NUS National University of Singapore
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POLICY BRIEF

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Social Prescribing

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Key Messages

- **Social prescribing is a means to identify people's non-medical, health-related social needs and address them** through non-clinical and support services in the community.
- **Social prescribing has grown in policy and practice globally** to address the determinants of health and wellbeing.
- Evidence shows that **social prescribing can contribute to better health and wellbeing outcomes for targeted individuals** but has less of an influence in supporting improvements in social isolation and loneliness.
- **Evidence does not currently support the effectiveness of social prescribing on system-level outcomes** such as reducing hospitalisations and health resource utilisation.
- **There is no 'one model' for social prescribing.** Robust evaluations are required to grow the evidence base for what works, in what contexts, and for which people.
- The implementation and roll-out of **social prescribing needs to be supported and informed by high-quality research programmes** if its potential is to be fully realised.
- **International collaboration** is needed to promote knowledge and best practice.

Executive Summary

What is social prescribing?

Social prescribing is a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community.

Why is social prescribing important?

Social prescribing is part of a long-term global movement towards more people-centred and integrated health systems through the promotion of multi-disciplinary primary and community care teams. It promotes a socio-environmental perspective on improving people's health that emphasises the importance of connected communities, health promotion and the mobilisation of community assets.

Social prescribing can take many different forms and has the potential to address multiple aims, such as improving individual health and well-being to meet people's material needs; supporting community capacity and self-determination by increasing access to health and social care services; and improving health care system sustainability and performance.

International approaches to social prescribing

Social prescribing has its origins in a charitable programme developed in Tower Hamlets in North-East London, in the late 1990s. Social prescribing has since grown as a global movement in policy and practice, for the most part developed in high-income countries, yet there has also been recent growth in Central and Eastern Europe, and parts of Asia such as China, Iran, India and Malaysia.

The adoption of social prescribing internationally has been an iterative and context-specific process. Most countries do not have a national system for social prescribing but include many regional approaches or pilot programmes. The range of client groups supported is diverse ranging from older people to people living with moderate to severe mental health needs, and from children and mothers to people living with disabilities and many other groups where social supports and connection to community have been identified as beneficial.

For example, Singapore has been implementing social prescribing since a 2019 pilot in SingHealth Community

Social prescribing is part of a long-term global movement towards a more integrated health and care system

Hospitals (SCH). The approach involves screening older patients for 'socially determined' health issues (i.e. non-clinical issues impacting on their health) through Wellbeing Coordinators that connect patients with relevant community resources after hospital discharge. Social prescribing delivered in primary and community care settings has since been established in each of its three regional health clusters and become a key policy tenet of HealthierSG, a national initiative by the Ministry of Health established in 2023 to enhance primary care and preventive healthcare.

Impact of social prescribing

The global research evidence for social prescribing is limited but shows that it can contribute to better health and wellbeing outcomes for targeted individuals. Yet, evidence does not support the effectiveness of social prescribing on system–level outcomes such as reducing hospitalisations and health resource utilisation. Robust evaluations are required to grow the evidence base for what works, in what contexts, and for which people. The implementation and roll-out of social prescribing needs to be supported and informed by high-quality concomitant research programmes if its potential is to be fully realised.

Implementing social prescribing

The implementation of social prescribing requires an adaptive process to be taken by local stakeholders in their own context. Key implementation success factors include the building of trusted relationships, developing the skills of the link worker, and the curation of a team-based working environment that supports the development of new networks and alliances. This requires dedicated education and training, sustainable funding and professional support structures. Ongoing investment in asset mapping, community engagement and service integration are needed to better understand and support people's needs through social prescribing.

Policy considerations

There is considerable variation in how social prescribing has been adopted in policy and practice. Guidance on best practice is emergent, meaning that there are many considerations that decision-makers will need to address in taking social prescribing policies forward. Key questions for debate include:

- What should be the priority aims and objectives of social prescribing at policy-level and how might effective progress and performance be judged?
- How can social prescribing schemes be best incentivised?
- Should social prescribing be focused on a defined patient cohort, or be more broadly applied across community settings?
- Is there a preferred national model for the adoption of social prescribing, or should innovations and variations be enabled to flourish?
- How can the workforce implications, including education and training, be addressed?
- How far should social prescribing take the health technology route?
- What should regulation, governance and accountability for social prescribing look like?

