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Social Prescribing: Connecting Primary Care, Communities and the Social Determinants of Health

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Abstract: Background: Many problems presented in clinical practice are shaped by loneliness, financial insecurity, unemployment, unsafe housing, caregiving burden, inactivity and weak social support. Medicines and conventional clinical services alone cannot adequately address these determinants. Social prescribing has emerged as a person-centred approach through which health professionals connect individuals with community-based, non-clinical services. **Objective:** This narrative review examines the conceptual foundations, models, evidence, implementation requirements and potential risks of social prescribing, with particular attention to recent international developments and its relevance to India. **Key findings:** Social prescribing commonly involves referral to a link worker or similar intermediary who explores "what matters" to the individual, develops a personalized plan and facilitates access to community resources. Interventions may include welfare and legal advice, physical activity, arts, nature-based programmes, peer support, volunteering, education and support for housing or employment. Systematic reviews suggest possible benefits for self-rated health, well-being, social connectedness, physical activity and selected condition-specific outcomes. However, effects on general quality of life, mental health, metabolic risk and health-service utilization remain inconsistent. Most studies are observational, interventions are heterogeneous, outcome measures vary and socially disadvantaged participants may face the greatest barriers to engagement. Social prescribing cannot substitute for adequately funded health care, social protection or community services. **Conclusion:** Social prescribing is best understood as a structured pathway linking clinical care with community assets rather than as a discrete therapeutic product. Its effectiveness depends on skilled link workers, accessible and sustainably financed community organizations, clear safeguarding arrangements, equitable referral processes and rigorous evaluation. India has many potentially enabling platforms—including Ayushman Arogya Mandirs, community health workers, local governments and self-help groups—but requires context-specific pilot studies before large-scale institutionalization.

Keywords: Social prescribing; primary health care; social determinants of health; link worker; community participation; health inequalities.

INTRODUCTION

Patients frequently seek medical care for problems whose origins and solutions lie partly outside biomedicine. Persistent pain may be aggravated by loneliness and unemployment; anxiety may reflect debt, domestic insecurity or caregiving strain; poor diabetes control may be influenced by food insecurity, unsafe neighbourhoods and limited opportunities for physical activity. Clinicians can diagnose and treat disease, but conventional consultations often lack the time, information and institutional connections needed to address such circumstances.

Social prescribing has developed as one response to this mismatch. It is generally defined as a process through which health or care professionals connect people with non-clinical services and activities

available in the community to improve health and well-being.[1] The approach recognizes that social relationships, income, housing, education, employment, environment and opportunities for meaningful participation influence health alongside clinical care.

The United Kingdom has been particularly influential in formalizing social prescribing within primary care. In the commonly described model, a general practitioner, nurse, pharmacist, social worker or another professional refers a person to a social prescribing link worker. The link worker conducts a person-centred conversation, identifies priorities, develops a support plan and connects the individual with relevant voluntary, community, social-enterprise or statutory services.[2] Social prescribing has also expanded internationally, including programmes in Australia, Canada, Japan, Singapore, South Korea and several European countries. The World Health Organization has promoted it as a community-level strategy supporting healthy ageing, integrated care and attention to social determinants.[1]

Enthusiasm has grown more rapidly than the evidence base. Social prescribing is sometimes presented as a means of improving well-being, reducing pressure on primary care and lowering hospital use. Yet the term encompasses highly diverse interventions, from brief referral to intensive case management. Consequently, the relevant question is not simply whether social prescribing "works," but which models work, for whom, under what circumstances and with what unintended effects.

Conceptual Foundations

Social prescribing lies at the intersection of personalized care, primary health care, community development and action on social determinants. It begins with the premise that health services should ask not only "What is the matter?" but also "What matters to this person?" This shift is intended to reveal goals and constraints that disease-focused encounters may overlook.

The concept is related to, but distinct from, ordinary signposting. Signposting usually involves providing information about an available service. Social prescribing generally includes a relational process: assessment of needs and preferences, collaborative goal setting, supported referral, follow-up and assistance in overcoming barriers. The intermediary function is particularly important for people who lack confidence, digital access, transport, literacy or familiarity with local services.

