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Global developments in social prescribing

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ABSTRACT

Social prescribing is an approach that aims to improve health and well-being. It connects individuals to non-clinical services and supports that address social needs, such as those related to loneliness, housing instability and mental health. At the person level, social prescribing can give individuals the knowledge, skills, motivation and confidence to manage their own health and well-being. At the society level, it can facilitate greater collaboration across health, social, and community sectors to promote integrated care and move beyond the traditional biomedical model of health. While the term social prescribing was first popularised in the UK, this practice has become more prevalent and widely publicised internationally over the last decade. This paper aims to illuminate the ways social prescribing has been conceptualised and implemented across 17 countries in Europe, Asia, Australia and North America. We draw from the 'Beyond the Building Blocks' framework to describe the essential inputs for adopting social prescribing into policy and practice, related to service delivery; social determinants and household production of health; workforce; leadership and governance; financing, community organisations and societal partnerships; health technology; and information, learning and accountability. Cross-cutting lessons can inform country and regional efforts to tailor social prescribing models to best support local needs.

SUMMARY BOX

- ⇒ Social prescribing is an approach that enables a range of stakeholders, often based in healthcare, to refer individuals to non-clinical interventions, such as social activities and social services, to empower individuals and improve their health and well-being.
- ⇒ Implementation of social prescribing is growing globally as a way to enable individual self-determination and to address the social determinants of health.
- ⇒ The forms of adoption within countries reflect local cultural, healthcare and political contexts.
- ⇒ More research and international coordination is needed to most appropriately position social prescribing in healthcare and other societal systems and to understand the impacts of this model and its growth globally.

INTRODUCTION

Following the 2008 WHO Commission on the Social Determinants of Health (SDH), global initiatives to address SDH focused on policy-level interventions, such as 'Health in All' approaches that engage actors across government, civil society, the private and research sectors.[1] Few global efforts have considered the role of the health sector itself in mitigating adverse SDH and their downstream effects. This is critical in the wake of the COVID-19 pandemic, which has demonstrated the connections between SDH, health inequities and health outcomes, as well as the role of healthcare systems in addressing these SDH.[2]

Social prescribing aims to leverage health and societal systems to address a range of psychosocial factors in order to improve health and well-being. It is a person-driven, supported referral often between medical and community assets. The model is rapidly spreading around the world. In this paper, we draw on examples from 17 countries (figure 1) developing social prescribing programmes to describe how it has been conceptualised and implemented around the world. We suggest what we consider to be its core components and potential contributions to global SDH action. This paper was informed by discussions and iterative feedback with a working group of social prescribing practitioners, researchers and advocates, convened through the third International Social Prescribing Conference hosted by the Social Prescribing Network.[3] We also conducted interviews with

experts from each country to better capture local policy and practice.

SOCIAL PRESCRIBING

As the global population ages and the burden of chronic disease grows, the health and social sectors have considered additional and alternative approaches to improve care delivery and health outcomes. While definitions vary across and within countries, social prescribing involves a deliberate, individualised process connecting individuals to non-clinical services and activities, typically provided by the voluntary and community sectors. Social prescribing aims to improve individual health and well-being, support community capacity and self-determination, reduce health inequalities, optimise health service use and decrease health service costs.[4 5] The practice links to multiple trends in global healthcare (box 1).

Social prescribing as it is now understood was developed in the UK, with schemes dating back for decades. General practitioners at the Bromley by Bow Health Partnership launched a social prescribing scheme to refer patients to in-house expert non-clinical services.[6] Similar models of service provision also existed in other countries, but many were not united under the term social prescribing. By 2016, the number of UK pilot schemes was growing, prompting the creation of a new international Social Prescribing Network[3] and associated conference.[7] At the conference, a definition of social prescribing emerged: the process of 'enabling healthcare professionals to refer patients to a link worker, to co-design a nonclinical social prescription to improve their health and well-being'.[7]

In 2018, England implemented a national strategy to reimburse one social prescribing 'link worker' for every primary care network in the country, extending access to more than 2.5 million individuals over 5 years. Since then, advocates in the UK have worked to disseminate their efforts through a 'social prescribing day', and more broadly through a global network as part of the National Academy of Social Prescribing, created by the National Health Service (NHS) England and the Global Social Prescribing Alliance, in partnership with the United Nations.