Conclusions

Social prescribing is an important global initiative to address the social determinants of health and shows considerable promise for improving the health and wellbeing of many people through social support programmes in the community. However, more research and international coordination is needed to most appropriately position social prescribing within health systems, to understand its impact, and the requirements for sustainable growth. An ongoing policy dialogue is required to communicate and discuss the issues essential to the future of social prescribing and so share knowledge, build consensus, and inform decision-making.

What is social prescribing and why is it important?

As the global population ages and the burden of chronic disease grows, the health and social sectors have considered alternative approaches to improve care delivery and outcomes for people with complex needs. Specifically, there has been increasing recognition of the necessity to integrate public health and primary and community care services to maximise health outcomes, tackle inequalities, address the social determinants of ill-health, and reduce system inefficiencies[1]. With more than 80 per cent of health outcomes related to the social determinants of health, there has also been a growing call for innovations that enable public health strategies to be seamlessly integrated within health systems[2 3].

Social prescribing is one such initiative. It has its origins in a charitable programme developed in Bromley-by-Bow, a deprived suburb of Tower Hamlets in North-East London, in the late 1990s. Faced with the growing unmet needs of people in its community, a ground-up movement was created that developed a range of community services for childcare, welfare advice, adult learning, and other resources. The charity built its own general practice, through which the social prescribing model emerged as the new model of primary care focused on the social determinants of their patient's health[4].

Social prescribing is a means for trusted individuals in clinical and community settings to identify that a person has non-medical, health-related social needs and to subsequently connect them to non-clinical supports and services within the community[5]. This is done by co-producing a social prescription – a non-medical prescription – that aims to improve a person's health and wellbeing. The social prescribing process aims to strengthen community connections and connect a person with community-based services that address their social, emotional and material needs including those related to loneliness and mental health[6].

Social prescribing is an emerging discipline that can take many different forms with potentially different aims and objectives. Indeed, social prescribing has the potential to address multiple aims, such as improving individual health outcomes and enhancing people's social and emotional wellness; investing in community capacity building to increase access and equity to services; and improving the effectiveness and sustainability of the health care system[6-7]. Table 1 represents a summary of these aims.

Social prescribing, then, represents part of a long-term global movement towards more people-centred and integrated health systems through the promotion of multi-disciplinary primary and community care teams that enable individually tailored and co-designed approaches to improve people's health and wellbeing[6]. It also fits within strategies to promote population health management that take a socio-environmental perspective on improving people's health and which emphasise the importance of connected communities, health promotion and the mobilisation of community assets[8 9]. At a systems-level, social prescribing seeks to promote value-based healthcare through the ability to improve people's care experiences and outcomes cost-effectively and equitably[10].

Table 1: The Multiple Aims of Social Prescribing

Level	Aim	Methods
Individual	Improve health and lifestyle outcomes	Improve diet Increase exercise Reduce smoking and substance use Enrolment in disease-management programs Increase in self-management of health Greater access to mental health and counselling
	Enhance social and emotional wellness	Reduce social isolation / increase social relationships Activate people to engage with their community, such as through volunteering, education and return to the workforce Enable safe living environments, including tackling elder abuse Engage in transformational activities such as music, connection to nature, art and spirituality Support cultural identity and connection for diverse communities
	Meet material needs	Food security Housing Community transport Financial and legal support Information and advice, with digital inclusion Access to care support and equipment for assisted daily living
Community	Increase access and equity in health and social services	Improve awareness of existing services and resources in the community Increase digital literacy to reduce barriers to services Access to social, legal and financial supports
	Build community capacity and resilience	Strengthen local networks of community organisations Expand referral pathways beyond medical practitioners and healthcare Support place-based approaches to health and wellbeing Enable community activation, participation and cohesion
System	Improve health care system sustainability and performance	Reduce medication use Delay transitions into residential care Prevent unnecessary hospitalisations Improve hospital discharge processes and reduce hospital lengths of stay Tackle inequalities in care Reduce costs of care

