it often fails to specify *how* these interactions occur or the relative weight of each component in specific conditions (Card, 2022). This can lead to a lack of meaningful scientific content (Roberts, 2023) and make it challenging to apply consistently in clinical practice and research (Williamson, 2022). The model provides insufficient guidance on integrating the vast amounts of information from these disparate domains into a coherent understanding of an individual's condition, often leaving practitioners to intuitively balance these factors (Hatala, 2012). The lack of defined parameters for assessing the interplay among biological, psychological, and social dimensions introduces subjectivity, hindering the development of standardized assessment protocols and targeted interventions.

Connected with the previous critique is the lack of a specific intervention design. While the BPS model encourages consideration of multiple factors, it does not inherently prescribe *which* specific interventions are most appropriate or effective for particular conditions. This can create a gap between understanding the various influences on a person's health and translating that understanding into concrete, tailored, and evidence-based intervention strategies. The model offers no direct tools for producing valid knowledge claims about disease or specific causal pathways, which can hinder the design of targeted treatments (Roberts, 2023). Practitioners in the field may choose either an eclectic approach to designing an intervention or a trial-and-error approach, which can be ineffective.

Despite the BPS model's widespread theoretical acceptance, the biomedical paradigm often remains dominant in medical education, clinical practice, and healthcare systems (Alitabar, 2025; Rashid, 2024; Xiao et al., 2021) This entrenched biomedical focus can make it challenging for healthcare professionals to genuinely adopt a biopsychosocial perspective, as their training and institutional structures often prioritize biological diagnoses and treatments(Alitabar, 2025; Williamson, 2022) The practical implementation of the model faces significant barriers, including insufficient interdisciplinary collaboration and financial constraints within healthcare systems(Alitabar, 2025; Bhartiya, 2021).

Another criticism revolves around the model's potential to medicalize social problems. Critics contend that by incorporating social factors into a medical framework, the BPS model may inadvertently frame social issues as individual health problems, potentially obscuring the need for broader social and systemic changes. This can lead to interventions that focus on modifying individual behavior rather than addressing the root causes of social inequities that contribute to health disparities. When a patient’s distress stems from poverty, discrimination, or other forms of social injustice, the BPS model risks individualizing these issues, diverting attention from the necessary systemic reforms.

3.5.4 The Human Rights Model

The human rights model of disability emphasizes the rights of persons with disabilities to participate fully and equally in society and advocates removing barriers that hinder their inclusion (Petasis, 2023). However, this model has its critiques and limitations. A significant critique of the Human Rights Model is its complexity in implementation and enforcement. While the Convention on the Rights of Persons with Disabilities provides a robust legal framework, translating its principles into concrete, enforceable laws and policies in diverse national contexts can be difficult (Degener, 2024). The model's effectiveness relies heavily on the political will and commitment of signatory states to uphold their obligations, and there can be a gap between ratification and genuine, on-the-ground change (Degener, 2024). The varied legal systems, cultural norms, and economic capacities of different nations present substantial hurdles to uniform application, leading to inconsistencies in how rights are realized globally. For instance, the interpretation of the "human rights model" by states and its implications for disability assessment remain unclear (Waddington & Priestley, 2020).

Another limitation og the model is that while the Human Rights Model offers broad principles of equality and non-discrimination, it can sometimes struggle to adequately address the specific needs and lived experiences arising from diverse impairments (Wickenden, 2023). By focusing on universal rights, there is a risk of overlooking the unique challenges and support requirements associated with particular conditions, potentially leading to a generic approach if not carefully applied (Waddington & Priestley, 2020). For example, while the model can explain why human rights do not require the absence of impairment, and views disability as a social construct, it faces the challenge of respecting a more person-centred approach in disability assessment without re-individualizing the concept of disability (Degener, 2016; Waddington & Priestley, 2020).

The strong emphasis on legal frameworks and policy within the Human Rights Model can, at times, lead to an over-legalization of disability issues, resulting in a bureaucratic approach (Lorion, 2019). This can occur when the focus shifts heavily towards compliance with regulations and legal mandates, potentially overshadowing the human element of inclusion and empowerment (Petersen et al., 2022). Administrative burdens and "red tape" can result from "onerous encounters with the state and its representatives in the form of public bureaucracies," which can "significantly impede core public sector values, such as legitimacy, equal opportunities, and procedural fairness" (Petersen et al., 2022). While critical for establishing rights, an overly legalistic implementation can create complex administrative processes that may not be easily navigable for individuals with disabilities, hindering access to justice or necessary supports (Masuku & Rama, 2020).

Similar to the social model, the human rights model has also faced scrutiny for not consistently or adequately addressing intersectionality (Brinkman et al., 2022). It may not fully account for how disability intersects with other marginalized identities—such as race, gender, sexual orientation, or socioeconomic status—to create compounded experiences of discrimination and exclusion (Brinkman et al., 2022; Wickenden, 2023) This oversight can lead to a less nuanced understanding of the unique challenges faced by individuals with multiple marginalized identities, potentially leaving some groups underserved by policies based solely on disability rights.

While the model frames discrimination as a human rights violation, proving such discrimination and ensuring accountability can be incredibly challenging. Discrimination against persons with disabilities is often subtle, systemic, and deeply embedded in societal structures and attitudes (Mohapatra et al., 2024), making it difficult to identify, document, and legally challenge (Rohmer & Louvet, 2016). There is often an absence of reliable and comparable data about the experiences of persons with disabilities, which hinders the measurement of disability equality outcomes and the effective monitoring of rights implementation (Priestley & García, 2021) This can lead to a gap between the recognition of rights and the practical ability to seek redress for violations (Adibayev & Susi, 2023; Nia, 2022).

4. Conclusion

In conclusion, while the medical model has been criticized for its individualistic focus and potential to perpetuate negative stereotypes, it remains crucial for diagnosis, treatment, and rehabilitation (Rosenthal, 2021). The social model, while revolutionary in its emphasis on societal barriers, has been critiqued for potentially overlooking the lived experiences and functional limitations associated with impairment. The biopsychosocial model offers a more holistic approach by integrating biological, psychological, and social factors, but it can be complex to implement effectively and may risk individualizing social problems. The human rights model provides a robust framework for advocating for the rights and inclusion of persons with disabilities, but its effectiveness depends on its translation into concrete policies and the recognition of intersectional identities (Petasis, 2023; Retief & Letšosa, 2018). These models have continuously shaped disability policies, curriculum approaches, and collaboration among school stakeholders in the implementation of inclusive education. The selection of an appropriate model for understanding disability may seem to be impossible, as all models offer unique strengths and limitations that require thoughtful considerations for policy decision-makers and practitioners. Acknowledging these limitations is crucial for refining their application, fostering more integrated and nuanced approaches, and ultimately better addressing the complex realities of health and disability in diverse contexts.

Conflict of Interest

The authors declare no conflicts of interest

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