As of 2021, social prescribing is gaining traction internationally with initiatives in at least 17 countries. Specific components and implementation approaches vary across settings, depending on country and community contexts. In this paper, we use the 'Beyond the Building Blocks' framework[8] (figure 2), which extends the WHO's six building blocks for health systems, to frame and describe the key characteristics of social prescribing in these varying contexts.

SERVICE DELIVERY

Social prescribing activities can vary in frequency, duration and degree of personalisation. Typically, a clinical or non-clinical professional will refer people with unmet social needs to a social prescribing worker, to identify meaningful goals, co-create social prescriptions to relevant services, provide motivational support and even co-attend activities. 'Signposting', the provision of general resource lists or referral without ongoing follow-up, is often noted as distinct from social prescribing because it lacks the core components of person-centredness, integration and trackability.[9] Some countries, however, use the two terms interchangeably.

In terms of delivery, some healthcare-based social prescribing programmes opt for a broad approach and make it available to all patients, as piloted in Portugal[10] and Spain.[11] Others target specific populations using referral criteria based on medical conditions (eg, diabetes, depression, anxiety, dementia),[12–14] sociodemographic characteristics (eg, older adults, children and adolescents, living in areas of high socioeconomic deprivation)[14 15] or prior healthcare utilisation (eg, frequent primary care or emergency department visits).[16]

Referrals from healthcare to social prescribing are, most commonly, from primary care (Germany, Netherlands, England, Canada),[5 17–19] but also come from outpatient services such as oncology and gynaecology (USA),[20] community-based nursing (Japan),[21] mental health teams (USA, UK),[22] rehabilitation and intermediate care (Singapore),[23] and acute care or emergency departments (USA, Australia).[24]

In some countries, identification is through standardised screening instruments for social risks such as food insecurity or social isolation (Australia, USA, Canada).[20] There are also options for self-referral, or referrals from non-healthcare professionals or community members such as hairdressers, taxi drivers or supermarket staff (Canada, England), but these approaches are less common.[25]

SOCIAL DETERMINANTS AND HOUSEHOLD PRODUCTION OF HEALTH

Underpinning social prescribing is health promotion, defined by the WHO as 'the process of enabling people to increase control over, and to improve their health'.[26] This transition from 'what is the matter *with* you' to 'what matters *to* you' entails a shift in understanding, from being a resource supplied by providers to being, at least in part, a product of individual and community self-determination. Social prescribing includes components linked to self-determination, including autonomy (the need to feel control over one's life and decisions); relatedness (the need to have close, affectionate relationships and to feel a sense of belonging); competence (the ability to influence outcomes, be capable and effective); and beneficence (the ability to give and to have a positive impact on others).[27]

Whatever the context, prescribed social interventions are inherently shaped by the target population and the local landscape of services or activities available. These can range from services that address basic material and legal needs (eg, food, housing, transportation), lifestyle