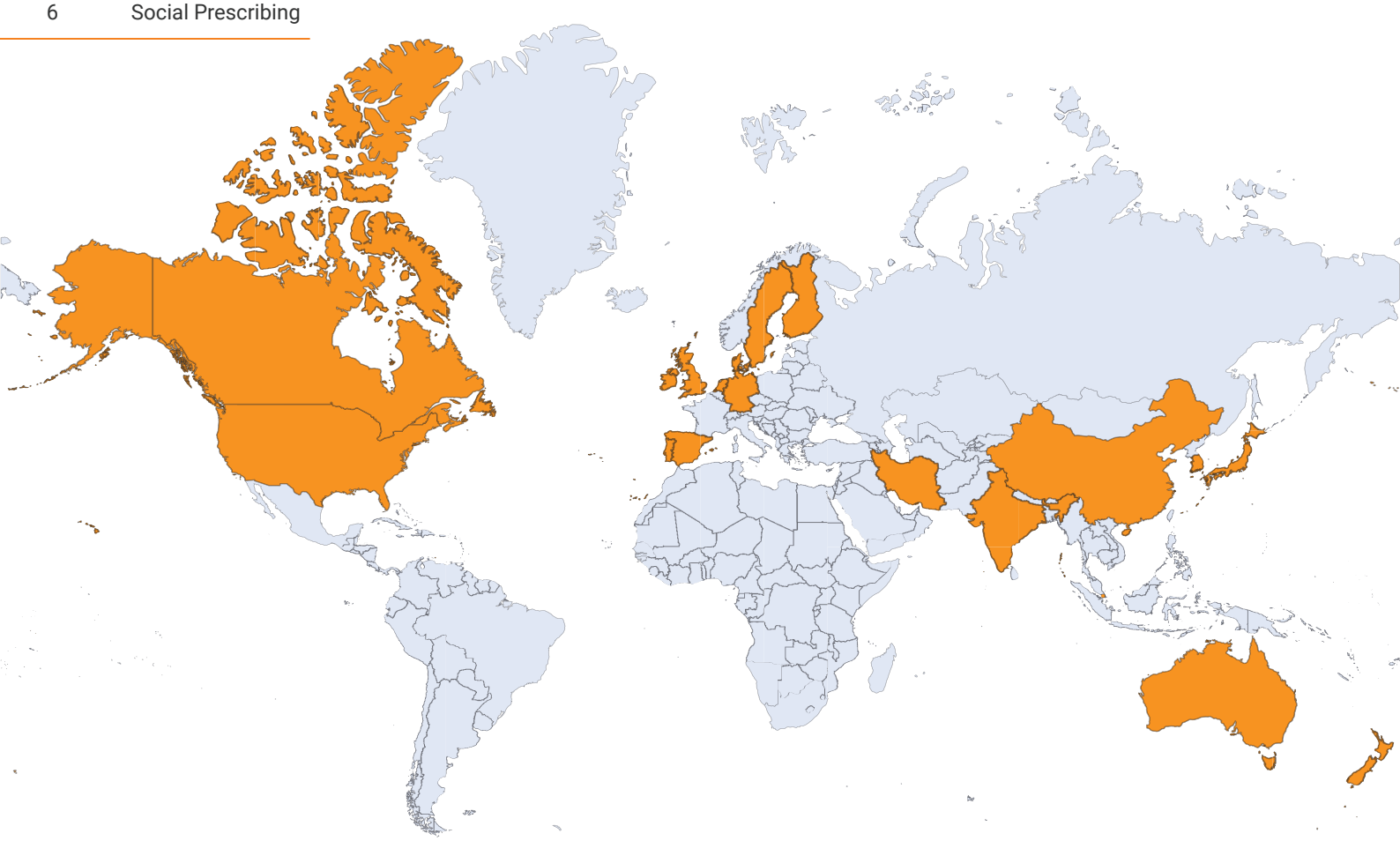


Figure 1: Countries with advanced social prescribing programmes (Morse et al, 2023)

International approaches to social prescribing

Social prescribing has grown as a global movement in policy and practice. Approaches within and between countries are, however, highly heterogenous due to a range of cultural, systemic and political contexts[6]. Countries with mature social prescribing programs have for the most part developed in high-income countries where their health systems provide Universal Health Coverage (Figure 1), yet there has also been recent growth in Central and Eastern Europe, and parts of Asia such as China, Iran, India and Malaysia[11 12].

