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Social Prescribing in the U.S. and England: Emerging Interventions to Address Patients' Social Needs

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INTRODUCTION

There is growing interest in the role of healthcare systems in addressing patients' social needs. This is no surprise; evidence on the impact of social factors on population health is well established. People's education, income, housing, and other social issues have a major impact on their health—a bigger impact, by most estimates, than health care.[1] These social factors, in turn, shape people's health behaviors, such as diet and physical activity, acting as the causes of the causes of disease.[2,3] Yet, despite a substantial body of evidence documenting the impact of the social determinants of health, far less is known about what healthcare systems can best do to address them.

One approach being developed in diverse national contexts is *social prescribing*—a term used in England to describe the process of connecting patients with non-medical services to improve their health and well-being. Though the U.S. and England have very different healthcare systems and levels of social services spending, both countries are increasingly experimenting with social prescribing as a way to address patients' social needs in clinical settings. Approaches vary, but the process usually involves screening for social needs (such as social isolation or access to food), referring to community-based services (such as welfare advice or housing support), and supporting people to access relevant services (often using a care coordinator or link worker). A variety of policy initiatives in both countries, such as accountable care organizations and other value-based payment models, have created new opportunities for these kinds of approaches to be developed within the healthcare system. Models that reward outcomes of care rather than just provision of services offer greater incentives for providers to respond to the social factors that impact health.

SOCIAL PRESCRIBING IN PRACTICE

One of the best-known examples of social prescribing in England can be found in Tower Hamlets in London, an urban area with high levels of socioeconomic deprivation. Family doctors identify patients in their clinics who could benefit from non-medical services and make referrals to a social prescribing coordinator using a standardized form in their electronic medical record. Coordinators contact patients by phone or meet them in person to discuss social issues and identify appropriate services, ranging from debt advice to language or dance classes. Some services are co-located with family doctors, others are provided elsewhere in the community. Coordinators follow-up with patients and offer further support when needed.

A parallel example in the U.S. is Health Leads, a nonprofit organization that trains and supervises volunteers to provide low-intensity social support to patients referred by their primary care providers. Patients are screened for social needs—including employment, housing, legal, and other needs—during regular clinic visits. Those who require support are referred to a Health Leads advocate, typically occupying a desk within the same building, who works with patients to identify and navigate relevant community-based resources. Advocates may help patients find information, complete applications or access local services. They maintain contact with patients as required and provide updates to the clinical team on progress in securing basic resources.

Although interest in social prescribing is growing, the idea is not entirely new. Family doctors in Tower Hamlets have been practicing social prescribing since at least the 1990s, and Health Leads has been in operation for more than 20 years. Looking further back, Jack Geiger —the early community health center pioneer in the U.S.

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—has described how he and colleagues wrote food prescriptions for malnourished children in the Mississippi Delta in 1964, filled by local grocery stores and paid for out of the health center's pharmacy budget.[4]

SOME PROMISING EVIDENCE, YET MORE GAPS IN KNOWLEDGE

These examples demonstrate that social prescribing is feasible, but evidence of its effectiveness is currently lacking. Two systematic reviews recently examined the evidence on interventions to address patients' social needs in clinical settings in the U.S.[5] and England[6] (with each review looking at the evidence in their own countries). Some promising approaches were identified, primarily in the U.S. Observational data from the U.S. show positive impacts of integrating legal services into clinical practice.[7–10] This includes reductions in inappropriate healthcare utilization, improvements in asthma control and general well-being, and favorable financial returns relative to medical–legal partnership costs. Several RCTs in the U.S. examining interventions in pediatric care that identify patients' and families' social needs and link to community-based resources have also reported positive results,[11–13] including one study showing decreases in social needs and improvements in parent-reported child health. And there is relatively strong evidence on the effectiveness of supported employment programs in helping people with severe mental health needs maintain employment.[14,15] Qualitative data from England suggest patients and providers involved in social prescribing interventions are generally satisfied with them.[6]

Overall, however, both reviews noted the paucity of the evidence base, which is characterized by poor-quality studies and small sample sizes. Taken together, the reviews paint a picture of a field where experimentation with social prescribing has outpaced evaluation of its impact, and the little evaluation done is often of poor quality. This is, perhaps, to be expected: efforts to address social needs encompass a wide range of interventions and have often emerged from the "bottom up" to fit local patients' needs rather than strict evaluation criteria. But the result is that knowledge of what works, when, and for which population groups, is limited.

FILLING EVIDENCE GAPS

These evidence gaps provide a major challenge for health policy and practice—particularly as the prevalence of social prescribing grows. Although the potential benefits from closer integration between health care and social services are significant, realizing this relies on the ability to learn quickly from social prescribing interventions and share evidence about what works in different contexts. This is easier said than done. Interventions to address social needs are complex, involve many steps—often spread widely between sectors and over time—and work alongside a range of other influences on people's health. Breakdown at any step in this process can mean that social needs are not improved and potential health benefits cannot be realized. Even if the process works smoothly, the timeframe needed to see changes in health outcomes may extend well beyond available funding. Addressing these challenges will require those establishing and evaluating social prescribing programs to be clear about their intended impact, along with the mediating steps and measures that are likely to contribute to achieving it. This includes care processes—like routes of referral, care navigation, and connections with community-based resources—as well as the perspectives of people using services about whether their needs are being addressed. Data will need to be collected to track how patients move from clinical settings into the community and the support they receive, including where services are located and how they are accessed. Measuring these care processes will help expand knowledge of the active ingredients of social prescribing for different groups.

A ROAD TO (NO)WHERE?

Ultimately, however, social prescribing can only work if effective services are available in the community to address patients' social needs. Once clinicians have identified unmet needs and referred patients to community-based resources, what happens if existing services are unable to meet those needs? This is not an abstract question. A recent study in Philadelphia, for example, tested food insecurity screening in pediatric care combined with referrals to a community-based partner to help families access the Supplemental Nutrition Assistance Program (SNAP).[16,17] Although patients' families were comfortable discussing their food needs with clinicians, many who reported food insecurity were not eligible for assistance through SNAP, or already had access to SNAP but still reported being food insecure.

This road to nowhere problem illustrates the limitations of social prescribing when investment in services to address the social determinants of health is lacking. Differences between the two countries are important: the ratio of spending on social services (such as income support, unemployment programs, and housing) to health care is higher in England than in the U.S., and higher ratios are strongly associated with better health outcomes.[18,19] The U.S. also spends less on social services as a proportion of its Gross Domestic Product. So in