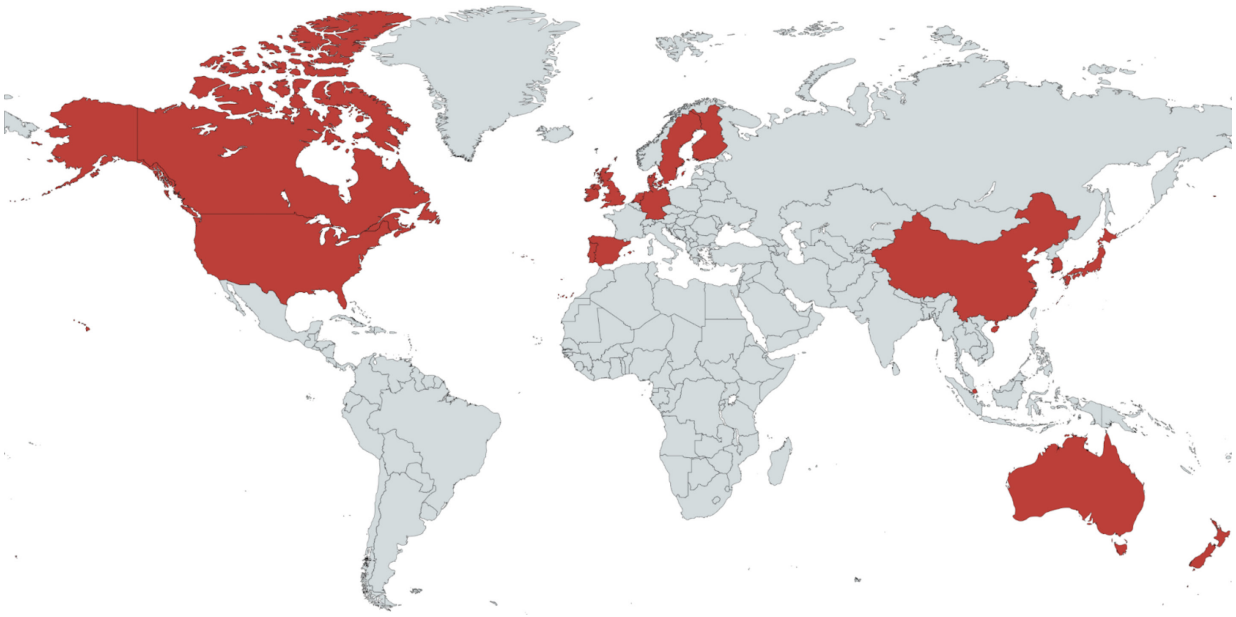

Figure 1 Examples of 17 countries which have developed and/or implemented social prescribing programmes: China, South Korea, Germany, Denmark, Australia, Finland, Sweden, Spain, Singapore, Ireland, the Netherlands, Portugal, Canada, New Zealand, UK, USA and Japan.

interventions to improve health behaviours (eg, exercise, diet, smoking), programmes to develop professional skills (eg, education, job training) or social activities (eg, volunteering, arts and crafts, nature activities, community engagement) (table 1).[28 29] In the USA, social prescriptions have largely focused on connecting patients to resources for basic needs, given significant socioeconomic inequalities and a weaker public social safety net.[30] In Sweden,[31] the Netherlands[18] and countries that position social prescribing as part of larger Healthy Aging national strategies, such as Singapore and China, social prescriptions have often focused on social isolation and overall well-being.[23 32]

The WHO estimates 70%–90% of healthcare takes place in the home.[8] Thus, social prescribing efforts have increasingly focused on the household production of health—the role of broader family or household members in shaping an individual's health behaviours and disease management. Social prescribing contributes through a range of mechanisms such as reducing the burden on carers; developing daily routines of eating and socialising; and impacting the health of household and neighbourhood environments.

WORKFORCE

Implementing social prescribing requires a workforce to assess individual needs and facilitate linkages to non-clinical supports. Across countries, titles for new social prescribing roles have been tailored to resonate with the local culture and population: 'link worker team' in China,[32] 'well-being coordinator' in Singapore,[23] 'community connector' in Wales[33] and 'well-being coach' in the Netherlands.[18] While customising workforce titles may facilitate stakeholder buy-in for local adoption, lack of standardisation can make international and national comparisons of social prescribing workforce difficult.[34]

Some countries have repurposed existing healthcare staff to administer social prescriptions. The first social prescribing projects in Portugal,[10] Germany,[19] Japan[21] and Canada[35] added these responsibilities to the roles of social workers, allied health professionals, nurses and volunteers. In Spain, social prescriptions are provided directly by primary care physicians, whose ongoing relationships with patients enable them to co-produce appropriately tailored prescriptions.[11] Health systems in the USA often use existing clinical and non-clinical staff, while also developing and training new roles specifically for social prescribing.[20]

There is the potential to employ social prescribing roles outside healthcare, for example, in community and social services as in Wales and the Netherlands.[18 33] Programme evaluation metrics will likely be influenced by those common in the sector in which the worker is employed.[36]

While there is currently no professional registration for social prescribing workers, England, Wales and the Netherlands have made progress in developing competency frameworks and training curricula. Competencies include partnership working, confidentiality, impact measurement, active listening, motivating and solution-based skills, and understanding the wider determinants of health and well-being.[33 36] English link workers created a professional membership body, the National Association of Link Workers, to promote professional development and create opportunities to share learning.[37] Dutch well-being coaches are social workers additionally trained in Welzijn op Recept through a collaboration of the