The international experience demonstrates a focus on a wide range of clients, such as older people living with complex comorbidities, people living with moderate to severe mental health needs, children and mothers, people living with disabilities and many other groups where social supports and connection to community have been identified as beneficial[13].

Moreover, significant variation internationally exists in how the policy of social prescribing has been taken

forward. For example, England uses a social prescribing link worker model based in primary care clinics. They take social referrals from general practitioners, and their role is to connect patients for social support across the range of local community supports available[12 14]. Wales, however, has moved away from the GP-led model to develop a national community-based prevention pathway. Referrals come from third sector and community services and are typically targeted at older people with specific health conditions and frailty[15].

The international experience supports the need for adapting social prescribing in local contexts

In Portugal and Spain, after a referral from a primary care practitioner, motivational interviewing is undertaken by 'facilitators' (most often social workers) to support patients to self-care as well as determine an appropriate referral to community resources[12 16]. Canada has a diverse approach to social prescribing across its 13 provinces and territories, but many of the models focus on building resilience amongst older people to supporting them to live independently at home[12 17]. Australia supports social prescribing through its Primary Health Networks (PHNs). The link worker model has become nearly universal, with social prescribing expanding from general practice into non-traditional pathways such as pharmacies, social services, schools, and community centres often supported through community-based alliances and NGOs[12 18].

Singapore has been implementing social prescribing since a 2019 pilot in SingHealth Community Hospitals (SCH) introduced a programme to support older patients with complex needs in transitioning back to the community after hospitalization[19]. The approach involved screening patients with 'socially determined' health issues through Wellbeing Coordinators to determine their needs and interest, the co-development of personalised care plans, and then the connection of patients with relevant community resources after hospital discharge. Social prescribing has since been established in each of its three regional health clusters and become a key policy tenet of HealthierSG, a national initiative by the Ministry of Health established in 2023 to focus on primary care and preventive healthcare.

Most countries do not have a national system for social prescribing. Indeed, the international experience supports the need for adapting social prescribing in local contexts[20]. Nonetheless, some have sought to standardise the model to support implementation, quality assurance, and competency training for staff roles (especially link workers). For example, the Canadian Institute for Social Prescribing acts as a multi-sectoral national hub to support the roll-out of social prescribing, including the creation of a national framework[21]. The Australian Social Prescribing Institute of Research (ASPIRE) and Singapore Community of Practice in Social Prescribing (SCOMP) provide similar support in national coordination, developing and sharing knowledge, enabling workforce development, and providing technical support and policy implementation guidance[22 23].

Social prescribing is part of a long-term global movement

Impact of social prescribing

Given the heterogenous nature of social prescribing, it is not surprising that impact has been measured using multiple instruments to examine varied program outcomes (Figure 2)[24]. The pooling of evidence from different programmes is therefore challenging due to differing research methods, evaluation tools, varying approaches to social prescribing delivery, and differences in the primary goals of the approach. Within these limitations, several evidence reviews have assessed the value of social prescribing, each supporting its potential to achieve intended benefits. For example:

- A review of the impact on service users from social prescribing referrals based in primary care through health care navigators uncovered 16 studies[25]. 6/16 studies reported improvements on a range of individual outcomes such as health and wellbeing, health-related behaviours, social contacts and day-to-day functioning.
- An evidence review of the effectiveness of social prescribing delivered in primary health care[26] included 13 studies from which: 8/10 studies that assessed physical or psychological wellbeing showed a positive impact; 2/2 studies examining mental health and depression found improvements in quality of life and measures of self-efficacy; but just 1/6 studies demonstrated positive change in service patterns by reducing primary care usage through social connectedness.
- A review of social prescribing based in general practices in the UK included 8 studies[27]. It found a broad range of social prescribing approaches. Each demonstrated improvements in one or more of: self-reported wellbeing, health status, quality of life, levels of physical activity, ability to self-care, and social connectedness. There was, however, a high risk of bias for all studies.
- A review on how social prescribing affected individual wellbeing, connectedness, loneliness and social isolation identified some 51 studies[28]. Statistically significant and positive change was seen in 28/42 wellbeing studies but just 3/20 social isolation studies, 5/14 loneliness studies and 3/14 social connectedness studies.