Social prescribing is also distinct from prescribing exercise or issuing generic lifestyle advice. Exercise-referral schemes may constitute one form of social prescription, but a comprehensive pathway can address practical, emotional and social needs. Similarly, social prescribing does not mean that clinicians should medicalize poverty or loneliness by converting every social problem into an individual treatment plan. Its purpose should be to connect people with support while informing broader action on structural causes.

The term "prescribing" itself remains contested. It may confer legitimacy and encourage clinicians to recognize community interventions as part of care. Conversely, it may imply a professional authority over activities that should be voluntary and community-owned. Participation must therefore be based on informed choice rather than clinical coercion.

Models and Components of Social Prescribing

Social prescribing programmes vary substantially in intensity. In a light-touch model, a clinician provides information or directly refers a patient to a community activity. More developed models include a link worker who offers multiple contacts over several weeks or months. Intensive models may involve case management, home visits and coordination across health, welfare, housing and social-care agencies.

A functional social prescribing pathway generally contains five components. First, eligible individuals are identified through clinical consultation, proactive population searches, self-referral or referral from community agencies. Second, the person meets a link worker or equivalent professional. Third, needs, strengths and personal goals are explored. Fourth, the individual is connected with suitable services or activities. Finally, progress and continuing needs are reviewed.

Potential prescriptions are broad. They may include walking groups, yoga, dance, sports, gardening, nature-based activities, arts and music programmes, libraries, adult education, volunteering, peer-support groups, befriending services and culturally specific community associations. Practical support may include welfare-benefit advice, food assistance, housing services, legal aid, debt counselling, employment support and assistance for caregivers.

The link worker is central but cannot compensate for the absence of community resources. Effective practice requires knowledge of local services, motivational and communication skills, cultural competence, safeguarding awareness and the ability to coordinate with clinical teams. Link workers must

also maintain boundaries: they are not substitutes for psychologists, social workers, physicians or emergency services when specialist care is needed.

Target Populations

Social prescribing is frequently offered to people with loneliness or social isolation, low-level anxiety or depression, long-term conditions, frequent health-care use or complex social needs. Older adults are a major target group because retirement, bereavement, disability and reduced mobility can weaken social networks. Nevertheless, the approach can be adapted for adolescents, caregivers, migrants, people with chronic pain, cancer survivors and those recovering from substance-use disorders.

Selection should not be based solely on diagnostic categories. Two people with the same disease may require very different forms of support. Conversely, broad eligibility without prioritization may overwhelm link workers and community providers.

Social prescribing is not appropriate as a stand-alone response to acute suicidality, psychosis, severe substance withdrawal, domestic violence, homelessness requiring urgent intervention or uncontrolled medical illness. In such circumstances, it may complement but must not delay statutory, specialist or emergency care.

Evidence of Effectiveness

Well-being and quality of life

Early evaluations frequently reported improvements in well-being, confidence and social connectedness. However, many used before-and-after designs without comparison groups. Participants who remain engaged may differ systematically from those who withdraw, and improvements may partly reflect recovery over time, regression to the mean or attention from a supportive professional.

A systematic review of link-worker interventions found that such programmes may improve self-rated health but may have little or no effect on health-related quality of life, general mental health or several other patient-reported outcomes.[3] The evidence was limited by small studies, heterogeneous programmes and risk of bias. For patients with multimorbidity in disadvantaged settings, intensive interventions may improve perceived quality of primary care and possibly reduce hospital use, but these findings were based on limited evidence.

A 2024 systematic review and meta-analysis of randomized and quasi-randomized studies involving adults with long-term conditions found some improvements in quality of life and condition-specific psychological outcomes, particularly among people with cancer or diabetes.[4] However, general psychological well-being did not consistently improve, and the overall certainty of evidence remained poor.

These findings suggest that social prescribing may be most effective when interventions are closely matched to a defined need and supported over time. Combining dissimilar schemes under one label may obscure important differences.

Mental health and loneliness

Social isolation and loneliness are commonly cited indications. Group activities, peer support, volunteering and creative programmes can provide social contact, belonging and purpose. Qualitative studies often describe improved confidence and reduced isolation among participants who form meaningful relationships.