BOX 1 TRENDS IN GLOBAL HEALTHCARE THAT HAVE INFORMED SOCIAL PRESCRIBING

- ⇒ Person-centred care: eliciting individuals' values and preferences to guide all aspects of their care and to support their realistic health and life goals.[70]
- ⇒ Integrated care: promoting comprehensive delivery of person-centred services across the life-course, designed to meet the multidimensional needs of individuals and delivered by a coordinated multidisciplinary team of staff working across settings and levels of care.[71]
- ⇒ Co-design: involving service users in the service design process and working with them to understand their met and unmet needs.[72]
- ⇒ Co-production: working with individuals who use health and care services, carers and communities in equal partnership, and working with groups of people at the earliest stages of service design, development and evaluation.[73]
- ⇒ Self-determination theory: recognising that individuals who experience self-determination (ie, the ability to make choices and exert control over one's life) are more motivated to take action and experience greater psychological health and well-being.[27]
- ⇒ Care coordination: deliberately organising health and social care activities, and sharing information among all participants involved with an individual's care to achieve safer and more effective care.[74]
- ⇒ Health promotion: enabling people to increase control over and to improve their health, and moving beyond a focus on individual behaviour towards a wide range of social and environmental interventions.[75]
- ⇒ Strengths-based approach: collaborating between the person supported by services and those supporting them and allowing them to work together to determine an outcome that draws on the person's strengths and assets.[76]
- ⇒ Asset-based community development: recognising that people in communities can organise to drive the development process themselves by identifying and mobilising existing (but often unrecognised) assets.[77]
- ⇒ Quadruple aim: enhancing patient experience, improving population health, reducing costs and improving the work life of healthcare clinicians and staff.[78]

social workers union and the National Welzijn op Recept network in the Netherlands.[38]

More broadly, all aligned roles should be offered training and support. Raising awareness of social prescribing roles is important to increase system buy-in and understanding of what constitutes a 'good' referral. In the UK (and more recently in other countries like Australia, Portugal and the USA), social prescribing 'champion' programmes that engage with trainees and students have aimed to improve staff buy-in.[39] Relatedly, supervision of social prescribing staff is important, given they are often working with vulnerable individuals experiencing difficult life circumstances.

LEADERSHIP AND GOVERNANCE

In the UK, grassroots organising and early pilots influenced robust national-level implementation.[7] Our practitioner experts reported in our interviews that leaders in the UK and elsewhere sought governmental support, aligning with existing structures (eg, Wellness Centres in the Netherlands) and priorities (eg, the Healthy China Action Plan, Singapore National Action Plan for Successful Ageing and English policies related to loneliness).[40–42] In Australia, leadership has been provided by both local community health centre pilots (ICP Health) and a comprehensive national policy collaboration between healthcare users and providers—the Consumers Health Forum and the Royal Australian College of General Practitioners.[43] In Canada, tracking health improvements and service cost reduction was essential to convince stakeholders to invest in social prescribing.[35] The triad of locally tested implementation pilots, supportive stakeholders and robust government support is emerging as an important combination for social prescribing's success at the national scale.

International implementers and practitioners in turn have begun to share promising practices through the English-based Social Prescribing Network[3] and its global spinoff, the International Social Prescribing Network. Policy actors involved with global governance have also begun to amplify impact through the WHO and United Nations-linked Global Social Prescribing Alliance.

FINANCING, COMMUNITY ORGANISATIONS AND SOCIETAL PARTNERSHIPS

Financing approaches for social prescribing approaches vary across countries.[44] Existing studies and our interview data showed that implementation of social prescribing may not require new funds if health systems are able to repurpose existing staff and infrastructure (Portugal, Canada, Netherlands, Spain, Japan).[10 18 21] However, many programmes do require additional funding, for salaries, management and infrastructure.[45] This can be developed from existing routes such as research funding (Korea),[14] or more flexible health funding mechanisms (value-based payments in the USA).[46] In England and Australia, funds have been granted through explicit additional mechanisms (NHS England reimbursement in primary care networks and Australia's Primary Health Networks).[47 48]