Overall, and despite significant variations in the intensity and frequency through which it has been delivered, the evidence suggests that positive changes to the health and lifestyles of individuals receiving social prescribing can often be made. Yet, evaluation methodologies have been heterogenous, employing a wide range of measures that lacked comparator groups, making it difficult to determine causal inference and which imply a high risk of bias.

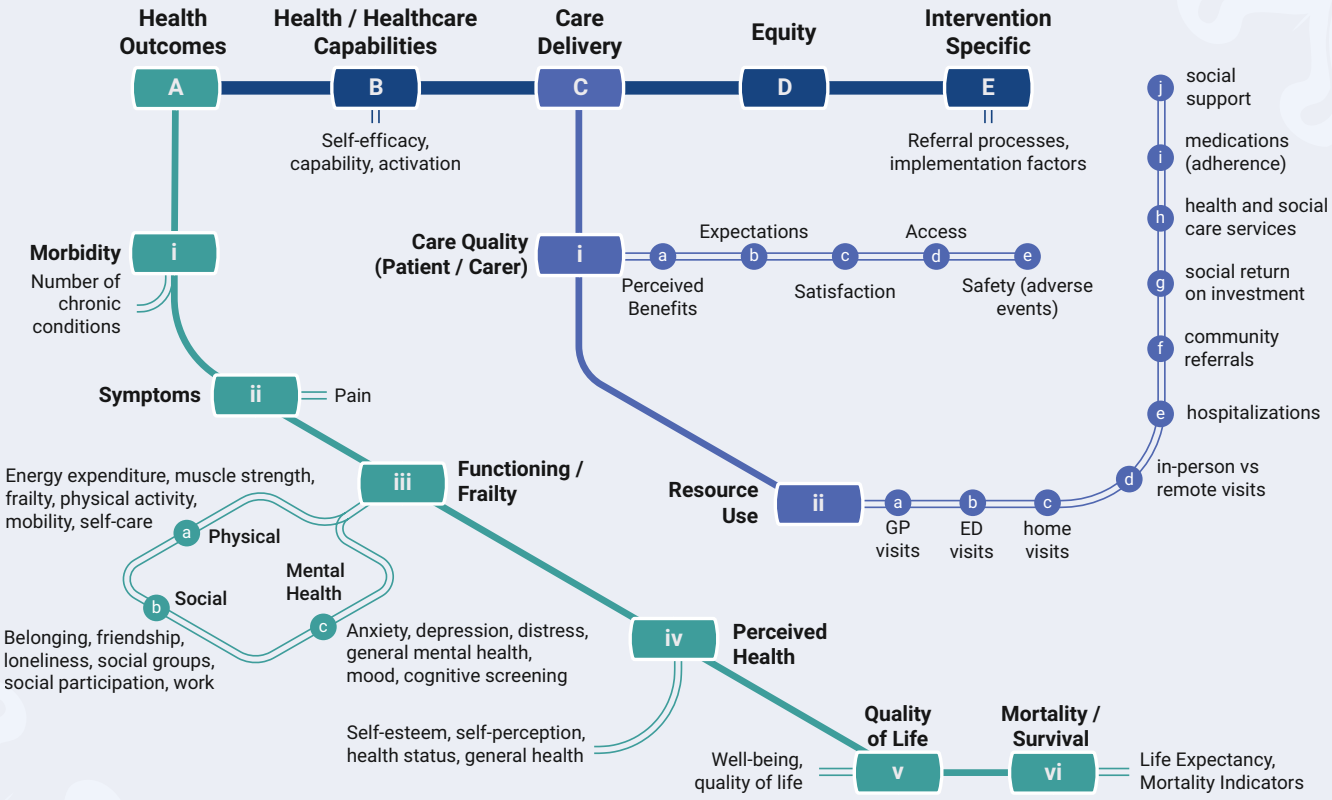
In terms of cost-effectiveness, the evidence-base is less well developed and mostly restricted to studies based in the UK. Recent reviews of social prescribing programmes have found no clear evidence for its effectiveness in reducing healthcare usage[29] with some suggesting that social prescribing needs to be targeted at 'responsive' populations to go beyond the marginal gains observed[30]. Case study evidence has shown that social prescribing can have a positive impact in certain cases. For example, a review of nine social prescribing initiatives across England demonstrated reductions in unnecessary hospital admissions and ED visits by between 23-66% as well as GP appointments between 42-50%[31]. Yet other case study evidence from Wales and Ireland has not concluded cost effectiveness advantages[32 33].