Nevertheless, quantitative effects on depression, anxiety and loneliness are inconsistent. Some participants referred for social isolation may be uncomfortable in groups or may experience stigma, sensory limitations, language barriers or social anxiety. A referral alone does not create meaningful connection. Benefits depend on the quality of the activity, continuity, interpersonal safety and whether participation aligns with the person's interests.

Social prescribing should therefore complement rather than replace evidence-based psychological and psychiatric care. Referring a person with significant depression to a community activity without assessment, follow-up or treatment can represent under-care rather than holistic care.

Physical activity and chronic disease

Physical-activity referral is among the most studied forms. A 2023 meta-analysis of randomized trials found that social prescribing exercise interventions produced a small increase in physical activity—approximately 21 minutes per week at intervention completion and 19 minutes per week during follow-

up of up to 12 months.[5] No consistent improvements were demonstrated for body weight, blood pressure, glucose or lipid measurements.

These results are important because statistically significant increases in activity may not be sufficient to produce measurable metabolic change. Adherence, baseline health, intervention intensity and access to safe environments influence outcomes. Evidence was also largely confined to exercise schemes; it cannot be generalized automatically to welfare advice, arts interventions or broader link-worker models.

Health-service utilization and costs

Social prescribing is often promoted as a means of reducing general-practice appointments, emergency attendance and hospital admission. Some local evaluations report reductions, but findings are difficult to interpret because high service use often falls naturally after a period of crisis. Selection bias is also likely when programmes preferentially recruit motivated individuals.

The systematic review by Kiely and colleagues found insufficient consistent evidence that link-worker programmes reduce health-service costs.[3] Economic evaluations rarely include the full costs borne by community organizations, participants and families. A reduction in clinical contacts should not be considered beneficial if it results from unmet need or displacement of work to poorly funded voluntary services.

The appropriate economic question is therefore broader than whether social prescribing saves money for health services. Evaluation should examine health outcomes, equity, community-sector costs and whether resources would produce greater benefit through direct investment in housing, welfare or mental-health services.

Table 1. Social Prescribing Interventions, Intended Outcomes, Evidence and Implementation Requirements

Social prescription or support pathway	Main needs addressed	Potential outcomes	Current evidence and limitations	Essential implementation requirements
Physical-activity and exercise groups	Inactivity, chronic disease risk, mobility limitation and social isolation	Increased activity, functional capacity, confidence and social contact	Randomized evidence suggests small increases in physical activity; effects on weight, blood pressure and metabolic outcomes are inconsistent	Clinical screening where required, graded programmes, accessible venues, trained facilitators and follow-up
Arts, music, dance and creative activities	Loneliness, low mood, loss of identity and cognitive or emotional needs	Well-being, self-expression, belonging and confidence	Qualitative findings are favourable; quantitative studies remain heterogeneous and often uncontrolled	Skilled facilitation, culturally appropriate programmes, inclusive participation and sustainable funding
Nature-based or green prescribing	Stress, inactivity, social isolation and limited contact with nature	Mental well-being, activity and social connectedness	Promising but variable evidence; access and seasonal barriers may influence participation	Safe green spaces, transport, accessibility, risk assessment and trained group leaders
Welfare, financial and debt advice	Poverty, debt, benefit insecurity and stress	Improved income, reduced anxiety and better ability to manage health	Strong rationale, but health outcomes are not consistently evaluated	Integration with authorized welfare services, confidentiality, legal competence and rapid referral
Housing and	Poor housing,	Improved	Effects depend on	Formal pathways to