The coordination of health systems, governments and community-based organisations delivering activities is centrally important.[34] Otherwise, there is a risk of underfunding and overprescribing community services. The Danish government, for instance, financially supported 'Exercise by Prescription' as a nationwide concept. However, there was no link worker to follow up with patients, and the exercise programmes offered by the physiotherapists were too generic and did not take into account the needs of different individuals.[49] In a pilot in Lisbon, Portugal, this coordination risk was mitigated through regularly integrating stakeholder input.[10] North Carolina, USA will extend this collaborative approach by directly reimbursing community-based organisations that receive referrals from the health sector.[50] In Wales, funding decisions have been devolved to regional

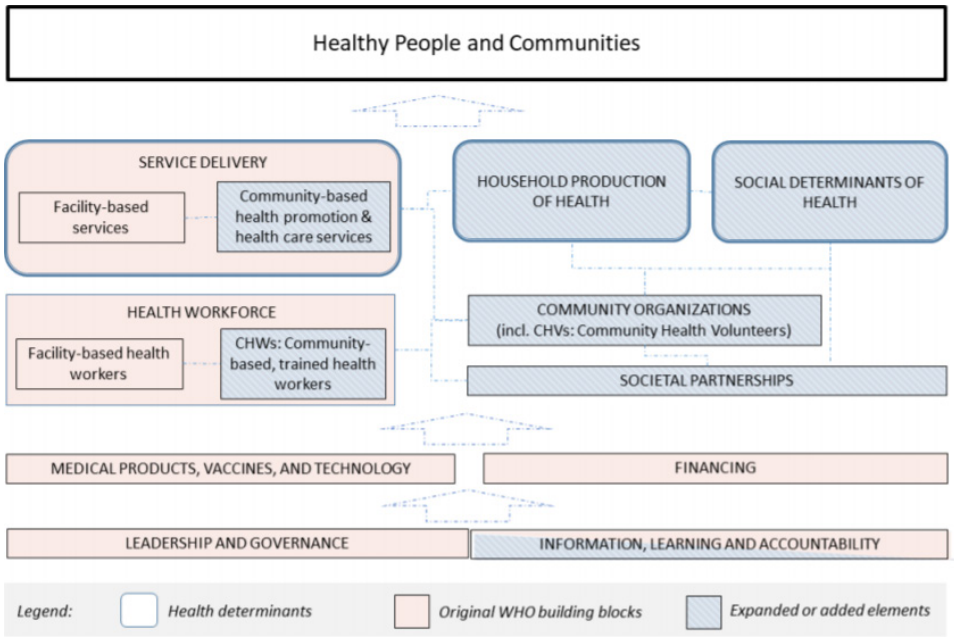

Figure 2 'Beyond the Building Blocks' expanded framework from Sacks *et al*[8]. CHV, community health volunteer; CHW, community health worker.

partnership boards that include representatives from the health, social, voluntary and housing sectors.[51]

HEALTH TECHNOLOGY

Technology has been used at all stages of the social prescribing referral pathway. First, electronic medical records can be helpful in the identification of potential referrals, through patterns of healthcare use, other screening tools, or employing algorithms and artificial intelligence to predict social needs.[52] Second, technology can support asset mapping. Digital maps and databases of referrable community resources (Spain, Australia, USA, Canada, Wales) can aid understanding of what resources currently exist in local communities.[53] Mobile apps for sharing referrals and care plans (Singapore) help bridge technological divides across sectors and providers. Integrated platforms for cross-sector communication and referral (UK, USA, Canada) facilitate resource curation and referrals.[54] Third, process tracking technologies can support evaluation and quality improvement. Process measures can assess if a referral takes place (enrolment), if it is taken up (engagement) and if an activity is completed (adherence).[55] Outcome measures, while diverse and include individual, community and system impacts, can often be captured through health technologies.

As with any technological solution, there are challenges across all contexts. Available community services change over time, staff may require training on platforms used and working across organisations presents further challenges. There have been efforts to standardise data coding (UK, USA), and to compile data across services.[56] Standardised data, such as England's Social Prescribing Observatory, enable comparisons across programmes and demonstrate the diverse needs of communities as well as areas for further SDH interventions. The development of agreed standardised indicators for social prescribing would facilitate global knowledge exchange and mobilisation.