The broader impact of social prescribing at a community level has been less frequently measured. Evidence from Australia suggests that participation in structured social prescribing programs may enhance civic health by fostering social trust, increasing volunteering, and strengthening neighbourhood networks[34]. These community-level benefits have also had a protective effect against loneliness and social isolation.

Overall, the global evidence for social prescribing shows that it has the potential to contribute to better health and wellbeing outcomes for targeted individuals, specifically on promoting self-reliance and on improving self-reported health and wellbeing, but perhaps less so for addressing social isolation and loneliness. There is much less evidence for effectiveness on system–level outcomes, such as improving equitable access or reducing hospitalisations and resource use.

Given the prevailing assumption about social prescribing as a route to cost-efficient healthcare, the evidence contains fundamental knowledge gaps. More robust evaluations are required to better understand what works, in what contexts, and for what people. It is therefore important that interest, investment and innovation are supported and informed by high-quality concomitant research programmes if the potential for social prescribing is to be fully realised[35].

Figure 2: Overview of social prescribing outcomes from primary studies adapted from 24



Implementing social prescribing

By its very nature, social prescribing requires collaboration across many sectors and disciplines which has led to different terminology and variations in interpretation between partners on its role and purpose. Despite such variation, there is emerging consensus on the core functions of a social prescribing model, as outlined in the WHO Regional Office for the Western Pacific Toolkit on How to Implement Social Prescribing[36]. The Toolkit was designed to help policymakers adopt social prescribing at the community level by outlining key steps for scaling-up practices, offering guidance on stakeholder engagement, workforce development and evaluation strategies.

Social prescribing requires collaboration across many sectors and disciplines

A key to the Toolkit is that it enables an adaptive process to be taken by local stakeholders for the effective development of their social prescribing model in their own context. This enables engagement of key stakeholders and ensures a 'fit for purpose' approach within the local context of adoption. Such guidance reflects existing evidence that broadly recommends adherence to an implementation 'process' rather than any set model of care[23 37 38 39 40]. This points to the need for social prescribing to pay attention to a range of key implementation success factors including the building of trusted relationships, developing the skills of the link worker, and the curation of a team-based working environment that supports the development of new networks and alliances.

To enable this, social prescribing should be integrated into the training of all health and social care professionals. In addition, a dedicated non-clinical workforce in social prescribing is likely essential. A well-supported and trained non-clinical social prescribing workforce, working in close partnership with healthcare professionals, should enhance the impact of professional practice and strengthen the integration of medical and social care to improve population health management in local communities.

Policy considerations

The implementation of social prescribing is gathering pace globally. Policy makers are looking to solutions like social prescribing that can take pro-active steps to maximise health outcomes, tackle inequalities, address the social determinants of ill-health, and reduce system inefficiencies.

There is considerable variation in how social prescribing has been adopted in policy and practice. The design, structure and implementation of social prescribing is being driven by different policy priorities and influenced by the specific regional and national contexts in which they are being adopted. The evidence presented in this brief suggests that guidance on best practice is emergent, meaning that there are many considerations that policy makers will need to address. For example:

- Given the range of potential benefits from social prescribing, what should the priority aims and objectives be at a policy-level to evaluate progress and performance?
    - Should there be a strategy for policy evaluation of social prescribing that encompasses, for example, initial discovery, pilot studies, randomized controlled trials (RCTs), mixed-methods case studies, systematic reviews, and widespread implementation trials?
    - What appetite is there to allow such time for social prescribing to mature and embed before evidence of effectiveness is demanded?
- How can social prescribing schemes be best incentivised?
    - How might the system encourage multi-stakeholder participation and investment in primary and community care settings to build the capabilities necessary to support people's access to the non-clinical care and the support they need?
    - What resources are required to build these community assets and develop a strategy for sustainable growth and implementation?
- Should social prescribing be focused on a defined cohort, or be more broadly applied?
    - If the model of care specifically targets at-risk individuals who would benefit from a social referral, how can those criteria be applied to ensure health equity?
    - Must the approach focus on specific neighbourhoods of the highest social need, or should it focus on communities where there is a more mature set of available services and supports that can better respond to people's needs?
    - How should social prescribing be adapted to ensure they are culturally specific and relevant to different population groups?
- Is there a preferred national model for the adoption of social prescribing?
    - To what extent is there appetite at a policy level to innovate from 'the ground up' and explore what works best and in what circumstances?
    - Should approaches to social prescribing be more tightly defined and granular, perhaps utilizing a national framework with clear quality criteria?
- How can the workforce implications, including education and training, be addressed to support social prescribing?
    - What support programmes need to be adopted to advance the essential role and skills of link workers so they become embedded within existing systems?
    - What mitigations are needed to avoid the potential risks in professionalising such roles, such as reinforcing a biomedical model of

health that may diminish the recognition and integration of social determinants of health and community-based, be mitigated?

- How and how much should social prescribing integrate health technology?
  - In the adoption of new technologies and AI-based solutions, how might programmes ensure the digital inclusion of its clients?
- What should regulation, governance and accountability for social prescribing look like?
  - Can co-productive relationships across multiple health and social care providers be encouraged in existing system architecture?
  - Should joint outcomes be mandated between the health and social care sectors, or can desired results be attained by less formal collaborative practices?

All health and care systems internationally are on a pathway to understand how social prescribing can work to the best advantage of its citizens and the system. Ongoing policy dialogue is needed to reflect and debate these concerns. Bringing together national and international partnerships to grow knowledge understanding will be a key part of the solution. Through this route, many of these questions can be resolved and social prescribing will become more able to address the root causes of health disparities, enhance patient outcomes and build community health.

Conclusions

Social prescribing is an important global initiative to address the social determinants of health. By connecting individuals to community resources and support systems that address their non-medical needs, social prescribing can promote a more holistic approach to health that can have a wide range of benefits to individuals and communities. This will support and complement the health system in driving improvements in the health of the population.

Social prescribing has a growing and mostly positive evidence-base. It shows how social support programmes in the community have the potential to actively improve people's health and wellbeing. However, more research and international coordination is needed to most appropriately position social prescribing within health systems, to understand its impact, and the requirements for sustainable growth. An ongoing policy dialogue is required to communicate and discuss the issues essential to the future of social prescribing and so share knowledge, build consensus, and inform decision-making.

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About CRiHSP

The NUS Centre for Research in Health Systems Performance (CRiHSP) was established in 2023 within the Yong Loo Lin School of Medicine at the National University of Singapore to become a world leading centre of excellence in research, innovation, dissemination and education on the optimisation of health systems performance for population health.

A core activity of CRiHSP is the provision of health policy intelligence through the review and synthesis of evidence for the effective implementation and impact of important policy developments that will influence the future of health systems. Through developing and disseminating knowledge and recommendations to policymakers, service providers, researchers and the wider public, CRiHSP aims to support decision-making that enables improvements in health system performance.

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CRiHSP Policy Briefings

These policy briefings are designed to distil the latest trends and evidence on an important policy issue for health and care systems, bringing timely and relevant recommendations to the attention of policymakers to support informed decision-making both in Singapore and internationally.

In developing this policy brief on Social Prescribing, researchers at the NUS Centre for Research in Heath System Performance (CRiHSP) undertook a rapid review to understand what the national and international experience tells us about the implementation and impact of social prescribing in policy and practice. CRiHSP then hosted a policy dialogue on social prescribing to bring together the evidence with practical experiences and expert opinion to support the development of key considerations for evidence-informed policymaking.

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