legal support	eviction risk, damp, overcrowding and unsafe conditions	security, reduced stress and potentially better respiratory health	whether structural remedies are actually available	housing authorities, legal aid and safeguarding services
Befriending, peer support and community groups	Loneliness, bereavement, caregiving burden and chronic illness	Social connection, emotional support and self-management	Benefits vary by relationship quality and participant preference; risk of exclusion or dependency exists	Matching, supervision, safeguarding, volunteer support and exit planning
Education, skills and volunteering	Unemployment, low confidence, loss of purpose and limited participation	Skills, self-efficacy, social identity and possible employment	Evidence is mainly observational and context-dependent	Partnerships with education and employment agencies, accessibility and protection from exploitation
Link-worker navigation	Multiple social and practical needs or difficulty accessing services	Improved navigation, personalized care and engagement	Some improvement in self-rated health and care experience; overall clinical evidence remains uncertain	Adequate caseloads, training, supervision, community directories, follow-up and multidisciplinary integration
Digital social prescribing	Geographic isolation, mobility limitation and service navigation	Remote support and wider reach	May improve convenience but can widen inequalities through digital exclusion	Assisted digital access, privacy protection, multilingual design and non-digital alternatives

Public Health Significance

Social prescribing has public health relevance because it attempts to operationalize action on social determinants within routine care. It can make poverty, loneliness, caregiving burden and exclusion more visible to health systems and provide pathways beyond repeated medical treatment.

It may also strengthen community participation. Local groups are not merely destinations for referrals; they can identify unmet needs, build social capital and shape preventive services. This orientation is consistent with primary health care, which emphasizes community participation, intersectoral action and care close to where people live.

However, social prescribing primarily operates at the individual or household level. Connecting a patient to debt advice may reduce distress, but it does not correct inadequate wages or insecure employment. Referring someone to a food programme does not address unaffordable healthy diets. Social prescribing should generate intelligence for policy change rather than normalize repeated management of structurally produced hardship.

Recent Advances

Recent developments include green social prescribing, arts-on-prescription, digital referral platforms and population-health approaches that proactively identify people at risk of social isolation. Nature-based programmes connect individuals with gardening, conservation, walking and outdoor activities. Arts-based models use music, visual art, dance, theatre or creative writing to support expression and connection.

Outcome measurement has also received greater attention. A 2024 umbrella review found substantial variation in the domains and instruments used across social prescribing studies.[6] Common outcomes included mental well-being, loneliness, quality of life, physical activity, social participation and health-service use. The absence of a standard core outcome set impedes comparison and encourages selective reporting.

A further advance is recognition of potential harms. Poorly matched activities may increase distress or reinforce feelings of failure. Group settings may inadvertently exclude people with disabilities, minority-language speakers or those unable to pay for travel. Opportunity costs arise when patients are directed to ineffective services instead of receiving appropriate clinical or social care. The community sector may also experience increased referrals without corresponding funding.

Challenges and Limitations

The central scientific challenge is intervention heterogeneity. A short exercise referral and a six-month link-worker programme involving housing, welfare and peer support may both be labelled social prescribing despite different mechanisms. Pooling them can produce results with limited practical meaning.

Randomization is difficult but not impossible. Waiting-list controls, cluster-randomized designs and stepped-wedge implementation can strengthen evidence. However, trials must capture context and implementation, because an intervention's effectiveness depends on local service availability and relationships.

Referral and participation inequalities are another concern. People with greater confidence, literacy, transport and social resources may benefit most. Those experiencing severe deprivation may be referred but remain unable to attend. Without practical support, social prescribing could widen rather than reduce health inequalities.

Community organizations frequently operate through short-term grants and volunteer labour. Increased clinical referrals can overwhelm them. Sustainable commissioning must cover staffing, premises, safeguarding, data management and evaluation rather than financing only the link worker.

Information governance is complex because health services and community groups may exchange sensitive data. Consent procedures should specify what information will be shared, with whom and for what purpose. Safeguarding responsibilities, crisis escalation and accountability for failed referrals must be explicit.

Indian Perspective

Social prescribing is not yet established as a standardized national programme in India. Nevertheless, the country has several structures that could support contextually adapted models. Ayushman Arogya Mandirs are intended to provide comprehensive primary care, including preventive, promotive, rehabilitative, palliative, mental-health and wellness services close to communities.[7] Community Health Officers, Auxiliary Nurse Midwives, Accredited Social Health Activists and multipurpose workers could identify social barriers and connect people with local support.