Table 1 Examples of social prescriptions across dimensions of health

Material needs	Health behaviours	Social–emotional
Food	Diet	Social relationships
Transportation	Exercise	Nature exposure
Financial needs	Smoking	Arts and cultural activities
Legal needs	Substance use	Volunteering
Housing	Chronic disease management	Job training and education
Digital inclusion	Mental health counselling	Community groups

INFORMATION, LEARNING AND ACCOUNTABILITY

Evidence related to social prescribing is still emerging. Studies demonstrate the potential for positive health benefits, including improved self-reported well-being, and reduced loneliness[28 57] or healthcare demand.[58] There is growing evidence for the various activities undertaken (physical activity, healthy eating, volunteering,[59] time in nature,[60] engagement with the arts[61]), with randomised controlled trials and strong quasi-experimental studies completed or underway to understand effectiveness of social prescribing schemes.[30 62–64] Additionally, reviews

have examined implementation of social prescribing in differing contexts.[9 65–67]

The complexity of social prescribing pathways makes evaluation difficult,[68] though technology-facilitated data standardisation and tracking aid this process through a Learning Health Systems approach using iterative feedback.[69] In particular, tying sociodemographic data of social prescribing participants to outcomes data can help elucidate what approaches to social prescribing work for whom and in what circumstances.[9] Interventions will likely need to be tailored for specific subpopulations (eg, older adults, persons with disabilities, immigrant communities, etc). Globally, health systems will require this level of understanding, as more health systems adopt accountable care reforms that tie healthcare payment to demonstrable improvements in population health outcomes and reduced costs.

CONCLUSION

Social prescribing shows promise for delivering healthcare action on SDH, and potentially impacting individual and community health through a person-centred, supported referral pathway. Drawing on examples from 17 countries around the globe, the Beyond the Building Blocks framework demonstrates some of the key characteristics and contributions of social prescribing to diverse health systems. In summary:

- Service delivery and household/social determinants of health: social prescribing moves care upstream to address SDH through self-determination and supported referral to community, voluntary and social services. Countries need to prioritise which populations to focus efforts towards (eg, older adults, persons with long-term medical conditions, etc) and from which settings they should engage staff to initiate referrals (eg, primary care, community-based organisations, etc).
- Health workforce: social prescribing requires a new or existing workforce of paid staff or volunteers to support individuals and communities through co-designed referrals. Training curricula and competency frameworks are needed to ensure that social prescribing providers have the knowledge and skills to be responsive to the complex needs of a diverse range of individuals.
- Financing, community organisations and societal partnerships: the health sector currently leads financing approaches, with social care financing models slower to emerge. Countries must explore which financing mechanisms can best support their programmes and align with existing initiatives, depending on their stage of adoption and need for flexibility (eg, leveraging existing staff and resources, applying for research funds or advocating for new government investments). Special attention must also be given to support the voluntary sector organisations that receive referrals, and not just the social prescribing programme itself.
- Leadership and governance: leaders working to start social prescribing programmes in their country have gained initial traction through grassroots implementation and pilots, policy-first approaches or a combination of both. Countries considering adopting social prescribing approaches should consider joining one of the cross-national leadership networks devoted to developing the field (eg, Global Social Prescribing Alliance, International Social Prescribing Network).
- Health technology: technology can support social prescribing across the referral pathway, from identifying individuals who might benefit from social prescribing, to aggregating available referrals through centralised resource directories, to tracking process and outcome measures. Countries should consider how standardised data coding and shared technology platforms can optimise service delivery and facilitate cross-sector collaboration.
- Information, learning and accountability: there is a need for a nuanced evidence base to assess implementation, effectiveness, cost-effectiveness and impact on health inequalities across diverse populations and geographies. Each country must decide which measures of success are most important to them, how they define return on investment and how to engage researchers in supporting evaluation to inform future efforts.

Overall, our practice experience in 17 countries shows that social prescribing has the potential to contribute to global goals for health and well-being, including United Nations targets (Sustainable Development Goal 3: Good Health and Well-Being), through reductions in health services use, empowerment, stronger intersectoral partnerships and improved measurability of SDH interventions. Global, collaborative efforts are needed to support robust evaluations in order to grow the evidence base and understand what works, in which contexts and for whom. As the world grapples with the inequitable fallout from the COVID-19 pandemic, the imperative for healthcare and social sector action on SDH is clear.

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