India also possesses extensive community assets: self-help groups, Panchayati Raj institutions, urban local bodies, senior-citizen associations, youth clubs, schools, Anganwadi centres, yoga groups, livelihood missions, legal-services authorities and civil-society organizations. Existing pathways for nutrition, social protection, disability support, substance-use services and palliative care could form part of a social-prescribing directory.

Direct transplantation of the British link-worker model would be inappropriate. Indian primary-care teams already face high workloads, uneven staffing and variable community-service availability. ASHAs should not simply be assigned an additional role without training, payment and workload assessment. A distinct social navigator or trained community resource coordinator may be necessary in high-need settings.

Potential initial applications include older adults experiencing loneliness, people with stable chronic diseases requiring activity and peer support, caregivers of dependent relatives, individuals with mild psychological distress, patients recovering from cancer or tuberculosis, and families requiring welfare or livelihood assistance. Social prescribing may be particularly useful in rural and Himalayan areas where formal specialist services are limited but community networks remain strong.

Pilot programmes should begin with mapping of community assets, assessment of unmet social needs and co-design with residents. Referral should be supported rather than merely documented. Evaluation must examine feasibility, acceptability, equity, health outcomes, costs and the burden imposed on frontline workers and community organizations.

Policy Implications

A national social-prescribing strategy would require standards without excessive centralization. Core principles could include person-centred assessment, voluntary participation, supported referral,

safeguarding, data protection and equitable access. States and districts would need flexibility to develop locally relevant community networks.

Funding should follow the referral pathway. Financing link workers while leaving voluntary organizations unsupported would create demand without capacity. Public procurement and local grants could strengthen community-based organizations, but accountability mechanisms must remain proportionate so that smaller groups are not excluded by complex administrative requirements.

Clinical teams require guidance on appropriate referral and red flags. Link workers need competency-based training, supervision and manageable caseloads. Community directories must be current; an outdated digital list is not a functioning referral system.

Performance indicators should move beyond numbers referred. Useful measures include successful contact, uptake, continued participation, goal attainment, well-being, social connectedness, equity, unmet need and appropriate escalation to statutory services. Health-service utilization should be interpreted cautiously rather than treated as the principal marker of success.

Future Directions

Research should identify which components generate benefit: the therapeutic relationship with the link worker, practical resolution of social problems, participation in activities, increased self-efficacy or greater social connection. Mixed-methods studies can examine both outcomes and mechanisms.

A core outcome set is needed, accompanied by validated measures suitable for different cultures and literacy levels. Studies should report referral, uptake, attendance and dropout separately. Non-participation is not merely missing data; it may reveal barriers or poor intervention fit.

Longer follow-up is required to determine whether benefits persist after active support ends. Economic evaluations should adopt a societal perspective and account for costs to patients, families, community organizations and public services.

Equity must be evaluated explicitly. Analyses should examine outcomes by socioeconomic position, gender, age, disability, ethnicity, rurality and digital access. Community members should participate in programme governance and research, not simply serve as recipients.

For India, pragmatic cluster trials embedded within Ayushman Arogya Mandirs could compare usual care with supported social-navigation models. Rural, tribal, urban-slum and mountainous settings should be studied separately because community assets and access barriers differ substantially.

Conclusion

Social prescribing offers a practical framework for connecting clinical care with the social and community conditions that influence health. It can provide patients with time, personalized support and access to resources that medicines alone cannot supply.

The existing evidence is encouraging but not conclusive. Improvements have been reported in self-rated health, social connection, physical activity and selected condition-specific outcomes, but effects on general quality of life, mental health, metabolic risk, hospital use and costs remain inconsistent. Methodological weaknesses, intervention heterogeneity and incomplete reporting limit confident conclusions.

Social prescribing should neither be dismissed because the evidence is still developing nor promoted as an inexpensive solution to social inequality. Its success depends on the quality of relationships, the availability of meaningful community support and the capacity to resolve—not merely document—social needs.

India has a substantial foundation for locally adapted social prescribing through comprehensive primary care, community health workers, local government and civil-society networks. Implementation should begin through carefully evaluated, adequately funded pilots rather than uncritical nationwide replication. Ultimately, social prescribing should complement strong clinical services, social protection and structural public-health action, not substitute for them.

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